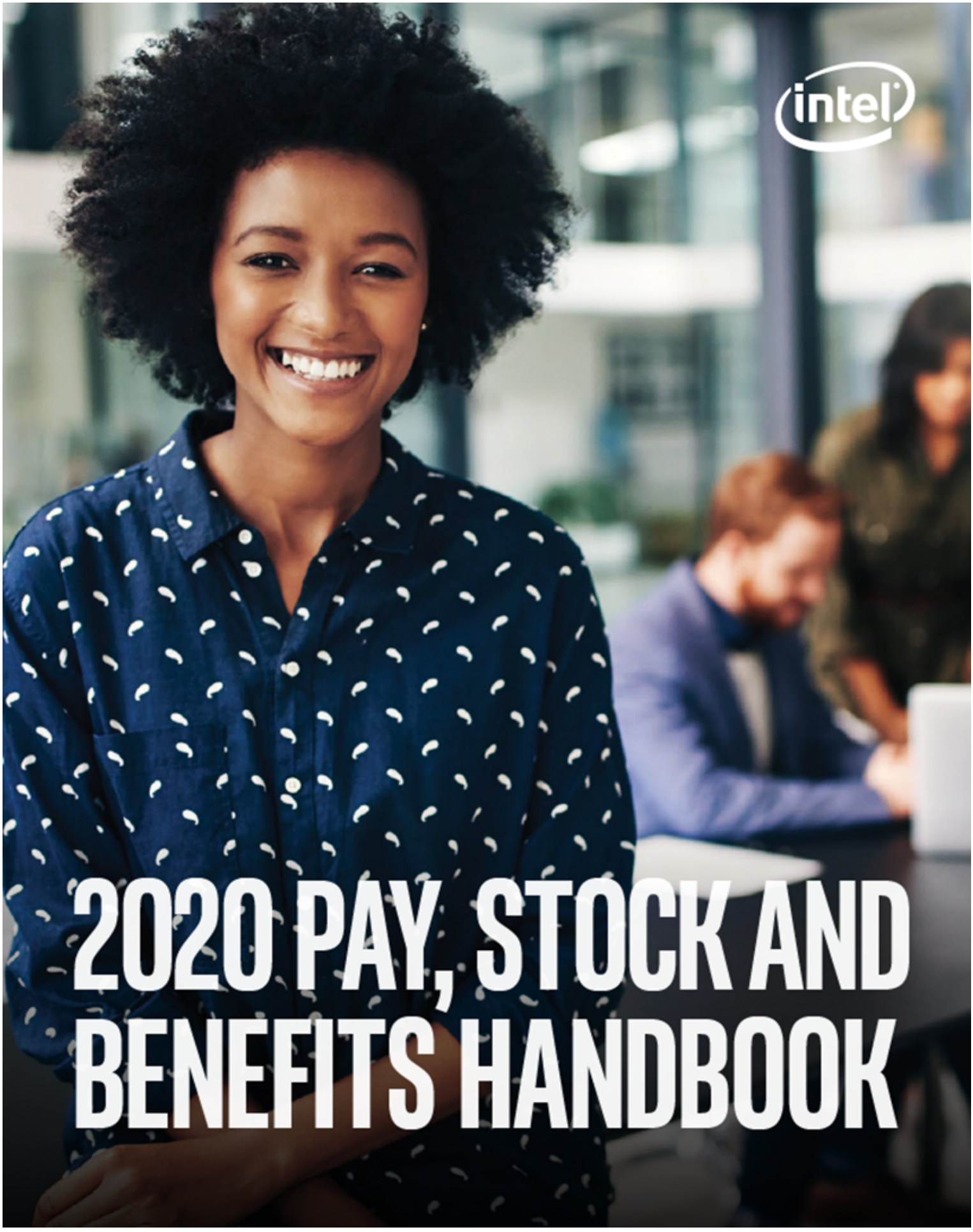
intel
2020 PAY, STOCK AND BENEFITS HANDBOOK

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Chapter 1
About the Handbook

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About the Handbook

This chapter explains the purpose, feedback-change process, and use of the handbook.

1.1 Overview

The handbook provides you with important information about how you are paid and how to use some of the benefits available to you. To get the most value from your pay, stock and benefits, take time to understand how the programs work. For an overview of the benefits that you and your dependents may be eligible for, see, Chapter 4, "Eligibility and Availability of Benefits."

1.2 Staying Up-to-Date

While information on the programs in this handbook is comprehensive, it is not intended to provide every detail that might apply to an individual situation. To determine how a particular plan provision applies to you, submit a question via *the Get HR Help* button on the respective program page on Circuit. If you do not have access to Intel's intranet, you may speak with a Contact Center representative by calling (800) 238-0486.

Information on the individual programs described in this handbook are updated regularly in the online handbook; use the online version to ensure you have the most accurate and up-to-date information. You can also order the latest printed or flash drive version of the handbook by submitting a request via the online request form posted on Circuit. U.S. employees will be notified of any material benefit program changes to this handbook via electronic or standard mail.

1.3 Where to Direct Feedback

The information in this handbook was compiled and written by Global Rewards and Talent Retention for U.S. employees. If you have comments, concerns, suggestions, or feedback regarding the handbook, please contact us through the PSB Handbook Admin email account.

1.4 Disclaimer

This publication satisfies legal requirements by providing written documentation about the benefit plans described within. The information in this handbook is a summary of your benefits and is not intended to take the place of or change official plan documents in any way. In the

event of a discrepancy between the information in this handbook and official plan documents, the plan documents will prevail. For some plans, this handbook contains the official plan document. Refer to Chapter 3, "Administrative Information," for more details.

This handbook does not constitute an employment contract. Nothing in this handbook, expressed or implied, gives you the right to employment with Intel, or affects the right of Intel to terminate your employment at any time, for any reason with or without notice

Intel reserves the right to amend, reduce, suspend or terminate any program or benefit in this handbook, at its sole discretion, at any time

Chapter 2
Pay, Stock and Benefits Philosophy

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Pay, Stock and Benefits Philosophy

This chapter provides information regarding Intel's philosophy for rewarding individual, business group and corporate success.

2.1 Intel's Rewards Philosophy

We believe the best way to inspire our people is to build a mixture of rewarding opportunities reflecting our company values and igniting the highest level of performance. Intel values and rewards the contributions every employee brings to the organization. Every part of Intel's Rewards Philosophy helps to attract and engage talented, innovative people, incent high team and personal performance, and reward those who role model and embody Intel Values and cultural behaviors.

2.2 Pay and Recognition

Being confident and informed on how individual pay is determined, drives trust and transparency across all of Intel. Personal pay is based on many factors such as experience, job, skills, performance, scope and location. All these factors create a total pay package that represents the appropriate pay for the work. Intel and business performance also drive pay through bonuses and sales commission programs.

Pay and recognition is comprised of your base salary, bonuses, stock, and cash recognition awards. The sum of these components equals your total compensation value and will vary based on your performance, job, location and skills. Your base pay is the foundation and is directly aligned to the labor market for a given job, grade and location. Bonus payouts share the success of Intel's profitability and achievement of company objectives. Stock connects your contribution to Intel's future success. Cash awards are made through RECOGNITION.INTEL.COM by manager and partners to appreciate real-time results. The sum represents your total compensation value.

Determining pay is not an exact science, however, we have four main intentions to help guide investments in Intel people – because your ingenuity, skills and applied knowledge ultimately drives Intel's growth. Our guidelines, systems and tools are designed in alignment with these intentions

- To reward people through pay that is **fair and equitable.**
- To deliver **market competitive** pay for the skills and talent needed to achieve our goals
- To **pay for performance** by rewarding and inspireing the highest contributing employees and teams.

- To create an ownership mindset and goodwill that results in solid financial and organizational health through **joint ownership.**

2.3 Benefits and Services

We strive to support our employees and their families through all stages of life and moments that matter by continually making investments in benefits and services that will have a positive impact on our employees well-being. Our innovative health coverage and wellness program are the foundation to having the healthiest employees on the planet. Paid time off programs such as vacation time and sabbaticals, provide you an opportunity to relax and recharge, while retirement and stock ownership allow you to plan for a secure future. Others help you and your family live your best life and manage life events as they occur including having a baby, college applications, caring for aging parents, illness, disability, or death. Through this continual investment we are able to attract and retain the best talent in the business.

2.4 Learning and Career

We aspire to be a "Talent First" employer – because our growth and innovation depends on the ingenuity of Intel people. As we build the workforce of the future with competitive 21st century skills, we provide career services, coaching, executive and technical leader and manager development programs. All qualified employees can participate in in-class and online learning resources, career planning, tuition reimbursement, and rich job assignments domestically and internationally. Our learning culture supports your growth, with >7,000 employee internal job moves per year.

2.5 Life and Community

All of you have unique work styles and lifestyles that Intel supports with of a variety of volunteer program, matching grant s and initiatives such as STEM education. The Intel Foundation recognizes a Global Intel Involved Hero each year for significant impact on community. We also support employee lifestyles through flexible hours, childcare programs, elder care, adoption assistance and new parent integration to ease transition back to work and to grow your family.

Chapter 3
Administrative Information

Chapter 3
Administrative Information

This section provides important information regarding the Employee Retirement Income Security Act (ERISA) of 1974 which describes certain federally mandated rights. Information about the appeals procedures and plan information, including insurer names, addresses, and phone numbers are also provided.

In the event of a discrepancy between the information in this handbook and official plan documents, the plan documents will prevail. For some plans, this handbook is the official plan document. This handbook is the plan document as well as the summary plan description for the Intel Health & Welfare Benefits Plan (the "Intel Group Health Plan" or the "Plan"), plan number 501, and the Employee Assistance Plan ("EAP"), plan number 521, and the Prepaid Legal Plan, plan number 533. This Handbook is the summary plan description for the disability plans, life insurance and voluntary plans.

3.1 ERISA Rights

As a participant in an Intel-sponsored employee health and welfare benefit plan or employee pension benefit plan described in this handbook, 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 the information and rights listed below.

Receive Information about Your Plan and Benefits

You are entitled to the following:

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continued Group Health Plan Coverage

You are entitled to the following:

- Continued 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 summary plan description and the documents governing the plan on the rules governing your Consolidated Omnibus Budget Reconciliation Act (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 employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension or welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a pension or 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 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 administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the plan, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or 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 U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator (see the section below: How the Plan is Administered). If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Agent for Service of Legal Process for Intel's Plans

General Counsel
Intel Corporation
2200 Mission College Blvd
Santa Clara, CA 95052

3.2 Unclaimed Funds

As a condition of entitlement to a benefit under the Intel Corporation Health and Welfare Plan (self-funded options), the Health Flexible Spending Account, the Limited Use Health Flexible Spending Account and the Dependent Care Assistance Plan, the Intel Short Term Disability Plan, Intel California Voluntary Short-Term Disability (CA-VSTD) Plan and the Intel Long Term Disability Plan (individually the "Plan" and, collectively the "Plans"), participants and beneficiaries must keep the Plans informed of their current mailing address and other relevant contact information. If the Plans are unable to locate any individual otherwise entitled to a benefit payment after exercising reasonable efforts to do so (as determined in the sole discretion of the Plan Administrator), the individual is not entitled to a benefit hereunder and forfeits any rights to any benefits.

In addition, as a further condition to any benefit entitlement under these Plans, any person claiming the benefit must present for payment the check evidencing such benefit within one year of the date of issue. Where a check is not received or is lost, it is the beneficiary's responsibility to notify the Plan Administrator within one year of the date of service, or for disability, the date the check was generated, and request that a new check be issued. If any check for a benefit payable under the Plan is not presented for payment within one year of the date of issue of the check, the Plan shall have no liability for the benefit payment, and the amount of the check shall be deemed forfeiture. Where it is administratively feasible, forfeited funds revert back to the respective Plan trust or bank account.

3.3 Anti-Assignment Rights

You may not assign your legal rights or rights to any payments under the Intel Group Health Plan (the "Plan"). Health care providers are not "beneficiaries" or "participants" of the Plan, and have no rights to receive benefits from the Plan under any circumstances. The Plan may make direct payment to health care providers of amounts otherwise payable to participants and/or their dependents to cover the costs of covered health care services, but it does so strictly for the convenience of participants and their dependents. Under no circumstances will such a payment be considered a "benefit" available under the Plan, or confer beneficiary standing upon a health care provider.

3.4 Health & Welfare Benefits Appeals

Topics

3.4.1 Appeals Overview

Intel sponsors the Intel Corporation Health and Welfare Plan (the "Plan"), which provides you a choice for selecting medical, vision and dental plan options and includes Extra Bucks, the Executive Health Program, and the Employee Assistance Plan (EAP). Intel also sponsors the Health Flexible Spending Account ("Health FSA") and Limited Use Health Flexible Spending Account ("Limited Use Health FSA") under the Intel Corporation Flexible Benefit Plan, the Short-Term Disability and Long-Term Disability plans, Life insurance, AD&D, a Business Travel and Accident plan, and several voluntary plans listed below. The appeals procedures for these options are described below.

The procedure for appealing a denial of a claim (an "Adverse Benefit Determination") will depend on the option(s) you are enrolled.

3.4.1.1 Overview - Self-Funded Medical, Vision & Dental Options

If you are enrolled in one of the available self-funded options listed below and wish to appeal an Adverse Benefit Determination, please review the "Self-Funded Medical, Vision & Dental Appeals" section of this chapter.

- Anthem Blue Cross High Deductible Health Plan (HDHP)
- Anthem J1-Visa
- Connected Care High Deductible Health Plan (HDHP)
    - Connected Care ACN HDHP (AZ)
    - Connected Care California HDHP
    - Connected Care HDHP (NM)
    - Connected Care Kaiser HDHP (OR)
    - Connected Care Providence HDHP (OR)
- Connected Care Copay
    - Connected Care Copay (NM)
    - Connected Care Kaiser Copay (OR)
- Connected Care Primary Care Plus
    - Connected Care ACN Primary Care Plus (AZ)
    - Connected Care Providence Primary Care Plus (OR)
- Aetna HMO (AZ)
- Kaiser Permanente HMO (CA)
- Presbyterian Health Plan HMO (NM)
- Extra Bucks (Health Reimbursement Account)
- Intel Dental Plan (administered by Delta Dental of California)
- Vision Service Plan (VSP)

3.4.1.2 Overview - Insured Options: Aetna International, HMSA (Hawaii), and the Dental Health Maintenance Organizations (DHMOs)

If you are enrolled in one of the available insured options listed below, and you wish to appeal an Adverse Benefit Determination the procedures are outlined in your benefits coverage booklets provided by the insurer. Contact your specific medical or dental plan directly with any questions.

- Aetna International
- HMSA (Hawaii)
- Dental Health Maintenance Organizations (DHMO)
    - Sun Life Dental
    - DeltaCare
    - Kaiser Permanente Dental

3.4.1.3 Overview – Executive Health Program

The Executive Health Program is part of the Intel Group Health Plan. The Executive Health Program appeals follow the self-funded appeals procedures (post service appeals) outlined in the Self-Funded Medical, Vision & Dental Appeal section, and are administered by Intel Health Benefits Services.

3.4.1.4 Overview - Employee Assistance Plan ("EAP")

EAP appeals also follow the self-funded appeals procedures (post-service appeals) outlined in the Self-Funded Medical, Vision & Dental Appeal section below. If you are denied EAP services due to ineligibility, please submit a written appeal request to ComPsych at the address provided below in the Contact Information chart.

3.4.1.5 Overview - Health Flexible Spending Account and the Limited Use Health Flexible Spending Account

If you receive a notice that your Health Flexible Spending Account ("Health FSA") or Limited Use Health Flexible Spending Account ("Limited Use Health FSA") claim has been denied (an Adverse Benefit Determination), you should carefully review the information provided regarding the denial. Most often, claims are denied because of missing information on the Claim Form, the supporting documentation was insufficient or failure to provide the required supporting documentation. When a claim is denied for these reasons, it is not necessary to appeal the denial. Simply resubmit your claim with the information requested in the denial letter.

If your claim is denied because the item or service is deemed an ineligible expense, you have the right to appeal the decision and request a review of the Adverse Benefit Determination. Your request must be in writing, and must be sent to the address below within 180 days from the date of the denial. As part of the appeal process, you or your authorized representative may examine documents, records, and other information relevant to your claim and submit issues, documents and comments in writing.

Within 30 days after the request for review is received, you will be notified in writing of the decision of the review. The review will take into account all comments, documents, records, and other information submitted relating to the claim without regard to whether such information was submitted or considered in a previous review. Under no circumstances will your appeal be reviewed by the same individual(s) who made the previous determinations or someone who is subordinate of any individual who made such previous determinations.

If your appeal is denied, the notice of the appeal decision will include the following:

- the specific reason on which the denial was based.
- specific references to the pertinent plan provisions on which the denials based.
- a statement indicating your right to request, free of charge, copies of all documents, records, and other information relevant to your claim, a statement indicating your right to file suit in federal court pursuant to ERISA Section 502(a) (to the extent applicable). You must commence any legal or equitable action for benefits within two years after the date that notification is sent to the participant or beneficiary (and/or his or her authorized representative) that the adverse benefit determination has been upheld on appeal.
- any other information required by federal law.

Please submit your written appeals request to:

YSA Claims and Appeals Management
YSA - Intel Corporation
P.O. Box 1407
Lincolnshire, IL 60069-1407

3.4.1.6 Overview – Intel Short-Term Disability and Intel Long-Term Disability Plans

If you wish to appeal an Adverse Benefit Determination from the Intel Short-Term Disability or Intel Long-Term Disability claims administrator, follow the process outlined in Disability Appeals section of this chapter.

3.4.1.7 Overview - Life Insurance, Accidental Death & Dismemberment (AD&D), and Business Travel Accident (BTA) Plans

If you wish to appeal an Adverse Benefit Determination from the life insurance, AD&D, or BTA claims administrator, follow the process outlined in Life Insurance and AD&D, Appeals section of this chapter.

3.4.1.8 Overview - Voluntary Benefits: Pre-Paid Legal, Long Term Care Insurance, Critical Illness Insurance, and Supplemental Long Term Disability Plans

If you wish to appeal an Adverse Benefit Determination from a voluntary benefit plan claims administrator, follow the process outlined in the specific appeals section of this chapter.

3.5 Self-Funded Medical, Vision & Dental Appeals

Topics

3.5.1 Overview

If you received notice of a denial of your claim (an "Adverse Benefit Determination"), you have up to 180 days from the date you receive the denial notice to file an appeal. If your appeal is denied, you have up to 4 months from the date you receive the appeal denial notice to request an external review.

Different appeals procedures apply, depending on whether your appeal involves an urgent-care claim, a pre-service claim, or a post-service claim and whether the claim is for benefits under the medical, vision or dental options. Refer to the table below for a summary of types of appeals and procedures. If your appeal is denied (a "Final Internal Adverse Benefit Determination") for a self-funded medical claim, you may request an external review to be conducted by an Independent Review Organization ("IRO")*. Review of a denied claim by an IRO is only available for the Plan's medical options, and not the vision, or dental options.

Intel Health Benefits Services will decide appeals for pre-service and post-service claims that involve your eligibility or enrollment in a plan.

> * An IRO is an independent review organization that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct external review.

3.5.2 Procedures for Self-Funded Medical, Vision & Dental Appeals

The following table summarizes the appeals process for each type of claim:

Table: Self-Funded Medical, Vision & Dental Appeals Processes

	Urgent Care Claims	Pre-Service Claims	Post-Service Claims«
Who will review and make a decision on your appeal	The claims administrator of the specific medical, vision or dental option you are enrolled at the time of service will review your appeal and make a determination as to whether the service is a covered benefit. The claims administrator will defer to the attending provider with regard to the decision as to whether a claim is an urgent care claim. The person who reviews and		

	Urgent Care Claims	Pre-Service Claims	Post-Service Claims«
	decides your appeal will be a different individual, and not the subordinate of, the person who made the initial benefit determination. Claims Administrators include: Aetna Anthem Blue Cross ComPsych (for the EAP) Connected Care – Prebyterian Health Services (New Mexico) – Providence Health and Services (Oregon) – Kaiser (Oregon) – Right Choice adminsters ACN Connected Care and Connected Care California plans Kaiser Permanente (California) Presbyterian Express Scripts Vision Service Plan (VSP) Delta Dental of California See the Contact Information Table at the end of this section for addresses and telephone numbers.		
	Intel Health Benefits Services decides appeals for pre-service and post-service claims that involve your eligibility or enrollment in the Plan, Executive Health Program and health FSA appeals.		
How to file an appeal	Submit a written or oral request directly with your medical, vision or dental claims administrator. See the Contact Information Table below for addresses and telephone numbers. All necessary information, including your appeal determination, will be transmitted between your specific claims administrator and you or your authorized representative, by telephone, facsimile, or	Submit a written request directly with the medical, vision or dental claims administrator within 180 days from the date you receive the notice of an adverse benefit determination (a claim denial). See the Contact Information Table at the end of this section for addresses and telephone numbers.	Submit a written request in writing directly with the medical, vision or dental claims administrator within 180 days from the date you receive the notice of an adverse benefit determination (a claim denial). See the Contact Information Table at the end of this section for addresses and telephone numbers.

	Urgent Care Claims	Pre-Service Claims	Post-Service Claims«
	other available similarly expeditious method.		
Time period for deciding your appeal ±	Your appeal will be decided as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for appeal.	Your appeal will be decided within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of your request for appeal.	Your appeal will be decided within a reasonable period of time, but not later than 60 days after receipt of your request for appeal.
How to request an external review for medical claims	You may request an expedited external review of your urgent care claim upon notice of the denial of your claim, and before an appeal decision. Submit your request by phone to your medical claims administrator who will immediately determine whether the request is eligible for expedited external review. If eligible, your claim will be immediately assign to an IRO. See the Contact Information Table below for addresses and telephone numbers.	If your appeal is denied, you may submit a request for external review within 4 months from the date you received your appeal denial letter. Instructions on how to request an external review are included on the denial notice (the "Notice of Final Internal Adverse Benefit Determination"). External reviews are conducted by an Independent Review Organization (IRO). Contact your medical claims administrator directly with questions.	If your appeal is denied, you may submit a request for external review within 4 months from the date you received your appeal denial letter. Instructions on how to request an external review are included on the denial notice (the "Notice of Final Internal Adverse Benefit Determination"). External reviews are conducted by an Independent Review Organization (IRO). Contact your medical claims administrator directly with questions.
Time period for deciding your external review	The IRO will make a decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for	The IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review.	The IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review.

	Urgent Care Claims	Pre-Service Claims	Post-Service Claims«
	an expedited external review.		

« Includes the Extra Bucks and the Executive Health Program under the Intel Group Health Plan, and the Supplemental LTD plan.
± The time period within which a decision on your appeal will be made shall begin at the time you file your appeal in accordance with the procedures in this section, without regard to whether you have submitted all the information necessary to make an appeal determination. However, if you so request, either your medical, vision or dental claims administrator, or Intel Health Benefits Services with regard to eligibility or enrollment, may, in their sole discretion, grant you additional time to submit more information on your appeal.

For all appeals to a self-funded medical, vision or dental option, regardless of the type of claim, including the self-funded Intel Dental plan (administered by Delta Dental), the following will apply:

- You or your authorized representative may review your file.
- You or your authorized representative will be able to submit written comments, documents, records, testimony, and other information or evidence relating to your claim for benefits (and may do so orally or electronically for urgent-care appeals).
- You or your authorized representative shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.
- All comments, documents, records, and other information submitted by you or your authorized representative that relate to your claim will be considered in the appeals process, regardless of whether such information was submitted or considered in the initial benefit determination.
- You will be notified of any new or additional evidence considered in connection with the claim, and will be given a reasonable opportunity to respond to the new evidence.
- The appeals process will not afford deference to the initial Adverse Benefit Determination, and shall be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.
- For Adverse Benefit Determinations that are 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 or investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional shall be an individual who was neither consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor is the subordinate of any such individual.
- Identification of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination, will be provided upon request.

3.5.3 Appointing an Authorized Representative

You may appoint an authorized representative to act on your behalf in submitting an appeal or an external review. Contact your claims administrator, or Intel Health Benefits Services, to find out the process for authorizing someone to act on your behalf.

If your appeal involves urgent care, a health care professional with knowledge of your medical condition (such as your treating physician) can act as your authorized representative without going through the usual process for your plan, or Intel Health Benefits Services, for authorizing a representative.

If you clearly designate an authorized representative to act and receive notices on your behalf with respect to a claim, then in the absence of any indication to the contrary, all information and notifications to which you are entitled will be directed to your authorized representative. For this reason, it is important that you understand and make clear the extent to which an authorized representative will be acting on your behalf.

3.5.4 Notification of Appeal Determination

For non-urgent care appeals, you will be notified in writing of the determination on your appeal. For urgent care appeals, you will be notified of the appeal determination by telephone, facsimile, email, or other available similarly expeditious methods.

In the case of an adverse determination, the notification will include the following information:

- Information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable). Diagnosis and treatment codes and corresponding meanings are available on request.
- Specific reason(s) for the adverse determination.
- Denial code and its corresponding meaning.
- Reference to the specific plan provisions on which the determination is based.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.
- A statement of your right to bring an action under section 502(a) of ERISA.
- If an internal rule, guideline or protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, and that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge upon request.
- If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limitation, either an explanation of the scientific or clinical judgment for the determination, applying the terms of your plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- A description of available internal appeals and external review process.

- For a medical claim, information on how to request an external review (as outlined in External Review Procedures below).
- For the Intel Dental plan (administered by Delta Dental), information on how to request a Voluntary Appeal (as outlined below).

3.5.5 External Review Procedures for the Medical Options

Note: This process does not apply to the insured medical options, Extra Bucks, the Executive Health Program, the Health FSA, the Intel Dental Plan, Vision Care or the DHMOs.

Following an adverse benefit determination on appeal, you may seek an external review—that is, a review of the decision by an independent party. For external reviews, the following procedures will apply:

- Appeals subject to external review are claims involving medical judgment and rescission of coverage.

- Preliminary Review: Within 5 business days following the date of receipt of your external review request, the claims administrator will determine whether the claim is eligible for external review based on the following criteria:

    - Whether you were covered under the Plan at the time the health care item or service was requested or provided;
    - Whether the denial is due to you're not being eligible for coverage under the terms of the Plan, except that rescission of coverage decisions are eligible for external review
    - Whether you have exhausted the internal appeal process, unless you are not required to exhaust the internal appeals process;
    - Whether all of the information and forms required to process the external review have been provided.

- Notice: Within 1 business day after completion of the preliminary review, the claims administrator must notify you in writing if the request is not eligible for external review or if it is incomplete. If the request is not eligible for external review, you will be provided notice of the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If incomplete, the claims administrator will describe the additional information needed in order to qualify for an external review. You then have the remainder of the 4 month period, or 48 hours from the notice, (whichever is longer) to cure the noted defects.
- Assignment to IRO: If the request is eligible for external review, the claim will be assigned to an IRO. The claims administrator will provide the assigned IRO the documents and any information considered in the denial of the claim or rescission of coverage. The IRO will notify you of the eligibility and acceptance of your claim for external review.
- Additional information & reconsideration by the health plan: You may submit additional information, in writing, that will be considered by the IRO within 10 business days from receipt of the notice of eligibility and acceptance from the IRO.

    - The IRO will forward any additional information submitted by you to the claims administrator for consideration.

- If the claims administrator determines upon reconsideration to reverse its denial decision, the claims administrator will provide you, and the IRO, with notice of the reversal within 1 business day of its decision. The IRO will terminate external review upon such notice from the claims administrator.

- Review: The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim anew and is not bound by any decisions or conclusions reached during the claims administrator's internal claim or appeal process. In addition to the documents and information provided, the IRO may consider the following:

    - Your medical records;
    - The attending health care professional's recommendation;
    - Reports from appropriate health care professionals and other documents submitted by the claims administrator, claimant, or the claimant's treating provider;
    - The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
    - Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal Government, national or professional medical societies, boards, and associations;
    - Any applicable clinical review criteria developed and used by the claims administrator, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
    - The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

- Decision: The assigned IRO must provide you written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to you and the claims administrator. If the IRO reverses the health plan's decision, the claims administrator will immediately provide coverage or payment for the claim. The IRO's decision notice will contain:
    - A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
    - The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
    - Reference to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
    - A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
    - A statement that judicial review may be available; and
    - Current contact information.

3.5.6 Voluntary Appeal Review for the Intel Dental plan (administered by Delta Dental)

Note: This process does not apply to the medical options, the vision care plans or the DHMOs.

If your appeal to Delta Dental is denied, you may file a voluntary appeal review with MRI. There are no fees or costs imposed on you for the voluntary appeal review. The decision as to whether or not to submit a denial of your appeal to a voluntary appeal review will have no effect on your rights to any other benefits under the Intel Dental plan. You are not required to undertake a voluntary appeal review before pursuing legal action.

If your appeal is denied by Delta Dental, you will receive in the denial letter a description of the process to follow if you wish to pursue a voluntary appeal review through MRI.

If you choose to file a voluntary appeal review with MRI:

- You may do so only after exhaustion of the required appeal to Delta Dental. Accordingly, you must first submit an appeal with Delta Dental, and receive a denial of your appeal before requesting a voluntary appeal review.

- After you receive a denial of your appeal, you must submit the request for a voluntary appeal review with Delta Dental in writing within 60 calendar days from the date of the appeal denial letter from Delta Dental.

- Delta Dental will forward a copy of the final appeal denial letter and all other pertinent information that was reviewed in the appeal to MRI. You may also submit additional information to MRI that you wish to be considered.

- MRI is an external review organization that utilizes independent professionals with appropriate expertise to perform the review of voluntary appeal reviews. In rendering a decision, MRI may consider any additional information submitted by you and will follow the plan documents governing your dental benefit.

- You will be notified of the decision of MRI within 45 days of the receipt of the request for the voluntary appeal review.

- The statute of limitations or other defense based on timeliness to file a civil action is suspended during the time that a voluntary appeal review is pending.

3.5.7 Civil Action

If you file your claim within the required time period and complete the entire claim and review procedures and your claim is still denied on appeal, you have the right to bring a civil action under Section 502(a) of ERISA. You must commence any legal or equitable action for benefits within two years after the date that notification is sent to the participant or beneficiary (and/or his or her authorized representative) that the adverse benefit determination has been upheld on appeal.

3.5.8 Contact Information for Claims Administrators– Where to File Your Appeal

Table: Contact Information

Claims Administrator	Mailing Address	Phone Number
Aetna HMO	Aetna US Healthcare, Inc. Appeals Resolution Team PO Box 14463 Lexington, KY 40512	(888) 218-0472
Anthem Blue Cross (HDHP, and J1-Visa)	Anthem Blue Cross PO Box 54159 Los Angeles, CA 90054 Attn: Intel Appeals	(800) 811- 2711 Fax: (909) 444-6990
ComPsych	ComPsych Corporation Attn: Customer Service NBC Tower, 13th Floor 455 Cityfront Plaza Drive Chicago, IL 60611-5322	(800) 568-9276
Connected Care (HDHP, Primary Care Plus, and Copay)	Arizona: Connected Care Grievance & Appeal Department PO Box 2900 Milwaukee WI 53201-2900 California: Connected Care Grievence and Appeal Department PO Box 2900 Milwaukee WI 53201-2900 Connected Care AZ and CA (out of area/Out of Network) Medical Appeals Cigna Attn: Appeals P.O. Box 188062 Chattanooga, TN 37422-8062 New Nexico: Presbyterian Health Services Attention: Connected Care Appeals P.O. Box 27489 Albuquerque, NM 87125	(800) 974-4517 (800) 971-4153 (505) 923-8000 or (855) 780-7737

Claims Administrator	Mailing Address	Phone Number
	Oregon: Providence Health Plan Appeals and Grievance Department PO Box 4158 Portland, Oregon 97208-4158 You may fax your grievance or appeal to 503-574-8757 or 800-396-4778 Kaiser Permenante For Medical Claims KPIC - Appeals 3701 Boardman - Canfield Rd. Bldg B Canfield, Ohio 44406 Fax 614-212-7110. For Pharmacy Kaiser Permanente Attn: SFAS National Self Funding 3840 Murphy Canyon Rd San Diego, CA 92123	
Delta Dental of CA (Intel Dental Plan)	Delta Dental of California P.O. Box 997330 Sacramento, CA 95899-7330	(800) 765-9470
Express Scripts	Express Scripts Health Solutions, Inc. 8111 Royal Ridge Pkwy Irving, TX 75063	(800) 899-2713
Extra Bucks	Contact your HDHP administrator.	
Health FSA & Limited Use Health FSA (Your Spending Account)	You may initiate via phone YSA Claims and Appeals Management *YSA - Intel Corporation* *P.O. Box 1407* *Lincolnshire, IL 60069-1407*	(877) GoMyBen (466-9236)
IROs	Contact information to be provided by your health plan supplier	
Kaiser	Kaiser Permanente Appeals 3701 Boardman-Canfield Canfield, OH 44406	N. California (800) 663-1771 S. California (800) 533-1833 Colorado (877) 883-6698 NW Oregon (866) 800-3402
MRI	Medical Review Institute (MRI) 2875 South Decker Lake Drive, Suite 550 Salt Lake City, UT 84119	Phone: 800-654-2422

Claims Administrator	Mailing Address	Phone Number
		Fax: (801) 261-3189
Presbyterian HMO	Presbyterian Health Plan Inc. P.O. Box 27489 Albuquerque, NM 87125	(800) 256-2219
VSP	Vision Service Plan P.O. Box 2350 Rancho Cordova, CA 95741-2356	(800) 877-7195
Intel Contacts		
Health Benefits Services	Intel Health Benefits Services, 1600 Rio Rancho Blvd, RR5-306 Rio Rancho NM, 87124	(800) 238-0486

3.6 Intel Short-Term Disability (STD) Plan or Intel Long-Term Disability (LTD) Plan Appeals

Topics

3.6.1 STD or First-Level LTD Appeal Overview

In the event that your claim is denied, you will receive a written notice from the disability claims administrator of the Adverse Benefit Determination that will outline the following:

- The specific reason for the denial
- Reference to the specific plan provisions on which the determination was based
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why this is necessary
- A description of the plan's appeal procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a)

of ERISA following a denial of your STD claim on review, or for LTD, following an adverse determination on second-level review
- Such other information, statements, and descriptions as may be required by applicable law.

Upon receipt of an Adverse Benefit Determination from the disability claims administrator; you have 180 days to make a written request for review by the ReedGroup Appeals Committee. The notice of the Adverse Benefit Determination will tell you how and where to send the written request for review.

3.6.2 STD or First-Level LTD Appeal Procedures

In the case of any review of an Adverse Benefit Determination, the following will apply:

- You and your authorized representative will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits as determined under applicable law.
- The ReedGroup Appeals Committee's review will take into account all comments, documents, records and other information timely submitted by you or on your behalf relating to your claim for benefits, without regard to whether such information was submitted or considered in the initial claim denial.
- The ReedGroup Appeals Committee's review will not afford deference to the initial claim denial and will be conducted by an appropriate fiduciary who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.
- The ReedGroup Appeals Committee's review will include consultation with an appropriate health care professional as may be required by, and in accordance with, applicable law.
- Medical or vocational experts whose advice was obtained on behalf of the plan in connection with the claim denial will be identified, without regard to whether the advice was relied upon in making the Adverse Benefit Determination.
- You will be notified of any new or additional evidence considered, relied upon or generated by (or at the direction of) the plan in connection with the claim, as well as any new or additional rationale for the denial. Such new or additional evidence and/or rationale will be provided to you as soon as possible and sufficiently in advance of the date on which the notice of adverse determination on first- or second-level review is required to be provided. You will be given a reasonable opportunity to respond to such new or additional evidence or rationale. The plan will consider your response to the new or additional evidence.

Following receipt of a request for review, the ReedGroup Appeals Committee normally will notify you of the review determination within 45 days. If the ReedGroup Appeals Committee determines that special circumstances require an extension of time to make the review determination, the 45-day period will be extended up to an additional 45 days. You will be notified of the extension within the initial 45-day period, and the notice will include an explanation of the special circumstances requiring the extension and the date a review determination is expected.

If an extension is required by the ReedGroup Appeals Committee due to your failure to provide information necessary to making the review determination, the 45-day extension period will not begin until you respond to the ReedGroup Appeals Committee's request for information.

In addition to extensions required by the ReedGroup Appeals Committee, you or your authorized representative may request an extension in writing at any time before the ReedGroup Appeals Committee makes the review determination. All timely extension requests will be granted, and the applicable time-period for the ReedGroup Appeals Committee to make the review determination will be extended by the period of your extension. For example, if you file a request for review on June 1, and then request a 15-day extension on June 30, the 45-day determination period will not end until July 31, rather than July 16 (the date the 45-day determination period would have ended had you not requested the 15-day extension).

The ReedGroup Appeals Committee will not grant an extension request or accept comments, documents, records, and other information submitted by you or on your behalf after the review determination has been made.

In the event that a claim is denied on review, you will receive a written notice from the ReedGroup Appeals Committee that will outline:

- The specific reason for the denial.
- Discussion of the decision, including reasons for disagreeing with views of treating professionals, medical or vocational experts consulted, or Social Security Administration disability determination.
- Reference to the specific plan provisions on which the determination was based.
- The internal rules, guidelines, protocols, standards, or other similar criteria of the plan that were used in the adverse benefit determination, or a statement that such guidelines or criteria do not exist.
- If the denial is based on medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, or you will be provided the explanation free of charge upon request.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits as determined under applicable law.
- A statement of your right to bring a civil action under section 502(a) of ERISA following a denial of your STD claim on review by the Reed Group Appeals Committee, or for LTD, following an adverse determination on second-level review.
- Information about the availability and how to access language services.
- Such other information, statements, and descriptions as may be required by applicable law.
- For LTD Claims only, information on how to initiate a second-level review See **Second-Level Appeal of an Upheld LTD Denial on Appeal.**

For STD, the review determination of the ReedGroup Appeals Committee is the final plan determination and no other mandatory review process is available. For STD, you may not bring a civil action under section 502(a) of ERISA before a review determination is made by the ReedGroup Appeals Committee, and not later than (i) two years after the date the ReedGroup Appeals Committee sends notification that it has upheld the adverse benefit determination on review; or (ii) the date established under otherwise required applicable law only in the event that the STD Plan's two-year limitations period is not enforceable.

The LTD Plan requires a second-level appeal prior to bringing a civil action under ERISA section 502(a).

Submit STD and LTD first-level appeals to:

ReedGroup Appeals Committee
P.O. Box 6248
Westminster, Colorado 80021

3.6.3 Second-Level Appeal of an Upheld LTD Denial on Appeal

If the LTD first-level appeal to ReedGroup is denied, you may request a second-level appeal with Claim Appeal Fiduciary Services (CAFS), an independent, external review organization. There are no fees or costs imposed on you for the second-level appeal. Upon a denial of an LTD first-level appeal, ReedGroup will notify you of the process to request a second-level appeal through CAFS.

If you choose to file a second-level appeal with CAFS:

- You may file a second-level appeal only after exhaustion of the required first-level LTD appeal to ReedGroup.
- You must submit to ReedGroup the request for a second-level appeal in writing within 180 calendar days from the date of the first-level LTD appeal denial.
- Within 10 days of receipt of your request, ReedGroup will forward a copy of the first-level LTD appeal denial letter and your full appeal claim file, including all pertinent information that was reviewed by ReedGroup, to CAFS. You may also submit additional information you wish to be considered.
- You will be notified of any new or additional evidence considered, relied upon or generated in connection with the claim denial, as well as any new or additional rationale for the denial. Such new or additional evidence and/or rationale will be provided to you as soon as possible and sufficiently in advance of the date on which the notice of adverse determination on second-level review is required to be provided. You will be given a reasonable opportunity to respond to such new or additional evidence or rationale. CAFS will consider your response to the new or additional evidence.
- You will be notified of CAFS' decision, generally within 45 days of CAFS' receipt of the request for the second-level appeal. CAFS will have the right to extend the time period for up to an additional 45 days, or toll the time frame based upon the facts and circumstances.

- CAFS has discretionary authority to approve or deny any second-level appeal.

Submit second-level appeals to:

ReedGroup Appeals Committee
P.O. Box 6248
Westminster, Colorado 80021

In the event that a second-level LTD appeal is denied, you will receive a written notice from CAFS that will outline:

- The specific reason for the denial.
- Discussion of the decision, including reasons for disagreeing with views of treating professionals, medical or vocational experts consulted, or Social Security Administration disability determination.
- Reference to the specific plan provisions on which the determination was based.
- The internal rules, guidelines, protocols, standards, or other similar criteria of the plan that were used in the adverse benefit determination, or a statement that such guidelines or criteria do not exist.
- If the denial is based on medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, or you will be provided the explanation free of charge upon request.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits as determined under applicable law.
- Information about the availability and how to access language services.
- A statement of your right to bring a civil action under section 502(a) of ERISA following an adverse determination on second-level review.
- Such other information, statements, and descriptions as may be required by applicable law.

Requests for additional time and requests to submit additional information received after the CAFS determination on review has been made shall be denied.

For LTD, you may not bring a civil action under section 502(a) of ERISA before the notice of an adverse determination on second-level review and not later than (i) two years after the date that CAFS sends notification that it has upheld the adverse benefit determination on second-level review; or (ii) the date established under otherwise required applicable law only in the event that the LTD Plan's two-year limitations period is not enforceable.

If you choose not to request a second-level appeal, the LTD Plan will assert that you have failed to exhaust administrative remedies.

3.6.4 Intel California Voluntary STD Appeal

Upon receipt of a notice of a claim denial from the disability claims administrator, you have 20 days to make a written request for review of the Adverse Benefit Determination. Requests can

be made in writing or in person to the California Employee Development Department (CA EDD). The notice of the claim denial will tell you how and where to submit your request for review.

You and your authorized representative may be provided by ReedGroup, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits as determined under applicable law.

3.6.5 Supplemental Long-Term Disability Appeal

Appealing the Initial Determination

If MetLife denies your claim, you may appeal the decision. You must submit your appeal to MetLife at the address indicated on the claim form, and provided below, within 180 days of receiving MetLife's decision. Appeals must be in writing and must include at least the following information:

- Name of Insured
- Name of the Plan
- Reference to the initial decision
- An explanation why you are appealing the initial determination

As part of your appeal, you may submit any written comments, documents, records, or other information relating to your claim.

After MetLife receives your written request appealing the initial determination:

- MetLife will conduct a full and fair review of your claim.
- Deference will not be given to the initial denial, and MetLife's review will look at the claim anew.
- The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination.
- The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim.
- If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.
- MetLife will notify you in writing of its final decision within a reasonable period of time, but no later than 45 days after MetLife's receipt of your written request for review, except that under special circumstances MetLife may have up to an additional 45 days to provide written notification of the final decision. If such an extension is required, MetLife will notify you prior to the expiration of the initial 45 day period, state the reason(s) why such an extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information, the time period from MetLife's notice to you of the need for an extension

to when MetLife receives the requested information does not count toward the time MetLife is allowed to notify you of its final decision. You will have 45 days to provide the requested information from the date you receive the notice from MetLife.

- If MetLife denies your claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied and reference any specific policies provision(s) on which the denial is based. If an internal rule, protocol, guideline or other criterion was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge.
- Upon written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim.

Submit appeals to:
Individual Disability Income Claims Department
PO Box 30429
Tampa, FL 33630-3429

3.7 Life Insurance and Accidental Death & Dismemberment (AD&D) Appeals

You or your authorized representative may appeal a denied claim to Minnesota Life within 60 days after you receive Minnesota Life's notice of an Adverse Determination on your claim.

You have the right to submit written comments, documents, records, and other information relating to your claim for benefits. Upon request and free of charge, you will be provided reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. Minnesota Life will review and take into account all comments, documents, records, and other information submitted that relate to your claim for benefits, without regard to whether such information was submitted or considered in the initial benefit determination.

Minnesota Life will notify you or your authorized representative of its decision within a reasonable period of time, but not later than 60 days after receipt of your written request for appeal, unless Minnesota Life determines that special circumstances require an extension of time for processing the appeal. If such a determination is made, written notice of the extension shall be furnished to you or your authorized representative before the end of the initial 60-day period.

In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which Minnesota Life expects to render the determination on review. If an extension is required due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the necessary information and the date by which you need to provide it to Minnesota Life. The 60-day extension of the appeal review period will begin after you have provided that information.

Minnesota Life will provide you or your authorized representative with a written notice of its determination on review. In the case of a denial of the claim on review, the notice will set forth the specific reason(s) for the Adverse Benefit Determination, and will reference the specific plan provisions on which the Adverse Benefit Determination is based.

Upon request, and free of charge, you will be entitled to receive reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. You will also be notified of your right to bring an action under section 502(a) of ERISA following a denial of your claim on final review.

Submit appeals to:

Minnesota Life
Group Claims
PO Box 64114
St. Paul MN 55164-0114

3.8 Business Travel Accident Appeals

You or your authorized representative may appeal a denied claim to ACE America Insurance Company (ACE) within 60 days after you receive ACE's notice of an Adverse Benefit Determination. You have the right to submit written comments, documents, records, and other information relating to your claim for benefits. Upon request and free of charge, you will be provided reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. ACE will review and take into account all comments, documents, records, and other information submitted that relate to your claim for benefits, without regard to whether such information was submitted or considered in the initial benefit determination.

ACE will notify you or your authorized representative of its decision within a reasonable period of time, but not later than 60 days after receipt of your written request for appeal, unless ACE determines that special circumstances require an extension of time for processing the appeal. If such a determination is made, written notice of the extension shall be furnished to you or your authorized representative before the end of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which ACE expects to render the determination on review. If an extension is required due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the necessary information and the date by which you need to provide it to ACE. The 60-day extension of the appeal review period will begin after you have provided that information.

ACE will provide you or your authorized representative with a written notice of its determination on review. In the case of an Adverse Benefit Determination, the notice will set forth the specific reason(s) for the Adverse Benefit Determination, and will reference the specific plan provisions on which the benefit determination is based. Upon request, and free of charge, you will be

entitled to receive reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. You will also be notified of your right to bring an action under section 502(a) of ERISA following a denial of your claim on final review.

Submit appeals to:

ACE Insurance
P.O. Box 15417
Wilmington, DE 19850

3.9 Hyatt Legal Plans (Pre-Paid Legal Services) Appeals

You or your authorized representative may appeal a denied claim to Hyatt Legal Plans within 60 days after you receive Hyatt Legal Plans' notice of an Adverse Determination on your claim. You have the right to submit written comments, documents, records, and other information relating to your claim for benefits. Upon request and free of charge, you will be provided reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. Hyatt Legal Plans will review and take into account all comments, documents, records, and other information submitted that relate to your claim for benefits, without regard to whether such information was submitted or considered in the initial benefit determination.

Hyatt Legal Plans will notify you or your authorized representative of its decision within a reasonable period of time, but not later than 60 days after receipt of your written request for appeal, unless Hyatt Legal Plans determines that special circumstances require an extension of time for processing the appeal. If such a determination is made, written notice of the extension shall be furnished to you or your authorized representative before the end of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which Hyatt Legal Plans expects to render the determination on review. If an extension is required due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the necessary information and the date by which you need to provide it to Hyatt Legal Plans. The 60-day extension of the appeal review period will begin after you have provided that information.

Hyatt Legal Plans will provide you or your authorized representative with a written notice of its determination on review. In the case of a denial of the claim on review, the notice will set forth the specific reason(s) for the Adverse Benefit Determination, and will reference the specific plan provisions on which the Adverse Benefit Determination is based. Upon request, and free of charge, you will be entitled to receive reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. You will also be notified of your right to bring an action under section 502(a) of ERISA following a denial of your claim on final review.

Submit appeals to:

Hyatt Legal Plans, Inc.
Director of Administration
Eaton Center 1111 Superior Avenue
Cleveland, Ohio 44114-2507
(For Florida plans contact Hyatt legal Plans of Florida, Inc. at the above address)

3.10 Long-Term Care Insurance Appeals

You or your authorized representative may appeal a claim which has been denied (in whole or in part) to MetLife within 60 days after you receive MetLife's notice of an Adverse Determination on your claim. This request for review should be sent in writing to Group Insurance Claims Review at the address of MetLife's office which processed the claim. You have the right to submit written comments, documents, records, and other information relating to your claim for benefits. When requesting a review, please submit a completed benefit authorization appeal form (completed by your physician or health care provider).

MetLife will re-evaluate all the information, will conduct a full and fair review of the claim and you will be notified of the decision. MetLife will notify you or your authorized representative of its decision within a reasonable period of time, but not later than 60 days from the date MetLife receives your request for review. In the case of a denial of the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied, references any specific plan provision(s) on which the denial is based, and any voluntary appeal procedures offered by the plan

Submit appeals to:

MetLife Long-Term Care
PO Box 937
Westport, CT 06881-9909

3.11 Critical Illness Insurance Appeals

In the event a claim has been denied in whole or in part, you or, if applicable, your beneficiary can request a review of your claim denial by MetLife. This request for review should be sent in writing to Group Insurance Claims Review at the address of MetLife's office which processed the claim within 60 days after you or, if applicable, your beneficiary received notice of denial of the claim. When requesting a review, please state the reason you or, if applicable, your beneficiary believe the claim was improperly denied and submit in writing any written comments, documents, records or other information you or, if applicable, your beneficiary deem appropriate. Upon your written request, MetLife will provide you free of charge with copies of relevant documents, records and other information.

MetLife will re-evaluate all the information, will conduct a full and fair review of the claim, and you or, if applicable, your beneficiary will be notified of the decision. Such notification will be provided within a reasonable period not to exceed 60 days from the date MetLife receives your request for

review, unless MetLife notifies you within that period that there are special circumstances requiring an extension of time of up to 60 additional days.

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied, references any specific plan provision(s) on which the denial is based, any voluntary appeal procedures offered by the plan, and a statement of your right to bring a civil action if your claim is denied after an appeal. Upon written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim.

Submit appeals to:

Metropolitan Life Insurance Company
Submit claims to the MetLife address that processed your claim which can be found on the claim form and denial letter
MetLife Critical Illness Insurance
PO Box 6120
Scranton, PA 18505-9972

3.12 Intel Quality Assurance Review (IQAR) for the Self-Funded Medical, Vision & Dental Options, STD and LTD

The Intel Quality Assurance Review (IQAR) is a process that provides an opportunity for Intel to assure that your claim and/or appeal(s) were processed in accordance with applicable laws and processes, and in compliance with plan terms. The IQAR is not a decision-making body and does not have authority to overturn or supersede any existing rulings, but instead offers a voluntary review of processes, procedures and communications used in and around the determination of your claim and/or appeal. Through this process, Intel monitors its suppliers to assure that they are providing the best quality in the handling of your case.

If you would like to request a review, submit concerns in writing to:

> Intel Quality Assurance Review
> Attn: Cathy A Arias – RNB-5-127
> 2200 Mission College Blvd.
> Santa Clara, CA 95054

IQAR will provide you with a response to your review request within 60-days following the receipt of your HIPAA Authorization. In some circumstances, the review process may take up to 120-days. If this is the case, you will be notified before the lapse of the initial 60-day period that additional time is necessary.

3.13 Benefit Information

Topics

3. 13.1 Overview

The Employee Retirement Income Security Act of 1974 (ERISA) requires that you be provided with the following benefit plan information. This section provides general and administrative information about all the benefits and programs described in this handbook.

Table: Benefit Plan Information

Plan sponsor or employer	Intel Corporation 1900 Prairie City Road, FM1-140 Folsom, CA 95630 (916) 356-8080
Employer identification number	94-1672743
Plan year ends	Dec. 31

If you need information about Pay, Stock and Benefits programs that you cannot locate in this handbook, send an online service request to an Employee Services representative via *Get Help.* (From Circuit, search for *Get Help*.) If you do not have access to Intel's intranet, call an Employee Services representative at (800) 238-0486 or see the Benefits Directory.

Intel reserves the right to amend, reduce, suspend or terminate any Pay, Stock and Benefits program or benefit, at its sole discretion, at any time, by appropriate action of its board of directors or their delegates, or as specified in any applicable plan document.

3.13.2 How the Benefits are Administered

The plan administrator, or anyone who has delegated authority from the plan administrator, has sole, discretionary authority to grant or deny benefits, to make findings of fact in any benefit determination, and to interpret the terms of each of the plans discussed in this handbook. In addition, reasonable plan expenses may be paid from plan assets.

For self-funded benefits, the plan administrator has delegated authority to the designated third party claims administrators ('Claims Administrators") to interpret and construe those benefit program and to determine all factual and legal questions under such benefit programs with respect to all claims for benefits and appeals of denied claims. This delegated authority includes interpreting and construing the plan and benefit programs and any ambiguous or unclear terms, and determining the amount of benefits, if any, you are entitled to receive. This delegated authority does not include decisions as to eligibility or enrollment. The plan

administrator has the sole authority and ultimate responsibility to make determinations regarding eligibility and enrollment decision for self-funded benefits.

For fully-insured benefits, the plan administrator delegates to the insurance company the sole authority, discretion and responsibility to interpret and apply the terms of the benefit program insured by such insurance company and to determine all factual and legal questions under the benefit programs insured by such company. This delegated authority does not include decisions as to eligibility or enrollment. The plan administrator has the sole authority and ultimate responsibility to make determinations regarding eligibility and enrollment decision for fully-insured benefits.

Claims for benefits under a fully-insured benefit program should be sent to the insurance company. The insurance company, and not Intel, is responsible for paying claims.

To find out which benefits are self-funded and fully-insured, see Important Benefit Facts which contains the contact information for the third party claims administrators and insurers for each benefit program.

3.13.3 The Plan Administrator

The plan administrator for the health and welfare plans described in the *Pay, Stock and Benefits Handbook* is the Benefits Administrative Committee (BAC). You may contact the BAC at:

Intel Corporation
Plan Administrator, BAC
Attn: Cathy A Arias – RNB-5-127
2200 Mission College Blvd.
Santa Clara, CA 95054
408-653-5553

3.13.4 How Plans are Funded

Intel contributes toward the monthly premiums for certain benefits. You may contribute for certain benefits through payroll deductions.
For the insured plans that underwrite the insurance policies, see Important Benefit Facts in the table later in this section.
Intel pays the cost of the self-insured medical, vision dental and Long-Term Disability (LTD) Plan benefits from its general assets.
Your contributions to Intel's Short-Term Disability (STD) Plan are held in trust. Intel establishes and annually reviews a funding policy for the trusts. The trustee for the Short-Term Disability trust is:

State Street Bank and Trust, N.A.
Specialized Services
125 Sunnynoll Court, Suite 200
Winston-Salem, NC 27106

The Long-Term Disability (LTD) Plan is not funded. Intel pays the cost of this benefit from its general assets.

3.13.5 Important Benefit Facts

The following table lists ERISA plan names and numbers, and provides you specific information about how each benefit is funded.

Table: Important Benefit Facts

Benefit Name	Funding Medium	Funding
Intel Retiree Medical Plan (IRMP) & Sheltered Employee Retiree Medical Account (SERMA) Plan Number: 526	Intel Retiree Health and Welfare Benefit Trust c/o State Street Bank and Trust, N.A. Specialized Services 125 Sunnynoll Court, Suite 200 Winston-Salem, NC 27106 Additionally, Intel may pay the cost of these benefits directly through its general assets.	This benefit is self-funded. IRMP is funded by retiree contributions. Intel may pay eligible claims incurred under the terms of the plan through its general assets. SERMA is funded through Intel's general assets.
Intel Corporation Health & Welfare Benefit Plan (Group Health Plan) Plan Number: 501 Medical, Dental, Vision and associated Extra Bucks (HRA) benefits in the following options are provided on a self-funded basis: -**Anthem Blue Cross Plans** – HDHP, and J1-Visa **Aetna HMO** **Kaiser Permanente** **Connected Care** **Presbyterian Health Plan HMO**	General assets unless otherwise stated.	This benefit includes options that are self-funded and options that are insured. The Plan is funded by employer contributions and employee contributions through pretax salary reductions. For the self-funded options, Intel pays eligible claims incurred under the terms of the Plan through its general assets. For the insured options, Intel has contracted with the insurer to administer and pay all eligible claims incurred under the terms of the Plan.

Benefit Name	Funding Medium	Funding
Delta Dental (Intel Dental Plan) **VSP Vision Plan** (VSP Basic Vision Plan, and VSP Vision Plus Plan) <u>Benefits in the following options are provided on a insured basis</u>: **DeltaCare DHMO** (CA) (Insured) **Sun Life DHMO (NM and AZ)** (Insured) **Aetna International** (Insured)	Delta Dental of California P.O. Box 1803 Alpharetta, GA 30023 Sun Life Financial PO Box 2940 Clinton, IA 52733-2940 Aetna Life Insurance Company 4630 Woodland Corporate Blvd. Tampa, FL 33614	
Intel Corporation Flexible Benefit Plan(self-funded) **Plan Number: 525** Health Flexible Spending Account (Health FSA) Dependent Care Assistance Program (DCAP) Limited Use Health Flexible Spending Account (Limited Use Health FSA)	Your Spending Account P.O. Box 64030 The Woodlands, Texas 77387-4030	This benefit is self-funded. You pay the contributions.
Group Life Insurance Plan Plan Number: 504	Minnesota Life Group Claims PO Box 64114 St. Paul MN 55164-0114	This benefit is self-funded. Intel pays the cost of the basic coverage. You pay the

Benefit Name	Funding Medium	Funding
		cost of supplemental coverage and your dependents' coverage.
Group Accidental Death & Dismemberment Plan Plan Number: 511	Minnesota Life Group Claims PO Box 64114 St. Paul MN 55164-0114	This benefit is insured. Intel pays the cost of the basic coverage. You pay the cost of supplemental coverage and dependents' coverage.
Business Travel Accident Plan Plan Number: 514	ACE America Insurance Company P.O. Box 15417 Wilmington, DE 19850	This benefit is insured. Intel pays the cost of this coverage.
Intel Corporation Short-Term Disability Plan Plan Number: 512	Intel Disability Benefit Trust c/o State Street Bank and Trust, NA Specialized Services 125 Sunnynoll Court, Suite 200 Winston-Salem, NC 27106	This benefit is self-funded. You pay the contributions.
Intel Corporation Long-Term Disability Plan Plan Number: 506	None	This benefit is self-funded.
Employee Assistance Plan Plan Number: 521	None	This benefit is self-funded
Pre-Paid Legal Services Plan Plan Number: 533	Hyatt Legal Plans, Inc. 1111 Superior Avenue Cleveland, OH 44114-2407 1-877- 770-4638 www.legalplans.com	This benefit is insured. You pay the cost of the premiums for this coverage.
Long Term Care Insurance Plan Plan Number: 532	Metropolitan Life Insurance Company Long-Term Care Group P.O. Box 937 Westport, CT 06881-0937 1-877-770-4638 www.metlife.com/mybenefits	This benefit is insured. You pay the cost of the premiums for this coverage.

Benefit Name	Funding Medium	Funding
Critical Illness Insurance Plan Number: 531	Critical Illness Insurance PO Box 6120 Scranton, PA 18505-9972 1-877-770-4638 www.metlife.com/mybenefits	This benefit is insured. You pay the cost of the premiums for this coverage.
Supplemental Long-Term Disability Plan Plan Number: 534	Individual Disability Income Claims Department PO Box 30429 Tampa, FL 33630-3429 1-877-770-4638 www.metlife.com/mybenefits	This benefit is insured. You pay the cost of the premium for this coverage

3.14 Benefits Directory for Medical, Vision and Dental Claims Administrators and Insurers

Table: Medical, Vision and Dental

Option	Group Numbers and Customer Service Numbers/Hours	Web Sites
Anthem Blue Cross **- High Deductible Health Plan** **- J1-Visa** Includes benefit services administered through the following specialty networks providers: Prescription benefits via Express Scripts	Anthem Blue Cross HDHP Group# ILY174056M2 (800) 811-2711 24-hour Nurseline[1]: (800) 811-2711 (800) 899-2713	www.anthem.com/ca -- Access the secure member Web site for a provider directory; online tools to help you track your account balance (where applicable), claims and benefits; and a 24-hour nurse line and personal health coach to help you manage a health condition www.express-scripts.com -- Find prescription-related resources and services, including mail service prescription refills and locate participating pharmacies
Intel Dental **(Delta Dental of California)**	Group #: 5178 (800) 765-9470 Monday--Friday 5 a.m. to 5 p.m. (Pacific)	www.deltadentalins.com/intel -- Intel Dental Plan's nationwide directory of Delta Dental PPO and Delta Dental Premier dentists. Includes dental benefits and coverage and claims status for you and your family. Send e-mails directly to Delta's Customer Service and Member Services department from this site
Aetna International **(Aetna Life Insurance Company)** For U.S. outbound long-term temporary business travelers	Group# 881627 24x7 Access: (888) 919-3229 (outside the USA, via AT&T + access) (813) 775-0185 (direct or collect outside the USA)	*www.aetnainternational.com* -- To access the Aetna International Welcome Kit for new members, from Circuit, search for Medical Plans

Option	Group Numbers and Customer Service Numbers/Hours	Web Sites
	24 Hour Informed Health line - Direct Line (800) 556-1555 Fax: (800) 475-8751 (859) 425-3363	
Vision Service Providers (VSP)	Group # 30042075 (866) 798-9193	www.vsp.com - Locate a VSP doctor or obtain information or how to use your VSP benefits. T register, use your WWID as the subscriber ID

Connected Care, Health Maintenance Organizations (HMOs) and Dental Health Maintenance Organizations (DHMOs) (Listed by state)

Arizona

Option	Group Numbers and Customer Service Numbers/Hours	Web Sites
Aetna U.S. Healthcare Inc. (HMO) (Aetna Life Insurance Company)	Group# SI 476721 888) 218-0472 (24 X 7) 24-hour Nurseline[1]: (800) 556-1555	www.aetna.com/index.htm -- Listing of participating medical facilities and providers
Arizona Care Network (ACN) – Connected Care ACN	Group # ACNCC0016 800-974-4517 8 am – 6 pm (Arizona time)	https://www.connectedcarehealth.com Access the provider directory. On line service allows members to view claims and plan benefit details.

Sun Life Dental plan (DHMO)	Group# 925490 (800) 247-6875	www.sunlife.com/onlineadvantage -- Select member services for information about dental health and provider information. Current members can access their account information online

California

Option	Group Numbers and Customer Service Numbers/Hours	Web Sites
Connected Care California	Group #INTELCCC (800) 971-4153 Monday – Friday 8 am – 6 pm PST	https://www.connectedcarehealth.com Access the provider directory. On line service allows members to view claims and plan benefit details.
Kaiser Permanente Northern California (Kaiser Foundation)	Group# 00110001 (800)663-1771 Monday--Friday, 7 a.m. to 7 p.m. (Pacific) 24-Hour Nurseline[1]: (916) 817-5200 (Folsom) (408) 236-6440 (Santa Clara)	http://my.kp.org/intel -- Access the physician directory and list of locations. Includes health and wellness information. Online service allows members to schedule doctor appointments and get answers to health questions.
Kaiser Permanente Southern California (Kaiser Foundation)	Group# 00110001 (800) 533-1833 Monday--Friday, 7 a.m. to 7 p.m. (Pacific) 24-Hour Nurseline[1]: (619) 528-5000 (San Diego)	http://my.kp.org/intel -- Access the physician directory and list of locations. Includes health and wellness information. Online service allows members to schedule doctor appointments and get answers to health questions
DeltaCare USA (DHMO) (Delta Dental of California)	Group #: 1562 (800) 422-4234 5 a.m.to 6 p.m.	deltadentalins.com/intel Access a provider directory, company profile and dental health information.

Hawaii

Option	Group Numbers and Customer Service Numbers/Hours	Web Sites
Hawaii HMSA	Group# 022482001 1-800-776-4672	http://www.hmsa.com

New Mexico

Option	Group Numbers and Customer Service Numbers/Hours	Web Sites
Connected Care (administered by Presbyterian Healthcare Services) **High Deductible Health Plan Copayment**	Group# GR009412 (855) 780-7737 Toll Free (505) 923-8000	www.phs.org Information on Connected Care Plan participating physicians, facilities, and basic health plan information and resources. Change your PCP online, request enrollment materials, and contact the Customer Service department
Presbyterian HealthCare (HMO)	Group# GR001459 (800) 356-2219 24-Hour Nurseline[1]: (800) 905-3282	www.phs.org -- Information on Presbyterian Health Plan's participating physicians, facilities, and basic health plan information and resources. Change your PCP online, request enrollment materials, and contact the Customer Service department
Sun Life Dental plan (DHMO)	Group# 925490 (800) 247-6875	www.sunlife.com/onlineadvantage -- Select member services for information about dental health and provider information. Current members can access their account information online

Oregon

Option	Group Numbers and Customer Service Numbers/Hours	Web Sites
Connected Care (administered by Providence Health & Services) **High Deductible Health Plan** **Primary Care Plus**	Group number 111395 Customer service number 503-574-5100 or 1-855-210-1590 Hours 8 am – 6 pm Monday through Friday	http://oregon.providence.org/our-services/i/intel
Connected Care (administered by Kaiser Permanente) **High Deductible Health Plan** **Copayment**	Group# 00110001 Connected Care: 1-844-533-2885 Hours of Operation: 11am-8pm EST or 8am -5pm PST M-F - Closed most national holidays	http://my.kp.org/connectedcare
Kaiser Permanente (Dental-DHMO)	Group# 1434 (503) 813-2000	http://my.kp.org/intel -- Access the dentist directory and list. Online service allows members to schedule appointments and get answers to dental questions

[1]A 24-hour toll-free line that provides enrolled members' information on a wide range of health topics. Kaiser Permanente does not specifically offer a 24-hour health information line, but members can contact the site clinic numbers listed to access health care resources.

Contact the HDHP administrator for Extra Bucks information.

3.15 Benefit Directory for the U.S. Leave of Absence, Disability, and Workers' Compensation

Supplier	Contact Information
Leave of Absence and Disability (STD & LTD) administration Contact ReedGroup for all your leave administration needs	ReedGroup Web site: www.Portal.ReedGroup.com/Intel_ **Call Center:** (866) 532-5664 Outside the U.S. (720) 490-4932 Monday--Friday, 5 a.m. to 6 p.m. (Pacific) **Fax** : (720) 279-2911 **Mailing Address:** ReedGroup, Ltd. P.O. Box 6248 Broomfield, CO 80021
Workers' Compensation administration Broadspire	If you are injured at work or become ill because of work, you must notify your manager and Occupational Health (OH) immediately. OH will then file your workers compensation claim with Broadspire

3.16 Benefit Directory for Other U.S. Benefit Suppliers

Supplier	Contact Information
Childcare Resource and Referral Program	(800) 854-1446
Flexible Spending Accounts (FSA) **Your Spending Account (YSA) by Aon Hewitt** Contact the Intel Health Benefits Center for the Health FSA, Limited Use Health FSA and Dependent Care Assistance Program	Intel Health Benefits Center at (877) GoMyBen (466-9236) Monday--Friday, 5 a.m. to 5 p.m. (Pacific) or visit the My Health Benefits Web site
Participant Advocacy Contact Participant Advocate to help you resolve issues with a complex health claim or accessing care	Intel Health Benefits Center at (877) GoMyBen (466-9236)
Health for Life Center Full-service primary care clinics with an onsite physician and medical staff.	Administered by Take Care Health Solutions; Presbyterian in New Mexico Contact Intel Health Benefits Center at (877) GoMyBen (466-9236)
Life insurance or AD&D insurance Minnesota Life	(877) 494-1673
Business Travel Accident ACE	Intel Health Benefits Center at (877) GoMyBen (466-9236)
Life Insurance Beneficiary Designation My Health Benefits	Intel Health Benefits Center at (877) GoMyBen (466-9236)
Work-Life Balance Resource and Referral Program Information/educational materials on childcare, adoption, parenting, elder care, and education	(800) 854-1446
Get Help and Employee Services Contact Center **Note:** Answers to most employee services and benefits questions can be found on Circuit	*Get HR Help* -- A confidential way to find answers to non-urgent employee services and benefits questions online or to submit a question directly to an Employee Services representative; from Circuit, search for *Get HR Help* **For urgent or sensitive employee issues** (i.e., harassment or violence in the workplace, urgent access to care issues, etc.) call an Employee Services representative at (800) 238-0486,

Supplier	Contact Information
	Monday--Friday (except Intel holidays) from 9 a.m. to 4 p.m. (Pacific)
Intel Retirement Plans Fidelity Investments	(888) 401-7377
Stock E*TRADE (Stock Plan Benefits Administrator) Computershare Investor Services (Transfer Agent)	http://www.etrade.com (800) 838-0908 (800) 298-0146
Employee Assistance Program (EAP) ComPsych	(800) 568- (9276)
Pre-paid Legal MetLaw Hyatt Legal Plans, Inc.	www.metlife.com/mybenefits (877) 770-4638
Long-Term Care MetLife	www.metlife.com/mybenefits (877) 770-4638
Critical Illness – MetLife	www.metlife.com/mybenefits (877) 770-4638
Supplemental Long Term Disability Plan MetLife	www.metlife.com/mybenefits (877) 770-4638
BenefitWallet **(Anthem HDHP HSA administrator)**	(866) 686-4798
Fidelity **(HSA administrator)**	(888) 401-7377

3.18 Newborns & Mothers Health Protection Act

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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

3.17 Women's Health & Cancer Rights Act - Breast Reconstruction Medical Benefits

Group health plans, health insurers, and health maintenance organizations that provide medical and surgical benefits for a mastectomy must provide certain benefits related to breast reconstruction as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA).

If you or your dependent undergoes a mastectomy and elect breast reconstruction in connection with the mastectomy, coverage will include the following:

- All stages of reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatments for physical complications of mastectomy, including lymph edemas.

Coverage will be provided as determined in consultation between the attending physician and the patient. This coverage is subject to deductibles and coinsurance limitations consistent with those established for other benefits under your medical plan. If you would like more information on WHCRA benefits as they apply to the Intel Group Health Plan, please call the specific health plan option you are enrolled or plan to enroll.

3.19 Medical Privacy

Intel has always taken voluntary steps to safeguard your personal information. The U.S. Department of Health and Human Services has also issued the Privacy and Security Rule under the Health Insurance Portability and Accountability Act (HIPAA), and the HITECH Act of the American Recovery and Reinvestment Act of 2009, with additional requirements for health plans.

Under the Privacy Rule, the Intel health "plans" (Intel Corporation Health and Welfare Benefits Plan, Intel Corporation Retiree Medical Plan, Sheltered Employee Retirement Medical Account, Employee Assistance Plan, Health For Life Wellness Programs, Health For Life Centers, the Health FSA and the Limited Use Health FSA under the Intel Corporation Flexible Benefit Plan) have implemented policies and procedures restricting the use and disclosure of your "Protected Health Information" (PHI). To view the policies and procedures, from Circuit search for Intel HIPAA Privacy Procedure.

Under the Security Rule, the plans have implemented administrative, physical and technical safeguards that reasonably and appropriately protect the confidentially, integrity and availability of the electronic PHI that it creates, receives, maintains, or transmits. To view the policy and procedures, from Circuit search for Intel HIPAA Security Procedure.

Intel is the plan sponsor of the plans. Members of Intel's workforce have access to the PHI for administration functions of the plans. Intel shall have access to PHI and electronic PHI from the plans only as permitted under this amendment or as otherwise required or permitted by HIPAA.

You are not required to take any affirmative action to be protected under the Intel HIPAA Privacy or Security policies and procedures. For detailed description of how medical information about you may be used and disclosed, and how you can get access to this information, see the Notice of Privacy Practices posted on Circuit. From Circuit search, My Life & Career, Healthcare Benefits, Medical Privacy Information.

The plans may disclose PHI to Intel to the extent necessary for plan administration purposes. Plan administration purposes means administration functions performed by Intel on behalf of the plans, such as quality assurance, claims processing, and auditing, population-based activities designed to improve health or reduce costs such as disease management or wellness programs. Enrollment and disenrollment functions performed by Intel, or a third party administrator, are performed on behalf of Intel as plan sponsor. Enrollment and disenrollment information is employer data and is not PHI.

Intel will not use or disclose PHI in a manner inconsistent with the HIPAA privacy rules.

Where required by HIPAA, Intel agrees that with respect to any PHI disclosed to it by the plans, Intel shall adhere to the following:

- Not use or further disclose the PHI other than as permitted or required by the plans or as required by law.
- Ensure that any agent, including a subcontractor, to whom it provides PHI received from the plans, agrees to the same restrictions and conditions that apply to Intel with respect to PHI.
- Not use or disclose the PHI for employment related actions and decisions or in connection with any other benefit or employee benefit plan of Intel.
- Report to the plans any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.
- Make available PHI to comply with HIPAA's right to access in accordance with 45 CFR § 164.524.
- Make available the information required to provide an accounting of disclosure in accordance with 45 CFR § 164.528.
- Make available PHI for amendment, and incorporate any amendments to PHI, in accordance with 45 CFR § 164.526.
- Make its internal practices, books, and records relating to the use and disclosure of PHI received from the plans available to the Secretary of Health and Human Services for purposes of determining compliance by the plans with HIPAA's privacy requirements.
- If feasible, return or destroy all PHI received from the plans that Intel still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to the purposes that make the return or destruction of the information infeasible.

- Ensure that the adequate separation between plans and Intel required by 45 CFR § 504(f) (2) (iii) is satisfied.
- If Intel creates, receives, maintains, or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization, which are not subject to these restrictions) on behalf of the covered entity, it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI.
- Intel will ensure that any agents to whom it provides such electronic PHI agree to implement reasonable and appropriate security measures to protect the information.
- Intel will report to the plans any security incident of which it becomes aware.

Adequate Separation Between Plans and Intel: Intel shall allow only specific parties' access to PHI to the extent necessary to perform the plan administration functions that Intel performs for the plans. In the event that any of these specified parties does not comply with the provisions of this section, the party shall be subject to disciplinary action by Intel for noncompliance pursuant to Intel's discipline and termination procedures.

Intel will ensure that the provisions of this section are supported by reasonable and appropriate security measures to the extent that the parties have access to electronic PHI.

Chapter 4
Eligibility and Availability of Benefits

Chapter 4
Eligibility and Availability of Benefits

This chapter summarizes general benefit eligibility information for U.S. Intel Corporation employees and U.S. employees of participating subsidiaries (Intel Massachusetts, Inc., Intel Americas, Inc., Intel Resale Corp., Intel Mobile Communications North America, Inc., Intel Federal LLC, and Intel Media, Inc.) based upon employment classification.

4.1 Eligibility Overview

Your employment classification determines whether you are eligible to participate in a particular program. For additional eligibility rules, see the detailed information provided in the relevant *Pay, Stock and Benefits Handbook* chapters.

4.2 Availability of Benefits by Employee Classification

- **General Full-Time Employee (GFT):** A U.S. Intel employee who works at least 32 hours each week.
- **Part-Time Employee (PTE):** A U.S. Intel employee who works fewer than 32 hours each week. Certain program benefits may be prorated.
- **Intel Contract Employee (ICE):** A U.S. Intel employee hired to work, by contract, for a specified length of time.
- **Intern**: A U.S. Intel employee hired to fulfill a short-term job assignment, usually for the summer or holiday break from school. Requires a personnel requisition through the College Relations Program.
- **Expatriate on U.S. Payroll**: A U.S. Intel employee on assignment outside of the United States for greater than 90 days. Such employees are also classified as GFT, PTE, etc., in the U.S. (their home country).
- **Inpatriate not on U.S. Payroll**: A non-U.S. employee on assignment within the U.S. for greater than 90 days, but not on U.S. payroll. Such employees may also be classified as a GFT, PTE, etc., in their home country.

The following abbreviations are used to designate benefit availability:

Automatic (A): You are automatically covered by, enrolled in, or begin accruing service credit toward this benefit.
Eligible (E): You are eligible for and may elect to participate in the benefit.
Ineligible (I): You are ineligible for the benefit and may not participate.
Home Country (HC): This is a local home country program.

Note: There may be limitations to eligibility or benefits.

Availability of Benefits by Employee Classification Chart

See the corresponding chapter for specifics on each program.

A = Automatic enrollment E = Eligible I = Ineligible HC = Home Country	General Full-time Employee	Part-time Employee	Intel Contract Employee	Intern	Expatriate on U.S. Payroll†	Inpatriate not on U.S. Payroll†
Quarterly Profit Bonus	A	A	I	I	A	HC
Annual Performance Bonus	A	A	I	I	E	E
Medical--employee	A	A	A	E[8]	A[1]	A[1]
Medical--dependent	E	E	E	E[8]	A[1]	A[1]
Dental--employee	A	A	A	E[8]	A[1]	A[1]
Dental--dependent	E	E	E	E[8]	A[1]	A[1]
Vision --employee	A	A	A	E[8]	A[1]	A[1]
Vision--dependent	E	E	E	E[8]	A[1]	A[1]
Pretax Contributions	E	E	E	E[8]	E	I
Intel Short-Term Disability	A	A	A	I[2]	A	HC
Intel Long-Term Disability	A	A	I	I	A	HC
Basic Life and Basic AD&D	A	A[5]	A	A	A	HC
Supplemental and Dependent Life/AD&D**	E	E[5]	I	I	E	HC
Business Travel Accident	A	A[5]	A	A	A	A
Retirement benefits: 401(k) Savings Plan	A[3]	A[3]	A[3]	I	E	HC
Minimum Pension Plan[7]	A	A	A	I	A	HC
SERMA	A[4]	A[4]	A[4]	A[4]	A[4]	HC
Stock Purchase Plan	E	E	E	E	E	HC
Equity Incentive Plan (formerly the Stock Option Plan)	E	E	I	I	E	HC
Vacation	A	A[5]	A[5]	A[5]	A	HC
Local Holidays	A	A[5]	A	A	A	A
Sabbatical	A	I[6]	I[6]	I[6]	A	I
Personal Absence—Non-exempt employees	A	A[5]	I	I	A	HC
Jury Duty	A	A	A	A	A	N/A
Bereavement	A	A	A	A	A	HC
Intel Paid Family and Intel Paid Bonding Leaves	E	E	I[9]	I[9]	E	E
Military Leave	A	A	A	A	A	HC
Personal Leave	E	E	I	I	E	HC
Employee Assistance Program	A	A	A	A	A	A

A = Automatic enrollment E = Eligible I = Ineligible HC = Home Country	General Full-time Employee	Part-time Employee	Intel Contract Employee	Intern	Expatriate on U.S. Payroll†	Inpatriate not on U.S. Payroll†
Health Flexible Spending Account	E	E	I	I	E	I
Dependent Care Assistance Program	E	E	E	E[8]	E	I
Work-Life Balance Programs	A	A	A	A	A	A
Tuition Assistance Program	E	E[5]	I	I	E	HC
Tuition for Teaching	E	E	I	I	E	I
Long Term Care[10]	E	E	E	E[8]	E	I
Critical Illness	E	E	E	E[8]	E	I
Hyatt Legal	E	E	E	E[8]	I	I
Supplemental Long Term Disability[10]	E	I	E	I	E	I
Adoption Assistance Plan	E	E	I	I	E	I

1. **Inpatriates and expatriates** will automatically be enrolled in Aetna International if on assignment greater than 90 days.
2. **Short-term Disability**: Interns who work for Intel Corp. in California will automatically be enrolled in the California Voluntary Short-term Disability Plan (CA-VSTD).
3. **Retirement--401(k):** All employees hired after January 1, 2007 and who do not enroll in the 401(k) Savings Plan within 45 days of their date of hire were automatically enrolled
4. **Retirement--SERMA:** If you were hired or rehired on or after January 1, 2014, you are not eligible for SERMA. See Chapter 18 for details on SERMA eligibility.
5. **Employee** receives prorated program benefits; refer to program chapter for details.
6. **Part-time Employees, Intel Contract Employees and Interns** are not eligible for sabbatical. If you are subsequently hired as a regular full-time, blue-badge employee, your service time as a PTE, ICE or intern will not count towards sabbatical eligibility. Your intern service will count towards sabbatical eligibility if you were subsequently hired as a regular full-time, blue badge employee, prior to January 1, 2018.
7. Employees hired after 12/31/10, and employees of companies acquired after 12/31/10 are not eligible for these benefits
8. **Interns:** If you waive benefits coverage for your Internship, and then are hired as a Full-time or Part-time Employee immediately following your internship, you will not be able to change your benefits enrollment from "waived" to enroll in the benefit because there is no change in your eligibility to enroll in the health benefits from an intern classification to Full-time or Part-time Employee.
9. Intel Contract Employees (ICE) and Interns are not eligible for Intel Bonding Leave or Intel Paid Family Leave, but may be able to take time off under the FMLA, if eligible, for bonding, pregnancy, or other medical and family related reasons.
10. Not open to new enrollment.

** The dependent life program includes Spouse/Domestic Partner Life and Child Life plans.
† Medical, dental and vision benefits for U.S. expatriates and inpatriates on relocation assignments greater than 90 days are provided by Aetna International. For information, contact Aetna International at (813) 775-0185 (direct or collect outside the USA) or (888) 919-3229 (outside the USA, via AT&T + access). Customer service representatives are available 24 hours a day, 365 days a year.

When you enroll, the *My Health Benefits* web site details the benefit options for which you are eligible. The site also provides information on the features and premium costs associated with each option.

Note on Employment Classifications and Eligibility

In determining your eligibility or that of your dependents, Intel's job classification will govern such eligibility. For instance, if Intel classifies and treats you as an independent contractor or other non-employee classification, and a government agency, court or other tribunal later determines you should have been classified as an employee, you will not be eligible for any Intel benefits programs because Intel had not classified you as an employee.

4.3 Dependent Eligibility

Topics

Unless otherwise noted, for all plans that provide dependent coverage, the eligibility of the dependents will depend on the employment classification of the employee, as set forth in the Availability of Benefits section.

4.3.1 Eligible Dependents

Eligible dependents are limited to the following:

- Your legally married **spouse** as per the laws of any U.S. or foreign jurisdiction having the legal authority to sanction marriages.

- Your eligible **domestic partner.*** An eligible domestic partner is a person with whom you are in a committed relationship, is 18 years or older, not related to you, has resided with you for greater than a year, and shares a mutual obligation of support for the basic necessities of life.

- Your eligible **child**, or **eligible domestic partner's child**, until the child's 26th birthday. An eligible "child" means an individual who is a son, daughter, stepson or stepdaughter, an adopted child, or eligible foster child. Custody of a child is not sufficient for eligibility. An adopted child includes an individual who is lawfully placed with you or your domestic partner for legal adoption. An eligible foster child is an individual who is placed with you or your domestic partner by an authorized placement agency or by a judgment, decree, or other order of any court of competent jurisdiction.

  A child's coverage continues to the end of the month of their 26th birthday. The child's coverage is automatically dropped at midnight on the last day of the month of their 26th birthday. As a result of the loss of eligibility for a child who turns 26, they are eligible to continue group health plan coverage through COBRA. A COBRA packet to enroll in COBRA will be mailed to your home address of record. Please see Chapter 11 for information on COBRA.

* **Domestic partner:** The eligibility criteria for enrollment of a domestic partner, or the children of a domestic partner, are detailed and complex. The nature of the complexity lies in the imputed income or the tax treatment of the benefits. For details on taxation, review Chapter 5, Section 5.10 Tax Treatment of Benefits. For information on Qualified Domestic Partner eligibility , see the section below under Special Eligibility Circumstances.

4.3.2 Special Eligibility Circumstances

Disabled Dependent
If an enrolled and otherwise eligible child is permanently disabled by a physical or mental condition before his or her 26th birthday, he or she **may remain** enrolled in the health plans and dependent life insurance plan regardless of age, as long as all of the following conditions are met:

- For medical and dental coverage, you continue to be enrolled in an Intel-sponsored medical or dental plan and cover the dependent under the same plan.
- The physical or mental condition(s) must result in significant and severe functional limitations that prevent the dependent from supporting himself or herself through gainful employment, and should be expected to continue indefinitely without significant improvement.
- The dependent must depend on you for primary financial support. Primary financial support is defined as contributing more than one-half toward your dependent's financial support in a calendar year.
- You must provide medical proof of disability; either Social Security Administration documentation or Intel's Disabled Dependent Questionnaire detailing the disability and expected duration of disability. You may be required to provide proof of your dependent's continued disability at reasonable intervals, as requested by Intel.
- You will be notified 30 days before your dependent's 26th birthday to submit a completed Disabled Dependent Questionnaire. If you do not respond by submitting the Disabled Dependent Questionnaire before your dependent's 26sth birthday, coverage will be terminated at midnight the last day of the month of your dependent's 26th birthday.

A newly hired employee enrolling a disabled dependent over the age of 26 must complete and return the Disabled Dependent Questionnaire within the 30-day period allowed for enrollment in the plan. If the required Disabled Dependent Questionnaire is not received within the time allowed, the dependent coverage will be terminated back to the effective date of coverage.

If your disabled dependent loses coverage under another medical plan, you may enroll your disabled dependent within 30 days after the loss of such coverage, provided the other coverage was in force prior to your dependent's 26th birthday. You must complete and return a Disabled Dependent Questionnaire within the 30-day timeframe for the coverage to take effect.

Qualified Domestic Partner
A domestic partner who meets Intel's domestic partner eligibility requirements noted above in the "Eligible Dependent" section above may be claimed as your "Qualified Domestic Partner" for group health plan coverage purposes if the following requirements are also met:

- You and your domestic partner have the same principal place of abode for the entire calendar year;
- Your domestic partner is a member of your household for the entire calendar year;

- During the calendar year, you provide more than half of your domestic partner's total support;
- Your domestic partner is not your (or anyone else's) qualifying child under Code § 152(c); and
- Your domestic partner is a U.S. citizen, U.S. national, or resident of the U.S., Canada or Mexico.

Your Qualified Domestic Partner's health coverage is not treated as income and is not reported on your Form W-2. In addition, unreimbursed health expenses incurred by your qualified domestic partner may be claimed for reimbursement under a Health FSA, Extra Bucks and HSA.

If you enroll your domestic partner in Intel's health benefits, and wish to claim your domestic partner as your Qualified Domestic Partner, you will be required to sign and return an Affidavit of Domestic Partner Tax Status.

Note: The criteria for a qualified domestic partner for group health plan purposes is not the same as the criteria for determining a tax dependent for federal or state income taxes. Please contact your tax advisor for more information on your individual situation and who can be claimed as a tax dependent for health benefits and on your tax filings. Any change in the tax status of your domestic partner directly impacts the calculation of your taxable income.

Qualified Medical Child Support Order (QMCSO)
Intel provides group health plan benefits to any eligible dependent as required by a QMCSO. You may request a free copy of Intel's procedures for determining whether an order qualifies as a QMCSO by calling the Intel Health Benefits Center at (877) GoMyBen (466-9236).

4.3.3 When Dependents Become Eligible

Your dependents become eligible for coverage at the same time you do. If you gain a new dependent after your initial eligibility date, you can add him or her to your benefit plans within 30 days of your dependent becoming eligible.

4.3.4 When Dependents Are Not Eligible

Dependents who are on active duty in the armed services of any country or international authority are not eligible for coverage under any plan through Intel except dependent life and AD&D insurance, exclusions apply.

If your spouse/ domestic partner or child has coverage as an Intel employee, he or she *may not enroll* as both a dependent and as an Intel employee. If both you and your spouse work for Intel and are covered as employees, you may enroll your child(ren) as dependent(s) of only one of you, not both.

If both you and your spouse/domestic partner work for Intel, you may not cover each other under the Spouse Life, Dependent Accidental Death & Dismemberment (AD&D), and Critical Illness Insurance (CII) plans. Your child(ren) may be covered as dependent(s) of only one of you for these dependent life insurance plans.

Charges for children born to covered dependent female children of Intel employees are not eligible for coverage in any plan, except for those costs associated with giving birth and the

routine well care of the newborn before discharge from the hospital. Charges incurred for a sick baby while in the hospital or when discharged are not covered.

In cases of divorce or dissolution of domestic partnership, your ex-spouse / ex-domestic partner is not eligible for coverage under any plan through Intel. You must drop your ex-spouse /ex-domestic partner within 30 days of the date of your divorce or disillusionment. Participants and former spouses can obtain a free copy of the Qualified Domestic Relations Order (QDRO) determination procedures via Fidelity NetBenefits at www.401k.com or by calling the Fidelity Service Center at (888) 401-7377.

Your Responsibility

It is your responsibility to ensure that you and the dependents you enroll are eligible for coverage in accordance with the terms and conditions of the plan. If you enroll a dependent who does not meet the eligibility requirements or you do not drop a dependent who no longer meets eligibility requirements, you will be required to repay Intel for any medical, dental and vision expenses paid for by the plan—as far back as administratively possible for the ineligible dependent, offset by premiums paid toward this ineligible coverage. You will not receive reimbursement for any premiums paid for ineligible dependents and could face disciplinary action, up to and including termination of employment. You may be asked to provide proof of eligibility from time to time.

If your dependent loses eligibility, he or she may be eligible for Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage, but only if you complete the transaction at *My Health Benefits* within 30 days of the event that results in loss of coverage.

You must access the *My Health Benefits* web site within 30 days of a dependent's loss of eligibility to drop the ineligible dependent from your coverage. A loss of eligibility can include instances such as: divorce, exceeding the dependent age limitation, or death of a dependent. Please refer to Chapter 11, COBRA, for complete information on COBRA.

4.4 Enrollment Conditions

In order to enroll in any of the group health plans, you must submit your elections via the *My Health Benefits* website, or call Intel Health Benefits Services in accordance with the enrollment rules.

Your enrollment also stipulates that you understand that enrollment is subject to the terms and conditions of the option you have selected under the respective group health plan, and that you have read the materials provided to you and are aware of the conditions of enrollment and any changes to the benefits. In the event of fraud or intentional misrepresentation of fact, coverage may be rescinded.

4.5 Audit of Eligibility

Intel conducts periodic audits to ensure only eligible dependents are enrolled in the Intel benefit plans. You may be selected to provide proof—e.g., a marriage certificate, birth certificate—that your covered dependents are eligible. You may also be required to provide proof of other events that allow a change to benefits or an extension of benefits under COBRA such as divorce. Disciplinary actions up to and including termination of employment may result if ineligible dependents are identified during the audit. Coverage may be rescinded.

Chapter 5
Health and Insurance Benefits Enrollment

Chapter 5
Health and Insurance Benefits Enrollment

The following information describes the enrollment processes for beginning, changing, or ending participation in a benefit program.

5.1 Benefit Elections Process and Descriptions

Enrollment

These guidelines are strictly enforced to meet federal regulations. It is your responsibility to initiate the enrollment processes according to these guidelines.

These guidelines are intended to:

- Help you understand how the process works
- Provide general benefit descriptions for default coverage
- Provide general benefit descriptions for the elective coverage options that are available when you enroll, change or stop participation in a benefit program.

Both your personal situation and the benefit plan provisions affect the availability of the various benefit programs. This chapter discusses these factors and summarizes information where possible. Note that retirement and stock programs have unique enrollment requirements and procedures. For more information on these benefits, see “Retirement Programs and Stock.” To find this information on Circuit, search for “Retirement Programs” or “Stock.”

You can review your plan eligibility and the employee contributions for you and your family and/or begin the enrollment process on the *My Health Benefits* website; from Circuit search for *My Health Benefits* *or* visit www.intel.com/go/myben.

Notice of Special Enrollment Rights

If you are waiving enrollment for yourself or your dependents (spouse and your children) because of other health insurance coverage, you may be able to enroll yourself and your dependents in the Intel Group Health Plan in the future, provided that you request enrollment no later than 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth*, adoption*, or placement for adoption, you may be able to enroll yourself and your dependent provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. For more information, see “Changing Benefit Elections” in this chapter.

*60 days for birth or adoption.

Additionally, you may be able to enroll yourself and your dependents in the Intel Group Health Plan under two additional scenarios:

- You or your dependent(s) Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility. You must request this special enrollment for you and your dependent(s) within 60 days of the loss of coverage for Medicaid or CHIP.
- You or your dependent(s) become eligible for a premium assistance subsidy* under Medicaid or CHIP. You must request this special enrollment within 60 days of the date that your eligibility for the premium assistance subsidy is determined.

* **Note on premium assistance subsidy**: Some states provide premium assistance subsidies to eligible, low-income children under a **qualified** employer-sponsored group health plan by reimbursing the difference in cost between the state plan and the employer's plan. The Health Flexible Spending Account and the high deductible health plans (HDHP) are not considered a qualified employer-sponsored group health plan.

5.2 Benefit Choices

The following benefit choices are currently available, depending on your location and eligibility. Specific plan provisions and restrictions are detailed in other chapters of the *Pay, Stock and Benefits Handbook.* Descriptions of the benefits below are general and do not include plan limitations or restrictions.

Health Benefit Options
Group Health Plan eligibility is generally based on where you live or work. You may enroll your eligible dependents in medical, dental, and vision coverage. See chapter 4 for a description of who qualifies as eligible dependents. You must elect the same medical, dental, or vision plan option for your eligible dependents as you do for yourself. Each of the medical benefit options include prescription benefits.

Medical and Dental Plan Options

- Anthem Blue Cross High Deductible Health Plan (Anthem Blue Cross HDHP) with Optional Health Savings Account (HSA)
- Connected Care Arizona Care Network High Deductible Health Plan (Connected Care ACN HDHP) with Optional Health Savings Account (HSA)
- Connected Care Arizona Care Network Primary Care Plus (Connected Care ACN PCP)
- Connected Care California High Deductible Health Plan (HDHP) with Optional Health Savings Account (HSA)
- New Mexico - Connected Care High Deductible Health Plan (CC HDHP NM) with Health Savings Account (HSA)
- New Mexico - Connected Care Copayment Plan (CC Copay NM)
- Oregon – Connected Care Providence High Deductible Health Plan (HDHP) with Health Savings Account (HSA)
- Oregon – Connected Care Kaiser High Deductible Health Plan (HDHP) with Health Savings Account (HSA)
- Oregon – Connected Care Providence Primary Care Plus (PCP)

- Oregon – Connected Care Kaiser Copay
- Hawaii HMSA (Hawaii Medical Service Association) PPO
- Delta Dental PPO (formerly Intel Dental Plan)
- Anthem J-1 Visa – Available only to J1-Visa employees and their eligible dependents.

Health Maintenance Organization (HMO) and Dental Health Maintenance Organization (DHMO) Options

- HMO plan offerings, by location, include the following:
    - California—Kaiser Permanente*
    - Arizona—Aetna U.S. Healthcare*
    - New Mexico—Presbyterian Health Plan*

      * Self-insured.
- DHMO plan offerings, by location, include the following:
    - Arizona and New Mexico—Sun Life Dental Plan
    - Oregon—Kaiser Permanente
    - California—DeltaCare USA

Vision Plans

The vision plan is administered through VSP. You have the choice to enroll in the VSP Basic Vision Plan or the enhanced VSP Vision Plus Plan.

Short-Term Disability

Short-Term Disability provides financial assistance if you are unable to work due to illness, injury or pregnancy. New employees and transfers are automatically enrolled and have the option to opt out of the Intel Short-Term Disability plan. For more information, see "Default Coverage and Disability Programs" in this chapter.

> **Note:** Enrollment in a Short-Term Disability plan is mandatory in certain states (CA, HI, NJ, NY, and RI).

Life Insurance / Accidental Death & Dismemberment (AD&D) Benefit Options

- **Supplemental Employee Life Insurance:** You can elect between one and seven times your eligible annual earnings.
- **Supplemental Employee AD& D Insurance:** You can elect between one and seven times your eligible annual earnings.
- **Spouse/Domestic Partner Life Insurance:** You can elect among six coverage levels for your spouse/domestic partner.
- **Child Life Insurance:** You can elect among four coverage levels for all eligible child[ren]

Dependent AD&D Insurance: You can elect among five coverage levels for your spouse/domestic partner and your eligible child[ren].

Flexible Spending Accounts (FSA): These benefits are offered by Intel to help offset the cost of health care and dependent care for employees and their families. FSA programs include the following:

- **Health Flexible Spending Account (Health FSA)**: The Health FSA allows you to pay for eligible non-reimbursed health care expenses with pretax dollars.

- **Limited Use Health Flexible Spending Account (Limited Use Health FSA):** The Limited Use Health FSA allows you to pay for eligible non-reimbursed vision or dental care expenses. Available to those enrolled in an HSA associated with an Intel HDHP.
- **Dependent Care Assistance Program (DCAP):** DCAP allows you to pay for eligible dependent care expenses with pretax dollars.

Long Term Care Insurance (LTC): Long Term Care insurance plan is closed to new enrollees as of December 31, 2011.

Critical Illness Insurance (CI): Critical Illness is an insurance product that pays out a lump sum in the event you experience a covered medical conditions. For more information please see the Pay, Stock and Benefits Handbook chapter 20, Voluntary Benefits.

Pre-Paid Legal (Hyatt Legal): Prepaid Legal Services (Legal Plan) provides personal legal services for you, your spouse/domestic partner, and dependent children. For more information please see Pay, Stock and Benefits Handbook chapter 20, Voluntary Benefits.

Supplemental Long Term Disability (Supp LTD): Supplemental Long Term Disability provides additional replacement income in the event you experience a disability and is a supplement to Intel's Long-Term Disability (LTD) plan. This plan is closed and no longer open for enrollment. For more information please see Pay, Stock and Benefits Handbook chapter 20, Voluntary Benefits.

5.3 Newly Hired or Rehired Employee

You have 30 days from your hire or rehire date to elect your benefits. You will receive an email notification based on your hire date or rehire date. This notification will contain instructions on accessing the *My Health Benefits* website to make your benefits elections. On the *My Health Benefits* website, you will also find details of the benefit programs, options, and premiums for which you are eligible, based on your employee classification and your work location. For additional information, see chapter 4 "Eligibility and Availability of Benefits" in the Pay, Stock and Benefits Handbook.

If your transaction is not submitted within 30 days of your start date at Intel, you will be enrolled automatically in default coverage for some benefits. You can change this default coverage by accessing the *My Health Benefits* website within the first 30 days of your hire or rehire date. Coverage will be effective as of your hire or rehire date.

5.4 Changing Benefit Elections

Topics

5.4.1 Overview

Generally, IRS regulations prohibit election changes to your pretax benefits (health coverage, Health FSA, Limited Use Health FSA or DCAP) at times other than the Annual Enrollment period or your initial enrollment period. However, federal law allows you to make election changes at other times during the year in a limited number of situations. If you experience a change in your work or family circumstances, commonly referred to as a qualified change-in-status event, you **may** be able to make certain changes in your health coverage, Health FSA, Limited Use Health FSA or DCAP consistent with the qualified event. If you experience a qualified change-in-status event that allows you to make a change to your benefits, you must complete the election changes within 30 days of the qualified change-in-status event.

You cannot change plans, enroll new dependents, or drop existing dependents based on the following:

- Dislike of a plan provider
- Desire to discontinue paying for the benefit
- Failure to follow the enrollment process in a timely fashion
- Failure to plan correctly for anticipated expenses under an FSA
- Changes in medical condition
- Changes in health care provider's recommendation

5.4.2 Qualified Change-in-Status Events

The IRS rules regulating election changes are complex. The following list contains qualified change-in-status events that **may** allow you to make certain changes to your health benefits, Health FSA, Limited Use Health FSA and DCAP. If you experience a qualified change-in-status event, you can access the *My Health Benefits* website to make your election changes consistent with the event. You have 30* days from the date of the event to make permitted changes to your benefits. The tool automatically outlines the benefit programs, options and premiums that are impacted. The IRS defines the qualified change-in-status events. These include but are not limited to the following:

- Birth*, adoption*, or obtaining or losing a foster child
- Marriage or divorce. For more information, see the section “When Dependents Are Not Eligible” in chapter 4 “Eligibility and Availability of Benefits.”
- Enter into or dissolve a domestic partnership
- Death of your spouse/domestic partner or eligible dependent. **Note:** In the event of the death of a covered dependent, call the Intel Health Benefits Center at (877) GoMyBen (466-9236).

- Dependent child(ren) gaining or losing eligibility under the Intel plans (for example, reaching age 26).
- Change in work shift or work hours for your spouse/domestic partner.
- Your spouse/domestic partner gaining employment.
- Your spouse/domestic partner terminating employment.
- Your spouse/domestic partner going on unpaid leave of absence.
- You or your spouse/domestic partner returning from unpaid leave of absence.
- Transfer or a change in residence for you, your spouse/domestic partner or a dependent child.
- Intel's receipt of a Qualified Medical Child Support Order (QMCSO) that requires health insurance coverage for your dependent child. (Employee and dependent child must be eligible for coverage.) See "Qualified Medical Child Support Orders" in chapter 4 "Eligibility and Availability of Benefits."
- You, your spouse/domestic partner or dependent child gaining or losing other health care coverage as a result of a change in eligibility, including COBRA coverage. **Note**: Early termination of COBRA coverage prior to the end of your COBRA coverage period, generally 18 months, is not considered a special enrollment event that would allow you to enroll in the Intel plans, Marketplace coverage or another group health. This is because you have not lost eligibility for the coverage.
- You, your spouse/domestic partner or dependent child becoming entitled to Medicare or Medicaid or losing Medicare or Medicaid entitlement.
- Termination of Medicaid or Children's Health Insurance Program (CHIP) coverage for you or your dependent(s) due to loss of eligibility. You must request this special enrollment within 60 days of the loss of coverage for Medicaid or CHIP.
- You or dependent(s) become eligible for a premium assistance subsidy under Medicaid or CHIP. You must request this special enrollment within 60 days of the date when eligibility for the premium assistance subsidy is determined.

*You have 60 days from the birth or adoption of a child to make permitted changes to your benefits.

5.4.3 Additional Qualified Change-in-Status Events for DCAP

- Your spouse begins or discontinues school full-time.
- Your dependent is gaining or losing DCAP eligibility. For example, if your child turns 13 in May and is no longer an eligible dependent, you can drop DCAP on your child's 13th birthday.
- A change in your DCAP provider or a significant decrease in coverage by your DCAP provider. For example, a relative moves into town and is able to care for your children instead of them attending a dependent care facility. (In this situation, you would be allowed to drop DCAP.)
- A change in the cost of a third-party DCAP provider who is not your relative. For example, if your dependent care costs change, you can either enroll in or drop DCAP, or increase or decrease your DCAP annual pledge, so long as the dependent care provider is not your relative.

All Election Changes Must Be Consistent with the Qualified Change-in-Status Event

If you experience a qualified change-in-status event, visit the *My Health Benefits* website; from Circuit search for *My Health Benefits* or from the Internet at www.intel.com/go/myben and make election changes that are consistent with the event. The tool automatically outlines the benefit programs, options, and premiums that are impacted. For more information, see "How to Make Benefits Election Changes" in this chapter. **Note:** If you drop your spouse/domestic partner or dependent child coverage, the dropped dependent may be eligible for COBRA.

For additional information, see *Pay, Stock and Benefits Handbook*, chapter 11 "COBRA Continuation Coverage."

5.4.4 How to Make Benefit Election Changes

If you experience a qualified change-in-status event, you have **30* days from the date of the event** to make permitted changes to your benefits. To make your benefits election changes, visit the *My Health Benefits* website. From Circuit, you search for *My Health Benefits*.

In the event of the death of a covered dependent or you are unable to access *My Health Benefits* from Intel's intranet or the internet, call the Intel Health Benefits Center at (877) GoMyBen (466-9236).

The tool will lead you through the enrollment process and outline the benefits programs and employee contributions that are impacted by the qualified change-in-status event. You must make your election change through the *My Health Benefits* website. For example, benefit changes cannot be made on an enrollment form provided by an HMO.

Medical, dental, and vision coverage changes will be effective as of the date of the qualified change-in-status event.

New paycheck deductions will be effective within two pay periods following the date you make the election change. There will be no retroactive deductions or refunds.

If you fail to complete the election changes **within 30 days** of the qualified change-in-status event, you will not be able to change benefit elections in the medical, dental, vision, Short-Term Disability, Health FSA or DCAP plans until the next Annual Enrollment period or unless you experience another qualifying change-in-status event. However, you may be eligible for life insurance through the Late Enrollment Process. You can make changes to AD&D and Child Life coverage at any time. For more information, see "Annual Enrollment Process" and "Late Enrollment Process" in this chapter.

If you are unable to access the *My Health Benefits website*, contact the Intel Health Benefits Center at (877) GoMyBen (466-9236) within 30* days of a qualified change-in-status event (e.g., marriage, divorce).

*60 days for birth or adoption.

Notes Regarding Dependent Enrollment

- If your dependent has coverage as an Intel employee, he or she may not enroll as both a dependent and an Intel employee.
- When both you and your spouse/domestic partner work for Intel and are covered as employees, only one of you may enroll a child as a dependent, not both. You may not cover each other under the Spouse/Domestic Partner Life or Dependent AD&D insurance plan, and your children may be covered as dependents of only one of you.

5.5 Late Enrollment Process

The only plans that permit late enrollment are the following:

- Supplemental Life insurance
- Spouse/domestic partner Life insurance

Each of these benefit programs requires employees to submit an Evidence of Insurability (EOI) to the life insurance company before enrollment. This is to ensure that you and your spouse/domestic partner are in good health when you enroll in the plan.

The completed application must be mailed to the life insurance company for approval of coverage. If your late enrollment application for life insurance is approved by the life insurance company, coverage will be effective on the date the EOI application is approved. To initiate the late enrollment process and obtain a personalized late enrollment application, you can visit the *My Health Benefits* website, where you can obtain and print the application. From Circuit, search for *My Health Benefits* or from the Internet at www.intel.com/go/myben. If you do not have access to the *My Health Benefits* website, call the Intel Health Benefits Center at (877) GoMyBen (466-9236) to obtain a copy of the late enrollment application.

5.6 Annual Enrollment Process

Each year Intel conducts an Annual Enrollment period for health and welfare benefits. Coverage for the benefits outlined in Annual Enrollment begins on Jan. 1 of the following year.

During Annual Enrollment, eligible employees may do the following:

- Enroll in, change or drop medical, vision or dental plan coverage.
- Enroll in or drop employee supplemental life, spouse/domestic partner life, child life, dependent AD&D, or employee supplemental AD&D life insurance. If you enroll in supplemental or spouse/domestic partner life insurance, you may be required to follow the Late Enrollment Process.
- Enroll eligible dependents in or drop them from medical, vision or dental plan coverage.
- Enroll or re-enroll in Health FSA, DCAP, or both for the next plan year. Eligible participants in the High Deductible Health Plans may enroll or re-enroll in the HSA.
- Enroll in or drop Intel Short-Term Disability plan coverage.

- Enroll in Critical Illness Insurance.
- Enroll in or drop coverage for the Prepaid Legal (Hyatt Legal) Plan.

Electing and changing your benefits elections during Annual Enrollment can be done online by visiting the *My Health Benefits* website. Detailed instructions will be communicated to employees prior to Annual Enrollment.

Important Notes about Annual Enrollment:

- You must re-enroll in Health FSA, Limited Use Health FSA, DCAP and HSA* each year during Annual Enrollment or your participation will cease Jan. 1.
- Employees are not required to enroll the same dependents in medical, vision, and dental coverage. For example, an employee may elect family medical coverage only and opt out of dental and vision or vice versa.
- Annual Enrollment is your only opportunity to enroll or drop Intel Short-Term Disability plan coverage, except for employees in California. For more information, see "Default Coverage" and "Disability Programs" in this chapter.
- Dependents dropped from medical, vision and dental coverage during Annual Enrollment are not eligible for COBRA.

*The Health Savings Account (HSA) option is not an Intel sponsored benefit. The HSA is offered by Fidelity for eligible participants in HDHPs in in AZ, CA, NM, and OR.

5.7 Default Coverage

If you are eligible*, you are automatically enrolled in default coverage effective from your date of hire or the date you first become eligible for benefits due to a change in employee classification. No action is required on your part unless you wish to select different plan options, waive coverage for yourself or enroll eligible dependents. Employee contributions may be required for default coverage in the medical and vision options. Employee contributions are required for the dental plans and the Short-term Disability Plan. You can change your plan elections during a 30-calendar-day enrollment period from your date of hire or rehire or from the date of your employee classification change. For more information, see "Changing Benefit Elections" in this chapter.

> ***Note**: Interns do not receive default coverage for health, dental, or vision coverage. Interns must enroll in each option for coverage. If you do not enroll in as an intern, and later become a full-time or part-time employee, you cannot enroll in coverage because you were eligible for coverage as an intern. You will have to wait for Annual Enrollment to enroll.

Default Enrollment

Anthem High Deductible Health Plan (HDHP) is the default health plan option for Intel employees, ***excluding*** employees who live and work in AZ, Northern CA, NM and OR (these default plans are below). You may choose an alternative plan available at your location or waive coverage. If you live in one state and work in another, the Anthem HDHP is the default health

plan. **Interns default to no coverage.** You can review the employee contributions for the Anthem HDHP at the *My Health Benefits* website. From Circuit, search for *My Health Benefits* or visit www.intel.com/go/myben**.**

Connected Care ACN HDHP (AZ) is the default health plan option for those employees who live and work in Arizona unless you choose an alternative plan available at your location or waive coverage, with one exception: interns default to no coverage. You can review the employee contributions for the Connected Care ACN HDHP (AZ) at the My Health Benefits website. From Circuit, search for My Health Benefits or visit www.intel.com/go/myben.

Connected Care California HDHP (Northern CA) is the default health plan option for those employees who live and work in Northern California unless you choose an alternative plan available at your location or waive coverage, with one exception: interns default to no coverage. You can review the employee contributions for the Connected Care California HDHP at the My Health Benefits website. From Circuit, search for My Health Benefits or visit www.intel.com/go/myben.

Connected Care HDHP (NM) is the default health plan option for those employees who live and work in New Mexico unless you choose an alternative plan available at your location or waive coverage, with one exception: interns default to no coverage. You can review the employee contributions for the Connected Care HDHP (NM) at the My Health Benefits website. From Circuit, search for My Health Benefits or visit www.intel.com/go/myben.

Connected Care Providence HDHP (OR) is the default health plan option for employees who live and work in Oregon unless you choose an alternative plan available at your location, or waive coverage, with one exception: interns default to no coverage. You can review the employee contributions for the Connected Care Providence HDHP (OR) at the My Health Benefits website. From Circuit, search for My Health Benefits or visit www.intel.com/go/myben.

Delta Dental PPO (formerly Intel Dental Plan) is the default dental plan option unless you choose an alternative plan available at your location or waive coverage, with one exception: interns default to no coverage.

VSP Basic Vision Plan is the default vision plan option unless you choose an alternative plan available at your location or waive coverage, with one exception: interns default to no coverage.

Long-Term Disability coverage is automatic and is equal to 65 percent of your eligible annual earnings up to a monthly maximum of $10,000.

Short-Term Disability default coverage varies by state**:**

- **California** employees are enrolled automatically in the Intel California Voluntary Short-Term Disability plan (CA-VSTD) unless you request the California State Disability Insurance (CA-SDI) Plan. The CA-VSTD Plan provides more generous benefits than the CA-SDI plan for the same contribution. Contact the Intel Health Benefits Center at (877) GoMyBen (466-9236) to make the request. You can review the employee contributions for the CA-VSTD Plan at the *My Health Benefits* website. From Circuit, search for *My Health Benefits* or visit www.intel.com/go/myben.

- **Hawaii, New Jersey, New York, Rhode Island** employees are enrolled automatically in the respective state's Short-Term Disability plan (as mandated by state law) and the Intel Short-Term Disability plan as a supplement to the state plan. Your participation in the Intel Short-Term Disability Plan is optional, however. You can review the employee contributions for the Intel Short-Term Disability Plan at the *My Health Benefits* website. From Circuit, search for "My Health Benefits" or visit www.intel.com/go/myben.
- **For all states except California**, **Hawaii, New Jersey, New York, Rhode Island,** new employees and transfers who work in non-mandated states are enrolled automatically in the Intel Short-Term Disability plan unless you opt out of participation. You can review the employee contributions for the Intel Short-Term Disability Plan at the *My Health Benefits* website. From Circuit, search for "My Health Benefits" or visit www.intel.com/go/myben.

Life Insurance and AD&D coverage is automatic and includes:

- **Basic Life Insurance** coverage equal to twice your eligible annual earnings to a maximum of $2M.
- **Basic AD&D Insurance** coverage equal to twice your eligible annual earnings to a maximum of $2M.
- **Business Travel Accident Insurance** coverage equal to five times your eligible annual earnings to an individual maximum of $1 million or $30 million aggregate maximum.

Other default coverage includes:

- **Paid Time Off Benefits**—service credit accrues for paid time off benefits from your date of hire, with some limitations.
- **Employee Assistance Plan (EAP)** automatically covers you and your dependents.

5.8 When Benefits Begin

Benefits with automatic enrollment: Default coverage describes the rules for the benefits programs in which you are automatically enrolled. **Interns do not receive default coverage and must enroll in each plan they are eligible to enroll.** To learn which benefits have automatic enrollment based on your employment classification, see the "Availability of Benefits" in this chapter.

Medical, dental and vision benefits (other than default coverage) become effective on one of the following dates:

- Your hire date—for you and your dependents, provided you enroll within 30 days of your date of hire.
- Your qualified change-in-status event—if you make your election within 30* days of your qualified change-in-status event. **60 days for newborns.*

- Your dependent's release-from-care date—if an enrolled dependent other than a newborn is hospitalized on the date coverage would normally begin, that dependent's medical coverage becomes effective on the day he or she is released from care by the attending physician.
- January 1 following elections made during Annual Enrollment.

Health care deductions**,** where applicable, will begin on the earliest of the following pay dates:

- The first pay date following your automatic enrollment in default coverage (30 days after your hire or employee classification change)
- The first pay date following the date you make the election

Health Flexible Spending Account (Health FSA), Limited Use Flexible Spending Account (Limited Use Health FSA) and Dependent Care Assistance Program (DCAP)

Participation becomes effective as of the following:

- Your hire date if you enroll within 30 days of your date of hire
- Your qualified change-in-status event if you make your election within 30 days of your qualified change-in-status event.
- If you enrolled in Health FSA during the Annual Enrollment period, your coverage election is effective on January 1 of the following calendar year.
- January 1 of the plan year for a rollover from the previous year's Health FSA or Limited Use Health FSA.

Employee Assistance Plan benefits become effective on your hire date for you and your dependents.

Supplemental, Spouse and Child Life Insurance, and AD&D:

Coverage becomes effective on the earliest of the following:

- The date of your hire or qualified status change if you make guaranteed issue* elections and enroll within 30 days of your date of hire or a qualified status change
- The date your supplemental or spouse life insurance Evidence of Insurability (EOI) application is approved by the life insurance company

*In the *Pay, Stock and Benefits Handbook*, chapter 15 "Life Insurance," see tables for "Coverage Election Requiring EOI" and "Coverage Election Requiring EOI Dependent Life Insurance."

For supplemental and spouse life insurance approved through EOI, premiums begin in the first pay period following approval date.

Voluntary Benefits: Critical Illness and Prepaid Legal (Hyatt Legal)

Participation becomes effective as of:

- Your hire date if you enroll within 30 days of your hire date.
- January 1 of the following plan year after you enroll during Annual Enrollment

Voluntary Benefit: Supplemental Long Term Disability (Supp LTD)

Enrollment in Supp LTD was closed to new enrollees as of May 1, 2016.

Voluntary Benefit: Long Term Care

Enrollment in the Long Term Care insurance plan was closed to new enrollees as of December 31, 2011.

5.9 When Benefits End

Topics

5.9.1 For Yourself

Medical, dental, and vision benefits cease at midnight on the earliest of the following dates:

- The last day of the month in which your employment with Intel ends. For example if your last day worked is October 31st, your benefits end at midnight on October 31st. If your last day worked is October 15th your benefits end at midnight on October 31st.
- The date Intel terminates your coverage for nonpayment of required contributions
- The date you elect to waive coverage during Annual Enrollment (effective Jan. 1 of the next calendar year).
- The last day of the month of a qualified change-in-status event (if elected within 30 days).
- The date Intel terminates the plan as a benefit program. Plan termination will not affect any benefits payable prior to the termination date.

Health Flexible Spending Account (Health FSA), and Limited Use Health Flexible Spending Account (Limited Use Health FSA)

Health FSA contributions cease with your last paycheck. You may submit claims for eligible expenses incurred from your coverage effective date through your coverage end date until March 31 of the following calendar year. Your coverage end date is the earliest of the following:

- December 31
- The date you are no longer eligible to participate due to a change in status event
- The last day of the month in which your employment terminated. You will have the opportunity to elect Health FSA or Limited Use Health FSA via COBRA for the remainder of that year. For every month you pay your COBRA premium, you extend your coverage end date to the end of that month. Please review Chapter 11 for more information on COBRA and Health FSAs.

- The date Intel terminates the benefit as a program. Benefit termination will not affect any benefits payable prior to the termination date.

Dependent Care Assistance Program (DCAP)

DCAP contributions cease with your last paycheck. Your coverage end date is the earliest of the following:

- December 31
- The last day of the month in which your employment terminated. However, you may submit claims for eligible expenses incurred from your coverage effective date through December 31 of the current year as long as you meet the DCAP requirements for reimbursement.
- The date you are no longer eligible to participate due to a change in status event
- The date Intel terminates the benefit as a program. Benefit termination will not affect any benefits payable prior to the termination date.

Employee Assistance Plan benefits cease at midnight on the earliest of the following dates:

- The last day of the month in which your employment with Intel ends. For example, if your last day worked is October 31st, your benefits end at midnight on October 31st. If your last day worked is October 15th your benefits end at midnight on October 31st.
- The date Intel terminates the plan as a benefit program. Plan termination will not affect any benefits payable prior to the termination date.

Basic Life Insurance, Accidental Death & Dismemberment (AD&D), Supplemental Life, Supplemental AD&D, Short-Term Disability, and Long-Term Disability benefits cease at midnight on the earliest of the following dates:

- The last day of the month in which your employment with Intel ends. For the exception, see "If you are Leaving Intel Due to a Disability (STD/LTD)" in "Chapter 10: Life Events and Impact to Intel Benefits and Programs" of the *Pay, Stock and Benefits Handbook*.
- The date you elect not to participate in any benefit for which an election is required or permitted.
- The date Intel terminates your coverage for nonpayment of required contributions.
- The date Intel terminates the plan as a benefit program. Plan termination will not affect any benefits payable prior to the termination date.

Voluntary Benefits: Long Term Care, Critical Illness, and Prepaid Legal (Hyatt Legal)

Participation ceases at midnight of the following dates:

- Your termination date, for Prepaid Legal (Hyatt Legal). If you have acquired a claim number, you can finish only that claim.*
- The date you elect not to participate in the voluntary benefit when an election is required or permitted (e.g. Annual Enrollment)
- The date your coverage is terminated for nonpayment of required premiums

- The date Intel terminates the respective voluntary benefit program. Plan termination will not affect any benefits payable prior to the termination date.

** Long Term Care and Critical Illness coverage may continue in accordance with the respective plan's continuation of coverage requirements. The billing for premiums will be sent to your home address until you cancel enrollment or do not pay your premium.*

Voluntary Supplemental Long-Term Disability (Supp LTD)

Participation ceases

- The date your coverage is terminated for nonpayment of required premiums.
- The date Intel terminates this voluntary benefit program.* Plan termination will not affect any benefits payable prior to the termination date.
- The date MetLife terminates your policy pursuant to the terms of your policy.

** Since these benefits are funded by policies issued by MetLife, you may be able to continue coverage under these policies even if Intel terminates this voluntary benefit program.*

5.9.2 For Your Dependents

Medical, vision, and dental benefits cease at midnight on the earliest of the following dates:

- The date your coverage ends for any reason.
- January 1 of the next calendar year when you elect to stop dependent coverage during Annual Enrollment
- The last day of the month in which your spouse/domestic partner or child, no longer meet the definition of a dependent for a plan. You must drop coverage for your spouse/domestic partner when they are no longer eligible for coverage through the *My Health Benefits* website. From Circuit, search for "My Health Benefits" or visit www.intel.com/go/myben. Dependent coverage is automatically dropped at midnight on the last day of the month of your child's 26th birthday. Please see chapter 4 for more information on dependent eligibility.
- The last day of the month in which your spouse/domestic partner or child are dropped from coverage due to a qualified change in status event
- The date your dependent enters active duty in the armed services of any state, country, or international authority
- The date Intel terminates dependent coverage for nonpayment of a required contribution
- The date your spouse/domestic partner or child becomes eligible for coverage as an employee of Intel
- The last day of the month in which Intel is provided with satisfactory written evidence that a QMCSO is no longer in effect
- The date Intel terminates the Intel Health and Welfare Benefits Plan

Employee Assistance Plan benefits cease at midnight on the earliest of the following dates:

- The last day of the month in which your employment with Intel ends. For example, if your last day worked is October 31st, your benefits end at midnight on October 31st. If your last day worked is October 15th your benefits end at midnight on October 31st.
- The date Intel terminates the plan as a benefit program. Plan termination will not affect any benefits payable prior to the termination date.

Spouse/Domestic Partner/Child Life Insurance and Dependent AD&D Plan coverage ends at midnight on the earliest of the following dates:

- The date your coverage ends for any reason
- The date you elect to stop dependent coverage
- The date your spouse/domestic partner or dependent child no longer meets the definition of a dependent for a plan
- The date your dependent enters active duty in the armed services of any state, country, or international authority
- The date Intel terminates dependent coverage for nonpayment of a required contribution
- The date your spouse/domestic partner or dependent child becomes eligible for coverage as an employee of Intel
- The date Intel terminates the Group Life Insurance Plan or Group AD&D Plan

In the event that you or your dependents lose coverage as a result of a qualifying event, you or dependents may be eligible for COBRA to continue medical, dental, and Health FSA benefits. For more information, see the *Pay, Stock and Benefits Handbook*, chapter 11 "COBRA Continuation Coverage."

For information on portability or conversion of your life insurance benefits, see "Life Insurance, Options Available When Life Insurance Coverage Ends" in this chapter.

5.10 Tax Treatment of Benefits

Employee contributions for medical, vision, dental, Health FSA, DCAP, and HSA* are paid with pretax dollars. Other benefits are paid with after-tax dollars.
The difference between pretax and after-tax dollars is the following:

Pre-tax dollars: Your contributions are deducted from your pay before taxes are calculated. This means you do not have to pay Social Security, Medicare, federal income tax, and (in most locations) state and local income taxes on the amount used for these expenses. With pretax deductions, you get an immediate tax savings and an increase in your spendable income when compared to purchasing the benefit with after-tax dollars.
After-tax dollars: Your full salary is taxed, and then contributions are deducted from the remaining balance.

After-tax contributions are automatically paid from your paycheck for optional life insurance—that is, Supplemental Life and Dependent Life, and Supplemental and Dependent AD&D—and the Intel STD plans.

** HSA is not an Intel-sponsored benefit; eligibility requirements apply, and contribution limits are set by the IRS. An HSA is made available for those enrolled in an Intel Group Health Plan HDHP option in order to receive payroll deductions directly into your HSA. The administrator for HSAs is Fidelity for eligible participants in HDHPs in AZ, CA, NM, and OR.*

Domestic Partners

Under the Internal Revenue Code, if your domestic partner does not qualify as your tax dependent (a qualified domestic partner) for purposes of health benefits, the cost of your domestic partner's health coverage will be included in your gross income and subject to federal tax including Social Security and federal income tax withholdings, as well as being reported as taxable earnings on your Form W-2. State tax treatment of domestic partner benefits varies by state. State tax treatment of domestic partner benefits varies by state. Your gross income for state tax purposes will be adjusted accordingly based on the state in which you reside. The cost of coverage for your domestic partner (and domestic partner's children if applicable) is obtained from the COBRA rates which are a combined total of the employee and company portion of the cost of coverage.

Consult with your tax or legal advisor regarding your specific circumstances.

Note that health expenses for a domestic partner (and the domestic partner's child(ren) if applicable) who is not your tax dependent are not eligible for reimbursement under the Health Flexible Spending Account (Health FSA or Limited Use Health FSA), or a Health Savings Account (HSA). Expense reimbursement for a domestic partner may be applied from an Extra Bucks Account (if applicable), but is taxable. In this case, Intel will provide you with a Form 1099 reflecting the reimbursement as taxable income.

Effect on Social Security Benefits

The amount of your income used to pay for pretax benefits is not included when Social Security taxes are computed; therefore, your Social Security benefits may be slightly reduced. If your income exceeds the maximum wage base for Social Security taxes, your benefits are not affected.

If you have questions about the effect of pretax contributions, see a qualified tax advisor.

Chapter 6

Medical and Vision Benefits

Chapter 6
Medical & Vision Benefits

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

6.1 Medical & Vision Benefits Overview

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

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

6.2 Medical Options

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

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

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

Arizona

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

Northern California

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

New Mexico

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

Oregon

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

Other Options – Availability will vary by location and eligibility:

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

- **Health Maintenance Organizations** (HMO)*:
    - Arizona - Aetna *
    - California - Kaiser Permanente*
    - New Mexico - Presbyterian Health Plan*

      * Self-funded

- **HMSA -** Hawaii PPO medical plan is the only medical plan available to employees who work and reside in Hawaii.
- **Anthem J1-Visa**
- **Aetna International** - the only medical and dental option for U.S. Expats (U.S. employees on a 2-way international assignment). For additional information, including the summary plan descriptions, from Circuit > My Benefits & Career > Career > Relocation > 2 Way International > Healthcare on Assignment.

6.3 General Provisions - Connected Care and Anthem

Topics

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

6.3.1 In-Network Benefits

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

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

Finding an In-Network Provider

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

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

Role of the Primary Care Physician

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

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

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

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

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

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

Obtaining In-Network Benefits Away From Home

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

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

6.3.2 Out-of-Network Benefits

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

6.3.3.3 Maximum Allowed Amount

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

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

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

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

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

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

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

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

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

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

- An amount based on the out-of-network provider fee schedule/rate, which the claims administrator has established in its discretion, and which the claims administrator reserves the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with the claims administrator, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data

- An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing MAA upon the level or method of reimbursement used by CMS, the claims administrator will update such information, which is unadjusted for geographic locality, no less than annually
- An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable providers' fees and costs to deliver care
- An amount negotiated by the claims administrator or a third party vendor which has been agreed to by the provider. This may include rates for services coordinated through case management
- An amount based on or derived from the total charges billed by the out-of-network provider

6.3.4 Specialty Networks

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

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

6.3.5 Deductible

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

6.3.6 Copayment

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

6.3.7 Coinsurance

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

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

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

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

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

6.3.8 Out-of-Pocket Maximums

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

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

6.3.9 Lifetime Maximum

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

6.3.10 Transition of Care

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

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

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

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

6.3.11 Elective Surgery

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

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

6.3.12 Second and Third Surgical Opinions

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

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

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

6.3.13 What to Do in an Emergency

All life-threatening emergencies will be covered at the in-network benefit level if certain steps are followed, as described below. If you have a medical emergency, seek care immediately.

Emergency In-Network Care

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

Emergency Out-of-Network Care

If you use out-of-network emergency services, your submitted claim will be reviewed to determine if the emergency hospital visit was medically necessary. If so, you will be responsible for any applicable deductible and in-network coinsurance amount. If not a medical emergency, the service will be paid at the out-of-network benefit level--subject to the MAA and the deductible.

Emergency Hospital Admission

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

If you do not contact your medical coverage within 48 hours after an emergency hospital admission, you will not be considered pre-certified for any surgical procedure or hospital admission and will be subject to denied or reduced benefits.

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

6.3.14 Hospital Preadmission Certification Continued Stay Review

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

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

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

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

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

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

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

6.3.15 Prescription Drug Benefit

Formulary Drug List

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

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

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

Quantity Limits

Certain prescriptions of drug therapies are only covered in certain quantities. These quantity limits are based on FDA-approved prescribing and safety information, clinical guidelines, and uses that are considered reasonable, safe and effective. Covered drugs are routinely reviewed to

ensure the limits match these criteria. The quantity limits currently in place include, but are not limited to, medications for migraine, impotence and emergency contraceptives.

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

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

These prior authorization criteria are a separate condition for the coverage of prescriptions or drug therapies, which must otherwise meet all other applicable terms and conditions for coverage under the Plan. Should you present a prescription to pharmacy or through mail order and the prescription requires authorization, the pharmacist will receive a message to have your physician contact the pharmacy benefit manager directly.

This will initiate the prior authorization process. Typically, the authorization process is completed within 24 hours, but in some cases may take up to three business days. Once your prescription is authorized, the authorization is valid for up to 12 months for most drugs.

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

Preferred Drug Step Therapy
Coverage under the Preferred Drug Step Therapy Program requires that a member try a generic drug or lower-cost brand-name alternative drug before higher cost non-preferred drugs, unless special circumstances exist.

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

6.3.16 Support Services

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

Case management provides assistance to individuals with treatment needs that extend beyond the acute care setting. The goal of case management is to ensure that patients receive

appropriate care in the most appropriate setting possible, whether at home, as an outpatient or as an inpatient in a hospital or specialized facility.

If you and your attending physician consent, the case manager appointed by the case management company will help coordinate services. You or the case manager can terminate the case management relationship at any time.

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

6.4 Connected Care

Topics

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

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

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

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

6.4.1. Connected Care Provider Network

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

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

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

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

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

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

6.4.2.1 Options

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

Intel offers the following Connected Care HDHP options:

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

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

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

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

Table: Connected Care HSA administrator

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

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

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

6.4.2.3 Features of the Connected Care HDHP

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

Table: Connected Care HDHP at a glance

Features	In-Network	Out-of Network*
Health Savings Account±: Maximum Annual Employee Contribution■	$3,550individual/$7,100 family	
Preventive Care	Covered 100%	40% coinsurance after deductible

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

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

Examples of Using the Connected Care HDHP

Example 1: Mary Jones

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

Year 1		Year 2	
Mary's pretax HSA contribution	$3,300	HSA rollover from year 1	$2,900
Total HSA funds available for year 1	$3,300	Mary's pretax contribution Total HSA funds available for year 2	$3,300 $6,200

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

Example 2: The Smith Family

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

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

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

6.4.2.4 Connected Care HDHP Preventive Care Benefit

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

6.4.2.5 Connected Care HDHP Prior Authorization Requirements

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

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

6.4.2.6 Connected Care HDHP Out-of-Pocket Maximums

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

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

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

6.4.2.7 Connected Care HDHP Prescription Benefits

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

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

Table: Connected Care HDHP prescription benefit coverage

Connected Care HDHP Prescription Drug Benefit			
Where	**Generic**	**Preferred Brand**	**Non-Preferred Brand**
Network Retail Pharmacy Up to 30-day supply*	5% Coinsurance	5% Coinsurance	5% Coinsurance
Mail Order Up to 90-day supply	5% Coinsurance	5% Coinsurance	5% Coinsurance
Certain medications are covered at 100%. These drugs are used to treat conditions such as high blood pressure, high cholesterol, and diabetes. For a list of medications covered at 100%, contact your Connected Care Customer Services representative. **Dispensing Limitation:** If you request a brand-name drug when a generic is available and "Dispense as Written" (DAW) is not specified by your doctor, you will be responsible for paying the generic copayment plus the difference in cost between the brand-name drug and the generic medication. * You may purchase up to a 90-day supply at select retail pharmacies; for details contact your Connected Care Customer Services representative.			

Connected Care HDHP Mail Order Pharmacy
Mail order is an alternative and convenient way for you to fill your maintenance (long-term) medications. You may receive up to a 90-day supply of your medication delivered to your home. Contact your HDHP for mail order options.

6.4.2.8 High Deductible Health Plan - Note on changing plans due to a qualified change in status:

If you change from one Connected Care HDHP option to another Connected Care HDHP option mid-year due to a qualified change in status event, your accumulated deductible and out-of pocket maximum amounts will transfer. If you change to or from a non-Connected Care HDHP option, your accumulated deductible and out-of pocket maximum amounts will not transfer. For example:

- You change from Connected Care HDHP to Anthem HDHP due to a qualified change in status, your deductible and out-of-pocket maximum from the Connected Care HDHP will not transfer and will start over with the Anthem HDHP.
- You change from Connected Care HDHP option to another Connected Care HDHP option due to a qualified change in status, your deductible and out-of-pocket maximum will transfer to the new Connected Care HDHP (it does not start over).

6.4.3 Connected Care Primary Care Plus – How the Plan Works

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

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

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

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

Table: Connected Care PCP at a glance

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

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

6.4.3.1 Connected Care PCP Preventive Care Benefit

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

6.4.3.2 Connected Care PCP Deductible

In the Connected Care PCP, the deductibles for in- and out-of-network accumulate separately. Once an individual has met the deductible traditional coverage will begin. For example, if you are enrolled in family coverage, once an individual family member meets the deductible, traditional coverage for the individual will begin. The individual deductible and other family member expense will continue to accumulate toward the family deductible. Primary care copayments and prescription drug copayments do not count toward the plan deductible.

6.4.3.3 Connected Care PCP Out-of-Pocket Maximums

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

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

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

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

6.4.3.4 Connected Care PCP Prior Authorization Requirements

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

6.4.3.5 Connected Care PCP Prescription Benefits

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

Connected Care PCP Prescription Benefit Coverage

Table: Details the Connected Care PCP prescription benefit coverage

Connected Care PCP Prescription Drug Benefit			
Where	**Generic**	**Preferred Brand**	**Non-Preferred Brand**
Network Retail Pharmacy* Up to 30-day supply	$10 Copayment	$20 Copayment	$35 Copayment
Mail Order Pharmacy Up to 90-day supply	$25 Copayment	$50 Copayment	$90 Copayment
Certain medications are covered at 100%. These drugs are used to treat conditions such as high blood pressure, high cholesterol, and diabetes. For a list of medications covered at 100%, contact your Connected Care Customer Services representative. **Dispensing Limitation:** If you request a brand-name drug when a generic is available and "Dispense as Written" (DAW) is not specified by your doctor, you will be responsible for paying the generic copayment plus the difference in cost between the brand-name drug and the generic medication. *You may purchase up to a 90-day supply at select retail pharmacies. Connected Care PCP may have an arrangement with a preferred retail pharmacy providing 90-day supply at reduced copay. Contact Connected Care PCP for more information.			

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

Network Retail Pharmacy

For medications purchased at a retail pharmacy:

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

Mail Order Pharmacy

Mail-order pharmacy service is an alternative and convenient way for you to fill your maintenance (long-term) medications. You may receive up to a 90-day supply of your medication delivered to your home. Contact Connected Care PCP for mail order options.

6.4.4 Connected Care Copayment – How the Plan Works

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

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

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

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

Table: Connected Care Copay at a glance

Features	In-Network	Out-of-Network*
Preventive Care	Covered 100%	40% coinsurance after deductible

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

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

6.4.4.1 Connected Care Copay Preventive Care Benefit

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

6.4.4.2 Connected Care Copay Out-of-Pocket Maximums

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

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

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

6.4.4.3 Connected Care Copay Prior Authorization Requirements

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

6.4.4.4 Connected Care Copay Prescription Benefits

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

Table: Connected Care Copay Prescription Benefits

Connected Care Copay Prescription Benefits			
Where	**Generic**	**Preferred Brand**	**Non-Preferred Brand**
Network Retail Pharmacy* Up to 30-day supply	$10 Copayment	$20 Copayment	$35 Copayment
Mail Order Up to 90-day supply	$20 Copayment	$50 Copayment	$90 Copayment
Certain medications are covered at 100%. These drugs are used to treat conditions such as high blood pressure, high cholesterol, and diabetes. For a list of medications covered at 100%, contact your medical plan. **Dispensing Limitation:** If you request a brand-name drug when a generic is available and "Dispense as Written" (DAW) is not specified by your doctor, you will be responsible for paying the generic copayment			

plus the difference in cost between the brand-name drug and the generic medication.

*You may purchase up to a 90-day supply at select retail pharmacies. Connected Care Copay may have an arrangement with a preferred retail pharmacy providing 90-day supply at reduced copay. Contact your Connected Care Copay plan for more information.

Mail Order Pharmacy

Mail-order pharmacy service is an alternative and convenient way for you to fill your maintenance (long-term) medications. You may receive up to a 90-day supply of your medication delivered to your home. Contact your medical coverage for mail order options.

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

Topics

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

6.5.1 Features of Anthem Blue Cross HDHP

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

Table: Anthem Blue Cross HDHPs at a glance

Features	In-Network	Out-of-Network*
Health Savings Account (HSA): Maximum Annual Employee Contribution■	$3,550 individual/$7,100 family	
Preventive Care	Covered 100%	40% coinsurance after deductible
Deductible (includes covered medical pharmacy and behavioral health services)	$1,570 individual $3,150 individual plus one or more children $3,940 individual plus spouse or individual plus spouse and one or more children	
Traditional Health Care Coverage (i.e., coinsurance rate when accessing care): • Primary Care Physician/Specialist • Urgent care • Inpatient hospitalization • Outpatient services	10% coinsurance after deductible	40% coinsurance after deductible
Out-of-Pocket maximum (includes covered medical pharmacy and behavioral health services)	$2,355 individual $4,710 individual plus one or more children $5,830 individual plus spouse or individual plus spouse and one or more children	
■ HSA is a voluntary program that allows you to set aside pretax contributions into an account, which may be used to pay for certain medical expenses on a pretax basis. The HSA is not an Intel-sponsored benefit or an ERISA welfare benefit plan. Please see the section below on Health Savings Accounts. * Out of network coverage limited to maximum allowable amount (MAA)		

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

Table: HSA administrator

Anthem Blue Cross HDHP
Fidelity (888) 401-7377

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

Examples of Using the HDHP

Example 1: Mary Jones

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

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

Example 2: The Smith Family

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

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

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

6.5.2 Anthem Blue Cross HDHP Preventive Care Benefit

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

6.5.3 Anthem Blue Cross HDHP Out-of-Pocket Maximums

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

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

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

6.5.4 Anthem Blue Cross HDHP Prior Authorization Requirements

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

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

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

6.5.5 Anthem Blue Cross HDHP Prescription Benefits

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

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

Anthem Blue Cross HDHP Maintenance Medication Coinsurance
Maintenance medications are used to treat ongoing conditions such as cholesterol, asthma, acid reflux, and high blood pressure. You will pay a higher coinsurance (i.e., a surcharge) for maintenance medication purchased at retail.

The additional retail refill surcharge will not count toward your out-of-pocket maximum. You will continue to pay this amount after meeting your out-of-pocket maximum. To avoid this surcharge you can purchase your maintenance medication through Express Scripts Pharmacy (mail order) Walgreens or Costco. By using the one of these options you avoid the higher retail cost and receive up to a 90-day supply of your maintenance medication prescriptions.

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

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

Anthem Blue Cross HDHP Mail Order Pharmacy
Mail order is the preferred way for you to fill your maintenance (long-term) medications. You may receive up to a 90-day supply of your medication delivered to your home.

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

Table: Details of the Anthem Blue Cross HDHP prescription benefit

Anthem Blue Cross HDHP Prescription Benefit All prescriptions except for maintenance medications (See chart below for maintenance medication prescription drug benefit)			
Where	**Generic**	**Preferred Brand**	**Non-Preferred Brand**
Network Retail Pharmacy Up to 34-day supply	10% Coinsurance	10% Coinsurance	10% Coinsurance
Mail Order Pharmacy	10% Coinsurance	10% Coinsurance	10% Coinsurance

Up to 90-day supply			

Anthem Blue Cross HDHP Prescription Benefit Maintenance Medications				
(Prescriptions you take for three months or more, such as high blood pressure or cholesterol medication.)				
Where	**When**	**Generic**	**Preferred Brand**	**Non-Preferred Brand**
Network Retail Pharmacy Up to 34-day supply	First two times you purchase each prescription (Retail Refill Allowance)	10% Coinsurance	10% Coinsurance	10% Coinsurance
Network Retail Pharmacy Up to 34-day supply	Beginning with the third refill	40% Coinsurance	40% Coinsurance	40% Coinsurance
Mail Order Pharmacy / Walgreens / Costco Up to 90-day supply	All maintenance prescription purchases	10% Coinsurance	10% Coinsurance	10% Coinsurance
Out-of-pocket costs for maintenance medications beyond the standard mail benefit will not apply toward deductible/out-of-pocket maximums. **Dispensing Limitation:** If you request a brand-name drug when a generic is available and "Dispense as Written" (DAW) is not specified by your doctor, you will be responsible for paying the generic copayment plus the difference in cost between the brand-name drug and the generic medication. **Retail Refill Allowance** limits do not apply to prescriptions purchased at **Costco and Walgreens**. Contact Express Scripts for more information.				

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

- You may purchase up to a 34 day supply
    - **While in your deductible:** you will pay 100% of the cost of the drug; this amount will apply toward your deductible and out-of-pocket maximum.
    - **After you met your deductible:** you will pay 10% of the cost of the drug; this amount will apply toward your out-of-pocket maximum.

    - **Once you have reached your out-of-pocket maximum:** the medical plan will pay 100% of the cost.

For maintenance medication purchased at a retail pharmacy:

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

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

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

6.6 Anthem J1-Visa – How the Plan Works

Topics

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

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

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

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

Table: Anthem J1-Visa at a glance

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

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

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

6.6.1 Anthem J1-Visa Preventive Care Benefit

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

6.6.2 Anthem J1-Visa Deductible

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

6.6.3 Anthem J1-Visa Out-of-Pocket Maximums

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

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

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

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

6.6.4 Anthem J1-Visa Prior Authorization Requirements

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

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

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

6.6.5 Anthem J1-Visa Prescription Benefit

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

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

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

Maintenance Medication
Maintenance medications are used to treat ongoing conditions such as cholesterol, asthma, acid reflux, and high blood pressure. You will pay a higher coinsurance (i.e., a surcharge) for maintenance medication purchased at retail. The additional retail refill surcharge will not count toward your out-of-pocket maximum and you will continue to pay this amount after meeting your out-of-pocket maximum. To avoid this surcharge you can purchase your maintenance medication through mail order. By using the mail order you avoid the higher retail cost and receive up to a 90-day supply of your maintenance medication prescriptions.

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

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

Mail Order Pharmacy
Mail-order pharmacy service is the preferred way for you to fill your maintenance (long-term) medications. You may receive up to a 90-day supply of your medication delivered to your home.

Mail order is provided through Express Scripts Pharmacy.

Table: Details the Anthem J1-Visa prescription benefit

Cigna J1-Visa Prescription Benefit All prescription except for maintenance medications (See chart below for maintenance medication prescription drug benefit)			
Where	**Generic**	**Preferred Brand**	**Non-Preferred Brand**
Network Retail Pharmacy Up to 34-day supply	$10 Copayment	$20 Copayment	$35 Copayment
Mail Order Pharmacy Up to 90-day supply	$25 Copayment	$50 Copayment	$90 Copayment
Cigna J1-Visa Prescription Benefit **Maintenance Medications** (Prescriptions you take for three months or more, such as high blood pressure or cholesterol medication.)			

Where	When	Generic	Preferred Brand	Non-Preferred Brand
Network Retail Pharmacy Up to 34-day supply	First two times you purchase each prescription (Retail Refill Allowance)	$10 Copayment	$20 Copayment	$35 Copayment
Network Retail Pharmacy Up to 34-day supply	Beginning with the third refill	$25 Copayment	$50 Copayment	$90 Copayment
Mail Order Pharmacy / Walgreens / Costco Up to 90-day supply	All maintenance prescription purchases	$25 Copayment	$50 Copayment	$90 Copayment
Out-of-pocket costs for maintenance medications beyond the standard mail benefit will not apply toward deductible/out of pocket maximums. **Dispensing Limitation:** If you request a brand-name drug when a generic is available and "Dispense as Written" (DAW) is not specified by your doctor, you will be responsible for paying the generic copayment plus the difference in cost between the brand-name drug and the generic medication. Retail Refill Allowance limits do not apply to prescriptions purchased at **Costco and Walgreens**. Contact Express Scripts for more information.				

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

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

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

For maintenance medication purchased at a retail pharmacy

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

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

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

6.7 Covered Medical Services - Connected Care and Anthem Blue Cross

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

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

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

Select desired service below:		
Durable Medical Equipment	Nutritional Counseling	Transplant Services
Emergency Services	Oral Surgery	Telephone, Video or Online Medical Visits
External Prosthetic Appliances	Orthotics	Travel and Living Expenses
Family Planning Services	Outpatient Services	Travel Immunizations
Hearing Care	Physician Services	Weight Reduction Services
Home Birth	Podiatry	

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

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

Acupuncture

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

Allergy Services

The office visit copayment or coinsurance applies for any visit in which clinical services are rendered by the physician (or designee). The office visit copayment applies for injections received in a physician's office when no other health service is received (for example allergy immunotherapy).

Ambulance

Ambulance transportation consists of either a local professional ground ambulance or an air ambulance used to transport the patient from where the illness or accident begins to the nearest hospital qualified to provide treatment of that illness or injury.

In the case of air ambulance service, the prescribing and receiving physicians must certify that use of any lesser transportation service would have jeopardized the life of the patient or that no alternative transportation was available. Other transportation is covered when authorized by the health plan medical director (or designee).

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

Autism Benefit

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

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

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

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

Breast Reconstruction, Breast Prostheses, and Complications of Mastectomy

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

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

Coverage will be provided in a manner determined in consultation between the attending physician and the patient. Benefits for breast reconstruction and breast prostheses are subject to deductibles and coinsurance limitations consistent with those established for other benefits under your medical plan.

Chiropractic Services

Chiropractic care includes charges for detection and correction of nerve interference in the vertebral column. Diagnostic laboratory and X-ray charges related to your chiropractic care are included under your chiropractic coverage. Chiropractic coverage is subject to limitations and shall be covered without regard to medical diagnosis.

Conception Services

Diagnostic services to establish the cause or reason for infertility, and to treat an underlying medical condition in a manner not otherwise excluded under the plan are covered benefits and are not subject to a lifetime maximum.

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

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

Dental Services

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

- In connection with accidental injury of sound natural teeth
- For surgery or treatment of disease or injury of the jaw
- For covered medical services for the treatment of temporomandibular joint (TMJ) syndrome
- For dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia, covered for the following:
    - Transplant preparation
    - Initiation of immunosuppressive
- For general anesthesia and associated facility charges for dental procedures rendered in a hospital or surgery center for members who have an underlying medical condition, health is compromised, and general anesthesia is medically necessary.
- For the direct treatment of acute traumatic injury, cancer, or cleft palate

Dental services for accidental damage are only covered medical services when they are received from a Doctor of Dental Surgery (D.D.S.) or Doctor of Medical Dentistry (D.M.D.), and the dental damage is severe enough that initial contact with a physician or dentist occurred within 72 hours of the accident.

Benefits are available only for treatment of a sound, natural tooth. The physician or dentist must certify that the injured tooth was a virgin or un-restored tooth, or a tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy--that is not a dental implant--and that functions normally in chewing and speech. Dental services for final treatment to repair the damage must have been started within three months of the accident and completed within 12 months of the accident.

Diagnostic and Therapeutic Radiology Services

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

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

Diabetes Education

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

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

Durable Medical Equipment

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

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

Such equipment includes, but is not limited to, crutches, hospital beds, wheelchairs, respirators and intermittent positive pressure breathing machines, oxygen tents, walkers, inhalators, dialysis machines, and suction machines.

Coverage for DME does not include exercise equipment, equipment that is not solely for the use of the patient, comfort items, routine maintenance, or DME for the convenience of the patient. Consumable supplies are not covered, except for ostomy supplies and those that are necessary for the function of authorized DME.

Wigs and hairpieces will be covered for hair loss resulting from disease or treatment of certain medical conditions. Covered conditions include, but are not limited to, chemotherapy and radiation treatments for cancer, alopecia areata, and endocrine and metabolic diseases. Documentation will be reviewed on a case-by-case basis and will require a doctor's recommendation, including an overall history of the medical problem.

Emergency Services

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

Emergency services are required in life-threatening emergencies when symptoms are severe and occur suddenly and unexpectedly, and immediate medical attention is necessary. Included are conditions that produce the following:

- Loss of consciousness or seizure
- Uncontrolled bleeding
- Severe shortness of breath
- Chest pain
- Broken bones
- Sudden onset of paralysis or slurred speech

External Prosthetic Appliances

Coverage is provided for the purchase and fitting of external prosthetic appliances that are used as a replacement or substitute for a missing body part, and are necessary for the alleviation or correction of illness, injury, or congenital defect.

External prosthetic appliances shall include the following:

- Artificial arms and legs
- Hearing aids
- Terminal devices, such as a hand or hook

Replacement or repair, as appropriate, of external prosthetic appliances is covered if necessitated by such circumstances as normal anatomical growth, physical changes which render the device ineffective, or excessive wear. Whether to repair or replace external prosthetic appliances will be at the sole discretion of the plan. If more than one prosthetic device can meet your functional needs, benefits are available only for the most cost-effective prosthetic device.

Family Planning Services

The covered family planning services include the following:

- Medical history
- Physical examination
- Related laboratory tests, medical supervision, and counseling in accordance with generally accepted medical practice--including medical services connected with surgical therapies (vasectomy or tubal ligation)
- Depo-Provera
- Oral contraceptives (covered under prescription benefits)
- Intrauterine devices (IUD) insertion and removal

Hearing Care

Office visits to determine hearing loss are covered. Analog and digital hearing aids are a covered item. Hearing aid batteries may be covered, check with your medical plan.

Home Birth

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

Home Health Care

Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule, and when skilled home health care is required. Skilled home health care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- They are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient
- They are ordered by a physician
- They are not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair
- They require clinical training in order to be delivered safely and effectively
- They are not custodial care

Home health care services are provided when you or an eligible participant requires skilled care and you or an eligible participant:

- Are homebound due to a disabling condition
- Are unable to receive medical care on an ambulatory outpatient basis
- Do not require extended daily attendance by a professional nurse or require confinement in a hospital or other health care facility, such as a skilled nursing facility

Home health care services include the following:

- Part-time or intermittent visits by professional nurses and other health care professionals
- Intravenous medications

Physical, occupational, and speech therapy provided in the home are subject to benefit limitations: see Rehabilitative Therapy for more information.

Hospice Care

Hospice care must be recommended by a physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social, and spiritual care for the terminally ill person, and short-term grief counseling

for immediate family members. Benefits are available when hospice care is received from a licensed hospice agency. Hospice care includes the following:

- Inpatient care for terminally ill patients (generally patients with six months or less to live)
- Services of a physician
- Health care services at home, including nursing care, use of medical equipment, rental of wheelchairs and hospital-type beds, and homemaker services
- Emotional support services
- Physical and chemical therapies
- Bereavement counseling sessions for family members
- Respite care

Hospital and Partial Hospital Services
Covered expenses for hospital room and board are limited to the semi-private (a room with two or more beds) room rate. Private room, intensive care, coronary care, and other specialized care units of a facility are covered when such special care or isolation is consistent with professional standards for the care of the patient's condition. When room and board for other than semiprivate care is at the convenience of the patient, payment will be made only for semiprivate accommodations.

Hospital Ancillary Services

The following ancillary services include:

- Care and services in an intensive care unit
- Administered drugs
- Medications, biologicals, fluids, and chemotherapy
- Special diets
- Dressings and casts
- General nursing care
- Use of an operating room and related facilities
- Blood and blood products
- The collection and storage of autologous (self-donated) blood up to six weeks prior to surgery
- X-rays, laboratory, and other diagnostic services
- Anesthesia and oxygen services
- Inhalation therapy
- Radiation therapy
- Such other services customarily provided in acute care hospitals
- Radiology, anesthesiology, pathology, and laboratory (RAPL) services received during an inpatient stay at an in-network hospital will be covered at the in-network benefit level regardless of the network status of the RAPL provider or facility.

Internal Prosthetic/Medical Appliances

Coverage for internal prosthetic appliances includes the purchase, maintenance, or repair of permanent or temporary internal aids and supports for defective body parts and family planning, specifically:

- Intraocular lenses
- Artificial heart valves
- Cardiac pacemakers
- Artificial joints
- Other surgical materials such as screw nails, sutures, and wire mesh

Maternity Care

Covered maternity care services are only payable for covered female employees, covered female spouses, covered female dependent children, and eligible covered female domestic partners.

Benefits for pregnancy will be paid at the same level as benefits for any other condition, sickness, or injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

The hospital length of stay for the mother or newborn child shall not be less than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery unless the attending provider, after consultation with the mother, determines an earlier discharge is appropriate. The attending provider cannot be required by the medical plan to obtain authorization for prescribing a length of stay that is within these limits.

Services rendered in a birthing facility for low-risk births following an uncomplicated pregnancy are eligible, provided the physician in charge is acting within the scope of his license and the birthing facility meets all legal requirements. The facility must have an agreement with a hospital for rapid transport in the event of an emergency.

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

Mental or Nervous Disorders or Substance Abuse

The mental health and chemical dependency benefits offer you confidential and convenient access to professional counseling. All mental health and chemical dependency services are strictly confidential and provided in accordance with applicable federal and state laws. See also the preadmission requirements under the General Provisions section of this chapter 6, “Hospital Preadmission Certification Continued Stay Review.”

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

- Alcohol and drug dependency

- Physical or mental abuse
- Eating disorders or other forms of obsessive behavior
- Anxiety or depression

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

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

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

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

Naturopath Services

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

Newborn Care

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

Non-Durable Medical Supplies

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

Nutritional Counseling

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

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

Oral Surgery

Oral surgery is covered if there is a medical diagnosis (e.g., a tumor in the mouth, TMJ pain/disability that has failed medical management, etc.) or if it is due to an accident (e.g., a broken jaw).

Orthotics

Coverage for orthotics (excluding shoes) is provided when prescribed by a physician. Replacements are covered only if needed to change the prescription, not when the device is lost or damaged. Orthotics for excluded conditions are not covered (e.g., orthotics for fallen arches or flat feet).

Outpatient Services

Outpatient services include diagnostic and treatment services; administered drugs, medications, biologicals, and fluids; and inhalation therapy. Services also can include certain surgical procedures, anesthesia, blood and blood products, and the collection and storage of autologous (self-donated) blood up to six weeks prior to surgery, and recovery room services.

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

Physician Services

Physician services include diagnostic and treatment services, including office visits (well woman, well baby), pre- and post-natal care, routine immunizations, allergy tests and treatments, lab work and X-rays, ultraviolet light/PUVA, injections, periodic health assessments, hospital care, consultation, and surgical procedures.

Online physician visits through an approved internet-based intermediary.

Podiatry

Certain surgical podiatry services, including incision and drainage of infected tissue of the foot, removal of lesions of the foot, removal or debridement of infected toenails, and treatment of fractures and dislocations of bones of the foot are covered. Podiatry services not covered are those procedures considered to be a part of a routine foot care, such as treatment of corns or calluses, non-surgical care of toenails, treatment of fallen arches, and other symptomatic complaints of the feet.

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

Prescription Drug Benefits

Prescription drug coverage is provided for medically necessary, Food and Drug Administration (FDA)-approved drugs and medicines for the treatment of a condition obtainable only by a physician's prescription on an outpatient basis. In addition, any prescribed drug or medicine must otherwise meet the applicable prior authorization or coverage review criteria utilized by your plan. Note that the plan may not cover drugs and medicines that have not been specifically approved by the FDA for the use prescribed by your physician.

Prescription Drug Mail Order Program

Maintenance medications, including medications for birth control or long-term health conditions such as high blood pressure, ulcers, or diabetes can be filled through the mail order program. You receive a 90-day supply of medications and pay the appropriate copayment/coinsurance. Prescriptions filled through mail order will be mailed to the member's home address or an address designated by the member.

Preventive Care

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

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

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

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

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

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

The types of preventive services that are covered are listed in the following chart. **Examples of Preventive Services**	
Well baby and well child care	Baby/child preventive care office visits Baby/child screening tests: • Lead level testing • Vision screenings • Hearing screenings Baby/child immunizations: (Note: Actual dosing regimen to be determined by physician.) • Hepatitis A • Hepatitis B • Diphtheria, tetanus, pertussis (DtaP) • H. influenza type b • Polio • Measles, mumps, rubella (MMR) • Varicella (chicken pox) • Influenza - flu shot • Pneumococcal conjugate (pneumonia)
Adult Preventive Care	Adult preventive care office visits Adult screening tests: • Coronary artery disease: periodic cholesterol and lipid screening • Annual clinical breast exam and mammogram • Routine pelvic exam, Pap test, and contraceptive management • Colorectal cancer screenings: annual fecal occult blood testing or flexible sigmoidoscopy • Prostate cancer screenings: digital rectal examination (DRE) and prostate specific antigen (PSA) at direction of physician and patient • Diabetes (type II) screening: periodic blood glucose testing for high-risk individuals (e.g., those with hypertension or hyperlipidemia) • Osteoporosis screening: periodic bone density screening Adult immunizations: • Influenza • Pneumococcal conjugate (pneumonia) • Diphtheria, tetanus, pertussis (DatP) • Measles, mumps, rubella (MMR)

	• Hepatitis A: recommended for high risk groups, such as international travelers, workers in food service or health care industry • Hepatitis B and Varicella: recommended for high-risk individuals • Meningococcal: considered for college students who live in dormitories and have a slightly increased risk of getting meningococcal disease • Human Papilloma Virus (HPV)

Well Women Preventive Care	Well-woman visits include adult and female-specific screenings and preventive benefits
	
	• Breastfeeding comprehensive support, supplies and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women are covered for one year after delivery.
	• Counseling for HIV, sexually transmitted diseases and domestic violence and abuse.
	• Domestic and interpersonal violence screening and counseling for all women.
	• Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs.
	  ○ generic birth control
	  ○ intrauterine devices (IUD)
	  ○ hormone contraceptive injections
	  ○ inserted contraceptive devices
	  ○ implanted contraceptive devices
	
	Note: Out of network coverage for contraceptive devices is covered per your plan's out of network benefit level; out of network coverage for contraceptive devices is not covered at 100%.
	
	• Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes.
	• Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women.
	• Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older.
	• Screenings and Counseling for pregnant women including screenings for anemia, bacteriuria, Hepatitis B, and Rh incompatibility and breast-feeding counseling.
	• Sexually Transmitted Infections (STI) counseling for sexually active women.
	• Sterilization services for women only. Other services during procedure are subject to deductible and co-insurance as outlined in your Summary of Benefits.

	• Well –woman visits to obtain recommended preventive services for women under 65.

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

Reconstructive Surgery

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

- Accidental injury sustained while covered
- A congenital anomaly in a child that results in a functional deficit--this does not include conditions related to growth, such as malocclusion.
- Reconstruction of a breast following partial or radical mastectomy while covered (refer to covered medical services under Breast Reconstruction)

Short –Term Rehabilitative Therapy

Short-term rehabilitative therapy that is part of a rehabilitative program, including physical, speech, and occupational, cognitive, osteopathic manipulative and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting. Coverage is available only for short-term rehabilitation following injuries, surgery, acute medical conditions, or acute exacerbation of chronic conditions.

Speech therapy by a qualified speech therapist is covered if performed to restore speech that has been impaired because of an injury or illness such as a stroke, head injury, or vocal cord injury; or because of impairment caused by congenital defect for which corrective surgery was performed.

Occupational therapy is covered only for purposes of training the patient to perform the activities of daily living.

Cardiac therapy is provided at two phases. Phase I begins during or just after the acute event (i.e., bypass surgery, myocardial infarction, or angioplasty). It includes nursing services, physical therapy and teaching the patient how to deal with his or her condition. Phase II is a hospital-based outpatient program after inpatient hospital discharge. It is physician directed with active treatment and EKG monitoring at a frequency of three times per week for approximately 12 weeks. Memberships to a gym or exercise programs do not quality as cardiac rehabilitation under the plan.

Therapies for Developmental Delay

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

Skilled Nursing Facility
Services for an inpatient stay in a licensed institution other than a hospital, (i.e., a skilled nursing facility or inpatient rehabilitation facility) are covered for covered persons who are convalescing from an injury or illness that requires an intensity of care or a combination of skilled nursing, rehabilitation and facility services that are less than those of a general acute hospital but greater than those available in the home setting.

The institution must maintain on the premises all facilities necessary for medical treatment, provide such treatment for compensation under the supervision of physicians, and provide nursing services.

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

Tobacco Cessation Services

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

Temporomandibular Joint Syndrome (TMJ)

Coverage for physician services includes the following:

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

Gender Confirmation (Transgender) Surgery

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

Transplant Services

Covered medical services for the following organ and tissue transplants when ordered by a physician include the organ recipient's medical, surgical, and hospital services, immunosuppressive

medications, and organ procurement costs required to perform any of the following human-to-human organ or tissue transplants:

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

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

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

- When the recipient is covered by an Intel plan, the plan will be the primary payer for both the recipient and the donor. However, if you are covered Intel plan and want to receive out-of-network benefits, a separate deductible, coinsurance, and out-of-pocket maximum will apply to each individual. The family maximum will apply only if the donor and recipient are both enrolled in the same Intel plan.

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

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

Telephone, Video or Online Medical Visits

Provider visits and other services received over the telephone, video, or online authorized by the plan are covered.

Travel and Living Expenses

Reasonable travel and living expenses for patients and a family member are covered for organ transplants. Reasonable travel and living expenses may be covered for other in-network services if the services are deemed appropriate and when services are not available within a reasonable distance from a patient's home. Travel and living expenses will not be covered for out of network care unless the care is directed by the medical plan medical director (or designee). All travel and living expenses require prior authorization. Travel and living expenses are subject to a lifetime

maximum; amounts above the lifetime maximum may be covered if deemed appropriate and approved by the appropriate medical coverage claim administrator.

Benefit payments related to health travel and living expenses may be considered taxable income to the subscriber per IRS rules. Refer to IRS publication 502 for additional details.

Travel Immunizations

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

Weight Reduction Services

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

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

The items below--as well as charges for services associated with non-covered benefits—are excluded from coverage under Connected Care, Anthem Blue Crossand Vision plans unless specifically listed as covered in the Covered Medical Services section.

Alternative treatments: Forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health, unless such treatment is otherwise specifically noted as a covered medical service under the plan.

Certain physical examinations: Physical, psychiatric, or psychological testing and examinations required for school, sports, or judicial or administrative proceedings or orders, for purposes of medical research, or to obtain or maintain a license of any type.

Corrective eye surgeries including, but not limited to laser surgery, radial keratotomies, and other refractive eye surgery:

Charges incurred for surgical techniques performed for the correction of myopia or hyperopia, including but not limited to the following:

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

- All related services

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

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

- Air conditioners
- Air purifiers and filters
- Batteries and battery chargers
- Dehumidifiers
- Humidifiers
- Home remodeling to accommodate a health need (such as, but not limited to, ramps and swimming pools).
- Hospital services do not include personal or comfort items such as:
- Personal care kits
- Television
- Telephone
- Newborn infant photographs
- Other articles that are not for the specific treatment of illness or injury

Cosmetic procedures: Services are considered cosmetic procedures when they improve appearance without making an organ or body part work better. The fact that a person may suffer psychological consequences from the impairment does not classify surgery and other procedures to relieve such consequences as a reconstructive procedure. Cosmetic procedures include, but are not limited to the following:

- Plastic surgery
- Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures)
- Pharmacological regimens
- Nutritional procedures or treatments
- Skin abrasion procedures performed as a treatment for acne
- Laser hair removal
- Breast implant replacement when implant is cosmetic
- Physical conditioning programs such as athletic training, body building, exercise, fitness, flexibility, and diversion or general motivation

Custodial care: Charges incurred for custodial care domiciliary care or rest cures, provided primarily to assist in meeting activities of daily living and that may be provided by persons without special skill or training, regardless of where the services are rendered (e.g., in an inpatient or outpatient setting). It may include, but is not limited to, help in getting in and out of bed, walking, bathing, dressing, eating and taking medication, as well as ostomy care, hygiene or incontinence care, and checking of routine vital signs.

Dental services: Except as specifically covered, dental care including medical or surgical treatments of a dental condition, all associated dental expenses, including hospitalization and anesthesia. Examples include the following:

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

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

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

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

- Any drug when a written prescription from a physician or other lawful prescriber is not obtained (including over-the-counter items)
- Anorectics or any drug used for the purpose of weight loss
- Anthrax vaccine/injection
- Non legend drugs other than insulin
- Charges for the administration or injection of any drug except for the administration of a vaccination

- Therapeutic devices or appliances, including support garments and other non-medicinal substances, regardless of intended use
- Drugs labeled, "caution - limited by federal law for investigational use" or experimental drugs, even though a charge is made to the individual
- Biological sera, blood, or blood plasma
- Any prescription refilled in excess of the number specified by the physician or any refill dispensed more than one year from date of the physician's original order
- Charges for vitamins (unless legend, prescription vitamins), over-the-counter drugs or contraceptives, whether or not prescribed by a physician and obtainable over-the-counter except as required by the Affordable Care Act (ACA)
- Norplant, unless administered in physician's office
- Prescription drugs used exclusively for cosmetic purposes or that are not medically necessary

Employment-related disease or injury: Charges incurred in connection with the following:

- Disease or injury sustained while doing any act or thing pertaining to any occupation or employment for remuneration or profit, except for the case of a self-employed dependent
- Disease or injury for which benefits are payable in accordance with the provisions of any Workers' Compensation or similar law, except in the case of a self-employed dependent
- Disease or injury while attending vocational, work hardening or training programs regardless of diagnosis or symptoms that may be present, or for non-medically necessary education

Excess of eligible expenses: Charges made in excess of the maximum allowed amount (MAA) for care or treatment that does not meet the definition of a covered medical service and for charges in excess of any specified limitation.

Experimental investigational services, or unproven services: Procedures, or devices, that are not generally recognized as being safe and effective by the medical community, or devices that have not been approved by the FDA for the indicated use--as determined by the claims administrator. Unproven services are those that are not consistent with conclusions of prevailing medical research that demonstrate that the health service has a beneficial effect on health outcomes, and that are not based on trials that are either well-conducted randomized controlled trials or well-conducted cohort studies. The fact that an experimental or investigational service or an unproven service is the only available treatment for a particular condition will not result in the payment of benefits if the service is considered to be experimental, investigational, or unproven in the treatment of that particular condition. If you have a life-threatening condition (one which is likely to cause death within one year of the request for treatment) each plan option may, in its sole discretion, determine that an experimental, investigational, or unproven service is not excluded as such under the plan option. For this to take place, the claims administrator must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Foot care: Routine foot care (including the cutting or removal of corns and calluses), nail trimming, cutting, or debriding and hygienic and preventive maintenance foot care. Examples include the following:

- Cleaning and soaking the feet
- Applying skin creams in order to maintain skin tone
- Other services that are performed when there is not a localized illness, injury or symptom involving the foot
- Treatment of flat feet
- Treatment of subluxation of the foot
- Orthotics for preventive maintenance foot care (e.g. orthotics for fallen arches or flat feet).

Infertility/Conception treatments: Expenses associated with fertility services.

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

Mental health and chemical dependency:

- Treatment of congenital and organic disorders, including, but not limited to, organic brain disease, Alzheimer's disease, and pervasive developmental disorders.
- Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
- Treatment of mental retardation, other than the initial diagnosis.
- Private hospital rooms and private duty nursing, unless determined to be a medically necessary service and authorized by the medical plan medical director (or designee).
- Damage to the facility of a participating provider or to the participating facility caused by member; the actual cost of such damage shall be billed directly to the member.
- Inpatient services, treatment, or supplies rendered without Preadmission Certification, except in the event of an emergency.
- Half-way houses, Co-dependency and Wilderness treatment programs.

Non-durable medical supplies:

Devices used specifically as safety items or to affect performance in sports-related activities; outpatient medical supplies and disposable supplies, like elastic stockings, ace bandages, gauze, dressings, and syringes, unless specifically stated in the Covered Medical Services section, tubing, nasal cannulas, connectors and masks unless part of DME.

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

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

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

Rehabilitative therapy: Any type of therapy, service or supply for the treatment of a condition that ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.

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

Services not medically necessary: Services not considered medically necessary are excluded. Each plan option utilizes its own internal guidelines and protocols for determining whether a service is medically necessary. Medically necessary services must meet all of the following criteria: consistency among symptoms, diagnosis, and treatment; appropriate and in keeping with standards of good medical practice; not solely for the convenience of the member or participating providers; not for conditions that have reached maximum medical improvement or are maintenance in nature.

Services provided by family members: Services performed by a provider who is a family member by birth or marriage, including your spouse, parent, child, brother, sister, or anyone who lives with you. This includes any service the provider may perform on himself or herself.

Services and supplies that do not meet the definition of a covered medical service: For further information, see the definition of Covered Medical Service.

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

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

Spinal column manipulation:

- Laboratory tests, X-rays, thermography, adjustments, physical therapy, or other services not documented as chiropractically necessary and appropriate, or classified as experimental or in the research stage.
- For spinal column manipulation, manipulation under anesthesia, anesthesia associated with spinal column manipulation or other related services.

Tests to determine unborn baby's gender: Amniocentesis and sonogram when used only to determine the sex of a child.

TMJ: Oral appliances used in the treatment of temporomandibular joint syndrome (TMJ).

Transplants: Organ or tissue transplants or multiple organ transplants other than those listed as covered medical services are excluded from coverage; donor expenses if recipient not covered

under the plan; health services for transplants involving mechanical or animal organs; any solid organ transplant that is performed as a treatment for cancer.

Travel and living expenses: Travel and living expenses for patients and a family member other than for organ transplant or other than for in-network services deemed appropriate and approved by the appropriate medical plan medical director (or designee).

Veteran's services: Health services received as a result of active military duty, war, or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. Also, health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.

Vision services:

- Limited coverage on certain cosmetic materials including blended lenses, contact lenses (except as noted), oversize lenses, progressive multifocal lenses, photochromic or tinted lenses, coated lenses (including scratch-resistant and anti-reflective coatings), laminated lenses, any balance remaining on a frame that exceeds the plan allowance, cosmetic lenses, optional cosmetic lenses, ultraviolet (UV)-protected lenses, high index lenses, polarized lenses, polycarbonate lenses, and edge treatments. For specific coverage limits on vision appliances and materials, contact your medical plan.
- Orthoptics or vision training (except as specifically defined under Covered Medical Services) and any associated supplemental testing.
- Plano lenses (non-prescription).
- Two pairs of glasses in lieu of bifocals.
- Replacement of lost or broken lenses or frames (originally furnished under this program), except at the normal intervals when service is otherwise available.

Weight management services: Except as otherwise authorized by the plan, expenses related to surgical and non-surgical weight reduction procedures, exercise programs, or use of exercise equipment; special diets or diet supplements such as, Nutri/System Program, Weight Watchers or similar programs; and hospital confinements for weight-reduction programs.

Miscellaneous exclusions:

- In the event that an out-of-network provider waives copayments/coinsurance, the annual deductible, or both for a particular health service, no benefits are provided for the health service for which the copayments or annual deductible are waived;
- Any charges for missed appointments, room or facility reservations--except in cases where the participating provider is notified at least 24 hours in advance that the appointment will not be kept--or in circumstances in which the member had no control over missing the appointment and could not notify the participating provider at least 24 hours before the scheduled appointment; completion of claim forms or record processing;
- Any charge for services, supplies or equipment advertised by the provider as free;
- Charges by a provider sanctioned under a federal program for reason of fraud, abuse or medical competency;

- Health services received after the date your coverage under the plan ends, including health services for medical conditions arising before the date your coverage under the plan ends;
- Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the plan;
- Any charges higher than the actual charge (the actual charge is defined as the provider's lowest routine charge for the service, supply, or equipment);
- Any charges prohibited by federal anti-kickback or self-referral statutes;
- Any additional charges submitted after payment has been made and your account balance is zero;
- Any outpatient facility charge in excess of payable amounts under Medicare;
- Any charges by a resident in a teaching hospital where a faculty physician did not supervise services;
- Services provided without cost by any governmental agency, except where such exclusion is prohibited by law;
- Services, treatment, or supplies for which no charge would usually be made or for which such charge, if made, would not usually be collected if no coverage existed;
- Services, treatment, or supplies to the extent that charges for the care exceed the charge that would have been made and collected if no coverage existed.

6.9 Comparison Charts for Connected Care

Topics

6.9.1 Table: Connected Care Overview

Features	Connected Care HDHP with HSA		Connected Care Primary Care Plus		Connected Care Copay	
Provisions[1]	In-Network[2]	Out-of-Network[2]	In-Network[2]	Out-of-Network[2]	In-Network[2]	Out-of-Network[2]
Where Available	Arizona, California, New Mexico, Oregon		Arizona, New Mexico, Oregon		New Mexico, Oregon	
How the plan works	Must use designated Connected Care network providers to receive the maximum benefit	May use any covered licensed practitioner of your choice	Must use designated Connected Care network providers to receive the maximum benefit	May use any covered licensed practitioner of your choice	Must use designated Connected Care network providers to receive the maximum benefit	May use any covered licensed practitioner of your choice
Deductible Whenever coinsurance percentages are payable by you, you must first meet the deductible before coinsurance begins	$1,400 individual $2,800 you and your children $3,500 you and your spouse or you, your spouse and your children You may use HSA funds to pay for eligible out-of-pocket medical expenses (i.e., deductible or coinsurance).		$250 individual $500 family Deductibles do not combine for in and out-of-network. An individual is only required to satisfy his/her own individual amount.	$250 individual $500 family	No deductible	Presbyterian: $250 individual $750 family Kaiser: $250 individual $500 family
Optional Health Savings Account (HSA)	Participants in the Connected Care HDHP may be eligible to fund an account with pre-tax dollars to cover out-of-pocket expenses related to the plan. The account may be funded up to an annual maximum amount of $3,450 if you have single coverage or $6,850 if you have family coverage. There is no limit on rollover amounts.		N/A		N/A	

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

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

6.9.2 Table: Connected Care Medical Benefits

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

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

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

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

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

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

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

6.9.3 Table: Connected Care - Mental Health Benefits

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

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

6.9.4 Table: Connected Care - Chemical Dependency Benefits

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

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

6.9.5 Table: Connected Care - Prescription Benefits

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

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

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

Dispensing Limitation: If you request a brand-name drug when a generic is available and "Dispense as Written" (DAW) is not specified by your doctor, you will be responsible for paying the generic copayment plus the difference in cost between the brand-name drug and the generic medication.

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

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

Topics

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

6.10.1 Table: Anthem Blue Cross Overview

Features	Anthem Blue Cross HDHP with HSA				Anthem J1-Visa	
Provisions	In-Network	Out-of-Network[1]	In-Network		In-Network	Out-of-Network[1]
Where Available	Nationwide				Nationwide	
How the plan works	Must use BlueCard Network Providers to receive the maximum benefit	May use any covered licensed practitioner of your choice			Must use Cigna OAP Providers to receive the maximum benefit	May use any covered licensed practitioner of your choice
Deductible Whenever coinsurance percentages are payable by you, you must first meet the deductible	$1,570 individual $3,150 you and one or more children $3,940 you and your spouse or you, your spouse and one or more children You may use HSA funds to pay for eligible out-of-pocket medical expenses (e.g., deductible or coinsurance).				$500 individual $1,000 family	$500 individual $1,000 family
	Note: See the Extra Bucks section for information on how Extra Bucks may be used to cover the cost of eligible medical services after your deductible is met.				Deductibles do not combine for in and out-of-network. An individual is only required to satisfy his/her own individual amount.	
Optional Health Savings Account (HSA)	Participants may be eligible to fund a Health Savings Account (HSA) with pre-tax dollars to cover out-of-pocket eligible medical expenses related to the plan. Please see the HSA section of this chapter for more information. The HSA may be funded up to an annual maximum amount of $3,550 if you have single coverage or $71000 if you have family coverage. There is no limit on rollover amounts.				N/A	
Out-of-Pocket Maximum	$2,355 individual $4,710 you and one or more children $5,830 you and your spouse or you, your spouse and one or more children				$1,500 individual $3,000 family	

Features	Anthem Blue Cross HDHP with HSA		Anthem J1-Visa
	Coinsurance and deductible apply toward the out-of-pocket maximum		Coinsurance and deductible apply toward the out-of-pocket maximum An individual is only required to satisfy his/her own individual amount.
Pre-existing conditional limitation	Does not apply		Does not apply
Lifetime maximum per covered member	There is no lifetime limit on the dollar value of benefits. Specific coverage provisions may be subject to a lifetime maximum.		
In-hospital Preadmission Certification, Continued Stay Review (CSR), or Surgical Pre-certification	Member or provider must obtain authorization from Anthem Blue Cross		Member or provider must obtain authorization
[1] In the sections indicated, coinsurance percentages that are payable by you are charged once the deductible has been met. For the out-of-network provisions under the plans, once you meet the deductible you will be responsible for paying amounts in excess of the MAA—which are not included when calculating the out-of-pocket maximum.			

6.10.2 Table: Anthem Blue Cross - Medical Benefits

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

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

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

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

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

Features	Anthem Blue Cross HDHP with HSA		Anthem J1-Visa	
Hospice Prior Authorization Required	10% coinsurance	40% coinsurance	10% coinsurance	40% coinsurance

6.10.3 Table: Anthem Blue Cross Mental Health Benefits

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

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

[2] Inpatient = confinement in a 24-hour supervised, skilled nursing setting. Alternate Care = less intensive level of services than inpatient that may include partial hospitalization, day hospital treatment, residential treatment centers and outpatient programs.

6.10.4 Table: Anthem Blue Cross Chemical Dependency Benefits

Features	Anthem Blue Cross HDHP with HSA				Anthem J1-Visa	
Provisions	In-Network Unless otherwise indicated, your coinsurance is based on discounted fees after you have paid the deductible and you are using Traditional Health Coverage	Out-of-Network[1] Unless otherwise indicated, your coinsurance is based on MAA after you have paid the deductible and you are using Traditional Health Coverage			In-Network Unless otherwise indicated, your coinsurance is based on discounted fees after you have paid the deductible	Out-of-Network[1] Unless otherwise indicated, your coinsurance is based on MAA after you have paid the deductible
Deductible	No separate deductible; plan deductible applies				No separate deductible; plan in-network deductible applies	No separate deductible; plan out of network deductible applies
Inpatient or Alternate Care[2]	10% coinsurance	40% coinsurance			10% coinsurance	40% coinsurance
Outpatient care	10% coinsurance	40% coinsurance			Office Visit: $15 copay Facility: 10% coinsurance	40% coinsurance
1 In the sections indicated, coinsurance percentages that are payable by you are charged once the deductible has been met. For the out-of-network provisions under the plans, once you have met the deductible you will be responsible for paying amounts in excess of the MAA—which are not included when calculating the out-of-pocket maximum.						
2 Inpatient = confinement in a 24-hour supervised, skilled nursing setting. Alternate Care = less intensive level of services than inpatient that may include partial hospitalization, day hospital treatment, residential treatment centers and outpatient programs.						

6.10.5 Table: Anthem Blue Cross Prescription Benefits

Features	Anthem Blue Cross HDHP with HSA				CIGNA J1-Visa	
Provisions	In-Network Unless otherwise indicated, your coinsurance is based on discounted fees after you have paid the deductible and you are using Traditional Health Coverage	Out-of-Network Unless otherwise indicated, your coinsurance is based on MAA after you have paid the deductible and you are using Traditional Health Coverage			In-Network	Out-of Network

Features	Anthem Blue Cross HDHP with HSA				CIGNA J1-Visa	
Deductible	No separate deductible; plan deductible applies				No deductible; prescription drug expenses do not count toward the plan deductible	No deductible; prescription drug expenses do not count toward the plan deductible
Retail Pharmacy Program for Non-maintenance drugs and Retail Refill Allowance. **Limited to a 34-day supply**	10% coinsurance	40% coinsurance			Generic: $10 copay Preferred brand: $20 copay Non-Preferred brand: $35 copay	Member pays the amount above allowable cost plus the following: Generic: $10 copay Preferred brand: $20 copay Non-Preferred brand: $35 copay
Retail Pharmacy Program for Maintenance drugs. **Limited to a 34-day supply**	40% coinsurance	40% coinsurance			Generic: $25 copay Preferred brand: $50 copay Non-preferred brand: $90 copay	Member pays the amount above allowable cost plus the following: Generic: $25 copay Preferred brand: $50 copay Non-preferred brand: $90 copay
Mail Service / Costco /Walgreens Program **Limited to a 90- day supply**	10% coinsurance	Not available			Generic: $25 copay Preferred brand: $50 copay Non-preferred brand: $90 copay	Not available

Dispensing Limitation: If you request a brand-name drug when a generic is available and "Dispense as Written" (DAW) is not specified by your doctor, you will be responsible for paying the generic copayment plus the difference in cost between the brand-name drug and the generic medication.

Retail Refill Allowance limits do not apply to prescriptions purchased at **Costco and Walgreens**. Contact Express Scripts for more information.

6.11 Extra Bucks Accounts

Overview of Extra Bucks

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

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

How Extra Bucks Works

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

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

Getting Reimbursed from Extra Bucks

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

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

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

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

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

Eligible Expense Criteria

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

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

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

Extra Bucks Eligible Expenses

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

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

6.12 Health Saving Account ††

Topics

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

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

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

The HSA offers three forms of tax savings.

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

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

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

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

6.12.1 HSA Contributions

For 2020, you can contribute up to an annual maximum amount of $3,550 if you have individual coverage in the HDHP, or $7,100 if you have family coverage in the HDHP. If you are married and both you and your spouse have HSAs, the family limit is divided between you both. An additional "catch-up" amount of up to $1,000 may be contributed by employees between the ages of 55 and 65. For information on making a "catch-up" contribution, contact your HSA administrator.

6.12.2 HSA Eligibility

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

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

Permitted insurance or coverage is:

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

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

6.12.3 HSA Distributions

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

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

Expenses must have been incurred after you established your HSA.

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

6.12.4 IRS Reporting

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

6.12.5 Qualified Medical Expenses

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

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

6.12.6 Using your HSA to Pay Your HDHP Deductible

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

6.13 HMO Options

Topics

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

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

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

6.13.1 Table: HMOs Available by Site

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

6.13.2 Table: HMO General Features Chart

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

6.13.3 HMO Provider Access

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

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

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

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

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

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

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

6.13.4 HMO Services and Service Area

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

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

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

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

6.13.5 HMO Out of Pocket Cost

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

6.13.6 HMO Emergency Care Claims Submission

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

6.13.7 HMO Eligibility and Enrollment

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

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

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

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

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

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

6.13.8 HMO Benefit Coverage

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

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

6.13.9 HMO Comparison Charts

The HMO Comparison Charts summarize benefit coverage for the HMO options, for a complete description of benefit coverage please contact the HMO directly. From Circuit, search Benefit Directory for contact information.

6.13.9.1: HMO Overview

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

Features	AETNA*	Kaiser Permanente*	Presbyterian Health Plan*
Locations	AZ	CA	NM
In-hospital preadmission certification, continued stay review, surgical pre-certification	Handled by your PCP	Handled by your PCP	Handled by your PCP or participating provider

6.13.9.2 Table: HMO Medical Benefits

Features	AETNA*	Kaiser Permanente*	Presbyterian Health Plan*
Locations	AZ	CA	NM
Primary care physician - Office visit services (including medical eye care) - adult medical care - injections	$15 copayment per office visit	$15 copayment per visit Injections only (materials and administration) are $0 copayment	$15 copayment per office visit
Specialist physician services, referral physician services,	$35 copayment per office visit	$35 copayment per visit	$35 copayment per office visit
Preventive care services - Preventive care - routine immunizations and injections - Well-child care (up to 18th birthday)	No Copayment	No Copayment	No Copayment
Allergy testing and treatment	$15 copayment	Allergy test: $35 copayment; Allergy Injections only (Material and administration) $0 copayment; otherwise office visit copayments apply	20% coinsurance
Chiropractic services	$15 copayment; 20 visit maximum per calendar year	$15 copayment, 20 visit maximum per calendar year; benefit available through network providers.	$25 copayment; 20 visit maximum per calendar year. Preauthorization required
Naturopath and acupuncture services by a licensed practitioner	Not covered; discount available through Natural Alternatives	Acupuncture only: $15 copayment; 20 visit maximum per calendar year	$25 per office visit for the following services: acupuncture services by a licensed practitioner (20 visit maximum per calendar year). Note: Naturopath is not covered
Second surgical opinions	$15 copayment if PCP; $35 if specialist	$15 copayment if PCP; $35 if specialist	$15 copayment if PCP; $35 if specialist

Features	AETNA*	Kaiser Permanente*	Presbyterian Health Plan*
Locations	AZ	CA	NM
Outpatient laboratory and X-ray services (including preadmission testing) in physician's office or in dedicated lab/X-ray facility	$15 copayment with PCP referral (at facility) No copayment if billed as part of office visit	No copayment required	No copayment required: $50 copayment on MRI Benefit Certification is required for MRI, PET and CT Scans
Inpatient hospital services semiprivate room and board **Note: Preadmission Certification may be required.**	$250 copayment per admission	$250 copayment per admission	$250 copayment per admission
Inpatient hospital Services **Preadmission Certification required.**	$250 copayment per admission	$250 copayment per admission	$250 copayment per admission
Outpatient hospital/surgical services **Note: Preadmission Certification may be required.**	$100 copayment $15 copayment for radiation therapy	$100 copayment per visit	$100 copayment per visit; no copayment for chemotherapy; 15% copayment up to max of $250 per prescription (yearly max of $1,500) for specialty pharmaceuticals in Oral inhalation or Self-administered forms Benefit Certification applies to certain procedures – see plan for details
Hospital emergency room	$100 copayment per visit (waived if admitted into a hospital, then hospital copayment applies)	$100 copayment per visit (waived if admitted into a hospital, then hospital copayment applies)	$100 copayment per visit (waived if admitted into a hospital, then hospital copayment applies)
Urgent care facility	$50 copayment per visit	$15 copayment per visit	$50 copayment per visit
Ambulance	No charge	$50 copayment per use	Ground: $50 copayment per occurrence; No charge for inter-facility transfer via ground transport Air: $100 copayment per occurrence
Maternity services **- Pre/Post-delivery exams** **- Professional services (physician charges)**	$35 copayment for initial office visit to confirm pregnancy and no charge thereafter	$35 copayment for initial office visit to confirm pregnancy; no copayment per visit thereafter	$35 copayment per visit up to a maximum of $150 per pregnancy $35 copayment per visit
Maternity services - Facility charges	See inpatient schedule	See inpatient schedule	See inpatient services
Newborn care	No charge; newborn must be enrolled for continuation of coverage	No charge; newborn must be enrolled for continuation of coverage	No charge; newborn must be enrolled for continuation of coverage

Features	AETNA*	Kaiser Permanente*	Presbyterian Health Plan*
Locations	AZ	CA	NM
			Note: If newborn remains in the hospital after the mother is discharged, an additional copayment of $250 may apply.
Birthing centers	Same as hospital	Same as hospital	Same as hospital
Nurse midwife	Covered as any other provider	Covered as any other provider through a Kaiser plan facility	Covered as any other provider
Services for infertility **- Office visit and diagnosis** **- Inpatient corrective surgical treatment (ICST)**	$35 copayment per office visit; no copayment for ICST Check with plan for details	Diagnosis and treatment covered at 50%; infertility drugs, in vitro fertilization, ZIFT, GIFT, and ovum transplants are not covered; donor services are excluded.	50% Coinsurance for office visit 50% for ICST, including drugs and injections Check with plan for details
Inpatient physical, occupational, and speech therapy (short-term rehabilitative therapy)	See Inpatient Hospital Services	See Inpatient Hospital Services.	See Inpatient Hospital Services.
Outpatient physical, occupational, and speech therapy for short-term rehabilitative therapy	$15 copayment per visit; 60-day consecutive visits/injury additional visits available with medical appropriateness determination benefit analysis	$15 copayment per visit; limited to 20 visits per calendar year.	$25 copayment per visit; after prior authorization, up to two months per condition; additional visits available with medical appropriateness determination benefit analysis
Outpatient physical, occupational, and speech therapy for developmental delay diagnosis	$15 copayment per visit	$15 copayment per visit; Kaiser Permanente does not base coverage of ST, PT, and OT on a particular diagnosis. Rather, Kaiser provides coverage of ST, PT, and OT based on the specific health care needs of each individual.	$25 copayment per visit; after prior authorization, up to two months per condition; additional visits available with medical appropriateness determination benefit analysis. Developmental therapy not covered on long term basis for chronic or incurable conditions
Cardiac rehabilitation outpatient therapy	$15 copayment if office visit; no charge if outpatient hospital visit	$35 specialist copayment per visit	$25 copayment per session; up to 12 sessions continuous ECG monitoring and 24 sessions intermittent ECG monitoring per calendar year
Pulmonary therapy	$15 copayment if office visit; no charge if outpatient hospital visit	$35 specialist copayment per visit copayment	$25 copayment per session (up to 24 sessions per year)
Dialysis treatment	$15 copayment if office visit; 100% if outpatient hospital visit	$35 specialist copayment per visit	20% coinsurance
Family planning services **- Physician office visit**	$15 copayment per visit	$15 copayment per visit	$15 PCP / $ 35 specialist copayment per visit
- Vasectomy	$15 copayment if billed as part of office visit; no copayment if performed as outpatient surgery	$15 copayment primary care $35 specialist copayment	$15 PCP / $ 35 specialist copayment if office visit; otherwise $100 copayment
- Tubal ligation	$15 copayment if billed as part of office visit; no copayment if performed as outpatient surgery	$100 copayment	$15 PCP / $35 specialist copayment if office visit; otherwise $100 copayment
- Abortion (elective or spontaneous)	$15 copayment if billed as part of office visit; no copayment if performed as outpatient surgery	Place of service copayment applies: - $15 primary care copayment - $35 specialist copayment	$15 PCP / $35 specialist copayment if office visit; otherwise $100 copayment

Features	AETNA*	Kaiser Permanente*	Presbyterian Health Plan*
Locations	AZ	CA	NM
		-$100 outpatient copayment	
- Depo-Provera	$15 copayment / vial; five vials/year	$15 primary care copayment $35 specialist copayment	$15 PCP / $35 specialist copayment if office visit
Hearing services **- Hearing examination** **- Hearing aid**	Covered as part of annual physical only Not covered	$15 copayment for PCP / $35 copayment for specialist Not covered	$15 PCP / $35 specialist copayment for screening Hearing aids covered for school-aged children up to a maximum of $2,200 every three years per hearing impaired ear.
Nutritional counseling	Not covered; discount available through Natural Alternatives	$15 primary care copayment $35 specialist copayment	$15 PCP / $35 specialist copayment
TMJ Services	Benefits based on place of service, if approved	Medical necessity applies; must refer to Benefits Booklet for this benefit.	$15 PCP / $35 specialist copayment; $250 copayment admission
Transplant services	No copayment required; covered under National Medical Excellence Program	Medical necessity applies; refer to Benefits Booklet for coverage	$15 PCP / $35 specialist copayment ; $250 copayment per admission
Travel and living expenses	Refer to Benefits Booklet for coverage	Refer to Benefits Booklet for coverage	Refer to Benefits Booklet for coverage
Weight reduction services	Subject to medical necessity	Weight management classes offered through Health Education Program at reduced fees for members	$15 PCP / $35 specialist copayment
Tobacco cessation services	Tobacco Cessation programs offered through HealthMedia Simple Steps Program	Tobacco cessation programs offered through Health Education Program at reduced fees for members	$$15 PCP / $35 specialist copayment
Orthotics	Not covered	See policy for types and circumstances of coverage.	50% copayment Benefit Certification required.
Durable medical equipment (DME)	No copayment required	100% coverage; some annual maximums may apply	50% copayment Benefit Certification required.
External prosthetic appliances	No copayment required	Covered under DME; copayment may apply; see Benefits Booklet	50% copayment Benefit Certification required.
Other healthcare facilities (e.g., skilled nursing facilities (SNF), inpatient physical rehabilitation facilities)	$ 250 copayment	No copayment required up to 100 day maximum per calendar year	$250 copayment per admission, 60 day maximum per calendar year. Benefit Certification required.
Home health care	No copayment required	No copayment required; medical necessity applies up to 100 visits per calendar year.	No copayment required Benefit Certification required.
Hospice	$250 copayment	No copayment required.	Inpatient $250 copayment per admission; in-home no copayment Benefit Certification required.

* Self-funded

6.13.9.3 Table: HMO Prescription Benefits

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

*Self-funded

6.13.9.4 Table: HMO Mental Health Benefits

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

* Self-Funded

6.13.9.5 Table: HMO Chemical Dependency Benefits

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

* Self-funded

6.13.10 Notice of Right to Designate a Primary Care Provider

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

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

6.14 Medical Coverage When Traveling Abroad

International Personal Travel

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

International Business Travel

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

International SOS

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

6.15 Vision Care Benefits

Topics

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

6.15.1 Overview

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

- The Basic Vision Plan or
- The Vision Plus Plan

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

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

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

6.15.2 Vision Care Benefits Comparison

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

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

Features	VSP Basic Vision (In-Network)	VSP Basic Vision (Out-of-Network)	VSP Vision Plus (In-Network)	VSP Vision Plus (Out-of-Network)
Vision Coverage Exam	Exam every calendar year			
Comprehensive Exam	$0	Reimbursed to $40	$0	Reimbursed to $40
Standard Contact Lens Fit	Up to $55	NA	Up to $55	N/A
Premium Contact Lens Fit	Up to $55	NA	Up to $55	N/A
Retinal Screening	Covered 100% if diabetic, Otherwise $25	NA	Covered 100% if diabetic, Otherwise $25	N/A
Eyewear	Frame every other calendar year and lenses every calendar year		Frame and lenses every calendar year	
Eyeglass Frames	$130 allowance/$70 if Costco affiliate	Reimbursed to $70	$200 allowance/$110 if Costco affiliate	Reimbursed to $110
Standard Single Vision Lenses	$25 copay	Reimbursed to $30	$10 copay	Reimbursed to $30
Standard Bifocal Lenses	$25 copay	Reimbursed to $50	$10 copay	Reimbursed to $50
Standard Trifocal	$25 copay	Reimbursed to $70	$10 copay	Reimbursed to $70
Standard Lenticular Lenses	$25 copay	Reimbursed to $85	$10 copay	Reimbursed to $85
Standard Progressive Lenses	$0 copay	Reimbursed to $50	$0 copay	Reimbursed to $50
Premium Progressive Lenses	$95-$105	Reimbursed to $50	$95-$105	Reimbursed to $50
Custom Progressive Lenses	$150 - $175	NA	$150 - $175	NA
UV Coating	$16 copay	NA	$16 copay	NA
Tint	$15 copay	NA	$15 copay	NA
Standard Scratch Resistant	$17 copay	NA	$17 copay	NA
Polycarbonate Single Vision Lenses	$31 copay	NA	$31 copay	NA
Polycarbonate Multi-Focal Lenses	$35 copay	NA	$35 copay	NA
Standard Anti-Reflective Coating	$41 copay	NA	$41 copay	NA
Other Add-ons & Services	NA	NA	NA	NA
Contact Lenses	Contact lenses every calendar year			
Contact Lenses (elective)	$130 allowance	$130 allowance	$200 allowance	$200 allowance
Contact Lenses (Medically necessary▪)	$25 copay	$210	$10 copay	$210
Laser Vision Correction (e.g., LASIK)	Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities	NA	$2,000 allowance; available once per lifetime ; plus an average 15% off the regular price or 5% off	$2,000 allowance; available once per lifetime

Features	VSP Basic Vision (In-Network)	VSP Basic Vision (Out-of-Network)	VSP Vision Plus (In-Network)	VSP Vision Plus (Out-of-Network)
			the promotional price; discounts only	
Other Treatment of Minor Medical Conditions of the Eye	$15 co-pay	NA	$15 copay	NA

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

▪Medically necessary means the patient has a condition where contact use corrects the condition / vision issue better than glasses. Types of conditions include: aphakia, anisometropia, high ametropia, nystagmus, and keratoconus.

6.15.3 How the Vision Care Benefit Works

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

Payable Benefits

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

For both vision care options, eye exam and prescription eyewear benefits are covered if you do not utilize VSP providers; however, the out-of-network benefits are lower than in-network benefits.

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

Filing a Claim

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

- Pay the provider the full amount and request an itemized copy of the bill. The bill should separately detail the charges for the eye exam and materials including lens type.
- Include the following information with the bill:
    - The name, address and phone number of the provider
    - The covered member's ID number (the employee's Intel worldwide ID)
    - The covered member's name, address and phone number
    - The name of the group (Intel)
    - The patient's name, date of birth, address and phone number
    - The patient's relationship to the covered member (such as self, spouse, child, etc...)

- Write the information on the bill or use the printable claim form available when members sign on to vsp.com.
- Send a copy of the itemized bill(s) with the above information to VSP at:
  VSP
  PO Box 385018
  Birmingham, AL 35238-5018

6.16 Claim Administration

Topics

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

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

6.16.1 Filing a Claim

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

Filing an In-Network Claim

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

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

Filing an Out-of Network Claim

You are responsible to pay the full amount due for medical services at the time of service. You must submit a claim form each time you use out-of-network services. Except as otherwise provided by the plan, you must submit a request for payment of benefits within one year of the date the service is provided.

Claims filed after one year from the date of service will be denied in full. If an out-of-network provider submits a claim on your behalf, you will be responsible for the timeliness of the submission. You are responsible to assure claims are paid, and if a claim is not submitted to your plan within one year of the date of service, benefits for that health service will be denied. This time limit does not apply if you are legally incapacitated. If your claim relates to an inpatient stay, the date of service is the date your inpatient stay ends. See the table below for how to obtain claim forms for the national plans.

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

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

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

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

6.16.2 Types of Claims and Determination Process

Any claim for health plan benefits (including Extra Bucks and the Executive Health Program), vision benefits, and dental benefits will fit into one of several claim types--each with its own process for reviewing a claim and time period in which a determination will be made. Extra Bucks claims for reimbursement for vision and dental expenses are post-service claims.

Pre-service Claims

Sometimes certain health services must be reviewed by a plan before the plan can provide benefits for those services. This is to ensure that the requested health services meet the plan's criteria for coverage. This process is called "care coordination notification," "prior authorization," or "utilization review." Services that require such review processes, and the procedures for obtaining such authorizations, are outlined in the respective sections for each plan option in this chapter. Claims submitted to request authorizations for these services are called "pre-service claims," because these services are typically not provided until the plan has authorized them.

Urgent Care Claims

There are some claims for medical care or treatment where waiting for the usual claim determination process to finish could seriously jeopardize your life, health, ability to regain maximum function, or--in the opinion of a physician with knowledge of your medical condition--would otherwise subject you to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim. Claims of this type are called "urgent care claims." These claims will be processed in an expedited manner, as outlined in the table below.

Post-Service Claims

Some health services either do not require Care Coordination notification, prior authorization, or utilization review, or you may receive such services before they are reviewed for authorization. These are called "post-service claims." For these, you will receive the health service and then you, your provider, or authorized representative will submit the claim to the plan for payment.

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

6.16.3 Time Periods for Making Claim Determinations

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

Table: Time Periods for Making Claim Determinations

	Urgent Care Claims	Pre-service Claims	Post-Service Claims±
General time period for deciding your claim	A decision will be made as soon as possible, taking into account the medical exigencies, but no later than 72 hours after your claim is received.	A decision will be made within a reasonable time, based on your medical circumstances, but no later than 15 days after your claim is received.	A decision will be made within a reasonable time, based on your medical circumstances, but no later than 30 days after your claim is received.
If claims administrator determines that more time is needed to decide your claim due to matters beyond its control	Your claims administrator may only take more time to decide your claim if additional information is needed (see below).	Before the end of the initial 15 days, the claims administrator will notify you of the circumstances requiring the extension of time and the date by which it expects to render a decision. The claims administrator may take up to 15 additional days to decide your claim.	Before the end of the initial 30 days, the claims administrator will notify you of the circumstances requiring the extension of time and the date by which it expects to render a decision. The claims administrator may take up to 15 additional days to decide your claim.
If your claims administrator determines that more time is needed to decide your claim because sufficient information was not received to determine whether benefits are	You will be notified no later than 24 hours after receipt of your claim of the specific information necessary to complete your claim. Once your response is received, your claim will be decided within 24 hours--without regard	Before the end of the initial 15 days, you will be notified of the need for additional information. The notice will specifically describe the required information, and you will be given up to 45 days to respond. Once	Before the end of the initial 30 days, you will be notified of the need for additional information. The notice will specifically describe the required information, and you will be given up to 45 days to respond. Once

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

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

6.16.4 Non-Claims Communications, Failed Claims

Communications that are not Claims for Benefits or are Failed Claims

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

- Questions concerning an individual's eligibility for coverage under the Plan without making a claim for benefits
- Requests for advance information on possible coverage of items or services--or advance approval of covered items or services--where the Plan does not otherwise require prior authorization for the benefit or service
- Casual inquiries about benefits or circumstances under which benefits might be paid under the terms of the Plan

However, if you or your authorized representative fail to follow the Plan's procedures for filing a pre-service claim, but otherwise: (1) communicate with your claims administrator; and (2) identify a specific person, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested, then you or your authorized representative shall be notified of the failure.

You will also be notified of the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to you or your authorized representative, as appropriate, as soon as possible, but not later than five days (24 hours in the case of failure to file a claim involving urgent care) following the failure. Notification may be oral, unless you or your authorized representative requests written notification.

Concurrent Care Claims

There may be situations where you are receiving an ongoing course of treatment that has been approved by your plan for a specified period of time, or number of treatments. If you, your provider, or authorized representative make a request to extend this course of treatment beyond what has been approved, this is called a "concurrent care claim." Depending on the nature of the treatment

you're receiving and your medical condition, a concurrent care claim will be treated as an urgent, pre-service, or post-service care claim.

For concurrent claims that meet the definition of urgent care claims, your claims administrator will follow one of two time periods for making a determination, depending on how long before treatment ends that you request an extension:

- If the request to extend is made at least 24 hours before treatment ends, your claims administrator will provide you with a determination within 24 hours of receipt of the claim.

- If the request to extend is made less than 24 hours before treatment ends, the time period and process for urgent care claims will be followed.

If the claims administrator decides to reduce or terminate a previously approved course of treatment, you will be notified of this determination, and you will be given an opportunity to appeal this decision within a reasonable period of time before your treatment is reduced or terminated. For information on how to file an appeal, review "Appeals" in chapter 3, Administrative Information section, of the *Pay, Stock and Benefits Handbook*.

6.16.5 Appointing an Authorized Representative

You may appoint an authorized representative to act on your behalf in submitting a claim for benefits and in appealing an adverse benefit determination. Contact your claims administrator of the Plan option you are enrolled to find out the process for authorizing someone to act on your behalf.

If your claim involves urgent care--or if you have a pre-service claim--a health care professional with knowledge of your medical condition, such as your treating physician, can act as your authorized representative without going through your Plan's normal process for authorizing a representative.

If you clearly designate an authorized representative to act and receive notices on your behalf with respect to a claim, then in the absence of any indication to the contrary, the claims administrator will direct all information and notifications to which you are entitled to your authorized representative. For this reason, it is important that you understand and make clear the extent to which an authorized representative will be acting on your behalf.

6.16.6 Notice of Claim Determination

For pre-service and urgent care claims, the claim administrator for the Plan option you are enrolled will notify you or your authorized representative of its determination on your claim, regardless of whether the determination is adverse or not. For post-service claims, you will receive a notice of the claim determination.

Adverse Benefit Determination?

An adverse benefit determination generally includes any denial, rescission, reduction, or termination of a benefit, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, rescission, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in the plan. However, if benefit is approved by the claims administrator that will be provided over a period of time, such as a

series of chemotherapy treatments, and has notified you of the scope of the treatment (such as how long and for how many treatments), the claims administrator will not provide you with a formal notification that the course of treatment is coming to an end, unless the Plan decides to reduce or terminate this course of treatment early.

You will receive a notice of an adverse benefit determination either in writing or electronically. However, for urgent care claims, you may be initially notified orally of the benefit determination. If you are notified orally, within three days you will also be provided with a written or electronic notification of the determination.

For all types of claims, notice of adverse benefit determinations will include the following information that applies to the determination on your claim:

- The date of service for the claim(s).
- The health care provider.
- The claim amount (if applicable).
- The denial code and its corresponding meaning, and any standards (if applicable) used in denying the claim.
- The specific reason or reasons for the adverse determination.
- Reference to the specific plan provisions on which the determination is based.
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary.
- For a final adverse benefit determination, a discussion of the decision shall be included.
- A description of the Plan's appeal procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, and that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge upon request.
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of your plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- A description of the expedited appeal process if your claim is an urgent care claim or you are receiving an ongoing course of treatment.

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

6.17 Third-Party Responsibility for Medical Expenses

You, individually and on behalf of your enrolled family member(s), as a condition of receiving any benefits, agree that if a health and welfare plan sponsored by Intel Corporation provides health services that are the result of any act or omission of any other party, the following will apply:

- The plan shall have all the rights that you or your family member(s) have to recover against any person or organization, to the full extent of all the benefits provided by the plan and any other amounts it is entitled to. The plan may, within its sole discretion, take action to preserve its rights, including filing a suit in your name.
- You and your family member(s) assign to the plan an amount equal to the benefits paid by the plan against any recovery you or your family member(s) are entitled to receive. The plan is also granted a lien on any such recovery.
- The plan's rights extend to any sources of recovery, including, but not limited to, payments from any uninsured, underinsured, no-fault, or any other motorist or other insurance coverage, or any Workers' Compensation award or settlement, or any other type of payments from a third party. The plan's right to recover shall also apply to settlements or recoveries with respect to a decedent, minor, and incompetent or disabled person.
- You or your family member(s) shall not do anything to prejudice the plan's right to recover, including making any settlement that reduces or excludes the benefits provided by the plan. In addition, the plan shall be entitled to recover reasonable attorneys' fees incurred in collecting any recovery proceeds held by you or your family members.
- The plan has the right to recover the full amount of benefits provided without regard to any of the following: any fault on the part of you or your family member(s); any attorney's fees or costs incurred by or on behalf of you or your family member(s); or whether or not you or your family member(s) have been fully compensated for all injuries or conditions.
- Any failure to follow these or other terms of the plan would cause irreparable and substantial harm, for which no adequate remedy at law would exist, and the plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien or constructive trust, as well as injunctive relief.
- Within its sole discretion, the plan has the right to reduce the amount it seeks to recover for the benefits it has paid to you or your family member(s). Any such decision shall not waive the plan's right to full reimbursement at any other time or grant you or your family member(s), or any other party, any right to such reduction.

6.18 Refund of Overpayments

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

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

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

If the covered person, or any other person or organization that was paid, does not promptly refund the full amount, Intel may reduce the amount of any future benefits that are payable under the Plan. The reductions will equal the amount of the required refund. Intel may have other rights in addition to the right to reduce future benefits.

6.19 Coordination of Benefits

Overview

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

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

Determining the Primary Plan

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

- If the other plan does not have a provision coordinating its benefits with the Plan, then the other plan is always the primary plan.
- The Plan is the primary plan for the active Intel employee and the secondary plan for a dependent that has coverage under another plan. If the active Intel employee is also covered under a dependent's plan (such as a spouse's plan), the dependent's plan is considered primary for the dependent and secondary for the active Intel employee.
- If the children of an Intel employee have dependent coverage under both parents' group medical plans, the birthday rule applies. The birthday rule stipulates that the plan of the

parent whose birthday is earlier in the year (not necessarily the older parent) is considered the primary plan. If both parents have the same birthday, the plan that has been in effect longer is the primary plan. If the other parent's plan adheres to the male primary role, the plan of the male parent will be considered primary.

- If the plans cover a person as a child of divorced or separated parents, the following rules apply:
    - If the specific terms of a court decree establish financial responsibility for medical, dental, or other health-care expenses for children, and the plan covering the parent with such responsibility has actual knowledge of those terms, then the parent with such responsibility will be primary.
    - In the absence of a court decree, the plan of the parent with sole custody will be primary.
    - In the event of joint custody (and no court decree), the birthday rule will apply.
    - In the event of remarriage of a parent with sole custody, that parent's plan will remain primary, the plan (if any) of the step-parent will be secondary, and the plan of the parent without custody will be third.
- If the person is covered under a plan as a laid-off, retired, or disabled employee, or as a dependent of a laid-off, retired or disabled active employee, the plan covering the person as an active employee or as a dependent of an active employee will be primary.
- If a person's coverage is provided under a right of continuation (e.g., COBRA) pursuant to federal or state law, the plan covering the person as an active employee or as a dependent of an active employee will be primary.
- If none of the other rules of this section apply, the plan under which the person has been covered for a longer period of time will be primary.

Examples of Coordinated Benefits

Your spouse is enrolled in his or her employer's medical plan. You and your spouse are also enrolled in the Plan, under the Anthem HDHP option. Your spouse incurs surgical expenses of $1,500. Your spouse's plan is the primary plan for his or her coverage, and he or she has already met the deductible.

Your spouse's plan, the primary plan for his or her coverage, pays 90 percent of the surgery bill or $1,350. Anthem HDHP in-network surgery is payable at 90 percent after the deductible is met. The Anthem HDHP in-network benefit is reduced by the amount by the primary plan from the benefit normally payable:

- Anthem HDHP benefit: $1,350
- Less the benefit paid by the primary plan: $1,350
- Anthem HDHP coordinated benefit: $0, the primary plan paid up to Anthem's normal liability

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

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

- Anthem HDHP coordinated benefit: $0

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

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

All Intel medical options under the Plan are primary with respect to active employees age 65 and over and their spouses age 65 and over, unless such individuals have elected Medicare as their primary coverage. The Plan options are primary to CHIP. The Plan options are also primary for all active employees and dependents who are under age 65 and eligible for Medicare (except those who are eligible for Medicare due to end stage renal disease (ESRD), in which case the Plan options are only primary for the first 30 months after it is determined there is Medicare entitlement due to ESRD). For more information about Medicare entitlement due to ESRD, visit: www.ssa.gov/mediinfo.htm or call (800) MEDICARE (633-4227).

How to File Claims if You Have Multiple Coverage

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

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

Chapter 7
Dental Plans

Chapter 7
Dental Plans

This chapter provides important information about choosing, understanding, and using your dental plan.

7.1 Overview

The Intel Group Health Plan provides a choice of dental plan options to meet your needs. Once eligible, you may choose between the two options available at most major U.S. sites:

- Delta Dental PPO (formerly Intel Dental)
- Dental Health Maintenance Organization (DHMO)

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

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

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

Each dental plan option utilizes its own internal guidelines and protocols for determining whether a service is covered.

7.2 Dental Plans Comparison

The chart below summarizes general benefit coverage for the Delta Dental PPO and DHMO options.

The Dental Plan Comparison chart is a summary of DHMO services and copayments. For a complete listing of all services, you can request a copy of your DHMO's Evidence of Coverage (EOC) member handbook and Schedule of Benefits listing of copayments.

Table: Dental Plan Comparison Chart

Feature	Delta Dental PPO (formerly Intel Dental	Sun Life Dental	Sun Life Dental	Kaiser Permanente Dental	DeltaCare USA
Location	All	AZ	NM	OR	CA
Annual Deductible	$50 per person; waived for Preventive and Diagnostic services	N/A	N/A	N/A	N/A
Dental Treatment Review	Treatment plans over $300 must be pre-certified	N/A	N/A	N/A	Required for referral to a specialist
Oral Exams and Cleanings	PPO Dentist: No copayment Premier and non-Delta Dentist: 10% coinsurance Oral Exam Limit: Adults and dependent children age 14 and up: one routine oral exam per year Dependent children up to age 14: two routine oral exams per year Cleanings: two cleanings per calendar year. No age limit.	$10 office visit copayment; $5 copayment for cleanings	$10 office visit copayment; $5 copayment adult cleanings	$10 office visit copayment**	No charge; 1 per 6-month period
X-rays	PPO dentist: No copayment for preventive X-rays Premier and non-Delta	No charge; Bitewing x-rays limited to one series of 2 and 4 films every 6 months. Full mouth x-rays and Panoramic films	No charge; Bitewing x-rays limited to one series of 2 and 4 films every 6 months. Full mouth x-rays and Panoramic films	$10 office visit copayment	No charge; Bitewing x-rays limited to one series of 4 films every 6 months. Full mouth x-rays are limited to

Feature	Delta Dental PPO (formerly Intel Dental	Sun Life Dental	Sun Life Dental	Kaiser Permanente Dental	DeltaCare USA
	Dentist: 10% coinsurance	are limited to one set every 36 months. $5 copayment for Panoramic film.	are limited to one set every 36 months. $5 copayment for Panoramic film.		one set every 24 months.
Extractions and Fillings	10% coinsurance after the deductible	Fee range $20-$135*	Fee range $20-$135*	$10 office visit co-payment	Fee range $0-$70***
Crowns, Pontics, Bridges	50% coinsurance after the deductible	Fee range $265-305* plus lab fee	Fee range $265-305* plus lab fee	20% coinsurance	Fee range $50-$85+***
Dentures	50% coinsurance after the deductible	Fee range $365-$465*	Fee range $365-$465*	20% coinsurance	Fee range $100-$115; full upper or lower
Root Canals	10% coinsurance after the deductible	Fee range $125-$275*	Fee range $125-$275*	$10 office visit copayment	Fee range $45-$155***
Periodontal Surgery	10% coinsurance after the deductible	Fee range $65-$350*	Fee range $65-$350*	$10 office visit copayment	Fee range $8-$200***
Annual Maximum	PPO Dentist: $2,000 Premier Dentist: $1,500 Out of network: $1,200	None	None	None	None
Orthodontia	50% coinsurance; Lifetime Maximum: PPO Dentist: $2,000 Premier Dentist: $1,500 Out of network: $1,000	25% discount for both adult and child	25% discount for both adult and child	50% coinsurance; $1,500 lifetime maximum	$350 start-up fee plus fee range

** Call Sun Life Dental directly for the schedule of benefits at (800) 247-6875.*

*** Call Kaiser Permanente Dental directly for the schedule of benefits at (503) 813-2000.*

**** Call DeltaCare USA HMO (CA) directly for the schedule of benefits at (800) 422-4234.*

7.3 Delta Dental PPO (formerly Intel Dental Plan)

How the Intel Dental Plan Works

Topics

Under the Delta Dental PPO, administered by Delta Dental of California, services are provided through the Delta Dental Plan Network or you may obtain care from any licensed provider. If you utilize the services of a Delta Dental dentist, you have the choice of seeing a Delta Dental Preferred Provider Organization (PPO) dentist or a Delta Dental Premier dentist, and the Intel Dental Plan will pay the Delta dentist directly for covered benefits. If you do not go to a Delta Dental dentist, the Delta Dental PPO will reimburse you for the covered expense as described under “Using a non-Delta Dentist” (see following information).

To determine if a dentist is a contracted provider, call Delta Dental at (800) 4-AREA-DR (427-3237) or access the provider directory online at deltadentalins.com/intel.

You can also use the “Find a Doctor and Facility Search tool” located on the My Health Benefits website. This tool allows you to narrow your search by specifying gender and specialty, view maps, and get driving directions.

Intel Dental Plan does not require or distribute ID cards; however, you may print an ID card online at deltadentalins.com/intel.

7.3.1 Payable Benefits

Benefits are payable after you satisfy an annual $50 deductible per person. The deductible is waived for preventive and diagnostic services. After the deductible, benefits are provided for Maximum Plan Allowance (MPA) dental charges as follows:

- **Preventive & Diagnostic services:** 100% of covered cost when performed by a Delta PPO dentist or 90% of covered costs if received from a Delta Premier or non-Participating dentist
- **Routine services:** 90% of covered costs
- **Major services:** 50% of covered costs
- **Orthodontic services:** 50% of covered costs to a lifetime maximum of $2,000 when performed by a Delta PPO dentist (see Dental Plan Comparison Chart for additional limitations)
- **Smileway program:** Offers expanded coverage for those diagnosed with diabetes, heart disease, HIV/AIDS, rheumatoid arthritis, or stroke. Expanded coverage includes 100% coverage for one periodontal scaling & root planning procedure per quadrant, and 100% coverage for 4 combinations of the following: teeth cleanings or periodontal maintenance. There is no cost, but the covered person MUST enroll in the optional benefit via the Delta Dental member portal (https://www.deltadentalins.com/). Participants can enroll themselves and covered dependents under 18 years. Covered dependents over 18 years must enroll themselves.

The maximum benefit per calendar year for preventive/diagnostic, routine and major services for each covered person is determined by the type of dentist you receive services from:

- Delta Dental PPO dentist: $2,000 annual maximum
- Delta Dental Premier dentist: $1,500 annual maximum
- Out-of-network: $1,200 annual maximum

The percentages of payable benefits are the same no matter which dentist you choose. However, your out-of-pocket costs may be lower if you select a Delta Dental PPO dentist who has a special agreement with Delta Dental, and generally charges lower fees than a Delta Dental Premier dentist or non-Delta dentist.

7.3.2 Fees and Payments

An expense is incurred when the service is performed or when the expense is deemed to be incurred because:

- The impression is taken for dentures or fixed bridgework
- Preparation of the tooth for crown work is begun
- Work on the tooth for root canal therapy is begun

Using a Delta Dentist

Payment to a Delta dentist will be based on the lesser of the following:

- The fee actually charged
- The accepted MPA fee that the dentist has on file with Delta Dental

Delta Dental pays Delta Dental PPO and Premier dentists directly. Delta Dental has an agreement with its dentists, so you are not responsible for filing any claims paperwork.

Your out-of-pocket costs may be lower if you select a Delta Dental PPO dentist, who has a special agreement with Delta Dental and generally charges lower fees than a Delta Dental Premier dentist or non-Delta dentist.

Using a Non-Delta Dentist

Payment to a dentist who is not a Delta Dental dentist will be based on the lesser of the following:

- The fee actually charged
- The Delta approved fee as set by the local Delta plan

Delta Dental will reimburse you for eligible charges. Payments made to you are not assignable; in other words, Delta Dental will not grant requests to pay non-Delta Dental dentists directly.

You must file your own claim form. Non-Delta Dental dentists may require you to submit the dentist bill and claim form to Delta Dental of California directly or may require payment for services in advance. See "Filing a Claim" in this chapter.

How to Find a Delta Dental PPO or Delta Dental Premier Dentist

Call Delta Dental at (800) 4-AREA-DR (427-3237) or access the provider directory online at deltadentalins.com/intel.

You can also use the "Find a Doctor and Facility Search tool" link on the My Health Benefits website. This tool allows you to narrow your search by specifying gender and specialty, view maps, and get driving directions.

7.3.3 Filing a Claim

If your dentist is a Delta Dental participating dentist, you do not need to file a claim form.

If you see a non-Delta dentist, you must submit a claim within 365 days of incurring the expense to the appropriate claims office listed below. Your claim must include the Intel Group Number 5178. To determine the status of a claim, contact Delta Dental of California at (800) 765-9470, or visit deltadentalins.com/intel.

Chapter 6: Medical Plans of the Pay, Stock and Benefits Handbook explains the procedures that apply to filing a claim for dental benefits. Refer to "Filing a Claim" in that chapter for more details.

Delta Dental Claim Forms

Forms are available from Delta Dental Member Services via online visit deltadentalins.com/intel or call (800) 765-9470.

Where to Send Your Claim(s):

Delta Dental of California
P.O. Box 997330
Sacramento, CA 95899-7330

If you disagree with how a claim was paid, see Appeals Process for National Plans in Chapter 3 of the Pay, Stock and Benefits Handbook, Administrative Information.

7.3.4 Dental Prescriptions

Prescriptions written by your dentist are covered as follows:

- **If you have medical coverage through a Health Maintenance Organization (HMO) Plan:** You can be reimbursed through Delta Dental.
- **If you are covered by Anthem HDHP, Connected Care CA, or Connected Care AZ:** You can use your Express Scripts benefit, or submit a claim to Delta Dental.
- **If you are covered by Connected Care NM or Connected Care OR Providence or Kaiser Permanente:** You can use your Connected Care prescription drug benefit or submit a claim to Delta Dental.

Prescriptions submitted to the Delta Dental will be reimbursed at 90% of the covered cost.

7.3.5 Pretreatment Estimate

Pretreatment estimates are not required, but recommended, for services over $300.

With a pretreatment estimate, Delta Dental will consider the treatment plan provided by your dentist, as well as applicable X-rays. Delta Dental will verify the services are covered by the Intel Dental Plan and process the predetermination as if it were a claim. Your dentist will receive an estimate of the amount Delta will pay for approved services and your coinsurance amount.

If a pretreatment estimate is not obtained, benefits will be limited to Delta Dental's ability to assess the treatment plan after the fact. Benefits will be limited to what would have been allowed in a pretreatment estimate, no matter what work was completed.

Pretreatment estimates *do not* take into consideration the following:

- Coordination of benefits with those that may be payable through another employer's dental plan
- Benefits already paid out under the Intel Dental Plan earlier in the year
- Calculation of the annual benefit maximum

7.3.6 Coordination of Dental Benefits

The Intel Dental Plan contains a provision designed to prevent duplication of benefit payments. The provision applies if you or your dependents are enrolled in the Intel Dental Plan and also

have coverage through another dental plan. This provision is identical to the coordination of benefits provision explained in the Pay, Stock and Benefits Handbook chapter 6: Medical Plans.

7.3.7 Preventive and Diagnostic Services

The Intel Dental Plan covers 100% of covered cost when using a Delta Dental PPO dentist for preventive and diagnostic (D&P) services. Otherwise, D&P is covered at 90% of covered cost. Maximum Plan Allowance (MPA) charge limits apply to services received from a non-Delta dentist. D&P services include:

Preventive

- Oral examination by a dentist (other than emergency examination): Adults and children age 14 and older are covered once each calendar year; a second oral exam by a dentist in a calendar year is available if conditions like periodontal disease or recent history of dental risk (restorative fillings or crowns) exist. Call Delta Dental for more information. Children up to age 14 are covered for an oral exam by a dentist twice per calendar year.
- Palliative (pain) treatment and emergency office visits as separate procedures only if no other service, except a single X-ray, is provided during the visit
- Consultation with a specialist (when treatment is not provided by that specialist and/or consultant)
- Prophylaxis (teeth cleaning)
    - Routine (limited to twice each calendar year; up to four routine cleanings per calendar year if it is documented by your dentist as necessary, due to periodontal conditions)
    - Periodontal (limited to twice each calendar)
    - Routine and periodontal cleanings in total are limited to four each calendar year
- Topical application of fluoride, including prophylaxis (limited to two per calendar year for children under age 18)
- Space maintainers for children under age 14
- Sealants for children through age 15, limited to permanent posterior first and second molars with no cavities or restorations, and with occlusal surface intact (limited to once every three years)
- If you are pregnant, you may receive additional services each calendar year, services include: one (1) additional oral exam and either one (1) additional routine cleaning or one (1) additional periodontal scaling and root planning per quadrant; written confirmation of your pregnancy must be provided by you or your dentist when the claim is submitted
- A full mouth debridement is allowed once in a lifetime and counts toward the cleaning frequency in the year provided
- The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different Provider/Provider's Office; contact Delta Dental for additional information
- Specialist consultations, screenings of patients, and assessments of patients are limited to once in lifetime per provider and count toward the oral exam frequency

Diagnostic

- Bitewing X-rays (not more than twice each calendar year)
- Complete series of intraoral X-rays (full mouth X-ray) or panoramic extraoral X-ray (limited to one treatment every five years)
- Panoramic X-rays combined with any other X-ray will be treated as a complete series (for example, full mouth X-ray), which is limited to one every five years.
- Intraoral X-rays, occlusal, and periapical
- Extraoral X-rays (only one of the listed extraoral procedures will be covered each five-year period), to include the following:
    - Sialography
    - Cephalometric film
    - Posteroanterior and lateral skull and facial bone survey
- Multiple X-rays that meet or exceed the fee for a complete series (full mouth X-ray) will be treated as a complete series and limited as such
- Biopsy of oral tissue
- Microscopic examination of biopsied material
- Bacteriologic culture of root canal
- Pulp vitality test: allowed once per day when definitive treatment is not performed
- Diagnostic cast

7.3.8 Routine Services

The Intel Dental Plan covers 90% of covered cost (reasonable and customary, R&C); charge limits apply to services received from a non-Delta dentist) after the deductible for the following routine services.

Restorative Dentistry

- Fillings (amalgam, silicate, plastic or composite, including pin retention when necessary) for the treatment of cavities (excluding inlays, crowns [other than stainless steel] and bridges); for more information, see Major Services section on page 11 of this chapter
- Stainless steel crown
- Re-cementing of inlays, crowns, and space maintainers (re-cementing of space maintainers is limited to once per lifetime)
- Protective restorations (sedative fillings) are allowed once per tooth per lifetime when definitive treatment is not performed on the same date of service.
- Delta Dental limits payment for prefabricated resin crowns under this section to services on baby (deciduous) teeth; stainless steel crowns are allowed on baby (deciduous) teeth and permanent teeth up to age 16
- Therapeutic pulpotomy is limited to once per lifetime for baby (deciduous) teeth only
- Root canal therapy and pupal therapy (resorbable filling) are limited to once in a lifetime; retreatment of root canal therapy by the same Provider/Provider office within 24 months is considered part of the original procedure
- Apexification is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation; Apexification visits have a lifetime

limit per tooth of one (1) initial visit, four (4) interim visits and one (1) final visit to age 19
- Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure
- When allowed, retrograde fillings per root are limited to once in any 24-month period
- When allowed, root amputation per root and/or hemisection is limited to once in a lifetime
- Pin retention is covered not more than once in any 24-month period
- Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required x-rays or select diagnostic procedures

Oral Surgery

- Extraction of teeth
- Alveoloplasty
- Removal of dental cysts and tumors
- Surgical incision and drainage of dental abscess
- Other surgical procedures, such as the following:
    - Tooth reimplantation
    - Surgical exposure to aid eruption
    - Surgical repositioning of teeth
    - Excision of hyperplastic tissue
- Covered oral surgery services are covered once in a lifetime except removal of cysts and lesions and incision and drainage procedures which are covered once in the same day
- Accession of tissue procedures and/or accession of exfoliative cytologic smears are allowed once in the same day; if more than one of these procedures is billed on the same day, for the same site, and by the same Provider/Provider office, Delta Dental will only pay for the most inclusive procedure
- The following oral surgery procedure is limited to age 19: transseptal fiberotomy/supra crestal fiberotomy by report
- The following oral surgery services are limited to age 19 (or ortho limiting age) provided orthodontics are covered: surgical access of an unerupted tooth, placement of device to facilitate eruption of impacted tooth, surgical repositioning of teeth

Periodontics

Surgical procedures (limited to only one of the listed periodontic surgical procedures for each quadrant in a 24-month period):

- Gingivectomy
- Gingival curettage (limited to once each quadrant in a 36-month period)
- Osseous surgery (limited to once each quadrant in a 36-month period)
- Scaling and root planing (limited to once each quadrant in a 24-month period)
- Periodontal appliance (limited to one appliance each three-year period)
- Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous

tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants
    - If in the same quadrant, scaling and root planing must be performed at least six weeks prior to the periodontal surgery
- Cleanings (regular and periodontal) and full mouth debridement are subject to a 30 day wait following periodontal scaling and root planing if performed by the same Provider

Endodontic Services

Pulp cap
Vital pulpotomy
Root canal therapy
Apexification
Apicoectomy
Retrograde filling, apicoectomy, and retrograde filling covered as a separate procedure only if performed more than one year after the root canal therapy is completed
Apical curettage
Hemisection or root amputation

Anesthesia

Intravenous sedation or general anesthesia is covered as a separate procedure when required for complex oral, periodontal, and apical surgical procedures.

General anesthesia, nitrous oxide, or intravenous sedation are covered benefits for all procedures for children up to the age of 7.

Nitrous oxide and intravenous sedation are covered for developmentally disabled members when administered for routine dental care. Developmental disability must be attributed to certain medical conditions such as, but not limited to, chromosomal birth defects or physical or mental conditions such as, but not limited to, Down Syndrome, cerebral palsy and autism.

Members with learning disabilities, attention deficit disorder, general dental anxieties, and dental phobias, for example, are not considered developmentally disabled under the plan. Proof of disability (e.g. a letter from a physician stating the diagnosis) must be submitted along with the dental claim and sent to Delta Dental in order for nitrous oxide and intravenous sedation for routine care to be paid.

Other Routine Services

- Treatment for temporomandibular joint (TMJ) syndrome to include examination, specialist consultation, temporary repositioning appliance, occlusal guard, complete occlusal adjustment, removable metal overlay stabilizing appliance, and X-rays
- Antibiotic drug injection
- Occlusal guard for pathological reasons (athletic mouth protectors not covered)

7.3.9 Major Services

The following major services are reimbursed at 50% of MPA charges for covered costs after the deductible has been met, and a pretreatment estimate is recommended before beginning treatment:

- Restorations
- Covered prosthodontics
- Other major services

Restorations

Restorations and crowns are covered for treatment of cavities only if the tooth cannot be restored by an amalgam, silicate, plastic, or composite filling.

Replacement crowns are limited to one every five years. Crowns (including replacement crowns) for the primary purpose of periodontal splinting, altering vertical dimension, restoring occlusion or restoring tooth structure that is worn are not covered.

Crowns and cast restorations include the following:

- Plastic (acrylic)
- Plastic, prefabricated
- Plastic with nonprecious metal
- Plastic with semiprecious metal
- Porcelain
- Porcelain with nonprecious metal
- Porcelain with semiprecious metal
- Nonprecious metal (full cast)
- Semiprecious metal (full cast)
- Cast post and core (limited to teeth that have had root canal therapy)
- Steel post and core

Crowns and onlays are limited to members age 12 and older, and are covered not more often than once in any five year period except when Delta Dental determines the existing crown or onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.

When an alternate benefit of an amalgam is allowed for inlays or porcelain/ceramic onlays, they are limited to members age 12 and older, and are covered not more than once in any five-year period.

Core buildup, including any pins, are covered not more than once in any five-year period.

Post and core services are covered not more than once in any five-year period.

Crown repairs are covered not more than once in any five-year period.

When allowed within six months of a restoration, the Benefit for a crown, inlay/onlay, or fixed prosthodontic service will be reduced by the Benefit paid for the restoration.

Recementation of crowns, inlays/onlays or bridges is included in the fee for the crown, inlay/onlay or bridge when performed by the same Provider/Provider office within six months of the initial placement. After six months, payment will be limited to one recementation in a lifetime by the same Provider/Provider office.

Covered Prosthodontics

- Implant surgical placement and removal, implant supported prosthetics, including implant repair and re-cementation
- Fixed bridges, initial placement, or replacement
- Removable full or partial dentures

Denture repairs are covered not more than once in any six-month period except for fixed denture repairs which are covered not more than once in any five-year period.

Fixed Prosthodontic appliances are limited to members age 16 and older. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Delta Dental's payment for implant removal is limited to one for each implant during the member's lifetime whether provided under Delta Dental or any other dental care plan.

When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.

Cone beam benefits (specific procedures) covered in conjunction with Implant only:

Delta Dental will cover the dentist's fee for standard partial or complete denture at the major services reimbursement level up to the maximum allowance. A standard partial or complete denture is defined as a removable prosthetic appliance provided to replace missing natural, permanent teeth which are made from accepted materials and by conventional methods.

Other Major Services

- Repairs to bridges and full or partial dentures
- Adding a tooth to a partial denture, upper or lower (limited to relining done more than six months after the initial installation and then not more than once each two-year period)
- Re-cementing of bridges
- Dentures are limited to a standard partial or denture; a standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post-delivery care including any adjustments and relines for the first six months after placement
    - Denture rebase is limited to one per arch in a 24-month period and includes any relining and adjustments for six months following placement

    - Dentures, removable partial dentures and relines include adjustments for six months following installation. After the initial six months of an adjustment or reline, adjustments are limited to two per arch in a calendar year and relining is limited to one per arch in a six-month period
    - Tissue conditioning is limited to two per arch in a 12-month period; however, tissue conditioning is not allowed as a separate benefit when performed on the same day as a denture, reline or rebase service
    - Recementation of fixed partial dentures are limited to once in a lifetime
- A labial veneer performed chairside is covered once in a 24-month period; a laboratory processed labial veneer is covered once every 5 years; labial veneers are generally considered cosmetic services; a single labial veneer may be authorized if the tooth meets the criteria for a laboratory processed crown; if a veneer is allowed, a repair is considered included in the original fee for the first 24 months and denied thereafter

7.3.10 Orthodontic Services

Orthodontic services are reimbursed at 50% of MPA charges for covered costs to a lifetime maximum. Lifetime maximum is determined by the type of dentist you choose; see Dental Plan Comparison Chart Orthodontic services include procedures, using appliances or surgery, to straighten or realign teeth that otherwise would not function properly. The following limitations apply:

- If orthodontic treatment is begun before you become eligible for coverage, Intel Dental Plan payments will begin with the first payment due to the dentist following your eligibility date; the Intel Dental Plan payment will be 50% of the remaining balance owed, up to the per person lifetime maximum
- IDP payments will stop when the first payment is due to the dentist following either loss of eligibility or the end of treatment if it is ended for any reason before it is completed
- X-rays and extractions that might be necessary for orthodontic treatment are not covered by orthodontic benefits, but may be covered under routine services

Orthodontic benefits are paid in two installments up to the allowed benefit. The initial payment is completed at the banding date and the second payment is completed 12 months later. (Banding is an Orthodontic procedure completed when a thin strip of metal or plastic is closely adapted to the crown of a tooth t which wires may be attached for tooth movement.)

If the total amount payable is $500 or less, it is paid in full as soon as the claim is processed. Installment payments stop when one of the following occurs:

- The full benefit payment has been made
- The patient's lifetime or annual maximum has been reached
- The patient loses eligibility under the Intel Dental Plan
- The treatment is terminated

Benefits are not paid to repair or replace any orthodontic appliance received under this program.

Benefits are not paid for orthodontic retreatment procedures.

7.3.11 Exclusions and Limitations

In addition to exclusions and limitations specified previously in this section, the Intel Dental Plan does not cover the following:

- Cleaning and scaling, if performed more frequently than twice each calendar year (unless necessary due to periodontal conditions)
- Oral examinations, bitewing X-rays and fluoride treatment, if performed more frequently than: Adults and dependent children age 14 and older may receive one routine oral exam with a dentist per year. Dependent children up to age 14 may receive two routine oral exams with a dentist per year.
- Fluoride treatments for adults and dependents 18 years or older
- The repair or replacement of a sealant on any tooth within three years of its application
- Full-mouth X-rays, unless five years have elapsed since the last X-rays
- Charges for dental treatment involving the use of gold, which are in excess of the charges that would have been made if a reasonable substitute could have been used
- Cosmetic treatment, experimental treatment, dietary planning, plaque control, and oral hygiene instruction
- Treatments for fluorosis (a type of discoloration of the teeth)
- Replacement of dentures or retainers that have been lost, mislaid, or stolen
- Replacement of existing dentures, bridgework, implants or retainers unless the existing denture, bridgework, implant or retainer is at least five years old and cannot be made serviceable
- The existing denture, bridgework or retainer was temporarily installed after the effective date of coverage for the individual and is replaced by a permanent appliance within 12 months
- The replacement denture, bridgework or retainer is required as a result of an initial placement of an opposing denture after the effective date of coverage for the individual
- The replacement denture, bridgework, implant or retainer is required as a result of accidental injury sustained after the effective date of coverage for the individual
- Certain Intel Dental Plan services provided in conjunction with any previous Delta Dental coverage through another employer (limitations apply)
- Expenses for treatment or services not recommended or prescribed by a dentist or physician
- Services to which the patient is entitled without charges or for which there would be no charge if there were no coverage, including reduction of fees by dentists to eliminate the employee's copayment
- Any single procedure, bridge, denture, prosthodontia, implant or other orthodontic service that was started before you were covered by this plan
- Services required as a result of illness or injury for which you are covered under Workers' Compensation or some similar program through Intel or any other employer or sponsor
- Charges made by a dentist for broken appointments or for completion of claim forms or narrative reports required by the Delta Dental claims administrator

- Services provided by the enrolled individual's spouse, parent, child, brother, sister or anyone who lives in the same household
- Amounts charged above MPA charges
- Expenses of dental treatment required as a result of war, any self-inflicted injury or from engaging in a riot or insurrection
- Treatment received from a dental or medical department maintained by the employer, a mutual benefit association, labor union, trustee or similar type of group
- Grafting any tissue from outside the mouth to tissue inside the mouth (extraoral grafts)
- Treatment paid for directly or indirectly by any government or for which a government prohibits payment of benefits
- Experimental procedures, drugs or devices that are not generally recognized as being safe and effective by the dental community, as determined by the Delta Dental claims administrator
- Services for restoring tooth structure lost from wear, for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Such services include but are not limited to equilibration and periodontal splinting
- All hospital costs and any additional fees charged by the dentist for hospital treatment
- Replacement of existing restorations for any purpose other than active tooth decay; replacement will not be made within two years, if done by the same dentist or by a dentist in the same dental office, unless due to external violent means, recurrent caries, or radiation therapy
- Dental photographs (except for photographs taken in conjunction with orthodontic treatment)
- Repair or replacement of occlusal guards or occlusal orthotic devices until after five years have elapsed
- Partial occlusal adjustments that exceed one per quadrant every four months or a complete occlusal adjustment once in a six-month period
- Prescribed or applied therapeutic drugs, premedication or analgesia (e.g., nitrous oxide) unless specified in the covered services sections
- Maxillofacial prosthetics
- Provisional and/or temporary restorations except an interim removable partial denture is covered only to replace extracted anterior permanent teeth during the healing period
- Services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development) and anodontia (congenitally missing teeth), except those services provided to newborn children for medically diagnosed congenital defects or birth abnormalities
- Laboratory processed crowns for members under age 12
- Fixed bridges and removable partials for members under age 16
- Interim implants
- Indirectly fabricated resin-based inlays and onlays
- Overdentures
- Treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision

- Preventive control programs including home care times, X-ray duplications, cancer screening, tobacco counseling
- Procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation
- Any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for benefits provided under the contract, will be the responsibility of the member and not a covered benefit
- Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called Optional Services; Optional Services also include the use of specialized techniques instead of standard procedures
    - Examples of Optional Services:
        - A composite restoration instead of an amalgam restoration on posterior teeth
        - A crown where a filling would restore the tooth
        - An inlay or porcelain/ceramic onlay instead of an amalgam restoration
        - Porcelain, resin or similar materials for crowns placed on a maxillary second or third molar, or on any mandibular molar (an allowance will be made for a porcelain fused to high noble metal crown)
- If a member receives Optional Services, an alternate benefit will be allowed, which means Delta Dental will base benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the Optional Service; the member will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure

7.4 Dental Health Maintenance Organization (DHMO)

With a Dental Health Maintenance Organization (DHMO), you may or may not have out-of-pocket expenses for dental care, depending on your dental needs. In order to receive benefits from a DHMO, you must use a dentist or a dental facility affiliated with the DHMO. DHMOs typically do not have out-of-area service provisions, therefore, if you have a dependent that lives outside the DHMO service area (e.g., a college student), the dependent might not be eligible for care outside of the service area.

DHMO information, including a schedule of benefits and listing of available dentists, is available by calling the DHMO Member Services phone number for your location; from Circuit search for Benefit Directory.

Copies of the DHMO's Evidence of Coverage (EOC) member handbook and Schedule of Benefits listing of copayments are available by contacting the DHMO directly. For contact information, search for Benefits Directory on Circuit.

DHMO Options

The table below lists the DHMOs available by site. The DHMO options available to you are based on whether you live or work within the DHMOs service area, and they will appear on the My Health Benefits website.

Intel's eligibility and enrollment procedures apply to DHMO members, and they supersede eligibility and enrollment information provided in the DHMO's EOC.

Disclaimer: Information provided by DHMOs is subject to change without notice and does not represent a commitment by Intel. Detailed benefit and supplier information is available by calling the DHMO directly.

Table: DHMO Options

State/Site	Dental Health Maintenance Organization
Arizona	Sun Life Dental Plan
California	DeltaCare USA
New Mexico	Sun Life Dental Plan
Oregon	Kaiser Permanente

Chapter 8
Flexible Spending Accounts

Chapter 8
Flexible Spending Accounts

This chapter provides important details regarding Health Flexible Spending accounts and the Dependent Care Assistance Program (DCAP).

8.1 Flexible Spending Accounts

Topics

8.1.1 Flexible Spending Account Overview

Flexible Spending Accounts (FSAs) provide you the opportunity to pay for eligible out-of-pocket expenses with pretax dollars. Annual elections are deducted from your salary each pay period before federal, state, and FICA taxes are withheld, which may reduce the amount of income tax you pay. State taxation varies by state.

The FSA options available for eligible Intel employee annual election are:

- The Health Flexible Spending Account (Health FSA) allows you to elect an annual amount through pretax payroll deductions to pay for eligible non-reimbursed medical, dental and vision expenses.
- The Limited Use Health Flexible Spending Account (Limited Use Health FSA) is available to those enrolled in an HSA, and allows you to use pretax payroll dollars to pay for eligible out-of-pocket dental and vision expenses.
- The Dependent Care Assistance Program (DCAP) allows you to elect an annual amount through pretax payroll deductions to pay for eligible dependent care expenses that enable you and your spouse, if married, to work, look for work or attend school full time.

If eligible, you may elect to participate in these FSA options independent of any other benefit elections you make during your enrollment period. All are governed by IRS forfeiture rules, which you should know about before deciding to enroll.

Intel's FSA program is administered by *Your Spending Account (YSA)* delivered by Aon Hewitt. You can access your Health FSA, Limited Use Health FSA or DCAP account by selecting the Spending Account tab on the *My Health Benefits* website.

8.1.2 "Use It or Lose It" Rule

Important information regarding forfeiture of unused flexible spending account and DCAP funds

Careful planning is required before enrolling in the Health FSA, Limited Use Health FSA, and DCAP. You have a run-out period until May 31 of the following year to submit claims for eligible expenses incurred from your coverage effective date through your coverage end date. With limited exception, funds remaining in these spending accounts at the end of the year are forfeited.

Due to the risk that your funds might be forfeited, it is very important you accurately estimate your eligible non-reimbursed health care expenses and eligible dependent care expenses for the year prior to enrolling in the Health FSA, Limited Use Health FSA, or DCAP. To assist you in determining what you should elect for the Health FSA, Limited Use Health FSA, or DCAP, visit the *My Health Benefits* website and use the FSA modeling tools, which assist with projecting your health care and dependent care expenses. It is a good idea to use these tools and look carefully at your individual and family expenses for the year before signing up for these programs**.**

8.1.3 Impacts during a Leave of Absence

Intel Paid Leaves and Short-Term Disability: Contributions to your Health FSA or Limited Use Health FSA and DCAP are taken from Intel Paid Leave and Short-Term Disability program payments and military adjustment pay.

Unpaid Leaves: Contributions to your Health FSA or Limited Use Health FSA and DCAP cease when your Intel regular pay is suspended. Upon verification that you have returned to work at Intel, these contributions may automatically resume (depending upon the date you return).
If you return to work before the end of the calendar year, your deductions will resume and recalculate to ensure you meet your annual election.
If you return to work after Jan. 1, you must re-enroll in the plan within 30 days to continue participation.
If your Health FSA or Limited Use Health FSA reimbursements exceeded your contributions, Intel may collect the balance of these funds through payroll deduction.

Note: Dependent care expenses incurred during a leave of absence longer than 2 weeks are not eligible for reimbursement from DCAP. Eligible dependent care expenses under Internal Revenue Code Section 21 are employment-related expenses for the care of your eligible dependent(s) that allow both you and your spouse to work or look for work.

8.1.4 Nondiscrimination Restrictions

The IRS imposes certain nondiscriminatory standards on all plans to which pretax contributions may be made. A test is conducted annually, which compares the benefits of employees who are highly compensated with all other employees. If this test is not satisfied, the amount being contributed by highly compensated employees may be limited or completely stopped. You will be notified if this restriction applies to you.

8.1.5 Note for High Deductible Health Plan Participants

You are not eligible to participate in the Health FSA program if you are enrolled in the Anthem Blue Cross HDHP or Connected Care HDHP. You may be eligible to contribute to a Health Savings Account (HSA) and may have funds deposited in a Limited Use Health FSA. Please see the section below on the Limited Use Health FSA. If eligible, you may elect to contribute pretax payroll deductions to an HSA to pay for eligible non-reimbursed health care expenses. The HSA eligibility rules and important details including contribution limitations and eligible expenses are discussed in the *Pay, Stock and Benefits Handbook,* chapter 6, "Medical Plans" in the "High Deductible Health Plan" section.

The HSA is not an Intel-sponsored benefit and is not an ERISA welfare benefit plan but is available through Fidelity for eligible participants in the Anthem Blue Cross HDHP and Connected Care HDHPs.

8.2 Health Flexible Spending Account

Topics

8.2.1 Overview

A Health Flexible Spending Account (Health FSA) allows you to pay for eligible non-reimbursed health care expenses for you or your IRS-qualified dependents with pretax dollars, which may result both in lower taxes and more spendable income. The Health FSA* is an optional benefit. You do not need to be enrolled in an Intel medical or dental plan to participate.

Any funds remaining in your 2019 Health FSA after the May 31 run-out period, up to $500, is carried over for use in 2020. Any carryover amount is added to the amount you elect for contribution to your Health FSA for 2020. The run-out period provides you extra time to submit

your claims. If you do not submit your claims with complete supporting documentation by the May 31 run-out period, your claim will be denied.

Because of the tax advantage of this plan, the IRS applies strict rules and limitations. Be sure you read and understand this section before participating in the Health FSA.

> **If you are enrolled in a High Deductible Health Plan with optional Employee-Funded Health Savings Account (HSA), you cannot enroll in the Health FSA. You can enroll in the Limited Use Health FSA. See the section below on the Limited Use Health FSA.*

If you are employed by different Intel subsidiaries within the same plan year, your combined contribution to your Health FSAs may not exceed the IRS annual contribution limit of $2,700. *For example, if you transfer from a subsidiary to Intel Corporation on July 1 and contributed $1,300 during your employment with the subsidiary, you can only contribute up to $1,400 under the Intel Health FSA.*

8.2.2 Eligibility

You may elect to participate in the Health FSA if you are a general full-time employee (GFT) or part-time employee (PTE) on the U.S. payroll. If you are enrolled in a HDHP, you are not eligible to participate in the Health FSA; however, you may be eligible to participate in a Health Savings Account (HSA) and the Limited Use Health FSA.

8.2.3 How the Health Flexible Spending Account (Health FSA) Works

8.2.3.1 Annual Election

You can allocate an annual election amount from $150 to a maximum of $2,700 per calendar year, based on your estimate of eligible non-reimbursed health care expenses for the upcoming year (including eligible expenses for qualified IRS dependents). Your annual election is divided by the total number of remaining pay periods in the year to determine your per-paycheck deduction and is taken on a pretax basis.

8.2.3.2 FSA Modeling Tools

The FSA modeling tools on the *My Health Benefits* website help you estimate your FSA contributions and potential annual tax savings.

8.2.3.3 Enrolling in or Changing Your Annual Election

If you are a newly hired or rehired employee, you can participate in the Health FSA for the balance of the year in which you are hired. To enroll in the Health FSA, visit the *My Health Benefits* website at www.intel.com/go/myben or call the Intel Health Benefits Center at (877) GoMyBen (466-9236). If you are hired in November or December, and want to enroll in an FSA for the remainder of the year, you will need to contact the Intel Health Benefits Center at (877) GoMyBen (466-9236) to complete your enrollment. Generally, once you enroll in the Health FSA (either during your initial enrollment period or the Annual Enrollment period), no changes to your annual election amount are permitted; however, federal law allows you to make election changes at other times during the plan year in certain limited situations. If you experience a

change in your work or family circumstances (e.g. birth, adoption), commonly referred to as a change-in-status event, you may be able to make certain changes to your Health FSA that are consistent with and a result of the change-in-status event.

You must re-enroll in Health FSA each year during Annual Enrollment. If you do not re-enroll, your participation will cease. Thus, each year when you re-enroll, you may change your designated annual election amount.

If you change your annual election amount due to a change-in-status event, your new annual election amount applies for expenses incurred from the date of your change-in-status event.

You have 30 days from your hire date or your change-in-status event date to make changes to your Health FSA. It is important that you determine your annual election amount based upon your coverage effective date, since expenses incurred before your coverage effective date will not be eligible for reimbursement. For more information on Annual Enrollment or change-in-status events, see Chapter 5: "Health Benefits Enrollment" in the handbook.

8.2.3.4 When Coverage Begins

Your coverage effective date is as follows:

- If you are enrolling in Health FSA as a newly hired or rehired employee, your coverage effective date is your hire or rehire date.
- If you are enrolling in Health FSA during the Annual Enrollment period, your coverage election is effective on the first day of the next calendar year.
- If you are enrolling in Health FSA due to a change-in-status event, your coverage election is effective the date of your change-in-status event.
- January 1 of the plan year for a rollover from the previous year's Health FSA.

8.2.3.5 When Coverage Ends

You may submit claims for eligible expenses incurred from your coverage effective date through your coverage end date until May 31 run-out period of the following year. Your coverage end date is the earliest of the following:

- December 31.
- The date you are no longer eligible to participate in Health FSA due to a change-in-status event.
- The last day of the month in which you terminate employment. You will have the opportunity to elect to continue your Health FSA coverage via COBRA for the remainder of the year. For every month you pay your Health FSA COBRA premium you extend your coverage end date to the end of that month. Carryover funds may also be eligible for continuation via COBRA. For more information on COBRA continuation coverage, please review Chapter 11.

8.2.3.6 Getting Reimbursed

When enrolling in Health FSA, you will receive a welcome letter from *Your Spending Account (YSA)* delivered by Aon Hewitt, Intel's FSA claims administrator, which includes instructions on how to submit eligible expenses for reimbursement. When you incur an eligible health care

expense (from your coverage effective date through your coverage end date) for you or your IRS-qualified dependent(s)*, you must submit your expense and attach a copy of your Explanation of Benefits or an eligible form of receipt. If you join Health FSA during the year as a new hire or after a change-in-status event, eligible health care expenses must be incurred from your coverage effective date through your coverage end date. You may file a claim for reimbursement after you have incurred eligible health care expenses.

* Health care expenses for a domestic partner (or a domestic partner's child(ren)) who is not your tax dependent are not eligible for reimbursement under the Health Flexible Spending Account (Health FSA or Limited Use Health FSA).

You have two options for getting reimbursed with your Health FSA. All employees who enroll in a Health FSA will receive a YSA Debit Card. The YSA Debit Card allows you to pay for eligible items directly out of your Health FSA account at the point of service at certified merchants. For example, when purchasing a prescription at a certified merchant pharmacy, you can use your YSA Debit Card to pay for your eligible out-of-pocket expenses. It is critical that you keep **all** of your receipts even if you use your YSA Debit Card, as you may be asked to submit your receipts to verify your purchase as an eligible expense. To see a detailed list of certified merchants and learn other important information about using the YSA Debit Card, please review the resource links provided on the *My Health Benefits* website. Choose the Spending Account tab, Manage Your Account, Knowledge Center. In addition, you can submit your claim using the *My Health Benefits* website and selecting the Spending Accounts tab. This allows you to enter in your provider, date of service, type of expense and amount online, then it will generate a fax cover sheet which you must sign and fax with your receipts before your claim can be processed.

Completed claim forms can be submitted via mail to Your Spending Account (YSA) at P.O. Box 661147, Dallas, Texas, 75266-1147 or via fax (888) 211-9900. Claim forms are available on the Spending Accounts tab from the *My Health Benefits* website. From Circuit search for My Health Benefits or visit www.intel.com/go/myben.

Fax: 1-888-211-9900
P.O. Box 661147
Dallas , Texas 75266-1147

Claims are typically processed by *Your Spending Account (YSA)* within five business days after receipt. You will receive reimbursement up to the amount of your eligible expense, not to exceed your annual election. Your reimbursement check will be mailed to your home address or you may elect to have your reimbursements direct deposited into an account of your choice.

You may submit claims for reimbursement until the May 31 run-out period of the following year for all eligible health care expenses incurred on or after your coverage effective date through your coverage end date – (typically January 1 – December 31). The run-out period provides you extra time to submit your claims. If you do not submit your claims with complete supporting documentation by the May 31 run-out period, your claim will be denied.

If you stop participating in the Health FSA mid-year (e.g., have a change in status event that allows you to drop coverage in the Health FSA) and have funds remaining in your Health FSA account, you may submit claims for eligible health care expenses incurred during your coverage effective date through your coverage end date (the date you stopped participating). Any funds

above $500 that remain in your Health FSA account after the May 31 run-out period of the following year is forfeited, as required by IRS regulations. Any funds remaining in your Health FSA after the May 31run-out period, up to $500, will carryover for use in the following plan year. Please see the section below, Forfeiture of Unused Funds, for more information.

The Health FSA is a type of health plan. Therefore, the procedures for claims described in chapter 6, "Medical Plans" also apply to your claims for Health FSA benefits. (See "Types of Claims" and "Claim Determination Process.") For purposes of those procedures, your Health FSA claims will be post-service claims.

8.2.4 Health FSA Eligible and Ineligible Expenses

Eligible and Ineligible Expenses for the Health Flexible Spending Account	
Eligible Health Care Expenses Include, but not limited to the following:	**Ineligible Health Care Expenses** Include, but not limited to the following:
• Acupuncture • Applied behavioral analysis for autistic children • Birth control-related expenses • Chiropractic services • Copayments and coinsurance • Contact lenses and solutions • Deductibles (medical and dental) • Dental expenses over coverage limits • Eye exams, eyeglasses, contact lenses and supplies • Hearing aids • Infertility treatments • Medical equipment or supplies • Obesity-related medical deductions • Orthodontia (braces) • Insulin • Physical therapy • Prescription drugs • Radial keratotomy or laser/LASIK eye surgery • Speech therapy • X-rays (**Note:** Some expenses may require a doctor's certification)	• Cosmetic expenses (including cosmetics and cosmetic surgery that isn't medically necessary) • Custodial care • Expenses claimed on income tax returns • Expenses reimbursed by other sources, such as your medical, dental, or vision insurance provider or any other health plan under which you have coverage • Fees for non-medical reasons for an exercise/athletic /health club membership • Hair transplants • Over the counter medicine or drugs (unless you have a prescription) • Insurance premiums • Nicotine patches and gum • Postage/handling fees • Weight reduction programs for general well-being

For a more detailed list, visit the Eligible Expense list in the Knowledge Center on the *My Health Benefits* website. Choose the Spending Account tab, Manage Your Account, Knowledge Center, Health Flexible Spending Account under Eligible Expenses.

Note: If you are enrolled in a High Deductible Health Plan with Optional Employee-funded Health Savings Account, you cannot enroll in the Health FSA.

8.2.5 Accessing Account Information

You may obtain your account balance at any time by visiting the Spending Accounts tab on the *My Health Benefits* website. For any questions regarding your balance, how to submit your claim, or to receive reimbursement, contact the Intel Health Benefits Center at (877) GoMyBen (466-9236) and select the FSA option. Representatives are available to answer your questions between 5 a.m. and 5 p.m. (Pacific), Monday through Friday.

8.2.6 Forfeiture of Unused Funds

Any funds remaining in your Health FSA after the May 31 run-out period, up to $500, will carryover for use in the following plan year. Any carryover amount is added to the amount you elect to contribute to your Health FSA for the following plan year. If you are enrolled in an HSA, your carryover amount up to $500 will automatically be deposited into a Limited Use Health FSA that can be used **only for dental or vision expenses**.

Any funds above the $500 carryover in your Health FSA account after the May 31 run-out period are forfeited in accordance with the "Use It or Lose It Rule" as required by IRS regulations.

With the exception of the carryover of funds to the next plan year up to $500, you may not carry any remaining funds over to reimburse the next year's eligible health care expenses. You may not use your Health FSA funds for any purpose other than eligible health care expenses.

This rule makes it very important that you take the time to estimate your eligible health care expenses as accurately as possible before you elect the amount of your contribution.

8.2.7 Overpayments

Most overpayments occur when the YSA Card is used to pay for an expense that cannot be substantiated as an eligible expense. Either the required documentation is not submitted or the expense is not medically necessary.

It is your responsibility to ensure you only use the YSA Debit Card to pay for eligible expenses and to submit receipts to verify your YSA Debit Card purchases when requested. Failure to submit receipts may result in suspension of your YSA Debit Card and may impact your taxable income.

8.2.8 Qualified Reservist Distribution

If you are a member of the U.S. Reserve Component and are called to perform military service for 180 days or more, or indefinitely, you may receive a taxable distribution of the remaining balance of your Health FSA account through a Qualified Reservist Distribution (a “distribution”). The requirements for the Distribution are:

- The request for the distribution must be made during the period beginning with the order or call to active duty and ending on the last day of the Health FSA plan year (December 31).
- Calls or orders that increase the total period of active duty to 180 days or more will qualify you for a distribution. You must provide a copy of the order(s) or call(s) to active duty.
- The distribution amount is the amount you have contributed to the Health FSA as of the distribution request less any reimbursements you have received as of the date of the distribution request.
- The distribution is included in your gross income and wages and is subject to employment taxes.
- Once your distribution is approved, you will no longer have pre-tax deductions taken from your Intel pay, and you will not be able to submit claims for eligible health care expenses.
- Your Health FSA debit card is inactivated at the time the distribution is made.
- You will have 30 days to re-enroll in the Health FSA when you return to work from your Military LOA.

For more information on the distribution, contact the Intel Health Benefits Center at (877) GoMyBen (466-9236).

8.3 Limited Use Health Flexible Spending Account

Topics

8.3.1 Overview

The Limited Use Health FSA allows you to pay for eligible non-reimbursed **dental and vision** expenses for you or your IRS-qualified dependents. The Limited Use Health FSA is an optional benefit. You must, however, be enrolled in an HSA to be enrolled in the Limited Use Health FSA.

Because of the tax advantage of this plan, the IRS applies strict rules and limitations. Be sure you read and understand this section before participating in the Health FSA.

If you are employed by different Intel subsidiaries within the same plan year, your combined contribution to your Limited Use Health FSA's may not exceed the IRS annual contribution limit of $2,700. *For example, if you transfer from a subsidy to Intel Corporation on July 1 and contributed $1,300 during your subsidiary employment, you can only contribute up to $1,400 under the Intel Limited Use Health FSA.*

8.3.2 Eligibility

There are two types of the Limited Use Health FSAs:

1. You may elect to participate in the Limited Use Health FSA if you are a general full-time employee (GFT) or part-time employee (PTE) on the U.S. payroll, and are enrolled in an HSA.

2. If you had a balance in your Health FSA at the end of last year, and are enrolled in an HSA for the current year, up to $500 of your Health FSA balance remaining after the run-out period (May 31) is carried over to a Limited Use Health FSA. Only individuals enrolled in an HSA may participate in this Limited Use Health FSA, and may not participate in the Health FSA in order to remain eligible to contribute to an HSA. Any remaining balance (up to $500) in your Limited Use Health FSA after the run-out period will carry over to a Limited Use Health FSA for the following plan year.

8.3.3 How the Limited Use Health Flexible Spending Account (Health FSA) Works

8.3.3.1 Annual Election

You can allocate an annual election amount from $150 to a maximum of $2,700 per calendar year, based on your estimate of eligible non-reimbursed **dental and vision** health care expenses for the upcoming year (including eligible expenses for qualified IRS dependents). Your annual election is divided by the total number of remaining pay periods in the year to determine your per-paycheck deduction, and is taken on a pretax basis.

8.3.3.2 FSA Modeling Tools

The FSA modeling tools on the *My Health Benefits* website help you estimate your Limited Use Health FSA contributions and potential annual tax savings.

8.3.3.3 Enrolling in or Changing Your Annual Election

If you are a newly hired or rehired employee, and enroll in an HSA in connection with enrollment in a High Deductible Health Plan ("HDHP"), you can participate in the Limited Use Health FSA for the balance of the year in which you are hired. To enroll in the Limited Use Health FSA election, visit the *My Health Benefits* website at www.intel.com/go/myben or call the Intel Health Benefits Center at (877) GoMyBen (466-9236). If you are hired in November or December, and want to enroll in a Limited Use Health FSA for the remainder of the year, you will

need to contact the Intel Health Benefits Center at (877) GoMyBen (466-9236) to complete your enrollment. Generally, once you enroll in the Limited Use Health FSA (either during your initial enrollment period or the Annual Enrollment period), no changes to your annual election amount are permitted; however, federal law allows you to make election changes at other times during the plan year in certain limited situations. If you experience a change in your work or family circumstances (e.g. birth, adoption), commonly referred to as a change-in-status event, you may be able to make certain changes to your Limited Use Health FSA that are consistent with and a result of the change-in-status event.

If you change your annual election amount due to a change-in-status event, your new annual election amount applies for expenses incurred from the date of your change-in-status event.

Except for the establishment or continuation of a Limited Use Health FSA as a result of a carryover only, you must re-enroll in the Limited Use Health FSA each year during Annual Enrollment. If you do not re-enroll, and do not have any carryover amount, your participation will cease. Each year when you re-enroll, you may change your designated annual election amount.

You have 30 days from your hire date or your change-in-status event date to make changes to your Limited Use Health FSA. It is important that you determine your annual election amount based upon your coverage effective date, since expenses incurred before your coverage effective date will not be eligible for reimbursement. For more information on Annual Enrollment or change-in-status events, see chapter 5 “Health Benefits Enrollment.”

8.3.3.4 When Coverage Begins

Your coverage effective date is as follows:

- If you are enrolling in Limited Use Health FSA as a newly hired or rehired employee, your coverage effective date is your hire or rehire date.
- If you are enrolling in Limited Use Health FSA during the Annual Enrollment period, your **coverage effective date is the first day of the next calendar year.**
- If you are enrolling in Limited Use Health FSA due to a change-in-status event, your coverage election is effective the date of your change-in-status event.
- January 1 of the plan year for HDHP participants who have a carryover from the previous year’s Health FSA.

8.3.3.5 When Coverage Ends

You may submit claims for eligible expenses incurred from your coverage effective date through your coverage end date until May 31 run-out period of the following calendar year. Your coverage end date is the earliest of the following:

- December 31
- The date you are no longer eligible to participate in the Limited Use Health FSA due to a change in status event
- The last day of the month in which you terminate employment. You will have the opportunity to elect to continue your Limited Use Health FSA via COBRA for the remainder of the year. For every month you pay your Limited Use Health FSA COBRA premium you extend your coverage end date to the end of that month. Carryover funds

may also be eligible for continuation via COBRA. For more information on COBRA continuation coverage, please review Chapter 11.

8.3.3 Getting Reimbursed

You will receive a welcome letter from *Your Spending Account (YSA)* delivered by Aon Hewitt, Intel's FSA claims administrator, which includes instructions on how to submit eligible expenses for reimbursement. When you incur an eligible dental or vision expense (from your coverage effective date through your coverage end date) for you or your IRS-qualified dependent(s)*, you must submit your expense and attach a copy of your Explanation of Benefits or an eligible form of receipt. You may file a claim for reimbursement after you have incurred eligible health care expenses.

* Health care expenses for a domestic partner (or a domestic partner's child(ren)) who is not your tax dependent are not eligible for reimbursement under the Health Flexible Spending Account (Health FSA or Limited Use Health FSA).

> **Note**: In the event that you have both an Extra Bucks Account and a Limited Use Health FSA (for dental or vision expenses only), you may seek reimbursement from the Extra Bucks only after there are no remaining amounts available in your Limited Use Health FSA.

You can submit your claim using the *My Health Benefits* website and selecting the Spending Accounts tab. This allows you to enter in your provider, date of service, type of expense and amount online. A fax cover sheet will be generated that you must sign and fax with your receipts before your claim can be processed. Completed claim forms can be submitted via mail to Your Spending Account (YSA) at P.O. Box 661147, Dallas, Texas, 75266-1147 or via fax (888) 211-9900. Claim forms are available on the Spending Accounts tab from the *My Health Benefits* website. From Circuit search for My Health Benefits or visit www.intel.com/go/myben.

Fax: 1-888-211-9900
P.O. Box 661147
Dallas, Texas 75266-1147

Claims are typically processed by *Your Spending Account (YSA)* within five business days after receipt. You will receive reimbursement up to the amount of your dental or vision eligible expense, not to exceed the balance in your account. Your reimbursement check will be mailed to your home address or you may elect to have your reimbursements direct deposited into an account of your choice.

You may submit claims for reimbursement until the May 31 run-our period of the following year for all eligible expenses incurred on or after your coverage effective date through your coverage end date (typically January 1 – December 31). The run-out period provides you extra time to submit your claims. If you do not submit your claims with complete supporting documentation by the May 31 run-out period, your claim will be denied.

Up to $500 remaining in your Limited Use Health FSA at the end of the plan year will carry over to a Limited Use Health FSA the following year. Any remaining funds above the $500 are forfeited.

If you stop participating in the Limited Use Health FSA mid-year (e.g., have a change in status event that allows you to drop coverage in the Limited Use Health FSA) and have funds remaining in your Limited Use Health FSA account, you may submit claims for eligible vison and dental expenses incurred during your coverage effective date through your coverage end date (the date you stopped participating). Any funds above $500 that remain in your Limited Use Health FSA account after the May 31 claims run-out period of the following year is forfeited, as required by IRS regulations. Any funds remaining in your Health FSA after the May 31 run-out period, up to $500, will carryover for use in the following plan year. Please see the section below, Forfeiture of Unused Funds, for more information.

For example, if you participate in the Limited Use Health FSA beginning January 1, but terminate employment on June 30, you may only be reimbursed for claims incurred from January 1 through June 30. You may submit for reimbursement claims incurred during your participation (January 1 - June 30) at any time during the current plan year through May 31 of the following year.

The Limited Use Health FSA is a type of health plan. Therefore, the procedures for claims described in Chapter 6: "Medical Plans" also apply to your claims Limited Use for Health FSA benefits. (See "Types of Claims" and "Claim Determination Process."). For purposes of those procedures, your Limited Use Health FSA claims are post-service claims.

8.3.3.1 Limited Use Health FSA Eligible and Ineligible Expenses

Eligible and Ineligible Expenses for the Health Flexible Spending Account	
Eligible Dental & Vision Expenses Include, but not limited to the following:	**Ineligible Dental & Vision Expenses** Include, but not limited to the following:
• Contact lenses and solutions • Deductibles (vision and dental) • Dental expenses over coverage limits • Eye exams, eyeglasses, contact lenses and supplies • Radial keratotomy or laser/LASIK eye surgery (**Note:** Some expenses may require a doctor's certification)	• Cosmetic expenses (including cosmetics and cosmetic surgery that isn't medically necessary) • Expenses claimed on income tax returns • Expenses reimbursed by other sources, such as your dental or vision plan or any other health plan under which you have coverage

For a more detailed list, visit the Eligible Expense list in the Knowledge Center on the *My Health Benefits* website. Choose the Spending Account tab, Manage Your Account, Knowledge Center, Eligible Expenses.

8.3.4 Accessing Account Information

You may obtain your account balance at any time by visiting the Spending Accounts tab on the *My Health Benefits* website. For any questions regarding your balance, how to submit your claim, or to receive reimbursement, contact the Intel Health Benefits Center at (877) GoMyBen

(466-9236) and select the FSA option. Representatives are available to answer your questions between 5 a.m. and 5 p.m. (Pacific), Monday through Friday.

8.3.5 Forfeiture of Unused Funds

Any funds remaining in your Limited Use Health FSA after the May 31

run-out period, up to $500, will carryover for use in the following plan year. Any carryover amount is added to the amount you elect to contribute to your Limited Use Health FSA for the following plan year. Any funds above the $500 carryover in your Limited Use Health FSA account after the May 31 run-out period are forfeited in accordance with the "Use It or Lose It Rule" as required by IRS regulations.

With the exception of the carryover of funds to the next plan year up to $500, you may not carry any remaining funds over to reimburse the next year's eligible health care expenses. You may not use your Limited Use Health FSA funds for any purpose other than eligible dental and vision health care expenses.

This rule makes it very important that you take the time to estimate your eligible dental and vision health care expenses as accurately as possible before you elect the amount of your contribution.

8.3.6 Qualified Reservist Distribution

If you are a member of the U.S. Reserve Component and are called to perform military service for 180 days or more, or indefinitely, you may receive a taxable distribution of the remaining balance of your Limited Use Health FSA account through a Qualified Reservist Distribution (a "distribution"). The requirements for the Distribution are:

- The request for the distribution must be made during the period beginning with the order or call to active duty and ending on the last day of the Limited Use Health FSA plan year (December 31).
- Calls or orders that increase the total period of active duty to 180 days or more will qualify you for a distribution. You must provide a copy of the order(s) or call(s) to active duty.
- The distribution amount is the balance in your Limited Use Health FSA less any reimbursements you have requested or received as of the date of the distribution request.
- The distribution is included in your gross income and wages and is subject to employment taxes.
- Once your distribution is approved you will not be able to submit claims for eligible dental or vision care expenses.

For more information on the distribution, contact the Intel Health Benefits Center at (877) Gombe (466-9236).

8.4 Dependent Care Assistance Program

Topics

8.4.1 Overview

The Dependent Care Assistance Program (DCAP) allows you to pay for eligible dependent care expenses with pretax dollars, which may result both in lower taxes and more spendable income. Eligible Dependent care expenses are defined by the Internal Revenue Code as employment-related expenses for the care of your eligible dependent(s) that allow both you and your spouse to work or look for work.

Because of the tax advantage of this plan, the IRS applies strict rules and limitations. Be sure you read and understand this section before participating in DCAP.

Eligible dependent care expenses are expenses for the custodial care of your eligible dependent(s) that allow both you and your spouse to work or look for work (your spouse is treated as working during any month that he or she attends school full time or is incapable of self-care).

If you are employed by different Intel subsidiaries within the same plan year, your combined contribution to your DCAP account may not exceed the IRS annual household contribution limit of $5,000. *For example, if you transfer from an Intel subsidiary to Intel Corporation on July 1 and contributed $2,500 during your subsidiary employment, you can contribute up to $2,500 under the Intel DCAP program.*

8.4.2 Eligibility

You may elect to participate in this program independent of any other benefit election if you are a general full-time employee (GFT), part-time employee (PTE), Intel contract employee (ICE), or Intern on the Intel U.S. payroll.

8.4.3 How the Dependent Care Assistance Program (DCAP) Works

8.4.3.1 Annual Election

You can allocate an annual election amount from $150 to a family maximum of $5,000 per calendar year

This family maximum is a legal limit that applies whether you are a single head-of-household or, if you are married, it applies to you and your spouse together. However, if you are married and filing separately, you and your spouse may each contribute up to $2,500 to a DCAP maintained by an employer. In addition, your total contribution cannot be more than your earned income or your spouse's earned income, whichever is less. If your spouse is not employed because he or she is a full-time student at an educational institution or is mentally or physically incapable of self-care, your spouse is considered to have an earned income of not less than, $250 per month if there is one eligible dependent and $500 per month if there are two or more eligible dependents.

If you join Intel mid-calendar year and you previously participated in another employer's DCAP, your maximum combined annual contribution under both plans is $5,000 (or $2,500 if you are married and file a separate return). It is your responsibility not to exceed the maximum combined annual contribution.

If your spouse is employed and is also eligible for a DCAP from his or her employer, you can each contribute to your respective plans. However, your combined contributions are subject to the above limitations.

Your annual election is divided by the total number of remaining pay periods in the year to determine your per-paycheck deduction. If you join DCAP during the year as a new hire or after a change-in-status event, your annual contribution will be divided by the remaining pay periods in the year to determine your per-paycheck deduction.

8.4.3.2 FSA Modeling Tools

The FSA modeling tools on the *My Health Benefits* website help you to estimate your FSA contributions and potential annual tax savings.

8.4.3.3 Enrolling or Changing Your Annual Election

If you are a newly hired or rehired employee, you can participate in DCAP for the balance of the year in which you are hired. To enroll in or change your DCAP election, go to the *My Health Benefits* website at www.intel.com/go/myben or call the Intel Health Benefits Center at (877) GoMyBen (466-9236). If you are hired in November or December, and want to enroll in an FSA for the remainder of the year, you will need to contact the Intel Health Benefits at (877) GoMyBen (466-9236) to complete your enrollment.

Generally, once you enroll in DCAP (either during your initial enrollment period or the Annual Enrollment period), no changes to your annual election amount are permitted. However, federal law allows you to make election changes at other times during the plan year in certain limited situations. If you experience a change in your work or family circumstances (e.g. birth, adoption,

divorce, marriage, etc.), commonly referred to as a change-in-status event, you may be able to make certain changes to your DCAP that are consistent with and a result of the change-in-status event.

Note: If you change your annual election amount due to a change-in-status event, your new annual election amount applies for expenses incurred from the date of your change-in-status event.

You have 30 days from your hire date or your change-in-status event date to make allowed changes to your DCAP. It is important that you determine your annual election amount based upon your coverage effective date, since expenses incurred before your coverage effective date will not be eligible for reimbursement. Your coverage effective date will be as follows:

- If you are enrolling in DCAP as a newly hired or rehired employee, your coverage effective date is your hire or rehire date.
- If you are enrolling in DCAP during the Annual Enrollment period, your coverage election is effective on the first day of the next calendar year.
- If you are enrolling in DCAP due to a change-in-status event, your coverage election is effective the date of your change-in-status event.

You must re-enroll in DCAP each year during Annual Enrollment. If you do not re-enroll, your participation will cease. Thus, each year when you re-enroll you may change your designated annual election amount.

For more information on Annual Enrollment or change-in-status events see Chapter 5 of the Pay, Stock and Benefits Handbook: Health Benefits Enrollment.

8.4.3.4 When Coverage Ends

Contributions to DCAP cease with your last paycheck. You may submit claims for eligible expenses incurred from your coverage effective date through your coverage end date until May 31 run-out period of the following calendar year. Your coverage end date is December 31 of the current year.

8.4.3.5 Getting Reimbursed

When enrolling in DCAP, you will receive a welcome letter from *Your Spending Account (YSA)* delivered by Aon Hewitt, Intel's FSA claims administrator, which includes instructions on how to submit eligible expenses for reimbursement.

You may file a claim for reimbursement after you have incurred eligible dependent care expenses. You can submit your claim using the *My Health Benefits* website and selecting the Spending Accounts tab. This allows you to enter in your provider, date of service, and amount online, then it will generate a fax cover sheet, which you must sign and fax with your receipts before your claim can be processed. Completed claim forms can be submitted via mail to Your Spending Account (YSA) at P.O. Box 661147, Dallas, Texas, 75266-1147 or via fax (888) 211-9900. Claim forms are available on the Spending Accounts tab from the *My Health Benefits* website.

If you join DCAP during the year as a new hire or after a change-in-status event, eligible dependent care expenses must be incurred from your coverage effective date through your coverage end date. You may file a claim for reimbursement after you have incurred eligible dependent care expenses.

Claims are typically processed by *Your Spending Account (YSA)* within five business days after receipt. You will receive reimbursement up to the amount of your eligible expense, not to exceed your account balance. Your reimbursement check will be mailed to your home address or you may choose to have your reimbursements direct deposited into an account of your choice. If the amount of the requested reimbursement exceeds the balance in your account, you will receive reimbursement up to your DCAP account balance. As soon as additional money is available in your account, the remainder of the claim will be reimbursed.

You may submit claims for reimbursement until May 31 of the following plan year for all eligible dependent care expenses incurred on or after your coverage effective date through December 31. If you stop participating in DCAP (e.g., terminate employment with Intel) and have funds remaining in your DCAP account, you may submit claims for eligible dependent care expenses incurred during the plan year through the end of the plan year until May 31 run-out period of the following year. However, no claims will be accepted that are incurred before your coverage effective date.

The run-out period provides you extra time to submit your claims. If you do not submit your claims with complete supporting documentation by the May 31 run-out period, your claim will be denied.

Any money that remains in your DCAP account after May 31 run-out period is forfeited, as required by IRS regulations.

8.4.4 Eligible Dependents

An eligible dependent is one of the following:

- Your dependent who is under age 13 when the care is provided and for whom you can claim an exemption on your federal income tax return
- Your spouse or dependent who is physically or mentally incapable of self-care and has the same principal place of abode as you for more than one-half of the taxable year

If you are divorced or legally separated, the following special rules also apply:

- If you are the custodial parent, your child can qualify as an eligible dependent, even if you have a signed agreement that allows the non-custodial parent to submit the federal income tax exemption for the child.
- If you are the non-custodial parent, your child will not be an eligible dependent even if you can claim the exemption for the child.

  Note: If both parents are claiming the same child for tax purposes (e.g., the year a divorce is final), please consult your tax advisor.

8.4.5 DCAP Eligible and Ineligible Expenses

The IRS defines eligible dependent care expenses under Internal Revenue Code Section 21 as employment-related expenses for the care of your eligible dependent(s) that allow both you and your spouse to work or look for work (your spouse is treated as working during any month that he or she attends school full time or is incapable of self-care). Expenses are for the care of an eligible dependent only if their main purpose is the person's well-being and protection (also referred to as custodial care).

Dependent Care Assistance Program	
Eligible Expenses	**Ineligible Expenses**
• Daycare services in your home • Services that are received outside your home for an eligible dependent under age 13 or for another eligible dependent who resides in your home at least eight hours each day, including day care expenses, before and after-school care, and summer day camp	• The cost of food, clothing, transportation, and education, including kindergarten and private school • Late fees, overnight camp expenses, and medical expenses • Expenses incurred for services provided by a dependent care provider who is your child (if under age 19 at the end of the year) or an individual claimed as a dependent by you or your spouse • Expenses incurred for services by a dependent care center (a center that cares for more than six individuals other than those who live there) that does not comply with state and local laws

For a more detailed list, visit the Eligible Expense list in the Knowledge Center on the *My Health Benefits* website. Choose the Spending Account tab, Manage Your Account, Knowledge Center, Dependent Care Assistance Program under Eligible Expenses.

The IRS requires that taxpayers who participate in DCAP or who claim the dependent care tax credit must provide the name, address, and tax ID number of the person or organization providing dependent care on IRS Form 2441, to be included with their federal income tax return. The IRS may disallow the benefit unless you can show a reasonable effort to obtain the necessary information. It is your responsibility to provide correct information to the IRS.

8.4.6 DCAP or the Federal Dependent Care Tax Credit

When you are determining your DCAP contribution, you should also take into consideration the Federal Dependent Care Tax credit that you may be allowed to claim on your federal tax return. Dependent care expenses reimbursed through DCAP may not be used to calculate the dependent care tax credit. In addition, pretax DCAP contributions reduce dollar-for-dollar the dependent care tax credit you may be eligible to claim.

Whether DCAP or the federal dependent care tax credit would be more advantageous to you depends on your individual circumstances. There is no formula to determine when you should

use DCAP and when you should use the dependent care tax credit. To obtain additional information regarding the dependent care tax credit, you can review IRS Publication 503, Child and Dependent Care Expenses at www.irs.gov.

Take the time to compare the benefits of using DCAP or the dependent care tax credit in your particular situation, or consult your tax advisor before you decide to enroll in DCAP.

8.4.7 Accessing Your Account

You may obtain your balance at any time by visiting the Spending Accounts tab on the *My Health Benefits* website. For any questions regarding your balance, how to submit your claim or receive reimbursement, please contact the Intel Health Benefits Center at (877) GoMyBen (466-9236) and select the FSA option. Representatives are available to answer your questions between 5 a.m. and 5 p.m. (Pacific), Monday through Friday.

8.4.8 Forfeiture of Unused Funds

You have until the May 31 run-out period of the following year to submit claims for reimbursement for eligible expenses incurred in the current year. Any money that remains in your DCAP account after the May 31 run-out period of the following calendar year is forfeited in accordance with the "Use It or Lose It Rule," as required by the IRS regulations. The run-out period provides you extra time to submit your claims. If you do not submit your claims with complete supporting documentation by the May 31 run-out period, your claim will be denied.

You may not carry any remaining funds over to reimburse the next year's eligible dependent care expenses, nor may you use your DCAP funds for any purpose other than eligible dependent care expenses. This rule makes it very important that you take the time to estimate your eligible dependent care expenses as accurately as possible before you elect the amount of your contribution.

8.4.9 Nondiscrimination Restrictions

The IRS imposes certain nondiscriminatory standards on all plans to which pretax contributions may be made. A test is conducted annually, which compares the benefits of employees who are highly compensated with all other employees. If this test is not satisfied, the amount being contributed by highly compensated employees may be limited or completely stopped. You will be notified if this restriction applies to you.

Chapter 9
Health and Wellness

Chapter 9
Health and Wellness

This chapter provides an overview of the Health and Wellness programs, and details on the Health for Life Centers.

9.1 Health and Wellness Programs

Our goal is to encourage a healthy lifestyle. As such, we continue to look for ways that make it easier for you to reach your full health potential. Our programs and services are designed to help you achieve and maintain good health so you can live a vibrant life. We can help you get started and reach your personal goals around health and wellness. For information on specific Health and Wellness programs, search under Pay and Benefits.

9.2 Health for Life Centers

The Health for Life Centers are part of Intel's continued commitment to provide primary care services through a physician and care team that positively affect your health and quality of life.

The five Health for Life Centers listed below provide a unique and personalized health care experience. These Health for Life Centers offer services you would typically receive at an off-site doctor's office. Each center is staffed with experienced physicians, nurse practitioners or physician assistants, registered nurses, and physical therapists. Behavioral health, chiropractors, and acupuncture services are available in some locations; contact your local Health for Life Center to determine if these services are offered near you.

Site	Phone Number	Location	Hours
Arizona CH3 Primary Care	(480) 554-2323	1st Floor	Mon-Fri 8 am–5 pm
Arizona OC2 Primary Care	(480) 715-6112	1st Floor	Mon-Fri 8 am–5 pm
New Mexico RR5 Primary Care	(505) 253-7900	1st Floor	Mon-Fri 7 am–4 pm
Oregon JF5 Primary Care	(503) 264-8315	1st Floor Pole K-12 near JF5 café	Mon-Fri 8 am–5 pm
Oregon RA3 Primary Care	(971) 214-8422	1st Floor near SW corner of RA3 café, in Stairwell 2 SE	Mon-Fri 7 am-7 pm

While Occupational Health is provided at the same location as some of the Health for Life Center locations, all other Intel sites for Occupational Health can be found on Circuit. Occupational Health is separate from the Health for Life Center services.

How Primary Care at the Health for Life Center Works for You

Eligibility

Intel blue-badge employees from any location are eligible to use the Health for Life Center services and programs. Eligible dependents of blue-badge employees age three and older, provided they are covered by an Intel U.S. Health Benefits Plan, are also eligible. There is no age limit for eligible dependents at the New Mexico Health for Life Center.

It is important to note that the Health for Life Center is not intended to replace health plan coverage offered to you and your eligible family members. Use of the Health for Life Centers is completely voluntary.

Convenient Care

The Health for Life Centers are managed and operated by third party administrators and staffed with physicians, nurse practitioners, or physician assistants to provide preventive and primary care on-site at designated locations. The services in the Health for Life Centers include most services that are available in community primary care offices, including physical exams, vaccinations, travel medicine, prescriptions, acute care, and lab work.

Additionally, the services offered at the Health for Life Centers include: :

Acupuncture (AZ & OR only)
Acute abdominal pain
Acute back pain
Allergy shots
Behavioral Health (AZ & OR only)
Blood pressure checks
Chest pains
Chiropractic (AZ & OR only)
Chronic disease management
Control of nasal bleeding
Cuts and contusions
EKG
Flu shots
Foreign body removal
Hyperglycemia
Hypoglycemia
Incision or drainage of cyst
Infections
Inhalations
Initial treatment of simple fractures
Migraines
Nail removal
Other acute care issues
Other routine surgical procedures
Pediatric Care
Physical therapy
Punch biopsy
Rashes and Insect bites
Referrals
Seizures
Skin tags and lesion removal
Strains and Sprains
Sutures
Traveler's health checks
Treatment of minor burns

Available preventive services, physicals, and screenings are based on guidelines from the United States Preventive Services Task Force, American Cancer Society, Advisory Committee on

Immunization Practices (ACIP), and American Academy of Pediatrics. The preventive benefit includes screening tests, immunizations, and counseling services designed to detect and treat medical conditions to prevent avoidable premature injury, illness, and death. Selected office-based surgical procedures are also available. Consult your Health for Life Center staff for service fee details.

Costs

The cost of services from the Health for Life Center depends on the services you receive and the U.S. Intel Group Health Plan option in which you are enrolled. If you are enrolled in a Primary Care Plus, Copayment, Aetna International or an HMO option under the Intel Group Health Plan, or waived coverage in the Intel Group Health Plan, preventive care and non-preventive care services are available at no cost.

If you are enrolled in a High Deductible Health Care Plan (HDHP) under the Intel Group Health Plan, preventive care services are available at no cost. You will pay a fee for service for your non-preventive care. The centers must charge employees enrolled in a HDHP for non-preventive care so that employees can remain eligible to contribute to a Health Savings Account (HSA) under the IRS HSA rules. The services charged by the Health for Life Centers are similar to fees you would pay at a community physician's office.

For HDHP members, the Health for Life Center will file the claim on your behalf and bill you for any amount owed. It is your responsibility to pay any amount you owe. The third party administrator that manages the Health for Life Center will pursue collection activity.

Note: Refer to the Pay, Stock, and Benefits Handbook Chapter 6: Medical and Vision Plans for information on HSA eligibility requirements and https://www.irs.gov/pub/irs-pdf/p969.pdf.

9.3 Health Screening

As part of our Health and Wellness program offerings, Intel may offer free health screenings. Availability of service and free health screening dates are announced and vary by site.

Eligibility
This program is intended only for U.S. Blue Badge employees and is not offered to dependents. It is important to note that the free health screening is not intended to replace health plan coverage or visits to your primary care physician. Use of the free health screening is completely voluntary and available to you for convenience and to enhance your quality of care.

Service
Your free health screening includes a measurement of basic lifestyle-related biometric measurements which help you identify if you are at risk for certain health conditions. A blood sample (e.g. finger-stick at campus sites / venipuncture at off-site lab) is typically required.

General Health Screening Availability

Your primary care provider can conduct a general health screening as part of your annual exam or physical – covered at 100% as preventive care. Employees located in Arizona, New Mexico or

Oregon can benefit from these services at your Intel Health for Life Center.

9.4 Flu Vaccinations

Intel offers several opportunities to receive a flu vaccine. To find out more information about Intel's flu vaccination program, visit http://goto/flu.

On-Site Flu Shot Clinic
As part of our Health and Wellness program offerings, Intel conducts on-site flu shot clinics for U.S. Intel Blue Badge employees at several campus sites in the fall. Availability of service and on-site flu clinic dates are announced in late Q3 and vary by site. To find out more information about Intel's on-site flu shot clinic schedule, visit http://goto/flu.

Eligibility
Open to U.S. Intel Blue Badge employees only with services provided at several campus sites. Obtaining your flu vaccination during the onsite flu vaccination clinics is completely voluntary and available to you for convenience.

General Flu Shot Availability
Intel employees and eligible dependents enrolled in the Intel Group Health Plan may obtain free flu shots by appointment through the Health for Life Centers in Arizona, New Mexico, and Oregon. Off-site, you can get your flu vaccination at your primary care provider or your in-network pharmacy.* Contact your health plan option for more information and to locate an in-network pharmacy to avoid paying out-of-network costs.

*Restrictions may apply for children. Contact the health plan option you are enrolled to determine if a flu vaccine may be administered at a pharmacy.

9.5 More Information

To find out more, go to Circuit > Pay and Benefits > Health and Wellness or go to www.intel.com/go/myben.

Chapter 10
Life Events and Impact to Intel Benefits and Programs

Chapter 10
Life Events Impact to Intel Benefits and Programs

This chapter outlines various life events and their impact to your benefits programs.

10.1 Life Events Overview

The following is an overview of various life events that may affect your Intel benefit and programs. This is a summary only. Each of Intel's benefit programs are based on eligibility and offered in accordance with the terms of the plan documents governing each program. In the event of a discrepancy in the information below and the plan document, the plan document will prevail.

For health benefits, once a life event occurs and Intel is notified, you will receive an e-mail notification from *My Health Benefits* directing you to the *My Health Benefits* web site. The *My Health Benefits* website provides details about the impact to your benefits as a result of that event. You may be able to make certain changes to your benefits that are consistent with your life event. For more information, review chapter 5 of the *Pay Stock and Benefits Handbook*, sections "Benefits Enrollment" and "Qualified Status Change Events."

Enrollment in the Intel retirement plans, Stock Option Plan (SOP), Restricted Stock Unit Plan (RSUP) and the Employee Stock Purchase Plan (ESPP) are **not** managed via *My Health Benefits*.

- For information about the Intel retirement plans, see *Pay, Stock and Benefits Handbook* chapter 18: "Retirement Programs."
- For information on Intel's SOP, RSUP, or ESPP see Option Expiration & Event Impact on Stock Benefits and Stock Termination Checklist as applicable. This information can be found by searching for the titles on Circuit.

10.2 Life Event Impacts to Benefits

Topics

The following information provides an overview of various life events and the impact to your benefits programs.

Life Event	Impact to Benefits
If your address changes or you transfer	**Your personal information:** If you change your address or transfer from one site to another, you can update your address by accessing your Personal Profile in Workday; from the Circuit menu, search for Workday and once logged into Workday, look for the Personal Information icon. If you are unable to access Circuit, call an Employee Services representative at (800) 238-0486. **Health benefits:** A change to your zip code **may** affect your health care options. The medical, dental, and vision options available to you are based on your home and worksite zip codes. Once you update your Personal Profile or your transfer information is processed, you will receive an e-mail notification directing you to the *My Health Benefits* Web site; from Circuit, search for "My Health Benefits" or on the Web at www.intel.com/go/myben. The *My Health Benefits* website will detail the impact to your benefits, your options, and your default coverage. Changes in benefits are effective as of the date you notify Intel of your new address or the effective date of your transfer. If you selected health benefits coverage based on your work address and then terminate employment with Intel, your eligible health plan options may change since COBRA coverage is based on your home zip code. Changes in benefits are effective as of the date you notify Intel of your

Life Event	Impact to Benefits
	new zip code. For more information, see *Pay, Stock and Benefits Handbook* chapter 11: "COBRA Continuation Coverage". **Retirement benefits:** After updating your Personal Profile, your updated address will be effective at Fidelity within the next 10 days. **Stock benefits:** After updating your Personal Profile, your address will be updated automatically in your stock account at E*TRADE and will be effective after three days. The updated address will be effective after one month at Computershare.
If you take a leave of absence	For information on how a leave of absence affects your benefits, see the specific benefit chapter.
If you retire	**Retirement benefits:** You are eligible to request a distribution of your vested account balance in any of the Intel retirement plans 30-days after your retirement/separation date from Intel. Distribution information for each of the plans you are eligible to receive a benefit from will be automatically sent to your home mailing address on file with Fidelity. If you have an outstanding loan from either the Intel 401(k) Savings Plan and/or Intel Retirement Contribution Plans, you may continue to make payments after you retire directly to Fidelity via check, money order or electronic fund transfer. For more information on the retirement benefits, see, "Retiring from Intel" section or for more information on distributions and loans, see, "Distributions after Separation of Employment" section in the *Pay, Stock and Benefits Handbook* chapter 18: "Retirement Programs." **Health, Flexible Spending Accounts, Disability, and Life Insurance:** Your medical, dental, and vision coverage ends on the last day of the month that your employment with Intel ends. You and your enrolled dependents may be eligible to elect COBRA continuation coverage for medical, dental, vision, and the Health Flexible Spending Account (FSA) benefits. For more information, see *Pay, Stock and Benefits Handbook*, chapter 11: "COBRA Continuation Coverage." Contributions to your Health FSA, Limited Use Health FSA, and DCAP cease with your last paycheck. You may submit claims for eligible expenses incurred from your coverage effective date through your coverage end date until the May 31st run-out period of the following calendar year. Coverage under the Intel STD and Intel Long-Term Disability (LTD) plans ends at midnight on your last day of employment. However, approved disability claims may continue to be paid after termination of

Life Event	Impact to Benefits
	employment, as long as you continue to meet all plan requirements. More information is given below within the section "**If you are unable to return from a leave of absence and qualify for benefits under an Intel Disability Plan**". Basic and supplemental life, basic and supplemental Accidental Death & Dismemberment (AD&D), spouse and child life, and dependent AD&D insurance ends on the last day of the month during which your employment with Intel ends. Business Travel Accident (BTA) insurance ends at midnight on your last day of employment. With the exception of BTA insurance, you may be able to convert or port any life insurance plans that you had as an active employee to individual policies within 31 days of retirement.See *Pay, Stock and Benefits Handbook* chapter 15: "Life Insurance." If you are enrolled in the supplemental, spouse, or child life insurance at the time you retire, you may be eligible for portable supplemental, spouse, or child life insurance coverage provided you apply in writing within 31 days of your retirement date. For information on portability, see *Pay, Stock and Benefits Handbook* chapter 15: "Life Insurance." For premium information and an application, contact Minnesota Life at 877-494-1673. **Intel Retiree Medical Plan (IRMP) Medical and Vision options:** If you meet the eligibility criteria for the Intel Retiree Medical Plan, you may enroll yourself, your spouse, domestic partner, and eligible dependent children. **COBRA**: Upon retirement you will have the option to enroll in COBRA coverage, if eligible, for up to 18 months or enroll directly in Intel Retiree Medical Plan. If you choose to enroll in COBRA first, you may elect the Intel Retiree Medical Plan when your COBRA coverage ends. For information on COBRA, see *Pay, Stock and Benefits Handbook* chapter 11. To obtain information about how to enroll, contact the Intel Health Benefits Center at (877) GoMyBen (466-9236). **Sheltered Employee Retirement Medical Account (SERMA):** For more information regarding SERMA, go to *Pay, Stock and Benefits Handbook*: chapter 18: "Retirement" or the Intel Retiree Medical Plan and Sheltered Employee Retirement Account Summary Plan Description available on www.intel.com/go/myben. You can also contact the Intel Health Benefits Center at (877) GoMyBen (466-9236). **Bonuses:** If eligible, any Quarterly Profit Bonus (QPB) payout will be made at the normal payout distribution time and will be prorated based on eligible

Life Event	Impact to Benefits
	earnings for the months of participation during the period in which retirement occurs. If eligible, any Annual Performance Bonus (APB) payout will be made at the normal payout distribution time and will be prorated based on the month of participation during the year in which retirement occurs. **Vacation:** Earned unused vacation is paid out in your final paycheck if you are a nonexempt employee, or an exempt employee who works in California or Massachusetts. **Stock Option Plan, Restricted Stock Unit Plan, and Stock Purchase Plan:** Carefully review the Option Expiration document, the Event Impact on Stock Benefits document, and the Stock Termination Checklist. **Supplemental Long Term Disability (Supp LTD), Long Term Care, and Critical Illness:** Upon retirement, MetLife will bill you for your coverage at home. **Prepaid Legal Service (Hyatt Legal Plans):** Coverage ends on the date of retirement. Any legal services in process will be covered until completed. Retirees do have the option to port their coverage. Contact Hyatt Legal (877-770-4638) within 30 days of the retirement date to request portability. You will receive a one time invoice for 30 months to be paid up-front. Coverage would end after the 30 months.
If you leave the employ of Intel	**Bonuses:** The payout of a QPB or APB bonus requires an employee to be employed on the Intel payroll through the last day of the applicable bonus period (March 31 for first quarter (Q1) QPB, June 30 for the second quarter (Q2) QPB, Sept. 30 for the third quarter (Q3) QPB, and Dec. 31 for fourth quarter (Q4) QPB and APB). No prorated bonuses will be paid if termination occurs before the last day of the applicable bonus period. In other words, the effective termination date for the employee must be July 1 or later for the employee to be eligible for Q2 QPB and Jan. 1 or later in order to be eligible for Q4 QPB and APB. For example, if your effective termination date was Dec. 31, you would not be eligible for either Q4 QPB or APB. **Health, Flexible Spending Accounts, Disability, and Life Insurance:** Your medical, dental, and vision coverage ends on the last day of the month during which your employment with Intel ends. You and your enrolled dependents may be eligible to elect COBRA Continuation Coverage for medical, dental, vision and the Health FSA benefits. For more information, see *Pay, Stock and Benefits Handbook*, chapter 11: "COBRA Continuation Coverage." Contributions to your Health FSA, Limited Use Health FSA, and DCAP cease with your last paycheck. You may submit claims for eligible

Life Event	Impact to Benefits
	expenses incurred from your coverage effective date through your coverage end date until the May 31st run-out period of the following calendar year. Coverage under the Intel STD and Intel LTD plans ends at midnight on your last day of employment. However, approved disability claims may continue to be paid after termination--as long as you continue to meet all plan requirements. Basic and supplemental life, basic and supplemental Accidental Death & Dismemberment (AD&D), spouse and child life, and dependent AD&D insurance ends on the last day of the month during which your employment with Intel ends. Business Travel Accident (BTA) insurance ends at midnight on your last day of employment. With the exception of BTA insurance, you may be able to convert or port any life insurance plans that you had as an active employee to individual policies within 31 days of employment termination. If you were enrolled in the supplemental, spouse, or child life plan at the time you leave employment, you may be eligible for portable supplemental and dependent life insurance coverage provided you apply in writing within 31 days of your employment termination date. For information on portability, *Pay, Stock and Benefits Handbook* see chapter 15: "Life Insurance." For premium information and an application contact, Minnesota Life at 877-494-1673. **Retirement Plan Accounts** Your contributions to the Intel 401(k) Savings Plan are deducted from your final paycheck. If you have an outstanding loan in the 401(k) Savings Plan and/or Intel Retirement Contribution Plan, you may continue to make payments on the outstanding loan(s) to Fidelity via check, money order, or electronic fund transfer. You are eligible to receive a distribution of your vested account balances in any of the Intel Retirement Plans 30-days after your termination date from Intel. Distribution information for each of the Plans you are eligible to receive a benefit from will be automatically sent to your home mailing address on file with Fidelity. For more information, see "Distributions after Separation of Employment" in *Pay, Stock and Benefits Handbook* chapter 18: "Retirement Programs." Contact the Fidelity Service Center at (888) 401-7377 for any questions on your Plan loans or distribution options. **Vacation:** Earned unused vacation is paid out in your final paycheck if you are a nonexempt employee, or an exempt employee who works in California or Massachusetts.

Life Event	Impact to Benefits
	Stock Option Plan, Restricted Stock Unit Plan, and Stock Purchase Plan: Carefully review the Option Expiration document, the Event Impact on Stock Benefits document, and the Stock Termination Checklist **Supplemental Long Term Disability, Long Term Care, and Critical Illness:** MetLife will continue to bill you for your coverage at your home address on file with MetLife. **Prepaid Legal Service (Hyatt Legal Plans):** Coverage ends on the date you leave Intel. Any legal services in process will be covered until completed.
If you are unable to return from a leave of absence and qualify for benefits under an Intel Disability Plan	**Short Term Disability (STD):** If you leave the employ of Intel while receving Intel STD benefits and you continue to qualify for benefits under the Intel STD Plan or the California Voluntary STD Plan, your benefits are treated as described in the section "If you leave the employ of Intel" with the exception of Life Insurance. Intel will continue to provide Basic and Supplemental Life Insurance coverage for you (at the same level you were enrolled in on the date your employment ended) during the period you remain qualified for STD benefits. **Long Term Disability (LTD):** If you qualify for LTD benefits under the Intel LTD plan, your benefits are treated as described in the section "If you leave the employ of Intel" with the exception of life insurance. . Intel will continue to provide Basic and Supplemental Life Insurance coverage for you (at the same level you were enrolled in on the date your employment ended) during the period you remain qualified for LTD benefits. **Retirement Plan Accounts:** If you qualify for benefits under the Intel LTD Plan for more than 24 months (inability to work in any Gainful Employment as defined by the Intel LTD Plan), the Intel 401(k) match true-up will be prorated as of the date your employment ends. You Intel Retirement Plan benefits are 100% vested (regardless of years of service). **Stock Option Plan, Restricted Stock Unit Plan, and Stock Purchase Plan:** Carefully review the Option Expiration document, the Event Impact on Stock Benefits document, and the Stock Termination Checklist.

Life Event	Impact to Benefits
	Supplemental Long Term Disability, Long Term Care, and Critical Illness: MetLife will continue to bill you for your coverage at your home address on file with MetLife. **Prepaid Legal Service (Hyatt Legal Plans):** Coverage ends on the date you leave Intel. Any legal services in process will be covered until completed.
If you are rehired at Intel within two years	Your benefits will be the same as those for a new hire, except that your prior service with Intel will be credited (based on prior employee classification and eligibility) to the following programs: • Personal absence • Vacation • Service awards **Intel Retirement Plans** have a one year break-in-service rule. Please see the *Pay, Stock and Benefits Handbook*, chapter 18: Retirement Programs for specific break-in-service rules for these plans. **Note: Sheltered Employee Retiree Medical Account ("SERMA")** has specific eligibility and service rules. Please see the *Pay, Stock and Benefits Handbook*, chapter 18: Retirement Programs for the SERMA rules on eligibility and how service is determined. **Stock Option Plan, Restricted Stock Unit Plan, and Stock Purchase Plan:** Carefully review the Option Expiration document, the Event Impact on Stock Benefits document, and the Stock Termination Checklist.
If you are rehired at Intel within five years	**Stock Option Plan, Restricted Stock Unit Plan, and Stock Purchase Plan:** Carefully review the Option Expiration document, the Event Impact on Stock Benefits document, and the Stock Termination Checklist. *All prior service counts towards leave of absence eligibility.
If you die	**Pay and bonuses:** Your final pay, including unused vacation (exempt and nonexempt), personal absence time (nonexempt), as well as your ESPP account balance, are paid to your surviving spouse, child(ren), or estate in accordance with the laws of the state in which you reside. Your ESPP contributions will not be used to purchase shares of stock for the subscription period during which your death occurs, and your surviving spouse or estate will not receive interest on your ESPP contributions.

Life Event	Impact to Benefits
	If you are in redeployment, your Base Pay Salary and Variable Length of Service Salary (per redeployment package offered and option elected) are paid to your surviving spouse, child(ren), or estate in accordance with laws of the state in which you reside. If you were sabbatical-eligible—that is, you were considered eligible to take sabbatical but died prior to your first day of taking sabbatical—your surviving spouse, child(ren), or estate will receive: • Employees outside of California: A payment of 4 or 8 weeks depending on your sabbatical eligibility. • California Employees: A payment of 4 or 8 weeks depending on your sabbatical eligibility and anytime earned towards the next sabbatical. If you were eligible for the QPB, your surviving spouse, child(ren), or estate will receive the applicable payout at the normal distribution time. If you were eligible for the APB, your surviving spouse, child(ren), or estate will receive that year's payout at the normal distribution time. **Health benefits, Flexible Spending Accounts, and Life Insurance:** Your surviving dependents that are enrolled in health benefits at the time of your death can elect COBRA coverage. If your death occurs while you are an employee, Intel will provide your eligible enrolled dependents six months of COBRA coverage at no charge. For more information, see *Pay, Stock and Benefits Handbook*, chapter 11: "COBRA Continuation Coverage." Your estate can submit claims for Health FSA or Limited Use Health FSA expenses incurred from your coverage effective date through the date of your death until the May 31st run-out period of the calendar year following your death. If your dependents were covered under the spouse or child life insurance plan, they may be eligible for portable dependent life insurance coverage. This coverage is available at group rates and does not require Evidence of Insurability, provided coverage is applied for within 31 days of the date of your death. Information will be mailed to your dependents if this applies. **Retirement benefits:** Your retirement benefits are payable to your designated beneficiaries. Retirement distributions are governed by federal regulations. For more information, see "Distributions after Separation of Employment" in *Pay, Stock and Benefits Handbook* chapter 18: "Retirement Programs."

Life Event	Impact to Benefits
	Stock Option Plan, Restricted Stock Unit Plan, and Employee Stock Purchase Plan: Carefully review the Option Expiration document, the Event Impact on Stock Benefits document, and the Stock Termination Checklist. This information can be found by searching for the titles on Circuit.

Chapter 11
COBRA Continuation Coverage

Chapter 11
COBRA Continuation Coverage

This chapter provides an overview of COBRA Continuation Coverage and the details associated with COBRA qualifying events.

11.1 Overview

The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) is a federal law that enables you or your enrolled dependents to continue medical and dental coverage in the event that you or they lose coverage as the result of certain qualifying events.

You should, however, investigate all of your options for health care coverage. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, 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. In the Marketplace, you may be eligible for a tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage or a tax credit through the Marketplace.

Additionally, you may qualify for a special enrollment opportunity for Marketplace coverage or another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees. For special enrollment, you must request enrollment within 30 days of when your group coverage ends. Otherwise, you will generally have to wait until the Marketplace or another group health plan for which you are eligible holds open enrollment. For more information about the Marketplace, visit www.healthcare.gov.

IMPORTANT NOTE: Early termination of COBRA coverage prior to the end of the maximum COBRA coverage period, generally 18 months, is not considered a special enrollment event that would allow you to enroll in Marketplace coverage. Another employer plan also may not allow you to enroll in their health plan. For example, if you are eligible for three months of Intel-paid COBRA and then choose to drop COBRA for the remainder of the COBRA period, you will not qualify for special enrollment in the Marketplace (and possibly another employer's health plan) and will have to wait for the next open enrollment period.

If you are retiring from Intel and have a SERMA balance, you may be eligible for Marketplace coverage, but are not eligible for Marketplace tax credits. Please review the Intel Retiree Medical Plan and Sheltered Employee Retirement Medical Account Summary Plan Description for additional information on the Intel retirement medical benefits.

11.2 COBRA Qualifying Events

Upon a qualifying event, you and your covered dependents will receive a COBRA election notice from the Intel Health Benefits Center. To receive COBRA coverage, you must enroll in continuation of coverage in accordance with Intel plan provisions and federal regulations governing COBRA.

For You

You qualify for COBRA if your employment at Intel is terminated for any reason.

You become a qualified beneficiary and have the right to elect COBRA to continue your coverage if you were covered under one of the Intel medical, dental, vision options, the Health Flexible Spending Account (Health FSA) or the Limited Use Health Flexible Spending Account (Limited Use Health FSA) the day before your termination. You also become a qualified beneficiary and have the right to elect COBRA to continue your coverage for the Employee Assistance Program (EAP), the Executive Health Program and the Health for Life Center (Arizona, New Mexico, and Oregon residents only). The Health for Life Center offers limited benefits. Please call Intel Health Benefits at (877) GoMyBen (466-9236) for additional information.

For Your Dependent(s)

Your spouse and dependent child(ren) become qualified beneficiaries and have the right to elect COBRA coverage if they are covered under one of the Intel medical, dental or vision options the day before a qualifying event. Your spouse and dependent child(ren) may also elect COBRA coverage for the Employee Assistance Program (EAP).

Intel offers continuation coverage for a domestic partner or the dependent child(ren) of a domestic partner, similar to the legally required COBRA rights offered to other COBRA beneficiaries.

Dependents will experience a qualifying event if one of the following occurs:

- You experience a qualifying event (i.e., your Intel employment is terminated for any reason)
- You divorce or discontinue a domestic partner relationship
- A dependent child ceases to be eligible for coverage under the terms of the Intel Group Health Plan
- You become enrolled in Medicare
- You die

Each qualified beneficiary is entitled to separate elections and may elect individual coverage regardless of whether you elect COBRA coverage for yourself.

11.3 Initiating a COBRA Event

Events Initiated by Intel Corporation

If your employment is terminated for any reason, the Intel Health Benefits Center will mail you or your impacted dependent(s) a personalized COBRA election notice. The election notice includes information on the cost of coverage, deadlines, an election form and your continuation rights and responsibilities.

Events You Must Initiate

If any of the following qualifying events occur, you are responsible for making applicable changes to your benefits via the *My Health Benefits* website at www.intel.com/go/myben or by calling the Intel Health Benefits Center at (877) GoMyBen (466-9236) within 60* days of a qualifying event, or the date coverage in the health plan ends. Once you make these benefit changes, you or your impacted dependent(s) will be mailed a personalized COBRA election notice. Qualifying events include the following:

- A divorce or dissolution of your domestic partner relationship
- A dependent child's loss of dependent status
- Receipt of written determination of disability as defined in Title II or Title XVI of the Social Security Act for you or your dependent

If you wish to make any applicable qualified status changes to your active benefits while an employee (not COBRA**) based on one of these events, you must notify Intel via the My Health Benefits website or by calling the Intel Health Benefits Center within 30 days of the event. See the Pay, Stock and Benefits Handbook, chapter 10: "Life Events and Impact to Intel Benefits and Programs" for more information on qualified status changes and the time limits that apply.*

If you have not initiated the COBRA process by accessing the *My Health Benefits* website or do not notify the Intel Health Benefits Center within 60 days of the qualifying event or the date coverage in the health plan ends, the dependent(s) may lose eligibility for COBRA continuation coverage. You must access the *My Health Benefits* website or call the Intel Health Benefits Center, even if Intel is otherwise notified of your divorce—for example, you submit a Qualified Domestic Relations Order (QDRO).

Note: If the 60-day period ends on a weekend or a business holiday, the notification period will be extended until the first business day following the 60th day.

Note: Dropping a dependent from your benefits coverage during Annual Enrollment is not a COBRA qualifying event. Your spouse or dependent dropped from coverage during Annual Enrollment will not be able to elect COBRA coverage.

11.4 Length of COBRA Coverage

Table 7-1 summarizes the length of continuation coverage to which you and your dependent(s) are entitled as qualified beneficiaries.

Table 7-1: Length of Continuation Coverage

Qualifying Event	Who	Maximum Coverage Period
Termination of employment or retirement[1]	Employee and dependent(s)	18 months
Divorce or dissolution of domestic partner relationship	Dependent(s)	36 months
Dependent child losing coverage due to reaching age 26	Child	36 months
Death of employee [2]	Dependent(s)	36 months
Employee enrolls in Medicare [3]	Dependent(s)	36 months

[1] Coverage for 29 months will be available only if you or your dependent(s) are receiving Social Security disability benefits at the time of termination of employment, at retirement, or if the effective date of the Social Security disability determination is within 60 days of your termination of employment, retirement or reduction of work hours. See Section 11.5 below for complete information.

[2] The first six months of COBRA coverage will be covered by Intel free of cost, if you meet the eligibility requirements. See Electing COBRA and Paying for COBRA.

[3] If you enroll in Medicare and later terminate employment or retire, the COBRA coverage period for your dependents will be the greater of 36 months from the date of your Medicare entitlement (either Part A or Part B) or 18 months from the date your Intel active coverage ends due to your termination of employment or retirement.

Note regarding Health FSA and Limited Use Health FSA: The Health FSA and Limited Use Health FSA, including carry over funds, may be continued through COBRA. If you elect and pay your COBRA premiums, your COBRA coverage will end at the end of the current year, with one exception. If you elect COBRA continuation of coverage for your Health FSA or Limited Use Health FSA when you first become eligible for COBRA and have funds remaining at the end of the plan year, you may carry over unused funds, up to a maximum of $500 for the remainder of your COBRA coverage period. The carry over funds are available until exhausted or your COBRA coverage period ends. There is no COBRA premium for carryover funds.

11.5 Disability Extension

If you or your dependent is found to be disabled by the Social Security Administration (theSSA) prior to or during the first 60 days of COBRA coverage, you can continue COBRA health insurance for up to an additional 11 months beyond the 18-month period. The additional 11 months is available for the disabled individual and all other individuals who became qualified beneficiaries as a result of your termination of employment, retirement, or reduction in work hours.

Notice of the SSA disability determination must be provided by calling the Intel Health Benefits Center at (877) GoMyBen (466-9236) **before** the end of the original 18-month COBRA coverage in order to be eligible for the 11 months extension. Written notification cannot be accepted.

11.6 Electing COBRA

Each qualified beneficiary has an independent right to elect COBRA. You or your dependents must elect COBRA within 60 days of the date that coverage would otherwise be lost because of a qualifying event, or within 60 days of the date election materials are mailed to you, whichever is later. If you or your dependents do not elect COBRA within this 60-day period, health care coverage will end in accordance with the provisions outlined under “When Benefits End” in chapter 5 “Health and Insurance Benefits Enrollment.”

Note: If the 60-day period ends on a weekend or a business holiday, the election period will be extended until the first business day following the 60th day.

While you are employed at Intel, you and your eligible dependent(s) have health plan options based upon your work or home addresses. If you and your eligible dependent(s) were previously enrolled in a health care plan option based on your work address, your eligible plan options may change since COBRA coverage is based ONLY on your home address.

Except as described above, at the time of the initial COBRA election, employees and their dependents are not able to elect a different medical and dental plan option than the option(s) in effect immediately before the loss of active coverage.

Note: If you or a dependent is a current COBRA participant and you have a second qualifying event, call Intel Health Benefits at (877) GoMyBen (466-9236) within 60 days of the qualifying event.

Annual Enrollment and Election Changes

After the initial COBRA election, COBRA participants have the same rights as active participants to change their COBRA elections at Annual Enrollment and upon a qualified change-in-status event.

The Intel Health Benefits Center will administer Annual Enrollment and change-in-status events for COBRA participants. During the Annual Enrollment period the following applies:

- You can change your group health care coverage to any other plan offered in your home ZIP code area.
- You can elect or waive medical, vision, dental, EAP and/or Health for Life Center (Arizona, California, New Mexico, or Oregon residents only) coverage.
- You can enroll new dependents or drop covered dependents following the eligibility criteria for changing benefit elections.
- You will **not** be eligible to re-enroll in the Health FSA or Limited Use Health FSA during Annual Enrollment.

Note: If Intel implements changes to health care benefits under the plan, your COBRA benefits also change.

11.7 Paying for COBRA

If you elect COBRA, the first COBRA coverage premium is due to the Intel Health Benefits Center within 45 days of the date you elect COBRA. Thereafter, your COBRA premium must be paid within 30 days of the date it is due. COBRA participants will receive monthly invoices. Payments are due on the first of the month. However, to avoid possible cancellation of your COBRA coverage, do not wait for your invoice to submit your monthly payment. For more information, see "Termination of COBRA" in this chapter.

You are required to pay the full medical, vision, and dental premiums and Health FSA or Limited Use Health FSA contributions (if enrolled) plus a 2% administrative charge for COBRA for yourself and for each COBRA-covered dependent.

If you or your dependents fail to elect COBRA or pay the premiums but continue to utilize health care services past the termination of coverage date, you will be responsible for repayment of all claims incurred.

If you die while you are an active employee, Intel will pay for medical, vision and dental COBRA coverage for your enrolled dependents for six months following your death. The six-month period is included as part of the maximum COBRA coverage of 36 months.

11.8 Medicare and COBRA

***It is critical that you enroll in Medicare in a timely manner in order to maximize your total health care benefits*. COBRA is not considered an active employer group health plan. Accordingly, if you delay enrollment in Medicare due to your enrollment in COBRA coverage, you will experience a Medicare premium penalty.**

An individual who is eligible for Medicare (Part A & B) may elect and retain COBRA coverage. However, electing COBRA is not always to your benefit. If you are eligible for Medicare and your

COBRA premium is not subsidized (e.g. you are paying the full cost for the monthly premium), you should carefully consider whether COBRA coverage is to your benefit since the coverage of your benefits under COBRA will be coordinated with Medicare.

Coordination of Medicare and COBRA
If you and/or your dependents are eligible for Medicare, **enroll in Medicare** even if you chose to enroll in COBRA. Medicare (Part A & B) pays claims first (as the primary payer) except if you are in the first 30 months of Medicare based on End Stage Renal Disease (ESRD).

If you are not enrolled in Medicare, but are **eligible** for Medicare (typically age 65 or older/disabled), Medicare Part A & B becomes the primary payer and the plan you are enrolled via COBRA will assume you are enrolled in Medicare. This means that your COBRA coverage will reduce plan benefits in coordination with Medicare. If you're not enrolled in Medicare Part A & B, then your out-of-pocket expenses will increase to include what Medicare would have paid. This coordination of Medicare occurs even if you are enrolled in a Medicare Part C program, such as Medicare Advantage program.* Benefits under Medicare and COBRA are limited so that the total of **all** coverage will not exceed the benefits under the Intel COBRA plan option you are enrolled.

***NOTE:** Medicare Advantage programs offer limited provider networks. If you elect to use a provider outside the Medicare Advantage Plan (outside of emergency care), your COBRA plan will reduce payment based on what Medicare would have paid. In turn, this increases your out of pocket since you will be responsible for the amount Medicare would have paid to your provider.

Medicare Special Enrollment Period
Individuals who do not enroll in Medicare when first eligible because they were covered under an ***active group health plan based on their own or a spouse's current employment*** may enroll during the Medicare Special Enrollment Period. The individual can enroll at any time while covered under the active group health plan based on current employment, or during the 8-month period that begins the month the employment ends or the active group health plan coverage ends, whichever comes first. Individuals with end stage renal disease ("ESRD") are not eligible to enroll during the Special Enrollment Period. **COBRA isn't considered an active employee group health plan, and if you delay your Medicare enrollment while on COBRA, you could experience a Medicare premium penalty.**

Extension of Maximum COBRA Coverage Period for Spouse/Dependents
If you were already enrolled in Medicare less than 18 months before your termination of employment, COBRA coverage for your spouse and dependents who were enrolled in Intel group health plan coverage the day before your termination ("COBRA qualified beneficiaries") can last until 36 months after the date you enrolled in Medicare. For example, if you enrolled in Medicare 8 months before the date of your termination of employment, COBRA coverage for your spouse and children (who are COBRA qualified beneficiaries) would last 28 months (36 months minus 8 months).

Medicare Questions
If you have Medicare questions, visit Medicare's Website at www.medicare.gov, or call 1-800-MEDICARE (1-800-633-4227).

11.9 Termination of COBRA

COBRA coverage for you or your dependent(s) will end after the 18-, 29- or 36-month period or calendar plan year to which you are entitled or when certain events occur.

Any balance of funds in the Health FSA or Limited Use Health FSA is forfeited at the end of your COBRA coverage period. Call Intel Health Benefits at (877) GoMyBen (466-9236) for more information.

COBRA coverage automatically terminates when any of the following occurs:

- The end of your maximum COBRA coverage period.
- On the date Intel no longer provides group health care coverage to any of its current full-time or part-time employees.
- If the first premium is not paid within 45 days of the date the Intel Health Benefits Center receives your notification to elect COBRA, retroactive to the first day that COBRA coverage would have begun.
- If any premium for COBRA (except the first) is not paid within 30 days of the due date, coverage will terminate as of the premium due date, and the plan will not be responsible for claims incurred following the coverage termination date.
- For Health FSA and Limited Use Health FSA:
    - the end of the current plan year, except for carry over funds.
    - For any carry over funds in your Health FSA or Limited Use Health FSA, the end of your COBRA coverage period unless your balance is exhausted.

By midnight on the last day of the month, you must call Intel Health Benefits at (877) GoMyBen (466-9236) to provide notice of the following events that terminate eligibility for COBRA coverage:

- At midnight on the last day of the month when any person with COBRA becomes covered (after the date of the COBRA election) under another group health plan.
- At midnight on the last day of the month that a person on 11 months of extended COBRA coverage is found by the Social Security Administration to be no longer disabled.

Note for participants in a High Deductible Health Plan (HDHP) with optional employee-funded Health Savings Account (HSA)

The HDHP includes two components: traditional health care coverage (an HDHP as defined by the IRS) and an HSA. While traditional health care coverage is subject to COBRA, the HSA is exempt from COBRA rules.

Members enrolled in a HDHP should understand the impact on the HSA when considering whether to elect COBRA for the HDHP. To understand the impact on the HSA, review your enrollment materials.

All of the expenses incurred during the year by the family before the qualifying event will be credited to the COBRA beneficiary's deductible and out-of-pocket maximum.

If you have questions about HSA contributions after you leave Intel or need additional information, contact your health plan's HSA administrator. Additional medical, vision, and dental supplier contact information is available: see "Benefits Directory" in the *Pay, Stock and Benefits Handbook*, chapter 3 "Administrative Information."

Chapter 12
Leaves of Absence

Chapter 12
Leaves of Absence

This chapter provides an overview of the provisions and rules that apply to Intel's Leaves of Absence programs for qualifying leaves beginning January 1, 2020 or later.

12.1 Overview

Intel provides leave programs to eligible employees in the event they are unable to work due to the following:

- Serious health conditions affecting an employee or the employee's qualifying family members.
- The need for bonding time with a newborn, foster or adopted child.
- Military service or the military service of a qualifying family member.
- Other personal circumstances.
- Other absences protected by applicable State law.

Intel's leave programs comply with the Federal Family and Medical Leave Act (FMLA) and other Federal and State laws governing leaves. Review the guidelines for each leave type outlined in this chapter for details.

Enforcement and Retaliation

Intel prohibits retaliation or the threat of retaliation against an employee for exercising or attempting to exercise any right provided by these guidelines or applicable law, or interference with any investigation, proceeding or hearing related to or arising out of employee's rights pursuant to these guidelines and applicable law.

Job Protection

Intel will reinstate you to the same job or an equivalent position when you return from your Intel paid leave of absence, for example, pregnancy, non work-related illness or injury, caring for a family member, or bonding with a new child. Intel will not reinstate you if, for reasons unrelated to your leave, your employment is terminated, or your position is eliminated due to a workforce action while you are on leave or holding your position creates an undue hardship. Additionally, Intel will not count paid absences under Intel's attendance or performance guidelines.

Notice of Need for Leave

Unless otherwise provided for below, you must provide timely notice and apply for your leave as soon as feasible, generally within 30 days if your leave is foreseeable, or within 48 hours of your first day of absence if your need for leave is sudden. If you do not provide notice within these timeframes, you are required to provide notice as soon as practicable. Even if you meet the eligibility requirements for the leave in question, your failure to provide notice, as required, may impact the date upon which you may begin your leave, unless ReedGroup, Intel's third party leave of absence administrator, determines it was not practicable for you to do so under the particular circumstances.

If you are unable to apply for the leave yourself, your family members, other responsible party, manager, ADA Case Manager (ACM), or Intel Occupational Health (OH) representative may apply for the leave on your behalf. It is your responsibility to ensure that ReedGroup is contacted timely regarding your need for a leave. To initiate a leave, contact ReedGroup, Intel's leave and disability administrator, at https://intel.leavepro.com or call ReedGroup at (866) 532-5664.

If you are absent and do not apply for a leave promptly, according to the guidelines above, your leave may be delayed or denied. Unexcused absences of 3 or more days are considered job abandonment and grounds for termination.

As with any absence, you must inform your manager in accordance with your business group's absence guideline.

Intermittent Leave: You are required to make reasonable efforts to schedule medically necessary intermittent leave so it does not unduly disrupt your organization.

Work-Related Injuries or Illness: If you are injured at work or become ill because of work, you must notify your manager and Occupational Health (OH) immediately. There are no exceptions to this reporting rule. During your leave, the site OH representative will work closely with you to assist you with the process of applying for your leave and filing a Workers' Compensation claim on your behalf.

Reporting Your Absences

You are required to report leaves of absence to your manager, or appropriate Intel representative, and ReedGroup timely and accurately. You are responsible for informing ReedGroup of any changes to your leave start or end dates and for confirming your return to work date.

Exempt Employees:

- **Reduced Workweek Absences Due to Medical Condition:** Except as otherwise required by law, your pay will be prorated based on ReedGroup's reporting of your physician certified reduced work hours.
- **Intermittent Absences:** You must report your absence to ReedGroup each time you miss work for qualifying reasons no later than 48 hours after your first date of absence**.** Report

hours via ReedGroup's web portal https://intel.leavepro.com or by calling ReedGroup at (866) 532-5664.

Nonexempt Employees:

- To ReedGroup:
    - You must report any absence from work due to a continuous, reduced workweek schedule or intermittent leave no later than 48 hours after the first date of your absence. Use ReedGroup's web portal at https://intel.leavepro.com or call (866) 532-5664.
- To Intel:
    - California/Oregon Non-Exempt Employees:
        - You do not need to code your leave on your timecard. Only hours worked prior to the start of your leave or hours worked after your return to work should be recorded and submitted to Payroll for payment.
        - If you were unable to record your last time card accurately before your leave, you must submit an amended timecard when you return to work.
    - All Other States Non-Exempt Employees:
        - Employees must record on their timecards all intermittent or Reduced Workweek leaves for Intel Paid Leaves.
        - There is no requirement to record your continuous leave on your timecard. Upon return to work, you must accurately record your hours worked and remaining hours on leave.
        - Hours reported cannot exceed your scheduled hours for that pay period.

Consequences of Failure to Report Your Absences Timely and Accurately

The failure to report your absences timely or accurately may result in any of the following:

- Leave and short-term disability pay may be affected.
- ReedGroup may not record your absence as leave, and Intel may record these absences for performance, discipline, and attendance purposes.
- Your manager may require you to take the absence as vacation, floating holiday (in CA) or personal absence time.

If the failure to report your leave in a timely manner as described above results in an overpayment to you, you will be required to reimburse Intel immediately. If you fail to do so, you may be subject to disciplinary action, up to and including termination.

If you will not be returning to work on your expected return-to-work date, you should immediately notify both your manager and ReedGroup.

Pay and Other Intel Benefits During Leave

Your regular pay from Intel is suspended during a leave. You may be eligible for leave pay which is intended to approximate your regular pay during certain leave types. For more information, see Pay and Benefits during a Leave in this Chapter.

Outside Employment During Leave Prohibited

Employees may not hold other employment while on a leave of absence, unless approved in writing by the employee's direct and next level managers. Working another job while on leave without approval may be deemed a voluntary resignation from employment at Intel.

Return to Work and Request for Accommodation

While Intel reserves the right to request a signed release to return to work by your health care provider on a case by case basis, it does not generally require you to provide a signed release by your health care provider if you are returning to work from a leave without medical restrictions.

If you are returning to work with medical restrictions and you request an accommodation to enable you to perform your job functions, Intel's American with Disabilities Act (ADA) Case Manager Team, working with ReedGroup, will engage with you, and, as necessary, your health care provider and/or manager, to determine whether an accommodation is warranted, and, if warranted, what accommodation might be provided in order to allow you to perform your essential job functions.

For guidance on returning to work after Personal Leave and Military Leave, see the specific Return to Work provisions in those sections.

For complete information on each leave type, review the specific section in this chapter.

12.2 Leave Types At-A-Glance

Intel Paid Leaves Intel leaves will run concurrent with any applicable Federal or State leave entitlements				
Leave Type	**Leave Reason**	**Eligibility**	**Max Duration**	**More Information**
Intel Short-Term Disability	• For your own serious health condition • Pregnancy	Date of hire for eligible employees	Up to 52 weeks based on health care provider certification	Disability Programs
Intel Paid Bonding Leave	• Bonding within first 12 months following child's birth,	Date of hire for eligible employees	Up to 12 weeks	Intel Paid Bonding Leave

	adoption or foster care placement			
Intel Paid Family Leave	• Care for a family member with a qualifying serious health condition	Date of hire for eligible employees	Up to 8 weeks	Intel Paid Family Leave

Intel Unpaid Leaves **Intel leaves will run concurrent with any applicable Federal or State leave entitlements**				
Leave Type	**Leave Reason**	**Eligibility**	**Max Duration**	**More Information**
Family Medical Leave Act (FMLA)	• Care for your own serious health condition • Care for family member with serious health condition as defined by law • Bonding within first 12 months following child's birth, adoption or foster care placement • Military Caregiver • Active Duty leave for qualifying exigencies and military family member	12 months of Intel employment and 1250 hours of work during the 12 months preceding leave request	Up to 12 weeks in a rolling 12 month period Military Caregiver Leave – Up to 26 weeks during a single 12 month period	Family Medical Leave Act (FMLA)

Intel Unpaid Leaves Intel leaves will run concurrent with any applicable Federal or State leave entitlements				
Leave Type	**Leave Reason**	**Eligibility**	**Max Duration**	**More Information**
Leave as an accommodation under the ADA	Following the interactive process, leave for your own disability that will allow you to return to perform your essential functions of your job with or without a reasonable accommodation	Date of hire	Leave as an accommodation must be reasonable and effective to allow the employee to return to work to perform the essential functions of their job and there is no undue hardship	See the Americans with Disabilities Act information on Circuit.
Intel Military Leave - Unpaid (military adjustment pay may be available)	Active duty or routine training in the U.S. armed forces including annual military duty for reservists	Date of hire	Up to 5 years in accordance with USSERA	Intel MIlitary Leave
Intel Personal Leave	Personal circumstances that will require absence for more than 2 weeks and cannot be accommodated by Intel's other leave or time off programs	Date of hire	Up to 52 weeks based on manager approval	Intel Personal Leave

In addition to the types of leaves stated in the tables above, there may be additional Federal, State, and local -specific leave entitlements with varying length of employment service requirements as defined by State law. Intel complies with all other State leaves available to you. To check the various leaves observed by your State, contact ReedGroup at (866)532-5664.

State Mandated Paid Leaves

Certain States provide State mandated paid leave and disability programs. State-mandated contributions will be reflected on your paystub. For more information, reference the website below for your applicable State.

For California employees, Intel offers a voluntary plan, Intel California Voluntary Short-Term Disability Plan (CA-VSTD), in lieu of the State-mandated State Disability Insurance (SDI) and Paid Family Leave (PFL) program. See the Disability Programs chapter of the Pay, Stock and Benefits Handbook.

State Mandated Leave	Information
District of Columbia	https://dcpaidfamilyleave.dc.gov/
Hawaii	http://labor.hawaii.gov/dcd/tdi-links/
Massachusetts	https://www.mass.gov/orgs/department-of-family-and-medical-leave
New Jersey	https://myleavebenefits.nj.gov/
New York	http://www.wcb.ny.gov/content/main/Workers/Workers.jsp https://paidfamilyleave.ny.gov/
Puerto Rico	https://www.trabajo.pr.gov/sinot.asp
Rhode Island	http://www.dlt.ri.gov/tdi/ http://ripaidleave.net/
Washington	https://www.paidleave.wa.gov/workers

State mandated leave and disability programs run concurrent with applicable Intel programs including Intel paid leave programs. Where State leave laws impose additional requirements, the State leave requirements will apply. To learn more, contact ReedGroup at (866) 532-5664.

12.3 FMLA Leave (Family and Medical Leave Act)

Topics

12.3.1 Overview

The Family and Medical Leave Act (FMLA) provides employees who have completed 12 months of Intel employment and 1250 hours of work during the 12-month period immediately preceding the leave, up to 12 workweeks of unpaid leave in a rolling backward 12-month period for one, or any combination of the following reasons:

- To care for your own Serious Health Condition (including any work-related injury) that makes you unable to perform the functions of your job.
- To care for your qualifying family member who has a serious health condition. For purposes of FMLA, family member means the employee's spouse, child, or parent.
- For any qualifying exigency arising out of your parent, spouse, or child, who is a military member of the National Guard and Reserves or the Regular Armed Forces, and who is in or has been notified of an impending call to covered active duty deployment to a foreign country.
- To bond with a child within the first 12 months following the child's birth, adoption or placement for foster care.

FMLA Leave is also provided during a single 12-month period, for up to 26 weeks to care for an active U.S. military qualifying family member or covered veteran* (spouse, child, parent or next of kin) who has sustained or aggravated a serious illness or injury in the line of active duty (Military Caregiver Leave). Next of kin means you are the nearest blood relative other than the military service member's immediate family .If FMLA is used for another FMLA qualifying reason (up to the maximum of 12 weeks) during the same 12-week period, the remaining time available for the Military Caregiver Leave would be limited to 14 weeks.

* A covered veteran is an individual who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran. Some exceptions to the five-year period apply. Please contact ReedGroup at (866) 532-5664 with any questions.

This FMLA entitlement runs concurrent with applicable State laws, except as otherwise provided by law. To learn more about the various leaves observed by your state contact ReedGroup at (866) 532-5664.

You may be eligible for Intel paid leave programs which will run concurrent with FMLA and/or State leave entitlements when applicable.

12.3.2 Definitions

A **serious health condition** is the inability to work due to an illness, injury, impairment or physical or mental condition that requires overnight inpatient care or continuing treatment by a health care provider. Continuing treatment includes a period of incapacity with at least two visits to a health care provider or one visit with a regimen of continuing treatment.

A **child** is a biological, adopted, or foster child, a stepchild, a legal ward, or a child of a person standing in loco parentis who is under 18 years of age or 18 years or older and incapable of self-care due to a physical or mental impairment. In loco parentis means an individual who assumes the status and responsibilities of a parent with regard to a child by providing either day-to day care or financial support.

12.3.3 Intermittent and Reduced Workweek Schedule Leaves

Although most FMLA leaves are taken as a continuous leave, FMLA leave due to your own or your qualifying family member's serious health condition, or military caregiver leave may be taken intermittently or on a reduced workweek schedule. A reduced workweek schedule is considered fewer hours or days than your usual schedule and an intermittent absence is typically for unplanned or unscheduled durations based on the frequency and duration certified by your health care provider.

Unless there are any State-mandated exceptions, employees may not take FMLA for reason of bonding with a child using an intermittent or reduced work schedule leave.

California Only: In accordance with State law, leave for bonding may be taken in split segment(s) of two weeks or greater. On two occasions, you have the option to take bonding leave in increments of less than two weeks.

12.3.4 Job Reinstatement Rights for FMLA Leave

Intel will reinstate you to the same job or an equivalent position when you return from your FMLA leave of absence. Intel will not reinstate you if, for reasons unrelated to your leave, your employment is terminated or your position is eliminated due to a workforce action while you are on leave. Additionally, Intel will not count FMLA absences under Intel's attendance or performance guidelines.

For leaves due to your own serious health condition, if medical restrictions prevent you from returning to perform all of the functions of your job and you need an accommodation, Intel's ADA Case Manager Team will engage with you, and as necessary, ReedGroup, your health care provider and/or manager to consider whether your medical restrictions can be accommodated

to permit you to perform the essential functions of your job. This collaboration will assist to determine if you are eligible for placement back into your original job, with or without an accommodation.

12.3.5 Pay and Benefits

FMLA leave is unpaid. You may be eligible for Intel Paid Leave or Short-Term Disability pay to approximate your regular pay during certain leave types, which may run concurrent with FMLA. For more information, refer to the relevant information in this chapter or in the Disability Chapter of the Pay, Stock and Benefits Handbook. For more information on Benefit Continuation, see Pay and Benefits during a Leave in this Chapter.

12.3.6 Employee Responsibilities

Notice of Need for Leave: You must provide timely notice of and apply for leave in accordance with guidelines set forth above.

Reporting Absences: You are required to report your absence in accordance with guidelines set forth above.

12.3.7 FMLA Certification

Medical certification supporting the need for leave is required for your own serious health condition, your qualifying family member's serious health condition, or military caregiver leave. Your leave is "pended" (awaiting approval) until ReedGroup receives the required medical certification. For qualifying exigency leave, Intel reserves the right to request documentation to support your need for leave (e.g., military orders or birth certificate).

Intel reserves the right to request the employee obtain a medical second opinion (third in the event of conflicting opinions), at Intel's expense, regarding the need for leave.

Certification for leave due to your own serious health condition: ReedGroup will send you the documents to obtain the required certification. Although ReedGroup typically provides assistance in obtaining the certification if you are also applying for short-term disability benefits, it is your responsibility to ensure appropriate certification is received within 20 calendar days from the date of your leave request or first date of absence if your leave has a future start date. If ReedGroup does not receive the certification within 20 calendar days from the specified timeframes, your leave may be denied and your absence may be unapproved and you may be subject to disciplinary action. Your health care provider may require that you sign an authorization to allow your health care provider to release the required medical information to ReedGroup.

The certification for your own serious health condition has mandatory requirements, including the following:

- Certification that you have a serious health condition and need to take time away from work due to the condition.

- The expected duration of your leave and if you need to take a reduced workweek schedule or intermittent absence, and the frequency and duration.
- Your health care provider's signature.

Additional medical information may be required to determine Intel Short-Term Disability (STD) eligibility, if applicable.

Work-Related Injuries or Illness: Sedgwick, Intel's Workers' Compensation Administrator, will work with ReedGroup and OH to assist you in the certification process.

Certification for leave to care for qualifying family member with a serious health condition or Military Caregiver Leave: ReedGroup will send you the documents to obtain the required certification. It is your responsibility to ensure appropriate certification is received within 20 calendar days from the date of your leave request or first date of absence if your leave has a future start date. If ReedGroup does not receive the certification within 20 calendar days from the specified timeframes, your leave may be denied and your absence may be unapproved and you may be subject to disciplinary action.

When a qualifying family member has a medically certified serious health condition, you may use FMLA Leave for the following purposes:
- To provide care for the covered individual who is unable to care for basic needs or remain safely alone.
- To provide transportation to and from medical appointments.
- To give comfort to the covered individual receiving care in the hospital or at home.

The certification for your qualifying family member has mandatory requirements, including the following:

- Verification that your qualifying family member has a Serious Health Condition that requires you to be away from work because the qualifying family member is unsafe, unable to care for basic needs, unable to transport him or herself to medical appointments, or needing your care during inpatient or home care.
- Verification of the frequency, duration, and type of absence you will need.

Certification for Active Duty leave due to qualifying exigency: ReedGroup will inform you of any documentation required to support your need for leave due to a qualifying exigency. If a qualifying family member is a military member of the National Guard and Reserves or the Regular Armed Forces and has been notified of active duty deployment to a foreign country, you may take a FMLA Leave for the necessities related to duty. The qualifying exigencies are:

- Preparing for a short-notice deployment.
- Military events & related activities.
- Arranging childcare & school activities.
- Financial & legal arrangements.
- Attending counseling.
- Rest & recuperation.
- Post-deployment activities, including attending funeral services.
- Additional activities related to the call to duty.
- Arranging for parental care for a military member's parent.

Certification for bonding leave:
In accordance with varying State requirements, proof of relationship may be required for certification of bonding with a child.

Accepted forms of proof of relationship examples are:

- Child's Birth Certificate
- Certificate of Placement, AD-907
- Child's hospital discharge record
- Child's passport showing immigration and naturalization service stamp I-551
- Declaration of paternity, CS-909
- Independent adoption placement agreement, AD-924
- Foster care placement record, SOC-815

For more information on Intel Bonding Leave certification forms or timelines, please contact ReedGroup at (866) 532-5664.

12.3.8 Leave Extensions

If you have a qualified circumstance that requires additional time away from work due to your own medical condition, you may be eligible to extend your leave beyond 12 weeks by requesting extended leave as an accommodation under the Americans with Disabilities Act ("ADA"). If you need to extend your leave, contact ReedGroup at (866) 532-5664.

12.4 Intel Paid Family Leave – applicable for new leaves beginning on or after January 1, 2020.

Topics

12.4.1 Overview

Intel Paid Family Leave provides eligible employees up to eight workweeks of paid leave in a rolling backward 12-month period to care for your family member with a Serious Health Condition as defined below. Intel Paid Family Leave may be taken intermittently at a minimum of one day increments.

Intel Paid Family Leave provides leave pay which is designed to approximate your regular pay. Regular pay includes base salary, commission target, compressed workweek overtime, shift differentials and shift premiums, including salary adjustments during your leave.

Intel Paid Family Leave runs concurrently with any time off you may be eligible for under the Family Medical Leave Act (FMLA) or any applicable State or local leave laws. Reinstatement rights or protections align with any applicable Federal, State, or local laws. To learn more about the various leaves observed by your State contact ReedGroup at (866) 532-5664.

Eligibility

U.S. General Full-Time Employee (GFT) and U.S. Part-Time Employee (PTE) are eligible as of your date of hire.

Definitions

For purposes of Intel Paid Family Leave, the following definitions apply:

Family member means your:

- Spouse
- Domestic Partner
- Parent
- Child
- Grandchild
- Grandparent

- Sibling

A serious health condition means you are unable to work due to a qualifying family member's illness, injury, impairment or physical or mental condition that requires overnight inpatient care or continuing treatment by a health care provider. Continuing treatment includes a period of incapacity with at least two visits to a health care provider or one visit with a regimen of continuing treatment.

- There are certain ailments that do not typically qualify as serious health conditions, including:
- Colds and flu
- Earaches
- Upset stomachs and minor ulcers
- Headaches (other than migraines)
- Routine dental or orthodontic problems or periodontal disease, and
- Cosmetic treatments (other than for restorative purposes), unless complications arise or inpatient care is required.

Although these conditions are not typically covered as a Serious Health Condition, the medical information dictates whether a particular employee's situation constitutes a Serious Health Condition.

Certification

Medical certification supporting the need for leave is required for your family member's Serious Health Condition.

The certification for your family member has mandatory requirements, including the following:

- Verification that your family member has a Serious Health Condition that requires you to be away from work because the family member is unsafe, unable to care for basic needs, unable to transport him or herself to medical appointments, or needing your care during inpatient or at home.
- Verification of the frequency, duration, and type of absence you will need.

ReedGroup will send you the documents to obtain the required certification. Your leave is "pending" (awaiting approval) until ReedGroup receives the required medical certification. It is your responsibility to ensure appropriate certification is received within 20 calendar days from the date of your leave request or first date of absence if your leave has a future start date. If ReedGroup does not receive the certification within 20 calendar days from the specified timeframes, your leave may be denied and your absence may be unapproved and you may be subject to disciplinary action.

12.4.2 Intermittent and Reduced Workweek Schedule Leaves

You may take Intel Paid Family Leave for a continuous eight weeks rolling backward 12-month period, or it may be taken intermittently at a minimum of one day increments. Unless there are

State-mandated exceptions, employees may not take Intel Paid Family Leave in less than one day increments.

12.4.3 Pay Calculation

Your regular pay stops upon your first day of leave. Your leave pay begins when documentation is received and determined to support your request for benefits. Leave pay is designed to approximate base salary, commission target, compressed workweek overtime, shift differentials and shift premiums, including salary adjustments during your leave..

While on Intel Paid Family Leave, your benefit payments will be issued on your regular pay date.

Reductions and Exclusions

Intel Paid Family Leave benefits will be reduced by benefits you are eligible to receive from any applicable State or local mandated paid leave program, including the Intel Corporation California Voluntary Short-Term Disability Plan.

No benefits are payable if:

- You are receiving benefits from other Intel paid leave benefits including Intel Paid Bonding Leave.
- You are receiving benefits under the Intel Short-Term Disability or Long-Term Disability Plan.
- You make a false statement or representation concerning your leave. (Disqualification is effective from the date that the disqualifying event took place.)
- You are incarcerated in a Federal, State, or municipal penal institution, jail, medical facility, hospital (public or private) or in any other place because of a criminal conviction of Federal, State, or municipal law or ordinance.
- You are suspended without pay.
- Your employment ends.

Intel reserves the right to stop leave pay if you are under disciplinary investigation.

12.4.4 Other Intel Benefits - Benefit Continuation

Your regular benefit deductions and contributions will be taken from Intel Paid Leave and Short-Term Disability program payments that are paid through Intel payroll, provided you remain eligible, and consistent with the terms of the Intel benefit plans (e.g., medical, dental, 401(k), Employee Stock Purchase Plan). Except to the extent an Intel benefit plan or program permits, Intel paid leave and disability pay will not be considered part of your salary or earnings for purposes of calculating certain Intel benefits including, but not limited to, Quarterly Profit Bonus, pension, and will not count towards accruals of Personal Absence or Vacation.

12.4.5 Taxation

Intel Paid Leave and Short-Term Disability payments are subject to applicable Federal, State and local taxes and withholdings.

12.5 Intel Bonding Leave – applies for children born, adopted or placed in Foster Care as of January 1, 2020 or later

Topics

12.5.1 Overview

Intel Paid Bonding Leave provides eligible employees up to 12 workweeks of paid leave to bond with a child. The Intel Paid Bonding Leave must be initiated and completed within the first 12 months following the child's birth, adoption, or placement in foster care and the child must be born, adopted or placed in foster care after your Intel hire date. If taking Intel Paid Bonding Leave for a child that has been adopted or placed in foster care, the child must be under the age of 18 (or 18 years or older and incapable of self-care due to a physical or mental impairment).

You may take Intel Paid Bonding Leave for a continuous 12-week period, or it may be split into two segments with both segments being two weeks or greater, up to a total of 12 weeks. Unless there are State-mandated exceptions, employees may not take Intel Bonding Leave on an intermittent or reduced work schedule basis.

Intel Paid Bonding Leave provides leave pay which is designed to approximate your regular pay. Regular pay includes base salary, commission target, compressed workweek overtime, shift differentials and shift premiums, including salary adjustments during your leave.

Intel Paid Bonding Leave will run concurrently with any time off you may be eligible for under the Family Medical Leave Act (FMLA) or any applicable State or local leave laws. Reinstatement rights or protections align with any applicable Federal, State, or local laws. To learn more about the various leaves observed by your State contact ReedGroup at (866) 532-5664.

12.5.2 Eligibility

U.S. General Full-Time Employee (GFT) and U.S. Part-Time Employee (PTE) are eligible as of your date of hire.

12.5.3 Certification

In accordance with varying State requirements, proof of birth/adoption/placement is required. Examples of accepted proof are:

- Child's Birth Certificate
- Certificate of Placement, AD-907
- Child's hospital discharge record
- Child's passport showing immigration and naturalization service stamp I-551
- Declaration of paternity, CS-909
- Independent adoption placement agreement, AD-924
- Foster care placement record, SOC-815

It is your responsibility to ensure appropriate certification and proof of birth/adoption/placement documentation is received within 20 calendar days from the date of your leave request, or first date of absence if your leave has a future start date. If ReedGroup does not receive the certification within 20 calendar days from the specified timeframes, your leave may be denied, your absence may be unapproved, and you may be subject to disciplinary action.

For more information on Intel Paid Bonding Leave certification forms or timelines, please contact ReedGroup at (866) 532-5664.

12.5.4 Pay Calculation

Your regular pay stops upon your first day of leave. Your leave pay begins when documentation is received and determined to support your request for benefits. Leave pay is designed to approximate base salary, commission target, compressed workweek overtime, shift differentials and shift premiums, including salary adjustments during your leave.

While on Intel Paid Bonding Leave, your benefit payments will be issued on your regular pay date.

Reductions and Exclusions

Intel Paid Bonding Leave benefits will be reduced by benefits you are eligible to receive from any applicable State or local mandated paid leave program, including the Intel California Voluntary Short-Term Disability Plan.

No benefits are payable if:

- You are receiving benefits from other Intel paid leave benefits including Intel Paid Family Leave.
- You qualify for benefits under the Intel Short-Term Disability or Long- Term Disability Plan.
- You make a false statement or representation concerning your leave. (Disqualification is effective from the date that the disqualifying event took place.)
- You are incarcerated in a Federal, State, or municipal penal institution, jail, medical facility, hospital (public or private) or in any other place because of a criminal conviction of Federal, State, or municipal law or ordinance.
- You are suspended without pay.
- Your employment ends.

Intel reserves the right to stop leave pay if you are under disciplinary investigation.

12.5.5 Other Intel Benefits - Benefit Continuation

Your regular benefit deductions and contributions will be taken from Intel Paid Leave and Short-Term Disability program payments paid through Intel payroll, provided you remain eligible, and consistent with the terms of the Intel benefit plans (e.g., medical, dental, 401(k), Employee Stock Purchase Plan). Except to the extent an Intel benefit plan or program permits, Intel paid leave and disability pay will not be considered part of your salary or earnings for purposes of calculating certain Intel benefits including, but not limited to, Quarterly Profit Bonus, pension, and will not count towards accruals of Personal Absence or Vacation.

12.5.6 Taxation

Intel Paid Leave and Short-Term Disability payments are subject to applicable Federal, State and local taxes and withholdings.

12.6 Intel Personal Leave

Topics

12.6.1 Overview

Intel Personal Leave provides up to 52 weeks of unpaid leave in a rolling 5year period, subject to manager approval, for absences in excess of 14 calendar days.

Intel Personal Leave may be used for personal circumstances such as the following:

- A family crisis, emergency, or a natural disaster requiring you to look after family members or property or other situations that are serious in nature and require your attention and care.
- The need to bond with your child or to care for a family member after other Intel paid leaves have been exhausted.
- Life events that require you to manage family responsibilities not otherwise covered under Intel's leave policies.

Intel Personal Leaves are not appropriate for extended vacations, time off to think about the future, a transition into retirement, a trial period at a new job, or a cooling off period to get over a work-related problem (among other reasons). Intel Personal Leaves are not appropriate to provide a break from work intended to delay or influence an employee's resignation decision.

Intel Personal Leaves are granted at your manager's discretion. Managers will consider Intel's business needs when evaluating an Intel Personal Leave request and approval requirements may vary by business group or site. Employees with documented performance issues are generally ineligible. Examples of such performance issues include, but are not limited to, employees currently on a Corrective Action Plan or Written Warning or who have received a recent " Formal Performance Action (FPA). Intel Personal Leaves are available only in continuous absences (a single period of time off with a defined start and stop date).

12.6.2 Eligibility

U.S. General Full-Time Employee (GFT) and U.S. Part-Time Employee (PTE) are eligible as of your date of hire.

12.6.3 Approval Process

Intel Personal Leaves must be approved by your direct manager, who is responsible for obtaining the next level of approval. Intel reserves the right to require additional satisfactory documentation of your legitimate need for an Intel Personal Leave.

Once you initiate the Intel Personal Leave with ReedGroup, an email will be sent to your manager of record. Your manager will be responsible for approving your Intel Personal Leave request by responding to the email from ReedGroup. The manager must approve the Intel Personal Leave within 20 days of the initiation of the leave or the leave will be denied. No exceptions will be made if the leave is denied. You must work with your manager to ensure the leave is approved before the start of your leave. If you wish to change the dates of your Intel Personal Leave, contact your manager and ReedGroup online at https://intel.leavepro.com or (866) 532-5664.

12.6.4 Intel Personal Leave for Reason of Education

In limited circumstances, and subject to manager approval, Intel employees may apply for an Intel Personal Leave for education when completing a job-related post-undergraduate degree program that requires full time participation. If approved, you may take an Intel Personal Leave for the reason of education for up to 52 weeks in a rolling backward 5-year period or, if you are enrolling in a two-year program, you may take up to two 52-week segments.

12.6.5 Job Protection

Personal Leave is job protected for the first 12 weeks of each approved absence. Job protection means Intel will reinstate you to the same job or an equivalent position when you return from your Personal leave of absence. Intel will not reinstate you if, for reasons unrelated to your leave, your employment is terminated, or your position is eliminated due to a workforce action while you are on leave or holding your position creates an undue hardship.

12.6.6 Pay and Other Intel Benefits

Intel Personal Leave is unpaid. Any paychecks processed during your unpaid leave either due to the cash-in of Personal Absence (PA), floating holidays (CA), or vacation time may have deductions for medical, dental, vision, supplemental, and dependent life/AD&D insurance coverage. This reduces the amount you will need to reimburse Intel at the end of your leave.

Benefit deductions and contributions cease during an unpaid leave. Intel will continue your medical, dental, vision, supplemental and dependent life/AD&D insurance coverage consistent with the terms of the applicable Intel benefit program. Upon return from leave or termination you will be required to reimburse Intel for premiums Intel paid on your behalf. Failure to reimburse Intel may result in collection charges, including reasonable attorney's fees, and may be grounds for termination.

If you are enrolled in Long-Term Care, Critical Illness, or Supplemental LTD, premium deductions cease during an unpaid leave. You will receive a bill from MetLife directly at your home address. You are required to pay the bill if you want to continue enrollment. Once you return from your leave, if you continued enrollment, payroll deductions will begin automatically.

If you are enrolled in Hyatt Legal, your premiums cease during an unpaid leave. Once you return from leave, payroll deductions will begin automatically.

12.6.7 Return to Work

Contact your manager prior to your return to confirm your job, or an alternative position is available. If you will not be returning to work on your expected return-to-work date, you should immediately notify both your manager and ReedGroup. You may reinstate any benefits that you may have dropped when you went out on leave within 30 days of your return to work. For more information, see "How to Make Benefit Election Changes" in the *Pay, Stock and Benefits Handbook*, Chapter 5: Health and Insurance Benefits Enrollment.

12.7 Intel Military Leave

Topics

12.7.1 Overview

Employees in the uniformed services, as defined under the Uniformed Services Employment and Reemployment Rights Act (USERRA) are eligible for Military Leave beginning on the first day of employment. Uniformed services include Army, Navy, Marine Corps, Air Force, Coast Guard, and Public Health Service commissioned corps. Disaster-response appointees may also be eligible for Military Leave when the Secretary of Health and Human Services activates the National Disaster Medical System or when the individual participates in a training program authorized by the Assistant Secretary for Public Health Emergency Preparedness or a comparable official of any Federal agency. As required for your situation, you may take an Intel Military Leave via a continuous (a single period of time-off with a defined start and stop date), reduced workweek schedule (fewer hours or days than your usual schedule), or intermittent absence (unplanned or regular monthly trainings) durations.

For information on leaves for employees whose family members are on, or called for active military duty, refer to the FMLA Leave section of this chapter. Additionally, some States (e.g., New York, Illinois) may provide leave entitlements in addition to FMLA. To learn more about the various leaves observed by your State contact ReedGroup at (866) 532-5664.

Eligibility

U.S. General Full-Time Employee (GFT), U.S. Part-Time Employee (PTE), ICE, and Interns are eligible as of your date of hire.

12.7.2 Reinstatement Rights

Eligible employees are generally entitled to re-employment under the Uniformed Services Employment and Reemployment Rights Act (USERRA) if the employee's service does not exceed five years. There are some exceptions to this five-year period, such as when a person's active duty is involuntarily extended. In order for you to qualify for re-employment rights you must meet the following criteria:

- You must have held a civilian job.
- You must have given advance written or verbal notice to your employer that you were leaving the job for service in the uniformed services unless giving notice was impossible, unreasonable, or precluded by military necessity.
- The period of service generally must not have exceeded five years; however, there are exceptions to this time limit for situations such as involuntary active duty extensions.
- You must have been released from service under honorable conditions.
- You must have reported back to the civilian job in a timely manner or have submitted a timely application for reemployment.

With the exception as required by USERRA, Intel will not reinstate you if, for reasons unrelated to your leave, your employment is terminated or your position is eliminated due to a workforce action while you are on leave. Intel will not count Intel Military Leave absences under Intel's attendance or performance guidelines.

12.7.3 Pay and Other Intel Benefits

Intel Military Leaves are unpaid. However, after 6 months of active Intel employment, U.S. full-time and part-time employees (including U.S. employees on an expatriate assignment), interns, and ICE may be eligible for Military Adjustment Pay. For more information regarding Military Adjustment Pay, please see the Paid Time Off Chapter.

If you are receiving Military Adjustment Pay, your regular benefit deductions and contributions, (e.g., medical, dental, vision, Health FSA) will continue.

If you are not receiving Military Adjustment Pay, benefit deductions and contributions cease during an unpaid leave. Intel will continue your regular benefit deductions, e.g., medical, dental, vision, Health FSA, consistent with the terms of the applicable Intel benefit program.

Upon return from leave or termination you will be required to reimburse Intel for any outstanding premiums Intel paid on your behalf. Failure to reimburse Intel may result in collection charges, including reasonable attorney's fees, and may be grounds for termination.

If you are enrolled in Long-Term Care, Critical Illness, or Supplemental LTD, premium deductions cease during an unpaid leave. You will receive a bill from MetLife directly at your home address. You are required to pay the bill if you want to continue enrollment. Once you return from your leave, if you continued enrollment, payroll deductions will begin automatically. If you are enrolled in Hyatt Legal, your premiums cease during an unpaid leave. Once you return from leave, payroll deductions will begin automatically.

Within 30 days from the start of your leave, manage your benefits.

- If you want to make changes to your medical, dental, Health FSA, or DCAP benefits, go to *My Health Benefits* Web site. From Circuit, search for My Health Benefits or from the Internet at www.intel.com/go/myben. If you do not have access to the website, call the Intel Health Benefits Center at (877) GoMyBen (466-9236).
    - You may also choose to drop yourself and your dependents from your coverage if you add them to your military coverage. Since military coverage differs from Intel's, ensure that you choose the health coverage that meets your needs. If you keep your Intel insurance while on leave, you will be responsible for reimbursing Intel for paying benefits on your behalf when your return.
    - If you are enrolled in the Health FSA, you may be eligible for a Qualified Reservist Distribution.

12.7.4 Employee Responsibilities

Notice of Need for Leave

You must provide timely notice (written or verbal) to your manager concerning your need for military leave. Notice must be as soon as feasible, generally within 30 days in advance if your leave is foreseeable, or within 48 hours of your first day of absence if your need for leave is sudden. The Department of Defense recommends that service members advise their employers as soon as they receive notification of impending military duty, even if you do not actually have written orders in hand. If you are unable to notify your manager yourself, ask a family member or HR representative to do it for you.

If you are volunteering for military service, please work with your manager to minimize business disruption.

If you know in advance that you will be scheduled for reoccurring assignments of duty, such as regular monthly trainings, you may apply for an intermittent Intel Military Leave for up to 6 months. You will still need to notify Intel of the date(s) when you will be absent as they occur. You are also expected to notify ReedGroup. If you are not able to notify ReedGroup, you are expected to ask your manager or HR representative to communicate to ReedGroup on your behalf.

12.7.5 Returning to Work

Contact your manager when seeking position reinstatement or job placement upon your return from Military Leave. Your restoration rights are based on the duration of your military service.

You must return to work within the following timeframes:

- **Military service of less than 31 days:** Return to work by the first regularly scheduled work period after last day of duty plus required travel time.
- **Military service of 31 to 180 days:** Return to work within 14 days of completion of duty.
- **Military service of 181 days or more:** Return to work within 90 days of completion of duty.

Following service-connected injury or illness: The above deadlines for returning to work are extended for up to two years for persons who are hospitalized or recovering due to a service-connected injury or illness.

Note: Intel reserves the right to request documentation demonstrating that an employee is eligible for reinstatement under USERRA following a Military Leave.

If you qualify for reemployment, Intel will comply with USERRA to determine the appropriate job position, if any, considering what you would have attained, with reasonable certainty, if you had not been absent due to military service.

Please engage your manager or HR to assist in the determination of the proper placement upon return from military service.

If you will not be returning to work on your expected return-to-work date, you should immediately notify both your manager and ReedGroup.

You may reinstate any benefits that you may have dropped when you went out on leave within 30 days of your return to work. For more information, see How to Make Benefit Election Changes in the *Pay, Stock and Benefits Handbook*, chapter 5: Health and Insurance Benefits Enrollment.

12.7.6 Leave Extensions

If you will not be returning to work on your expected return-to-work date, you should immediately notify both your manager and ReedGroup claim coordinator by calling (866) 532-5664 to extend your leave.

12.8 Pay and Benefits During a Leave

Topics

12.8.1 Overview

During all leaves your regular pay is suspended, except as otherwise required by applicable law. You may be eligible for Intel Paid Leave benefits depending on the type of leave. Refer to Intel paid leave programs in this Chapter, and Disability Chapter of the Pay, Stock and Benefits Handbook.

Your regular benefit deductions and contributions will be taken from Intel Paid Leave and Short-Term Disability program payments paid through Intel payroll, provided you remain eligible, and consistent with the terms of the Intel benefit plans (e.g., medical, dental, Health FSA, 401(k), Employee Stock Purchase Plan). Except to the extent an Intel benefit plan or program permits, Intel paid leave and disability pay will not be considered part of your salary or earnings for purposes of calculating certain Intel benefits including, but not limited to, Quarterly Profit Bonus, pension, and will not count towards accruals of Personal Absence or Vacation.

12.8.2 Intel Benefit Continuation

Intel Paid Leaves and Short-Term Disability: Benefit deductions and contributions will be taken from Intel Paid Leave and Intel Short-Term Disability payments paid through Intel payroll, and military adjustment pay, provided you remain eligible, and consistent with the terms of the Intel benefit plans (e.g., medical, dental, 401(k), Employee Stock Purchase Plan). You may be able to make certain changes to your benefits during your leave. For information, contact Intel Get HR Help (800) 238-0486.

Except to the extent an Intel benefit plan or program permits, Intel Paid Leave and Intel Short-Term Disability pay will not be considered part of your salary or earnings for purposes of calculating certain Intel benefits including, but not limited to, Quarterly Profit Bonus, pension, and will not count towards accruals of Personal Absence or Vacation.

Unpaid leaves: Benefit deductions and contributions cease during an unpaid leave. Intel will continue your medical, dental, vision, supplemental and dependent life/AD&D insurance coverage consistent with the terms of the applicable Intel benefit program. Upon return from leave or termination you will be required to reimburse Intel for premiums Intel paid on your behalf. Failure to reimburse Intel may result in collection charges, including reasonable attorney's fees, and may be grounds for termination.
Any paychecks processed during your unpaid leave either due to the cash-in of Personal Absence (PA), floating holidays (CA), or vacation time may have deductions for medical, dental, vision, supplemental, and dependent life/AD&D insurance coverage. This reduces the amount

you will need to reimburse Intel at the end of your leave. If you are enrolled in Long Term Care, Critical Illness or Supplemental LTD, premium deductions cease during an unpaid leave. You will receive a bill from MetLife directly at your home address. You are required to pay the bill if you want to continue enrollment. Once you return from your leave, if you continued enrollment, payroll deductions will begin automatically. If you are enrolled in Hyatt Legal, your premiums cease during an unpaid leave. Once you return from leave, payroll deductions will begin automatically.

For detailed information on how a leave of absence impacts your Intel benefits, refer to the relevant chapters in the Pay, Stock and Benefits Handbook.

12.8.3 Overpayments

If you believe you were overpaid either on your Intel regular paychecks for periods of time during which you were on a leave, or through Intel Paid Leave or short-term disability payments, you must immediately notify ReedGroup. In the event of an overpayment, even inadvertently as a result of an administrative error—you will be required to reimburse Intel. If you fail to pay back any overpayments, you will be subject to disciplinary action, up to and including termination.

12.8.4 Changing Your Benefit Elections Due to Your Leave

You may be able to make certain changes to your benefits during your leave. For more information, see the relevant chapters in the *Pay, Stock and Benefits Handbook*.

Chapter 13
Paid Time Off

Chapter 13
Paid Time Off

This chapter explains the paid time off benefits that Intel offers including: Vacation, Personal Absence (PA) for Non-Exempts, Paid Sick Time, Holidays, Sabbatical, Jury Duty, and Bereavement, and Military Leave.

13.1 Overview

Paid time off benefits are a key component of Intel's total rewards package. They provide employees with the flexibility to take time away from work to spend with family and friends, travel, or just relax. We all need time to recharge occasionally in order to remain healthy and productive.

Some of the paid time off benefits employees receive vary depending upon their employment status. All the benefits discussed in this chapter are available to General Full-Time (GFT) employees. If an employee's status is Part-Time Employee (PTE), Intel Contract Employee (ICE), or intern, see "Availability of Benefits by Employee Classification" in chapter 4 **before** reading this chapter.

13.2 Vacation

Topics

The vacation benefits discussed in this section are available to GFT employees. If employee status is PTE, ICE, or intern, see "Availability of Benefits by Employee Classification" in chapter 4 **before** reading this section.

13.2.1 Exempt General Guideline

As a general guideline, vacation time amounts to about three weeks per year; exempt employees do not receive a specific allotment of vacation time, vacation time is not earned, and has no cash value, with few exceptions specifically identified below. After ten years of service, vacation time amounts to about four weeks per year. Intel encourages employees to take vacation time every year. Unused vacation time will not carry over from one calendar year to the next (except by law for California employees), and unused vacation time will not be paid out at termination (except by law for California, Colorado, Illinois, Massachusetts, and Rhode Island employees). Exempt employees cannot cash out vacation time in lieu of taking time off. New hires and interns receive prorated vacation time during the year of hire (e.g., about 1.25 days

per month). Exempt vacation is not tracked through Payroll. Managers and employees are responsible for tracking & scheduling vacation usage.

Exempt employees do not accrue vacation while on unpaid leave (including in California, Colorado, Illinois, Rhode Island, and Massachusetts where there are varying requirements for vacation accrual for active employees).

ICE and part-time employees: ICE employees receive accrued vacation time at a prorated rate of 1 day per month of worked time. Part time employees receive vacation time on a prorated basis, based on their standard work schedule.

California exempt employees: This section supersedes and applies to California exempt employees instead of the Exempt General Guidelines. Accrued unused vacation will be paid out at termination. For full-time employees, vacation time accrues on a prorated basis of 1.25 days (10 hours, assuming an 8-hour workday) per month for employees with service less than ten years, and 1.67 days (13.36 hours, assuming an 8-hour workday) per month for employees with service more than ten years. New hires and interns receive prorated vacation time during the year of hire. ICE and part-time employees accrue pursuant to the ICE and part-time employees section above.

Accrued unused vacation is carried over from year to year or paid out subject to Section 12.2.3 below, but vacation accrual is capped at twice the employee's annual accrual rate. The maximum amount a full-time employee can accrue is six weeks (30 days or 240 hours, assuming full time employment) of vacation for employees with up to ten years of service and eight weeks (40 days or 320 hours, assuming full-time employment) of vacation for employees with ten years or more of service. Part-time and ICE employees are subjected to a prorated cap. Once an employee has accrued the maximum amount, no further vacation time will be earned accrued until vacation time is taken and the accrued balance is reduced below the cap. Exempt employees cannot cash out vacation time in lieu of taking time off. Exempt vacation is not tracked through Payroll. Managers are responsible for tracking unused accrued vacation time and providing this information to Payroll for termination payout.

For more information, from Circuit search California Exempt Vacation Policy Q&A.

Colorado, Massachusetts, Illinois, and Rhode Island exempt employees: Accrued, unused vacation for the current year will be paid out at termination. Vacation time accrues on a prorated basis of 1.25 days per month for employees with service less than ten years, and 1.67 days per month for employees with service more than ten years. Exempt vacation is not tracked through Payroll. Managers are responsible for tracking unused accrued vacation time and providing this information to Payroll for termination payout.

13.2.2 Nonexempt Vacation/Hour Accrual

A Non-Exempt employee earns 3.1 hours of paid vacation per each pay period (up to 80 hours per year) for the first five years of employment. Interns and ICE employees accrue paid vacation time at 3.7 hours per pay period; however they do not accrue any PA time.

Part-time employees accrue vacation on a pro-rated basis, based on their standard work schedule. For example, an employee with a standard work schedule of 20 hours per week will accrue vacation at a rate of 1.55 hours per pay period.

If employment with Intel ends, any earned but not taken vacation will be paid at the employee's final base rate of pay (not inclusive of bonuses or other incentives).

Vacation, floating holidays (CA) and personal absence (PA) time is not accrued during a leave of absence, whether the leave of absence is paid or unpaid leave. If during a leave, you supplement your income by requesting PA or vacation cash-in, this request will not result in additional vacation or PA accrual.

Anniversary Vacation Hour Accrual

As employees remain with Intel, additional vacation hours are given in recognition of years of service per the following table:

Table: Anniversary Vacation Hour Accrual

Completion of Years	Additional Vacation Hours Earned
5 years	8 hours
6 years	16 hours
7 years	24 hours
8 years	32 hours
9 years (and beyond)	40 hours

Anniversary vacation hours will be added to an employee's vacation bank no later than the end of the month following the anniversary month. For example, if an employee's employment anniversary is February 1, anniversary vacation hours should appear by the end of March.

Intel encourages employees to take a minimum of one continuous week of vacation yearly. To promote this, the number of hours of vacation that can be carried over into a new calendar year is limited to 160 hours. Any accrued vacation above 160 hours will be cashed out on the first paycheck in February.

It is recommended that employees schedule vacation time at least three working days in advance to allow for coordination of coverage, etc. Managers may require more or less notice based on the ability of the department to meet business requirements. Vacation requests are granted in the order they are received and are subject to managerial discretion.

13.3 Holidays

The holiday benefits discussed in this section are available to GFT, ICE, and intern employees.

Intel designates ten holidays each calendar year plus one floating holiday (to be taken at the employee's discretion with manager approval) subject to applicable local laws. Some employees may receive more than one floating holiday or fewer than ten designated holidays due to shift or worksite production schedules. Holiday time is not accrued and is based on the calendar year, not the workweek calendar. Floating holidays should be taken within the calendar year.

If an Intel designated holiday falls during a leave of absence, whether paid or unpaid, you will not receive holiday pay; however, floating holidays are not affected by time on a leave within a calendar year. You cannot use holiday time to supplement pay during a leave, unless otherwise provided by law

Part-time employees receive holiday time on a prorated basis, based on their standard work schedule. For example, a Non-Exempt employee with a standard work schedule of 20 hours per week would be eligible to receive ½ of the full-time equivalent annual holiday allocation (44.3 hours per year) during the course of the year. Part-time exempt employees would be eligible for holidays that fall within their standard work schedule. For PTE status, see "Availability of Benefits by Employee Classification" in chapter 4 **before** reading this section.

California exempt employees: Floating holiday(s) not used within the calendar year will be carried over into the next year up to a maximum of 2 floating holidays; once a floating holiday is earned, it cannot be forfeited. Earned, unused floating holiday(s) will be paid out upon termination.

Colorado Exempt Employees: Floating holiday(s) not used within the calendar year will be paid out upon termination.

California and Colorado nonexempt employees: Floating holiday(s) not used within the calendar year will be automatically cashed out in February of the following year at the base rate of pay (not inclusive of bonuses or other incentive payments) and without shift differential. Earned, unused floating holiday(s) will be paid out upon termination at the employee's base rate of pay, not inclusive of bonuses or other incentives.

Oregon U.S. Veterans: Oregon law entitles U.S. veterans to take the Veterans Day holiday off. Intel Oregon U.S. veterans that meet the criteria outlined in Oregon Revised Statute: ORS 408.225, paragraph e, can request the day off via the normal time off request process. The day will be unpaid. However, if an employee would like pay for this day, they are welcome to use their floating holiday, vacation or PA non-discipline time. If business reasons do not allow for the day off, a replacement day will be granted that must be used before the next year's Veterans Day. This is only an option if the day was requested and denied due to business reasons. If Veterans Day is a non-scheduled work day for an employee, no replacement day is offered. The law applies only to those scheduled to work on Veterans Day. If an employee qualifies and wishes to take the day off, they *must* request it via the normal time off request process.

Massachusetts U.S. Veterans: Massachusetts law requires employers to provide paid time off on Veteran's Day to veterans who live or work in Massachusetts and want to participate in local Veteran's Day exercises, parades, or service. For purposes of this policy, a veteran is any person who lives or works in Massachusetts with an honorable discharge who served in any branch of the U.S. military or who served full time in the National Guard under certain conditions. Any person who served in wartime and was awarded a service-connected disability or Purple Heart is also a qualifying veteran.

If you are a veteran (as described above) living or working for Intel in Massachusetts and you wish to take the day off to participate in local Veteran's Day exercises, you can request the day off via the normal time off request process. You will be required to use your floating holiday, vacation, or PA non-discipline time if available. If you do not have any floating holidays or accrued time off, you will still be allowed to take off Veteran's Day with pay.

13.4 Sabbatical

Topics

The sabbatical benefit is available to U.S. and Canadian General Full-time (GFT) employees.

If an employee is a PTE, ICE, or intern employee, see "Availability of Benefits by Employee Classification" in chapter 4 **before** reading this section.

13.4.1 Overview

The sabbatical benefit is one of Intel's most popular benefits. It's the opportunity for eligible employees to enjoy an extended period of time away from work to rejuvenate and return to Intel revitalized with fresh ideas and new perspectives. In addition, sabbaticals allow other employees the opportunity to cross train and assume greater responsibilities.

A sabbatical is distinctly different from a vacation. It is not a benefit earned for past service, but an incentive for continued service employees to continue working for Intel and to return to Intel with increased creativity and productivity. A sabbatical is either four weeks (28 calendar days) or eight weeks (56 calendar days) in length and must be taken in one continuous leave. Holidays that fall within the sabbatical do not extend it. Subject to manager approval, vacation time can be scheduled immediately before or after sabbatical dates to extend the total time away from Intel. When returning from sabbatical, employees return to the same or an equivalent position unless the organization is impacted by a restructure. In those cases, employees may use their transition period to look for another position upon their return.

13.4.2 Eligibility

General Full Time (GFT) employees who have worked at least a full four years of eligible service within the U.S. or Canada are eligible to take a sabbatical. Sabbatical eligibility dates reset after each sabbatical is taken.

Your sabbatical eligibility is impacted as follows:

- All time spent on a leave of absence, whether paid or unpaid (with the exception of Intel Personal), counts toward sabbatical eligibility.
- Any time taken for Intel Personal Leave will not count toward sabbatical eligibility.
- Generally, for sabbatical eligibility purposes, no credit will be given for time served with a merged company prior to the merger.
- Time spent in a country other than the U.S. or Canada as a local hire is not eligible toward sabbatical.
- If terminated and returned to Intel previous eligible service will not count toward sabbatical.

Sabbatical cannot be taken while in an ineligible employment status (See Chapter 4) and you will not accrue time toward sabbatical while in an ineligible employment status.

If sabbatical eligible, sabbatical time must be taken prior to transferring to an ineligible employment status. If employee enters an ineligible employment status after becoming sabbatical eligible, their earned eligibility will remain once they return to an eligible employment status.

13.4.3 When Employees Can Take Sabbatical

Employees may not take their sabbatical before their actual eligibility date.

- Employees can choose to take a four-week sabbatical upon completion of four years of eligible service, or an eight-week sabbatical upon completion of seven years of eligible service. Sabbatical eligibility dates reset after each sabbatical is taken.
- Employees who choose an eight-week sabbatical upon completion of seven years of eligible service must start their sabbatical no later than three years after their eligibility date (i.e. three-year window). Employees who do not start the sabbatical within the three-year window will forfeit their sabbatical. (Please see Termination and Sabbatical section for state rules and other information regarding unused sabbatical.) Postponements for business or personal reasons will not be allowed except as stated below:
    - Employees on Short-Term Disability, Intel Paid Family, Intel Paid Bonding, Industrial, or Military Leave, or on international assignment at the time the three-year window expires will have six months to start their sabbatical once the leave or international assignment is concluded.
- Employees who don't take a four-week sabbatical will be eligible to take an eight-week sabbatical under the rules in this chapter.

Corrective Action Plans and Written Warnings

To be eligible to take sabbatical, employees must be meeting the expectations and performing at their job and grade level in the quarter immediately preceding the sabbatical. Employees may not take sabbaticals while on a Corrective Action Plan (CAP) in a CAP/Buyout decision period (exempt employees) or a Written Warning/Buyout decision period (nonexempt employees). Upon the successful completion of the CAP or Written Warning, or upon a demotion in lieu of completing the CAP or Written Warning, employees are eligible to take a sabbatical. The recent receipt of a Permanent Written Warning may also delay eligibility to take a sabbatical. Employees who terminate while on a CAP or Written Warning will receive a sabbatical payout as noted in this chapter. Employees who are on a CAP, Written Warning, or Permanent Written Warning at the time the three-year window expires will be allowed to start their sabbatical within six months after the satisfactory resolution of the CAP, Written Warning, or Permanent Written Warning.

13.4.4 Impacts to Compensation and Benefits

Employees retain all Intel benefits while on sabbatical.

For sabbatical purposes, pay includes base, scheduled overtime, and shift differential. Employees will receive pay designed to approximate a normal paycheck for their regular work schedule. Participation in the Annual Performance Bonus (APB) and Quarterly Profit Bonus (QPB) programs will continue without interruption.

Sales employees on the commission plan will receive a pay designed to approximate a normal paycheck for their regular work schedule and commission payments. Participation in the Quarterly Profit Bonus (QPB) program will continue without interruption.

If, during sabbatical, an employee is involved in an activity (not usually and customarily performed) for which payment is received, the employee may not be eligible for full compensation. This does not refer to a job that is normally held in addition to an Intel position that is consistent with our Code of Conduct and avoids conflict of interest.

Termination and Sabbatical

- **Employees outside of California, Colorado, and Illinois**: Employees outside of California and Illinois who terminate, voluntarily or involuntarily, before becoming eligible for sabbatical, will not be paid for any time which would have counted toward sabbatical eligibility. Employees who have reached their sabbatical eligibility date at the time of their termination will be paid out for their unused sabbatical time which has not been forfeited.
- **California, Colorado, and Illinois Employees**: California, Colorado, and Illinois employees who terminate, voluntarily or involuntarily, will receive payment for unused sabbatical time. Payment upon termination for unused sabbatical time, up to 11 weeks, will be on a pro-rated basis using a calculation which looks to the next sabbatical eligibility date (i.e. only the eligible service completed towards the next sabbatical eligibility date is calculated for payout at termination). If the employee has not taken the eight-week sabbatical by end of the three-year window, the employee will not be

allowed to take a sabbatical until his/her next eligibility date and will not accrue additional sabbatical time for pay out at termination because they will have met their 11 week cap (8 weeks for the sabbatical + 3 weeks for the 3 year eligibility window). These are prospective calculations and used only if a terminating employee opted not to take sabbatical; they are not earned wages and are subject to adjustment and recalculation for use.

- **Sabbatical Pay**: Sabbatical pay will be paid at employees' final rate of pay based on a close approximate calculation including base rate, scheduled overtime, shift differential as applicable.
- **All Employees:** A manager may extend an employee's termination date rather than pay out sabbatical only under limited circumstances. If the exception is granted, the employee will have to schedule their sabbatical through the normal process and the manager should process the termination with a date immediately after the last day of sabbatical. Termination dates will not be extended for employees who are impacted by a people movement action, who accept a CAP buyout, or who are terminated for policy violations.

13.4.5 Taking a Leave of Absence during Sabbatical

If, during sabbatical, an employee is incapacitated due to an unexpected serious health condition that would normally qualify for an Intel Short-Term Disability or Industrial Leave, sabbatical may be extended. Likewise, sabbaticals will be extended for the period during which an employee goes on Military Leave due to unanticipated military duty. To seek sabbatical extensions under these circumstances, an employee must apply and be approved for Intel Short-Term Disability, Industrial, or Military Leave during the sabbatical period. If a leave is taken during a sabbatical, the sabbatical time will restart at the conclusion of the leave. Before the leave expires, employees need to contact a Reed Group, Ltd. Representative at (866) 532-5664.

13.4.6 Scheduling a Sabbatical

For details on scheduling sabbatical, see the Sabbatical Checklist on Circuit.

13.5 Sick Time, Qualifying Reasons and Personal Absence

Exempt Employees

Intel provides time off for exempt employees related to sick time or other qualifying reasons (listed below). With notice to their managers, exempt employees are allowed to take discrete amounts of time off for personal absence reasons or for illness or reasons required under the paid sick time laws enacted in many states and cities in the U.S. Exempt employees receive their normal salary during these short-term absences.

When the use of sick time or time off for other qualifying reasons is foreseeable, Intel expects employees to make a good faith effort to notify their manager in advance. Employees must also make a good faith effort to schedule the leave in a manner that does not unduly disrupt Intel's

operations. When the use of sick time or time off for other qualifying reason is not foreseeable, employees are expected to notify their manager consistent with the requirements in our attendance policy, or as soon as practicable under the circumstances. Failure to provide appropriate notice or failure to make reasonable efforts to schedule leave in a manner that does not unduly disrupt operations may result in discipline.

Intel does not provide a specific amount of time off related to qualifying reasons or sick time (as defined below) for exempt employees, but does provide at least the minimum required amount of leave specified by applicable federal, state or local statute, rule or ordinance. Paid sick leave laws have tracking and reporting requirements. In accordance with these requirements, a tracking tool is available to all exempt employees in the U.S. to track absences related to sick time. Sick time tracking for exempt employees is done via the Tracker Tool and can be accessed from the paid sick time page. Sick time may be used and recorded in one-hour increments, subject to applicable local laws. Absences not related to sick time will not be tracked.

When exempt employees are absent for qualifying reasons, including but not limited to sick time as set forth below, exempt employees will be paid their normal salary while away from work. Exempt employees must initiate a leave of absence for sick leave in excess of 14 consecutive calendar days, see Intel's Leave of Absence guidelines.

If there is overlap between an employee's paid sick time and any paid or unpaid leave for which they may be eligible, please refer to Intel's Leave of Absence policies for information on how to apply for a leave, and how pay may be impacted.

Sick Time or Other Qualifying Reasons:

- Your own mental or physical illness, injury or health condition
- Your own need for a medical diagnosis, care or treatment of your mental or physical illness, injury or health condition
- Your own need to receive preventative medical care
- Care of a family member
    - Who needs medical diagnosis, medical appointment, care, or treatment of a mental or physical illness, injury, or health condition, or
    - Who needs preventative medical care
- To care for an infant, newly adopted child, or newly placed foster child
- Intel's closure due to a public health emergency (including closure to limit exposure to an infectious agent, biological toxin or hazardous material)
- Care of a child when the child's regular childcare provider or school has been closed due to a public health emergency (including closure to limit exposure to an infectious agent, biological toxin or hazardous material)
- Care for yourself or a family member when it has been determined by the health authorities having jurisdiction or by a health care provider that you or your family member's presence in the community may jeopardize the health of others because of exposure to a communicable disease, whether or not you or the family member have actually contracted the communicable disease.

- For reasons related to domestic violence, sexual assault or stalking that affect you or a family member including but not limited to if you or a family member has been a victim of domestic violence, sexual assault, or stalking, and the time off is used for treatment, assistance (e.g., from a victim services organization), counseling, relocation, safety planning or implementation, or taking related legal action, including preparation for or participation in any related civil or criminal legal proceeding
- For the donation of the employee's or a family member's bone marrow or organ to another person
- To attend a school-related conference, meeting, function, or other event requested or required by your child's school, or to attend a meeting regarding care provided to your child in connection with your child's condition or disability
- Oregon only: To attend the funeral of a family member, make arrangements necessitated by the death of a family member, and/or grieve the death of a family member within 60 days of the date on which an employee learns of a family member's death.
- Any other reason for which paid sick time may be used, as specified by applicable federal, state or local statute, rule or ordinance

For purposes of this policy, a family member includes a child (including a biological, adopted, foster child, a step-child, a child of whom the employee has legal or physical custody or guardianship, legal ward, a child of a domestic partnership or civil union of the employee, and a child to whom the employee stands in loco parentis), grandchild, spouse, domestic partner, civil union partner, parent(including biological, adoptive, or foster parent, step-parent, or legal guardian of an employee or of the employee's spouse, domestic partner, or civil union partner, or a person who stood in loco parentis of the employee or the employee's spouse, domestic partner, or civil union partner when the employee, spouse, or partner was a minor child), grandparent (including foster or step-grandparent), grandchild, or parent or grandparent of spouse, domestic partner, or civil union partner, sibling (including half, adopted, or step sibling), sibling of a spouse, domestic partner, or civil union partner of the employee, spouses of siblings, any other individual related by blood to the employee or whose close association with the employee is the equivalent of a family relationship or as otherwise required by applicable law. The calendar year for purposes of exempt sick time is January 1 to December 31.

Employees taking sick leave for qualifying reasons will not be required to work an alternate shift to make up for their absence. Leave for a qualifying reason is considered an excused absence and will not be considered for purposes of evaluating an employee's attendance.

Non-Exempt Employees & Personal Absence Time

The personal absence (PA) benefit discussed in this section is available to general full-time (GFT) and part time nonexempt employees.

Eligible Non-Exempt employees accrue 3.1 hours per pay period of PA time, which can be used once it is accrued. PA will be accrued during any pay period where any hours are worked or paid through a benefit (e.g., vacation, holiday, sabbatical) in the pay period.

Part time employees accrue PA on a pro-rated basis, based on their standard work schedule. For example, an employee with a standard work schedule of 20 hours per week will accrue PA at a rate of 1.55 hours per pay period.

Interns and ICE employees do not accrue PA time. Interns and ICE employees may use their accrued vacation time for any reason, including the Personal Absences described below.

Personal absence (PA) time is not accrued during a leave of absence, whether the leave of absence is paid or unpaid leave. If during a leave, you supplement your income by requesting PA or vacation cash-in, this request will not result in additional vacation or PA accrual.

When the use of PA is foreseeable, Intel expects employees to make a good faith effort to notify their supervisor in advance. Employees must also make a good faith effort to schedule the leave in a manner that does not unduly disrupt Intel's operations. When the use of PA is not foreseeable, the employee is expected to notify their supervisor consistent with the requirements in the attendance policy, or as soon as practicable under the circumstances. Requests to use PA may be made orally, in writing, or electronically, and whenever possible should include the expected duration of absence. Employees should also update their timecards to reflect PA usage. Failure to provide appropriate notice or failure to make reasonable efforts to schedule leave in a manner that does not unduly disrupt operations may result in discipline.

Employees may carry over accrued PA time from year to year. For limitations on the amount of PA time available during a rolling 12-month period, see the Attendance Guideline.

If PA accrual is exhausted, however, Non-Exempt employees may, with prior manager approval, supplement PA pay by using accrued vacation hours and coding their timecard with the appropriate time code. Otherwise, absences for which no PA accrual is available will be unpaid.

Accrued PA may be cashed in:

- At any time
- In any increment
- Multiple times per year

This conversion to cash can be requested on the timecard. Intel strongly recommends that employees maintain a minimum of 40 hours of accrued PA in case of emergencies.

PA time is converted to cash as follows:

- Shift Differential is included in the PA cash out
- At time and one half of straight time pay for hours over a 40-hour balance
- At straight time for hours below a 40-hour balance
    - As example, if employee has a 50-hour balance and chooses to cash out 20 hours, 10 of those hours would be cashed out at straight time and 10 hours would be cashed out at time and one half of straight time
- CWW Differential is included

Personal Absence Reasons

As referred to in this chapter, Personal Absences are absences for the following reasons:

Absences reasons that are categorized as Protected include:

- Your own mental or physical illness, injury or health condition
- Your own need for a medical diagnosis, care or treatment of your mental or physical illness, injury or health condition
- Your own need to receive preventative medical care
- Care of a family member
    - Who needs medical diagnosis, medical appointment, care, or treatment of a mental or physical illness, injury, or health condition, or
    - Who needs preventative medical care
- To care for an infant, newly adopted child, or newly placed foster child
- Intel's closure due to a public health emergency (including closure to limit exposure to an infectious agent, biological toxin or hazardous material)
- Care of a child when the child's regular childcare provider or school has been closed due to a public health emergency (including closure to limit exposure to an infectious agent, biological toxin or hazardous material)
- Care for yourself or a family member when it has been determined by the health authorities having jurisdiction or by a health care provider that you or your family member's presence in the community may jeopardize the health of others because of exposure to a communicable disease, whether or not you or the family member have actually contracted the communicable disease.
- For reasons related to domestic violence, sexual assault, or stalking that affect you or a family member including but not limited to if you or a family member has been a victim of domestic violence, sexual assault, or stalking, and the time off is used for treatment, assistance (e.g., from a victim services organization), counseling, relocation, safety planning or implementation, or taking related legal action, including preparation for or participation in any related civil or criminal legal proceeding
- For the donation of the employee's or a family member's bone marrow or organ to another person
- To attend a school-related conference, meeting, function, or other event requested or required by your child's school, or to attend a meeting regarding care provided to your child in connection with your child's condition or disability
- Oregon only: To attend the funeral of a family member, make arrangements necessitated by the death of a family member, and/or grieve the death of a family member within 60 days of the date on which an employee learns of a family member's death.
- Any other reason for which paid sick leave may be used as specified by applicable federal, state or local statute, rule or ordinance.

Absence reasons that are categorized as Non-Protected include but are not limited to:

- Personal appointments that are not for Protected reasons, e.g., meeting with financial planner, electrician, etc.
  Unexpected personal issues and unexpected situations that require time away from work, e.g., urgent house repair issue, etc.

For purposes of this policy, a family member includes a child (including a biological, adopted, foster child, a step-child, a child of whom the employee has legal or physical custody or guardianship, legal ward, a child of a domestic partner or civil union of the employee, and a child to whom the employee stands in loco parentis), grandchild, spouse, domestic partner, civil union partner, parent (including biological, adoptive, or foster parent, step-parent, or legal guardian of an employee or of the employee's spouse, domestic partner, or civil union partner, or a person who stood in loco parentis of the employee or the employee's spouse, domestic partner, or civil union partner when the employee, spouse, or partner was a minor child), grandparent (including foster or step-grandparent), grandchild, or parent or grandparent of spouse, civil union partner, or domestic partner, sibling (including half, adopted, or step sibling), sibling of a spouse, domestic partner, or civil union partner of the employee, spouses of siblings, any other individual related by blood to the employee or whose close association with the employee is the equivalent of a family relationship or as otherwise required by applicable law.

The minimum increment that PA may be used is one hour, subject to applicable local laws. Should employees use all of their PA for any reason, they do not have the right to additional sick leave until additional time is accrued and available.

Protected Personal Absence

Intel offers up to 40 hours (and more where required by law) of personal absence to be designated as Protected Personal Absence per calendar year. The calendar year for designating Protected Personal Absence is January 1 to December 31. Employees may designate the absence as Protected Personal Absence by communicating with their manager and allocating time in a timekeeping tool (where possible) if it meets all of the following conditions:

- Employee must have Personal Absence hours accumulated and subsequently uses those Personal Absence hours for the requested absence
- Employee must be taking absence for reason defined as Protected above
- Employee must have used less than 40 hours of designated Protected Personal Absence already within the calendar year.

Employees taking Protected Personal Absence will not be required to work an alternate shift to make up for their absence. Nor will employees be required to search for or find a replacement worker as a condition of taking PA time. Protected Personal Absence is considered an excused absence and will not be considered for purposes of evaluating an employee's attendance.

Once the limit of Protected Personal Absence has been reached within the calendar year, any additional absence hours within the calendar year will be designated as Non-Protected Personal Absence, even if the absence is for a qualifying Protected Absence reason. If an employee does not have Personal Absence hours accrued and available to use, all absence time

will be designated as non-Protected Personal Absence, even if the absence is for a qualifying Protected absence reason.

Employees may receive discipline for using more than 80.5 hours of non-Protected Personal Absence hours, as defined within the Attendance Guidelines.

If Employment with Intel Ends

Any accrued PA will be paid out.

Enforcement and Retaliation

Employees will not be disciplined for taking approved time off that is job-protected under any federal, state, and local ordinance including paid sick leave laws. Intel prohibits retaliation or the threat of retaliation against an employee for exercising or attempting to exercise any right provided in this policy, or interference with the exercise of rights under this policy, or any investigation, proceeding or hearing related to or arising out of an employee's rights pursuant to this policy and applicable law.

Arizona employees: Retaliation against an employee who requests or uses earned paid sick time/protected personal absence is prohibited. An employee has the right to file a complaint if earned paid sick time/protected personal absence as required by law is denied by an employer or if he/she is subjected to retaliation for requesting or taking earned paid sick time/protected personal absence.

The Arizona Industrial Commission's contact information is as follows: 800 W. Washington Street, Phoenix, AZ 85007 / 602-542-4661 or 2675 E. Broadway Boulevard, Tucson, AZ 85716 / 520-628-5188.

13.6 Jury Duty

The jury duty benefit discussed in this section is available to GFT, PTE, intern employees, and Intel Contract Employees (ICEs).

Employees are encouraged to serve if they are called for jury duty.

> *For more information on jury duty pay and other related paid absences, see "Paid Absences" and "Overtime Eligibility" on Circuit.

Exempt

Exempt employees will be paid their full salary for any work week interrupted by jury duty.

Nonexempt

Non-Exempt employees who work all or part of their regular shift on the day they are on jury duty will be paid for any combination of jury duty and time worked (see note).

The time served as a juror or witness will not affect any employee benefits, including PA and vacation accrual. Employee's managers should be notified in advance when summoned as a juror or a witness by providing a memorandum from the court clerk stating the period of duty.

Employees are required to provide a copy of the receipt from the court clerk to their manager. Timecards should be coded for jury duty. Regular base pay is paid for hours worked if you return to work after jury duty.

If an employee receives compensation from the court for their service as a witness or a juror, they can accept the compensation and do not need to notify Payroll. Intel's jury duty benefit is not reduced by any court compensation, if received from the court.

Note: Serving as a witness or on jury duty does not include court appearances as the defendant or plaintiff.

13.7 Bereavement

Bereavement is available to GFT, PTE, intern employees and Intel Contract Employees (ICEs).

Absences of up to ten scheduled work days* that are due to the death of a parent, parent-in-law, step parent, spouse, Domestic Partner, grandparent, grandchild, child, step-child, brother, sister, brother-in-law or sister-in-law usually will be paid. With the evolving nature of families and relationships, this list will always be incomplete. Additional relationships may be considered at manager's discretion Time off for bereavement will not affect any employee benefits, including PA and vacation accrual.

If an employee is on an Intel Paid Family Leave to care for an eligible family member, and that family member passes away during the leave, the employee's Intel Paid Family Leave will end on the date of death and their bereavement leave will begin. For any questions on how Bereavement impacts an Intel Paid Family Leave, contact a ReedGroup, Ltd. Representative at (866) 532-5664.

Oregon employees: If an employee needs additional time off for bereavement, Oregon employees who qualify for OFLA are eligible to take up to two weeks of leave per death of a family member in a rolling 12-month period. OFLA bereavement leave is unpaid; however, Non Exempt employees may cash out accrued, unused Personal Absence and Exempt employees may cash out vacation or up to 72 hours of unused sick time.

Bereavement under this section shall count toward the total amount of OFLA leave authorized by applicable law. OFLA leave for bereavement purposes may be used to make arrangements

necessitated by the death, to attend the funeral or memorial service, or to grieve. For more information, please contact the ReedGroup.

Note: Employees may download the Exempt Payout Form from the ReedGroup site, https://intel.leavepro.com.

*For employees working compressed work week or an alternate work schedule, bereavement may not exceed 84 scheduled work hours.

13.8 Military Leave

Intel Military Leaves account for time away from work and are unpaid. However, employees may be eligible for Military Adjustment Pay after six months of active Intel employment, U.S. full-time and part-time employees (including U.S. employees on an expatriate assignment), interns, and Intel contract employees (ICE). The intent is to limit adverse impacts of service to Intel pay if the situations here apply:

- Routine Duty and Training: Intel provides Military Adjustment Pay for up to 30 working days during a rolling backward 12-month period for typical military duty. The Military Adjustment Pay coordinates the difference between the employee's Intel base pay and military pay for the timeframe designated by Military Leave Earning Statement (LES).

  Calculation: (Intel gross base pay + applicable shift differential) - military pay* based on the gross military basic pay stated on the supporting Military Leave Earning Statement (LES) = Military Adjustment Pay.

- Active Military Orders: Intel provides up to two years of Military Adjustment Pay for employees called to active duty.

  Calculation: (Intel gross base pay + applicable shift differential) - military pay* based on the gross military basic pay stated on the supporting Military Leave Earning Statement (LES) = Military Adjustment Pay.

*Military pay includes gross military basic pay. Military pay does not include any additional military supplemental pay such as food allowance, housing allowance, separation allowance, jump pay, hazard duty, etc.

Notes:

- Employee's gross Military Adjustment Pay will be taxed at their W-4 rate.
- Intel reserves the right to review, update, and change or discontinue its Military Adjustment Pay policy at any time.

- Intel provides Military Adjustment Pay for military service for each of an employee's normally scheduled Intel workdays. For days that employees work for the military outside of their normal Intel workdays, no adjustment occurs.

To receive Military Adjustment Pay, an employee must (1) report their military absences to the Reed Group to account for time away from work and (2) verify their military pay by submitting each Leave and Earnings Statement (LES) to Intel U.S. Payroll at military@intel.com.

13.9 Paid Time Off while on Leave of Absence

Exempt Vacation

In all states except California, Colorado, Illinois, Massachusetts and Rhode Island, the amount of vacation available during a year is not impacted by time taken on a leave of absence. California, Colorado, Illinois, Massachusetts, and Rhode Island employees accrue vacation as active employees only, and time on leave impacts the amount of vacation earned in the year of the leave.

The use of vacation time scheduled before or after a leave of absence to extend the period of absence is subject to managerial discretion. Exempt employees may request to use their available vacation to supplement income during all unpaid leaves of absence except Personal Leave.

Non-Exempt Vacation & Personal Absence Time

Vacation and personal absence (PA) time is not accrued during a leave of absence for nonexempt employees. Vacation time can be cashed in during a leave. For instructions on how to cash in vacation time, refer to the Leave Guides on Circuit.

Non-Exempt employees: Vacation and personal absence (PA) time is not accrued during leave. Employees can request PA or vacation cash-in for otherwise unpaid leaves. The receipt of paid leave benefits does not result in additional vacation or PA accrual.

Note: For instructions on how to cash in PA, refer to the Leave Guides on Circuit.

Chapter 14
Disability Programs

Chapter 14
Disability Programs

This chapter provides an overview of the provisions and rules that apply to Intel's Disability programs.

14.1 Disability Overview

Topics

14.1.1 Overview

Intel's Short-Term Disabilty (STD) Plans provide up to 52 weeks of benefits, intended to approximate your regular pay, if you are unable to work due to pregnancy or a non-work-related illness or injury. If you work in a mandated State, benefits you might be eligibile for through a State plan will reduce your Intel STD plan benefit amount. Intel's Long-Term Disablity (LTD) provides partial wage replacement for disabilities that extend beyond 52 weeks. The disability benefit provisions of Intel's STD and Intel's LTD plans are different. If you qualify for STD benefits, you should not assume that you also will qualify for Intel's LTD Plan benefits.

14.1.2 Contributions for Short Term Disability

Beginning January 1, 2020, the cost of STD coverage is paid by Intel. If you work outside of California in a State with mandated disability or paid family leave programs, you are required to pay the employee contribution as determined by the applicable state.

14.1.3 State Mandated Paid Leaves

Certain States provide State mandated paid leave and disability programs. State mandated contributions will be reflected on your paystub. For more information, reference the website below for your applicable State.

For California employees, Intel offers the Intel California Voluntary Short-Term Disability Plan (CA-VSTD), in lieu of the State mandated State Disability Insurance (SDI) and Paid Family Leave

(PFL) program. See State Mandated Paid Leaves in the Leaves chapter of the Pay, Stock and Benefits Handbook

State Mandated Leave	Information
District of Columbia	https://dcpaidfamilyleave.dc.gov/
Hawaii	http://labor.hawaii.gov/dcd/tdi-links/
Massachusetts	https://www.mass.gov/orgs/department-of-family-and-medical-leave
New Jersey	https://myleavebenefits.nj.gov/
New York	http://www.wcb.ny.gov/content/main/Workers/Workers.jsp https://paidfamilyleave.ny.gov/
Puerto Rico	https://www.trabajo.pr.gov/sinot.asp
Rhode Island	http://www.dlt.ri.gov/tdi/ http://ripaidleave.net/
Washington	https://www.paidleave.wa.gov/workers

State mandated leave and disability programs run concurrent with applicable Intel programs including Intel Paid Leave programs. Where State leave laws impose additional requirements, the State leave requirements will apply. To learn more, contact ReedGroup at (866) 532-5664.

14.1.4 Other Intel Benefits - Benefit Continuation

Your regular benefit deductions and contributions will be taken from Intel Paid Leave and Short-Term Disability program payments that are paid through Intel payroll, provided you remain eligible, and consistent with the terms of the Intel benefit plans (e.g., medical, dental, 401(k), Employee Stock Purchase Plan). Except to the extent an Intel benefit plan or program permits, Intel paid leave and disability pay will not be considered part of your salary or earnings for purposes of calculating certain Intel benefits including, but not limited to, Quarterly Profit Bonus, pension, and will not count towards accruals of Personal Absence or Vacation.

Taxation

Intel Paid Leave and Short-Term Disability payments are subject to applicable Federal, State and local taxes and withholdings.

14.2 Intel Short-Term Disability Plan ("Intel STD Plan") – This Summary Plan Description applies to claims under the Intel STD Plan beginning on or after January 1, 2020

Topics

14.2.1 Eligibility

U.S. General Full-Time Employee (GFT), U.S. Part-Time Employee (PTE) or Intel Contract Employees (ICE) are automatically covered in the Intel STD Plan as of your date of hire. If you work in a State with mandatory coverage refer to "Short-Term Disability Coverage in Other Mandatory States" in this chapter for more information.

14.2.2 Disability Determination

You will be considered eligible for Intel STD Plan benefits if you:

- Meet the definition of Disabled/Disability: You are considered disabled and eligible for Intel STD Plan benefits under the Intel STD Plan when you are unable to perform your regular and customary work because of any physical or mental illness, injury, or condition (including pregnancy-related disability) that has been certified by a Physician.
    - Physician means any licensed medical professional practicing within the scope of his or her license and rendering care and treatment to you that is appropriate for the condition and locality. The term does not include you, your spouse, the immediate family (including parents, children, siblings or spouses of any of the foregoing, whether the relationship derives from blood or marriage), of you or your spouse, or a person living in your household.

- Have been ordered not to work by a medical authority because you are infected with, or suspected of being infected with, a communicable disease.
- In order to receive Intel STD Plan benefits for substance related disorders, you must be participating in an inpatient or intensive outpatient addiction recovery program.
- Adhere to the teachings of any bona fide church, sect, denomination, or organization, and depend for healing entirely upon prayer or spiritual means, and you receive a certificate from a duly authorized or accredited practitioner from such an organization and this practitioner provides the nature and estimated duration of your Disability.

14.2.3 Successive Disabilities

A relapse of your condition (successive disability) separated by fewer than 60 consecutive calendar days of continuous active work on a full-time basis is considered one Disability Benefit Period, unless the relapse disability is due to an illness or injury found by ReedGroup to be unrelated to the cause of your original disability and occurs/began after you return to work with Intel on a full-time basis for at least one full work day.

14.2.4 Contributions

As of January 1, 2020, no contributions are required for the Intel STD Plan.

14.2.5 How to File a Claim for Intel STD Plan Benefits

You, your representative, or Intel's representative may initiate your claim for Intel STD Plan benefits with ReedGroup, Intel's STD Plan Claims Administrator, by calling 1-866-532-5664 or on the web at https://intel.leavepro.com. ReedGroup will contact your health care provider to obtain medical information. Your claim application will be processed once ReedGroup receives all applicable medical information.

It is your responsibility to file your claim for Intel STD Plan benefits within 90 days of the start of your disability. ReedGroup may periodically request supplemental certification or information to support a claim for Intel STD Plan benefits. Your claim will not be accepted later than 90 days after the start of your disability unless there are extraordinary circumstances beyond your control, as determined by, and at the sole discretion of ReedGroup.

ReedGroup has the right to request an independent medical examination or other information necessary to determine qualification for Intel STD Plan benefits.

If you do not qualify for Intel STD Plan benefits, ReedGroup will send you a denial letter providing an explanation of denial and information on how to appeal. For more information about denials, refer to "If a Claim is Denied" in this chapter.

Any Intel STD Plan benefits will run concurrent with any time off you may be eligible for under the Family and Medical Leave Act (FMLA) or any applicable State or local leave laws, or applicable Intel paid or unpaid leave, benefit plan, or program.

14.2.6 When Intel STD Plan Benefits Begin

- Intel STD Plan benefits are payable as of the first date of disability if certified by a Physician and your claim is approved by ReedGroup. You will be considered disabled for a full calendar day if you are unable to work any or all of your regularly scheduled workday.

- The date of disability and Intel STD Plan benefits cannot be delayed due to vacation, personal hours, or sick time that may be available to you.

14.2.7 Intel STD Plan Benefit Duration and Amount

Intel STD Plan benefits approximate your regular weekly earnings while on leave. The maximum Intel STD Plan benefit for any Disability Benefit Period is 52 times the applicable weekly rate. Disability Benefit Period means the continuous period of absence and disability beginning with the first day with respect to which you sustained a Disability and your claim has been approved.

If your STD claim is approved, you'll be paid through Intel payroll. Pay calculations may vary based on factors such as your normal work schedule, State mandated leave benefits, benefit deductions, and tax withholdings.

Earnings include your base salary, commission target, compressed workweek overtime, shift differentials and shift premiums on the day before your disability begins. Earnings do not include any compensation earned while you are not an eligible employee nor do they include any items of compensation which are not considered by Intel to be part of regular earnings, such as optional overtime, awards, bonuses (including relocation, APB, and QPB), and other differentials or allowances.

For weeks of disability less than a full week, your benefit will be calculated based on a variable percent of your weekly benefit rate. The variable percent is based on hours missed of your standard pay schedule.

The weekly Intel STD Plan benefit is reduced by Other Income Benefits described in the Reduction of Benefits provision below.

If you are terminated after starting a leave of absence and qualify for Intel STD Plan benefits, you may continue to receive such benefits provided your condition began before you were terminated and you otherwise meet the qualification for benefits under the Intel STD Plan.

14.2.8 Intel STD Plan Payment Schedule

If your STD claim is approved, your benefit payments will be issued on your regular pay date.

14.2.9 Other Intel Benefits - Benefit Continuation

Your regular benefit deductions and contributions will be taken from Intel Paid Leave and Short-Term Disability program payments that are paid through Intel payroll, provided you remain eligible, and consistent with the terms of the Intel benefit plans (e.g., medical, dental,

401(k), Employee Stock Purchase Plan). Except to the extent an Intel benefit plan or program permits, Intel paid leave and disability pay will not be considered part of your salary or earnings for purposes of calculating certain Intel benefits including, but not limited to, Quarterly Profit Bonus, pension, and will not count towards accruals of Personal Absence or Vacation.

14.2.10 Taxation

Intel Paid Leave and Intel STD Plan payments are subject to applicable Federal, State and local taxes and withholdings.

14.2.11 Reduction of Benefits

Benefit payments from the Intel STD Plan are reduced by other disability or Other Income Benefits you or your dependents receive, or are entitled to receive. Other Income Benefits include:

- Any wage or salary for any work performed at Intel, any other employer, or any new self-employment earnings earned on or after your first date of Disability, including commissions, bonus, overtime pay or extra compensation, excluding any payments made by Intel that are not Earnings.
- Any State mandated disability plan or Intel plan established in lieu thereof including the Intel Corporation California Voluntary Short-Term Disability Plan.
- Any Federal Social Security Act awards (primary and dependent) as a result of your disability.
- Any benefits you receive or are entitled to receive for workers' compensation or employer liability law of any State, or Federal government; such benefits shall include but not be limited to temporary disability and permanent disability payments (whether total or partial).
- Any and all settlements and judgments, as described under Right of Recovery section below.
- Any payments resulting of the act or omission of any person or entity whose action caused the disability regardless of whether the payments are from insurance or other sources and for any automobile no-fault wage replacement benefits to the extent available to you.

If you receive benefits from any type of individual disability insurance plan, your benefit amount payable under the Intel STD Plan will not be reduced by those benefits.

14.2.12 Applying for Social Security Disability Insurance

If your Disability Benefit Period lasts for more than 180 days, you may be required to apply for Social Security disability insurance (SSDI) and provide proof of filing within 30 days from date of application. If the Social Security Administration denies your eligibility for any such entitlement, you will be required to follow the process established by the Social Security Administration to reconsider the denial and, if denied again, to request a hearing before an Administrative Law Judge of the Office of Hearings and Appeals.

14.2.13 Reimbursements and Overpayments

You must sign and return the reimbursement agreement and any other required documentation from Reed Group.

If you receive an overpayment from the Intel STD Plan or Intel Paid Leave program or payroll, you will be required to repay Intel the full amount of the overpayment, including any overpayments due to benefits described in the Reduction of Benefits section.

14.2.14 Right of Recovery

If you receive a settlement or judgment related to your disability, the Intel STD Plan is entitled to a first-dollar basis recovery from ***any and all*** settlements or judgments, and is entitled to an automatic lien for that recovery. You must fully cooperate with the Intel STD Plan's efforts to recover benefits paid by providing all information requested by ReedGroup. You are also expected to notify ReedGroup within 30 days if you intend to pursue or investigate a claim to recover damages for your disability against a third party. Future payments under the Intel STD Plan may also be reduced by the amount of any and all settlements and judgments related to your disability.

14.2.15 If a Claim is Denied

If your Intel STD Plan claim is denied, you will be given a written notice with:

- The specific reasons for the denial;
- Discussion of the decision, including reasons for disagreeing with views of treating professionals, medical or vocational experts consulted, or Social Security Administration disability determination;
- Reference to specific Intel STD Plan provision(s) on which denial is based;
- The internal rules, guidelines, protocols, standards, or other similar criteria of the Intel STD Plan that were used in the adverse benefit determination, or a statement that such guidelines or criteria do not exist;
- If the denial is based on medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, or you will be provided the explanation free of charge upon request;
- A description of any additional information needed to perfect your claim and an explanation of why such information is necessary;
- A statement regarding your right to obtain relevant documents, as determined under applicable law;
- Information about the availability and how to access language services; and
- An explanation of the appeal procedures and time limits that apply.

If you disagree with how a claim was paid or denied under the Intel STD Plan, you may file an appeal. Under the Intel STD Plan, you must file an appeal with Reed Group within 180 days of the date of the written denial notice. The appeal must be signed by you, and must include your name, WWID, the name of your employer, and your reason for filing the appeal. If the denial is upheld on appeal, you have a right to bring a civil action under section 502(a) of ERISA up to 2 years from the date Reed Group notifies you of the appeal denial. If you would like more

information on the appeal process; see “Disability Appeals,” in *Pay, Stock and Benefits Handbook*, chapter 3.

14.2.16 Exclusions

No Intel STD Plan benefits are payable if any of the following is true:

- You are receiving benefits from other Intel Paid Leave programs including Intel Paid Family Leave or Intel Paid Bonding Leave.
- You qualify for benefits under the Intel Corporation Long-Term Disability Plan.
- You do not follow the advice and treatment plan of your treating Physician.
- You refuse modified work approved by your treating Physician.
- You receive, are entitled to receive, or make a claim for benefits under any statutory Unemployment Compensation Act.
- Your claim is for any illness that is diagnosed using non-conventional methods not in accord with generally accepted professional medical standards.
- You make a false statement or representation concerning your disability. (Disqualification is effective from the date that the disqualifying event took place.)
- You are incarcerated in a Federal, State, or municipal penal institution, jail, medical facility, hospital (public or private) or in any other place because of a criminal conviction of Federal, State, or municipal law or ordinance.
- Your disability is the result of an illness or injury caused by, or arising out of, the commission of, arrest, investigation, or prosecution of any crime that results in a felony conviction.
- If you are subject to termination due to misconduct, including but not limited to any conduct that may result in termination under any applicable employment guideline such as Intel’s Workplace Behavior/Discipline and Discharge guidelines.

14.2.17 Termination of Intel STD Coverage

Your coverage will terminate on the earliest of the following:

- The date you terminate employment.
- The date you are laid off.
- The date you cease to be an eligible employee.
- The date the Intel STD Plan terminates.

14.3 Intel Short-Term Disability Coverage in California - This summary is applicable to claims under the Intel California Voluntary Short-Term Disability Plan ("Intel CA-VSTD Plan") beginning on or after January 1, 2020

Topics

14.3.1 Eligibility

The State of California mandates that employees working in California participate in a Short-Term Disability (STD) plan that provides disability coverage for employees who take time off work due to their own disability, referred to as STD, or to care for a seriously ill family member, or to bond with a new child referred to as California Paid Family Leave (PFL).

Intel sponsors the Intel California Voluntary Short-Term Disability Plan (Intel CA-VSTD Plan in lieu of the Intel California state plan. If you work in California, upon hire or transfer into the State of California, you will automatically be enrolled in the Intel CA-VSTD Plan unless you request the California State Disability Insurance (CA-SDI). Keep in mind the CA-VSTD provides more generous benefits at no cost to you, while CA-SDI requires an employee contribution. Contact the Intel Health Benefits Center at (877) GoMyBen (466-9236) to make the request. The change between plans is effective the first day of the next quarter.

To provide you access to Intel's overall STD benefits intended to approximate your regular pay, California employees are eligible for coverage through both Intel's STD Plan (see Section 14.2) and the Intel CA-VSTD Plan.

14.3.2 California State Disability Insurance Contact

For information regarding the CA-SDI or to file a claim (if you are enrolled in the CA-SDI vs. the Intel CA-VSTD Plan), employees can visit http://www.edd.ca.gov/Disability or call the CA Disability Insurance (DI), Statewide Toll-Free Number at (800) 480-3287. For general information and questions, contact your local Employee Development Department office.

14.3.3 Disability Determination

You will be considered eligible for CA-VSTD benefits if any of the following apply:

- You meet the definition of disability: You are considered disabled and eligible for benefits under the Intel CA-VSTD Plan when you are unable to perform your regular and customary work because of physical or mental illness, injury, or a condition (including pregnancy related disability) that has been certified by a Physician.
    - Physician means any licensed medical professional practicing within the scope of his or her license and rendering care and treatment to you that is appropriate for the condition and locality. The term does not include you, your spouse, the immediate family (including parents, children, siblings or spouses of any of the foregoing, whether the relationship derives from blood or marriage), of you or your spouse, or a person living in your household.
- You have been ordered not to work by a medical authority because you are infected with, or suspected of being infected with, a communicable disease.
- In order to receive benefits for substance related disorders, you must be participating in an inpatient or intensive outpatient addiction recovery program.
- You adhere to the teachings of any bona fide church, sect, denomination, or organization, and depend for healing entirely upon prayer or spiritual means, and you receive a certificate from a duly authorized or accredited practitioner from such an organization and this practitioner provides the nature and estimated duration of your disability.

14.3.4 Successive Disabilities

A relapse of your condition (successive disability) separated by fewer than 60 consecutive calendar days of continuous active work on a full-time basis is considered one period of disability, unless the relapse disability is due to an illness or injury found by Intel to be unrelated to the cause of your original disability and it occurs/began after you return to work with Intel on a full-time basis.

14.3.5 Contributions

As of January 1, 2020, no contributions are required for the Intel CA-VSTD Plan.

14.3.6 How to File a Claim for Intel CA-VSTD Plan Benefits Due to Your Own Disability

You, your representative, or Intel's representative may initiate your claim for benefits with ReedGroup, Intel's CA-VSTD Plan Claims Administrator, by calling 1-866-532-5664 or on the web at https://intel.leavepro.com. ReedGroup will contact your health care provider to obtain medical information. Your claim application will be processed once ReedGroup receives all applicable medical information.

It is your responsibility to file your claim for STD benefits within 49 days following the first date of disability. ReedGroup may periodically request supplemental certification or information to support a claim for benefits. Your claim will not be accepted later than 49 days after the start of

your disability unless there are extraordinary circumstances beyond your control, as determined by, and at the sole discretion of, ReedGroup.

ReedGroup has the right to request an independent medical examination or other information necessary to determine qualification for benefits.

If you do not qualify for STD benefits**,** ReedGroup will send you a denial letter providing an explanation of denial and information on how to appeal. For more information about denials, see "If a Claim is Denied" in this chapter**.**

Any Intel CA-VSTD Plan benefits will run concurrent with any time off you may be eligible for under the Family and Medical Leave Act (FMLA) or any applicable State or local leave laws, or applicable Intel paid or unpaid leave, benefit plan, or program.

14.3.7 When Intel CA-VSTD Plan Benefits Begin

Benefits are payable as of the first date of Disability if certified by a Physician and your claim has been approved by ReedGroup.

You will be considered disabled for a full calendar day if, due to illness or injury, you are unable to work all or any portion of your regularly scheduled workday.

The date of disability and Intel CA-VSTD Plan benefits cannot be delayed due to vacation, personal hours, or sick time that may be available to you.

14.3.8 Benefit Duration and Amount

Intel CA-VSTD Plan benefits provide up to 70% of Earnings up to a maximum of the California workers' compensation temporary disability indemnity weekly benefit amount in effect at the commencement of disability. The maximum Intel CA-VSTD Plan benefit for any Disability Benefit Period is 52 times the applicable weekly rate.

Disability Benefit Period means the continuous period of absence and disability beginning with the first day with respect to which you sustained a disability for which you have filed a valid claim for benefits.

If your leave is approved, you'll be paid through Intel payroll. Pay calculations may vary based on factors such as your normal work schedule, State mandated leave benefits, benefit deductions, and tax withholdings.

Earnings include your base salary, commission target, compressed workweek overtime, shift differentials and shift premiums on the day before your Disability begins. Earnings do not include any compensation earned while you are not an eligible employee nor do they include any items of compensation which are not considered by Intel to be part of regular Earnings, such as optional overtime, awards, bonuses (including relocation, APB, and QPB), and other differentials or allowances.

For weeks of disability less than a full week, your benefit will be calculated based on a variable percent of your weekly benefit rate. The variable percent is based on hours missed of your standard pay schedule.

If you are disabled and you are working reduced hours, you may receive both earnings and STD benefits (Intel STD and Intel CA-VSTD) if the earnings combined with your STD payment are not more than your pre-disability Earnings.

If a benefit payable under the Intel CA-VSTD Plan would be less than the benefit payable under the CA-SDI, you will receive the higher CA-SDI benefit.

If you are covered under more than one California disability program, the liable plans equally share the liability for benefits.

If you are terminated after starting a leave of absence and qualify for STD benefits, you may continue to receive such benefits provided your condition began before you were terminated and you otherwise meet the qualification for benefits under the STD plans.

14.3.9 Intel CA-VSTD Plan Payment Schedule

If your STD claim is approved, your benefit payments will be issued on your regular pay date.

14.3.10 Other Intel Benefits - Benefit Continuation

Your regular benefit deductions and contributions will be taken from Intel paid leave and Short-Term Disability program payments that are paid through Intel payroll, provided you remain eligible, and consistent with the terms of the Intel benefit plans (e.g., medical, dental, 401(k), Employee Stock Purchase Plan). Except to the extent an Intel benefit plan or program permits, Intel paid leave and disability pay will not be considered part of your salary or earnings for purposes of calculating certain Intel benefits including, but not limited to, Quarterly Profit Bonus, pension, and will not count towards accruals of Personal Absence or Vacation.

You may change or terminate any of these deductions as allowed by law and Intel's benefit plan provisions. For additional information or to make changes, refer to the Impact to Benefits section of the Leave of Absence chapter in the Pay, Stock and Benefits Handbook, or contact Intel's Get HR Help at (800) 238-0486.

14.3.11 Taxation

Intel Paid Leave and STD payments are subject to applicable Federal, State and local taxes and withholdings.

14.3.12 Reimbursement and Overpayments

You must sign and return the reimbursement agreement and any other forms required by Reed Group.

If you receive an overpayment from the Intel CA-VSTD Plan or payroll, you will be required to repay Intel the full amount of the overpayment.

14.3.13 If a Claim Is Denied

If your Intel CA-VSTD Plan claim is denied, you will be given a written notice with the specific reasons for the denial, the controlling plan provisions, and an explanation of the review procedure.

If you disagree with how a claim was paid or denied under the Intel CA-VSTD Plan you may file an appeal. As a California participant, your appeal rights are governed by the State. Under California rules, you must file any appeals with the California Employment Development Department within 20 days of the date of the written denial notice. The appeal must be signed by you and must include your name, Social Security Number, the name of your employer, and your reason for filing the appeal. If you would like more information on the appeals process, see "Disability Appeals" in *Pay, Stock and Benefits Handbook,* chapter 3.

14.3.14 Exclusions

No benefits are payable if any of the following is true:

- You are receiving benefits from other Intel Paid Leave programs including Intel Paid Family Leave, Intel Paid Bonding Leave, or Intel CA-VPFL.
- You are receiving, or are eligible to receive, benefits under any Federal or State Unemployment Compensation Act.
- You are receiving, or eligible to receive, Disability benefits from any State (including CA) or from the Federal government.
- For any period of time that you would otherwise qualify for PFL benefits on a day that you are eligible to receive benefits for your own disability.
- For any days you are receiving wages as defined by CUIC Sections 926-940. However, you may receive wages plus disability benefits that do not exceed your regular weekly wage, excluding overtime pay, immediately prior to the commencement of your disability.
- For any days for which benefits are payable under a workers' compensation or employer liability law of California or any other State or the Federal government, for any of the following:

    a. Temporary disability benefits.
    b. Permanent disability benefits for the same injury of illness.
    c. A maintenance allowance, if you elected to receive the maximum permanent disability benefits.
    d. Benefits are payable for any difference between the benefits listed immediately above in a), b), or c) and the weekly benefit amount.

- You are incarcerated in a Federal, State, or municipal penal institution, jail, medical facility, or hospital (public or private) or in any other place because of a criminal conviction of Federal, State, or municipal law or ordinance.
- Your disability is the result of an illness or injury caused by, or arising out of the commission of, arrest, investigation, or prosecution of any crime that results in a felony conviction.
- You make a false statement or representation concerning your disability.

Disqualification is effective from the date that the disqualifying event took place.

14.3.15 Termination of Intel CA-VSTD Plan Coverage

Your coverage will terminate on the earliest of the following:

- Midnight on the date you terminate employment.
- Midnight on the 15th day following your commencement of a layoff.
- The date you cease to be an eligible employee.
- The date of your death.
- The date the Intel CA-VSTD Plan terminates. As of the beginning of the Calendar Quarter next following the date you give notice of your intention to withdraw from CA-VSTD.

14.4 California Paid Family Leave ("CA PFL") - This summary is applicable to claims for CA-PFL beginning on or after January 1, 2020

Topics

14.4.1 Overview

The State of California mandates that employees working in California participate in a Short-Term Disability (STD) plan that provides benefits for eligible California for employees who take time off work due to their own disability, referred to as STD (as described in Section 14.3 above), or to care for a seriously ill family member, or to bond with a new child referred to as California Paid Family Leave (PFL).

Intel sponsors the Intel California Voluntary Short-Term Disability (Intel CA-VSTD Plan) in lieu of the Intel California state plan to provides STD and PFL benefits.

CA PFL provides partial wage replacement for a maximum of eight weeks within a 12-month period.

CA PFL benefits are available for eligible California employees who take time off from work for the following reasons:

- To care for a family member with a serious health condition.
    - The person you are caring for must be your dependent child, parent, spouse, domestic partner or child of a domestic partner, grandparent, grandchild and sibling.
    - The doctor of the person in your care must provide certification of the serious health condition. Certification forms are available through the application process. Refer to "How to Apply for CA PFL Benefits" in this chapter. Intel may periodically request supplemental certifications or information to support a claim for benefits.
- To bond with a new child within 12 months of the birth, adoption, or foster care placement of the child.
    - The new child must be your biological child, adopted child, foster child, or the child of your domestic partner.

You may be required to provide documentation supporting your claim for CA PFL. The Intel CA-VSTD Plan provides STD and PFL benefits.

If you work in California, upon hire or transfer into the State of California, you will automatically be enrolled in the Intel CA-VSTD Plan unless you request the California State Disability Insurance (CA-SDI). Keep in mind the CA-VSTD provides more generous benefits at no cost to you, while CA-SDI requires an employee contribution. Contact the Intel Health Benefits Center at (877) GoMyBen (466-9236) to make the request. The change between plans is effective the first day of the next quarter.

14.4.2 When Benefits Begin

CA PFL benefits begin on the first day of the employee's approved absence for CA PFL.

14.4.3 Benefit Duration and Amount

Intel CA PFL benefits provide up to 70% of your Earnings up to a maximum of the California workers' compensation temporary disability indemnity weekly benefit amount in effect at the commencement of PFL. The maximum Intel CA PFL benefit for any PFL Benefit Period is eight times the applicable weekly rate. Note that you may also be eligible for supplemental benefits under Intel's Paid Family Leave program. See the Leaves chapter of the Pay, Stock and Benefits Handbook

PFL Benefit Period means a twelve-month period beginning with the first day of absence you establish a valid claim for PFL to care for a seriously ill family member, or to bond with child during the first year after the birth or placement of the child in connection with foster care or adoption.

Periods of family care leave for the same family member within a twelve-month period will be considered one PFL Benefit Period.

If your leave is approved, your benefit payments will be issued on your regular pay date. Pay calculations may vary based on factors such as your normal work schedule, State mandated leave benefits, benefit deductions, and tax withholdings. Earnings include your base salary, commission target, compressed workweek overtime, shift differentials and shift premiums on the day before your Disability begins. Earnings do not include any compensation earned while you are not an eligible employee nor do they include any items of compensation which are not considered by Intel to be part of regular earnings, such as optional overtime, awards, bonuses (including relocation, APB, and QPB), and other differentials or allowances.

For weeks of PFL less than a full week, your benefit will be calculated based on a variable percent of your weekly benefit rate. The variable percent is based on hours missed of your standard pay schedule.

If you take CA PFL and you are working, you may receive both earnings and PFL (CA-PFL and Intel Paid Family Leave) if the earnings combined with your PFL payments are not more than your regular earnings.

If you are covered under more than one California paid family leave program, the liable plans equally share the liability for benefits.

If you are terminated after starting a leave of absence and qualify for PFL benefits, you may continue to receive such benefits provided your leave began before you were terminated and you otherwise meet the qualification for benefits under the PFL plan.

14.4.4 Other Intel Benefits - Benefit Continuation

Your regular benefit deductions and contributions will be taken from Intel paid leave and Short-Term Disability program payments that are paid through Intel payroll, provided you remain eligible, and consistent with the terms of the Intel benefit plans (e.g., medical, dental, 401(k), Employee Stock Purchase Plan). Except to the extent an Intel benefit plan or program permits, Intel paid leave and disability pay will not be considered part of your salary or earnings for purposes of calculating certain Intel benefits including, but not limited to, Quarterly Profit Bonus, pension, and will not count towards accruals of Personal Absence or Vacation.

14.4.5 Taxation

Leave and disability pay is subject to applicable Federal, State and local taxes and withholdings.

14.4.6 Re-established Claims

A re-established claim occurs when there is an interruption of the period for which benefits are claimed for the same family member. Should an interruption occur, you may file to have the CA PFL re-established if the claim is subsequent to your first claim within the same 12-month period.

14.4.7 Contributions

As of January 1, 2020, no contributions are required for the Intel CA-VSTD Plan which also includes CA-PFL.

14.4.8 Exclusions and Limitations

No benefits are payable if any of the following apply:

- You are receiving benefits from other Intel disability plans including Intel Short-Term Disability Plan, Intel CA Voluntary Short-Term Disability Plan, or Intel Long-Term Disability Plan.
- You are receiving, or are entitled to receive, benefits under any Federal or State Unemployment Compensation Act.
- You are receiving, or eligible to receive, PFL benefits from any State (including CA) or from the Federal government.
- You are receiving, or are entitled to receive disability benefits for your own disability.
- You are incarcerated in a Federal, State or municipal penal institution, jail, medical facility, or hospital (public or private) or in any other place because of a criminal conviction of Federal, State, or municipal law or ordinance.
- If another family member is ready, willing, able and available for the same period of time in a day that you are providing the required care.
- You make a false statement or representation concerning your PFL. Disqualification is effective from the date that the disqualifying event took place.

14.4.9 Overpayment

If you receive an overpayment of CA PFL benefits under the Intel CA-VSTD Plan, you will be required to re-pay the overpayment to the Intel CA-VSTD Plan in full.

14.4.10 How to Apply for CA PFL Benefits

To apply for CA PFL, contact ReedGroup at https://intel.leavepro.com. Call ReedGroup at (866) 532-5664 or Outside U.S. (720) 490-4932 with PFL questions.

It is your responsibility to assure the claim for CA PFL benefits is filed. Claims must be filed within 49 days of the first day of your leave.

14.4.11 If a Claim Is Denied

If your CA PFL claim is denied, you will be given a written notice with specific reasons for the denial, the controlling plan provisions, and an explanation of the review procedure.

As a California participant, your appeal rights are governed by the State. Under California rules, you must file any appeals with the California Employment Development Department within 30 days from the date of the written denial notice. The appeal must be signed by you and must include your name, Social Security Number, the name of your employer, and your reason for

filing the appeal. The notice of the CA PFL claim denial will tell you how and where to submit your request for review. If you would like more information on the appeals process, see "Disability Appeals" in *Pay, Stock and Benefits Handbook*, chapter 3: Administrative Information.

14.4.12 Termination of CA PFL Coverage

Your coverage will terminate on the earliest of the following:

- Midnight on the date you terminate employment.
- Midnight on the 15th day following your commencement of a layoff.
- The date you cease to be an eligible employee.
- The date of your death.
- The date the Intel CA-VSTD Plan (which includes CA PFL) terminates.
- As of the beginning of the Calendar Quarter next following the date you give notice of your intention to withdraw from CA-VSTD (which includes CA PFL).

14.5 Intel Long-Term Disability Plan ("Intel LTD Plan") - This Summary Plan Description applies to claims with dates of disability (on the first day you are eligible to receive Intel STD benefits) beginning on or after January 1, 2020.

Topics

14.5.1 Overview

All U.S. general full-time and part-time employees are automatically covered under the Intel LTD Plan. Intel LTD benefits provide continuing income protection if your Disability continues for longer durations.

It is important to note that not all employees who qualify for STD benefits will qualify for Intel LTD benefits.

For information on how LTD will impact your Intel Benefits, review information found in the "Life Events Overview" in the *Pay, Stock and Benefits Handbook,* chapter 10.

14.5.2 Cost of Coverage and Taxation

Intel automatically provides LTD coverage and no contribution is required. The cost of coverage is calculated by multiplying the premium equivalent rate as determined by Intel, by your covered earnings. The cost of coverage is taxable to you and treated as imputed income and reported on Form W-2.

14.5.3 Long-Term Disability Determination

To qualify for Intel LTD benefits, you must satisfy the Elimination Period and be under the Regular Care of a Physician and meet all the other terms and conditions of the Intel LTD Plan. You must provide ReedGroup satisfactory proof of disability to qualify for Intel LTD benefits. ReedGroup requires continued proof of your disability for Intel LTD benefits to continue.

14.5.4 Elimination Period

You must be continuously disabled for the greater of the maximum benefit of any Intel-sponsored short-term disability plan, or 52 weeks (Elimination Period).

You will be considered disabled for a full calendar day during the Elimination Period if, due to illness or injury, you are unable to work all or any portion of your regularly scheduled workday.

In order to provide you with the opportunity to attempt to return to work, you are allowed a temporary recovery period. If you return to full-time active work for sixty (60) consecutive calendar days or less during the Elimination Period, this will be considered a temporary recovery, and those days of active work will not interrupt the Elimination Period. During a period of temporary recovery, you will not qualify for any change in rate of Covered Earnings. If you return to active work for more than 60 consecutive calendar days, you will start a new Elimination Period.

14.5.5 Definition of Disability/Disabled

You are considered disabled under the Intel LTD Plan if you are under the Regular Care of a Physician, have a greater than 20% loss in Covered Earnings, and:

- ReedGroup determines you are unable to perform the duties you are normally required to perform in your Regular Occupation due to an illness or injury. Your Regular Occupation is the occupation you routinely perform at the time the Disability begins. ReedGroup will consider the occupation as it is normally performed in the general labor market in the national economy.
- After Intel LTD benefits have been payable for 24 months, you are disabled if ReedGroup determines that due to the same illness or injury you are unable to perform the duties of any Gainful Occupation for which you are reasonably fitted by

education, training, or experience. Gainful Occupation is an occupation, including self-employment, that is or can reasonably be expected to provide you with an income that exceeds 65% of your monthly Covered Earnings within 12 months of returning to work.

    - Physician means a licensed medical professional practicing within the scope of his or her license and rendering care and treatment to you that is appropriate for the condition and locality. The term does not include you, your spouse/domestic partner, your immediate family (including parents, children, siblings or spouses of any of the foregoing, whether the relationship derives from blood or marriage), of you or your spouse, or a person living in your household.

- Regular Care means you personally visit a Physician(s) as frequently as is medically required to effectively manage and treat the condition(s) causing your disability; and you are receiving appropriate treatment and care which conforms with generally accepted medical standards for the condition(s) causing your disability; and you adhere to the treatment plan prescribed by the Physician, including taking medications.

The criteria for qualifying for Intel LTD benefits is different than Social Security Disability Insurance ("SSDI") and Workers' Compensation. Each are based on entirely different standards than determinations made under the Intel LTD Plan. Workers' Compensation, SSDI, and STD determinations, whether favorable or unfavorable, are not binding on the Intel LTD Plan.

14.5.6 How to Apply for Intel LTD Benefits

If you are currently receiving STD benefits, ReedGroup will mail you a packet around day 240 after your disability began. You may also request a packet directly from ReedGroup.

The LTD claim packet will include required forms and other important information. The completed forms must be sent to ReedGroup within 31 days of satisfaction of your Elimination Period and in accordance with the instructions in the LTD claim packet. Your claim will not be considered filed with the Intel LTD Plan until the forms are completed and submitted to ReedGroup. You are encouraged to include in your claim every diagnosis that may entitle you to Intel LTD benefits.

14.5.7 If a Claim is Denied

If your LTD claim is denied, you will be given a written notice with:

- The specific reasons for the denial;
- Discussion of the decision, including reasons for disagreeing with views of treating professionals, medical or vocational experts consulted, or Social Security Administration disability determination;
- Reference to specific Intel LTD Plan provision(s) on which the denial is based;
- The internal rules, guidelines, protocols, standards, or other similar criteria of the Intel LTD Plan that were used in the adverse benefit determination, or a statement that such guidelines or criteria do not exist;
- If the denial is based on medical necessity, experimental treatment, or similar

exclusion or limit, an explanation of the scientific or clinical judgment for the determination, or you will be provided the explanation free of charge upon request;
- A description of any additional information needed to perfect your claim and an explanation of why such information is necessary;
- A statement regarding your right to obtain relevant documents, as determined under applicable law;
- Information about the availability and how to access language services; and
- An explanation of the appeal procedures and time limits that apply.

If you disagree with how a claim was paid or denied under the Intel LTD Plan, you may file an appeal. Under the Intel LTD Plan you must file an appeal with ReedGroup within 180 days from the date of the written claim determination notice. Once the appeal process is complete and if the LTD denial is upheld on first level review, you may submit a written request for a second level review within 180 days following the receipt of your first level appeal determination notice. If the denial is upheld on appeal, you have a right to bring a civil action under section 502(a) of ERISA up to 2 years from the date you are notified the appeal denial is upheld on second level review. See Chapter 3 of the *Pay, Stock and Benefits Handbook*, Short-Term Disability (STD) or Long-Term Disability (LTD) Appeals for information on the appeals process.

14.5.8 Benefit Amount and Maximum Benefit Period Benefit Amount

The Gross Disability Benefit under the Intel LTD Plan provides the lesser of 65% of your Covered Earnings up to a maximum benefit of $20,000 per month.

If approved, benefit payments are made monthly after the Elimination Period has been met.

Covered Earnings include base salary, compressed workweek overtime, commission target, shift premium and shift differentials on the day before your Disability begins (the first day you are eligible to receive Intel STD benefits). Covered Earnings do not include any compensation earned while not an eligible employee nor do they include any items of compensation which is not considered by Intel to be part of regular earnings such as optional overtime, awards, bonuses (including relocation, APB and QPB), and other differentials or allowances.

14.5.9 Maximum Benefit Period

The duration of Intel LTD Plan benefits are based on your age at Disability, as summarized in the table below.

Age at Disability	Maximum Period of Disability Benefits Payments
Less than age 62	To your Social Security Normal Retirement Age
Age 62	60 months
Age 63	48 months
Age 64	42 months
Age 65	36 months
Age 66	30 months
Age 67	24 months

Age at Disability	Maximum Period of Disability Benefits Payments
Age 68	18 months
Age 69 or older	12 months

If you are terminated after starting a leave of absence and qualify for disability benefits, you may continue to receive such benefits provided your condition began before you were terminated and you otherwise meet the qualification for benefits under the disability plans.

14.5.10 When Intel LTD Benefits Are No Longer Payable

Benefits will end the earliest of the following:

- During the first 24 months of disability benefits, when ReedGroup determines that you are able to work in your Regular Occupation on a part-time basis allowing for your documented restrictions but you choose not to work
- After 24 months of disability benefits, when ReedGroup determines you are able to work in any Gainful Occupation on a part-time basis allowing for your documented restrictions, but you choose not to work;
- The day you no longer have a Covered Earnings loss of greater than 20%.
- The end of your Maximum Benefit Period.
- The date ReedGroup determines you are not disabled under the terms of the Intel LTD Plan.
- The end of the month in which you die.
- The date you are no longer receiving Regular Care.
- The date you decline to participate in a rehabilitation program ReedGroup considers appropriate for your situation, and approved by an independent physician.
- The date you fail to cooperate with ReedGroup in the administration of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

14.5.11 When Intel LTD Benefits Are Limited

Limited Benefit Period

If you are disabled primarily or exclusively due to Mental Illness and/or Self-Reported Symptoms, the Intel LTD Plan will limit your benefits to a lifetime maximum equal to the lesser of 24 months or the Maximum Benefit Period.

1. Mental Illness means a psychiatric or psychological condition regardless of cause, or substance related disorders. This limitation will not apply to a Disability resulting from schizophrenia, dementia, or organic brain disease. For purposes of this limitation, organic brain disease means a physiologic affliction or physical disease of the brain resulting in decreased mental functioning, rather than a psychiatric illness. For substance related disorders, you are required to participate in an addiction recovery program recommended by a Physician.
2. Self-Reported Symptoms means the manifestations of your condition which you tell your Physician, that are not verifiable using tests, procedures or clinical examinations standardly accepted in the practice of medicine. Examples of self-

reported symptoms include, but are not limited to, headaches, pain, fatigue, stiffness, soreness, ringing in ears, dizziness, numbness, and loss of energy.

Pre-Existing Condition Limitation

Benefits are not payable for any disability caused by, contributed by, or resulting from a pre-existing condition. You have a pre-existing condition if you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the three (3) months just prior to your first day of employment, and your disability began in the first 12 months after your first day of employment.

This limitation will not apply to a period of disability that begins after you have been continuously employed, without Disability, for at least 12 months.

Please see Section 14.8.15 for additional exclusions.

14.5.12 Reduction of Benefits

Benefit payments under the Intel LTD Plan are reduced by other disability or Other Income Benefits you or your dependents receive, or are entitled to receive. Other Income Benefits include:

- any amounts received (or assumed to be received*) by you or your dependents under:
  - the Canada and Quebec Pension plans;
  - the Railroad Retirement Act;
  - any local, State, provincial or Federal government disability or retirement plan or law, or Intel plan established in lieu thereof;
  - any work loss provision in "no-fault" auto insurance;
  - as otherwise set forth in the Intel LTD Plan.
  - any gross amounts received (or assumed to be received*) by you or your spouse and/or dependents due to disability or retirement because your disability under the United States Social Security Act, excluding attorney's fees related to obtaining such Social Security benefits.
  - any proceeds payable under any franchise or group insurance or similar plan. If other insurance applies to the same claim for disability, and contains the same or similar provision for reduction because of other insurance, the Plan Administrator will pay for its pro rata share of the total claim. "Pro rata share" means the proportion of the total benefit that the amount payable under one Plan, without other insurance, bears to the total benefits under all such policies.
- any amounts received (or assumed to be received*) by you or your dependents under any workers' compensation, occupational disease, unemployment compensation law or similar State or Federal law, or Intel plan established in lieu thereof, payable for injury or illness arising out of work with Intel, including all permanent and temporary disability benefits. This includes any damages, compromises or settlement paid in place of such benefits, whether or not liability is admitted.

Dependents include any person who receives (or is assumed to receive*) benefits under any applicable law because of your entitlement to benefits.

Benefits received from any individual disability insurance plan will not reduce the benefit amount payable under the Intel LTD Plan.

Amounts recovered from third parties or insurance by or on behalf of you (including for lost earnings or lost earning capacity), through settlement, judgment, arbitration or otherwise, are addressed below in the Right of Recovery section.

*** Assumed Receipt of Benefits**
ReedGroup will assume you (and your dependents, if applicable) are receiving benefits for which they are eligible from Other Income Benefits. ReedGroup will reduce your Disability Benefits by the amount from Other Income Benefits it estimates are payable to you and your dependents.

ReedGroup will waive Assumed Receipt of Benefits, except for Disability Earnings for work you perform while Intel LTD Plan benefits are payable, if you sign the reimbursement agreement required by ReedGroup and submits:

1. satisfactory proof of application for Other Income Benefits;
2. satisfactory proof that all appeals for Other Income Benefits have been made unless Reed Group determines that further appeals are not likely to succeed; or
3. satisfactory proof that Other Income Benefits were denied.

14.5.13 Reimbursements and Overpayments

You must sign and return a reimbursement agreement and any other forms required by ReedGroup.

If you receive an overpayment from the Intel LTD Plan or payroll, you will be required to repay Intel the full amount of the overpayment. ReedGroup may use any or all of the following to recover an overpayment of Intel LTD Plan benefits: request a lump sum payment of the overpaid amount, reduce any amounts payable under the Intel LTD Plan, and/or take any appropriate collection activity available.

14.5.14 Right of Recovery

If you receive a settlement or judgment related to your disability, the Intel LTD Plan is entitled to a first-dollar basis recovery from ***any and all*** settlements or judgments and is entitled to an automatic lien for that recovery. You must fully cooperate with the Intel LTD Plan's efforts to recover benefits paid by providing all information requested by Reed Group. You are also expected to notify ReedGroup within 30 days if you intend to pursue or investigate a claim to recover damages for your disability against a third party. Future payments under the Intel LTD Plan may also be reduced by the amount of any and all settlements and judgments related to your Disability.

14.5.15 Successive Periods of Disability

Once a period of disability has ended, any new period of disability will be treated separately. However, two (2) or more separate periods of disability due to the same or related causes will be deemed to be one period of disability and only one Elimination Period will apply if the periods are separated by less than six (6) months of continuous work and you will not qualify

for any change in rate of Covered Earnings. If you become covered under any other group long term disability plan, you will not be eligible for payments under this Intel LTD Plan.

14.5.16 Rehabilitation Program

You may be eligible to participate in a rehabilitation program. ReedGroup, in its sole discretion, will determine whether or not you are eligible for a rehabilitation program. As your claim is reviewed, medical and vocational information will be analyzed to determine an appropriate return-to-work program. Any rehabilitation program must be approved by ReedGroup for the purpose of helping you return to work. It may include participation in one or more of the following activities:

- return to work on a modified basis with a goal of resuming employment for which you are reasonably qualified by training, education, experience and past earnings;
- on-site job analysis;
- job modification/accommodation;
- training to improve job-seeking skills;
- vocational assessment;
- short-term skills enhancement;
- vocational training; or
- restorative therapies to improve functional capacity to return to work.

Return to Work Provision

During any month you work part-time, your benefits will be calculated as outlined below.

Your monthly Intel LTD Plan benefit will be calculated as follows during the first 12 months you work and receive Intel LTD Plan benefits:

1. Add your Gross Disability Benefit and Disability Earnings.
2. If the sum from 1. exceeds 100% of your Covered Earnings as of your first date of disability, then subtract your Disability Earnings from the sum in 1.
3. Your Gross Disability Benefit will be reduced by the difference from 2., as well as by any Other Income Benefits as outlined in section 14.4.12.
4. If the sum from 1. does not exceed 100% of your Covered Earnings , your Gross Disability Benefit will be reduced by any Other Income Benefits as outlined in 14.4.12.

After Intel LTD Plan benefits are payable for 12 months, the monthly benefit payable is the gross disability benefit reduced by any Other Income Benefits as outlined in 14.4.12, and 50% of Disability Earnings.

For this return to work provision, Disability Earnings means any wage or salary for any work performed for any employer or any new self-employment earnings earned on or after your first date of disability, including commissions, bonus, overtime pay or other extra compensation however, excluding any such payments made by Intel that are not Covered Earnings.

14.5.17 Exclusions

You are not entitled to receive Intel LTD Plan benefits if your disability arises out of, relates to, is caused by or results from any of the following:

- war or any act of war, declared or undeclared, insurrection, or rebellion.
- active participation in a riot.
- commission or attempted commission of a felony.
- the revocation, restriction or non-renewal of your license, permit or certification necessary to perform the duties of your occupation unless due solely to injury or illness otherwise covered.
- service in the military or armed forces of any non-U.S. country.

In addition, ReedGroup will not pay benefits for any period of disability during which you are incarcerated in a penal or correctional institution.

You may not knowingly, and with intent to injure, defraud or deceive ReedGroup, or provide any information, including filing a claim or appeal, that contains any false, incomplete or misleading information. These actions, as well as submission of materially false information, will result in denial of your claim or appeal, and are subject to prosecution and punishment to the full extent under State and/or Federal law.

Chapter 15
Life Insurance

Chapter 15
Life Insurance

This chapter provides important information on the Life Insurance benefits provided to you by Intel and outlines the additional dependent and supplemental coverage available for purchase.

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15. 1 Overview

Life insurance coverage is available for both you and your eligible family members. Intel pays the cost of your basic life and basic Accidental Death & Dismemberment (AD&D) insurance. You may supplement this basic coverage by purchasing additional amounts of coverage for yourself. You may also purchase dependent coverage for your spouse/domestic partner and eligible children. For a complete description of all Intel group life insurance plans, you can access the Certificate of Coverage for each plan online. From Circuit, search for “Life Insurance Forms”.

15.2 Basic Life Insurance

Topics

15.2.1 Overview

If you are a general full-time employee (GFT), part-time employee (PTE), Intel Contract Employee (ICE) or an intern, your basic life insurance is automatic and fully paid by Intel.

Your basic life insurance coverage* is equal to twice your eligible annual earnings rounded to the next higher $1,000. (See definition for eligible annual earnings below.) PTE basic life insurance coverage is prorated to 62.5 percent of your full-time equivalent eligible annual earnings rounded to the next higher $1,000. The maximum basic life insurance coverage amount is $2,000,000.

*Once you have reached age 70, coverage under the basic life plan is reduced. See “Age-Based Coverage Reduction” in this chapter for important information on coverage amounts.

15.2.2 Eligible Annual Earnings

Eligible annual earnings include base salary plus commission or Annual Performance Bonus (APB) targets. They do not include overtime, bonuses, shift premiums, or other adjustments to base pay. Any change to your basic life coverage or your supplemental life coverage due to a change in eligible annual earnings becomes effective on the date your eligible annual earnings change.

Example of Basic Life Insurance Coverage

If your eligible annual earnings are $56,200, your basic life insurance protection is $113,000 ($56,200 x 2 = $112,400, rounded to $113,000).

Example of PTE Basic Life Insurance Coverage

If your full-time equivalent eligible annual earnings are $56,200, your basic life insurance protection is $71,000 (($56,200 x 2) x 62.5% = $70,250, rounded to $71,000).

15.2.3 Will Preparation & Legal Services

As part of the basic life insurance coverage, you are eligible for will preparation & legal services including:

- Consultation with an attorney — You are entitled to a free 30-minute initial consultation, in person or over the phone, with an attorney in your state of residence. You may use the time to discuss pre-existing or future legal matters, or to have documents reviewed.
- Will preparation, financial power of attorney, living will and certain other legal document preparation.
- Receive referrals to local attorneys and mediators.
- Download legal forms — You can download certain legal forms, such as affidavits, collections forms, real estate forms, family and personal forms online at www.lifeworks.com. These forms are not legally valid and are intended to be "for your information." You are encouraged to use your initial attorney consultation to discuss your personal situation and receive proper advice.
- Access to a library of legal information and resources for your reference.
- Retain an attorney at a 25 percent discount — After your initial consultation, you may retain your network attorney and receive a 25 percent discount off the normal hourly rate. You are not obligated to retain your attorney, and if you don't feel comfortable with whom you were originally matched, you may request a referral to another attorney in your area.

To be matched with an attorney in your area, and for more information, please visit www.lifeworks.com or call 1-877-849-6034. Username: IntelWill, password: IntelPrep

15.2.4 When does Coverage Begin?

Basic life insurance is automatic and your coverage begins on the first day of employment. If you are absent from work on the day on which you would normally become insured, you will become insured on the day you begin active work**.**

15.2.5 When does Coverage End?

Basic life insurance ceases at midnight on the earliest of the following dates:.

- The last day of the month in which your employment with Intel ends.
- The date Intel terminates the plan as a benefit program. Plan termination will not affect any benefits payable prior to the termination date.

See section 15.6 Life Insurance Conversion and Portability for coverage options after leaving Intel

15.3 Supplemental Life Insurance

Topics

If you are a GFT or PTE, you may purchase additional life insurance on your own life at group rates.

15.3.1 Supplemental Plan Options

You may elect supplemental life coverage in increments from the amount of your eligible annual earnings up to seven times the amount of your eligible annual earnings. PTE supplemental coverage is prorated to 62.5 percent of full-time equivalent eligible annual earnings. The maximum supplemental life insurance coverage amount is $2,000,000. Coverage elections may be subject to evidence of insurability approval.

To help you determine your life insurance coverage needs, use the Life Insurance Estimator via the My Health Benefits web site at www.intel.com/go/myben > Life Changes > Other Life Changes > At will Life/AD&D Coverage Change (from drop down) > View/Change Employee Supplemental Life > Estimate Your Employee Supplemental Life Needs (under Tools and Calculations)

15.3.2 How Coverage is Calculated

Coverage is calculated by multiplying your eligible annual earnings by your elected coverage (1x to 7x), and then rounding to the next higher $1,000.

- **Example of Supplemental Life Insurance Coverage:** If your eligible annual earnings are $56,200 and you choose the 3x coverage plan, your supplemental coverage is $169,000 ($56,200 x 3 = $168,600, rounded to $169,000).

- **Example of PTE Supplemental Life Insurance Coverage:** If your full-time equivalent eligible annual earnings are $56,200 and you choose the 3x coverage plan, your supplemental life insurance protection is $106,000; ($56,200 x 3) x 62.5% = $105,375, rounded to $106,000.

15.3.3 Evidence of Insurability

Evidence of Insurability ("EOI") is a statement of your medical history that the insurance carrier uses to determine whether you are approved for coverage. The following table shows when your election requires EOI. The need for EOI depends on when you add or increase coverage, the coverage options you elect, or both.

Table: Coverage Election Requiring EOI Event	Timing	Plan Selection	EOI Required
New hire, rehire, or change from ICE/Intern to GFT/PTE, or change-in-status event (CSE) (e.g., birth or marriage)	Enrolling within 30 days of hire or classification change or CSE effective date (60 days for adding a child)	Elect plan 1x or 2x and coverage is <= $500,000	No
New hire, rehire or change from ICE/Intern to GFT/PTE, or change-in-status event (CSE) (e.g., birth or marriage)	Enrolling within 30 days of hire or classification change or CSE effective date (60 days for adding a child)	Elect plan 1x or 2x and coverage is > $500,000 **or** elect plans 3x to 7x	Yes
New hire, rehire or change from ICE/Intern to GFT/PTE, or change-in-status event (CSE) (e.g., birth or marriage)	Enrolling **after** 30 days of hire or classification change or CSE effective date (60 days for adding a child)	Elect any plan (1x to 7x)	Yes
At will	Enrolling or adding coverage at anytime	Elect any plan (1x to 7x)	Yes

Supplemental life insurance coverage options are 1x, 2x, 3x, 4x, 5x, 6x and 7x. When electing a level of coverage that requires EOI approval—that is, 3x through 7x—the system automatically

records 2x coverage. Once the EOI is processed and approved, the system updates your coverage to approved higher level.

15.3.4 When is Coverage Effective?

If you enroll within 30 days of becoming eligible, you are insured retroactively to the date of your eligibility (subject to EOI requirements). If you enroll in supplemental life insurance more than 30 days after you first become eligible, your coverage will be effective upon approval of your EOI by the life insurance company. If you are absent from work on the day on which you would normally become insured, you become insured on the day you return to active work. For more information, see "Late Enrollment" in the *Pay, Stock and Benefits Handbook*, chapter 5 "Health Benefits Enrollment".

15.3.5 When does Coverage End?

Supplemental life insurance ends on the last day of the month during which your employment with Intel ends. See section 15.6 for coverage options after leaving Intel.

You can drop or decrease coverage at will (at any time) via the My Health Benefits web site at www.intel.com/go/myben > Life Changes > Other Life Changes > At will Life/AD&D Coverage Change (from drop down)

15.3.6 Cost of Coverage

You pay the entire cost of supplemental life insurance. Premiums are based on your age and they are calculated per $1,000 of coverage. Premium information is available online via the *My Health Benefits* web site at www.intel.com/go/myben > Plan Information tile > + Plan Rates > Life Insurance Rates.pdf.

Note: Age banded rates used for the following year is based on the Date of Birth as of January 1 in the following year. For example, 2020 rates are based on your age as of 1/1/20. The annual enrollment election comparison will reflect January 1 age band rates if your date of birth is after annual enrollment and before January 1.

15.3.7 Minnesota Life Exclusions and Limitations

The supplemental plan does not cover a death due to either of the following:

- Suicide occurring within 24 months after your effective date of insurance
- Suicide occurring within 24 months after the effective date of any increases, other than salary increases. Your beneficiary will be paid the amount of insurance in effect the day before the increase.

15.4 Basic and Supplemental Life Insurance Provisions

Topics

15.4.1 Accelerated Death Benefit

If you are terminally ill and your life expectancy is less than 12 months, you may request up to 80 percent of your basic life and supplemental life (if enrolled) insurance coverage to be paid in advance. This allows you to make your own decisions about how to use your life insurance benefit. The remaining life insurance amount will be paid to your beneficiaries upon your death. For additional information on eligibility for the Accelerated Death Benefit, access the applicable Certificate of Coverage online. From Circuit, search "Life Insurance Forms". You may also call an Employee Services representative at (800) 238-0486 for more information or to request an Accelerated Death Benefit form.

15.4.2 Continued Coverage While on a Leave of Absence/Receiving Intel Disability Benefits

Basic life and supplemental life insurance continues during a leave of absence, whether the leave of absence is paid or unpaid leave.
If you qualify forIntel disability benefits, and are unable to return to work, the full amount of your life insurance—that is, basic life and any supplemental life election you have made—will be continued by Intel at no cost to you. This coverage will continue until you are no longer eligible for disability benefits or your date of termination of employment, whichever is later. While Intel is continuing your basic life and supplemental life coverage, you cannot also port or convert these coverages to individual policies. See section 15.6.

15.4.3 Age-Based Coverage Reduction

On January 1 following the year in which you reach age 70, coverage under the basic life plan is reduced. For example, suppose you turn 70 in May of 2019, your coverage will be reduced on January 1, 2020.

Table: Age-Based Coverage Reduction

Attainment of age:	Benefit* Reduced to:
70	70% of the benefit
75	45% of the benefit
80	30% of the benefit
85	15% of the benefit

*Benefit as referenced in the Age-Based Coverage Reduction table is the insured's pre-age-70 coverage amount.

Each time your prior coverage is reduced, you may convert the amount of basic life insurance you are losing to an individual policy. For additional information, see "Options When Life Insurance Coverage Ends."

For additional information, you can access the applicable Certificate of Coverage online. From Circuit, search "Life Insurance Forms," If you do not have access to Intel's intranet; call an Employee Services representative at (800) 238-0486.

15.5 Spouse/Domestic Partner Life Insurance and Child Life Insurance

Topics

15.5.1 Overview

If you are a GFT or PTE, you may purchase life insurance for your spouse/domestic partner or eligible child(ren).

An eligible spouse is defined as your lawful spouse who is not legally separated from you and who is not also eligible for insurance as an employee under the certificate to which this supplement is attached.

An eligible domestic partner is defined as someone with whom you are in a committed relationship, who is not eligible as an employee under the policy to which this rider is attached, and:

- Is 18 years old or older; and
- Is not related to you; and
- Has resided with you for longer than one year; and
- Shares mutual obligations of support for the basic necessities of life.

An eligible child is defined as your and your spouse/domestic partner's children, stepchildren, legally adopted children and foster children. Children are eligible from live birth (stillborn or unborn children are not eligible) to the attainment of age 26. For legally adopted children and foster children, eligibility begins at the time of placement with you or your domestic partner. Children age 26 or older are also eligible if they are physically or mentally incapable of self-support and were incapable of self-support prior to age 26.

If your spouse/domestic partner or child is an Intel employee, you may not purchase spouse/domestic partner or child life insurance for them. A dependent child may not be covered under the child life insurance by more than one employee.

15.5.2 Spouse/Domestic Partner and Child Life Insurance Options

You may cover your spouse/domestic partner under the Spouse/Domestic Partner Life Insurance or you may cover eligible dependent children under the Child Life Insurance. You may not cover your spouse/domestic parter or dependent child who is also an Intel employee.

Spouse/Domestic Partner Life Insurance Coverage Options: You may purchase life insurance coverage in the following increments: $20,000, $50,000, $100,000, $150,000, $200,000, or $250,000. Coverage elections may be subject to EOI approval (see "Coverage Election Requiring EOI for Spouse/Domestic Partner Life Insurance" table).

Spouse/domestic partner life coverage cannot exceed 100 percent of your combined basic and supplemental life coverage. For example, if you have $113,000 basic life coverage and $113,000 supplemental life coverage, the maximum amount of spouse/domestic partner life coverage you could purchase is $200,000 ($113,000 + $113,000 = $226,000).

You can drop or decrease Spouse/Domestic Partner and Child Life Insurance coverage at will (at any time) via the My Health Benefits web site at www.intel.com/go/myben > Life Changes > Other Life Changes > At will Life/AD&D Coverage Change (from drop down)

Table: Coverage Election Requiring EOI*
for Spouse/Domestic Partner Life Insurance

Evidence of Insurability ("EOI")*

Event	Timing	Coverage	EOI Required
New hire, rehire, or change from ICE/Intern to GFT/PTE, or change-in-status event (CSE) (e.g., birth or marriage)	Enrolling within 30 days of hire, classification change, or CSE effective date	Elect $20,000 or $50,000	No
New hire, rehire, change from ICE/Intern to GFT/PTE, or CSE (e.g., birth or marriage)*	Enrolling within 30 days of hire, classification change, or CSE effective date	Elect plan > $50,000	Yes
New hire, rehire, change from ICE/Intern to GFT/PTE, or CSE (e.g., birth or marriage)	Enrolling **after** 30 days from hire date or classification change	Elect any plan	Yes
At will	Enrolling or adding coverage at anytime	Elect any plan	Yes

***Note:** When electing a level of coverage that requires EOI approval, the system automatically records guarantee issue coverage. Once the EOI is processed and approved, the system updates your coverage to the approved higher level.

Child Life Insurance: You may purchase life insurance coverage in the following increments: $5,000, $10,000, $15,000, or $20,000. The monthly premium for the Child Life Insurance covers all eligible dependent children. Child Life Insurance coverage does not require EOI.

For additional information on change-in-status events, revew Chapter 5 of the Pay Stock and Benefits Handbook, Changing Benefits Elections.

15.5.3 When dose Coverage Begin?

If you elect Spouse/Domestic Partner Life 1 ($20,000) or Spouse/Domestic Partner Life 2 ($50,000) within 30 days of the dependent becoming eligible, your spouse/domestic partner becomes insured retroactively to the date of eligibility. If you elect Spouse/Domestic Partner Life 3 or greater, or you elect any coverage more than 30 days after your spouse/domestic partner first becomes eligible, you will be required to submit an EOI application, which requires approval by the life insurance company. Coverage is effective from the date the insurance provider approves your EOI application. For more information, see “Late Enrollment” in this chapter.

An employee’s newborn child is automatically covered for $10,000 for 30 days from the child’s live birth. To continue coverage, you must elect child coverage within those 30 days; otherwise the coverage will terminate at the end of the 30-day period.

If you elect child life coverage within 30 days of the dependent becoming eligible, your dependents are insured retroactively to the date of eligibility. If you elect child life coverage after 30 days of your dependent(s) becoming eligible, the insurance becomes effective as of the date of election.

15.5.4 When does Coverage End?

Spouse/Domestic Partner and Child Life Insurance coverage ends on the last day of the month during which your employment with Intel ends. See section 15.6 for coverage options after leaving Intel.

15.5.5 Coverage During a Leave of Absence

Spouse/Domestic Partner and Child Life Insurance coverage continues consistent with the terms of the insurance during a leave of absence, regardless of whether the leave is paid or unpaid leave. Your premiums for coverage will be deducted from any pay you receive. Upon return from leave or termination of employment, you will be required to reimburse Intel for any premiums Intel paid on your behalf. Failure to reimburse Intel may result in collection charges, including reasonable attorney's fees and may be grounds for termination.

15.5.6 Cost of Coverage

You pay the entire cost for dependent life insurance coverage through payroll deduction. The cost is a per-pay-period premium based on the coverage level you elect for the Spouse/Domestic Partner Life Insurance or the Child Life Insurance. Premium information is available online via the *My Health Benefits* web site at www.intel.com/go/myben > Plan Information tile > + Plan Rates > Life Insurance Rates.pdf.

Payroll reports imputed income (the difference between your payment for Spouse/Domestic Partner Life and the IRS determined standard cost) to the IRS as taxable income as required by the IRS.

15.5.7 Exclusions and Limitations

- The Spouse/Domestic Partner Life Insurance does not cover a death due to suicide occurring within 24 months of the initial effective date of insurance.
- The Spouse/Domestic Partner Life Insurance does not cover a death due to suicide within 24 months of the date any increases or additional insurance becomes effective for your dependent. As the beneficiary, you will be paid the amount of insurance in effect the day before the increase.
- The Child Life Insurance do not cover the death of a stillborn or unborn child. Coverage begins at live birth.

15.5.8 Options When Life Insurance Coverage Ends

When coverage ends under the Basic life insurance, supplemental life insurance, and the dependent life insurance, you may have an option to purchase coverage directly from the insurance provider without Evidence of Insurability (EOI).

15.6 Life Insurance Conversion and Portability

If your employment terminates or you retire, you will have options for continuing to be insured without providing Evidence of Insurability. Minnesota Life will mail portability and conversion details/options and paperwork to you at home. Elections must be made within 31 days of receiving the paperwork.

Only the coverage for which you were eligible and insured as an active employee is eligible for portability or conversion. Rates are higher than those paid by active employees.

Portability: You may continue to be insured under a term life contract as follows:

- Portability is an option for in-force: Basic Life, Supplemental Life, Spouse/Domestic Partner Life, Child Life and AD&D.
- Ported coverage terminates when you reach age 80 or your dependent's qualifying age (age 70 for spouse/domestic partner and age 26 for children). You or your dependents are not eligible to port coverage once you reach these ages.

- Your ported coverage reduces to 70% at age 70.
- The maximum amount of insurance that may be ported will be the amount in force at the time of your termination or retirement, but not to exceed more than $1,000,000.
- Rates continue to increase with age.

Conversion: You may convert your in-force term life insurance to an individual whole life policy as follows:

- Conversion is an option for in-force: Basic Life, Supplemental Life, Spouse/Domestic Partner Life and Child Life insurances. AD&D insurance is not convertible.
- There are no age or coverage maximums. Also, coverage doesn't decrease or terminate based on age.
- Rates are based on age at the time of conversion.

If you die without taking action to port or convert within the 31-day opportunity, your beneficiary will receive the full amount of your group insurance that was available for portability/conversion.

Full details, options, costs and election forms will be included in what Minnesota Life mails to you. You may also feel free to call Minnesota Life to discuss, (877) 494-1673.

For full details regarding the Portability and Conversion features of the contract, refer to the Term Life Insurance Certificate of Coverage. From Circuit, search "Life Insurance Forms".

15.7 Accidental Death and Dismemberment Insurance

Topics

15.7.1 Overview

Accidents are one of the leading causes of death among people under age 40. In addition to basic life insurance coverage, Intel pays the cost of your basic Accidental Death & Dismemberment (AD&D) insurance. Benefits are payable for death or serious physical loss that occurs within one year of an accident.

You may supplement this basic coverage by purchasing additional amounts of coverage for yourself. You may also purchase dependent AD&D coverage for your spouse/domestic partner and eligible children. If you and your spouse/domestic partner are both employees of Intel, you cannot cover each other under dependent AD&D. Dependent children cannot be covered twice if both parents are employees of Intel.

15.7.2 Benefits

A benefit is payable for death or losses resulting from bodily injuries sustained through accidental means as shown in the "AD&D Benefits" table. The loss must take place while you are insured and within one year of the accident.

15.7.3 Basic AD&D Insurance

If you are a GFT, PTE, or ICE or an intern, your basic AD&D insurance is automatic and fully paid by Intel. Your coverage begins on the first day of employment. If you are absent from work on the day that you would normally become insured, you become insured on the day you commence active work.

Your basic AD&D insurance coverage for accidental death (the maximum benefit amount) is equal to twice your eligible annual earnings rounded to the next higher $1,000. Part-time employee (PTE) basic AD&D insurance coverage is prorated to 62.5 percent of your full-time equivalent eligible annual earnings rounded to the next higher $1,000. The maximum basic AD&D insurance coverage amount is $2,000,000.

Eligible Annual Earnings

Eligible annual earnings include base salary plus commission or Annual Performance Bonus (APB) targets. They do not include overtime, bonuses, shift premiums or other adjustments to base pay.

Example of Basic AD&D Coverage

If your eligible earnings are $56,200, your basic AD&D insurance protection is $113,000 ($56,200 x 2 = $112,400, rounded to $113,000).

Other Basic AD&D benefits include the following:

Seatbelt/airbag benefit: If you die as a result of a covered private passenger vehicle accident while properly wearing a seatbelt or lap and shoulder harness, the plan pays an additional 10 percent of the principle sum of coverage (up to a maximum of $25,000) for the seatbelt benefit. An additional airbag benefit of 5 percent of the principle sum of coverage (up to a maximum of $12,500) is payable if the seatbelt benefit is payable and if you are positioned in the seat protected by a properly functioning, original, factory-installed supplemental restraint system that inflates on impact.

- **Comatose benefit:** If you lapse into a coma within 365 days of a covered accident, and the coma continues for seven consecutive days, the plan will pay a coma benefit of 1 percent of

your coverage amount every month, starting on the seventh day of the coma and continuing for 100 months.

- **Spouse/Domestic Partner education benefit:** If you die as a result of a covered accidental injury, the plan pays an additional benefit to your spouse/domestic partner if he or she enrolls in a professional or trade school program for obtaining an independent source of support and maintenance. The plan pays tuition up to maximum of $7,500 per academic year for up to 30 months up to a maximum of 15 percent of the full amount shown in the schedule of benefits. Enrollment in a qualifying program must occur within 12 months from the insured's date of death.

  Dependent Child Education Benefit: If you die as a result of a covered accidental injury, the plan pays an annual benefit on behalf of each child who, on the date of your death, is enrolled as a full-time student in an accredited college, university, or vocational school above the 12th grade level or who is at the 12th grade level and enrolls as a full-time student in an accredited college, university, or vocational school within 365 days of the date of your death. The plan pays tuition up to $7,000 per academic year for up to four consecutive years. Overall benefit maximum is 40 percent of the insured's amount of AD&D insurance.

  Disappearance Benefit: If your body has not been found after one year from the date the conveyance in which you were traveling disappeared, exploded, sank, became stranded, made a forced landing or was wrecked, it shall be presumed that you have died, and an additional benefit will be paid for your death.

  Child Care Benefit: If you die as a result of a covered accidental injury, the beneficiary will receive an additional benefit amount on behalf of each child enrolled in a qualified childcare center. The amount is equal to the lowest of these three amounts:

  - The actual cost charged by the childcare center per year
  - 20 percent of the insured's amount of insurance
  - $7,500

  This benefit is payable annually for up to four consecutive years, but not beyond the date the child reaches age 12. Enrollment must occur within 12 months from the date of the insured's death.

  HIV/ARC Benefit: If you suffer an accidental bodily injury while in the performance of your duties for your employer which causes you to acquire and test positive within one year of the accident for Human Immunodeficiency Virus (HIV) or Aids Related Complex (ARC), the benefit payable will be equal to 20% of your AD&D insurance in effect on the day of the accident and is paid in addition to any other benefit payable because of such accident. The employee must submit both a worker's compensation injury report and submit a blood test for HIV/ARC within 48 hours of the accident.

  Felonious Assault Benefit If you die or suffer a covered dismemberment as a result of a covered accident caused by felonious assault, the policy will pay an additional benefit equal to the lesser of $20,000 or 20% of the amount payable due to the death or dismemberment.

Hospital/Extended Care Facility Benefit: If you require hospitalization or extended care as a result of a covered accident, an additional benefit will be paid during such hospitalization or extended care facility stay. A monthly benefit of the lesser of $2,500 or 1% of your AD&D insurance will be paid after a five day waiting period, for up to 12 months**.**

Occupational Benefit: If you die as the result of a covered accident while performing your customary duties at your normal place of business or at other places you are required to travel, you will be paid an additional benefit equal to your amount of AD&D insurance.

Common Carrier Benefit: If you die as the result of a covered accident which occurs while you are a fare paying passenger on a common carrier vehicle, you will be paid an additional benefit equal to the amount of your AD&D insurance.

For additional information, see the applicable Certificate of Coverage online. From Circuit, search for "Life Insurance Forms;" if you do not have access to Intel's intranet; call an Employee Services representative at (800) 238-0486.

15.7.4 Supplemental AD&D Insurance

If you are a GFT or PTE, you may purchase additional AD&D insurance.

If you enroll within 30 days of becoming eligible, you are insured retroactively to the date of your eligibility. If you are absent from work on the day that you would normally become insured, you will become insured on the day you return to active work. If you enroll after 30 days of becoming eligible, you become insured as of the date you enroll.

You can elect supplemental AD&D coverage in increments of the amount of your eligible annual earnings up to seven times the amount of your eligible annual earnings rounded to the next higher $1,000. PTE supplemental AD&D insurance coverage is prorated to 62.5 percent of your full-time equivalent eligible annual earnings rounded to the next higher $1,000. The maximum supplemental AD&D insurance coverage amount is $1,000,000.

Examples of Supplemental AD&D Coverage

GFT: If your eligible annual earnings are $56,200 and you choose the 3x coverage plan, your supplemental AD&D coverage will be $169,000 ($56,200 x 3 = $168,600, then rounded to $169,000).

PTE: If your full-time equivalent eligible annual earnings are $56,200 and you choose the 3x coverage plan, your supplemental AD&D coverage will be $106,000. ($56,200 x 3) x 62.5% = $105,375, which is then rounded to $106,000.

Other supplemental AD&D benefits include:

Seatbelt/airbag benefit: If you, your insured spouse/domestic partner, or children die as a result of a covered private passenger vehicle accident while properly wearing a seatbelt or lap and shoulder harness, the plan pays an additional 10 percent of the principle sum of coverage (up to a maximum of $25,000) for the seatbelt benefit. An additional airbag benefit of 5 percent

of the principle sum of coverage (up to a maximum of $12,500) is payable if the seatbelt benefit is payable and if you, your spouse/domestic partner or children are positioned in the seat protected by a properly functioning, original, factory-installed supplemental restraint system that inflates on impact.

Comatose benefit: If you, your insured spouse/domestic partner or child(ren) lapses into a coma within 365 days of a covered accident, and the coma continues for seven consecutive days, the plan will pay a coma benefit of 1 percent of the insured's coverage amount every month, starting on the seventh day of the coma and continuing for 100 months.

Spouse/Domestic Partner education benefit: If you die as a result of a covered accidental injury, the plan pays an additional benefit to your spouse/domestic partner if he or she enrolls in a professional or trade school program for obtaining an independent source of support and maintenance. The plan pays tuition up to maximum of $7,500 per academic year for up to 30 months up to a maximum of 15 percent of the full amount shown in the schedule of benefits. Enrollment in a qualifying program must occur within 12 months from the insured's date of death.

Dependent Child Education Benefit: If you or your insured spouse/domestic partner die as a result of a covered accidental injury, the plan pays an annual benefit on behalf of each child who, on the date of your death, is enrolled as a full-time student in an accredited college, university, or vocational school above the 12th grade level or who is at the 12th grade level and enrolls as a full-time student in an accredited college, university, or vocational school within 365 days of the date of your or your insured spouse/domestic partner's death. The plan pays tuition up to $7,000 per academic year for up to four consecutive years. Overall benefit maximum is 40 percent of the full amount of the insured's amount of AD&D insurance.

Disappearance Benefit: If your body has not been found after one year from the date the conveyance in which you were traveling disappeared, exploded, sank, became stranded, made a forced landing or was wrecked, it shall be presumed that you have died, and an additional benefit will be paid for your death.

Child Care Benefit: If you or your insured spouse/domestic partner die as a result of a covered accidental injury, the beneficiary will receive an additional benefit amount on behalf of each child enrolled in a qualified childcare center. The amount is equal to the lowest of these three amounts:

- The actual cost charged by the childcare center per year
- 20 percent of the insured's amount of insurance
- $7,500

This benefit is payable annually for up to four consecutive years, but not beyond the date the child reaches age 12. Enrollment must occur within 12 months from the date of the insured's death.

HIV/ARC Benefit: If you suffer an accidental bodily injury while in the performance of your duties for your employer which causes you to acquire and test positive within one year of the accident for Human Immunodeficiency Virus (HIV) or Aids Related Complex (ARC), the benefit

payable will be equal to 20% of your AD&D insurance in effect on the day of the accident and is paid in addition to any other benefit payable because of such accident. The employee must submit both a worker's compensation injury report and submit a blood test for HIV/ARC within 48 hours of the accident.

Felonious Assault benefit: If you die or suffer a covered dismemberment as the result of a covered accident caused by felonious assault, the policy will pay an additional benefit equal to the lesser of $20,000 or 20% of the amount payable due to the death or dismemberment.

Hospital/Extended Care Facility benefit: If you require hospitalization or extended care as the result of a covered accident, an additional benefit will be paid to the insured employee during such hospitalization or extended care facility stay. A monthly benefit of the lesser of $2,500 or 1% of your AD&D insurance will be paid after a five days waiting period for up to 12 months**.**

Occupational benefit: If you die as the result of a covered accident while performing your customary duties at your normal place of business or at other places you are required to travel, you will be paid an additional benefit equal to your amount of AD&D insurance.

Common Carrier benefit: If you, your insured spouse/domestic partner or children die as the result of a covered accident which occurs while you are a fare paying passenger on a common carrier vehicle, you will be paid an additional benefit equal to the amount of your AD&D insurance.

For additional information, see the applicable Certificate of Coverage online. From Circuit, search for "Life Insurance Forms" if you do not have access to Intel's intranet; call an Employee Services representative at (800) 238-0486.

Cost of Coverage
You pay the entire cost of supplemental AD&D insurance. Premiums are calculated as a flat rate per $1,000 of coverage. Premium information is available online via the *My Health Benefits* web site at www.intel.com/go/myben.

Table: AD&D Benefits

Description of Loss	Percent of Maximum AD&D Benefit
Life	100%
Both hands or both feet or sight of both eyes	100%
One hand and one foot	100%
One hand or foot and sight of one eye	100%
Loss of speech and loss of hearing in both ears Sight of both eyes	100% 100%
Total and irreversible paralysis of four limbs (quadriplegia)	100%

Description of Loss	Percent of Maximum AD&D Benefit
Permanent Brain Damage	100%
Loss of one arm or one leg	75%
One hand or foot	50%
Loss of speech or loss of hearing in both ears	50%
Sight of one eye	50%
Total and irreversible paralysis of both lower limbs (paraplegia)	50%
Total and irreversible paralysis of both upper and lower limb on one side (hemiplegia)	50%
Total and irreversible paralysis of one limb (uniplegia)	25%
Loss of thumb and index finger on the same hand	25%

The maximum payable for any combination of losses from any one accident will not exceed 100 percent of the AD&D benefit amount.

15.7.5 Dependent AD&D Insurance

If you are a GFT or PTE, you may purchase dependent AD&D insurance for your spouse/domestic partner and eligible children from any of the plan options shown in "Table: Dependent AD&D Insurance." If your spouse/domestic partner or child has coverage as an Intel employee, he or she may not be enrolled as a dependent on your coverage. A dependent child may not be covered by more than one employee in the plan.
You can purchase dependent AD&D insurance from any of the plan options shown in the "Dependent AD&D Insurance" table.

Table: Dependent AD&D Insurance

Plan	Spouse/Domestic Partner	Each Child
A	$50,000	$10,000
B	$100,000	$20,000
C	$150,000	$30,000
D	$200,000	$40,000
E	$250,000	$50,000

15.7.6 Exclusions and Limitations

The basic, supplemental, and dependent AD&D plans do not cover losses resulting from any of the following:

(1) Physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity; or
(2) Infection, other than infection occurring in an external accidental wound; or
(3) Suicide or attempted suicide; or
(4) Intentionally self-inflected injury; or
(5) Any incident related to:
    - travel in an aircraft as a pilot, crew member, flight student or while acting in any capacity other than as a passenger
    - travel in an aircraft or device used for testing or experimental purposes
    - travel in an aircraft or devise designed for travel beyond the earth's atmosphere.
(6) Committing or attempting to commit a felony; or
(7) The voluntary intake or use by any means of:
    - any drug, medication or sedative, unless it is taken or used as prescribed by a physician; or
    - an over the counter drug, medication or sedative unless it is taken as directed; or
    - alcohol in combination with any drug, medication, or sedative; or
    - poison, gas, or fumes; or
(8) War, whether declared or undeclared; or act of war, insurrection, rebellion or riot; or
(9) If the insured person is involved in an incident where he or she is the operator of a vehicle or other device and this person's blood alcohol level met or exceeded the level that creates a legal presumption of intoxication under the law of the jurisdiction in which the incident occurred.

15.7.7 AD&D Coverage During a Leave of Absence

AD&D Insurance coverage continues consistent with the terms of the insurance during a leave of absence, regardless of whether the leave is paid or unpaid leave. Any premiums for Supplemental AD&D or Dependent AD&D coverage will be deducted from any pay you receive. Upon return from leave or termination of employment, you will be required to reimburse Intel for any premiums Intel paid on your behalf. Failure to reimburse Intel may result in collection charges, including reasonable attorney's fees, and may be grounds for termination.

15.7.8 Options When AD&D Coverage Ends

Basic and supplementation Accidental Death & Dismemberment (AD&D) and dependent AD&D insurance ends on the last day of the month during which your employment with Intel ends.

When coverage ends under the basic, supplemental, and dependent AD&D plans, you may have options to purchase coverage directly from the insurance provider.

Basic, Supplemental, and Dependent AD&D Insurance Portability

If your employment terminates, you retire, or your employment status changes to an ineligible classification (e.g., ICE or intern), you may be eligible for portable basic, supplemental, or dependent AD&D insurance coverage) at group rates. You are not eligible for portable coverage if you are an employee age 80 or older or spouse/domestic partner age 70 or older. Upon losing coverage, Minnesota Life will mail you the information and the forms you need to port your coverage. You must apply within 31 days of the date that your coverage is terminated due to one of these three events or 31 days from the date on the packet from Minnesota Life.

For important details on supplemental and dependent AD&D insurance portability, including eligibility, coverage and premium rates, refer to the applicable Certificate of Coverage. From Circuit, search "Life Insurance Forms". For portability rate information and an application, contact Minnesota Life at (877) 494-1673.

15.8 Business Travel Accident Insurance

Topics

15.8.1 Overview

Intel provides Business Travel Accident (BTA) insurance for all active general full-time employees (GFT), part-time employees (PTE), Intel Contract Employees (ICE), and interns, both U.S. and international. This coverage is in addition to basic life and basic AD&D insurance provided to eligible employees. The amount of your BTA is equal to five times your eligible annual earnings rounded to the next higher $1,000. PTE BTA insurance coverage is prorated to 62.5 percent of your full-time equivalent eligible annual earnings. BTA insurance is subject to a $1 million maximum.

The maximum amount payable to all Intel employees involved in an accident is $30 million (the aggregate limit per covered accident). This amount is distributed proportionately among the persons entitled to receive benefits.

This handbook is a brief description of the important features of the insurance plan. It is not a contract of insurance. In case of a conflict between the terms contained here and the terms contained in the Policy, the Policy will govern. The Policy is located in My Health Benefits, under Plan Information/Certificates of Coverage.

15.8.2 Eligible Annual Earnings

Eligible annual earnings include base salary plus commission or Annual Performance Bonus (APB) targets. They do not include overtime, bonuses, shift premiums, or other adjustments to base pay. Any change to your BTA coverage due to a change in eligible annual earnings becomes effective on the date of your eligible annual earnings change.

15.8.3 Benefits

A benefit is payable for losses resulting from bodily injuries sustained through accidental means while on Intel business travel or work-related errands. The loss must take place while insured and within one year of the accident.

BTA provides additional benefits under certain conditions and for consequences involved when a covered death or loss occurs. These additional benefits include, but are not limited to, conditions such as use of seatbelts and airbags, airline hijacking and carjacking, need for bereavement and trauma counseling following a death or loss, needs for alternative commuting, home alteration, and vehicle modification provisions. For additional information, see the applicable Certificate of Coverage online. From Circuit, search for “Life Insurance Forms.” If you do not have access to Intel's intranet, call an Employee Services representative at (800) 238-0486.

15.8.4 Exclusions and Limitations

BTA does not cover loss resulting from any of the following:

- Intentionally self-inflicted Injury
- Suicide or attempted suicide
- War or any act of war, whether declared or not
- A Covered Accident that occurs while on active duty service in the military, naval or air force of any country or international organization. Upon Our receipt of proof of service, we will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days
- Sickness, disease, bodily or mental infirmity, bacterial or viral infection, or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food
- Piloting or serving as a crewmember in any aircraft (except as provided by the Policy)
- Commission of, or attempt to commit, a felony
- The Covered Person being legally intoxicated as determined according to the laws of the jurisdiction in which the Injury occurred
- Riding in any aircraft except as a fare-paying passenger on a regularly scheduled or charter airline (except as provided by the Policy)
- Injury or loss contributed to the use of any drug or narcotic, except as prescribed by a doctor

15.8.4.1 Table: Business Travel Accident Benefits

Description of Loss	Percent of Maximum Benefit
Life	100%
Both hands or both feet or sight of both eyes	100%
One hand and one foot	100%
One hand or foot and sight of one eye	100%
Speech and hearing in both ears	100%
Total and irreversible paralysis of four limbs (quadriplegia)	100%
Heart Failure	100%
Permanent Brain Death	100%
Total paralysis of the upper and lower limbs on one side (hemiplegia)	75%
Total paralysis of both lower limbs or both upper limbs (paraplegia)	75%
One hand or foot	50%
Speech or hearing in both ears	50%
Sight of one eye	50%
Total and irreversible paralysis of both lower limbs (paraplegia)	50%
Total and irreversible paralysis of both upper and lower limb on one side (hemiplegia)	50%
Thumb and index finger on same hand	25%

Note: For paralysis, a doctor must determine the loss of use to be complete and not reversible at the time the claim is submitted.

15.8.5 When does BTA Coverage Begin?

Business Travel Accident (BTA) Insurance is automatic and becomes effective on your hire date.

15.8.6 When does BTA Coverage End?

Business Travel Accident (BTA) insurance ceases at midnight on the earliest of the following dates:.

- The last day of the month in which your employment with Intel ends.
- The date Intel terminates the plan as a benefit program. Plan termination will not affect any benefits payable prior to the termination date.

15.9 Beneficiary Information for Payment of Insurance Benefits

Topics

15.9.1 Overview

You are the beneficiary of your dependents' life insurance and AD&D insurance. If you are not living at the time of the death of an insured dependent, payment goes to your estate.

You have the opportunity to designate life insurance beneficiaries for each of your insurance plans. These choices include plans for your Intel-provided insurance (basic life, AD&D, and BTA), as well as any additional supplemental plans you may have elected (supplemental life and supplemental AD&D).

Beneficiary information for all benefit programs is confidential. In the event of your death, Intel will provide the last beneficiary designation of record to the life insurance company.

15.9.2 Beneficiary Designations

In the event of your death, for your life, AD&D and BTA insurance benefits are paid to your designated beneficiaries. You may designate one or more beneficiaries to receive life insurance and accidental death and dismemberment payments. Your beneficiary can be one or more individuals, a trust, an estate, or a charity. If one of your primary beneficiaries dies before you, the beneficiary's share is divided equally among surviving primary beneficiaries. You may also name one or more secondary beneficiaries to receive benefits if no primary beneficiary survives you.

Primary and secondary sums must each equal 100 percent on all plans. Accordingly, when designating multiple primary beneficiaries, the percentages must add up to 100 percent for each plan type; the same applies to multiple secondary beneficiaries.

To designate your beneficiaries, go to the *My Health Benefits* web site at www.intel.com/go/myben**.**

Note: As of September 1, 2015, any Life Insurance beneficiary designation(s) made prior to January 1, 2007 will not be valid due to prior tools being replaced. You must designated your beneficiaries through the *My Health Benefits* web site at www.intel.com/go/myben**.**

If you have not designated beneficiaries or there is no designated beneficiary living at the time of your death, benefits are paid to your surviving family members in the following order:

- Lawful spouse*
- Natural or legally adopted child or children—shared equally among survivors or paid to the sole survivor

- Parents— shared equally or paid to the sole survivor
- Sisters or brothers—shared equally among survivors or paid to the sole survivor
- Estate of the insured

*A domestic partner is only eligible if he or she is insured under the policy as a domestic partner at the time of the employee's death.

The insurance provider will provide your beneficiary the option to have the money auto deposited or a lump sum check mailed to them.

The insurance provider has the right to recover any overpayments due to fraud or processing errors.

You can view, add, or change your beneficiary information as often as you wish by accessing your information online via the *My Health Benefits* web site at www.intel.com/go/myben.

Note: Intel retirement plans require a separate beneficiary designation; contact Fidelity Investments at (888) 401-7377 or visit the NetBenefits web site at www.401k.com and see "Beneficiaries."

15.10 Absolute Assignment

You may elect to permanently transfer the benefit ownership of your basic and supplemental life, basic and supplemental AD&D, and BTA insurance policies. This plan feature is most useful for estate planning. If you have questions regarding estate planning or setting up a trust, you should seek assistance from either a tax consultant or legal advisor. If you would like to transfer the benefit ownership of the policy permanently, you must notify Minnesota Life (Life and AD&D) by completing an Absolute Assignment form. On Circuit, search for "Absolute Assignment" or "Life Insurance Forms."

After completing the Absolute Assignment process, your beneficiary of record on the *My Health Benefits* web site at www.intel.com/go/myben becomes the beneficiary named on your Absolute Assignment form.

15.11 Filing a Claim

To initiate the processing of a claim, you need a claim form and proof of claim. In some cases, you need additional proof of loss or death. You can request a claim form by calling an Employee Services representative at (800) 238-0486.

Proof of claim means proof of the cause of death (normally a certified copy of the death certificate) or in the case of dismemberment, a proof of loss. Proof of claim is provided at the claimant's expense. In some cases, the claimant must give the insurance carrier authorization to

obtain additional medical and non-medical information as part of the proof of claim. The insurance carrier will deny the claim if the appropriate information is not submitted or authorized.

In the case of death, the insurance carrier has the right and opportunity to request an autopsy, unless forbidden by law.

You or your beneficiary should initiate the claim as soon as possible, so that a claim decision can be made in a timely manner. You must submit the claim form and proof of claim no later than 90 days after date of death or date of other loss. If it is not possible to give proof within this time, you must give it no later than one year after the proof is required. These time periods will not apply during any period you or your beneficiary lacks the legal capacity to give insurance carrier proof of claim.

In the event that the claim is denied, you may submit an appeal to Minnesota Life. Please refer to the appeals process in chapter 3, Administrative Information.

Chapter 16
Pay and Bonuses

Chapter 16
Pay and Bonuses

This chapter contains an overview of pay and bonuses for Exempt and Non-Exempt employees, including annual pay and differentials as well as bonus pay (Annual Performance Bonus (APB) and Quarterly Profit Bonus (QPB)). Base pay and bonuses make up a significant portion of an employee's total rewards package.[1]

16.1 Overview

The primary elements of an employee's pay are base pay and variable pay in the form of cash bonuses. Intel shares its success with employees by offering two bonuses, the Annual Performance Bonus (APB) and the Quarterly Profit Bonus (QPB).[2] Commissioned sales employees receive commissions instead of the APB. The total pay employees receive from year to year varies based on individual targets and Intel's business performance. Generally, the better the company performs, the better the variable bonus pay (APB and QPB). Additional forms of pay may be available based on employee's work schedule.

16.2 Base Pay Overview

Intel regularly benchmarks against top companies in the tech industry to make sure that base pay is competitive in order to provide a strong financial foundation for employees. Multiple factors are considered when determining base pay for a given employee performing a specific job, such as:

- How much competitor companies generally pay for the job. This is strongly influenced by marketplace supply and demand.
- The location of the job and the cost of labor.
- The responsibilities and scope of the job or grade level.
- Compensation for other Intel positions that require substantially similar work, when viewed as a composite of skill, effort and responsibility performed
- The individual employee's relevant education, skill, experience, and, for current employees, job performance

Each job, grade, and location combination is assigned a pay range that consists of a minimum, midpoint (target), and maximum. Pay ranges are reviewed annually and updated as appropriate.

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[1] In the Workday system, exempt and non-exempt employees are referred to respectively as "Salaried" and "Hourly" employees.

[2] Subject to local law, Intel may change the components of compensation offered to employees at its discretion, and as explained in this handbook and any other relevant policies and communications.

In the U.S., as required by federal and state labor laws, all employees are classified as being either exempt or non-exempt from overtime rules under federal and state wage and hour laws.

16.3 Base Pay Ranges

Base Pay Ranges represent Intel's determination of the appropriate compensation based upon the factors identified in Section 16.2, above. Multiple jobs that are paid similarly in the market will be grouped together in the same Intel Pay Range. An employee's job code, grade and country/location determine their Pay Range, which are reviewed annually and updated to incorporate changes in market movement. Managers are responsible for ensuring job codes are accurate and up-to-date, and using Pay Ranges to help guide pay decisions.

Pay range assignment in the U.S. is dependent upon the employee's work location. Employees must physically work at their Intel designated site (or with Intel customers) more than 50% of their regular schedule. Additionally, for U.S. employees on a temporary assignment, pay range assignment will be based on the home Intel site. Employees must not use Intel funding or travel resources (i.e. Intel Shuttle) to get to their designated Intel site.

Managers can see the Pay Range for each of their current employees by opening the Base Pay Comparisons Report (BPCR) or they can look up the Pay Range based on the employee's country and grade in the Compensation Reference Tool (CRT)

Employees can see their current pay range, plus job code, and value of their total pay package on the Pay Modeling Application on Circuit, or can contact Get HR help.

16.4 Pay Increases

Intel believes in market competitive pay and pay for performance. There are two key steps to the process. First, Intel provides managers with an annual cash increase budget based on average wage movement data compiled by external survey companies. Second, managers distribute pay increases based on their assessment of each individual's performance, how their performance compares to that of their peers, and their position in the pay range for their job.

Review of employee pay, and compensation adjustments generally occur once a year through the Annual Rewards Planning process.

16.5 Pay Practices

16.5.1 Call-In Pay

Non-Exempt Employees
Non-Exempt employees receive Call-In pay when they are called into work, at Intel's direction and with less than 24 hours' prior notice, on a day the employee is not scheduled to work. A non-Exempt employee called into work in this situation will receive the following:

- Pay for one-half of their regular shift at their base rate or pay for the actual time worked, whichever is greater. If applicable state law requires a greater payment, Intel will comply with applicable state law.
- Overtime pay, if applicable, depending on the overtime requirements that govern the employee's work site. See Overtime Pay in the "Non-Exempt Classification Compliance Guidelines" section of this chapter. Employees should use the Call-In payroll code.

An employee who performs requested call-in work from home or does not report into work after being called will not receive Call-In pay. An employee who performs work from home will not receive Call-in pay but will receive pay for actual time worked. Under those circumstances, the employee should report this time as actual time worked and will be paid for all hours worked at the applicable base rate or overtime rate.

Except as otherwise required by applicable law, if the employee receives 24 hours prior notice or is on-call under the terms of Intel's On-Call pay practice, they will not receive Call-In pay, but may be eligible for Sent-Home Pay.

For exceptions to the Call-In pay practice, see "Exceptions to Call-In," "Called-Back," and "Sent Home Pay" in this chapter.

Exempt Employees

Exempt employees are not eligible for Call-In pay. If the nature of the work requires an exempt employee to work additional hours or days on a continual basis, the manager has the discretion to offer compensatory time off.

For additional information on compensatory time, see "Compensatory Time Off" in this chapter.

16.5.2 Called-Back Pay

Non-Exempt Employees
Non-Exempt employees receive Called-Back pay when, at Intel's direction, they return to work for a second time in one workday after completion of their regular shift. A non-exempt employee called back to work in this situation receives the following unless greater payments are required by applicable state law:

- A minimum of two hours of pay at the employee's base rate or for the actual time worked, whichever is greater
- Overtime pay, if applicable, depending on the overtime requirements that govern the employee's work site. See "Overtime Pay" in this chapter

An employee who performs work from home will not receive Called-Back pay but will receive pay for actual time worked. Under those circumstances, the employee should report this time as actual time worked and will be paid for all hours worked at the applicable base rate or overtime rate.

Employees should use the Called-Back payroll code. For exceptions to the Called-Back pay practice, see "Exceptions to Call-In," "Called-Back," and "Sent Home Pay" in this chapter.

Exempt Employees
Exempt employees are not eligible for Called-Back pay. If the nature of the work requires an employee to return to work on a continual basis, the manager has the discretion to offer compensatory time off. For additional information on compensatory time, see "Compensatory Time Off" in this chapter.

16.5.3 On-Call Pay

What Is On-Call Status?
For business reasons, employees may be required to be available, or on-call, during normally scheduled time off. An employee is on-call under these practices if his or her manager reaches a specific arrangement with the employee that places the employee on-call for a particular period of time. On-call assignments must be documented by completing the On-Call Notice Agreement to ensure understanding and avoid confusion. Generally, the arrangement between the manager and employee should establish:

- The hours and days the employee will be on-call and any modifications to that schedule.
- The expected response times. The response time rules differ depending upon whether an employee is exempt or non-exempt (hourly).
- While on-call, non-exempt employees are expected to respond to a call or message within 30 minutes. Managers must allow a minimum of 30 minutes to respond. If an employee is required to report to work, in general, the goal is to begin work within one-hour, measured from the point of response to the call. The Company understands that, in some cases, the employee may not be able to meet the one-hour response time, in which case, arrangements should be

made in advance with their manager. However, if contacted, an employee cannot decline to provide the requested assistance altogether.
- The employee must be accessible to the work site by cellular phone. If the employee does not have a cellular phone, Intel will provide one to the employee while on-call.
- The employee shall remain free from the influence of illegal drugs or alcohol while on-call.
- If business necessitates, the employee may be required to log on to a computer or the Intel network or may be required to report to the work site. The employee will be allowed a reasonable period of time to get to a place where he or she can log on and/or reach the site, consistent with the response time rules described above.
- With prior approval from the employee's manager, the employee may trade on-call responsibility with a qualified, available coworker.
- Employees will have no restrictions on their time or activities beyond these basic guidelines while on-call.
- As described below, for non-exempt employees, on-call time will be paid to the employee according to the On-Call pay practice. Exempt employees do not receive guaranteed pay for on-call time, but as described below, may be eligible for discretionary payments.

On-Call Notice Agreements must be promptly updated when on-call assignments change.

What Is Not Considered On-Call

Examples of situations where employees are not considered on-call (and are ineligible for On-Call pay under this guideline) include the following:

- Employees who choose to carry a cellular phone but have not been requested to be on-call by their manager, even if they are called on the phone while away from work. Non-Exempt employees should report the time spent responding to calls by their manager as actual hours worked.
- Employees who are part of a call tree where, by definition, if the employee is not available to respond to a call, the caller moves on to the next employee on the list. If, as part of the call tree, non-exempt employees actually perform work, they must record the hours worked and will be paid that time at the applicable base or overtime rate, but will not receive On-Call pay.

On-Call Notice Agreement

On-call assignments (whether exempt or non-exempt) should be documented by the employee's manager using the On-Call Notice Agreement. Unless the employee has been told by his or her manager, in writing, that the employee is on-call, then the employee is not on-call, and is not entitled to On-Call pay under this practice. Access the On-Call Notice Agreement on Circuit.

How On-Call Time Is Paid

Non-Exempt Employees
Non-Exempt employees will be paid for all hours worked, whether responding to a question over the phone or addressing a problem by computer from home (or other location).

Also, subject to the restrictions described below, non-exempt employees required to be on-call will be paid one hour of base pay for every eight hours on-call. This amount is equivalent to paying 12.5 percent of the base hourly rate for every hour on-call.

See tables below for examples:

On-Call Shift	Number of Straight-Time Hours Paid
8	1.00 hour of pay
10	1.25 hours of pay
12	1.50 hours of pay
16	2.00 hours of pay
20	2.50 hours of pay
24	3.00 hours of pay

Employees will code their time cards with the actual hours spent on-call and separately track the actual hours (if any) that are worked while on-call. Specifically this means that an employee should not record the same time as being both on-call and hours worked. Non-Exempt employees should report the time spent responding to a page or call as actual time worked.

Coordination with Other Nonexempt Pay

Other Non-Exempt Pay

An employee's entitlement to Call-In, Called-Back and On-Call pay are coordinated. A non-exempt on-call employee who must report to work or who must work from home will be paid for actual hours he or she works, but those actual work hours are not also counted as On-Call hours. Hours that qualify for Call-In or Called-Back pay also are not counted as On-Call hours. For example, if a non-exempt employee who is on call must report to work, the employee will be eligible for Call-In pay if the work time is less than one-half of the employee's usual day's work, up to a maximum of 4 hours. The employee will also be eligible for On-Call pay for those hours the employee was on-call, but did not work. And if the employee is called back to work from on-call status a second time in the same day, the employee will be eligible for Called-Back pay if the second work period is less than two hours. Additional examples:

Example one:
A non-exempt employee is on-call for an eight-hour shift per the On-Call Notice Agreement. During the on-call shift, the employee returns to work for two hours. The employee will record two hours of actual work time. The Employee should also record, two hours of Call-In Pay and four hours for On-Cal pay. The employee will be paid: for two hours of actual work time; for two hours of Call-In Pay; and 0.50 hours of straight-time pay for the remaining time spent on-call.

Example two:
A non-exempt employee is on-call for a 12-hour shift per the On-Call Notice Agreement. During the on-call shift, the employee returns to work for four hours. The employee should record four hours of work time and eight hours of On-Call time on their time card. The employee will be paid for four hours of actual work time and for eight hours of on-call time (1.00 hours at straight time pay).

Exempt Employee

Exempt employees do not receive guaranteed pay for on-call time. However, they may, at the discretion of their supervisor, receive the additional pay described in this section, if the supervisor provides an on call agreement for the employee to sign and if eligibility requirements are met.

Eligible exempt employees granted discretionary on-call pay may receive the equivalent of one hour of straight-time pay for every 10 hours on-call. This is the equivalent of paying 10 percent of the hourly equivalent of the employee's salary (i.e., the annual salary divided by 2080) for every hour on-call. See table below for examples of on-call pay:

On-Call Hours	Number of Straight-Time Hours Paid
8	0.80 hour of pay
10	1.00 hour of pay
12	1.20 hours of pay
16	1.60 hours of pay
20	2.00 hours of pay
24	2.40 hours of pay

Using the Exempt Timecard Web Form, employees will code their time cards with the actual hours spent on-call. To determine exempt employee eligibility for on-call pay, see "Exempt Employee Eligibility."

Exempt Employee Eligibility

Exempt employees, grades two through six and grade 29 interns only, who support a 24-hour operation (e.g., production or computer systems) and are required to be available, or on-call, during normally scheduled time off on a continuing basis are eligible for discretionary On-Call pay. Exempt On-Call time should only be utilized if it is not feasible to grant compensatory time off. For additional information on compensatory time, see "Compensatory Time Off" policy.

Managers are encouraged to structure exempt on-call arrangements that enable the business to operate efficiently with as little added cost as possible. For instance, instead of paying one employee discretionary payments to be on-call every weekend, the manager could utilize a rotating schedule of employees and provide compensatory time off to each. Not only does this arrangement reduce cost for the department, it also minimizes the personal impact on employees regarding their unscheduled days. For additional information, see "How On-Call Time Is Paid" in this chapter.

Exempt employees who are required to work from home while on-call, or return to work, do not receive any additional pay other than their regular pay and discretionary On-Call pay, if any. For additional information, see the On-Call Notice Agreements.

16.5.4 Sent-Home

This practice applies to those situations where a nonexempt employee reports to work on a regularly scheduled workday, or on a day for which they had at least 24 hours prior notice of a need to work, but at Intel's direction is not put to work or ends up working less the time than regularly scheduled for that shift, either because there is no work or for other reasons within Intel's control. An employee will also be sent home if they report to work under the influence of drugs or alcohol or are otherwise unfit to perform the work.

A non-exempt employee in this situation will be paid for one half of the regularly scheduled shift, from a minimum of two hours to a maximum of six hours, at the employee's base rate, or for the actual time worked, whichever is greater to the extent applicable state law requires a greater payment, Intel will comply with applicable state law.

Exempt employees are not eligible for Sent-Home pay.

16.5.5 Exceptions to Call-In, Called-Back, and Sent-Home Pay Practices

For non-exempt employees, the Call-In, Called-Back, and Sent-Home pay practices do not apply when any of the following occur:

- Intel's operations cannot commence or continue due to threats to employees or property
- Intel's operations cannot commence or continue due to the recommendation of civil authorities
- Public utilities fail to supply electricity, water, or gas, or there is a failure in the public utilities or sewer system
- The interruption of work is caused by an act of God or other cause beyond Intel's control.
- The employee reports to work under the influence of drugs or alcohol or is otherwise unfit to perform the work
- An employee is on-call and is called in to work at a time other than his or her regularly scheduled work hours. In this situation, the employee will be paid according to the On-Call pay practice

16.6 Nonexempt Classification Compliance Guidelines

Topics

16.6.1 Non-Exempt Classification

In addition to the federal Fair Labor Standards Act (FLSA), some states have their own wage and hour laws, which may be more restrictive than federal law. In those cases, Intel follows state law for the purpose of classifying and paying non-exempt employees who work in that state as exempt or non-exempt. In addition to compliance requirements, Intel has established guidelines that govern payment of non-exempt work.

16.6.2 Meals and Rest Periods

Employees are entitled, encouraged, and expected to take meal and rest periods throughout the day. Intel shall relieve employees of all duties and shall not exercise control over employees' activities during those periods. Employees are free to spend their meal and rest period time as they choose (consistent with any other Company policies that may apply during off-duty time). Employees are not required to remain on-premises or "on-call" during off-duty meal and rest periods.

At all times, Intel will provide any meal and/or rest periods required by applicable state law. Non-exempt employees are required to immediately notify their manager or Human Resources if they believe they are being pressured or coerced by any manager or other employee to not take any portion of a provided meal or rest period.

Non-Exempt employees should take their rest periods in the middle of each four-hour work period to the extent that it's reasonable, and not combine them with meal periods or skip them to leave work early. For example, if a nonexempt employee is scheduled to work eight hours in a day, starts work at 8:00 a.m., and takes a meal period from noon to 12:30 p.m., the employee should start the first rest period by no later than 10:00 a.m. to the extent that it's reasonable and start the second rest period by no later than 2:30 p.m. to the extent that it's reasonable. Rest periods are considered time worked and are paid. Rest period durations are defined by your manager and are no less than 10 continuous minutes and no more than 15 continuous minutes.

Intel provides employees with meal periods as required by state law. If an employee works more than five hours per day, Intel provides a meal period of not less than 30 continuous minutes, which must start prior to the end of the fifth hour of work. For example, if an employee is scheduled to work eight hours and starts work at 8:00 a.m., the meal period should begin no later than 12:59 p.m. The meal period is typically unpaid.

California

In California, Intel provides non-exempt employees with one rest period for every four hours or major fraction of four hours (i.e. more than two hours) that an employee works in a day. For example, non-exempt employees who work up to six hours in a day are authorized and permitted to take one rest period. Non-Exempt employees who work more than six hours in a day are authorized and permitted to take a second rest period. Non-Exempt employees who work more than 10 hours in a day are authorized and permitted to take a third rest period.

Employees in California working more than 10 hours per day must take a second meal period of not less than 30 continuous minutes. California employees who qualify for the second meal period should take two separate meal periods of at least 30 continuous minutes each; the two meal periods cannot be combined. It is recommended that the second meal period be taken at least two hours prior to shift end and, in any event, must begin after working no more than 9 hours and 59 minutes in the day.

Washington

Non-Exempt employees in Washington state are entitled to a 30-minute meal period for each five consecutive hours worked in a work day. Employees working three or more hours longer than a normal work day shall be allowed at least one 30-minute meal period prior to or during the overtime period.

Oregon

Non-Exempt employees in Oregon who work more than seven hours in a day must take a meal period after the third hour worked, but before commencement of the sixth hour worked. Employees working between six and seven hours in a day must take a meal period after the second hour worked, but before commencement of the fifth hour worked. Non-Exempt Oregon employees working more than 14 hours in a day must take a second meal period of not less than 30 minutes, and a fourth rest break. Business unit guidelines may provide more specific guidelines.

16.6.3 Oregon and New Mexico Legal Limitations on Hours Worked

In Oregon, Intel complies with the Oregon labor statute that requires that no employee work longer than 13 hours in any 24-hour period unless there is an emergency. Intel will also not require Oregon employees to work more than 55 hours a week. However, Intel will permit an employee to work up to 60 hours in one workweek if it is requested by the employee or consented to in writing. In New Mexico, Intel complies with the New Mexico labor statute, which requires that no employee work longer than 16 hours a day, unless there is an emergency.

16.6.4 Overtime Pay

Overtime is paid to non-exempt employees according to the laws that govern the state in which they work. All unscheduled overtime work must be approved by a manager before it is performed.

California: Overtime

Overtime is paid to non-exempt employees at 1.5 times the regular rate for hours worked in excess of eight and up to 12, in one day and 40 hours in a workweek (see note). Hours worked on the seventh consecutive work day are covered by the policy for “Double” in this chapter.

Oregon: Overtime

Overtime is paid to non-exempt employees at 1.5 times the regular rate for hours worked in excess of 10 in one day and 40 hours in a workweek (see note).

All Other States: Overtime

Overtime is paid to non-exempt employees at 1.5 times the regular rate for hours worked in excess of 40 hours in a workweek (see note).

Note: For California and Oregon, hours for which an employee receives daily overtime or double time for the seventh consecutive day worked are not counted again for purposes of determining whether an employee qualifies for weekly overtime (greater than 40 hours in a week).

For examples of how overtime is paid, see “Overtime, Non-Exempt Employee” on Circuit.

Coordination of Daily and Weekly Overtime Pay

Both California and Oregon have requirements that preclude the double counting of weekly and daily overtime hours. Sometimes these requirements are referred to as "anti-pyramiding rules."

In California, an employer does not count an hour credited toward daily overtime or double time for the seventh consecutive day worked in determining whether a person has exceeded the overtime threshold for hours worked in excess of 40 hours in a workweek. For example, a nonexempt employee works 10 hours each day on Monday through Thursday. The employee also works two hours on Friday. Total hours worked in the week are 42 hours.

The employee receives daily overtime for the eight hours of daily overtime worked Monday through Thursday. The employee does not receive weekly overtime for the two hours worked on Friday because the eight hours of daily overtime do not count in determining whether the employee worked in excess of 40 hours in the workweek. Rather, for purpose of determining whether the employee is entitled to weekly overtime, the employee only worked 34 hours (4 x 8 + 2 = 34 hours).

In Oregon, whenever overtime is calculated on a daily basis, it also must be calculated on a weekly basis. Oregon requires that an employee receive the greater of the two amounts. For example, a non-exempt employee in Oregon works a 12-hour shift Monday through Thursday for a total of 48 hours that week. The employee is entitled to four hours of daily overtime for the hours worked in excess of 10 in a workday. The employee is also entitled to eight hours of overtime for the hours worked in excess of 40 in a workweek. It is important to note the employee is not entitled to 12 hours of overtime pay (e.g. four hours daily overtime plus eight hours weekly overtime). Rather, the employee is entitled to the greater of the two overtime amounts. In this example, the greater of the two amounts is eight hours of overtime for hours worked in excess of 40 in a workweek. Therefore, the employee will receive eight hours of overtime pay for that workweek calculated at the regular rate of pay.

For examples of how overtime is paid, see "Timecard Training" on Circuit.

All States: Double Time

Double time is paid to non-exempt employees at two times the rate of pay for the following:

- All hours worked in excess of 12 hours in one day
- All hours worked on the seventh consecutive day worked in the scheduled workweek

California: Day of Rest Non-Exempt employees in California who work more than 30 hours in a workweek or more than six hours in any day of the workweek are entitled to a day of rest within each workweek. The Intel workweek runs from Sunday through Saturday.

Managers shall not require or pressure employees to work all seven days in the same workweek except where the nature of the work reasonably requires that employees work all seven days. Managers who have situations that necessitate a non-exempt employee to work seven consecutive days in a workweek should work with their business group compensation representative.

Under those circumstances, Intel will ensure that employees receive the equivalent of one rest day per week over the course of each calendar month. Notwithstanding, non-exempt employees may voluntarily choose to perform work in all seven days of a workweek if presented with the opportunity to do so. In those cases, Intel will pay California non-exempt employees extra overtime pay for the hours worked on the seventh consecutive day of work, as explained above.

Exempt employees are also expected to take at least one day off from work each week. If the nature of their work necessitates working the entire seven days of a workweek, the employee (and employee's manager) should ensure the receives the equivalent of one day's rest in seven

Oregon: Manufacturing employees in Oregon who work a shift of eight or more hours are entitled to at least ten hours of rest before beginning a new shift, unless the employee is required to work additional hours due to disruptions in business operations caused by a power outage, major equipment breakdown, severe weather or similar emergency outside the company's control.

16.6.5 Work Time

Work time is defined as all time required by Intel for an employee to do their job. Work time specifically includes the following:

- Changing into uniforms before and after work (bunny suits)
- Training time
- Work-related meetings
- Rest period time (except meal periods)
- Pass-down time
- Work performed off-site or at home
- Travel time (see below)

All non-exempt employees are responsible for accurately recording their time worked and meal periods taken using the My Timecard tool. See "Timecard Policy" on Circuit for more details.

16.6.6 Exit Interview Pay

It is strongly recommended that exit interviews be scheduled during the employee's regularly scheduled work day. If an exit interview must be conducted outside of the regularly scheduled work day, the manager should ensure that the interview time does not constitute overtime hours (see "Overtime Pay" in this chapter).

If it is necessary for a non-exempt employee to report to work outside the employee's regularly scheduled work day to participate in an exit interview, he or she will receive pay for actual time spent in exit interview or as may otherwise be required by applicable law.

16.6.7 Hazardous Weather Pay

Intel's intent is to remain open during all regularly scheduled work days regardless of weather conditions. In those instances where weather creates hazardous driving conditions, the following will apply for nonexempt employees:

> If an employee arrives late to work because of weather conditions or feels it is too hazardous to report to work, they may elect to be paid for the missed time from their vacation or Personal Absence (PA) accrued hours. This can be done by using appropriate payroll codes in the timecard tool. Otherwise, hours not worked will not be paid.

The same guidelines apply if an employee leaves work early because of changes to school schedules or road conditions.

16.6.8 Travel Pay

All employees are expected to plan and carry out travel in a manner that minimizes the hours worked and the expense to the company. When a nonexempt employee travels across different

time zones, the employee's work time, including travel time, should be recorded in the hours applicable to the employee's regular worksite.

Commute Time

Commute time to and from an employee's normal place of work is not compensable, whether the commute relates to regular work shift, to a request to return to work after having left work for the day, or to work on a scheduled day off.

Same Day Travel to Work Locations Other than Normal Place of Work

Travel time to and/or home from a location that is not an employee's normal place of work is compensable, only to the extent that it exceeds normal commute time. Once the employee has reported to their first work location of the day, all travel to other work locations during the day is compensable.

Travel that Includes an Overnight Stay Away from Home

Non-Exempt employees will be paid travel time to and from an overnight destination whether or not the travel occurs during an employee's regular work hours and whether or not the employee is a passenger on a plane, train, boat, bus, taxi, automobile or other mode of transportation. Time spent in the evening at the hotel is not work time (unless the employee actually performs work).

Work Performed During Commute Time

Any time spent working during otherwise non-compensable commute time is compensable. For example, if an employee takes public transportation to work, any time spent working during the commute is work time and should be reported on the My Timecard tool as hours worked.

Time Cards

An employee's timecard should reflect the actual time spent working and traveling during a trip using the guidelines above. In the event that a regularly scheduled shift is greater than the actual hours worked/traveled, the employees should use the Keep Pay Whole notation on the My Timecard tool.

16.6.9 Voting Rights Pay

Legal requirements for time off to vote vary by state. Unless otherwise noted, states do not require companies to provide time off to vote. Intel managers should consider providing employees unpaid time off only to the extent non-working time is inadequate to exercise the right to vote. Employees must give notice of time off requests at least two working days in advance of Election Day. The time off must be taken either at the beginning or the end of employee's regular work shift, whichever allows the most free time for voting and the least time off from work. Intel may specify the working hours during which employees may be absent. Time off must be taken as PA or vacation; however, if the employee does not have PA time available and does not want to use vacation hours, the "no pay" option may be used.

In states with specific voting leave requirements, Intel managers need to apply the following requirements. In cases where states require time-off for voting to be paid, employees may document this time on their timecards as “Voting Leave”.

Arizona: In a primary or general election, employees are allowed up to three consecutive hours’ time off without loss of pay only to the extent they have fewer than three consecutive hours between the opening of the polls and the beginning of their regular work shift, or the end of their regular work shift and the closing of the polls. Employees must apply for time off before the day of the election. Intel may specify the working hours during which employees may be absent.

California: In a statewide election, employees that do not have enough time outside of working hours to vote, may take off enough working time that, when added to voting time available outside of working hours, will enable the employee to vote. Up to two hours of such time off will be without loss of pay. If the employee knows or has reason to believe time off will be necessary to vote on Election Day, the employee must give notice of the need for time off at least two working days in advance of Election Day. The time off must be taken either at the beginning or the end of the employee's regular work shift, whichever allows the most free time for voting and the least time off from work.

Colorado: In a general election, employees who are registered to vote are allowed up to two hours of time off without loss of pay for the purpose of voting, unless they have three or more hours available outside of their shift during polling hours to vote. Employees must obtain permission from their manager for time off before Election Day. Intel may specify the working hours during which employees may be absent, but the hours shall be at the beginning or ending of the work shift if employees request.

Massachusetts: In special, primary, and general elections, eligible voters can take time off for the first two hours after the opening of the polls to the extent nonworking time is inadequate to exercise the right to vote. Employees must notify their manager of the need to take time off in advance of Election Day.

New Mexico: In a primary or general election, statewide special election, congressional election, or school district election, employees are allowed up to two hours of time off without loss of pay only to the extent they have fewer than two consecutive hours after the polls open and their work shift begins, or three consecutive hours after their regular work shift ends and the polls close. Intel may specify the working hours during which employees may be absent.

Oregon: Today all elections in Oregon are conducted by mail. The State of Oregon does not require companies to provide paid time off to vote and employees are not entitled to time off with pay.

Texas: In special, primary, and general elections, employees are allowed time off to vote without loss of pay unless the polls will be open for at least two consecutive hours outside of their work hours.

Utah: In special, primary, and general elections, employees may be given up to two hours of time off to vote on Election Day. Employees should obtain permission for time off before Election Day. However, if the employees have three or more hours available outside their shift to vote, then Intel need not grant them time off to vote during work hours.

Washington: Today all elections in Washington are conducted by mail. The State of Washington does not require companies to provide paid time off to vote and employees are not entitled to time off with pay.

16.6.10 Charitable Work

Non-Exempt employees will be paid for participation in charitable activities that are required or sponsored by Intel and that occur on site or during regular work hours. For example, participation during work hours in an Intel sponsored blood drive or a department-sponsored volunteer event at a Food Bank are charitable activities. Employees should receive approval from their manager in advance to ensure that their temporary absence during work hours will not adversely impact business operations.

Time spent voluntarily in charitable activities outside an employee's work hours is not paid, even if it is sponsored by Intel (such as marshaling at the Special Olympics on a weekend, where Intel was a corporate sponsor for the event). Moreover, nonexempt employees will not be paid for participation in activities or events that are not required or sponsored by Intel An example of unpaid volunteering would be a parent volunteering at a child's school during the day for the Intel Involved Volunteer Matching Grant Program.

16.7 Extra Pay Guidelines

Topics

16.7.1 Compensatory Time Off

If an employee is classified as exempt and works extended hours on a continuing basis, they may be eligible for compensatory time off. Compensatory time off is available at the manager's discretion at the end of special projects or activities—not for routine work that requires an employee to work extra hours. Compensatory time off should not be computed on an hour-by-

hour basis based on the number of extended hours worked. Access further information by searching Circuit for “Compensatory Time.”

By law, non-exempt employees must be paid for all hours worked and are not eligible for compensatory time off.

Some examples of Compensatory Time are:

- Granting an employee an extra day off after extensive weekend travel for Intel has occurred.
- Giving an employee an afternoon off following a week of late-night meetings.
- Granting an employee some time off following a period of very extended days worked in support of meeting a key business objective.

16.7.2 Flex Time

Flextime refers to time adjustments made to regular work schedules with prior manager approval. It is not a policy to support employees coming and going any time they want.

For non-exempt employees, adjustments to time must occur within the same workweek. For example, a nonexempt employee may work out an arrangement with their manager to take a long lunch break in exchange for making the time up at the end of the day. Based on management approval, flexing of work time may occur across multiple workdays, employees should record their time as it is worked (applicable overtime or double-time rules will apply).

It is the responsibility of the employee to ensure that time sheets are accurate. Any changes to the time cards to reflect flex-time must be made within the time permitted. Flextime may not be applicable in work situations where the work must be performed during set hours that cannot be adjusted.

Managers approving flextime schedules must understand that all flextime schedules must comply with any applicable state law wage and hour requirements regarding meal and break periods.

16.7.3 Exempt and Non-Exempt Shift Differential Pay

Intel pays shift differentials to compensate employees for working non-standard shifts that may significantly interfere with normal personal schedules. Shift differentials are determined through market analysis of competitive practices in our industry.

If an employee is hired to work on a shift that qualifies for a differential but are initially trained on a non-differential shift, the employee will not receive differential pay until they begin working their regular shift.

If an employee permanently transfers to a shift that does not qualify for a shift differential, the employee will stop receiving a shift differential the first day of the new shift.

For more information about Shift Differential Pay, see the policy on “Shifts and Schedules” on Circuit.

For treatment of pay during Temporary Shift Changes, see the policy on “Temporary Shift Changes” in this chapter.

16.7.4 Differential Overpayments

If an employee believes they were overpaid for a shift differential, they must immediately notify their manager and/or contact Get HR for help. If an employee is ever overpaid via their regular Intel paychecks, even inadvertently as a result of an administrative error, Intel must be reimbursed for the overpayment immediately, subject to applicable law. A failure to pay back any overpayments will be subject to disciplinary action, up to and including termination, subject to applicable law.

16.8 Temporary Shift Changes

Topics

16.8.1 Nonexempt Employee Overview

At Intel's direction, a non-exempt employee may be required to temporarily work a different shift for a period of at least one full workweek, but typically no more than 12 workweeks. If business conditions require a nonexempt employee to move temporarily to a shift that pays less in terms of a shift differential, scheduled overtime, compressed workweek schedule premium, or gross pay for normally scheduled hours, the employee will continue to receive regular gross pay as though he or she worked the original shift schedule. For example, an employee working on a compressed workweek schedule asked to transfer temporarily to a shift 1 schedule (M-F 8 hours/day) for at least one week will receive pay she would have received had she worked the regular compressed workweek schedule.

Where business necessity requires non-exempt employees to work one continuous workweek or longer on a shift that pays a shift differential, compressed workweek schedule premium, or scheduled overtime that is greater than they currently receive based on their original schedules, then they will receive the benefit of the temporary schedule. For example, an employee on shift 1 who temporarily transfers to a compressed workweek schedule will be paid under the compressed workweek schedule. Thus, employees who are required to work one continuous workweek or longer on a different shift will receive the greater of pay related to their regular schedule or the one to which they temporarily transferred. The adjustment may be due to shift differential, compressed workweek schedule premium, or scheduled overtime.

When working on a Temporary Shift Change, non-exempt employees should record their actual time worked on their timecard. Refer to the "Keep Pay Whole" policy on Circuit for more information about how to code timecards on a Temporary Shift Change.

16.8.2 Length and Duration of Approved Temporary Shift Change

- Minimum length is one full workweek
- Temporary Shift Changes must be worked in consecutive weeks
- No more than 12 consecutive workweeks (see note)

Note: The duration of the temporary assignment should not exceed 12 consecutive workweeks unless specific business conditions warrant a longer assignment. A longer assignment should be discussed with and approved by the business group general manager and Business HR to ensure internal equity and headcount staffing and to explore other alternatives. Business HR can contact the appropriate business compensation representative for further consultation. Payroll should be notified of the approved assignment extension.

16.8.3 Examples of Acceptable and Unacceptable Business Condition Qualifiers

Examples of typical business conditions leading to a temporary shift change where the nonexempt employee is paid the greater of the regular schedule or the temporary schedule include, but are not limited to, the following:

- Training with employees or resources on another shift
- Sabbatical coverage
- Temporarily working on another shift to fulfill business needs

Examples of business conditions that do not qualify as Approved, Temporary Shift Changes include, but are not limited to, the following:

- Redeployment
- Leaving work early due to a holiday
- Employee initiated shift change due to flex-time considerations (e.g., daycare issues or other personal reasons)

For information on how this pay practice is administered, please search for "Temporary Shift Change" and "Keep Pay Whole" on Circuit.

Exempt Employees Overview

Exempt employees are expected to work the hours required by the nature their jobs. Travel requirements and other business needs may necessitate working hours that fall outside the employee's typical schedule. In cases where an exempt employee must work on a shift that differs from their normal schedule for a period of between two and 12 consecutive weeks (such as to cover a sabbatical, or cover for business needs), the employee may be eligible for a Temporary Shift Change, at the discretion of their manager. Temporary Shift Changes for exempt employees should be processed through Workday.

16.9 Non-Exempt Compressed Workweek Schedule Premium

Outside of California and Oregon, Intel pays a compressed workweek (CWW) schedule premium to all non-exempt employees working a CWW schedule. A CWW schedule premium is paid according to the schedule an employee works. A CWW schedule is defined as any schedule that requires the employee to work 11.5 hours or greater in one day.

California and Oregon employees working a compressed workweek (CWW) schedule will not receive a CWW premium.

The CWW schedule premium will be applied to base scheduled straight-time hours and overtime hours as applicable. Search for Compressed Workweek (CWW) Schedule Premium on Circuit for more information.

Paid Absences: CWW Schedule Premium Eligibility

Holiday: The CWW schedule premium is paid for those hours that correspond to an employee's regularly scheduled straight-time hours.

Jury Duty, Bereavement, and Sabbatical: The CWW schedule premium is paid for those hours that correspond to an employee's regularly scheduled straight-time hours.

Vacation and Personal Absence (PA): The CWW schedule premium is **not** paid.

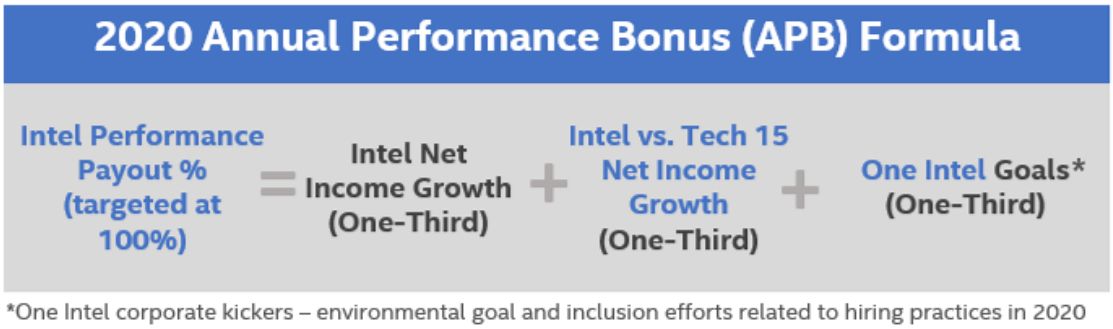
16.10 Annual Performance Bonus

Topics

16.10.1 Overview

The Annual Performance Bonus (APB) program is designed to motivate and reward employees by adding to their cash compensation based on the company's annual performance. Company performance is measured based on two parts: financial and operational. The **financial parts** of the formula are calculated by comparing Intel's net income against the prior year, and by comparing its annual net income growth against the net income growth of the Tech 15 companies (Amazon, Apple, Applied Materials, Broadcom, Cisco, Facebook, Google/Alphabet, HP Inc, IBM, Microsoft, Dell, Nvidia, Oracle, Qualcomm, Texas Instruments). The **operational part** of the formula is comprised of the One Intel goals. APB directly connects Intel employees

to the annual net income (i.e. profitability) of the company while encouraging them to focus on company profitability and efficiency.



*One Intel corporate kickers – environmental goal and inclusion efforts related to hiring practices in 2020

Bonus opportunities or "APB Goals" for employees grade seven and above are set for each employee at the sole discretion of Intel, but generally will be based on established APB Goal ranges. APB Goals generally increase with grade: the higher the pay grade, the higher the bonus opportunity. Non-exempt and exempt grades 2 through 6 have fixed APB Goals of approximately 3.3% of their base pay. An employee's APB Goal represents 3x the APB Target percent shown in Workday, Intel's HR system of record.

APB Payouts will be calculated on a 100% scale based on the financial and operational results of the company as illustrated by the example below:

Employee base salary	APB Goal %	APB Goal Amount ($)	Intel Performance Payout %	APB Payout
$100,000	6.0% of base pay	$6,000	100%	$6,000

Part-time employees (PTEs) and employees who work 39 standard hours per week or less will have their APB payouts prorated based on the percent of full-time hours worked.

APB payouts for non-exempt employees will be adjusted to reflect the overtime hours they worked during the prior year.

16.10.2 Changes to the Annual Performance Bonus Goal
(Grades 7 and above only)

Changes to an employee's APB Goal are based on several performance-related factors, including the influence the employee has on company results, the appropriate balance between base pay and APB Goal amounts, and the employee's level of contribution compared to peers. Intel retains the right to increase or decrease an employee's APB Goal in its sole discretion.

16.10.3 Eligibility

With limited exceptions, non-commissioned, general full-time employees (GFTs) and part-time employees (PTEs) are eligible to participate in the APB program as set forth in their governing pay arrangements. This includes hourly employees. The bonus payment will be prorated for employees who become eligible after January 1 to reflect the actual months of participation. For Personal Leave, Intel will prorate your APB payout for each calendar day that you are on Personal Leave. For example, if you are on Personal Leave for 30 days, your APB payout will be reduced by 30 ÷ 365 = 8.2%

Temporary employees (Intel Contract Employees (ICE), student, and Interns) in United States and select countries globally (subject to local law) will not be eligible to receive APB. To the extent intern/student eligibility for APB varies by country, employees should direct any questions to their local HR.

If employment is terminated due to misconduct, even after December 31, including but not limited to any conduct that would result in termination under any applicable employment guideline such as Intel's Workplace Behavior/Discipline and Discharge guidelines, such employee will lose eligibility for APB for the relevant performance period unless otherwise required by applicable local law.

16.10.4 Participation

Annual Performance Bonus can be prorated based on job status changes during the calendar year. The effective APB start month for new hires, rehires, transfers, or employees promoted, demoted, or who change status is outlined below:

If the employment change takes place between:

The 1st through the 15th of the month, then participation is effective the first day of the current month.
The 16th through the end of the month, then participation is effective the first day of the next month.

APB calculation for rehires will be prorated based on the number of months the employee is employed, based on the explanation above. Months worked prior to the rehire date are not part of the APB calculation.

Subject to local law and except as described below, to earn and receive an APB payout, an employee must be employed on the Intel payroll through the last day of the applicable bonus period (December 31 for APB). Subject to local law, no prorated bonuses will be paid if termination (for any reason) occurs before the last day of the applicable bonus period.

Exceptions: If, during the bonus year, the employee retires (see *Pay, Stock and Benefits Handbook* Chapter 18, "Retirement Programs" for U.S. retirement eligibility requirements), the APB payout will be prorated according to the number of full calendar months of participation. If the retirement, as defined above, is between the 16th and the end of the month, the employee will receive credit for the full month. If the retirement occurs before the 16th of the month, the employee will not receive credit for the month of retirement.

If, during the bonus year, an eligible employee dies, the APB payout will not be prorated, but paid calculated as if the employee continued to be employed through the end of the year.

Plan Changes and Termination

Receiving a payout in any year does not guarantee a payout in any future year. Intel reserves the right to amend, reduce, suspend, or terminate the Annual Performance Bonus (APB) Program, the Intel Performance Payout %, or any provision regarding the calculation of APB, at its sole discretion, at any time prior to year-end, for all employees or any group of employees by appropriate action of its board of directors or Chief Executive Officer, or their delegates. No other person or entity has the authority to make any representation regarding the terms under which Intel will provide APB and no employee has the right to rely on representations from any other source. An APB payout is not intended to replace any pension benefits and shall not be considered part of any employee's normal or expected compensation for any purpose under his or her employment with the employer entity.

16.11 Quarterly Profit Bonus Program

Topics

16.11.1 Overview

The Quarterly Profit Bonus (QPB) is another component of an employee's total pay. Intel shares its profits with employees by paying a cash bonus four times a year. QPB directly connects Intel employees to the quarterly profits of the company while encouraging them to focus on company profitability and efficiency.

Each January, April, July, and October, QPB uses 5% of Intel's net income to create a fund that is divided among eligible employees. Employees receive a payout based on the following formula:

5% of adjusted Net Income / Cost of a day's Pay*

* Cost of a day's pay includes payroll items (such as base pay, shift differential, overtime, etc.) pro-rated 1x APB targets (1/3 APB Goal), commissions, as well as the previous period's QPB payout. Specific eligible items will vary slightly from country to country. It does not include share-based expense.

The QPB cash payout is expressed as a number of days of pay and, while all employees receive the same number of days pay, each employee's payout is based on the value of one day of

his/her eligible earnings. The QPB payout will not be paid if the bonus payment would turn a profit into a loss for the company for the three-month plan period.

QPB Formula Examples

This example is based on the second quarter of 2018 (Q2'18) where Intel's Adjusted Net Income was $2,808M (rounded) and the cost of one day's pay for all employees worldwide was $37.7M*.

QPB Formula Example
5% of Adjusted Net Income
$5,056M x 5% = $252.8M
$252.8M/$41.6M*= 6.1 days payout

*The value of a worldwide day's pay will increase or decrease with headcount and salary changes

16.11.2 Eligibility[3]

With limited exceptions, GFTs and PTEs are eligible to participate in the QPB as set forth in the employees' governing pay arrangements, only if the employee meets the following two conditions: 1) must be employed on Intel's payroll as of the cutoff date for each three-month bonus period and 2) must have received eligible earnings from Intel as of the cutoff date.

The bonus payment will be calculated based on actual eligible earnings during the plan period.

Eligible earnings may be decreased as a result of a leave of absence, whether paid or unpaid. Intel paid leave programs and short-term disability payments are not considered as eligible earnings for QPB calculation purposes.

Temporary employees (Intel Contract Employees (ICE), student, and Interns) in United States and select countries globally (subject to local law) will not be eligible to receive QPB. Since intern/student eligibility for QPB varies by country, employees should direct any questions to their local HR.

Exceptions

If, during the bonus period, the employee retires (see *Pay, Stock and Benefits Handbook* Chapter 18, "Retirement Programs" for U.S. retirement eligibility requirements), the QPB payout will be prorated based on actual eligible earnings during the plan period up to the last day of employment.

[3] QPB is not offered in Brazil.

If, during the bonus period, an eligible employee dies, the QPB payout will be prorated based on actual eligible gross earnings during the plan period up to the last day of employment.

If employment is terminated due to misconduct, including but not limited to any conduct that would result in termination under any applicable employment guideline such as Intel's Workplace Behavior/Discipline and Discharge guidelines, such employee will lose eligibility for QPB for the relevant performance period unless otherwise required by applicable local law.

Eligibility Cutoff Date

Subject to local law, and except as otherwise provided in the plan, to earn and receive a payout of the QPB bonus, an eligible employee must be employed on the Intel payroll through the last day of the applicable bonus period (March 31 for first quarter (Q1) QPB, June 30 for second quarter (Q2) QPB, September 30 for third quarter (Q3) QPB, and December 31 for fourth quarter (Q4) QPB).

No prorated bonuses will be paid if termination effective date in Workday (for any reason) occurs prior to the last day of the applicable bonus period.

Eligible Earnings

All eligible earnings for each three-month period are used to calculate a day's pay. For purposes of this policy, eligible earnings means base pay, shift differentials, overtime pay, compressed workweek schedule premium, reporting-in pay, (e.g., vacation, PA, holiday, and sabbatical pay), QPB payment from the preceding plan period, and one-quarter of the current APB target amount or one-quarter of the current commission target (the target amount is prorated for months of employment, eligibility, percent of full-time hours worked, and leaves of absence). Intel reserves the right to change (including reduce) the components of eligible earnings at its sole discretion.

16.11.3 Example of QPB Calculation

The table below is an example of how one might determine a day's pay (U.S. only)** for purposes of QPB.

One Day of Pay Earnings Calculation

First Quarter (Q1) Period
Eligible earnings Jan 1-Mar 31 =$15,000
$15,000 divided by 520 hours* = $28.85/hour
$28.85 x 8 hours = **$230.80** **(one day's pay)**

*13 weeks multiplied by eight hours by 5 working days per week = 520 hours per three-month QPB bonus period.

**Calculation of a days' pay may vary by country. For information, please contact Get HR Help or a local Business HR representative.

Plan Changes and Termination

Receiving a payout in any year does not guarantee a payout in any future year.

Intel reserves the right to amend, reduce, suspend, or terminate the Quarterly Profit Bonus (QPB) Program, or any provision regarding the calculation of QPB, at its sole discretion, at any time prior to year-end, for all employees or any group of employees by appropriate action of its board of directors or Chief Executive Officer, or their delegates.

No other person or entity has the authority to make any representation regarding the terms under which Intel will provide QPB and no employee has the right to rely on representations from any other source. A QPB payout is not intended to replace any pension benefits and shall not be considered part of any employee's normal or expected compensation for any purpose under his or her employment with the employer entity.

Payout History

Search Circuit to view the QPB profit sharing bonus payout history.

Chapter 17
Stock

Chapter 17
Stock

This chapter provides an overview of Restricted Stock Units (RSUs), Stock Options, and the Employee Stock Purchase Plan (ESPP).

17.1 Overview

Intel's stock plans are intended to give designated employees the opportunity to have an ownership stake in Intel. As a stock plan participant and owner of Intel stock, you share in the company's future and have the potential to accumulate capital for your financial needs.

Intel offers stock benefits under two stock plans: the **2006 Equity Incentive Plan** and the **2006 Stock Purchase Plan**. Under the Equity Incentive Plan, Intel grants Restricted Stock Units (RSUs). Previously, Stock Options were also awarded, however this practice was discontinued in 2014. RSUs are currently the only type of stock awards granted to employees. Under the Employee Stock Purchase Plan (ESPP), eligible employees have an opportunity to purchase Intel stock at a price that is less than market value on the day of purchase.

Intel stock is listed on NASDAQ under the symbol INTC.

17.2 Restricted Stock Units (RSU)

Topics

17.2.1 Overview

A Restricted Stock Unit (RSU) is an agreement by Intel to issue you a share of Intel stock once you have satisfied the vesting requirements and any tax withholding requirements. The terms and conditions of this agreement are contained in:

- 2006 Equity Incentive Plan (EIP) document
- Notice of Grant for a particular grant
- Grant agreement for a particular grant

The terms contained in the EIP plan document apply to all awards granted under the EIP. The terms contained in the notice of grant and grant agreement apply to a particular grant. The plan document is available on Circuit. Your notice of grant and grant agreement are available through your E*TRADE Stock Plan account at E*TRADE Financial Corporate Services (Intel's stock plan administrator). Within a week of approval, when the RSU grant is approved, you may log into your E*TRADE account and view all the details. The detail displayed such as grant date, vest schedule, number of RSUs granted, and the related grant agreement constitutes your notice of grant. Access your new grant by navigating to the Holdings tab within My Stock Plan, locate the related grant under the section titled Restricted Stock (RS), then expand the desired grant record. The grant agreement can be accessed by clicking View Grant Documents.

You are encouraged to retain a copy of the grant agreement for your records.

Copies of the current Equity Incentive Plan document and plan prospectus are available on Circuit and can also be found by searching for "Equity Incentive Plan Documents".

The information in this document describes the most common grant agreement terms and conditions for RSUs (Insight rewards and new-hire employee grants). Not described here are special retention-based programs (which are ineligible for vesting acceleration at retirement), special performance-based programs (such as Performance Stock Units), or RSUs assumed by Intel pursuant to mergers and acquisitions (M&A RSUs). For more information regarding M&A RSUs, please consult the plan document and grant agreements governing those RSUs, which can be found on Circuit. The individual M&A related grant agreements are also attached to each RSU grant in your E*TRADE Account.

Do not assume all of your RSU grants have the same grant agreement with the same terms and conditions. It is very important that you review the terms of the grant agreement for each of your grants.

17.2.2 Eligibility and Grant of RSUs

All employees considered by Intel to be general full-time employees and part-time employees ("blue-badge" employees) are eligible to receive RSUs.

Intel is not required to grant RSUs to all eligible employees. Management recommends employees for grants of RSUs based, in part, on an employee's expected future contributions. Even if you receive an RSU grant, do not assume you receive vested shares unless you meet the vesting and other requirements in your grant agreement, which include being employed by Intel on the vesting date.

Annual RSU recommendations occur during Intel's Insight performance review process. All recommendations for the granting of RSUs is sent to the Compensation Committee of Intel's Board of Directors or its delegated subcommittee for review and approval. The Compensation Committee (and its delegate) are not obligated to approve management's recommended grants. RSUs are granted to employees only if approved by the Compensation Committee (or its delegate).

17.2.3 Timing of RSU Notification

The Compensation Committee reviews all RSU grant recommendations for approval typically in the second month of each calendar quarter—that is, February, May, August and November. Your grant is loaded to E*TRADE within approximately one week after approval, at which time you may login to your E*TRADE account to obtain your notice of grant. There, you can access detail such as grant date, vest schedule, number of RSUs granted, and the related grant agreement. (Each of those elements constitutes your Notice of Grant). Access your Notice of Grant by navigating to the Holdings tab within My Stock Plan, locate the related grant under the section titled Restricted Stock (RS), and then expand the desired grant record. The grant agreement can be accessed by clicking View Grant Documents.

Note for Eligible New Hires: RSU recommendations for eligible newly hired employees are typically submitted for approval by the Compensation Committee in accordance with the schedule below. Within the week after the grant date you will receive E*TRADE account activation instructions by way of email. After activating your E*TRADE account, you can view your newly granted RSUs.

General Timing of Grant Recommendations and Grant Dates

Grant Recommendations Submitted for	Date of Grant & Delivery
Eligible new hires in January, February, March, and Insight grants	May
Eligible new hires in April, May, June	August
Eligible new hires in July, August, September	November
Eligible new hires in October, November, December	February

17.2.4 Vesting, Vesting Acceleration, and Conversion

Vesting. The vesting schedule specifies dates and the number of RSUs that will convert to shares of Intel stock as of each date. Vesting schedule requirements are typically met through continuous employment. If you are employed by Intel on a vesting date, the number of RSUs scheduled to vest will vest on that day. Once all applicable tax withholding has been satisfied, shares from vested RSUs are deposited into your E*TRADE account. You can view the vesting schedule by navigating to the Holdings tab within My Stock Plan, locate the related grant under the section Restricted Stock, then expand the related grant record.

Vesting Acceleration upon Certain Events. The grant agreements for most (but not all) RSUs provide for vesting acceleration upon death, disability, or retirement. You must review the grant agreement for a particular RSU grant to see if it has vesting acceleration. Vesting acceleration means certain RSUs that would have vested in the future will vest sooner upon your death, disablement, or retirement. If your grant agreement has an acceleration provision for death, it will typically provide that upon your death, all of your outstanding RSUs will become 100% vested. If your grant agreement has an acceleration provision for disablement, it will typically provide in the event you meet the definition of disablement as described in the grant agreement, all your outstanding RSUs will become 100% vested.

If your grant agreement has a section on retirement vesting acceleration, it will typically contain two types of retirement qualifications: Rule of 75 and Standard Retirement at age 60.

Under the Rule of 75, if your combined age and years of service with Intel is 75 or greater (calculated in whole years), all RSUs that were scheduled to vest within one year of your retirement date will vest as-of your retirement date.

Under the Standard Retirement provisions, if you retire at age 60 or higher, you receive one year of vesting acceleration *for every five years of service*. As with Rule of 75, your years of service are in whole years only; you don't receive credit for partial years of service. For example, if you retire at age 60 or greater with 16 years of service, you will receive three years of vesting acceleration, meaning that all RSUs scheduled to vest within three years of your retirement date will vest upon your retirement.

If you are eligible for both Rule of 75 retirement and Age 60 retirement, you will receive whichever results in the most RSUs being vested. If you joined Intel through an acquisition, your prior service with the acquired company may or may not count, as service with Intel for purposes of RSU retirement vesting acceleration will depend on the acquisition.

Conversion of RSUs to Intel Stock. One RSU converts into one share of Intel common stock when vested. Only RSUs that are vested will be converted to shares of Intel stock. RSUs will only vest if you meet the vesting requirements in your grant agreement, which typically requires you to remain employed by Intel on the vesting dates that are specified in the vesting schedule for each grant of RSUs.

17.2.5 RSU Cancellation

At the time your employment with Intel is terminated, all unvested RSUs will be canceled. In addition, if your business group is acquired by another company, your unvested RSUs may be canceled, even though you continue to perform the same job for your group.

You are responsible for ensuring you understand how your change of employment status impacts your RSUs. Carefully review the terms of your grant agreement. Find out How a Life Event Could Impact Your Stock Awards on Circuit. Also, if you leave Intel ensure you understand what you need to do by reviewing the Stock Checklist for Terminating Employees.

17.2.6 Tax Considerations

The tax rules associated with RSUs are complex. Intel and E*TRADE Financial Corporate Services do not provide tax or legal advice. Consult the plan prospectus and your tax advisor for details. For general information, review the tax information on Circuit. In addition, E*TRADE publishes a tax guide annually to help you understand your tax statements and more.

The grant agreements for Intel-granted RSUs state that a portion of the shares issued to you when your RSUs vest will be withheld to satisfy tax withholding obligations applicable for the country in which you work. In certain countries, the withheld RSU shares will be sold to pay for tax withholding obligations (Global Tax Table).

17.3 Stock Options

Topics

17.3.1 Overview

Intel no longer grants stock options to employees within the regular, ongoing stock award program. This section principally applies to employees who hold outstanding stock options previously granted by Intel.

A stock option is the right to purchase a specified number of shares of Intel stock at a fixed price (known as the exercise price, grant price, or strike price) for a specific period of time. You must typically meet the stock option's vesting requirements before you can exercise your option. The exercise price is the average of the high and low price of Intel stock as quoted on NASDAQ on the stock option grant date.

The terms contained in the 2006 Equity Incentive Plan (EIP) document apply to all awards granted under the EIP. The terms contained in the notice of grant and grant agreement apply to a particular grant. The plan document is available on Circuit. Your notice of grant and grant agreement are available through your E*TRADE Stock Plan account at E*TRADE Financial Corporate Services (Intel's stock plan administrator).

You are encouraged to retain a copy of the grant agreement for your records.

You may also view the vesting schedule for your stock options through your E*TRADE account. The vesting schedule specifies dates and the number of stock options that are exercisable as of each date. Typically, you must continue to be employed by Intel on the vesting date for the stock option to vest on that date.

Copies of Copies of the current Equity Incentive Plan document and plan prospectus are available on Circuit and can also be found by searching for "Equity Incentive Plan Documents".

This section describes standard stock options that were granted in the hiring and Insights process. This section doesn't apply to special retention-based programs (which aren't eligible for vesting acceleration at retirement), or stock options granted under any plan assumed by Intel pursuant to mergers and acquisitions (M&A options).

Do not assume all of your RSU grants have the same grant agreement with the same terms and conditions. It is very important that you review the terms of the grant agreement for each of your grants.

For more information regarding M&A stock options, please consult the plan document and grant agreements governing those stock options, which can be found on Circuit. The individual M&A related grant agreements are also attached to each stock option grant in your E*TRADE Account.

17.3.2 Eligibility

Intel no longer grants Stock Options to employees within its normal, ongoing stock programs. In general, any grant of a Stock Option must be approved by the Compensation Committee of the Board of Directors or its delegate.

17.3.3 Setting the Exercise Price

The exercise price for a specific Stock Option is the average of the high and low price of Intel stock as quoted on NASDAQ on the date of grant.

17.3.4 Timing of Stock Option Notification

Your Notice of Grant became available after the Compensation Committee approved your Stock Option grant. Log in to your E*TRADE account to view details about your outstanding stock options, such as grant date, vest schedule, number of RSUs granted, and the related grant agreement. Once logged in, navigate to the Holdings tab within My Stock Plan, locate the related grant under the section titled Stock Options & Related Shares, and then expand the desired grant record. The grant agreement can be accessed by clicking View Grant Documents.

17.3.5 Vesting and Exercise

You may only exercise a stock option if it is vested, you meet certain guidelines pertaining to your employment status, as specified in your stock option grant agreement. In addition, the exercise price must be below the current trading price for Intel stock, as reported on the NASDAQ stock exchange. The vesting schedules for your stock options are available through your E*TRADE account. **Please note that Intel's standard Stock Options expire seven years after the grant date. If you want to exercise your vested stock options, it is solely your responsibility to do so before they expire.**

Exercise methods available allow you to exercise to sell shares and receive cash, and exercise by paying cash to receive shares of Intel stock.

Note: For administrative or other legal reasons (such as insider trading laws), Intel may suspend the ability to exercise options, or limit exercises to paying cash to receive shares of Intel stock, for limited periods of time for certain employees.

17.3.6 Stock Option Expiration/Cancellation

Unvested Stock Options are canceled upon termination of your employment. Vested Stock Options are canceled at the end of specified periods following termination of your employment (for example, 90 days), unless the grant expiration date (see below) occurs first. Cancellation and expiration information for Stock Options is included in your Notice of Grant, Stock Option grant agreement, available within your E*TRADE account. **You are responsible for ensuring you**

understand how your change of employment status may impact your Stock Options. Carefully review the terms of your grant agreement.

Intel's standard Stock Options expire seven years after the grant date. All vested options must be exercised prior to their expiration date or they will be canceled and you will lose them. The expiration date cannot be extended and expired options cannot be reinstated.

A change in your employment status can affect the vesting of your Stock Options and the length of time you have to exercise vested options following termination of your employment (unless the expiration date occurs first). Find out How a Life Event Could Impact Your Stock Awards on Circuit. Also, if you leave Intel ensure you understand what you need to do by reviewing the Stock Checklist for Terminating Employees.

Different events (such as retirement, death, and disablement) may affect the vesting of your Stock Options, in some cases accelerating (or partially accelerating) the vesting of your Stock Options such that they will not be canceled immediately upon your termination of employment. These events may also change the period of time you have to exercise vested options after termination of your employment. For example, the post-termination exercise period may be extended from 90 days to 365 days (unless the expiration date occurs first – in no event may any Stock Option be exercised after its expiration date). Some Stock Options do not have vesting acceleration terms for retirement or disablement, however. Your grant agreement contains the actual specific terms governing the effect of your employment status change on your outstanding Stock Options.

17.3.7 Tax Considerations

The tax rules associated with Stock Options are complex. Intel and E*TRADE Financial Corporate Services do not provide tax or legal advice. **Consult the plan prospectus and your tax advisor for details. For general information, review the tax information on Circuit. In addition, E*TRADE publishes a tax guide annually to help you understand your tax statements and more.**

17.4 Employee Stock Purchase Plan (ESPP)

Topics

17.4.1 Overview

By enrolling in the Employee Stock Purchase Plan (ESPP), you can purchase shares of Intel stock at a discounted price through payroll deductions. The payroll deductions are made over the course of a six-month subscription period, and the stock is purchased on your behalf at the end of the subscription period. Your participation is voluntary and you are eligible to participate in the plan if both of the following apply:

- You are employed on the last day on which the NASDAQ market is open and Intel stock is traded before February 1 or August 1 (depending on the applicable subscription period).
- You are an employee of Intel Corp. or an Intel subsidiary that is allowed to participate in the ESPP. Some Intel subsidiaries are not designated as participating subsidiaries; therefore, employees of those subsidiaries are not eligible to participate, usually for legal or administrative reasons.

17.4.2 Enrollment and Subscription Periods

There are two ESPP enrollment and subscription periods each year.

Enrollment periods: The ESPP has two enrollment periods during which all eligible employees may enroll for payroll deductions. Global enrollment periods are:

- January 1-31
- July 1 - 31

Subscription periods: There are two subscription periods that follow the enrollment periods. The subscription periods are February 20 to August 19 and August 20 to February 19. During the subscription period, if you are enrolled, money that will be used to purchase stock is deducted from your paycheck each pay period in accordance with your elections. See "Payroll Deductions" in this chapter for more details.

To Enroll

During the enrollment period, use your E*TRADE Stock Plan account to enroll. When you enroll, you will choose a contribution level from 2% to 10% of your regular earnings, which includes

payouts from the Quarterly Profit Bonus (QPB) program, the Annual Performance Bonus (APB) program, and commissions. You must enroll by midnight Pacific Time on January 31 or July 31 to participate in the corresponding subscription period.

Once you have enrolled in ESPP, you will be automatically re-enrolled in each subsequent subscription period at your current contribution level, until you change your contribution level or withdraw from ESPP (see below) or unless you transfer to a new country that is not allowed to participate in ESPP.

To Change Your Contribution Level or Withdraw from ESPP

Access your E*TRADE Stock Plan account to do any of the following:

- During the enrollment period: you may increase or decrease your contribution level for the upcoming subscription period.
- During the subscription period: you may decrease your contribution level for the subscription in which you are contributing at that time. You are allowed to decrease only once per subscription period, and you may not decrease your contribution level below 2% (though you may withdraw from ESPP – see below). You are not allowed to increase your contribution level during the subscription period.
- Withdraw from ESPP: you may withdraw from ESPP at any time before the last 48 hours of the subscription period. When you withdraw from ESPP, you will receive a full refund of your contributions within the next three payroll periods. You will not receive interest on refunded ESPP contributions.

17.4.3 ESPP Contributions by Payroll Deductions

When you enroll in the ESPP, you authorize payroll deductions from 2% to 10% of your regular earnings, including payouts from QPB, APB, and commissions. These deductions can only be made on an after-tax basis. These monies are accumulated until the end of the subscription period, when they are used to purchase Intel stock.

17.4.4 Stock Purchases

Stock is purchased twice a year at the end of each subscription period. Your stock purchase price is the lower of 85% of the fair market value (average of the highest and lowest sale prices of the day) of Intel stock on either:

- The last trading day before February 1 (for the February 20 – August 19 subscription period) or August 1 (for the August 20 to February 19 subscription period)
- The last trading day of the subscription period

The number of shares purchased for you is calculated by dividing the balance in your account by the purchase price. No fractional shares are issued. Any remaining funds not used to purchase shares will be refunded.

Example: If the balance of your stock purchase payroll deductions at the end of the subscription period is $100 and the stock purchase price is $21, you will receive four shares of

stock. The remaining $16 will be refunded to you through the normal payroll process. This example does not include any tax consideration.

Your shares will be electronically deposited into your E*TRADE Stock Plan account within two business days after the end of the subscription period, unless you select an alternate distribution election.

17.4.5 Maximum Share Limits

Based on IRS limits, Intel restricts the number of shares that may be purchased in a calendar year through ESPP to a market value of $25,000, based on the grant date value. The grant date is the last trading day before February 1 (for the February 20 – August 19 subscription period) or August 1 (for the August 20 to February 19 subscription period). The grant date value is the fair market value (average of the highest and lowest sales prices of the day) of Intel stock on the grant date.

If you reach the limit, you will receive a refund of your excess contributions without interest at the end of the subscription period. It is important for you to understand the Maximum Share Limits rule. **It is your responsibility to monitor your contributions and assess the likelihood of making excess contributions that receive no interest during the subscription period. If you withdraw or change your contribution level during a subscription period, then you must actively re-enroll or restore your contribution levels during the next enrollment period.** Learn more about these maximum share limitations on Circuit.

17.4.6 Stock Sale

At the end of a subscription period, ESPP shares are deposited into your E*TRADE Stock Plan account. Subject to local non-U.S. laws and any trading restrictions imposed by Intel, you may sell your stock anytime.

If you would like to sell your stock automatically after purchase at the close of the subscription period, you may elect to do so through QUICKSale, the automatic sales process at E*TRADE Financial Corporate Services. The QUICKSale election can be made after the start of the Subscription Period (February 20 or August 20) and can be changed until 1 p.m. (Pacific) on purchase day. Through QUICKSale, your ESPP shares are automatically sold after your shares are deposited to your E*TRADE Stock Plan account (assuming market conditions allow). This is typically one business day after the purchase date.

Like all sales transactions, the gain that one ultimately receives from a QUICKSale of shares depends upon the sales price on the QUICKSale date. There is no guarantee that the sale proceeds will exceed the purchase price.

The actual deposit into your account may vary depending on the policies of your bank and any intermediary banks involved in the transfer. Please be aware that your bank and the intermediary bank may charge additional fees.

Foreign exchange risk: for employees outside of the U.S., foreign exchange creates the potential for risk. The movement of local currency against the U.S. dollar can affect whether there is a gain on a sale. For non-U.S. employees, their non-U.S. dollar denominated payroll deductions are converted to U.S. dollars to purchase shares. Intel uses an average rate to convert local

currency contributions to U.S. dollars, but this averaged rate might be different than the market exchange rate at the time of purchase. Similarly, when proceeds from the sale of shares are converted from U.S. dollars back to local currency, the foreign exchange rate is based on market conditions at that time, which may be different than the rate in effect for purchase. In addition, currency conversions require a foreign exchange spot transaction, which carries a sales charge.

17.4.7 Tax Considerations

The tax rules for employee ESPPs are complex. The exact tax treatment with respect to your shares will depend on your specific circumstances and the length of time you hold your stock. Intel and E*TRADE Financial Corporate Services do not provide tax or legal advice. Visit the plan prospectus and the Stock Purchase Plan Tax on Circuit for more information, or call your tax advisor or legal counsel as appropriate. To view your stock purchase details, access your E*TRADE Stock Plan account. You may need the information contained in "Stock Plan Confirmations" to complete your U.S. tax reporting.

17.5 Additional Information

To perform any of the following activities, login to your E*TRADE Stock Plan account at: www.etrade.com.

- **Complete a form W-9 or W-8 to avoid additional tax withholding on the sale of your stock**
- Restricted Stock Units (RSUs) and Stock Options:
    - View how many stock options you have available to exercise
    - View how many stock options and RSUs can potentially vest
    - Exercise options and view a confirmation of exercise
    - Sell shares received through an options exercise or vested RSUs
    - Access your vesting and expiration dates
    - Model different exercise scenarios (for options only)
    - View your Notice of Grant and your grant agreement
- Employee Stock Purchase Plan (ESPP):
    - Choose to have shares deposited or sold via QUICKSale
    - Sell ESPP shares in your account

To access more information about your stock benefits at E*TRADE, login into your E*TRADE Stock Plan account and select the Knowledge link at the top of the page.

For assistance, please contact E*TRADE: www.etrade.com/contact. Representatives are available Sunday to Monday 4:00 p.m. – 1:00 a.m. EST, Monday to Thursday 7:00 a.m. – 1:00 a.m. EST and Friday 7:00 a.m. – 6:00 p.m. EST.

Detailed stock information on the topics listed below and various training resources are available on Circuit:

- How a Life Event Could impact Your Stock Benefits

- RSUs and Stock Options:

    - Overview and eligibility
    - How to exercise
    - Online grant notification

- Employee Stock Purchase Plan (ESPP):

    - Overview and eligibility
    - How to enroll, withdraw, or change your contribution
    - Historical ESPP prices

E*TRADE Stock Plan account information

Chapter 18
Retirement Programs

Chapter 18
Retirement Programs

This chapter provides the Summary Plan Description (SPD) for the Retirement Plans offered through the Intel 401(k) Savings Plan, Intel Retirement Contribution Plan, and Intel Minimum Pension Plan.

18.1 Intel Retirement Plans

18.1.1 Summary Plan Description

This Summary Plan Description (SPD) contains valuable information about your eligibility to participate in the Intel U.S. retirement plans, your plan benefits, your distribution options and many other features of the Plans. You should take the time to read this SPD to get a better understanding of your rights and obligations in the Plans.

This SPD describes the Intel 401(k) Savings Plan, Intel Retirement Contribution Plan, and Intel Minimum Pension Plan (collectively, the "Plans") benefits and obligations as contained in the Plan Documents, which govern the operation of the Plans. If the language in this SPD and the Plan Documents conflict, the Plan Documents always govern.

This SPD describes the current provisions of the Plans which are designed to comply with applicable legal requirements. The Plans are subject to federal laws, such as the Employee Retirement Income Security Act (ERISA), the Internal Revenue Code, and other federal and state laws which may affect your rights. The provisions of the Plans are subject to revision due to a change in laws or due to pronouncements by the Internal Revenue Service (IRS) or Department of Labor (DOL). Intel may also amend or terminate these Plans at any time at its discretion. If the provisions of the Plans that are described in this SPD change, you will be notified.

18.1.2 Intel Retirement Plans

Intel's retirement program is comprised of:

- For all eligible employees: Intel 401(k) Savings Plan ("401(k) Savings Plan")
- For certain eligible employees hired before January 1, 2011: Intel Retirement Contribution Plan ("Retirement Contribution Plan")
- For certain eligible employees hired before January 1, 2011: Intel Minimum Pension Plan ("Minimum Pension Plan")

These Plans have been designed as a partnership between you and Intel, with each playing an important role in enabling you to save and prepare for your future. Intel's retirement benefits add to Social Security and your other sources of income to help you attain your retirement goals.

18.1.3 Plan Eligibility

In general, you are eligible to participate in the Intel 401(k) Savings Plan provided you are:

- Employed by Intel or a participating Intel subsidiary as a U.S. employee (includes those U.S. employees on expatriate assignments)
- Not a member of a collective bargaining unit
- Not a college intern or summer intern status employee
- Not an international service employee (inpatriate)
- Not otherwise excluded (persons not classified by Intel as employees are excluded, whether or not they are or may be common law employees of Intel)

The 401(k) Savings Plan is available to eligible employees of Intel Corporation and its subsidiaries that are designated as a Participating Company. The following subsidiaries are Participating Companies: Intel Massachusetts, Inc., Intel Americas, Inc., Intel Resale Corp., Intel Federal LLC, and Intel Mobile Communications North America Inc.

Employees who meet the above eligibility rules and were hired before January 1, 2011 may participate in the Retirement Contribution Plan and the Minimum Pension Plan. However, effective January 1, 2020, participants will no longer receive credit for additional pay or years of service under to the Minimum Pension Plan and no additional contributions will be made to the Retirement Contribution Plan after a final contribution for 2019 to be made in early 2020. If you were hired prior to January 1, 2011 you may have a balance in the Retirement Contribution Plan and/or a benefit under the Minimum Pension Plan. Refer to the specific Retirement Contribution Plan and Minimum Pension Plan sections for the eligibility and/or service requirements for each Plan.

18.2 401(k) Savings Plan

Topics

18.2.1 401(k) Savings Plan Overview

The 401(k) Savings Plan is an optional savings tool that allows you to defer a portion of your eligible pay for retirement. Your participation in the 401(k) Savings Plan may serve as a valuable strategy in preparing for retirement. The earlier you make a commitment to your retirement savings, the greater benefit you will derive from your 401(k) Savings Plan account. For employees hired on or after January 1, 2011, the 401(k) Savings Plan account includes Intel's discretionary retirement contributions. As of January 1, 2020, the 401(k) Savings Plan account includes Intel's matching contributions.

18.2.2 Eligibility and Participation

All regular U.S. employees employed by Intel or a participating Intel subsidiary, including those on expatriate assignments outside the U.S., may participate in the 401(k) Savings Plan.

You are not eligible to participate if you are:

- A member of a collective bargaining unit
- A college or summer intern status employee
- An international service employee (inpatriate)
- Otherwise excluded—that is, not classified by Intel as an employee

18.2.3 Enrolling in the 401(k) Savings Plan

All regular U.S. employees employed by Intel or a participating Intel subsidiary, including those on expatriate assignments outside of the U.S., may participate in the Intel 401(k) Savings Plan from their date of hire.

You may enroll and begin contributing at any time on or after the date that you are eligible to participate. When you enroll, your payroll contributions to the 401(k) Savings Plan will

commence as soon as is administratively feasible, generally within one to two pay periods.

For years prior to 2020, you were not required to enroll in Intel's 401(k) plan to receive Intel's discretionary retirement contribution. You are automatically eligible to receive Intel's discretionary retirement contribution on the first day of the calendar quarter coincident with or next following one year of service with Intel. Please note that effective January 1, 2020, Intel has replaced the discretionary contribution with a 401(k) match. Please refer to Section 18.3.2 Eligibility and Participation and Section 18.2.4 Contributions for more information.

Auto Enrollment Feature

Eligible employees will be automatically enrolled in the 401(k) Savings Plan as follows:

Hire Date	Auto Enroll	Contribution % of eligible pay	Investment Fund**	Auto Increase***	Change contribution rate	Change investment options	Opt-out option
On or after 1/1/2011 and before 1/1/2013	Auto enroll 45 days after hire	3% regular pay* effective within 1-2 pay periods from enrollment date	Target Date Fund based on age and assumed retirement age of 65	1% to a maximum of 10%	Yes	Yes	Yes
On or after 1/1/2013 and before 1/1/2020	Auto enroll 45 days after hire	6% regular pay* effective within 1-2 pay periods from enrollment date	Target Date Fund based on age and assumed retirement age of 65	2% to a maximum of 16%	Yes	Yes	Yes
On or after 1/1/2020	Auto enroll 45 days after hire	5% regular pay and bonuses/commissions pay effective within 1-2 pay periods from enrollment date	Target Date Fund based on age and assumed retirement age of 65	2% to a maximum of 15%	Yes	Yes	Yes

*Regular pay does not include bonuses and commission pay, or if you are a nonexempt employee, lump sum payments of accrued vacation pay and personal absence.
**The Target Date Fund is based on your age and assumed retirement at age 65
***Auto Increase Percentage is pre-set to occur on April 1st of every year.

Auto Re-enrollment for 2020

Eligible employees as of September 26, 2019 who do not make an affirmative election between November 18 - December 13, 2019, will be automatically re-enrolled in the 401(k) Savings Plan as follows:

Eligible employee as of	Re-enroll	Contribution % of eligible pay	Investment Fund	Auto Increase & AIP
9/26/2019, and no election made 11/18/2019-12/13/2019	Auto re-enroll 1/1/2020	If existing contribution election (active or automatic) as of 11/12/19 is less than 5% in any pay type (regular pay, bonus and commission pay, and vacation and personal absence cash out), re-enrollment at 5% in the applicable pay type effective 1/1/2020 Existing contribution elections (active or automatic) at 5% or more in any pay type will be unchanged for re-enrollment effective 1/1/2020, except your catch-up elections in effect on 11/12/2019 will be added to your regular pay contribution election effective 1/1/2020 Any re-enrollment contribution increases apply to pre-tax contributions, unless your contribution elections are 100% Roth, in which case re-enrollment contribution increases will apply to Roth	Existing investment elections apply to any re-enrollment contribution increases If you do not have existing investment elections, re-enrollment contribution increases will be invested in the Target Date Fund based on age and assumed retirement age of 65	Yes, if auto increase / AIP election is in place on 11/13/ 2019 No, if no auto increase / AIP election in place on 11/13/2019

If you need to adjust your contribution to the 401(k) Savings Plan, you can change your contribution rate (including to 0%) at any time. See "Resources" in this chapter for online and phone enrollment tools.

18.2.4 Contributions

There are different methods of contributing to the 401(k) Savings Plan. You may start, change, or stop your contributions at any time. Allow one to two pay periods for any changes to become effective. See "Resources" in this chapter for online tools and phone numbers.

- **Pre-tax contributions**
  Pre-tax contributions are deducted from your eligible pay before income taxes are taken out. Pre-tax contributions can lower the amount of current income taxes you pay each pay period. You pay no income taxes on pre-tax contributions and earnings until your account is distributed.
- **Roth contributions**
  Roth contributions are deducted from your eligible pay after income taxes are taken out. Any earnings that accumulate on your Roth contributions are distributed free from federal income tax provided they are a qualified distribution. (Note: Roth contributions are made to your Intel 401(k) Savings Plan account, there is no separate plan for Roth

contributions).

For additional information, see the Distributions of Roth contributions section under "Federal Income Tax Considerations" in this chapter.

- **After-tax contributions on and after January 1, 2020**
  After-tax contributions are deducted from your eligible pay after income taxes are taken out. Any earnings that accumulate on your after-tax contributions are taxed when you receive a distribution.

  For additional information, see the Distributions of after-tax contributions section under "Federal Income Tax Considerations" in this chapter.

Example of Pre-tax and Roth/After-tax contributions: Assume that you earn $75,000 annually, or $3,125 semi-monthly, and elect to contribute 8% on a pre-tax, Roth and/or after-tax basis. The following table illustrates the difference in take home pay between pre-tax, Roth and/or after-tax contributions. This hypothetical example is based solely on Federal income tax rate of 25%. No other payroll deductions are taken into account.

Examples		Pre-tax Contribution	Roth/ After-Tax Contribution
a)	Semi-monthly Income	$3,125	$3,125
b)	Pre-Tax Contribution @ 8%	$250	
c)	Federal Income Taxes @ 25%	$718.75	$781.25
d)	Roth/After-Tax Contribution @ 8%		$250
e)	Take Home Pay (a-b-c-d)	$2,156.25	$2,093.75

You should consult a tax and/or a financial advisor to determine if pre-tax, Roth, and/or after-tax contributions are right for you.

Note: Eligible participants who are residents of Puerto Rico are not eligible to defer contributions to the Roth source under current tax laws.

Contribution elections

You may make a separate pre-tax, Roth, and/or after-tax contribution election for each of the following eligible pay types:

- Regular pay (base pay, overtime and shift premiums)
- Regular annual and quarterly bonuses, and commission pay
- Vacation and personal absence cash-out pay (non-exempt employees only). This does not apply to regular vacation pay.

Contribution percentage limits

You may contribute from 1% up to a 50% maximum (in whole percentages) for each of the

eligible pay types on a pre-tax, Roth and/or after-tax basis. Contributions are made through automatic payroll deductions. The combined total of your pre-tax and Roth contribution elections are capped at the IRS annual contribution limit. When you reach the maximum allowable contribution amount in a given year, payroll deductions will cease for that year and will resume again in January of the following year.

IRS annual contribution limit

The IRS annual contribution limit for pre-tax and/or Roth contributions is $19,500 for 2020. An additional $6,500 of pre-tax and/or Roth contributions is allowed for those who are age 50 or over in 2020.

Each calendar year, the total combined amount of pre-tax and/or Roth contributions, made by you to the 401(k) Savings Plan, and any other 401(k) Plan in which you participated, cannot exceed the IRS annual contribution limit. Your after-tax contributions are not included in this limit.

In your first year of employment with Intel, it is your responsibility to monitor your combined year-to-date contributions for all 401(k) Plans in which you participated to ensure you do not exceed the IRS annual contribution limit. Before your combined annual 401(k) contributions exceed the IRS annual contribution limit, you may want to reduce your 401(k) Savings Plan contribution percentage to zero for the remainder of the year. If you change your contribution, your contribution percentage is not automatically restarted in the new calendar year. You will need to elect to restart your contributions for the new year.

- You can determine your Intel year-to-date (YTD) contributions by reviewing the YTD totals of your pre-tax, Roth, and/or after-tax contributions shown on each of your paystubs. Please see "My Paystub Dictionary of Terms" under the related links within your paycheck or see "Resources" in this chapter for the paycheck deduction codes.
- If your combined contributions exceed the IRS annual contribution limit, you will need to request a refund from either your prior employer's plan or the 401(k) Savings Plan. The deadline to request a refund from the 401(k) Savings Plan is March 1 for contributions made in the previous year. Refunds from the 401(k) Savings Plan should be requested through the Fidelity Service Center. You are required to provide copies of all W-2s (including Intel) for the year you are requesting to be refunded. If you fail to request a refund of the excess contribution, you may be taxed a second time when the excess amount is ultimately distributed from the 401(k) Savings Plan.
- If you joined Intel as a result of a Mergers and Acquisitions (M&A) action or transfer from a non-participating Intel subsidiary which is part of the Intel Controlled Group, please confirm with your Intel Human Resources representative that Intel U.S. Payroll is monitoring the IRS limit for you.

After your first year, contributions to the 401(k) Savings Plan are monitored and automatically stopped by Intel U.S. Payroll before exceeding the applicable IRS limit, unless you participate in another unrelated employer plan.

Military Leave make-up contributions

If you are reinstated to an active/eligible status under the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), you may make additional contributions to the 401(k) Savings Plan upon return from a qualified military service leave. The military leave make-up contributions are subject to the IRS annual dollar limits that would have been in place had you remained actively employed during the period of covered military service. These make-up contributions may be made over a period of 5 years from the date you return from military leave, or three times the length of qualified military service, whichever is shorter. Make-up contributions must be made through payroll deductions from your eligible pay. Any make-up contribution percentage you elect will be taken from your paycheck in addition to any existing payroll deductions.

For years prior to 2020, if eligible, you will receive the Intel retirement contribution based on any eligible compensation paid to you during your military leave (such as eligible bonuses or military adjustment pay) as well as an amount up to the eligible compensation you would have received had you not entered military service. The portion of the retirement contribution based on eligible compensation you would have received had you not entered military service will be deposited to your account as soon as administratively feasible (generally later than the retirement contribution is made as additional time is needed to calculate and process the amount) even if you are on a qualified military leave at the time the annual contribution is made.

Starting in 2020, you will receive the 401(k) match based on any make-up contributions made after your military leave and applying the matching formula for the year the make-up contributions relate to. The match will be based on your make-up contributions and eligible compensation paid to you during your military leave (such as eligible bonuses or military adjustment pay). The match on your make-up contributions will be deposited to your account at the time the make-up contribution is made. The match true-up, if any, will be deposited to your account at the time the match true-up contribution is made.

Annual Increase Program

The Annual Increase Program (AIP) allows you to automatically increase your pre-tax and/or Roth contributions each year. You may elect an annual (whole) percentage increase from 1% to 3% and designate the date on which the increase would take effect. Your contributions will automatically increase each year by the percentage you elected on the closest payroll cycle date until your contribution percentage reaches 50%. The increase will apply to your pre-tax contributions, unless you have only elected Roth contributions. You may change or stop the AIP election at any time.

Employees hired on or after January 1, 2011, and who are ***auto enrolled*** in the 401(k) Savings Plan are also enrolled in the AIP as follows:

Hire Date	Auto Enroll	Annual Increase Program (AIP)	Contribution Increase	Change AIP increases	Opt-out option
On or after 1/1/2011 and before 1/1/2013	Yes at 3%	Yes	1% of regular pay* every April 1 to a maximum of 10%	Yes to 2% or 3%	Yes
On or after 1/1/2013 and before 1/1/2020	Yes at 6%	Yes	2% of regular pay* every April 1 to a maximum of 16%	Yes to 1% or 3%	Yes
On or after 1/1/2020	Yes at 6%	Yes	2% of regular pay* every April 1 to a maximum of 15%	Yes to 1% or 3%	Yes

*Regular pay does not include bonuses and commission pay, or if you are a nonexempt employee, lump sum payments of accrued vacation pay and personal absence.

Catch-up Contributions
Beginning on January 1st of the year you turn age 50, and each year thereafter, you may contribute more in pre-tax and/or Roth contributions ($6,500 in 2020) than the standard IRS annual contribution limit. Note: If you are eligible to make catch-up contributions, your pre-tax and/or Roth contribution elections will continue until you reach the IRS annual contribution limit including the amount allowed for catch-up contributions. If you do not wish to contribute to this limit, you must change your election when you reach the IRS annual contribution limit ($19,500 for 2020).

An important note about contributions to the 401(k) Savings Plan: When choosing 401(k) contribution percentages for pre-tax, Roth and/or after-tax from regular pay, bonuses/commissions, and vacation/personal absence (PA) to defer into your 401(k) Savings Plan account, you should determine how much of your pay is available. Consider your other obligations that have priority over the 401(k) Plan contributions such as taxes, garnishments, and other benefit deductions. In the event your combined 401(k) contribution elections exceed your available net pay, no 401(k) contributions will be taken from your pay. Other deductions to consider include, but are not limited to, the following: federal and state income tax, FICA, medical and dental premiums, and the Employee Stock Purchase Plan. You can verify your paycheck deductions via My Paystub.

Highly compensated employees: Highly compensated employees (HCEs) are generally those whose pay is among the top 20% of Intel employees. For 2019, HCEs were those who earned more than $196,940.70 with Intel during 2018. The 401(k) Savings Plan is required to compare the average percentage of compensation deferred by HCEs with that of the non-HCE employees during and after the plan year. If the margin between the average deferral percentage of HCEs and the non-HCE employees is greater than what the Tax Code permits, then the deferrals of HCEs may have to be limited, refunded, or both.

Annual aggregate limit: The combined total of your 401(k) Savings Plan contributions and Intel match cannot exceed the IRS's annual aggregate limit (for 2020, $57,000, or 100% of taxable compensation, if less).

401(k) Match: Beginning January 1, 2020, Intel will make a matching contribution to your 401(k) account. You begin participation for purposes of the match on the first day following receipt of your election to make pre-tax or Roth contributions to the 401(k) Savings Plan. Intel does not match after-tax contributions.

If you are an eligible participant, your match is determined as follows:

- For each payroll period between January 1, 2020 and December 31, 2020, Intel will provide a 2:1 match on your pre-tax and Roth contributions up to 5% of your eligible pay (maximum match is 5%).
- For each payroll period on and after January 1, 2021, Intel will provide a 1:1 match on your pre-tax and Roth contributions up to 5% of your eligible pay (maximum match is 5%).

The match is calculated each pay period. For 2020, if you contribute 3% or more of eligible pay during a pay period, you would receive the maximum 5% match for that pay period. Starting in 2021, if you contribute 5% or more of eligible pay during a pay period, you would receive the maximum 5% match for that pay period.

After the plan year ends, Intel will compare the match you received during the year to the match you were eligible to receive based on your eligible pay and contributions over the plan year as a whole. If there is a difference, Intel will contribute the amount equal to the difference ("match true-up") for eligible employees. You will not be eligible for the match true-up if you terminate employment before the end of the year (December 31) unless you satisfy the Intel's retirement eligibility requirements, terminate employment because of permanent and total disability (as defined in Section 18.6.2 Disability and Death Benefits), or die. If you terminate employment with Intel in the month of December as a result of a redeployment or VSP action, and comparable jobs are not available within Intel you may be eligible for the match true-up. To be eligible, you must be in good standing with Intel and your job elimination generally cannot be as a result of a divestiture. Intel will determine good standing, comparable jobs, and other terms necessary to apply this special rule based on uniform definitions.

In this calculation, eligible pay includes your regular base pay plus regular annual and quarterly bonuses, commissions, overtime, shift differential, compressed workweek schedule (CWW), and other premiums you receive after becoming eligible for the 401(k) Savings Plan. Beginning in 2020, eligible pay also includes payments under the Intel paid leave and short-term disability programs when paid through Intel U.S. payroll. In accordance with federal tax law, pay in excess of $285,000 in 2020 (as adjusted for subsequent years) will not count in the calculation of the 401(k) match. In addition, the portion of income deferred into SERPLUS is not considered as eligible pay in the Intel 401(k) Savings Plan.

The 401(k) match will be invested based on the investment election you have on file in your account at the time the match is made. If you have no investment election on file, the match will be invested in a 401(k) Target Date Fund based on your approximate year of retirement at age 65. Once an investment election is made, you may change investment elections for future contributions, for existing balances already in your account, or for both future contributions and existing balances.

Intel's Retirement Contributions to the 401(k) Savings Plan: Intel made Retirement Contributions to the 401(k) Savings Plan on behalf of eligible participants for years prior to 2020. For 2020 and beyond, Intel's contribution is a 401(k) match.

18.2.5 Vesting in the 401(k) Savings Plan

You are always 100% vested in your personal contributions and any rollovers made to your 401(k) Savings Plan account. You are also 100% vested in any 401(k) match contributed by Intel.

For employees who received a discretionary retirement contribution in their 401(k) Savings Plan account for plan years prior to 2020, the following vesting schedule applies to the Intel Retirement Contribution.

Completed Years of Service	Percent Vested
Fewer than 2	0%
2 but less than 3	20%
3 but less than 4	40%
4 but less than 5	60%
5 but less than 6	80%
6 or more	100%

How Vesting Service is Determined

Your length of service with Intel plays a key role in determining your vesting. For purposes of counting vesting service only, all service with Intel and any U.S. or foreign subsidiary directly or indirectly owned at least 80% by Intel (the "Intel Controlled Group") is counted. The 401(k) Savings Plan begins counting service on your date of hire. If you have previous service as an Intern or International service employee, that service counts towards determining your vesting. If you have previous service as a contingent (leased) employee or you are an acquired employee, contact Get HR Help to determine if your previous service is counted. If you leave the Intel Controlled Group and are later rehired, see the "Participation and Vesting upon Re-Employment" section for further information.

A year of service is defined as a period of 12 consecutive months during which you receive pay from a member of the Intel Controlled Group, including normal periods of absence for vacations, holidays, and temporary approved leaves. For purposes of determining your initial eligibility for a Retirement Contribution, you will receive credit for a year of service after you have completed 365 days without a break in service of 12 months or more. If you leave the Intel Controlled Group but return to service within a 12-month period, you will be considered to have been continuously in service with the Intel Controlled Group during the period of absence.

Regardless of your service, you will be 100% vested in your Retirement Contribution benefit if you meet any of the following conditions:

- You are employed by Intel while you are age 60 or older.
- You terminate employment because of permanent and total disability (as defined in Section 18.6.2 Disability and Death Benefits).

- You are employed by Intel at the time of your death.

Additional Special Vesting Rules
If Intel eliminates your job through an involuntary workforce action or VSP action which results in the termination of your employment with Intel, and comparable jobs are not available within Intel, you may be eligible for full vesting in the Retirement Contribution benefit. If you are eligible for full vesting, your 401(k) Savings Plan account will reflect the vesting change as soon as possible after the Plan passes a special non-discrimination test. If the Plan fails the special non-discrimination test, full vesting cannot be granted and will be reconsidered during the next regular annual non-discrimination test. To be eligible, you must be in good standing with Intel and your job elimination generally cannot be as a result of a divestiture. Intel will determine good standing, comparable jobs, and other terms necessary to apply this special vesting schedule based on uniform definitions. This special vesting schedule is subject to IRS nondiscrimination testing.

If you terminate employment with Intel as a result of a Divestiture, and you accept a job offer from, and become an employee of, the acquiring company on the agreed upon hire date, you may be eligible for full vesting in the Retirement Contribution benefit. If you are eligible for full vesting, your 401(k) Savings Plan account will reflect the vesting change as soon as possible after the Plan passes a special non-discrimination test. If the Plan fails the special non-discrimination test, full vesting cannot be granted and will be reconsidered during the next regular annual nondiscrimination test.

Participation and vesting in Intel's discretionary Retirement Contributions upon reemployment

Below are the Bridge of Service rules for eligibility and vesting:

Length of Service + break	Participation in Intel's Discretionary Retirement Contributions	Vesting in Intel's Discretionary Retirement Contributions
If a nonvested employee left and break plus service was less than or equal to 365 days	Participation begins the first day of the calendar quarter coincident with or next following the date at which service + break = 365 days	Contributions vest by counting all service and breaks
If a nonvested employee left and break was less than 365 days and total service was greater than or equal to 365 days	Participation begins the first day of the calendar quarter coincident with or next following the date at which service + break = 365 days; or if this is met in a calendar quarter preceding date of rehire, participation begins upon return to Intel as an eligible employee	Contributions vest by counting all service and breaks

If a nonvested employee left and break was greater than or equal to 365 days, but less than five years and total service was less than 365 days	Participation begins the first day of the calendar quarter coincident with or next following the date at which total service = 365 days	Contributions vest by counting all service
If a nonvested employee left and break was greater than or equal to 365 days, but less than five years and total service was equal to or greater than 365 days	Participation begins the first day of the calendar quarter coincident with or next following the date at which total service = 365 days; or if this is met in a calendar quarter preceding date of rehire, participation begins upon return to Intel as an eligible employee	Contributions vest by counting all service
If a nonvested employee left and break was greater than five years	Participation begins the first day of the calendar quarter coincident with or next following latest date of hire (DOH) plus 365 days	Contributions made prior to the break are forfeited. Contributions made after rehire vest by counting all service after the last DOH
If an employee who was at least partially vested left (regardless of the length of the break)	Participation begins upon return to Intel as an eligible employee	Contributions vest by counting all service

18.2.6 Rollovers from Other Plans

If you are eligible to participate in the 401(k) Savings Plan, you may roll over an eligible retirement plan distribution, provided the distribution meets the specific Tax Code and Plan requirements. Generally, eligible retirement plans include:

- Individual retirement accounts or annuities under Tax Code Section 408
- Qualified retirement plans under Tax Code Section 401(a), including designated Roth accounts
- Annuity plans under Tax Code Section 403(a)
- Tax-exempt entity plans under Tax Code Section 403(b)
- Governmental plans under Tax Code Section 457

In addition, the Plan will accept rollovers from conduit IRAs (rollover IRAs), non-conduit IRAs (traditional IRAs, Simplified Employee Pension plans (SEP-IRAs)), and SIMPLE IRA distributions (made more than two years from the date you first participated in the SIMPLE IRA). Once these balances have been rolled into the 401(k) Savings Plan, they must follow the terms and conditions of the 401(k) Savings Plan.

Eligible rollover distributions into the Plan do not include required minimum payments under Tax Code Section 401(a)(9), any distribution that is one of a series of substantially equal periodic payments made for your life expectancy (or the joint life expectancy of you and your beneficiary), hardship withdrawals, or distributions of pre-1988 after-tax dollars.

18.2.7 Investment Options

Intel's contributions, and investment earnings accumulate in the Plan on a tax-deferred basis until the money is paid out to you.

There are a variety of investment options for your contributions to the 401(k) Savings Plan. You may split your investment in any whole percentage increments among any of the investment options offered under the 401(k) Savings Plan. The investments are broken down into three primary categories, Target Date Funds, Core Funds, and Fidelity BrokerageLink®.

Within each investment category are a number of investment funds from which to choose. You should review the fund prospectus and/or fund fact sheet available at Fidelity's NetBenefits website for each of the funds in which you are interested. Those documents provide information about the Fund's investment strategy, expenses, and operation, including any trade limitations (see below in this section under "Investment election information" for details on trade limitations).

The following are general descriptions of the investment categories offered in the 401(k) Savings Plan. Choose from the available funds in one or all investment categories to build your portfolio:

Investment Category	Brief Description
Target Date Funds	• Provide a single fund approach to investing based on your age and anticipated date of retirement at age 65. The number, as in Target Date 2045, represents the approximate year when you plan to start withdrawing your benefits. • Each fund offers a broadly diversified mix of domestic and international stocks and bonds, and includes investments not typically available to individual investors, such as hedge funds and commodities. • These are professionally managed funds, continuously monitored and automatically rebalanced for you. • Funds are available only under Intel Plans and not to the general public. Because these funds are not quoted on a public exchange, they do not have "ticker" symbols, and therefore cannot be looked up in the newspaper or on the Internet.
Core Funds	• Enables you to build your own portfolio from a broad range of investment choices representing all the major asset classes, including short term investments, bond funds, domestic and international stock funds and the Intel Stock Fund. • If you invest in Core Funds, you should consider monitoring your portfolio and rebalancing at least once a year to ensure you have the appropriate investment mix.

Investment Category	Brief Description
Fidelity BrokerageLink®	• You can choose to invest in asset classes or investment strategies beyond those offered in the Target Date Funds or Core Fund categories. • These additional investment options may be appropriate for you if you want a more customized investment approach. • Intel and the Investment Policy Committee do not monitor or determine the funds in your BrokerageLink® account.
Intel Stock Fund	• Consists primarily of Intel common stock purchased by a subsidiary of Fidelity on the open market, based on your investment instructions. • You can invest up to 20% of your 401(k) contributions into the fund.

To view the available funds, most recent fund performance, or the quarterly fund fact sheets for the Target Date and Core Funds, visit the Fidelity NetBenefits website or call the Fidelity Service Center. To research the funds available in Fidelity BrokerageLink®, visit www.Fidelity.com or call the Fidelity Service Center. See "Resources" in this chapter for current URL and phone numbers.

Free$tock

If you were a Plan member before 1987, contributions that were invested solely in Intel stock are referred to as Free$tock. If you have Free$tock, you have the option of exchanging your investment from Intel stock to any of the 401(k) Savings Plan's investment options.

Risk of investing in the Intel Stock Fund

Because assets in the Intel Stock Fund are invested primarily in Intel common stock, the return on any investment in the Intel Stock Fund will be primarily dependent upon changes in the market price of Intel common stock and any dividends paid on the common stock. In turn, changes in the market price of Intel common stock are substantially dependent upon the financial performance of Intel and the market's perception of Intel's future potential financial performance. Many factors may affect Intel's financial performance and the market's perception of its future financial performance. In addition, as a result of the absence of diversification in the Intel Stock Fund, it is generally a riskier investment than other funds available under the 401(k) Savings Plan, many of which are significantly more diversified. You should recognize that any investment option, including the Intel Stock Fund, could decline in value, which could mean a loss of value in your plan account.

The Intel Stock Fund will incur costs that will affect the overall return of the Fund. Among other potential costs, the Intel Stock Fund may be required to pay a management fee for the purchase of the shares of Intel common stock and may be required to pay brokerage fees to the brokers who actually buy and sell the shares on the open market. The Intel Stock Fund also will incur fees in connection with satisfying various accounting and legal requirements. In addition, the Intel Stock Fund may hold small amounts of cash or other short-term investments for liquidity purposes. Because of the expenses borne by the Intel Stock Fund and the fact that it may hold assets other than Intel common stock, returns on the Intel Stock Fund will vary from the

performance of Intel common stock (INTC). Any or all of these factors may have a substantial effect on the overall return of the Intel Stock Fund offered in the 401(k) Savings Plan.

In considering whether to allocate plan assets and contributions to the Intel Stock Fund, carefully review the information in Intel's periodic reports on Form 8-K, quarterly reports on Form 10-Q, annual reports on Form 10-K, and other reports and documents filed with the SEC. Copies of these reports can be obtained from Intel's website at www.INTC.com, the SEC at 800-SEC-0330 or www.sec.gov, or by calling Intel's transfer agent, Computershare Investor Services, at 800-298-0146.

Dividends paid on the Intel Stock Fund

If you invest any portion of your 401(k) Savings Plan account in the Intel Stock Fund, you have the right to elect to receive in cash any dividends earned on the common stock in the Intel Stock Fund that is allocated to your account. You may change your dividend election payment at any time, but at least 10 days in advance of a dividend payment for such change to take effect. Otherwise, the change in election will apply to the next following payment. Cash dividend payments of less than $10 will automatically be reinvested in your account unless you select electronic funds transfer (EFT) as the payment method. If you do not elect to receive dividends in cash, the dividends earned on the common stock in the Intel Stock Fund will be reinvested in the Intel Stock Fund. Because of the time it takes to process and settle securities transaction sand to reinvest cash dividends, changes in your account balance in the Intel Stock Fund during the days preceding or following the ex-dividend date—the date on which the right to receive cash dividends, stock dividends, and stock splits vests—may affect whether shares are credited to your account as a result of the dividend or stock split. The portion of the 401(k) Savings Plan that is invested in the Intel Stock Fund is considered an employee stock ownership plan (ESOP).

Allocation of shares in the Intel Stock Fund

Shares purchased in the open market on any given day are allocated to your account and the accounts of other participants for whom shares are being purchased on that day based upon the following: (1) the amount being invested in the Intel Stock Fund on behalf of each such account; and (2) the daily weighted average purchase price of open market purchases. The weighted average purchase price for any given day is calculated by dividing the aggregate price of all purchases on that day by the number of shares purchased. You will be considered the owner of the shares of Intel common stock allocated to your account for purposes of any matters submitted to the stockholders for a vote. Any vote that you submit on behalf of your Intel Stock Fund shares will be kept confidential. When reporting voting results for the Intel Stock Fund shares, the report will only show the aggregate vote for all Intel Stock Fund shares that are voted. The number of shares of Intel common stock allocated to your account will be reflected on your 401(k) Savings Plan account statement.

Currently, the Intel Stock Fund is a daily share accounted fund. A daily share accounted fund is an investment option in which participants' accounts reflect ownership of the underlying stock rather than ownership of units in the fund itself. If transaction requests for daily share accounted funds are requested before 4 p.m. (Eastern) on a business day, the transactions typically will receive the weighted average purchase price or sale price on the following business day. Otherwise, it will receive the weighted average purchase price or sale price on the second business day after the transaction is received. The weighted average purchase price for

any given day is calculated by dividing the aggregate price of all purchases for the daily share accounted fund (less any transaction fees) on that day by the number of shares purchased. Similarly, the weighted average sale price on any given day is calculated by dividing the aggregate price of all sales on behalf of the daily share accounted fund (less any transaction fees) on that day by the number of shares sold. There is currently a two-day settlement period after the purchase or sale date for this fund.

In determining whether to allocate assets to the Intel Stock Fund and how much to allocate, you should carefully consider the level of your participation in the other Intel stock benefit plans and the fact that your overall compensation is already substantially tied to Intel's performance. Certain of the other investment options that invest in stocks may also invest in Intel's common stock, although any such holdings are typically limited to no more than 5% of the Fund's assets.

Investment election information

When you elect to contribute to the 401(k) Savings Plan, you must select one or more investment options for your contributions. This election will generally apply to your entire contribution (pre-tax, Roth, Retirement Contribution, 401(k) match, after-tax).
Any contribution made by Intel will be invested based on the future contribution election you have on file in your account at the time the Intel contribution is made. If you have no future investment election on file, the contribution will be invested in a Target Date Fund based on your approximate year of retirement at age 65. Once an investment election is made, you may change investment elections for future contributions, for existing balances already in your account, or for both future contributions and existing balances.

Beginning in 2020, you may invest your Roth balances separately from your non-Roth balances in the 401(k) Plan. This feature is not available in the self-directed BrokerageLink account.

Investment election changes may be made on a daily basis, subject to each fund’s policy regarding frequent trading restrictions and short-term redemption fees. Some investment funds limit frequent transfers in and out of the fund aimed at making short-term gains (called "market timing") to prevent incurring excessive costs and negatively affecting the return of the fund. Intel has adopted an excessive trading policy consistent with rules that Fidelity—Intel's provider of retirement administrative services—has implemented. The policy applies to the frequency of trading in and out of the investment choices offered in the 401(k) Savings Plan fund lineup.

Fidelity monitors the number of roundtrip (in and out) transactions in shareholder accounts. A roundtrip is a mutual fund purchase or exchange purchase followed by a sell or exchange sell within 30 calendar days in the same fund and account. Excessive trading in life stage funds, core asset funds, Intel stock fund, mutual funds or other investment options subject to such restrictions will result in the limitation or prohibition of additional purchases (other than contributions and loan repayments) for 85 calendar days; additional excessive trading will result in a limitation of one exchange day per calendar quarter for a 12-month period. To view Intel's excessive trading policy, visit Fidelity’s NetBenefits website. See the “Resources” section for additional information.

If you direct any portion of your 401(k) Savings Plan account to Fidelity BrokerageLink®, you have the option to set up a standing order to direct your future contributions directly to your

BrokerageLink® account. Standing orders are currently limited to the available mutual funds and do not include ETFs. You should review the commission schedule and/or call the Fidelity Service Center to understand any fees that are applicable to the transactions you make on the investment funds in your BrokerageLink® account.

The investment options under the 401(k) Savings Plan each have different investment objectives and, consequently, different elements of risk and potential for growth. Before deciding how to invest your account, you need to assess your own tolerance for risk in view of your long-term plans and the length of time you expect to continue working.

Subject to the limitations on investments in the Intel Stock Fund, you may invest 100% of your future contributions in any of the investment options, or you may split your investment in minimum increments of 1% among any combination of the investment options. You may also make an exchange of your existing balance in increments of 1% or a specific dollar amount (except in the Intel Stock Fund).

The 401(k) Savings Plan is intended to operate as an ERISA Section 404(c) plan. The Plan offers participants and beneficiaries the opportunity to exercise control over the assets contributed and accumulated on their behalf by allowing them to choose the manner in which these assets will be invested from a broad range of investment alternatives. This means that you or your beneficiaries may not hold Intel, the Plan's service providers, or any of their respective employees or agents liable as plan fiduciaries for any losses sustained in your account that are the result of your exercise of control over how your contributions are to be invested. In other words, you bear the risk of the performance of your directed investments, even if that performance is poor. Plan fiduciaries will not provide advice as to how you manage your investments in your account under the Plan. Accordingly, for advice on how the assets in your account should be invested, you should consult an investment advisor.

The Investment Policy Committee reserves the right without advance notice, and on a temporary or permanent basis, to do the following: add, change, or remove one or more investment option(s) under the 401(k) Savings Plan, change the dates on which elections can be made or on which elections become effective, and to limit the number of changes you may make to your contribution selections during any calendar year.

You may obtain the following additional information concerning the investment options available under the 401(k) Savings Plan by visiting Fidelity NetBenefits or by calling the Fidelity Service Center (see "Resources" in this chapter for online and phone number information):

- A description of the annual operating expenses of each available investment fund (e.g., investment management fees, administrative fees, transaction costs) which reduce the rate of return to participants and beneficiaries, and the aggregate amount of such expenses expressed as a percentage of average net assets of the designated investment option
- Copies of any prospectuses, financial statements and reports, and of any other materials relating to the investment funds available under the Plan to the extent this information is provided to the Plan
- A list of assets comprising the portfolio of each investment fund which constitutes "plan assets" within the meaning of ERISA
- Information concerning the value of shares or units in each investment fund, as well as

past and current investment performance of such alternatives, determined, net of expenses, on a reasonable and consistent basis
- Information concerning the value of shares of mutual funds held in your account

When you plan your asset allocation strategy for your 401(k) Savings Plan account, you should consider how your Intel Retirement Contribution Plan account, if applicable, is invested, and how any other assets you may hold are invested, to assure that you are well diversified in your overall asset allocation. You are strongly encouraged to read all of the fund descriptions and disclosure materials relating to the investment options under the Plans, and seek professional tax advice and/or financial planning guidance.

18.2.8 Roth In-Plan Conversion

You may convert certain pre-tax (generally only available if you are at least age 59.5 or have left Intel) and/or after-tax contributions to Roth contributions within the 401(k) Savings Plan (called a Roth in-Plan Conversion or RIPC). Pre-tax amounts and earnings on any after-tax amounts converted to Roth will be subject to current income taxes at the time of conversion, but is not subject to mandatory withholding. You may wish to increase your tax withholding or estimated tax payments to avoid an underpayment penalty.

When you convert to Roth within the 401(k) Savings Plan, those amounts will be transferred to your "Roth In-Plan Conversion Account." However, conversion does not change the time when your converted contributions can be withdrawn. Other factors may also need to be considered before you can make an informed decision on whether to convert non-Roth contributions to Roth Contributions. Please consult with a professional tax advisor for advice. Your decision to convert to Roth within the plan is irrevocable.

If you have any questions or need more information on converting your account(s) to Roth, please contact the Fidelity Service Center.

18.3 Retirement Contribution Plan and Minimum Pension Plan

Topics

18.3.1 Retirement Contribution Plan and Minimum Pension Plan Overview

Prior to 2020, for many employees, the Retirement Contribution Plan was Intel's contribution

toward your retirement savings. Any discretionary retirement contribution declared was made on a tax-deferred basis and deposited typically in late January or early February for the preceding year's eligibility period.

For eligible employees hired before January 1, 2011, the Minimum Pension Plan may provide an age 65 minimum pension benefit if their Retirement Contribution Plan account balance does not provide a minimum level of retirement income as determined by the pension formula.

18.3.2 Eligibility and Participation

You are eligible to participate in the Retirement Contribution Plan and Minimum Pension Plan upon satisfying the conditions outlined in the "Plan Eligibility" section in this chapter and the service requirements below.

If eligible, you began participation in the Retirement Contribution Plan and Minimum Pension Plan on the first day of the calendar quarter coincident with or next following one year of service with Intel. For example, if an eligible employee was hired on April 1, 2010, he or she became a participant on April 1, 2011. In contrast, if the employee was hired one day later on April 2, 2010, he or she became a participant on July 1, 2011.
Employees hired before January 1, 2011 are eligible for the Intel Minimum Pension Plan and any discretionary contributions the Company made towards your retirement for your eligible years of participation prior to 2015 were made to your Retirement Contribution Plan account.

Effective January 1, 2020:

- Intel will no longer make discretionary contributions in the Retirement Contribution Plan and/or the 401(k) Plan.

Effective January 1, 2015 through December 31, 2019:

- For eligible employees who on January 1, 2015 are in jobs grade 6 and below or equivalent, Intel's discretionary contributions, if any, for years 2015 through 2019 will be deposited into your Retirement Contribution Plan account for each of those years that you remained in one of those eligible grades
- For eligible employees grade 6 or below or equivalent who move into a grade 7 and above or equivalent (see the Job Grade Table below) after January 2015 and remain in one of those grades until the following January 1, Intel's discretionary contribution, if any, for each year after the move and through 2019 will be deposited into your 401(k) Savings Plan account, even if you later move back to grade 6 or below or equivalent in a following calendar year
- For eligible employees who on January 1, 2015, are in grade 7 and above or equivalent (see the Job Grade Table below) or are Intel Contract Employees (ICE) in grade 96-99 on January 1, 2015, Intel's discretionary retirement contributions, if any, for years 2015 through 2019 will be deposited into your 401(k) Savings Plan account even if you later move to grade 6 or below or equivalent

Job Grades Considered 7 and Above by Calendar Year	
Individuals who were in any of the following job grades as of January 1 of the corresponding calendar year become ineligible for continued earnings and service accruals in the Minimum Pension Plan and any Intel discretionary retirement contributions on your behalf will be deposited into your 401(k) Savings Plan account even if you later move to a grade considered 6 or below	
Calendar Year	**Grades Classified as 7+**
2015	7-13 23-28 43-49 73-74 83-89 All Executive Grades
2016	7-13 23-28 44-49 83-89 All Executive Grades
2017	7-13 23-28 44-49 84-89 All Executive Grades
2018	7-13 23-28 44-49 84-89 All Executive Grades
2019	7-13 23-28 44-49 84-89 All Executive Grades

If you were hired or you transferred to the U.S. (with no prior U.S. service) on or after January 1, 2011: you are not eligible for the Intel Retirement Contribution Plan or the Minimum Pension Plan. Because you are not eligible for participation in these Plans, any discretionary Intel retirement contribution is made to your Intel 401(k) Savings Plan account.

18.3.3 How Service for Eligibility and Vesting is Determined

Your length of service with Intel plays a key role in determining your eligibility and vesting. For purposes of your eligibility and vesting service only, all service with Intel and any U.S. or foreign subsidiary directly or indirectly owned at least 80% by Intel (the "Intel Controlled Group") is counted. The Retirement Contribution Plan and Minimum Pension Plan begin counting service on your date of hire. If you have previous service as an Intern or International service employee,

that service counts towards determining your eligibility. If you have previous service as a contingent (leased) employee or you are an acquired employee, send a request to Get HR Help on Circuit to determine if your previous service is counted. If you leave the Intel Controlled Group and are later rehired, see "Participation and Vesting upon Re-Employment" in this chapter for further information.

A year of service is defined as a period of 12 consecutive months during which you receive pay from a member of the Intel Controlled Group, including normal periods of absence for vacations, holidays, and temporary approved leaves. For purposes of determining your initial eligibility, you will receive credit for a year of service after you have completed 365 days without a break in service of 12 months or more. If you leave the Intel Controlled Group but return to service within a 12-month period, you will be considered to have been continuously in service with the Intel Controlled Group during the period of absence.

18.3.4 Vesting in the Retirement Contribution Plan and Minimum Pension Plan

Vesting refers to the percentage of an account or benefit that you have earned, based on your length of service with Intel, and will not be forfeited if you terminate employment.

The following vesting schedule applies to participants who are active employees as of December 31, 2007, or later.

Completed Years of Service	Percent Vested
Fewer than 2	0%
2 but less than 3	20%
3 but less than 4	40%
4 but less than 5	60%
5 but less than 6	80%
6 or more	100%

The following vesting schedule applies to participants who terminated employment prior to December 31, 2007, with a vested Retirement Contribution Plan account balance or vested Minimum Pension Plan benefit.

Completed Years of Service	Percent Vested
Fewer than 3	0%
3 but less than 4	20%
4 but less than 5	40%
5 but less than 6	60%
6 but less than 7	80%
7 or more	100%

Regardless of your service, you will be 100% vested in all of your Retirement Contribution Plan and Minimum Pension Plan benefits if you meet any of the following conditions:

- You are employed by Intel at age 60 or older
- You terminate employment because of a permanent and total disability (as defined in Section 18.6.2 Disability and Death Benefits)

- You are employed by Intel at the time of your death

Additional special vesting rules:

- If you were an active employee on January 1, 1987, 100% vesting in your Retirement Contribution Plan account balance is automatic when you reach age 55 rather than age 60
- If Intel eliminates your job through a redeployment or VSP action which results in the termination of your employment with Intel, and comparable jobs are not available within Intel, you may be eligible for full vesting in the Retirement Contribution Plan. If you are eligible for full vesting, your Retirement Contribution Plan account will reflect the vesting change as soon as possible after the Plan passes a special non-discrimination test. If the Plan fails the special non-discrimination test, full vesting cannot be granted and will be reconsidered during the next regular annual non-discrimination test. To be eligible, you must be in good standing with Intel and your job elimination generally cannot be as a result of a divestiture. Intel will determine good standing, comparable jobs, and other terms necessary to apply this special vesting schedule based on uniform definitions. This special vesting schedule is subject to IRS nondiscrimination testing. This special vesting rule is not available in the Minimum Pension Plan
- If you terminate employment with Intel as a result of a divestiture, and you accept a job offer from and become an employee of the acquiring company on the agreed upon hire date, you may be eligible for full vesting in the Retirement Contribution Plan. If you are eligible for full vesting, your Retirement Contribution Plan account will reflect the vesting change as soon as possible after the Plan passes a special non-discrimination test. If the Plan fails the special non-discrimination test, full vesting cannot be granted and will be reconsidered during the next regular annual nondiscrimination test. This special vesting rule is not available in the Minimum Pension Plan. If your Retirement Contribution Plan account was fully vested as a result of redeployment, VSP, or divestiture and you are rehired by Intel at a later date, eligibility for any future contributions and vesting will be determined based on the Plan's eligibility and vesting rules at the time of your rehire taking into account your actual service

Participation and vesting upon reemployment

If you left Intel but were later rehired prior to January 1, 2015, you may have needed to satisfy additional eligibility requirements before you began or resumed participation. However, a former employee who was rehired on or after January 1, 2011, and prior to January 1, 2015, was not be eligible to participate in the Retirement Contribution Plan and Minimum Pension Plan unless he or she was an active participant prior to January 1, 2011.

An employee rehired on or after January 1, 2015, regardless of grade level, was not able to actively participate or resume participation in the Retirement Contribution Plan and Minimum Pension Plan under any circumstance.

If you were not fully vested when you terminated your Intel employment and you are later rehired, you may be able to resume vesting in the benefit you earned during your previous period of employment if:

- You were at least 20% vested when you terminated, or
- You were 0% vested when you terminated, and your break-in-service was less than five years

18.3.5 Retirement Contribution Plan Contributions

Intel's Retirement Contribution Plan contribution was a discretionary contribution determined annually by the Chief Executive Officer. Intel will not make discretionary contributions under Intel's Retirement Contribution Plan. Instead, Intel added a match to the 401(k) Savings Plan on January 1, 2020.
Retirement contributions (for plan years prior to 2020) and investment earnings accumulate in the Plan on a tax-deferred basis until the money is paid out to you.

Retirement Contribution while on Military Leave

Prior to 2020, if you were an eligible participant and are on a qualified military leave under the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), you will receive a retirement contribution based on any eligible compensation paid to you during your military leave (such as eligible bonuses or military adjustment pay) as well as an amount up to the eligible compensation you would have received had you not entered military service. The portion of the retirement contribution based on eligible compensation you would have received had you not entered military service will be deposited to your account as soon as administratively feasible (generally later than the retirement contribution is made as additional time is needed to calculate and process the amount) even if you are on a qualified military leave at the time the annual contribution is made.

Investment of Retirement Contribution Plan Contributions

Intel's Retirement Contributions and investment earnings accumulate in the Plan on a tax-deferred basis until the money is paid out to you.

You have a choice of investment options for your Retirement Contribution Plan account. You may split your investment in any whole percentage increments among any of the investment options offered under the Retirement Contribution Plan. Any future retirement contributions will be invested in the Global Diversified Fund unless you choose otherwise.

The investment options for the Retirement Contribution Plan provide investment choices in each major asset class category including the Global Diversified Fund, Target Date Funds, low cost index funds, and a Stable Value fund.

You may change investment elections for future retirement contributions, for existing balances already in your Retirement Contribution Plan account, or for both future contributions and existing balances. Investment election changes may be made on a daily basis, subject to the Intel excessive trading policy (see Section 18.2.7 under "Investment election information" for details on trade limitations).

When you plan your asset allocation strategy for your Intel Retirement Contribution Plan account, you should consider how your 401(k) Savings Plan account, if applicable, is invested, and how any other assets you may hold are invested, to assure that you are well diversified in your overall asset allocation. You are strongly encouraged to read all of the fund descriptions and disclosure materials relating to the investment options under the Plans.

For information on the available investment funds, excessive trading policy or to make exchanges visit Fidelity's NetBenefits website or call the Fidelity Service Center. See "Resources" in this chapter for additional information.

The Investment Policy Committee reserves the right without advance notice, and on a temporary or permanent basis, to do the following: add, change, or remove one or more investment option(s) under the Retirement Contribution Plan, change the dates on which elections can be made or on which elections become effective, and to limit the number of changes you may make to your account selections during any calendar year.

18.3.6 Minimum Pension Plan Benefits

The amount of the Minimum Pension Plan benefit is determined by a formula that is based on your final average pay, Social Security covered compensation and length of service when you separate employment with Intel, or, if earlier, when you ceased earning benefit accruals because of being in an ineligible pay grade or because you transferred to a non-U.S. payroll.

- For active U.S. employees who are Minimum Pension Plan participants as of December 31, 2014, whose benefit accruals stopped effective January 1, 2015, because of being grade 7 or above (or equivalent) or because of being an Intel Contract Employee (ICE), the Minimum Pension Plan benefit formula will be calculated using your final average pay, Social Security covered compensation, and length of service calculated as of December 31, 2014
- For U.S. employees who are Minimum Pension Plan participants whose benefit accruals stop after January 1, 2015, as a result of being promoted to grade 7 or above (or equivalent) or because of becoming an ICE employee, the Minimum Pension Plan benefit formula will be calculated using your final average pay, Social Security covered compensation, and length of service calculated as of December 31 of your year of promotion or year of becoming an ICE employee
- For U.S. employees who are Minimum Pension Plan participants whose benefit accruals stop after January 1, 2015, as a result of a transfer to non-U.S. payroll, the Minimum Pension Plan benefit formula will be calculated using your final average pay, Social Security covered compensation, and length of service calculated as of your date of transfer to non-U.S. payroll
- For U.S. employees who are Minimum Pension Plan participants as of December 31, 2019, whose benefit accruals stopped effective January 1, 2020, because of being grade 6 or below (or equivalent), the Minimum Pension Plan benefit formula will be calculated using your final average pay, Social Security covered compensation, and length of service calculated as of December 31, 2019

This formula results in a monthly benefit beginning at age 65, which is compared to the monthly annuity equivalent of your Retirement Contribution Plan account balance as of the date of your termination of Intel employment. The amount, if any, by which the Minimum

Pension Plan monthly formula benefit exceeds the monthly annuity value of your Retirement Contribution Plan account, is your minimum pension benefit.

If the monthly annuity value of your Retirement Contribution Plan account balance as of the date of your termination of Intel employment produces a benefit that is equal to or greater than the Minimum Pension Plan formula benefit, you will receive your benefit from the Retirement Contribution Plan only.

Calculating the Minimum Pension benefit

The formula for calculating your minimum pension from the Plan at normal retirement is the sum of:

0.75% of final average pay plus
0.65% of excess final average pay
times your years of service with Intel (up to 35 years)
minus the Annuity Value of your Retirement Contribution Plan account

If the result of the formula is less than or equal to zero, you receive only the value of your Retirement Contribution Plan account. You may request a pension estimate by visiting Fidelity's NetBenefits website or calling the Fidelity Service Center.

Final average pay

This is the average of your highest five consecutive years of pay in the last 10 years during which you were an eligible participant accruing benefits in the Plan. If your eligibility in the Plan is fewer than five years, this number will be your average pay during all your years of participation. Pay in excess of $285,000 in 2020, and adjusted annually for changes in cost of living, will not count in the pension calculation.

Covered compensation

This is the average maximum compensation taken into account for Social Security benefits, based on tables provided by the IRS during the 35-year period, which ends in the year you reach your Social Security retirement age.

While covered compensation is generally calculated using tables in effect at termination of employment:

- For U.S. employees who are Minimum Pension Plan participants as of December 31, 2014, whose benefit accruals stopped effective January 1, 2015, because of being in grade 7 or above (or equivalent) or because of being an Intel Contract Employee (ICE), covered compensation will be calculated using the 2014 table.
- For U.S. employees whose benefit accruals stop after January 1, 2015, as a result of being promoted to grade 7 or above (or equivalent) and remain in one of those grades through the end of that calendar year, or becoming an ICE employee, or being transferred to a non-U.S. payroll, covered compensation will be calculated using the table in effect during the year of promotion, transfer to ICE or transfer to non-U.S. payroll.

- For active non-U.S. employees as of December 31, 2014, who have accrued benefits in the Intel Minimum Pension Plan, covered compensation will be calculated using the 2014 table.
- For U.S. employees who are Minimum Pension Plan participants as of December 31, 2019, whose benefit accruals stopped effective January 1, 2020, because of being grade 6 or below (or equivalent), the Minimum Pension Plan benefit formula will be covered compensation will be calculated using the 2019 table.

Excess final average pay

This is the excess, if any, of your final average pay over your covered compensation. This part of the formula is intended to provide additional retirement income for the portion of your pay not covered by Social Security benefits.

Years of service for calculating the amount of your Minimum Pension Plan benefit

In general, the total number of years of service used in determining the amount of your Minimum Pension Plan benefit is the same as the number of years for which you receive credit under the rules defined in the "How Service for Eligibility and Vesting is Determined" section. However, the following years of service will not be counted:

- Years of employment as a college intern or summer intern status employee
- Years of employment completed before a break in service of five years or more during which you had no vested interest in the Minimum Pension Plan
- Years of employment while on international payroll with an Intel company located outside of the United States
- Years of pre-acquisition employment with a company acquired by Intel
- Years of employment with an Intel company not participating in the Minimum Pension Plan
- Years of service after December 31, 2014, in which you are in grade 7 or above (or equivalent) or are an Intel Contract Employee (ICE). If you are promoted from grade 6 or below (or equivalent) to one of the above mentioned ineligible grades after January 1, 2015, you will be credited with benefit service for the full calendar year in which your promotion occurs (or to the date you terminate your Intel employment, if earlier), but no benefit credit will be counted for any year thereafter even if you later move back to grade 6 or below (or equivalent) in a following calendar year
- Years of service after December 31, 2019

If you stop accruing benefit service for any reason on or after January 1, 2015 (e.g., you terminate your Intel employment or because of any of the bullet items listed above), you will not be able to resume earning benefit credit under any circumstance thereafter.

The maximum service that will be credited by the Plan is 35 years.

Annuity value of your Retirement Contribution Plan account

When you leave Intel, the final balance of Intel's contributions (plus earnings) in your Retirement Contribution Plan account (adjusted, if applicable, for outstanding loans and prior

withdrawals) will be converted into a lifetime annuity value for calculation purposes. The calculation is based on your age when you leave Intel and some assumptions about interest and mortality that are defined by the Plan. Due to IRS regulations, this actual annuity benefit may differ significantly from the annuity that can be purchased by transferring your Retirement Contribution Plan balance into the Minimum Pension Plan as described in the "Annuity options" section of the Distribution after Separation of Employment chapter.

Basic illustrations

- Carol is a grade 7 employee. On December 31, 2014, her final average pay and years of service produce an age 65 benefit of $1,500/month. On June 30, 2016, she stops working for Intel. At that time, the projected annuity value of her Retirement Contribution Plan account at age 65 is $1,000/month. Her benefit payable from the Minimum Pension Plan at age 65 is $500/month.
- John is a grade 6 employee who is promoted to grade 7 in April, 2018. On December 31, 2018, his final average pay and years of service produce an age 65 benefit of $1,000 per month. On September 10, 2022, he stops working for Intel. At that time, the projected annuity value of his Retirement Contribution Plan account at age 65 is $1,500/month. John will not receive any benefit from the Minimum Pension Plan.

Detailed examples of 2016 pension calculations: Assume the persons in this example are:

- Grade 6 or below, i.e., they continue to earn benefit accruals after December 31, 2014,
- Age 65 at retirement in 2016, and
- Have the following Minimum Pension Plan data:

Example 1		**Example 2**	
Final average pay	$94,000.00	Final average pay	$94,000.00
Years of service	**20 years**	Years of service	**5 years**
Covered compensation	$77,640	Covered compensation	$77,640

First, calculate the monthly value of the Retirement Contribution Plan account:

Example 1		**Example 2**	
Retirement Contribution Plan account balance after 20 years of Intel contributions and market returns	$300,000	Retirement Contribution Plan account balance after 5 years of Intel contributions and market returns	$37,000
Divide by the current annuity factor. (This example uses an annuity factor from October 2015. The actual annuity factor can change quarterly)	189.3888	Divide by the current annuity factor. (This example uses an annuity factor from October 2015. The actual annuity factor can change quarterly)	189.3888
Monthly annuity value of Retirement Contribution Plan account	$1,584.04	Monthly annuity value of Retirement Contribution Plan account	$195.37

Next, calculate the monthly retirement benefit under the minimum pension formula:

Final average pay	$94,000.00	Final average pay	$94,000..00
Multiply by	.75%	Multiply by	.75%
	$705.00		**$705.00**
Excess final average pay ($94,000 - $77,640)	$16,360	Excess final average pay ($94,000- $77,640)	$16,360
Multiply by	.65%	Multiply by	.65%
	$106.34		**$106.34**
Add the two benefit factors together ($705.00 + $106.34)	$811.34	Add the two benefit factors together ($705.00 + $106.34)	$811.34
Multiply by years of service	20 years	Multiply by years of service	5 years
	$16,226.80		**$4,056.70**
Divide by 12 to get the minimum monthly pension benefit from the formula	$1,352.23	Divide by 12 to get the minimum monthly pension benefit from the formula	$338.06
Subtract the monthly annuity value of the Retirement Contribution Plan account balance	$1,584.04	Subtract the monthly annuity value of the Retirement Contribution Plan account balance	$195.37
Monthly benefit paid from Pension Plan	**$0.00**	Monthly benefit paid from Pension Plan	**$142.69**

If your Retirement Contribution Plan account produces a higher benefit, as in Example 1, you receive your Retirement Contribution Plan account and no benefit from the Minimum Pension Plan. The Retirement Contribution Plan account balance of $300,000 could be paid out as a lump sum or as an annuity payable each month from the Minimum Pension Plan. Due to IRS regulations for calculating annuities from Retirement Contribution Plan account balances that are transferred into the Minimum Pension Plan, this annuity amount will differ from the $1,584.04 annuity amount that was subtracted from the Minimum Pension Plan benefit.

If the minimum pension benefit formula produces a higher benefit, as in Example 2, you receive your Retirement Contribution Plan account balance and the difference between the Retirement Contribution Plan annuity value ($195.37) and Minimum Pension Plan annuity ($338.06) calculations of $142.69, payable each month from age 65 until death. This benefit may be payable at different times and in different forms. See "Distributions after Separation of Employment" in this chapter for more information on your distribution options.

Time of retirement – normal, early, late

The Pension Plan formula assumes you will retire at age 65, but you have the option of retiring before or after that age. If you terminate employment on or before age 65 and do not elect to commence your benefit by the time you reach age 65, distribution will automatically commence as soon as administratively possible after you reach age 65. The form of payment will be based on your marital status on record at Fidelity. Your minimum pension benefit will be computed using your final average pay, years of service, and Retirement Contribution Plan account balance at the time you terminated employment. If applicable, the amount of your benefit from

the formula will be increased, using interest and mortality assumptions defined by the Plan, to reflect the delay in commencing your benefit after your attainment of age 65.

- **Normal retirement (age 65)**
  Retirement at age 65 is considered normal retirement
- **Early retirement (before age 65)**
  Once you terminate employment, you can begin receiving your retirement benefits at any time prior to age 65. The minimum pension benefit calculation will use your final average pay, years of service, and Retirement Contribution Plan account balance as of the date you terminate. Your benefit from the formula will be reduced, using interest and mortality assumptions defined by the Plan, to reflect the longer period of time you will likely be receiving monthly payments. If you meet one of the special early retirement definitions when you begin your benefit, the calculation could result in a slightly higher benefit. To be eligible for early retirement, you must be age 55 or older and have completed at least 15 years of service, or the combined total of your age plus your length of service (both calculated in completed, whole years) must be equal to or greater than the number 75
- **Late retirement (after age 65)**
  You may elect to work beyond age 65, which is considered "late" retirement. If you do, you will continue to accrue service, and your minimum pension will be computed using your final average pay, years of service, and Retirement Contribution Plan account balance at the time you actually retire. The amount of your benefit from the formula will also be increased, using interest and mortality assumptions defined by the Plan, to reflect the shorter period of time you will likely be receiving monthly payments

When you terminate

Fidelity will calculate your Minimum Pension Plan benefit using your actual service, final average pay, and Retirement Contribution Plan balance as of your last day at Intel. This balance will be adjusted, if applicable, for outstanding loans and prior withdrawals. If you qualify for Normal, Early or Late Retirement described above, you will be eligible to receive a retirement contribution for the year you retire (provided a contribution is made that year), and your retirement benefit may include that contribution.

- If your Retirement Contribution Plan balance produces a higher benefit than the pension formula, you will receive payment of your Retirement Contribution Plan account balance only, in the distribution form that you elect
- If the pension formula produces a higher benefit, you will receive a lifetime annuity or a lump-sum distribution from the Minimum Pension Plan and receive a distribution of your Retirement Contribution Plan account balance based on the benefit option you select. To commence your Minimum Pension Benefit, visit Fidelity's NetBenefits website or call the Fidelity Service Center.

18.3.7 Qualified Supplemental Employee Retirement Plan (QSERP)

QSERP provides additional benefits from the Plan that offset certain benefits from the Sheltered Employee Retirement Plus (SERPLUS) plan. Employees who had a vested SERPLUS balance of at least $5,000 on Dec. 31, 2003, were eligible to participate. Upon separation from employment from Intel, the lump sum value of your QSERP benefit will be subtracted from your

SERPLUS balance the month following your date of separation/retirement. QSERP is added to the amount of any minimum pension benefit and must be distributed using the same payment method and commencement date as any MPP benefit. Since QSERP is part of the Minimum Pension Plan, all of the same rules and regulations apply. For more information call the Fidelity Service Center.

18.3.8 Pension Benefit Guaranty Corporation (PBGC)

Your pension benefits under the Intel Minimum Pension Plan are insured by the Pension Benefit Guaranty Corporation (PBGC), a federal insurance agency. If the Plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under their plan, but some people may lose certain benefits.

The PBGC generally covers Normal and Early Retirement benefits and certain benefits for your survivors.

The PBGC guarantee generally does not cover: (1) benefits greater than the maximum guaranteed amount set by law for the year in which the Plan terminates; (2) some or all of benefit increases and new benefits based on Plan provisions that have been in place for fewer than five years at the time the Plan terminates; (3) benefits that are not vested because you have not worked long enough for the company; (4) benefits for which you have not met all of the requirements at the time the plan terminates; and (5) certain early retirement payments that result in an early retirement monthly benefit greater than your monthly benefit at the Plan's normal retirement age.

Even if certain of your benefits are not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money your Plan has and on how much the PBGC collects from employers.

For more information about the PBGC and the benefits it guarantees, ask your plan administrator or contact the PBGC's Technical Assistance Division, 1200 K Street N.W., Suite 930, Washington, D.C. 20005-4026 or call 202-326-4000; this is not a toll-free number. TTY/TDD users may call the federal relay service toll-free at 800-877-8339 and ask to be connected to 202-326-4000. Additional information about the PBGC's pension insurance program is available through the PBGC's Website on the Internet at www.pbgc.gov

Note: The 401(k) Savings Plan and Retirement Contribution Plan are not subject to the PBGC insurance protection.

18.4 Loans and Withdrawals While Employed

Topics

18.4.1 Loans and Withdrawals Overview

The 401(k) Savings Plan and Retirement Contribution Plan include a loan feature and certain in-service withdrawal provisions. These allow you access to your vested plan account balances while you are an active employee on U.S. Payroll (active employees who permanently transfer to a country outside the U.S., former employees, beneficiaries, and former spouses of employees are not eligible for these provisions).

- The loan feature allows you to borrow against your vested account balances. Loans are available for any reason. Loans have an advantage over in-service withdrawals as you are generally not taxed on the loan proceeds unless your loan violates IRS requirements.
- The in-service withdrawal provision is available on certain account sources or for severe financial reasons, such as hardship withdrawal. Certain restrictions and taxes may apply to in-service withdrawals.

It is recommended that you consult a tax advisor before requesting a loan or in-service withdrawal.

18.4.2 Loans

What you can borrow

You are permitted to borrow up to the lesser of $50,000 or 50% of your vested account balance. Funds withdrawn do not share in the Plan's investment gains or losses, but interest paid on the loan will be credited directly to your accounts. The minimum amount you can apply for is $500. You may take loans from either the 401(k) Savings Plan or the Retirement Contribution Plan, but you may have only two loans outstanding at one time: two from the 401(k) Savings Plan, two from the Retirement Contribution Plan, or one from each Plan. The following borrowing limitations apply:

- You may not borrow from the 401(k) Savings Plan an amount that would cause your loans outstanding under the 401(k) Savings Plan to exceed 50% of your vested balance under the 401(k) Savings Plan.
- You may not borrow from the Retirement Contribution Plan an amount that would cause your loans outstanding under the Retirement Contribution Plan to exceed 50% of your vested balance under the Retirement Contribution Plan.

The maximum amount of the combined balance of all loans that you have outstanding under all Intel retirement plans cannot exceed $50,000, minus the highest balance outstanding on all loans at any single time in the last 12 months. If you were hired at Intel from an M&A or subsidiary, participated in their retirement plans, and have an outstanding loan against that Plan account, that outstanding loan balance will count towards the $50,000 limit in the Intel Plans.

When you request a loan, you must choose whether you would like to have the loan proceeds taken from the 401(k) Savings Plan or the Retirement Contribution Plan, if you have loan amounts available under each Plan. The loan amounts available under the 401(k) Savings Plan and under the Retirement Contribution Plan will be different, and you may take loans from either Plan, or both Plans. When you request a loan from the 401(k) Savings Plan, you may either choose the fund(s) you would like the loan proceeds taken from or the loan proceeds will be taken pro rata across all funds. One additional day (trade + 1 day) is required to process your loan request if you are invested in the Intel Stock Fund, regardless if loan proceeds are requested from the Intel Stock Fund. See “Investment Options” in this chapter for more information on the Intel Stock Fund as a daily share accounted fund. Participants who invest in certain investment options are subject to redemption fees if the minimum holding period requirement is not met. A short-term redemption fee may be charged if the loan proceeds are taken from these funds before you have satisfied the fund’s applicable holding period. If all or a portion of your 401(k) Savings Plan account is invested in funds in Fidelity BrokerageLink®, you will be required to transfer the necessary amount back to the Invesco Government & Agency Portfolio before your loan can be processed. For additional information on redemption fees on these funds, view the investment information on Fidelity’s NetBenefits website or call the Fidelity Service Center.

Loan provisions

Loans are generally granted for periods of up to five years (nine years for buying or building your primary residence) and are secured by either your vested 401(k) Savings Plan account balance or your vested Retirement Contribution Plan balance.

Loans requested from your Retirement Contribution Plan require notarized spousal consent if you are married.

The loan amount will bear a fixed rate of interest equal to the prime rate plus 1% as reported by Reuters on the last business day of each month. The interest you pay on the loan is credited directly to your plan account.

Loans initiated on or after July 1, 2014 will be assessed a one-time $50 loan application fee and there will be no ongoing quarterly processing fee. Loans initiated prior to July 1, 2014, were assessed a one-time $35 loan application fee and will continue to be assessed a quarterly processing fee of $3.75. Applicable fees will be deducted from the account from which your loan was taken. If all or the majority of your 401(k) Savings Plan account is invested in Fidelity BrokerageLink®, you will be required to maintain a small balance in the 401(k) Savings Plan investment fund(s) in order for the quarterly fees to be deducted from your Plan account balance.
Loan repayments are made through regular after-tax payroll deductions. As long as you are receiving a paycheck from U.S. Payroll, you generally cannot stop your loan repayments for

any reason, including bankruptcy, unless you go on a leave of absence. You may also prepay your loan in part or in full. If you have two loans outstanding, one loan must be fully repaid before you will be allowed to initiate a new loan. There is a 30-day waiting period from the date an existing loan is paid until you can request a new loan. There is no waiting period between loan requests when applying for a second loan when only one existing loan is outstanding. All loan repayments and interest will be invested according to your current investment choices for contributions.

If you leave Intel, go on a leave of absence, transfer to a non-participating subsidiary, or are transferred to a non-U.S. site, your loan repayments through payroll deductions will stop, however, you may continue to make loan payments directly to Fidelity via check, money order or electronic fund transfer. If you are on a leave of absence, you should receive a letter from Fidelity approximately two weeks from the time you start your leave, on how to continue your loan payments through Electronic Loan Payments. If you do not receive this information, contact the Fidelity Service Center. If you fail to continue making payments on your Plan loan(s), the outstanding balance(s) may be treated as a distribution subject to income taxes and penalties.

For additional information, see "Distributions after Separation of Employment" in this chapter. If you need assistance on your loan, contact the Fidelity Service Center. If you joined Intel as part of a merger or acquisition, these rules may not apply to loans under your M&A Retirement Plan.

If you have a 401(k) Savings Plan and/or Retirement Contribution Plan loan prior to the start of a qualified Military Leave, you can elect that the interest rate on your outstanding loan be capped at 6% during the time you are on Military Leave. You may choose to suspend your loan payments at the current interest rate, prior to leaving on Military Leave. If you choose to suspend your loan and keep your original interest rate, the length of your leave will be added to the end of the life of the loan and amortized at the original interest rate. Loan repayments may also continue to be taken from your supplemental pay, if available. If no supplemental pay is available, then your loan will automatically be suspended until your return from Military Leave.

If, for any reason, payroll withholding does not occur and you fail to make a loan payment on time, your loan will be declared in default. If a default is declared, Intel may require immediate payment of the entire unpaid balance or deduct the unpaid balance from the assets in your vested 401(k) Savings Plan account balance or your vested balance in the Retirement Contribution Plan, as applicable. If the loan is declared to be in default, it is considered a taxable distribution and may be subject to income taxes and penalties. If a loan in default is not repaid, it will be considered outstanding for purposes of calculating your maximum available loan. More detailed information about the loan and terms is included in the loan application.

18.4.3 401(k) Savings Plan withdrawals while employed

Under certain circumstances, you may withdraw money from your 401(k) Savings Plan accounts while you are still employed. Withdrawals may be subject to taxes and penalties depending on the sources of your 401(k) Savings Plan account from which you withdraw. You should consult a tax advisor before requesting a withdrawal from your account. Withdrawals may be subject to an individual service fee. See "Plan Fees and Expenses" in this chapter for more information. If all or a portion of your 401(k) Savings Plan account is invested in funds in Fidelity BrokerageLink®, you will be required to transfer the necessary amount back to the Invesco

Government & Agency Portfolio before your withdrawal can be processed. To initiate a withdrawal, contact the Fidelity Service Center.

Withdrawals are permitted only according to the following rules:

Age 59½ withdrawals

Withdrawals of pre-tax and/or Roth contributions and earnings and 401(k) match and earnings are permitted for employees who are at least age 59½. Withdrawals from your pre-tax source will be subject to ordinary income tax.

Withdrawals from your Roth source may be subject to taxes if your withdrawal is requested prior to meeting the qualified distribution rules.

Hardship withdrawals

Withdrawals are permitted in the event of certain financial hardships which are limited to the following situations:

- Payment of extraordinary medical expenses previously incurred by or necessary to obtain care for you, your spouse, dependents, or a primary beneficiary(ies)
- The purchase of your primary residence (excluding mortgage payments)
- Payment of tuition and related education fees for the next 12 months of post-secondary education for you, your spouse, dependents, or a primary beneficiary(ies)
- To prevent eviction of or foreclosure on your principal residence
- Payment of funeral expenses for your spouse, dependents, parents or a primary beneficiary(ies)
- Repair damage of primary residence that would qualify under the casualty deduction under Code section 165
- Payment of expenses and losses incurred on account of a federally declared disaster in the area of your principal residence or principal place of employment
- Other circumstances or events identified by the Secretary of the Treasury.

You can update your beneficiary elections for the 401(k) Savings Plan online at www.netbenefits.com or by calling the Fidelity Service Center at 1-888-401-7377. See "Designating a Beneficiary" and "Resources" in this chapter for additional information.

For the calendar year in which you receive pre-tax money as a hardship withdrawal, you must pay income taxes on such withdrawal, which may include an additional 10% penalty tax if you are under age 59½. Withdrawals from your Roth source may be subject to taxes if your withdrawal is requested prior to meeting the qualified distribution rules. The hardship withdrawal amount can be increased for the anticipated income taxes and any penalty due on the withdrawal.

Hardship withdrawal requests must be approved by Fidelity, the plan record keeper and can be made only once in a rolling 12-month period.

After-tax withdrawals

If you participated in the 401(k) Savings Plan before 1988 or after 2019, you may have an after-tax account available for withdrawal. After-tax withdrawals may be made for any reason.

You may withdraw after-tax contributions made before January 1, 1988, without penal ty. If you withdraw after-tax contributions made on or after January 1, 1988, a portion of this withdrawal is assumed to be interest earned and subject to ordinary income tax, and a 10% early withdrawal penalty may apply. **Note:** After-tax withdrawal rules do not apply to your Roth contributions.

Free$tock withdrawals

If you participated in the 401(k) Savings Plan before 1987, you may have a Free$tock account available for withdrawal. Only one withdrawal of Free$tock is permitted in a rolling 12-month period. Payment will be made in either cash or shares of stock according to your withdrawal instructions. If you do not make a specific election, the shares of Intel common stock will be sold and you will receive a cash distribution equal to the value of such shares. This withdrawal will be subject to ordinary income tax and a 10% early withdrawal penalty may apply.

Age 70½ withdrawals

Withdrawals of any or all of your vested Retirement Contribution source are permitted for eligible participants who are at least age 70½. In addition, a withdrawal may be required for participants who are age 70½ (see "401(k) Savings Plan and Retirement Contribution Plan: Account balances more than $5,000" in Section 18.5 for additional information). Age 70½ withdrawals may be subject to an individual service fee and will be subject to ordinary income tax.

18.4.4 Retirement Contribution Plan Withdrawals while Employed

Age 70½ withdrawals

Withdrawals of any or all of your vested account balance are permitted for eligible participants who are at least age 70½. Age 70½ withdrawals may be subject to an individual service fee and will be subject to ordinary income tax. Age 70½ withdrawals requested from your Retirement Contribution Plan require notarized spousal consent if you are married.

18.5 Distributions after Separation of Employment

Topics

18.5.1 Distributions overview

You can receive distributions from your 401(k) Savings Plan, Retirement Contribution Plan and/or Minimum Pension Plan benefit after you have separated employment with Intel. Distributions are different from in-service withdrawals which are available while you are employed with Intel. To initiate a distribution, contact the Fidelity Service Center and request a distribution packet for the Plan from which you are requesting a distribution. If all or a portion of your 401(k) Savings Plan account is invested in funds in Fidelity BrokerageLink®, you will be required to transfer the entire BrokerageLink® balance back to the Invesco Government & Agency portfolio before your 401(k) distribution can be processed. Please seek professional tax advice and/or financial planning guidance.

18.5.2 Termination of Employment

When you terminate your employment with Intel, you can request a distribution as early as 30 days after you leave Intel. You can receive the following:

- Your pre-tax, Roth, after-tax, rollover, match and merged account balances, and vested Intel discretionary retirement contribution account balance in the 401(k) Savings Plan.
- Your vested account balance in the Retirement Contribution Plan.
- A benefit from the Minimum Pension Plan, if the balance in your Retirement Contribution Plan account does not provide a minimum level of retirement income as determined by the pension formula.

Note: If you transfer to a non-participating subsidiary or to a country outside of the U.S. and are no longer eligible for participation in the Plans, under U.S. tax law you are not eligible to receive a distribution of your account balance(s) until you have separated employment within Intel's control group.

18.5.3 Forms of Distribution at Termination

The following general rules apply to distributions from the 401(k) Savings Plan, Retirement

Contribution Plan and Minimum Pension Plan:

- **401(k) Savings Plan, Retirement Contribution Plan and Minimum Pension Plan**: **Account balances $1,000 or less**
    - If your account value in any of the Plans is $1,000 or less, it will automatically be paid to you in a single lump sum. **Note**: If your 401(k) Savings Plan account balance is comprised of Roth, pre-tax and after-tax contributions, the $1,000 limit is applied separately to your Roth balance, your pre-tax balance (pre-tax deferral, discretionary Retirement Contributions, and 401(k) match) and your after-tax balance.
- **401(k) Savings Plan: Account balances more than $1,000 but not more than $5,000**
    - If your 401(k) Savings Plan account value is more than $1,000 but less than or equal to $5,000, you may elect to roll over your account to an IRA, to another employer's eligible retirement plan that accepts rollovers, or receive your account value in a single lump sum. If you do not make a distribution election within 60 days from the date you receive your termination packet, your account will be rolled over into a Fidelity Rollover IRA in your name. Information on how to access your IRA account will be mailed to you after your Fidelity Rollover IRA has been established. Your IRA account is between you and Fidelity. **Note:** If your 401(k) Savings Plan account balance is comprised of Roth, pre-tax and after-tax contributions the $1,000 limit is applied separately to your Roth balance, your pre-tax balance (pre-tax deferral, discretionary Retirement Contributions, and 401(k) match) and your after-tax balance.
- **Retirement Contribution Plan and Minimum Pension Plan: Account balances more than $1,000 but not more than $5,000**
    - If your vested Retirement Contribution Plan account value or Minimum Pension Plan benefit is more than $1,000 but less than or equal to $5,000, you may elect to roll over your account to an IRA to another employer's eligible retirement plan that accepts rollovers or receive your account value in a single lump sum. If you do not make a distribution election within 60 days from the date you receive your termination packet, your account will be rolled over into a Fidelity Rollover IRA in your name. Information on how to access your IRA account will be mailed to you after your Fidelity Rollover IRA has been established. Your IRA account is between you and Fidelity.
- **401(k) Savings Plan and Retirement Contribution Plan: Account balances more than $5,000**
    - Your vested 401(k) Savings Plan or Retirement Contribution Plan account balances are more than $5,000, they will remain in your account until you request a distribution. You may elect to roll over your account to an IRA or to another employer's eligible retirement plan that accepts rollovers. You may request a partial distribution with the minimum amount of $5,000 (full account balance if less) or receive your account value in a single lump sum. If you were hired prior to January 1, 2019, you may also elect to receive your account value as an annuity paid from the Minimum Pension Plan.
    - If you do not elect a distribution prior to age 70½, federal law requires that you begin receiving benefits from the Plan. The first Plan distribution (referred to as a Minimum Required Distribution or MRD) must be made no later than April 1 of the calendar year after the calendar year you have reached age 70½. Additional distributions must be made by December 31 of that year and each year

following. If you are married and elect a form of distribution other than a joint and survivor annuity under the Retirement Contribution Plan, a notarized spousal consent form is required before your distribution can be processed. **Note:** If the total value of your 401(k) Savings Plan account is over $5,000 and is comprised of Roth, pre-tax and after-tax contributions, the $1,000 limit described in the **$1,000** and **$1,000 but not more than $5,000** sections does not apply.

- **Minimum Pension Plan: Account balances more than $5,000**
    - If the present value of your vested Minimum Pension Plan benefit is more than $5,000, it will be automatically paid as an annuity at age 65, unless you elect another form of distribution, such as lump sum. You may request your Minimum Pension Plan benefit to commence prior to age 65, but the amount of your benefit will be reduced. If you do not elect a form of distribution before your 65th birthday, your Minimum Pension benefit will be paid in a single life annuity or, if you are married, as a 100% joint and survivor annuity with your spouse. If you are married and elect a form of distribution other than a joint and survivor annuity under the Minimum Pension Plan, a notarized spousal consent form is required before your distribution(s) can be processed.
- **Distributions from Roth contributions.** If you contributed to the 401(k) Savings Plan on a Roth basis, special rules apply. Earnings accumulate on your Roth contributions and are distributed federal income tax free if the distribution is a qualified distribution. A qualified distribution is defined as (1) made after you have attained age 59½, become disabled, or die AND (2) made after the fifth tax year beginning with the year you first made a Roth contribution in the 401(k) Savings Plan. Roth account balances may be rolled over to another employer's Roth account that accepts Roth rollovers or a Roth IRA, but not to any other account in an employer's plan or to a traditional IRA.
- **Distributions from after-tax 401(k) contributions**: If you contributed to the 401(k) Savings Plan before 1988 or after 2019 on an after-tax basis, those contributions are not taxable when distributed. Eligible after-tax contributions made to your 401(k) Savings Plan account can be rolled over to an IRA or to another employer's plan that accepts after-tax monies. The earnings on after-tax contributions can then be tax deferred.
- **Outstanding loan balances at distribution.** If you have a loan outstanding and you do not receive or request a distribution of your Plan account, you may continue to make payments directly to Fidelity in order to avoid default. If you have a loan outstanding and you receive a distribution of your account (whether automatically or by election), the amount of your outstanding loan will be included in the taxable portion of the distribution.
    - If you have a loan outstanding and your account is rolled over directly to another employer's eligible retirement plan or to an IRA (whether automatically or by election), the balance due on your loan will be deemed distributed to you in a taxable distribution if you do not pay off the loan in advance of the rollover.
    - If any portion of the defaulted loan is from the Roth source, taxes may apply if you have not met the qualified distribution rules.

Before making a distribution election, you should consult a tax advisor and review the tax consequences of each of your distribution options. See Federal Income Tax Considerations in this chapter for additional information.

Lump sum distributions

If you elect to take a lump sum distribution, you may:

- Take the entire distribution in cash and pay the taxes due on the eligible amount in the year received.
- Take the entire distribution in cash (or cash and shares of Intel common stock with respect to any whole shares allocated under the Intel Stock Fund or as Free$tock) and pay the taxes due on the cash and your cost basis on the stock.
- Take the entire distribution in cash (or cash and shares of Intel common stock with respect to any whole shares allocated under the Intel Stock Fund or as Free$tock) and then within 60 days roll over part or all of the distribution into an IRA or into another employer's eligible retirement plan that accepts rollovers.
- Request a direct rollover of your entire account to an IRA or to another employer's eligible retirement plan that accepts rollovers.
- Take part of your distribution in cash or shares of Intel stock with respect to any whole shares allocated under the Intel Stock Fund or as Free$tock, or both, and request that the rest of your account be transferred to an IRA or to another employer's eligible retirement plan that accepts rollovers, in a direct rollover.

If you take a distribution in cash or shares of Intel stock and subsequently roll it over, rather than transferring that amount in a direct rollover, your distribution will be subject to tax withholdings. See Federal Income Tax Considerations in this chapter for additional information. You may roll over shares of Intel stock to an IRA or to another employer's eligible retirement plan only if the plan or IRA accepts such stock.

Annuity options

You may choose among three annuity options under the Plan for your 401(k) Savings Plan account (if you were hired before January 1, 2019) or Retirement Contribution Plan account. All annuity options are distributed from the Minimum Pension Plan. If you want to receive your 401(k) Savings Plan account or Retirement Contribution Plan account in the form of an annuity, your Plan account(s) will be transferred to the Minimum Pension Plan. The accounts will be converted to an annuity using rules set out in IRS regulations, which will result in an annuity amount different from the annuity amount subtracted from the Minimum Pension Plan benefit. An annuity paid from the Minimum Pension Plan will be subject to its spousal consent rules.

Generally, if you are married and do not elect a joint and survivor annuity under the Retirement Contribution Plan or Minimum Pension Plan, notarized spousal consent is required. Roth funds cannot be converted to an annuity within the Intel Minimum Pension Plan. If you choose to convert your 401(k) Savings Plan account into an annuity and you have Roth funds, you must provide instructions to either rollover the Roth funds to a qualified retirement plan/IRA or take a distribution of those Roth funds.

- **Single Life Annuity:** This option provides a monthly payment to you for the rest of your life with no provision for continuing payments to a survivor.
- **50% or 100% Joint and Survivor Annuity:** This option provides a reduced monthly payment to you for the rest of your life, and after your death, monthly payments to your designated beneficiary for life. The amount of each payment to your beneficiary is 50%

or 100% of the amount of each payment made during your life. This annuity is calculated based upon a single life annuity and then actuarially reduced to reflect the fact that payments are guaranteed for the lives of two people. The amount of the reduction is based on your age and the age of your beneficiary when payments begin. The benefit can be calculated so that either 50% or 100% of the benefit will be continued to your designated beneficiary in the event of your death.

- **10- or 15-year Period-Certain Annuity:** This annuity provides a reduced monthly payment to you for the rest of your life and, if you die before receiving payments for the 10- or 15-year guarantee period, provides monthly payments to your designated beneficiary for the remainder of the guarantee period as elected. This annuity is calculated based upon a single life annuity and then actuarially reduced to reflect the guarantee period.

Investment of deferred account balances

Unless you elect to receive a distribution, the funds in your 401(k) Savings Plan and/or Retirement Contribution Plan account(s) will continue to be invested in the investment options selected by you or the respective default investment options for each plan if you have not selected your investments. Following your termination of employment, you will continue to be entitled to change the allocation of your 401(k) Savings Plan and/or Retirement Contribution Plan account balances among the available investment funds offered under each plan.

401(k) Savings Plan - merger accounts

If you were an employee of a company acquired by Intel, the benefits you earned before the acquisition may have been transferred to the 401(k) Savings Plan in a merger account. If you have a merger account, special distribution options may be available to you. For more information about your merger account distribution options contact the Fidelity Service Center.

18.5.4 Distributions to Beneficiaries

Spousal and non-spousal beneficiaries

Beneficiaries must take a full distribution of a participant's account balance(s) following the participant's death.

If you are a beneficiary as the surviving spouse, you may choose to have an eligible rollover distribution paid in a direct rollover to an IRA, into another employer's eligible retirement plan that accepts rollovers, or paid to you in the form of a life annuity or a single lump sum. If the value of the account is $5,000 or greater and the surviving spouse beneficiary does not elect a distribution from the Retirement Contribution Plan prior to March 1 of the year following the participant's death, the surviving spouse beneficiary's Retirement Contribution Plan account balance will automatically be transferred into the Minimum Pension Plan on March 1 and the surviving spouse beneficiary will receive an immediate single life annuity commencing March 1 from the Minimum Pension Plan. Retirement Contribution Plan account balances less than $5,000 or the total vested value of the account balance from the 401(k) Savings Plan will be paid as a lump sum if no distribution is taken within 90 days of the transfer of assets to the surviving spouse beneficiary's account.

If you are a non-spousal beneficiary, you may choose a direct rollover to an IRA that will be treated as an "inherited IRA". A non-spousal beneficiary cannot roll over the payment themselves. A non-spousal beneficiary must instruct the Plan Administrator of the distributing plan to make a direct rollover to an "inherited IRA" that the non-spousal beneficiary has established on his or her behalf. If the non-spousal beneficiary does not take a distribution within 90 days of the transfer of assets into the non-spousal beneficiary's account from either the Retirement Contribution Plan or 401(k) Savings Plan, the Plan accounts will be paid as a lump sum regardless of the value of the account balance.

If distribution of your account already started in the form of an annuity payment before your death, your beneficiary may or may not be entitled to additional payments, depending on the form of annuity payment you elected. See "Annuity options" in this chapter for details. Survivor benefits in the pension plan, in the event you die before benefit payments begin, are payable only to your spouse.

Under federal law, spouses are defined as same-sex or opposite sex couples who are legally married. Other statuses, such as a registered domestic partnerships or civil unions, cannot be recognized as marriages for retirement plan purposes under IRS rules, and domestic partners or civil union members are not considered spouses.

Alternate payees

If you are an alternate payee as a result of a Qualified Domestic Relations Order (QDRO), and you are the participant's spouse or former spouse, you have the same choices as the employee except that no survivor benefits will be paid from the Minimum Pension Plan to your spouse if you have remarried. You can have any lump sum payments to which you are entitled from any of the Plans paid as a direct rollover or paid to you. If you have it paid to you, you can keep it or roll it over yourself to an IRA or to another employer's eligible retirement plan that accepts rollovers. If you are an alternate payee and you are not the participant's spouse or former spouse, you can have any lump sum payments to which you are entitled from any of the Plans paid to you. You cannot choose a direct rollover, and you cannot roll over the payment yourself.

18.5.5 Federal Income Tax Considerations

Consult a professional tax advisor

The following summary of federal income tax consequences does not purport to be a complete statement of the law in this area. Any U.S. tax advice contained in this document is not intended be used, and cannot be used, by any person for the purpose of avoiding any U.S. federal tax penalties that may be imposed on that person. The summary does not address the effects, if any, of other federal taxes, such as inheritance taxes, or of state, local or foreign tax laws.
Because of the complexity of the tax laws with respect to these matters, and because such laws may change, Intel recommends that you consult a tax advisor to assess your tax situation, as well as the effect and applicability of state, local and other tax laws.

General tax information

The Plans are intended to qualify under Section 401(a) of the Tax Code. Qualification under Sections 401(a) has the following key effects:

- Except for any Roth and after-tax contributions that you make, you are not taxed on the amounts you contribute to the Plans until these amounts are distributed or withdrawn from each Plan.
- You are not taxed on earnings or gains in the Plans until these amounts are distributed or withdrawn from each Plan.
- The trust that holds the Plans' assets is not taxed on contributions or earnings.

In general, when you receive money from the Plans, the amount of the distribution is required to be reported to the IRS. Annuity payments and lump sum payments are taxable income in the year each payment is received.

Taxation of Distributions

In general, the recipient of a distribution from the Plans will be subject to federal income tax and other state and local taxes in the year of such distribution on the amount of the distribution. The tax treatment of any distribution depends in part on whether the distribution includes shares of Intel common stock, whether the distribution qualifies as a lump sum distribution, and whether any portion of the distribution is eligible to be rolled over to an IRA or other eligible retirement plan. The following effects are possible:

- Amounts paid to you are subject to withholding taxes.
- Some distributions may also be subject to a 10% penalty tax for early withdrawal.
- Distributions of Intel stock received as shares may be taxed less than distributions taken as cash.
- Special tax treatment is available for some distributions.
- Distributions may be rolled over to an IRA or another retirement plan.

Distributions of Roth contributions

Roth contributions (including amounts converted through a Roth in-plan conversion) included in your 401(k) Savings Plan account distributed from your Roth account are not taxed, but earnings might be taxed. The tax treatment of earnings included in the distribution depends on whether the payment is a qualified distribution. If a distribution is only part of your designated Roth account, the payment will include an allocable portion of the earnings in your designated Roth account. If the payment from the Plan is not a qualified distribution and you do not make a rollover to a Roth IRA or a designed Roth account in another employer's plan, you will be taxed on the earnings in the distribution. If you are under age 59½, a 10% additional income tax on early distributions will also apply to the earnings, unless an exception applies. If you make a rollover, you will not have to pay taxes currently on the earnings and you will not have to pay taxes later on payments that are qualified distributions. If the payment from the Plan is a qualified distribution, you will not be taxed on any part of the payment even if you do not make a rollover. If you make a rollover, you will not be taxed on the amount you roll over and any earnings on the amount you roll over will not be taxed if paid later in a qualified distribution.

Generally, qualified distributions are distributions that occur any time after the Roth account has existed for 5 years and the participant is at least 59.5 years of age. Distributions prior to meeting those requirements will result in income and/or early withdrawal tax. Note that death or disability of the

participant may also enable qualifying distributions.

You may roll over the distribution to a Roth IRA, a Roth individual retirement account or Roth individual retirement annuity, or a designated Roth account in another employer's plan that will accept the Roth rollover, but not to any other account in a plan or to a traditional IRA.

Distribution of after-tax contributions

If your 401(k) Savings Plan account distribution includes after-tax contributions, that portion of your distribution is not taxed. If after-tax contributions are only part of the distribution, an allocable portion of your after-tax contributions is generally included in the payment. If you have pre-1988 or post-2019 after-tax contributions maintained in separate accounts, a special rule may apply to determine whether the after-tax contributions are included in a distribution.

You may roll over to an IRA a distribution that includes after-tax contributions through either a direct rollover or a 60-day rollover. You must keep track of the aggregate amount of the after-tax contributions in all of your IRAs in order to determine your taxable income for later payments from the IRAs. If you do a 60-day rollover to an IRA of only a portion of the payment made to you, the after-tax contributions are treated as rolled over last.

You may roll over to a new employer's plan all of the distribution that includes after-tax contributions, but only through a direct rollover and only if the new employer's plan separately accounts for after-tax contributions. Notably In the case of a rollover to a 457(b) plan, which is a governmental section 457(b) plan. You can make a 60-day rollover to a new employer plan of part of a distribution that includes after-tax contributions, but only up to the amount of the payment that would be taxable if not rolled over.

Amounts paid to you

When you receive money from the Plans, your distribution amounts are required to be reported to the IRS. Payments you receive from an annuity purchased with tax-deferred contributions and lump sum distributions are taxable income in the year received. If you choose to have your Plan benefits paid to you:

- You will receive only 80% of the taxable portion of the payment that is eligible for rollover, because the Plan administrator is required to withhold 20% of the taxable portion of the payment and send it to the IRS as income tax withholding to be credited against your taxes. Any non-taxable portion of the payment will be paid to you in full.
- Your payment will be taxed in the year it is paid unless you roll it over. You may be able to use special tax rules that could reduce the tax you owe. However, if you receive the payment before age 59½, you also may have to pay an additional 10% penalty tax for early withdrawal.
- You can roll over the 80% payment to your IRA, or to another employer plan that accepts your rollover, within 60 days of receiving the payment. The amount rolled over will not be taxed until you withdraw it from the IRA or employer plan.
- If you want to roll over 100% of the payment to an IRA or to an employer plan, you must replace the taxes that were withheld by depositing into the IRA or employer plan an amount equal to the amount withheld. If you roll over only the amount you actually received, you will be taxed on the amount that was withheld for taxes (the 20% federal

withholding tax plus any state or other taxes withheld).

You may avoid the 20% withholding if you elect to take your distribution in the form of a direct rollover. Direct rollovers are explained in greater detail in the Direct Rollover section.

Penalty tax

Distributions that are not rolled over will be subject to an additional 10% tax on early distributions unless an exception applies. Generally, the following payments are exempt from the 10% additional tax:

- Payments to you upon termination of employment after reaching age 55
- Payments to you after retirement due to disability
- Payments made to your beneficiary after your death
- Annuity payments based on your life expectancy
- Payments that do not exceed your tax-deductible medical expenses for the year (whether or not you itemize deductions)
- Payments to an alternate payee under a qualified domestic relations order
- Payments made to comply with a levy by the IRS
- Payments to individuals called to active duty for at least 179 days after September 11, 2001
- Payments of ESOP dividends
- Corrective distributions of contributions that exceed tax law limitations

Withholding taxes

Mandatory withholding: If you take a lump sum distribution that is eligible for rollover as cash (whether or not you roll it over into another plan or to an IRA), the Plan administrator is required to withhold 20% federal income tax from the taxable portion of the payment and report it to the IRS as income tax withholding to be credited against your taxes. Your distribution may also be subject to additional withholding taxes if you live in a state that imposes withholding taxes on retirement plan distributions.

Voluntary withholding: If any portion of your payment is not an eligible rollover distribution but is taxable, the mandatory withholding rules described above do not apply. In this case, you may elect not to have withholding apply to that portion. To elect out of withholding, ask Fidelity for the election form and related information.

Intel Stock

Intel stock in the Intel Stock Fund or your Free$tock account in the 401(k) Savings Plan may be distributed as shares, or the shares may be sold and distributed as cash. Under current Tax Code rules, if you elect to receive a distribution of shares, the amount of tax you pay may be less than if you elect to receive a cash distribution.

Under this special rule, you may have the option of not paying tax on the net unrealized appreciation of the stock until you sell the stock. Generally, net unrealized appreciation is the increase in the value of the stock while it is held by the Plan. If you elect to receive a distribution

of shares, you will be taxed only on your cost basis in the shares. Generally, your cost basis in the Intel Stock Fund is the amount of contributions or transfers into the Intel Stock Fund, plus dividends, less the amount of cash (if any) in your Intel Stock Fund account.

The Plan administrator is still required to withhold 20% federal taxes of the total taxable cash and taxable amount of Intel common stock and report it to the IRS as income tax withholding to be credited against your taxes. However, the Plan administrator is not required to withhold the entire 20% if the cash portion of your distribution is less than 20% of the combined total of cash and taxable common stock amounts. In that case, you will receive only the shares of Intel common stock, and all cash will be credited as income tax withholding.

To use this special rule, one of two requirements must be met:

- The payment must qualify as a lump sum distribution, as described below—or it would qualify except that you do not yet have five years of participation in the Plan—or
- The stock included in the payment must be attributable to non-Roth employee contributions, if any.

You may elect not to have the special rule apply to the net unrealized appreciation. In this case, your net unrealized appreciation will be taxed in the year you receive the stock, unless you roll over the stock. The stock (including any net unrealized appreciation) can be rolled over to an IRA or another employer plan either in a direct rollover or a rollover that you make yourself. If you roll over the stock to an IRA or another plan, the special rule for taxing stock distributions will not apply to a later distribution of the amounts rolled over. If you receive Intel stock in a payment that qualifies as a lump sum distribution, the special tax treatment for lump sum distributions described below (such as five-year averaging) also may apply.

If you wish to take advantage of this special tax rule only with respect to your shares, you may take your shares in a distribution and roll over the rest of your distribution in a direct rollover or a 60-day rollover.

18.5.6 Payments Eligible for Rollover

Payments from the Plans may be eligible rollover distributions. This means that they can be rolled over to an IRA or to another employer plan that accepts rollovers. Fidelity will advise you as to what portion of your payment is an eligible rollover distribution.

A payment from the Plans that is eligible for rollover can be rolled over in two ways. You can choose to have all or any portion of your payment either:

- Paid to another retirement plan or IRA in a direct rollover, or
- Paid to you and deposited by you within 60 days into another retirement plan or IRA (a 60-day rollover).

This choice will affect whether withholding taxes apply to your distribution.

Payments that cannot be rolled over

Generally, the following types of payments cannot be rolled over:

- **Long-term payments**: You cannot roll over a payment if it is part of a series of equal (or almost equal) payments that are made at least once a year and that will last for:
    - Your lifetime (or your life expectancy), or
    - Your lifetime and your beneficiary's lifetime (or life expectancy), or
    - A period of 10 years or more.
- **Required minimum payments**: Beginning in the year you reach age 70½ or retire, whichever is later, a certain portion of your payments cannot be rolled over because it is a minimum required distribution (MRD) payment that must be paid to you.
- **Hardship withdrawals**: A hardship withdrawal from the 401(k) Savings Plan cannot be rolled over.

Direct rollovers

If you choose to have your distribution transferred in a direct rollover:

- Your payment will not be taxed in the current year and no income tax will be withheld.
- Your payment will be made directly to your IRA or, if you choose, to another employer plan that accepts your rollover.
- Your payment will be taxed later when you withdraw it from the IRA or the qualified employer plan.
- Your pre-tax payment will be taxed under special tax rules if your payment is made directly to a Roth IRA.

Direct rollover to an IRA: You can open an IRA to receive the direct rollover. The term "IRA" includes individual retirement accounts and individual retirement annuities. If you choose to have your payment made directly to an IRA, contact an IRA sponsor, usually a financial institution, to find out how to have your payment made in a direct rollover to an IRA at that institution. If you are unsure of how to invest your money, you can temporarily establish an IRA to receive the payment. However, in choosing an IRA, you may wish to consider whether the IRA you choose will allow you to move all or a part of your payment to another IRA at a later date, without penalties or other limitations.

Direct rollover to a Roth IRA: You may roll over your pre-tax distribution directly to a Roth IRA. A special rule applies under which the amount of the payment rolled over, reduced by after-tax amounts, will be taxed. However, the 10% additional income tax on early distributions will not apply unless you take the amount rolled over out of the Roth IRA within five (5) years, counting from January 1 of the year of the rollover. If you roll over the payment to a Roth IRA, later payments from the Roth IRA that are qualified distributions will not be taxed, including earnings after the rollover. See "Distributions from Roth contributions" in this chapter for the definition of a qualified distribution.

Direct rollover to an Employer Plan: If your new employer has a retirement plan, ask the administrator of that plan whether it will accept your rollover. An employer plan is not legally required to accept a rollover. If your new employer's plan does not accept a rollover, you can choose a direct rollover to an IRA.

60-day rollover: If you have an eligible rollover distribution paid to you, you can still decide to roll over all or part of it to an IRA or another employer plan that accepts rollovers. This is also known as an indirect rollover. If you decide to roll over, you must make the rollover within 60

days after you receive the payment. The portion of your payment that is rolled over will not be taxed until you take it out of the IRA or the employer plan.

You can roll over up to 100% of the eligible rollover distribution, including an amount equal to the 20% tax that was withheld. If you choose to roll over 100%, you must find other money within the 60-day period to contribute to the IRA or the employer plan to replace the 20% tax that was withheld. On the other hand, if you roll over only the 80% that you received, you will be taxed on the 20% that was withheld.

- Example: Your eligible rollover distribution is $10,000, (all taxable) and you choose to have it paid to you. You will receive $8,000, and $2,000 will be sent to the IRS as income tax withholding. Within 60 days after receiving the $8,000, you may roll over the entire $10,000 to an IRA or employer plan. To do this, you roll over the $8,000 you received from the Plan, and you will have to find $2,000 from other sources (e.g., savings, loans). In this case, the entire $10,000 is not taxed until you take it out of the IRA or employer plan. If you roll over the entire $10,000, when you file your income tax return, you may receive a refund of the $2,000 withheld. If, on the other hand, you roll over only $8,000, the $2,000 you did not roll over is taxed in the year it was withheld. When you file your income tax return, you may receive a refund of the part of the $2,000 withheld. However, any refund is likely to be larger if you roll over the entire $10,000.

18.5.7 Beneficiaries

In general, the rules summarized above that apply to payments to employees also apply to payments to surviving spouses of employees and to spouses or former spouses who are alternate payees. You are an alternate payee if your interest in the Plan results from a qualified domestic relations order, which is an order issued by a court, usually in connection with a divorce or legal separation. Some of the rules summarized above also apply to a deceased employee's beneficiary who is not a spouse. However, there are some exceptions for payments to surviving spouses, alternate payees and other beneficiaries that should be mentioned.

If you are a surviving spouse or an alternate payee as a result of a QDRO, you may choose a direct rollover to an IRA or to an eligible employer plan or payment to you. If you have the payment paid to you, you can still decide to roll over all or part of it to an IRA or to an eligible employer plan. If you decide to roll over, you must make the rollover within 60 days after you receive the payment. Thus, you have the same choices as the participant.

If you are a beneficiary other than a surviving spouse, you may choose a direct rollover to an IRA which will be treated as an "inherited IRA." You cannot roll over the payment yourself. You must instruct the Plan Administrator of the distributing plan to make a direct rollover to an "inherited IRA" that you have established on your behalf. You will be required to receive required minimum distributions from the IRA in accordance with IRS regulations. See IRS Publication 590, "Individual Retirement Arrangements," for more information.

If you are a designated beneficiary other than a surviving spouse and you do not choose a direct rollover to an IRA, the taxable portion of your payment will be taxed in the year it is paid and federal income tax will be withheld to the extent required. If you are a surviving spouse, an alternate payee or another beneficiary, you may be able to use the special tax treatment for lump sum distributions and the special rule for payments that include company stock, as

described above.

If you receive a payment because of the employee's death, you may be able to treat the payment as a lump sum distribution if the employee met the appropriate age requirements, whether or not the employee had five years of participation in the Plan.

Required Minimum Distributions

Distributions from the Plans generally must begin on or before April 1 of the calendar year following the later of the calendar year in which you reach age 70½, or the calendar year in which you retire. A 50% non-deductible excise tax will be imposed on amounts required to be distributed commencing on this date that are not so distributed.

Taxation of Excess Contributions

If you make contributions to the 401(k) Savings Plan in excess of limitations imposed by the Plan or the Tax Code, you will be subject to taxation as follows:

- Contributions by you to the Plan in excess of the maximum tax-excludable amount under Tax Code Section 402(g) for each calendar year (IRS Annual Contribution Limit), taking into account your tax-excludable salary reduction contributions under all arrangements qualifying under Tax Code Section 401(k), all simplified employee pension arrangements qualifying under Tax Code Section 408 and all annuity contracts qualifying under Tax Code Section 403, together with income thereon, are includable in your gross income for federal income tax purposes for the taxable year of the contribution, and also will be subject to taxation on distribution, unless the distribution occurs by April 15 following the close of the taxable year in which the excess amount was contributed. Excess contributions of Roth contributions are distributed tax-free but earnings are taxable. If you made both Roth and pre-tax contributions to the 401(k) Savings Plan during the calendar year, excess contributions will be taken from the Roth source first followed by the pre-tax source.
- If you are a highly compensated employee, contributions for a Plan year that are in excess of the limitations on these contributions under Tax Code Section 401(k) and that are distributed to you, after adjustment for gains or losses, are included in your gross income for federal income tax purposes in the taxable year in which the contribution occurred, if the distribution is within two and one-half months after the close of the Plan year in which the contribution occurred. Otherwise, the excess distribution will be included in gross income in the taxable year in which the distribution occurs, and Intel will be liable for an excise tax equal to 10% of the amount of the excess contributions distributed.

18.5.8 Tax Effects on Intel

Intel treats amounts contributed to the Plan under your salary reduction election as employer contributions, which are deductible by Intel in the year that the contributions are made. As discussed above, these contributions are not taxable to you until the year in which you receive a distribution from the Plan. Separate tax rules may apply to Roth contributions and after-tax contributions; see "Distributions from Roth contributions" and "Distributions from after-tax 401(k) contributions" in this chapter for more information. There are no tax consequences to

Intel as a result of Plan distributions made to you.

18.5.9 Fees and Expenses

The following table is provided to help you understand how fees are assessed and paid for the Plan. There are several services available to help you better understand the fees and expenses charged within the 401(k) Savings Plan and/or Retirement Contribution Plan.

Plan expense	Description	Payer
Administrative Expenses	Fees associated with the cost of recordkeeping, accounting, legal and trustee services. They also include additional fees for special features and services, such as telephone and Internet access to your account and financial modeling tools.	Plan administrative expenses are currently paid by Intel to the extent those expenses are not offset by expense reimbursements.
Asset-based fees, also called investment management fees	Generally associated with managing fund investments and assessed as a percentage of fund assets.	Asset-based fees are deducted from a fund's total return and are identified in the fund prospectus. For some funds, a portion of the investment management fee is used to pay fund expenses, referred to as an expense reimbursement. Fee and expense information can also be found in in the 401(k) Plan Participant Disclosure Notice.
Plan expense	**Description**	**Payer**
Individual service fees	Charged to you when you use a particular plan feature	Loans and minimum required distributions are all subject to individual service fees charged to your account. • Loan origination fee: $50 per application for loans initiated after June 30, 2014 and $35 per application for loans initiated prior to July 1, 2014• Loan maintenance fee: $0 maintenance fee for loans initiated after June 30, 2014 and $3.75 per quarter per loan for loans initiated prior to July 1, 2014 • Overnight mail delivery: $25

Plan expense	Description	Payer
Investment transaction fees	Some investment funds charge a redemption fee or surrender charge to discourage short-term buying and selling	Participants who invest in certain investment options are subject to redemption fees if they don't meet the minimum holding period requirement.
Intel Stock Fund fees	The Intel Stock Fund incurs costs such as management fees and brokerage fees.	The Intel Stock Fund bears these costs, which affects the overall return of the fund.

Your quarterly statement shows the total assets in your account, how they are invested, and the increases and decreases in the value of your investment options during the period covered by the statement. Your statements also show any administrative fees deducted directly from your account.

The prospectuses for the investment funds available in the Plans also contain information regarding plan fees and expense information. The 401(k) Plan and Retirement Contribution Plan Participant Disclosure Notices also contain information regarding plan fees and expenses. Participant Disclosure Notices, Plan and Fund prospectuses are available online at Fidelity NetBenefits or by calling the Fidelity Service Center. The Summary Annual Report of the Plan also includes fee and expense information and is mailed to participants annually in Q3/Q4.

18.6 Other Plan Information and Benefits

Topics

18.6.1 Other Plan Provisions

Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA)

If you interrupt your employment with Intel due to U.S. military service (including full-time National Guard duty) and you later return to Intel, you may be entitled to certain re-employment rights under USERRA. Under USERRA and the Tax Code, you may be allowed to make military catch-up contributions to the 401(k) Savings Plan or receive a Retirement Contribution Plan contribution (for years prior to 2020) for the period of qualified military leave. In addition, loan repayments may be suspended during a period of qualified military leave. See the "Contributions" and "Loans" sections of the 401(k) Savings Plan and Retirement Contribution Plan for additional information. For more information about your rights under USERRA, please contact Get HR Help via Circuit.

Qualified Domestic Relations Orders (QDROs)

Under the terms of a qualified domestic relations order (QDRO), the Plans may be required to transfer all or part of your plan benefits to your former spouse as part of a marital property settlement. In addition, a qualified domestic relations order may require that all or part of your account balance be used to satisfy your child support obligations. Copies of the Plans' procedures and model documents pertaining to qualified domestic relations orders are available to you and your (former) spouse or children, or your attorneys online from Fidelity Employer Services Company LLC. Fidelity will notify you if any of the Plans receive a qualified domestic relations order that affects your benefits. See "Resources" in this chapter for additional information.

Keep your address information up-to-date

If you are no longer an active employee of Intel, are a beneficiary or an alternative payee, it is your responsibility to keep your contact information updated so that you may continue to receive account and plan information. Update your home mailing address and personal email address online via Fidelity's NetBenefits website or call the Fidelity Service Center. See "Resources" in this chapter for additional information.

Active participants should use the Personal Profile tool on Circuit to update your address.

18.6.2 Disability and Death Benefits

Disability benefit
Effective January 1, 2019, you will be considered "permanently and totally disabled" if you are you are receiving benefits from the Intel Corporation Long-Term Disability Plan (LTD plan) and have terminated employment with Intel. Prior to January 1, 2019, you are considered "permanently and totally disabled" generally if you are approved in the "Any Occupation" classification of the Intel Corporation Long-Term Disability Plan.

- Regardless of your job grade, if you become permanently and totally disabled, you will become 100% vested in your Retirement Contribution Plan account balance, your Minimum Pension Plan benefit, and in Intel's discretionary contributions made to your 401(k) Savings Plan account, whichever are applicable.
- If you are grade 7 or above (or equivalent) or an ICE employee whose pay and service accruals under the Minimum Pension Plan formula stopped accruing on or after January 1, 2015, and you become permanently and totally disabled, your Minimum Pension Plan benefit will be calculated using your Retirement Contribution Plan balance as of your last day of employment at Intel.
- If you are grade 6 or below (or equivalent) whose pay and service accruals under the Minimum Pension Plan formula stopped accruing on January 1, 2020, and you become permanently and totally disabled, your Minimum Pension Plan benefit will be calculated using your Retirement Contribution Plan balance as of your last day of employment at Intel.
- If your pay and service accruals under the Minimum Pension Plan stopped accruing because you were on a non-U.S. Payroll on or after January 1, 2015, and you become permanently and totally disabled, your Minimum Pension Plan benefit will be calculated using your Retirement Contribution Plan balance as of your last day of employment at Intel.

You may withdraw your entire 401(k) Savings Plan or Retirement Contribution Plan account balances at any time once you become permanently and totally disabled. You do not have to pay a 10% penalty tax on withdrawals if you are disabled; however, the taxable portion of your distribution is subject to a 20% federal income tax withholding at the time of the withdrawal if you do not roll it over into another tax-deferred plan.

Death benefit

If you are married: The Minimum Pension Plan automatically provides a surviving spouse benefit if you die while employed at Intel, and you had accrued a benefit in the Minimum Pension Plan, or you had terminated employment after earning a vested retirement benefit that had not yet commenced. The Minimum Pension Plan benefit is determined net of the annuity value of the Retirement Contribution Plan account balance. The payment of the benefit is determined as if you had chosen a 100% joint and survivor annuity the day before your death. See the "Retirement Contribution Plan and Minimum Pension Plans" section in this chapter for more information about Plan eligibility.

The Retirement Contribution Plan and 401(k) Savings Plan account balances will be paid to your surviving spouse unless your spouse consented to the designation of a different person to receive Retirement Contribution Plan and 401(k) Savings Plan benefits according to Intel's

beneficiary designation procedures. Payments to a beneficiary other than your spouse will be made only in a single lump sum. Retirement Contribution Plan payments to your spouse will be paid as an annuity from the Minimum Pension Plan, unless your spouse elects prior to March 1 following the year of your death to receive payment in a single lump sum. See the "Retirement Contribution Plan and Minimum Pension Plans" section in this chapter for more information about Plan eligibility.

If you are single: If you die while still employed and are single, your Retirement Contribution Plan account will become 100% vested. Your Retirement Contribution Plan account and 401(k) Savings Plan account balances will be paid in a lump sum to your beneficiary. No death benefits are payable under the Minimum Pension Plan to a beneficiary other than a spouse.

18.6.3 Designating a Beneficiary

You may designate a beneficiary to receive your 401(k) Savings Plan and Retirement Contribution Plan accounts in the event of your death before benefits start. If you do not designate a beneficiary or there are no designated beneficiaries who are living when payment is to be made, the benefits will be paid in the following order of priority:

1. To your spouse
2. To your children, in equal shares, if you have no spouse
3. To your estate if you have no spouse or children

Your beneficiary can be one or more persons or trusts, and can include primary and contingent beneficiaries. Your beneficiary designation under the 401(k) Savings or Retirement Contribution Plans can be, but does not need to be, the same as the beneficiary for other Intel benefit plans, such as life insurance. Your designated beneficiary under the 401(k) Savings Plan may be different from the beneficiary you designate for the Retirement Contribution Plan. If you previously submitted a single beneficiary designation covering both Plans, or your beneficiary designation was executed before 1996, when the 401(k) Savings and Retirement Contribution Plans officially became separate plans that beneficiary designation would apply to both Plans until you submit new beneficiary designations.

If you are married, your spouse must consent to a designation of a trust, of any other person or persons as beneficiary, and the spouse may revoke the consent if you change the designation after the original consent was given. The consent must be in writing, a notary public must witness the consent, and the consent must acknowledge that, by giving consent, your spouse waives all or some rights to these benefits.

If you designated your spouse as your beneficiary and you divorce your spouse after January 1, 2019, your spousal beneficiary designation will be deemed revoked upon receipt of proof of divorce. If you do not designate a beneficiary after your divorce, the benefits will be paid to your contingent beneficiary, if any, or, if none, in the order of priority listed above.

Only a participant can change his or her beneficiary. A beneficiary is not permitted to designate a beneficiary or change the participant's designated beneficiary. Your beneficiary election must be made using the proper Plan beneficiary form in accordance with the Plan procedures. You can make beneficiary designations at any time by visiting Fidelity NetBenefits website and using the beneficiary online tool or calling the Fidelity Service Center. Any other beneficiary

designation, such as through a will, is not valid. See "Resources" in this chapter for additional information.

18.6.4 Quarterly Statements

Your quarterly statements are available at the Fidelity NetBenefits website. If you prefer to receive your statements at your home mailing address, you must make the selection from My Profile tab on the Fidelity NetBenefits website. Quarterly statements will show the following:

- The balance in your 401(k) Savings Plan and/or Retirement Contribution Plan accounts
- The balance in your pretax deferred contribution account, if applicable
- The balance in your Roth contribution account, if applicable
- The balance in your Roth in-plan conversion account, if applicable
- The balance in your Free$tock account, if applicable
- The balance in your rollover account, if applicable
- The balance in your post January 1, 2019 after-tax contribution account, if applicable
- The balance in your pre-January 1, 1988 after-tax contribution account, if applicable
- The balance in your matching contribution account, if applicable
- The balance in your merged account, if applicable
- The balance in your Retirement Contribution account, if applicable
- The balance in your Fidelity BrokerageLink® account, if applicable
- Your vesting percentage
- Your withdrawal activity, if applicable
- Your outstanding loan balance, if applicable
- The investment funds held during the statement period
- The investment performance of each of your accounts
- Fees and expenses you incurred in any of your Plan accounts

18.6.5 Resources

To access account information or to obtain additional information about the 401(k) Savings Plan, Retirement Contribution Plan or Minimum Pension Plan contact Fidelity Investments.

- **Online via Fidelity NetBenefits** at www.netbenefits.com/intel.
  Fidelity NetBenefits is available 24 hours a day, seven days a week with the exception of any scheduled downtime.

- **Fidelity Service Center** at 888-401-7377 or TDD 800-655-0962 is available 24 hours a day, seven days a week with the exception of any scheduled downtime. Service Center Representatives are available Monday–Friday from 5:30 a.m. to 9 p.m. Pacific

  If you are calling the Fidelity Service Center from outside the U.S., you will need the AT&T country access code which can be found on the AT&T Direct website at: http://att.com/traveler/. Participants calling from an area unsupported by AT&T Direct should use the following international collect number 508-787-9902.

  For security purposes, all calls are recorded. There are several levels of security are available including the verification of a Personal Identification Number (PIN) or Passwords. A new security feature has also been added, Fidelity MyVoice.

Fidelity My Voice does not require a PIN or Password. It detects and verifies your voiceprint. You may enroll by calling Fidelity and say "account access", tell the associate you're interested and then speak. Fidelity MyVoice will create a unique voiceprint. Once enrolled, you may access your account with MyVoice.

Fidelity provides the following services:

- Enrollment into the 401(k) Savings Plan, Contribution and Investment Elections
- Fund Performance Information
- Information on Benefit Eligibility and Provisions
- Literature Request for Statements, Retirement Initiation Packages, Policies, Fund Facts and Prospectus' and more
- Loan and Distribution Assistance
- Rollover Forms and Assistance
- Self-Directed Brokerage-Brokerage Link Account Assistance
- Updating Beneficiaries
- Updating Personal Information after Leaving Intel

Retirement planning assistance which includes the following:

- Financial Wellness Planning and Tools
- Benefit Estimates and Projections
- Distribution Planning
- Educational Workshops and Material
- Minimum Required Distribution (MRD) Calculations
- Retirement Initiation Packages

- **Qualified Domestic Relation Orders (QDRO's).** You can:

  - Access the Plans' procedures and model documents online via Fidelity Employer Services Company LLC at https://qdro.fidelity.com/. You, your spouse, or attorneys can access this information by setting up an account on the web site
  - Call the Fidelity Service Center – 888-401-7377 or TDD 800-655-0962. Representatives are available Monday–Friday from 5:30 a.m. to 9 p.m. Pacific
  - QDROs for the Intel 401(k) Savings Plan, Intel Retirement Contribution Plan and Intel Minimum Pension Plan should be sent or faxed to Fidelity at the address below:

    Fidelity Employer Services Company
    QDRO Administration Group
    P.O. Box 770003
    Cincinnati, OH 45277-0066
    Attn: Intel Corporation
    or, fax to 877-665-4284

- **Fidelity BrokerageLink® Accounts**
  - Access your BrokerageLink® account through your Plan account on NetBenefits, www.netbenefits.com/intel or directly through Fidelity's retail platform, www.Fidelity.com
  - See "Online via Fidelity NetBenefits" section for additional BrokerageLink® information
  - To change your address for your BrokerageLink® account, please call the Fidelity Service Center at 888-401-7377. (Address changes made via Circuit will not carry over to your BrokerageLink® account and will require you to call Fidelity)

- **Payroll Deduction Codes for the 401(k) Savings Plan**
  - Applies to the Annual IRS Limit (For 2020: $19,500 or $26,000 for age 50 or over)
    - 401K – Pre-tax contributions
    - 401KBC – Pre-tax bonus/commissions contributions
    - 401KVP – Pre-tax vacation/PA cash out (non-exempt) contributions
    - Roth 401K – Roth after-tax contributions
    - Roth BC – Roth bonus/commissions contributions
    - Roth VP – Roth vacation/PA cash out (non-exempt) contributions
  - Applies to the Annual IRS Limit ($57,000 for 2020)
    - AFT – After-tax Base Pay and Salary
    - AFTBC – After-tax Bonus and Commission
    - AFTVP – After-tax Vacation & PA Cashin

18.7 Filing a claim

Topics

18.7.1 Claim Process

If you or your beneficiary disagrees with a plan benefit determination, you may make a claim.

18.7.2 Making a Claim

Your claim should be in writing, and you should explain why you disagree with the benefit determination. You should also include any other information you believe is necessary to support your claim.

Direct your claim to the following address:

Intel Corporation
Attention: Intel Global Retirement
1900 Prairie City Road, FM1-118
Folsom, CA 95630

18.7.3 Reviewing the Claim

Intel Global Retirement will review your claim and conduct an investigation of your records. You will receive a response within 90 days of submitting your claim. If Global Retirement believes that special circumstances justify an extension of time to review the claim, Global Retirement may notify you that it will take up to an additional 90 days to review your claim. The response will be in writing and will explain any adjustments that have been made to the original benefit.

18.7.4 Understanding the Ruling

If you receive a written response denying your claim in whole or in part, the written response will explain the specific reasons for the claims denial and reference the provisions of the plan document or applicable law on which the decision is based. In addition, you will be provided with information on any other materials that may be necessary to justify your claim and an explanation of the Plan's appeal procedures. Under the Plan's appeal procedures, if your claim is denied, you may file a written request for appeal within 60 days of the denial. The request must be addressed to the Intel Retirement Plans Review Panel and sent to the following address:

Intel Corporation
Attention: Intel Retirement Plans Review Panel
1900 Prairie City Road, FM1-118
Folsom, CA 95630

The Intel Retirement Plans Review Panel will review the appeal and make a decision within 60 days of your request for an appeal. If more time is necessary (up to an additional 60 days is permitted), you will be notified in writing. The Intel Retirement Plans Review Panel determination also will be in writing, and it will state the reasons for the decision and the plan provisions on which the determination is based.

The decisions of the Intel Retirement Plans Review Panel will be final except for cases in which there are conflicting claims made by more than one claimant or beneficiary for the same benefits. In these cases, the Intel Retirement Plans Review Panel can direct that payment of all benefits be withheld until the conflict has been resolved by agreement between the claimants.

18.7.5 No Assignment of Rights

Except in certain circumstances relating to a default under a loan from 401(k) Savings Plan accounts, your interests or property rights in the Plans, in the trust fund, or in any payment to be made under the Plans may not be assigned, alienated, optioned or made subject to

attachment, garnishment, execution, levy, or other legal or equitable process or bankruptcy, and any such action will be void. These restrictions do not apply to the creation or assignment of a right to a benefit under the Plan pursuant to a beneficiary Qualified Domestic Relations Order (QDRO).

18.8 General information

Topics

18.8.1 Plan Administration

The Retirement Plans Administrative Committee, which currently consists of Intel employees, is the plan administrator responsible for the general operation and administration of the Plan, and for carrying out and interpreting the Plan's provisions. The Investment Policy Committee for the 401(k) Savings Plan and Retirement Contribution Plan, which currently consists of Intel employees and one non- employee/non-director member, selects the investment options available to participants. The Investment Policy Committee for the Minimum Pension Plan, which current consists of Intel employees has asset management responsibility for the Minimum Pension Plan. Each of these committees is a named fiduciary as that term is used in ERISA. Intel's Chief Financial Officer appoints the members of each of these committees. The Retirement Plans Administrative Committee has delegated day to day operating responsibility to Intel's Global Retirement Program Office and has contracted with Fidelity Investments to provide Plan recordkeeping services. To obtain additional information about the Plan and its administrators, you may contact the Fidelity Service Center. See "Resources" in this chapter for more information.

18.8.2 Future of the Plans

Intel intends to continue the 401(k) Savings Plan, Retirement Contribution Plan and Minimum Pension Plan but reserves the right to amend or terminate any of the Plans, in its sole discretion, at any time. The procedures for amending and terminating the Plans are set forth in the plan documents. If any material changes are made in the future, you will be notified. Any changes made to the Plans will not reduce any amounts already in your account.

18.8.3 Plan Termination

Minimum Pension Plan termination

If the Minimum Pension Plan is terminated, the company is required to pay only the amount in the Trust Fund toward covered benefits. See "Pension Benefit Guaranty Corporation (PBGC)" in

this chapter for more information. You may obtain additional information on the PBGC insurance protection and limitations, write to the PBGC.

Inquiries to the PBGC should be addressed to the following:

Office of Communications PBGC
1200 K Street NW, F14
Washington, D.C. 20005-4026
800-326-4000

Retirement Contribution Plan and 401(k) Savings Plan termination

If the Retirement Contribution Plan or 401(k) Savings Plan is terminated, Intel will comply with the tax rules governing termination by treating all participant account balances as fully vested for all employees who are participants on the date of termination.

18.8.4 ERISA Rights

As a participant in the 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 the information and rights listed below.

18.8.5 General Information about your Plans and Benefits

You are entitled to the following:

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies
- Receive a summary of the plan's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this summary annual report
- Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age 65) and if so, what your benefits would be at normal retirement age if you stop working under the Plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The Plan must provide the statement free of charge

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

Enforce your rights

If your claim for a pension or 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 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 administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or 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 U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with your questions

If you have any questions about your Plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Questions about the Plans

Contact your Plan Administrator at the following address:

Intel Corporation
Attn: Retirement Plans Administrative Committee
1900 Prairie City Road, FM1-118
Folsom, CA 95630

Fidelity Service Center 1–888-401-7377

Agent for service of legal process

General Counsel Intel Corporation
2200 Mission College Blvd
Santa Clara, CA 95052

Service of legal process may also be made upon the Trustee.

Trustee information

Intel 401(k) Savings Plan Trust
Intel Retirement Contribution Plan Trust
Intel Minimum Pension Plan Trust
State Street Bank & Trust Company
One Lincoln Street
Boston, MA 02111

Plan sponsor information

Intel Corporation
1900 Prairie City Road, FM1-118
Folsom, CA 95630

EIN: 94-1672743

General Plan information

Intel Retirement Contribution Plan
number 001
Plan effective date July 1, 1979
The Plan year begins on January 1 and ends on December 31
Type of Plan and Plan Funding: This plan is a defined contribution pension plan. The plan is funded by Intel contributions. These contributions are deposited into individual accounts established on each participant's behalf.

Intel Minimum Pension Plan

number 002

Plan effective date January 1, 1988

The Plan year begins on January 1 and ends on December 31

Type of Plan and Plan Funding: This plan is a defined benefit pension plan. The plan is funded by Intel contributions. These contributions are actuarially determined.

Intel 401(k) Savings Plan

Plan number 003

Plan effective date July 1, 1979

The Plan year begins on January 1 and ends on December 31

Type of Plan and Plan Funding: This plan is a 401(k) plan. The plan is funded by employee and employer contributions. These contributions are deposited into individual accounts established on each participant's behalf.

18.9 Retiring from Intel

Topics

18.9.1 Overview

The Intel Pay, Stock and Benefit philosophy of sharing the risk, while at the same time providing financial security, is reflected in the design of your retirement benefits. Understanding the retirement eligibility rules and how your retirement benefits work is essential to maximize the value these benefits offer.

Additional information on each of the benefit plans described in this section may be found in a benefit-specific chapter of the *Pay, Stock and Benefits Handbook*, in applicable Summary Plan Descriptions, or by searching in Circuit for the plan of interest.

18.9.2 Eligibility

In general, you are eligible to participate in Intel's 401(k) Savings Plan provided you are:

- Employed by Intel as a U.S. employee of a participating company (includes those U.S. employees on expatriate assignments)
- Not a member of a collective bargaining unit
- Not a college intern or summer intern status employee
- Not an international service employee (inpatriate)
- Not otherwise excluded (persons not classified by Intel as employees are excluded, whether or not they are or may be common law employees of Intel)

You will generally not be eligible for a 401(k) match true-up if you terminate employment before the end of the year (December 31), unless you satisfy the retirement eligibility requirements, terminate employment because of permanent and total disability (as defined in Section 18.6.2 Disability and Death Benefits), or die. If you terminate employment with Intel in the month of December as a result of an involuntary workforce action or VSP action, and comparable jobs are not available within Intel, you may be eligible for a contribution. To be eligible, you must be in good standing with Intel and your job elimination generally cannot be as a result of a divestiture. Intel will determine good standing, comparable jobs, and other terms

necessary to apply this special rule based on uniform definitions.

Refer to Chapter 4 of the *Pay, Stock and Benefits Handbook*, "Eligibility and Availability of Benefits," or to applicable Summary Plan Descriptions for additional eligibility requirements specific to each benefit program.

18.9.3 How Service is Determined

Your length of service with Intel plays a key role in determining your retirement program eligibility and benefits, so it is important that you know how the program defines service. The retirement programs begin counting service on your date of hire. If you transfer to Intel Corporation from another Intel entity, your service with the other entity may also count in determining your eligibility and benefits.

A year of service is defined as a period of 12 consecutive months during which you receive pay from Intel, including normal periods of absence for vacations, holidays, and temporary approved leaves. For purposes of determining your initial eligibility, you will receive credit for a year of service after you have completed 365 days without a break in service of 12 months or more. If you leave Intel but return to service within a 12-month period, you will be considered to have been in service with Intel continuously during the period of absence. If you leave Intel and return to service within 5 years, your previous eligible service will count towards the Rule of 75 and 55 + 15 Intel retirement eligibility rules. Refer to the specific sections in *Pay, Stock and Benefits Handbook* or to applicable Summary Plan Descriptions for additional bridge of service rules specific to each benefit program.

18.9.4 Retirement Eligibility Rules

To meet U.S. retirement eligibility requirements, you must meet one of the following definitions:

- **Age 65**—Be at least 65 years old with no minimum years of service requirement (normal retirement age)
- **55 & 15**—Be at least 55 years old and complete at least 15 years of eligible service
- **Rule of 75**—Satisfy the requirements of the Rule of 75, which means the combined total of your age plus your length of service (both calculated in completed, whole years) is equal to or greater than the number 75

18.9.5 Benefits of Meeting Retirement Eligibility Rules

- Intel Retiree Medical Plan (IRMP) and Intel Retiree Vision Plan
- Sheltered Employee Retirement Medical Account (SERMA) (if hired prior to January 1, 2014)
- Stock Acceleration (Rule of 75 only)
- 401(k) Match-true-up, pro-rated QPB and APB

18.9.6 Intel Retiree Medical Plan (IRMP) - Medical, Vision and the Sheltered Employee Retirement Medical Account (SERMA)

The information provided here about IRMP and SERMA is only a summary. Please review the Intel Retiree Medical Plan and the Sheltered Employee Retirement Medical Account Summary Plan Description and Plan Document for complete plan rules. On Circuit, (search "IRMP SERMA SPD"), or log on to **My Health Benefits**. From the Internet you can access **My Health Benefits** at intel.com/go/myben. Once on **My Health Benefits,** click on the Plan Information tile, "More Information" section. Or call 877-GoMyBen (466-9236) to request a copy.

IRMP Medical and Vision Eligibility

If you retire from Intel as a U.S. employee and have satisfied the eligibility requirements, Intel offers retirees and their eligible dependents the option to purchase medical and vision coverage through the Intel Retiree Medical Plan (IRMP). Coverage for yourself, your spouse/domestic partner or eligible dependent child(ren) is only available to you after you retire and have met the eligibility requirements. Service requirements discussed below apply in determining eligibility for this plan. You must be an Intel U.S. employee at retirement to be eligible for the plan.

If both you and your spouse/domestic partner are retirees of Intel in the U.S. and are eligible, each of you can be covered individually under the IRMP. However only one of you may enroll your eligible dependent child(ren).

If you die, your surviving spouse/domestic partner or surviving eligible child(ren) may continue coverage in the IRMP medical and vision plans. However, if your spouse remarries following your death, your spouse may not add the new spouse as a dependent in plans.

Sheltered Employee Retirement Medical Account (SERMA)

The Sheltered Employee Retirement Medical Account ("SERMA") is a Health Reimbursement Arrangement subject to IRS rules^. SERMA has no cash value; therefore, you cannot receive cash in lieu of SERMA.

If you were hired prior to January 1, 2014, and are eligible, SERMA will be established for you. You may use your SERMA** credits to purchase IRMP medical and vision plan coverage and/or to reimburse yourself for other eligible health insurance premiums paid by you for you and your eligible dependents. Please refer to the Intel Retiree Medical Plan and Sheltered Employee Retirement Medical Account Summary Plan Description for detailed information on SERMA. From Circuit, search for Intel Retiree Medical Coverage or contact the Intel Health Benefits center at 877-466-9236.

^ *For IRS rules, see also IRS Publication 969, section on Health Reimbursement Arrangements* - https://www.irs.gov/pub/irs-pdf/p969.pdf.

**SERMA reimbursements for eligible premiums for a Domestic Partner and eligible enrolled dependent(s) of a Domestic Partner are generally treated as taxable (imputed) income.

SERMA Eligibility

If you were hired prior to January 1, 2014 and retire from Intel as a U.S. employee and have satisfied the SERMA eligibility requirements, Intel establishes a SERMA for you.

On or after January 1, 2014, if you separate from Intel or transfer from an Intel SERMA participating entity to a non-participating subsidiary or entity, your past years of service for the purpose of calculating SERMA will be forfeited. For example, you are not eligible for SERMA if you were:

- Hired on or after January 1, 2014
- Rehired on or after January 1, 2014
- Transferred to a U.S. Intel entity from a non-participating Intel subsidiary (e.g., Wind River, Mobileye, Havok) or non-participating Intel entity (e.g., Intel China) on or after January 1, 2014

Special Eligibility Circumstances:

- If you were hired before January 1, 2014 and you are a U.S. retirement eligible employee prior to transferring to a non-participating Intel entity (e.g. China), a SERMA will be established if you are a U.S. employee upon your retirement, based on your SERMA eligible service prior to your transfer.
- If you have entered into a written agreement with Intel pertaining to SERMA, you will be eligible for SERMA under the terms established in that written agreement.

NOTE: All eligible dependents including Domestic Partners must be listed as your dependent on the My Health Benefits website in order for a SERMA reimbursement to be processed. For more information visit My Health Benefits or call 1-877-GoMyBen.

SERMA credit calculation

SERMA credit available upon retirement is capped using eligible years of service up to the 2020 anniversary of your hire date.

- **For service before January 1, 2004**
  Only completed general full-time years of service as a U.S. employee (including intern) count for earning SERMA credit. Part-time service, Intel Contract Employee (ICE) service, and Personal Leave will not count in establishing the benefit amount. Also, Medical Leave and other leave time (except Military Leave) over 183 days within a seven-year period will not count toward the calculation of the SERMA amount. If you left Intel and were rehired before January 1, 2004, your past completed general full-time U.S. years of service will count toward your SERMA credits, provided you returned to Intel within five years of your termination date and returned to Intel before January 1, 2004.

- **For service after January 1, 2004**
  Eligible Intel years of service for earning SERMA credits after January 1, 2004 includes the following: general full-time service, intern service, ICE service, part-time service, and all leave-of-absence time (including Personal Leave time). If you leave Intel and are later rehired PRIOR to January 1, 2014, your past completed general full-time years of

service will count toward your SERMA, provided you return to Intel within two years of your termination date. If you had SERMA after originally retiring from Intel and return to Intel again PRIOR to January 1, 2014 as an employee, additional years of completed eligible service will earn credits to your account once you terminate from Intel.

- **If you left Intel and were rehired on or after January 1, 2014,** you are not eligible for SERMA.

Note: If you retired from Intel and then are rehired after January 1, 2014, any established SERMA credit you earned upon your original retirement will not be impacted; however, no additional SERMA credits will be earned.

Service with Intel subsidiaries or other Intel-owned entities, which have been designated as participating companies by the Intel Benefits Administrative Committee, will count for SERMA credits to the extent determined by the same committee.

SERMA contributions and interest

Intel credits your SERMA with a specified dollar amount for each year of completed eligible service with Intel. This dollar amount is a one-time credit Intel makes to your SERMA after you retire. The only other contributions to your account will be in the form of annual interest earned on your account following your retirement.

Intel's contribution credit is $1,500 for each year of completed eligible service. This amount, however, may be adjusted in the future at Intel's sole discretion.

If you retire from Intel and a SERMA account has been established for you, then subsequently rehire as a U.S. employee, your SERMA account will be held. Upon your subsequent retirement as a U.S. employee, you may resume using your earned SERMA credits. Retirees rehired on or after January 1, 2014, will not earn additional SERMA credits.

SERMA used toward IRMP (Medical/Vision)

After you retire and a SERMA is established for you, you can use credits from your SERMA in increments of 25% (i.e., 0, 25, 50, 75, 100%) toward the cost of monthly Intel medical or vision plan insurance premiums for you, your spouse/domestic partner*, and your eligible child(ren). The percentage you elect from your SERMA must be the same for you, your spouse/domestic partner, and your dependent child(ren).

If you choose an amount other than 100%, then you are responsible for paying the remainder of the insurance premium cost. When you elect the percentage to use from your account, the larger the percentage you choose, the faster your account balance will be depleted.

SERMA used toward other eligible health insurance

After you retire and a SERMA is established for you, you can use credits from your SERMA to reimburse yourself for eligible insurance premiums for you, your spouse/domestic partner*, and your eligible children. You may use SERMA to reimburse other insurance coverage while you are

enrolled in an IRMP medical or vision plan.

Eligible reimbursements are for the following insurance premiums:

- Individual health plans
- Individual dental plans
- Individual vision plans
- Other employer retiree group plans
- COBRA
- Medicare
- Medigap
- Long-term care

*****SERMA reimbursements for a Domestic Partner are generally treated as taxable (imputed) income. You will receive a Form 1099 at the end of the plan year**.**

Your SERMA Balance

When you retire, you can use your SERMA for as long as you have credit remaining in the account. Any unused balances that remain in your SERMA will be forfeited upon your death, or the death of your surviving spouse/domestic partner or surviving eligible dependent child(ren). However, your surviving spouse or surviving eligible child(ren) can continue to use the account until his or her death or loss of eligibility.

Intel reserves the right to return the credit from your SERMA to the program when one of the following occurs:

- You, your spouse, and eligible child(ren) have died
- You, your surviving spouse/domestic partner or surviving eligible child(ren) have not used the account after 20 (twenty) consecutive years

Complete information is available in the IRMP and SERMA SPD the official plan document, available at www.intel.com/go/myben under the Plan Information tile or contact the Intel Health Benefits center at 877-466-9236.

Note: For any discrepancies between the information in this handbook and official plan documents, see “Disclaimer” in chapter 1 of the *Pay, Stock and Benefits Handbook*.

Intel Catastrophic Rx Health Reimbursement Account

The Intel Catastrophic Rx Health Reimbursement Account (HRA) is available to Medicare eligible retirees and eligible dependents enrolled in a Medicare Part D Plan to provide more financial protection and extra peace of mind regarding prescription expenses. No enrollment or election is necessary for the Catastrophic RX HRA, but you do need to be enrolled in a Medicare Part D Plan to receive reimbursement.

Catastrophic Rx reimbursements for a domestic partner are generally treated as taxable (imputed) income.

Complete information on the Catastrophic Rx HRA is available in the IRMP SPD available at

www.intel.com/go/myben under the Plan Information tile or contact the Intel Health Benefits center at 877-466-9236.

18.9.7 Stock Acceleration

Stock Option Program (SOP) and Restricted Stock Unit (RSU)

When you leave Intel, you may qualify for vesting acceleration under one of the following rules:

- Rule of 75 (Intel Retirement Rule)
- Age 60 (Intel Stock Acceleration Rule)

Note: There is no stock acceleration under the 55 + 15 retirement rule

Changes to your stock options that qualify for acceleration and new expiration dates are updated on your stock account approximately three (3) business days following your retirement date. You may view your stock account on the E-Trade Financial Corporation website.

Stock Option expiration

Stock options granted must be exercised prior to the expiration date or they are lost.

Stock Acceleration and Expiration Date table

	Retirees that are age 60 and above.	**Retirees that meet the Rule of 75**	**All other types of retirement**
Vested Stock Options	Your vested options will expire on the earlier of their expiration date or the first anniversary of your retirement date.	Your vested options will expire on the earlier of their expiration date or the first anniversary of your retirement date.	Your vested options will expire 90 days from your retirement date.
Accelerated Stock Options	You will receive one year of accelerated vesting for every five years of service. Your accelerated grants will expire on the earlier of their expiration date or the first anniversary of your retirement date.	You will receive one year of accelerated vesting. Your accelerated grants will expire on the earlier of their expiration date or the first anniversary of your retirement date.	N/A
Restricted Stock Options (RSUs)	You will receive one year of accelerated vesting for every five	You will receive one year of accelerated vesting. Any	N/A

	Retirees that are age 60 and above.	Retirees that meet the Rule of 75	All other types of retirement
	years of service. Any unvested RSUs will be cancelled as of your retirement date. Once RSUs vest they are converted to shares of stock which are yours to keep or sell	unvested RSUs will be cancelled as of your retirement date. Once RSUs vest they are converted to shares of stock which are yours to keep or sell	

Note: The rules that govern certain grants received from the Executive Long-Term Stock Option Plan, SOP Plus or Merger and Acquisition (M&A) converted grants may differ. Please consult the applicable plan documents and terms and conditions relating to the specific details governing those grants.

18.9.8 Pro-rated Annual Performance Bonus and Quarterly Profit Bonus

Intel 401(k) Plan Match True-Up: If you are an eligible participant in the 401(k) Savings Plan, you may receive a match true-up for the year in which you retire, even if you are not employed on December 31st. The match true-up is calculated based on your eligible contributions and eligible earnings in the year you retire.

Annual Performance Bonus (APB): You receive a prorated pay-out at the normal APB distribution time for the period you worked in the year you retire.

Quarterly Profit Bonus (QPB): You receive a prorated pay-out at the normal QPB distribution time based on your eligible earnings in the period you retire.

18.9.9 Life Insurance Portability/Conversion

Upon retirement, you may be eligible to purchase portable supplemental life insurance at competitive group rates and without providing evidence of insurability from our life insurance provider Minnesota Life, provided that you are enrolled in Supplemental life when you retire. In addition, you may also elect to continue coverage for your dependents if you are enrolled in the dependent life plan before you leave Intel.

Another option is to convert your Basic group life insurance after retiring. Minnesota Life has a choice of policies for conversion, but they are more expensive than purchasing portable supplemental life or dependent life insurance.

For more information on this opportunity and other life insurance options, refer to *Pay, Stock and Benefits Handbook* Chapter 15, “Life Insurance” or contact Minnesota Life at 877-494-1673.

Chapter 19
Employee Support Programs

Chapter 19
Employee Support Programs

This chapter provides an overview of programs designed to provide support as you balance work with the demands of life.

19.1 Overview

Intel makes it a point to hire the best and brightest. Intel also believes that it is important for employees to have the resources to meet the challenges of work and life--and thrive. For this reason, Intel has Employee Support Programs to help its employees, including personal resources, adoption, and tuition assistance.

19.2 Personal Resources Program

Topics

19.2.1 Overview

Intel offers a comprehensive personal resources benefit package. Intel's Personal Resources Program is available to you and your eligible dependents.* This includes **Guidance Resources:** referrals, resources, and information to help you with many of life's every day concerns, including child care, retirement and financial planning, elder care, house repair and pet services; and an Employee Assistance Plan ("EAP") - counseling services designed to address significant life problems. The Personal Resources Program is designed to enhance quality of life not just for you, but for your family members too.

*Refer to Chapter 4, Section 4.3 for the definition of eligible dependents.

You and your eligible dependents have access to the Personal Resource Program on your first day of work. This includes general full-time employees (GFT), part-time employees (PTE), Intel Contract Employees (ICE), interns, and expatriates and inpatriates. You are eligible to access the EAP regardless of the medical plan you have chosen, or if you have waived medical coverage.

19.2.2 Guidance Resources

Topics

19.2.2.1 Guidance Resources

The GuidanceResources® program provides you with referrals, resources, and information on a wide range of topics including but not limited to: health and fitness, financial and legal assistance, parenting and eldercare assistance, and concierge services. Consultants are available to employees and their eligible dependents 24 hours a day, 365 days a year.

You can also download the mobile application to use on your mobile device or tablet.

Telephone Access: (800) 568-9276 or visit the web at www.guidanceresources.com. You'll be taken to a brief registration page, a single sign on where you'll create your own unique user name and password. You'll need to enter the **company Web ID of "Intel",** if you login outside Intel's intranet (Circuit).

The online resource and Guidance Consultants are available to assist you in a variety of ways:

- Telephone Consultations. You can speak confidentially with an expert consultant to help you work through your issue and identify options and resources.
- Personalized Searches and Referrals: Guidance Consultants will work with you to develop a list of referrals for services (e.g., childcare, eldercare, adoption agencies, legal or financial professionals etc.) in your community.
- Educational Materials such as booklets, articles and help sheets on a variety of topics.
- Online access to articles, streaming audio, video, and much more.

You are responsible for the actual costs of engaging any childcare, eldercare, and/or educational services. However, you can obtain listings, educational materials, and brochures at no charge.

19.2.2.2 myStrength App

GuidanceResources partners with myStrength to offer an interactive Computerized Cognitive Behavioral Therapy (CCBT) program. This digital program is quick, easy, and effective. Based on clinical models like cognitive behavioral therapy, positive psychology, and motivational interviewing, the myStrength platform has helped thousands of people to improve and sustain their health and well-being.

Every time you use the program, it captures your preferences and goals, current emotional and motivational states, and ongoing life events. Sophisticated machine learning algorithms within the platform then created individualized experiences through interactive programs, in-the-moment coping tools, inspirational resources, and community support. These experiences help you reduce personal roadblocks, eliminate stress, and overcome mental barriers on the road to a better you.

Visit GuidanceResources Online at www.guidanceresources.com and enter your company ID: **INTEL**, to register and begin using the myStrength platform.

19.2.3 Employee Assistance Plan

Topics

19.2.3.1 Employee Assistance Plan

The Employee Assistance Plan (EAP) is a behavioral health program available to help you through tough times. It provides you and your eligible dependents confidential and convenient access to short-term professional counseling services at no cost to you.

Counseling services are provided through ComPsych® at (800) 568-9276. ComPsych oversees an extensive network of licensed mental health care professionals, which include the following:

- Psychologists
- Clinical social workers
- Marriage, family, and child counselors
- Other clinical providers

By contacting ComPsych, you can speak directly with a clinician. The clinician will assess your personal situation or that of an eligible dependent by telephone and suggest ways to find the help you need.

Note: Some sites have on-site counseling through the Health for Life Center. Please contact your Health for Life Center to determine if EAP on-site counseling is available.

If the ComPsych clinician refers you to a counselor, you or an eligible dependent can receive up to five visits per issue to help identify, clarify, and resolve the problem. These counselling sessions are designed to provide you and your eligible dependent with confidential and convenient access to short-term professional counseling. The costs of these visits are paid entirely by Intel.

If you need additional assistance beyond the five EAP visits, you will be encouraged to contact your health plan for referral and treatment.

If you would like a referral to a counselor or if you have questions, call the EAP at (800) 568-9276. You can call the phone number 24 hours a day, seven days a week. The phones are answered by ComPsych Master's Level intake specialists. The clinical staff is available if you are in a crisis or for every day issues.

You will be asked to explain the reason for your call so the intake specialists can put you in touch with either a community resource or a counselor most appropriate for you and your situation. If you are referred to a counselor, it is important that you feel comfortable with that counselor. You should state any preferences you may have, such as gender, race, licensing, or language preferences. Being open about your situation and preferences during your initial contact with the EAP enables the intake coordinator to best serve you.

During this phone call, you are provided the name of a counselor in your area. You may then contact the counselor to arrange for a convenient appointment. Different counselors have different treatment styles and philosophies. It is important that you feel comfortable with your counselor. If you are not satisfied with the counselor assigned to you, call the EAP toll-free phone number (800- 568-9276) immediately after your first session for a referral to a different counselor.

If you need to cancel or reschedule an appointment, contact the counselor as soon as possible. If you cancel an appointment with less than 24 hours' notice one of your five free counseling sessions will be deducted.

Teenagers often talk with an impartial listener more readily than they would with a parent. Therefore, if your teenage child calls the EAP and is able to provide verification of eligibility, the EAP will arrange for the teenager to see a counselor. The counselor then determines, on a case-by-case basis, whether the parent(s) should be involved.

After the five EAP visits, you may be eligible to continue your treatment through the mental health provisions of the medical plan in which you and your dependent are enrolled.

19.2.3.2 Appeals

If your claim for EAP benefits is denied, you may file an appeal. An EAP appeal is a "post service" appeal. Please see the Appeals procedures in *Pay, Stock and Benefits Handbook*, chapter 3, Administrative Information under Self-Funded Health Plan Appeals.

19.2.3.3 Exclusions and Limitations

The EAP does not cover the following:

- Services provided by a non-network counselor
- Inpatient hospital or alternate care treatment
- Treatment or services for mental retardation, autism, or pervasive development disorders
- Counseling services beyond the five sessions offered for each issue to you and each eligible dependent
- Counseling required by law or paid for by Workers' Compensation
- Services received before your participation begins
- Treatment by psychiatrists

19.3 Adoption Assistance Program

Topics

19.3.1 Overview

The Adoption Assistance Program provides eligible employees financial reimbursement of qualified adoption expenses. Your Spending Account™ (YSA), a division of Hewitt Associates, is the administrator of the Adoption Assistance Program.

19.3.2 Eligibility

You are eligible to participate in the Adoption Assistance Program if you are a general full-time (GFT), part-time (PTE), or expatriate on U.S. payroll. You must be employed at the time expenses are incurred and reimbursed. If both parents are employees of Intel, only one of them can submit a claim for the Adoption Assistance Program.

19.3.3 Limits

You will be eligible for up to $15,000 per finalized adoption with no lifetime maximum.

19.3.4 Eligible Child

The definition of an eligible child is:

- A child* who is under age 18 at the time the adoption is final, or
- An individual, any age, who is physically or mentally incapable of caring for him or herself. Proof of diagnosis and medical necessity is required.

  *includes the child of an employee's spouse or domestic partner (e.g. stepchild).

19.3.5 Eligible Expenses

Eligible expenses include:

- Domestic agency and placement fees
- Foreign agency and placement fees

- Travel expenses associated with adoption
- Medical expenses for the child not otherwise covered by insurance prior to the adoption
- Legal fees and court costs associated with the adoption
- Counseling fees associated with placement and initial adjustment Immigration, immunization, and translation fees
- Home evaluations associated with adoptions
- Expenses that were part of an unsuccessful attempt to adopt a child
- Expenses Incurred carrying out any surrogate parenting arrangements
- Expenses incurred in connection with adoption of your spouse's or your existing child (e.g. stepchild)
- Administrative fee paid to the donor service agency covering donor selection and matching, coordination of medical appointments, legal referrals, etc.
- Psychological evaluation and medical insurance for egg retrieval complications for the donor Legal fees for negotiation of the donor contract

Ineligible expenses include but are not limited to those that are:

- Incurred prior to the date of employment or after termination of employment
- Incurred in connection with establishing legal guardianship Reimbursed or paid by a federal, state, or local program, or from another employer or other party
- Taken as a credit or deduction under any other provision of the Internal Revenue Code
- Living expenses for the care of the child
- Temporary foster care provided before placement of child in the employee's home

19.3.6 Getting Reimbursed

Claims must be filed in writing, no later than 90 days of the finalized adoption date. The date of the expense and complete description of the expense must be clearly documented on the itemized receipts or other documentation provided. Participant-provided information, whether verbal or written, will not be accepted in lieu of third party information.

You will be required to complete the YSA claim form with each claim submission. Request an Adoption Assistance Claim Form by accessing *My Health Benefits* at www.intel.com/go/myben or by calling the Intel Health Benefits Center at (877) GoMyBen (466-9236).

Canceled checks and online bank statements will not be accepted in lieu of an itemized receipt. Credit card receipts without a description of the item are not acceptable. The participant will provide translation in English and YSA will convert the currency to U.S. dollars based upon the exchange rate on the day the service was rendered.

Diagnosis and medical necessity will be required if the adoption is for a child with special needs.

19.3.7 Tax Considerations

The tax treatment of adoption expenses is complex. The adoption assistance expansion in 2016 may have different tax implications than prior adoption assistance reimbursements. Certain expenses that are eligible for Intel reimbursement may be subject to federal income taxation. In

some cases Intel will know that all or a portion of a reimbursement is taxable, and will report such a reimbursement as taxable on Form W-2. In other cases, Intel will not have sufficient information to determine whether all or a portion of a reimbursement is taxable, but the information reported and coded on Form W-2 will enable the accurate completion of Form 1040, in conjunction with Form 8839 that generally must be completed for claiming adoption credits or employer-provided adoption benefits.

Note that all adoption assistance reimbursements are wages subject to FICA taxation (Social Security and Medicare taxes).

This information is not intended to be tax advice. You should always consult with your tax advisor about your personal tax situation.

19.4 Cord Tissue and Blood Storage

19.4.1 Overview

Intel provides reimbursement for long-term storage of cord tissue and/or blood. Your Spending Account™ (YSA), is the administrator of this reimbursement.

19.4.2 Eligibility

You are eligible for reimbursement for long-term storage if you are a general full-time (GFT), part-time (PTE), or expatriate on U.S. payroll. You must be employed at the time expenses are incurred and reimbursed.

19.4.3 Limits

Reimbursement for cord tissue and/or blood storage will be up to $15,000 per child. If the same child is adopted or is from a surrogacy birth, then the cord tissue and/or blood storage amount is combined with the adoption and/or surrogacy for a total combined benefit of $15,000.00. There is no limit on the number of children for whom cord tissue and/or blood storage reimbursement is available.

19.4.4 Eligible Expenses

Eligible expenses include:

- Any courier or processing fees.
- Annual storage or lifetime storage fee – if paying annually – you will need to submit a claim each year with the reimbursement being tracked to the per child limit. You must continue to be an active employee to be reimbursed for annual fees.

19.4.5 Getting Reimbursed

Claims must be filed in writing. The date of the expense and complete description of the expense must be clearly documented on the itemized receipts or other documentation provided. Participant-provided information, whether verbal or written, will not be accepted in lieu of third party information.

Reimbursement will occur for claims incurred up to 12 months prior to the claim submission date.

You will be required to complete the YSA claim form with each claim submission and clearly check the Cord Blood Storage box. Request an Adoption Assistance Claim Form by accessing My Health Benefits at www.intel.com/go/myben or by calling the Intel Health Benefits Center at (877) GoMyBen (466-9236).

Canceled checks and online bank statements will not be accepted in lieu of an itemized receipt. Credit card receipts without a description of the item are not acceptable.

Tax Considerations
Reimbursement for cord tissue and/or blood storage will be treated as taxable income and taxed accordingly. The IRS provides no provisions to allow this reimbursement to be tax free. **This information is not intended to be tax advice. You should always consult with your tax advisor about your personal tax situation.*

19.5 Tuition Assistance Program

Topics

19.5.1 Overview

As an Intel employee, you are encouraged to continue your professional development. To support you in this endeavor, Intel's Tuition Assistance Program (TAP) provides financial assistance to eligible participants completing a *job-related* degree program/coursework.

Important
Intel reserves the right to discontinue tuition assistance due to poor employee performance or economic/business circumstances.

19.5.2 Employee Eligibility Criteria

Participation in the Tuition Assistance Program depends upon the following:

- You meet Intel's employment status requirement(s):
    - You are a blue-badge general full-time (GFT) or a part-time employee (PTE).
    - You are on active status and employed by Intel for the duration (from beginning to end) of any coursework/term of study for which you are requesting tuition assistance.
    - Interns and summer students are **not** eligible.
- You perform to Intel's standards:
    - Your job performance is currently rated as "Successful" or better
- If you are new to Intel and have not yet had a formal review, you are subject to satisfactory performance as approved by your supervisor/manager and must be at

Intel for at least 6 months.

- You meet your business group's or site's requirements if applicable:
    - Participation criteria and approval requirements may vary by business group or by site. You will want to meet with your manager to better understand your business group's or your site's educational and tuition assistance requirements.
      Note: It is important to keep this in mind should you transfer from one group to another.
- Eligibility to participate in the Tuition for Teaching program differs from the Tuition Assistance Program. Please refer to the Tuition for Teaching program page for more information.

19.5.3 Education Approval Form (EAF)

The Education Approval Form (EAF) is a highly recommended first step in Intel's Tuition Assistance Program's process, whether you are pursuing an education program or taking just one course.

Prior to beginning the tuition assistance application process, you should complete the EAF, review with your manager in a 1:1, and obtain management approval.

Once the EAF has been completed, signed, and approved, it should be retained by you for your records. You do not need to submit the form to the Intel Tuition Assistance Service Center or the Intel Extended Education program team.

Important
If your manager changes after initial EAF approval, it is your responsibility to ensure that your new manager is knowledgeable about your Education Approval Form and education goals and is willing to support the cost associated with the program.

Access the Education Approval Form (EAF).

19.5.4 Tuition Assistance Coverage

With the exception of graduate-level business programs, employees who meet eligibility criteria are eligible for tuition assistance up to 100 percent for eligible schools/programs/expenses.

Graduate-level business programs only: Intel will reimburse up to a total cost of $50K (inclusive of tuition and eligible expenses) for any graduate-level business program. If the total program cost (inclusive of tuition and eligible expenses) exceeds $50K, you are to pay the difference.

Note: Because tuition and related expenses come out of your department budget, the coverage percentage is ultimately at the discretion of your manager.

19.5.5 Eligible Schools

In order for a school to be eligible for tuition assistance, one of the following must apply:

- Be a school located in the U.S.
- For management/business-related coursework/program, a school must have AACSB accreditation.
- For technical/engineering-related coursework/program, a school must have ABET accreditation.
- For graduate or doctorate law programs, a school must be ABA approved.
- For coursework or programs not covered above, a school must have U.S. regional accreditation.
- All U.S. regionally accredited community/junior colleges (two-year schools) are eligible for tuition assistance.

Important
There is no tuition assistance provided if one of the above criteria is not met.

19.5.6 Eligible Coursework and Programs

In order for coursework/degree programs to be eligible for tuition assistance, one of the following must apply:

- Is work-related. You must be able to presently, or in the future, apply the skills learned to your job at Intel.
- Is required to complete the general education requirements for a work-related degree.
- Teaches necessary, basic skills such as English as a second language.

Note: Audited courses are acceptable for reimbursement as long as the eligibility requirements for schools and coursework are met.

You will only be reimbursed for taking a course once, i.e., you may audit a course or take it for credit, but Intel will not reimburse you for both instances.

19.5.7 Grade Requirements

In order to be reimbursed, you must receive:

- "C" (2.0) or better for undergraduate coursework (a C- does not meet this requirement)
- "C" (2.0) or better for law school coursework (a C- does not meet this requirement)
- "B" (3.0) or better for graduate coursework (a B- does not meet this requirement)
- Credit/Pass
- For Doctoral Dissertations, the school must indicate that a satisfactory level of progress is being made toward the completion of the dissertation.
- For audited courses, there is no grade requirement.

If the grade requirement is not met, you will not be reimbursed for tuition and eligible expenses for that course. There is no appeals process, and exceptions will not be made.

If you drop or receive a grade of Incomplete in a course while participating in Intel's Tuition Assistance Program, you will be disqualified from receiving reimbursement for any of the associated costs specific to the course. You will only be reimbursed for those courses that you complete and receive the minimum required grade.

For Prepaid Graduate Tuition, if the grade requirement is not met or if you drop a course, you will be required to repay the amount of tuition and related expenses prepaid by Intel.

19.5.8 Program Eligibility Changes

You will lose eligibility to participate in Intel's Tuition Assistance Program (TAP) due to any of the following events or circumstances:

- Your employment status changes:
    - You are not employed for the duration (at the beginning **and** end) of any coursework/term of study for which you are requesting tuition assistance.
    - Your employment with Intel has been suspended or terminated.
    - You are redeployed.
        - If you are redeployed while in process with coursework, Intel will provide tuition assistance for the in-process coursework only—no future/additional tuition assistance will be provided—as long as the coursework, program, and school meet the eligibility requirements outlined in the Tuition Assistance Program (TAP) policies.
        - If you are redeployed and not in process with coursework, you cannot begin any education program/coursework as you are no longer eligible for tuition assistance.

- Your job performance rating falls below “Successful”

19.5.9 Potential Tax Implications

Tuition assistance benefits **may be** taxable. When you complete the tax questions (see the list directly below) on the Tuition Assistance Program online tool, your responses will determine whether tuition reimbursement paid by Intel will be taxable. Once you have submitted your online application request, you cannot update your responses to the taxability questions.

- Question 1: Does this program or course maintain or improve skills required in your current job?
- Question 2: Is this program or course required to meet the minimum education requirements for your current job?

- Question 3: Is this program or course part of a study program to qualify you for a job in a new field?

Taxable reimbursements will be recorded by Intel Payroll as income and taxed at a supplemental rate, and recorded on the employees' W2 statement for the year.

Important

Intel Corporation does not advise on any income tax requirements or issues. Use of any information from this site or any other web site referred to is for general information only and does not represent tax advice either expressed or implied. You are encouraged to seek professional tax advice for income tax questions and assistance.

19.5.10 Reimbursable Educational Expenses

- Tuition and required program fees
- Required textbooks and software
- Required lab fees
- Required technology fees
- Required student body fees
- Thesis/dissertation fees

* **Note**: Software will be permitted if the software is an essential piece of course material and the cost is roughly equivalent to the cost of what you might expect to pay for a textbook. Manager approval is required. However, if the software is very expensive, then a shared arrangement or licensing may be considered. Please discuss with your manager if this is the case

Only what is listed above is a reimbursable educational expense. All other expenses/fees are your responsibility.

19.5.11 Get Help

For questions about the TAP Policies, contact GP Strategies Worldwide, Intel's Tuition Assistance Program Administrator, at inteltuition@gpworldwide.com or by phone at 1-866-549-0720.

19.5.12 Employee Education Advisory Program

Intel offers educational counseling services for employees considering an undergraduate degree, graduate degree, or certification. The Employee Educational Advisory Program only recommends coursework which meets the eligibility requirements for the Tuition Assistance Program.

Manager approval is required for program participation. When you complete an advising request form, an approval request will be routed to your manager. Manager approval

for/participation in the Employee Education Advisory Program does not guarantee acceptance for the Tuition Assistance Program. Employees will need to submit a separate request that is subject to management approval in order to receive funding for coursework through the Tuition Assistance Program.

19.6 Tuition for Teaching

Topics

19.6.1 Overview

Intel's Tuition for Teaching program reimburses qualified expenses for any eligible U.S. Intel employee accepted by Intel into the program who would like to obtain their initial teaching certification in STEM [Science, Technology, Engineering, or Math] and become a public school teacher.

The Tuition for Teaching program does not cover expenses associated with secondary certifications (special education, counseling, English as a Second Language, etc.) or certification renewals.

As long as the education institution is regionally accredited, Tuition for Teaching participants may select the training path, program, and courses that best fit their needs within the STEM educational field.

Paths to certification include:

- Traditional college programs and courses
- Alternative programs tailored to workers who wish to make a career change to teaching

19.6.2 Eligibility

You are eligible to apply for the Tuition for Teaching Program if you are a general full-time (GFT), part-time (PTE), or expatriate employee on U.S. payroll for a minimum of 3 years from your most recent hire date at the time of your application to the program, and you:

- Are retirement eligible or on redeployment
- Have completed 10 hours of volunteer time in a public classroom within the last 7 years
- Can provide documentation that you have earned a Bachelor's (or higher) degree

If you have an interest in the Tuition for Teaching program and the Encore Fellowship program, you have the option to enroll in one of these two benefit offerings, not both.

If a participant engages in conduct or activities that could result in termination under Intel's Workplace Behavior/Discipline and Discharge guideline, eligibility or continued participation in the program shall be determined by the program manager or their delegate.

19.6.3 Application Process

Employees who meet the eligibility requirements may apply for the Tuition for Teaching program at any time during the year.

- Checklist
- Application form

A brief interview will be scheduled between you and the program manager or designated delegate to review the program expectations and next steps. You will receive a confirmation of your application status within 10 business days of the meeting date.

19.6.4 Once You've Been Accepted

After receiving confirmation that you have been accepted into the Tuition for Teaching program:

- You may remain in the Tuition for Teaching program for up to four years from the date of acceptance or until you reach the monetary cap of $15,750 for the program, or until your certification is complete, whichever is less.
- To remain eligible for reimbursement under the program, you must adhere at all times to Intel's Conflict of Interest guidelines as outlined by Intel's Code of Conduct.
- You must provide necessary documentation for reimbursement. Refer to Intel's Tuition for Teaching program checklist on Circuit for details. **Note:** You will not be reimbursed for any test fees or course work for which you do not receive a passing grade.

19.6.5 Reimbursement Limits

Intel's Tuition for Teaching program provides reimbursement of qualified expenses to a maximum of $5,250 per calendar year (tax free) and up to a program maximum of $15,750. Qualified expenses submitted must be for the year in which the expense was incurred.

19.6.6 Eligible Expenses

Intel's Tuition for Teaching program defines qualified expenses as:

- Testing fees
- Tuition and program fees
- Required textbooks/materials
- Required lab fees
- Required student body fees
- Fingerprinting fees

Only what is listed above is a reimbursable educational expense. All other expenses/fees are your responsibility.

19.6.7 Non-reimbursable Expenses

- Computers, laptops, and tablets
- College, University or program application fee
- Supplies: paper, notebooks, calculators, and the like
- Late fees
- Admission fees, such as file setup
- Secretarial services
- Tutors
- Graduation fees
- Software, unless it is specifically required for a course
- Mileage
- Parking fees

19.6.8 Getting Reimbursed

To begin the process of requesting reimbursement, you need to complete and submit a Reimbursement application using the Intel Tuition Assistance Program online tool.

Important: Before completing and submitting your request, note the following:

- Requests for reimbursement can only be submitted up to 90 days from course end date. **Any request submitted after 90 days have passed from course end date will not be honored; reimbursement is forfeited.**

- The start date of course(s) cannot be greater than 60 days from the date of application submission.
- There is no limit to the number of courses on an application.

If you are a first-time user, you will need to click on *First time user or forgot your password* (below the Login button) to have a password sent to your Intel e-mail account. After logging in with this password, you will be required to create your own unique password before continuing.

Access the Intel Tuition Assistance Online Tool from Circuit.

Understanding the Grade Requirements

When participating in the Tuition for Teaching program, you must receive:

- "C" (2.0) or better for undergraduate coursework (a C- does not meet this requirement)
- "C" (2.0) or better for law school coursework (a C- does not meet this requirement)
- "B" (3.0) or better for graduate coursework (a B- does not meet this requirement)
- Credit/Pass

If you do not meet these grade requirements, you may not be reimbursed for tuition and expenses for that course.

If you dropped a course while participating in Intel's Tuition for Teaching program, you will be disqualified from receiving reimbursement for any of the associated costs specific to the course dropped. You will only be reimbursed for those courses for which you complete and receive the minimum grade requirement.

Note: For audited courses, there is no grade requirement.

19.6.9 Submitting Your Grades and Required Documentation

Routine audits of submitted documentation are performed. Any attempt to commit fraud by submitting fraudulent or altered documentation is subject to disciplinary action, including termination of employment.

Within 90 days of successfully completing your approved course(s), e-mail the following course completion documents to the Intel Tuition Assistance Service Center at inteltuition@gpworldwide.com. If unable to e-mail, fax to 1-866-549-0712.

- Official grade report(s)

- Itemized school invoice/receipt(s) displaying proof of payment for tuition and eligible materials & fees (refer to Reimbursable Educational Expenses above for listing)

19.6.10 Payment Process and Timing

Tuition reimbursements are processed and paid on the same cycle as Intel paychecks. Reimbursements will be processed within two pay periods after you submit your documentation.

19.6.11 Potential Tax Implications

Employer-provided tuition assistance benefits may be taxable. However, U.S. employer-provided tuition reimbursement is currently tax-free up to $5,250 per employee per calendar year through at least 2016 for both undergraduate and graduate studies. Intel will not include reimbursements under this program into your income as long as the tax law continues in place. Visit the IRS Web site page on Educational Expenses to find out more about educational tax credits and eligibility.

Important
Intel Corporation does not advise on any income tax requirements or issues. Use of any information from this site or any other web site referred to is for general information only and does not represent tax advice either expressed or implied. We encourage you to seek professional tax advice for income tax questions and assistance.

19.6.12 Intel's Commitment to Education

Intel's Tuition for Teaching program will create new teachers, who, with their experience and passion, can motivate and inspire students to study and pursue jobs in many fields, especially math, science, engineering and technical fields.

Tuition for Teaching is just one example of Intel's long-standing commitment to inspire and help students realize the promise of education. Intel annually invests more than $100 million around the world to improve the quality of education, particularly in the fields of math, science and technology. To learn more about Intel's global commitment to education, visit http://www.intel.com/education.

Intel reserves the right at its sole discretion to modify and or end the program at any time. Should the program change or be discontinued, Intel commits to continue reimbursement for current program participants for classes in session at the time of the modification or cancellation. No other reimbursement shall be paid.

Chapter 20
Voluntary Benefits

Chapter 20
Voluntary Benefits

This chapter provides information on the two Critical Illness Insurance plans, Long-Term Care Insurance, Pre-paid Legal Services, and Supplemental Long-Term Disability Insurance.

20.1 Critical Illness Insurance

The Critical Illness Insurance Plan provides you with a lump-sum payout when you are diagnosed with a covered condition. During Intel's Annual Enrollment or as a new hire, you may enroll in the Critical Illness Insurance 3.5 Plan.

20.1A Critical Illness Insurance – 3.5 Plan

Topics

20.1.1A Overview of Intel Corporation Critical Illness 3.5 Plan

Critical Illness is an insurance product that pays a lump sum benefit payment upon diagnosis of a covered condition. You may use the insurance benefit as you see fit to help pay for costs not typically covered by other types of insurance.

In case of a conflict between the terms contained here and the terms contained in the Certificate of Insurance, the Certificate of Insurance will govern.

If you enroll, you can access and print your Certificate of Insurance by going to www.metlife.com/mybenefits, enter your company name and click 'submit.' On the Home Page, click on **'Register Now'** and perform the one-time registration process, if you don't already have an account.

- Enter your first and last name, identifying data and email address
- Create a unique user name and password for future access to MyBenefits
- For security purposes, choose and answer three identity verification questions to be utilized in the event you forget your password
- Read and agree to the website's Terms of Use
- A confirmation of your registration will be sent to the email address you provided
- Once you have selected the applicable product, click on the **'Certificate Detail'** tab
- Click on the **'View My Most Recent Certificate'**

Once you are enrolled, you may also request a copy by calling MetLife at (877) 770-4638.

20.1.2A Eligibility

If eligible, you may enroll in this coverage within 30 days of your hire date, during Annual Enrollment, or an approved life change event including: marriage/new domestic partner, birth, and adoption. Eligible individuals must apply for coverage on the My Health Benefits website at http://goto.intel.com/myhealthbenefits. Eligible individuals include general full-time employees (GFT) and part-time employees (PTE) as well as the following eligible dependents of the eligible employees: spouse, domestic partner* and dependent children as defined below. If your spouse or domestic partner has coverage as an Intel employee, he or she *may not enroll* as both a dependent and as an Intel employee.

Spouse means your lawful spouse. The term does not include any person who:

- is serving in the armed forces, or auxiliary units of the armed forces, of any country;
- lives outside the United States for more than 48 consecutive months; or
- is insured under the Group Policy as an employee.

*Domestic Partner means each of two people, one of whom is a GFT or PTE, who:

1. have established a domestic partnership pursuant to Section 297 of the California Family Code; or
2. are of the same or opposite sex and have a mutually dependent relationship so that each has an insurable interest in the life of the other. Each person must be:

    - 18 years of age or older;
    - unmarried;
    - the sole domestic partner of the other;
    - sharing a primary residence with the other;
    - not related to the other in a manner that would bar their marriage in the jurisdiction in which they reside.

A MetLife domestic partner declaration attesting to the existence of an insurable interest in one another's lives must be completed and signed by the employee. Please contact MetLife for the declaration.

The term "Domestic Partner" does not include any person who:

- is serving in the armed forces, or any auxiliary units of the armed forces, of any country;
- lives outside the United States for more than 48 consecutive months; or
- is insured under the Group Policy as an employee.

Dependent Child means the following:
Your biological, adopted, or step child who is under age 26.

The term "Dependent Child" does not include an unborn or stillborn child, or any person who;

- is serving in the armed forces, or any auxiliary units of the armed forces, of any country;
- lives outside of the United States for more than 48 consecutive months**;** or
- is insured under the Group Policy as an employee.

A person cannot be insured as a Dependent Child of more than one employee. Your adopted child will not be a Dependent Child prior to the date the child is placed in your home for adoption. Your stepchild will not be a Dependent Child prior to the date the child's parent becomes your Spouse or Domestic Partner.

20.1.3A Changing Your Annual Election

Generally, once you enroll in Critical Illness Insurance, no changes to your annual election are permitted, with the exception of Annual Enrollment or within 30 days of an approved life change event including: divorce or end of a Domestic Partner relationship.

Your Critical Illness Insurance enrollment will automatically renew each year, unless you elect to cancel your enrollment either during Annual Enrollment or within 30 days of an approved life change event as noted above.

20.1.4A Cost of Coverage

You pay the entire cost for Critical Illness insurance. Premiums are based on your age and the benefit amount you choose. Enrollment and premium information is available online at My Health Benefits website at http://goto.intel.com/myhealthbenefts.

20.1.5A Premium Payment While on Leave of Absence

Once on leave of absence, if applicable to you, MetLife will begin to bill you directly to your home address for your Critical Illness Insurance election. Once you return from your leave, payroll deductions will begin automatically.

20.1.6A Beneficiary Designation and Payment of Benefits

Critical Illness benefits are paid to you while you are living, unless you have assigned this insurance. In the event of your death, Critical Illness Insurance benefits are paid to your designated beneficiaries. All benefits will be paid in U.S. currency.

To designate a beneficiary or update an existing beneficiary, you may:

- Contact MetLife at (877) 770-4638, Prompt 3 and request a beneficiary designation form be mailed to you
- Download a beneficiary form from MetLife's website at www.metlife.com/mybenefits *Enter Intel Corporation in the Company Name field. Click the 'Next' button.*
- Designate a beneficiary or make a change to an existing beneficiary on the same website at any time
- Paper forms are accepted via fax at (855) 306-7350 or postal mail at:
  Metropolitan Life Insurance Company
  Attn: Critical Illness Insurance Service Center
  PO Box 80826
  Lincoln, NE 68501-0826
- If a form is missing information, a letter will be sent advising the form is incomplete and to resubmit
- Once the completed form is received, is deemed to be in good order and processed, a confirmation letter is sent to you noting the beneficiary change
- Beneficiary changes cannot be processed over the phone

If two or more beneficiaries are designated and their shares are not specified, they will share the insurance equally.

If there is no beneficiary designated or no surviving beneficiary at the time of your death, legal documentation (such as a will or formal paperwork from a lawyer advising who oversees the estate) must be submitted with the claim advising who is entitled to the benefit.

If no supporting information is provided at time of claim, benefits will be issued to the Estate of the insured.

If for any reason the individual entitled to the benefit is unable to cash the check issued to the Estate, individuals may reach out to MetLife at (877) 770-4638, Prompt 3 to review with a Representative what documentation is needed to reissue the benefit.

20.1.7A Proof of Good Health

Proof of good health is not required. There are no medical exams to take and no health questions to answer.

20.1.8A Benefit Options

Critical Illness Insurance coverage is available to you, your spouse/domestic partner and dependent children.

Eligible Individual	Initial Benefit
Employee	$15,000 or $30,000
Spouse/Domestic Partner	100% of the employee's Initial Benefit
Dependent Child(ren)	100% of the employee's Initial Benefit

20.1.9A Covered Conditions

Covered Conditions	Initial Benefit	Recurrence Benefit
Full Benefit Cancer	100% of Initial Benefit	100% of Initial Benefit
Partial Benefit Cancer	25% of Initial Benefit	25% of Initial Benefit
Heart Attack	100% of Initial Benefit	100% of Initial Benefit
Stroke	100% of Initial Benefit	100% of Initial Benefit
Coronary Artery Bypass Graft	100% of Initial Benefit	100% of Initial Benefit
Kidney Failure	100% of Initial Benefit	Not applicable
Alzheimer's Disease	100% of Initial Benefit	Not applicable
Major Organ Transplant Benefit	100% of Initial Benefit	Not applicable
22 Listed Conditions*	25% of Initial Benefit	Not applicable

***22 Listed Conditions**
MetLife Critical Illness Insurance will pay 25% of the Initial Benefit Amount for each of the 22 Listed Conditions until the Total Benefit Amount is reached. A Covered Person may only receive one payment for each Listed Condition in his/her lifetime. The Listed Conditions are Addison's disease (adrenal hypofunction); amyotrophic lateral sclerosis (Lou Gehrig's disease); cerebrospinal meningitis (bacterial); cerebral palsy; cystic fibrosis; diphtheria; encephalitis; Huntington's disease (Huntington's chorea); Legionnaire's disease; malaria; multiple sclerosis (definitive diagnosis); muscular dystrophy; myasthenia gravis; necrotizing fasciitis; osteomyelitis; poliomyelitis; rabies; sickle cell anemia (excluding sickle cell trait); systemic lupus erythematosus (SLE); systemic sclerosis (scleroderma); tetanus; and tuberculosis.

20.1.10A Filing a Claim for the 3.5 plan

To file a claim for benefits, you must give MetLife notice of the claim and submit proof as described in the certificate. Notice of claim and proof must be given to MetLife by following the steps below:

You must give MetLife notice, in writing, to the address below, or call (877) 770-4638 within 20* days after the Covered Condition Occurs or as soon thereafter as is reasonably possible

Metropolitan Life Insurance Company
Attn: Critical Illness Insurance Service Center
PO Box 80826
Lincoln, NE 68501-0826

MetLife will send a claim form to you and explain how to complete it. You should receive the claim form within 15 days of giving notice of the claim.

When you receive the claim form you must complete it as instructed and return it with the required proof described in the certificate. If you do not receive a claim form within 15 days after giving MetLife notice of claim, you may send MetLife acceptable proof as described in the certificate. Acceptable proof as described in the certificate should be provided within 90 days after the date of the Covered Condition or as soon as reasonably possible, not to exceed one year.

You can also submit a claim for the 3.5 plan online at: www.metlife.com/mybenefits
*Time limit for claim submittal may vary based on your state of residence. Please contact Metlife to understand your time limit for filing a claim.

20.1.11A Initial Determination

After MetLife receives your claim for benefits and acceptable proof, MetLife will review your claim and notify you of its decision to approve or deny your claim.

Such notification will be provided to you within a reasonable period, not to exceed 90 days from the date we received your claim, unless MetLife notifies you within that period that there are special circumstances requiring an extension of time of up to 90 additional days.

If MetLife denies your claim in whole or in part, the notification of the claims decision will state the reason your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. The notification will also include a description of the Plan review procedures and time limits, including a statement of your right to bring a civil action if your claim is denied after an appeal.

If you need to appeal a denied claim, see Pay, Stock and Benefits Handbook: Chapter 3, “Administrative Information”.

20.1.12A Mammogram Benefit

If the insured undergoes a covered mammogram while insured and if approved by the insurance company, the plan will pay $200.

Product features and availability vary by state. Please contact MetLife at (877) 770-4638 for more information.

20.1.13A Reduction of Benefits on Account of Prior Claims Paid

Benefits payable under the plan for all covered conditions will not exceed the total benefit amount that applies to the insured. The plan will reduce what is paid for a claim so that the amount that is paid, when combined with amounts for all claims previously paid for the same insured, does not exceed the total benefit amount that was in effect for that insured on the date of the most recent covered condition.

20.1.14A Covered Benefit Exclusions

The plan will not pay benefits for a Major Organ Transplant:

- Performed outside the United States
- Involving organs received from non-human donors
- Involving implantation of mechanical devices or mechanical organs
- Involving stem cell-generated transplants (other than for a bone marrow transplant)
- Involving islet cell transplants

The plan will not pay benefits for a Diagnosis of Stroke for:

- Cerebral symptoms due to migraine
- Cerebral injury resulting from trauma or hypoxia
- Vascular disease affecting the eye or optic nerve or vestibular functions

The plan will not pay benefits for a Diagnosis of Full Benefit Cancer for:

- Any benign tumor, dysplasia, intraepithelial neoplasia or pre-malignant growth
- Any papillary tumor of the bladder classified as Ta under TNM Staging
- Any tumor of the prostate classified as T1aN0M0 under TNM Staging
- Any papillary tumor of the thyroid that is classified as T1N0M0 or less under TNM Staging and is one centimeter or less in diameter unless there is metastasis
- Any non-melanoma skin cancer unless there is metastasis
- Any malignant tumor classified as less than T1N0M0 under TNM Staging
- Any condition that is Partial Benefit Cancer

The plan will not pay benefits for a Diagnosis of Partial Benefit Cancer for:

- Any benign tumor, dysplasia, intraepithelial neoplasia or pre-malignant growth
- Any papillary tumor of the bladder classified as Ta under TNM Staging
- Any tumor of the prostate classified as T1aN0M0 under TNM Staging
- Any papillary tumor of the thyroid that is classified as T1N0M0 or less under TNM Staging and is one centimeter or less in diameter
- Any non-melanoma skin cancer
- Any melanoma in situ classified as TisN0M0 under TNM Staging

The plan will not pay benefits for Coronary Artery Bypass Graft:

- Performed outside the United States; or
- That does not involve median sternotomy (a surgical incision in which the sternum, also known as the breastbone, is divided down the middle from top to bottom).

The plan will not pay benefits for a Diagnosis of Alzheimer's Disease for:

- Other central nervous system conditions that may cause deficits in memory and cognition (e.g., cerebrovascular disease, Parkinson's disease, normal-pressure hydrocephalus);
- Systemic conditions that are known to cause dementia (e.g., hypothyroidism, vitamin B12 or folic acid deficiency, niacin deficiency, hypercalcemia, neurosyphilis);

- Substance-induced conditions; or
- Any form of dementia that is not diagnosed as Alzheimer's disease.

The plan will not pay benefits for listed conditions:

- A Diagnosis of multiple sclerosis for clinically isolated syndrome (CIS);
- A Diagnosis of systemic lupus erythematosus (SLE) for any form of Lupus that is not Diagnosed as systemic lupus erythematosus (SLE); or
- A suspected or probable Diagnosis of a Listed Condition

20.1.15A Preexisting Condition Exclusion

Preexisting Condition means a sickness or injury for which, in the three months before a covered person becomes insured under this plan medical advice, treatment or care was sought by such covered person, or, recommended by, prescribed by or received from a physician or other practitioner of the healing arts.

The plan will not pay benefits for a covered condition that is caused by or results from a Preexisting Condition if the covered condition occurs during the first 6 months that a covered person is insured under this plan.

With respect to a Benefit Increase, the plan will not pay benefits for such Benefit Increase for Covered Conditions that are caused by or result from a Preexisting Condition if such Covered Condition Occurs during the first 6 months after such increase in the Total Benefit Amount.

This provision does not apply to benefits for the following Covered Conditions: Heart Attack and Stroke.

Plan design varies by state. Please contact MetLife at (877) 770-4638 for more information.

20.1.16A Intoxication and Controlled Substances

The plan shall not be liable for any loss sustained or contracted in consequence of the covered person's being intoxicated or under the influence of any controlled substance unless administered on the advice of a physician.

20.1.17A General Exclusions

The plan will not pay benefits for any covered conditions caused by, contributed to by, or resulting from a covered person:

- Participating in a felony, riot or insurrection
- Intentionally causing a self-inflicted injury
- Committing or attempting to commit suicide while sane or insane
- Voluntarily taking or using any drug, medication or sedative unless it is:
    - Taken or used as prescribed by a physician
    - An "over the counter" drug, medication or sedative taken according to package directions
- Engaging in any illegal occupation
- Serving in the armed forces or any auxiliary unit of the armed forces of any country

The plan will not pay benefits for covered conditions arising from war or any act of war, even if war is not declared.

The plan will not pay benefits for any covered condition for which diagnosis is made outside the United States, unless the diagnosis is confirmed in the United States, in which case the covered condition will be deemed to occur on the date the diagnosis is made outside the United States.

The plan will not pay benefits for any covered condition that does not first occur for a covered person while such covered person is insured under this plan.

20.1.18A When Does Coverage End?

Your insurance will end on the earliest of:

- The date the group policy ends
- The date you die
- The date insurance ends for your class
- The date the total benefit amount has been paid for you
- The end of the period for which the last full premium has been paid for you
- The date you cease to be in an eligible class
- The date your employment ends for any reason

A dependent's insurance will end on the earliest of:

- The date your insurance under this plan ends
- The date dependent insurance ends under the group policy for all employees or for your class
- The date the person ceases to be a dependent
- The date the total benefit amount has been paid for that dependent
- The date you cease to be in a class that is eligible for dependent insurance
- The end of the period for which the last full premium has been paid for the dependent

20.1.19A Continuation of Coverage

Under certain circumstances, you can take your coverage with you if you leave Intel. In order to continue coverage, you must make a request in writing to MetLife within a specified period after you leave your employer. You must also continue to pay your premiums to keep the coverage in force. Proof of good health will not be required to obtain continuation of coverage. If you obtain continuation of coverage, you may also continue dependent insurance.

20.1 B – Critical Illness Insurance – 1.0 Plan

This plan is closed to new enrollment effective 1/1/2019

Topics

20.1.1B Overview Critical Illness Insurance – 1.0 Plan

The Critical Illness – 1.0 Plan is an insurance product that pays a lump sum benefit payment in the event you experience one of six covered medical conditions: cancer, heart attack, stroke, kidney failure, major organ transplant or coronary artery bypass graft. You may use the insurance benefit as you see fit to help pay for costs not typically covered by other types of insurance.

In case of a conflict between the terms contained here and the terms contained in the Certificate of Insurance, the Certificate of Insurance will govern.

If you enrolled for coverage, you would have received a Certificate of Coverage detailing the plan benefits. You may also request a copy by calling MetLife at (877) 770-4638.

20.1.2B Eligibility

This plan is no longer eligible for enrollment. Eligible individuals must have applied for coverage with MetLife. In order to have been eligible for enrollment, you had to be an eligible individual who was a general full-time employees (GFT), part-time employees (PTE), Intel Contract Employees (ICE), interns, and expatriates who were paid on U.S. payroll as well as the following eligible dependents of the eligible employees: spouse and dependent children.

20.1.3B Cost of Coverage

You pay the entire cost for Critical Illness insurance. Premiums are based on your age, smoker status and the benefit amount you choose. Enrollment and premium information is available online at www.metlife.com/mybenefits or by calling (877) 770-4638.

20.1.4B Beneficiary Designation and Payment of Benefits

Critical Illness benefits are paid to you while you are living, unless you have assigned this insurance. In the event of your death, Critical Illness Insurance benefits are paid to your designated beneficiaries. All benefits will be paid in U.S. currency.

To designate a beneficiary or update an existing beneficiary, you may:

- Contact MetLife at (877) 770-4638, Prompt 3 and request a beneficiary designation form be mailed to you
- Designate a beneficiary or make a change to an existing beneficiary at any time
- Paper forms are accepted via fax at (866) 268-2621 or postal mail at:
  Metropolitan Life Insurance Company
  Attn: Critical Illness Insurance Product
  PO Box 6120
  Scranton, PA 18505-9972
- If a form is missing information, a letter will be sent advising the form is incomplete and to resubmit
- Once the completed form is received, is deemed to be in good order and processed, a confirmation letter is sent to you noting the beneficiary change
- Beneficiary changes cannot be processed over the phone

If two or more beneficiaries are designated and their shares are not specified, they will share the insurance equally.

If there is no beneficiary designated or no surviving beneficiary at the time of your death, benefits are paid to your surviving family members in the following order:

- Your spouse or domestic partner
- Your child(ren)
- Your parent(s)
- Your sibling(s)
- Estate of the insured

20.1.5B Proof of Good Health

Proof of good health is required for all eligible participants for all benefit options.

20.1.6B Benefit Options

Employee	$10,000 - $100,000
Spouse	$10,000 - $100,000
Dependent Child(ren)	$5,000

20.1.7B Covered Conditions

Covered Condition	Percent of Total Benefit Amount
Heart Attack	100%
Kidney Failure	100%
Major Organ Transplant	100%
Stroke	100%
Full Benefit Cancer	100%
Partial Benefit Cancer	The lesser of: 25% of the total benefit amount, or $15,000
Coronary Artery Bypass Graft	The lesser of: 25% of the total benefit amount, or $15,000

20.1.8B Benefit Waiting Period

- 90 days for Partial Benefit Cancer and Full Benefit Cancer
- 30 days for all other covered conditions

All insurance under the plan will be void if you experience a covered condition during the waiting period.

Contributions paid for insurance that is voided under this section will be returned to you without interest except if your dependent child is the covered person whose insurance is void under this provision, in which case contributions paid for that insurance will be returned to you only if there is no insurance remaining in effect for any dependent child under this plan. If you are the insured whose insurance is void under this provision, insurance for your dependents will also be void.

Plan design varies by state. Please contact MetLife at (800) GET-MET8 (438-6388) for more information.

20.1.9B Filing a Claim for the 1.0 Plan

To file a claim for benefits, you must give MetLife notice of the claim and submit proof as described in the certificate. Notice of claim and proof must be given to MetLife by following the steps set below:

You must give MetLife notice, in writing, to the address below, or call (877) 770-4638 within 30 days of the date of the Covered Condition.

Metropolitan Life Insurance Company
Attn: Critical Illness Insurance Service Center
PO Box 6120
Scranton, PA 18505-9972

MetLife will send a claim form to you and explain how to complete it. You should receive the claim form within 15 days of giving notice of the claim.

When you receive the claim form you must complete it as instructed and return it with the required proof described in the certificate. If you do not receive a claim form within 15 days after giving MetLife notice of claim, you may send MetLife acceptable proof as described in the certificate. You must provide acceptable proof no later than 90 days after the date of the Covered Condition. If notice of claim or acceptable proof is not provided within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice and acceptable proof are provided as soon as is reasonably possible, but in no event, other than in the absence of the claimant's legal capacity, later than 12 months from the date the Covered Condition occurred.

20.1.10B Initial Determination

After MetLife receives your claim for benefits and acceptable proof, MetLife will review your claim and notify you of its decision to approve or deny your claim.

Such notification will be provided to you within a reasonable period, not to exceed 90 days from the date we received your claim, unless MetLife notifies you within that period that there are special circumstances requiring an extension of time of up to 90 additional days.

If MetLife denies your claim in whole or in part, the notification of the claims decision will state the reason your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. The notification will also include a description of the Plan review procedures and time limits, including a statement of your right to bring a civil action if your claim is denied after an appeal.

If you need to appeal a denied claim, see Pay, Stock and Benefits Handbook: Chapter 3, “Administrative Information”.

20.1.11B Mammogram Benefit

If the insured undergoes a covered mammogram while insured and if approved by the insurance company, the plan will pay $150.

Product features and availability vary by state. Please contact MetLife at (877) 770-4638 for more information.

20.1.12B Reduction of Benefits on Account of Other Claims Paid

Benefits payable under the plan for all covered conditions will not exceed the total benefit amount that applies to the insured. The plan will reduce what is paid for a claim so that the amount that is paid, when combined with amounts for all claims previously paid for the same insured, does not exceed the total benefit amount that was in effect for that insured on the date of the most recent covered condition.

20.1.13B Covered Benefit Exclusions

The plan will not pay benefits for a Major Organ Transplant:

- Performed outside the United States
- Involving organs received from non-human donors
- Involving implantation of mechanical devices or mechanical organs
- Involving stem cell generated transplants (other than for a bone marrow transplant)
- Involving islet cell transplants

The plan will not pay benefits for a Diagnosis of Stroke for:

- Cerebral symptoms due to migraine
- Cerebral injury resulting from trauma or hypoxia
- Vascular disease affecting the eye or optic nerve or vestibular functions

The plan will not pay benefits for a Diagnosis of Full Benefit Cancer for:

- Any benign tumor, dysplasia, intraepithelial neoplasia or pre-malignant growth
- Any papillary tumor of the bladder classified as Ta under TNM Staging
- Any tumor of the prostate classified as T1aN0M0 under TNM Staging
- Any papillary tumor of the thyroid that is classified as T1N0M0 or less under TNM Staging and is one centimeter or less in diameter unless there is metastasis
- Any non-melanoma skin cancer unless there is metastasis
- Any malignant tumor classified as less than T1N0M0 under TNM Staging
- Chronic Lymphocytic Leukemia (CLL), less than Stage III, as defined by RAI classification; or
- Any condition that is Partial Benefit Cancer

The plan will not pay benefits for a Diagnosis of Partial Benefit Cancer for:

- Any benign tumor, dysplasia, intraepithelial neoplasia or pre-malignant growth
- Any papillary tumor of the bladder classified as Ta under TNM Staging
- Any tumor of the prostate classified as T1aN0M0 under TNM Staging
- Any papillary tumor of the thyroid that is classified as T1N0M0 or less under TNM Staging and is one centimeter or less in diameter
- Any non-melanoma skin cancer
- Any melanoma in situ classified as TisN0M0 under TNM Staging

The plan will not pay benefits for Coronary Artery Bypass Graft performed outside the United States.

20.1.14B Preexisting Condition Exclusion

Preexisting Condition means a sickness or injury for which, in the 12 months before a covered person becomes insured under this plan medical advice, treatment or care was sought by such covered person, or, recommended by, prescribed by or received from a physician or other practitioner of the healing arts.

The plan will not pay benefits for a covered condition that is caused by or results from a Preexisting Condition if the covered condition occurs during the first 12 months that a covered person is insured under this plan.

Plan design varies by state. Please contact MetLife at (877) 770-4638 for more information.

20.1.15B Intoxication Exclusion

The plan will not pay benefits for any covered condition that is caused by, contributed to by, or results from a covered person's involvement in an incident, where such covered person is intoxicated at the time of the incident and is the operator of a vehicle involved in the incident.

Intoxicated means that the covered person's alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred.

20.1.16B General Exclusions

The plan will not pay benefits for any covered conditions caused by, contributed to by, or resulting from a covered person:

- Participating in a felony, riot or insurrection
- Intentionally causing a self-inflicted injury
- Committing or attempting to commit suicide while sane or insane
- Voluntarily taking or using any drug, medication or sedative unless it is:
    - Taken or used as prescribed by a physician
    - An “over the counter” drug, medication or sedative taken according to package directions
- Engaging in any illegal occupation
- Serving in the armed forces or any auxiliary unit of the armed forces of any country

The plan will not pay benefits for covered conditions arising from war or any act of war, even if war is not declared.

The plan will not pay benefits for any covered condition for which diagnosis is made outside the United States, unless the diagnosis is confirmed in the United States, in which case the covered condition will be deemed to occur on the date the diagnosis is made outside the United States.

The plan will not pay benefits for any covered condition that does not first occur for a covered person while such covered person is insured under this plan.

20.1.17B When Does Coverage End?

Your insurance will end on the earliest of:

- The date the group policy ends
- The date you die
- The date insurance ends for your class

- The date the total benefit amount has been paid for you
- The end of the period for which the last full premium has been paid for you
- The date you cease to be in an eligible class
- The date your employment ends for any reason

A dependent's insurance will end on the earliest of:

- The date your insurance under this plan ends
- The date dependent insurance ends under the group policy for all employees or for your class
- The date the person ceases to be a dependent
- The date the total benefit amount has been paid for that dependent
- The date you cease to be in a class that is eligible for dependent insurance
- The end of the period for which the last full premium has been paid for the dependent

20.1.18B Continuation of Coverage

Under certain circumstances, you can take your coverage with you if you leave Intel. In order to continue coverage, you must make a request in writing to MetLife within a specified period after you leave your employer. You must also continue to pay your premiums to keep the coverage in force. Proof of good health will not be required to obtain continuation of coverage. If you obtain continuation of coverage, you may also continue dependent insurance.

Long-Term Care Insurance

This Plan is closed to new participants as of 12/31/2011

Topics

This section provides important information on the Long-Term Care insurance benefit that is available for purchase.

20.2.1 Overview

Long-Term Care insurance coverage is available to help provide for the cost of long-term care. This coverage is available to you and your eligible family members who are residents of the U.S., Puerto Rico and the Virgin Islands as outlined in the Pay, Stock and Benefits Handbook: Chapter 4, “Eligibility and Availability of Benefits”.

If you enrolled for coverage, you received a Certificate of Coverage detailing the plan benefits specific to your coverage. You may also request a certificate by calling MetLife at (877) 770-4638.

In case of a conflict between the terms contained here and the terms contained in the Certificate of Insurance, the Certificate of Insurance will govern.

20.2.2 Eligibility

This plan is no longer eligible for enrollment. In order to have been eligible for enrollment, you had to be an eligible individual who was a general full-time employees (GFT), part-time employees (PTE), Intel Contract Employees (ICE), Expatriates on U.S. payroll, retirees and their family members as follows:

- Spouse (or surviving spouses)
- Parents and parents-in-law
- Adult children and stepchildren age 18 and older
- Grandparents and grandparents-in-law

Eligible family members were able to enroll in the plan, even if the employee did not enroll.

20.2.3 Cost of Coverage

You pay the entire cost for Long-Term Care insurance. Premiums are based on your age and your coverage selection. Premium information is available by calling (877) 770-4638.

20.2.4 Premium Payment While on Leave of Absence

Once on leave of absence, if applicable to you, MetLife will begin to bill you directly to your home address for your Critical Illness Insurance election. Once you return from your leave, payroll deductions will begin automatically.

20.2.5 Proof of Good Health

Proof of good health is not required:

- For new hires within 30 days of hire if you are Actively at Work on the effective date for all benefit options
- If you are not Actively at Work on your effective date, coverage will become effective on the first of the month following your return to work (provided you are Actively at Work on that date)

If you wish to enroll at any other time, proof of good health is required.

Proof of good health is required for all other eligible participants. The proof of good health must be submitted to MetLife to determine approval for coverage.

20.2.6 Return of Contributions

If you are covered on the date of your death, the insurance company will refund to your estate those contributions that were due and paid up to your 65th birthday as follows:

- *If you die before age 65*: All contributions less any benefits paid to you or on your behalf under this plan.

- *If you die on or after age 65 but before age 75*: All contributions due and paid up to your 65th birthday - reduced by 1/120 of that amount for each full month you were covered after your 65th birthday - less any benefits paid to you or on your behalf under this plan.

Contributions that were due and paid after you turn 65 will not be refunded. Also, contributions will not be refunded if:

- Nonforfeiture coverage was being provided on the date of your death (The nonforfeiture feature provides some coverage if you have paid premiums for at least three years and elect to stop making payments.)
- You die on or after age 75

The time limit for submitting proof of a claim to the insurance company for a refund of contributions is 90 days after the date of the insured's death.

If coverage ends because of your death, any additional contributions paid for any period beyond the date of your death will be refunded to your estate.

20.2.7 Benefit Options

	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6
Daily Benefit Amount	$100	$100	$200	$200	$300	$300
Total Lifetime Amount (years)	3 years	5 years	3 years	5 years	3 years	5 years
Total Lifetime Benefit Amount	$109,500	$182,500	$219,000	$365,000	$328,500	$547,500
Total Lifetime Maximum (days)	1,095 days	1,825 days	1,095 days	1,825 days	1,095 days	1,825 days

Benefits are payable for the actual cost of services up to the daily benefit.

If an insured is eligible for benefits and is outside of the United States, the plan will pay a per diem benefit upon completion of the waiting period. The per diem benefit will be equal to 50% of the home care daily benefit. The per diem benefit will be paid in US dollars. This benefit will be paid up to a maximum of 10 years while the insured is outside of the United States.

20.2.8 Covered Services

Covered services include:

- Nursing home (skilled, intermediate and custodial care in a licensed nursing home or Alzheimer's facility)
- In-patient hospice care
- Assisted living facility (or Alzheimer facility)
- Home care services
- Services from a licensed home care agency for: R.N., L.P.N., L.V.N., home health aide, physical, respiratory, occupational and speech therapy, and homemaker services, social worker, social worker from an agency
- Care from a nurse (R.N., L.P.N., L.V.N.) or a licensed therapist who is unaffiliated with a licensed agency
- Adult day care
- At-home hospice care
- Ongoing advisory services
- Informal Care (30 days per calendar year)

Covered Service	Percent of Daily Benefit
Nursing Home	100%
In-Patient Hospice Care	100%
Assisted Living Facilities	100%
Home Care Services	75%
Informal Care	25%

20.2.9 Eligibility for Benefits

You will be eligible to receive benefits only if a licensed health care practitioner employed or retained by the insurance company certifies that you are Chronically Ill. "Chronically Ill" means that:

1. You are unable to perform, without substantial assistance from another individual, at least two activities of daily living for a period of at least 90 days due to a loss of functional capacity; or
2. You require substantial supervision to protect you from threats to health and safety due to severe cognitive impairment.

20.2.10 How to Access Benefits

When an insured anticipates a need for services covered under the plan, the insured, or anyone acting on his or her behalf, initiates the request for benefits via the toll-free telephone line (877) 770-6438 (no forms are required). The caller will be assisted by a MetLife Care Coordinator. The Care Coordinator will obtain information needed to determine the insured's eligibility for benefits. The insured's representative and/or others who may have relevant information about the insured's condition may be contacted. MetLife may arrange an onsite assessment at MetLife's expense.

Once the necessary information has been obtained, a MetLife Nurse Care Coordinator will make a decision regarding benefit eligibility. Insureds are notified of the decision within 10 business days of receipt of all necessary information.

If benefits are approved, a claim form is enclosed with the benefit notification letter.

If benefits are denied, MetLife will send a declination letter to the insured indicating the reason for denial and explaining the process for appealing the decision.

20.2.11 Filing a Claim

Once an insured has fulfilled the waiting period and has received a covered service, he or she has the option of assigning benefits to the care provider. MetLife will then work directly with the provider regarding payment. Assigning benefits eliminates the need for the insured to submit claims on a regular basis. Approved claims will be paid within 10 business days of receipt of all relevant information.

An insured who disputes a claim reimbursement can submit the information to MetLife in writing. Such disputes will be reviewed by a claims manager. A decision will be made and confirmed in writing within 10 business days of receipt of all relevant information.

20.2.12 Appealing a Denied Claim

Please see Pay, Stock and Benefits Handbook: Chapter 3, “Administrative Information for the Appeals process”.

20.2.13 Waiting Period

The waiting period is 90 calendar days.
Once satisfied, the waiting period does not need to be completed again for subsequent benefit periods. If only partially completed, days will be credited toward a subsequent waiting period, as long as 180 or more days have not passed.

20.2.14 Waiver of Premium

Premium payments will be waived on the date as of which you complete both the Waiting Period and are certified as chronically ill.
In all other cases, premium payments are waived beginning on the first day of the month following the month in which you complete the waiting period and are eligible for benefits. You must resume payment of your contribution beginning on the first day of the month following the month in which you are no longer eligible for benefits.

20.2.15 Payment of Benefits

All benefits will be paid in U.S. currency. All benefits will be paid directly to you unless you have completed a valid assignment of benefits to a provider of long-term care services.

20.2.16 Restoration of Benefits

Your total lifetime benefit will be restored, if all of the following conditions are met:

1. Your total lifetime benefit has not been exhausted;
2. You have paid contributions for a continuous period of 24 months from the date as of which you were no longer chronically ill; and
3. You provide proof satisfactory to a licensed health care practitioner employed or retained by the insurance company that you were not chronically ill at any time during this 24-month period.

20.2.17 Extension of Benefits

If as of the date your coverage ends, you are certified as chronically ill, and are confined in a nursing home, hospice facility or assisted living facility, the insurance company will extend the payment of benefits for qualified long-term care services received in the nursing home, hospice facility or assisted living facility so long as without interruption, you remain chronically ill and confined in the nursing home, hospice facility or assisted living facility. Subject to the waiting period and all other requirements of this group policy, benefits will be extended only until the earliest of:

- The date you are no longer certified as chronically ill
- The date you are no longer confined in the nursing home, hospice facility or assisted living facility
- The date the total lifetime benefit has been paid

20.2.18 Transition Expense Benefit

A benefit providing up to ten times the daily benefit to be used for long-term care purposes, such as a personal emergency response system, caregiver training, durable medical equipment, or offsetting costs of qualified services received during the waiting period. It is payable after completion of the waiting period. To access this benefit, proof of payment for a covered expense must be submitted to the insurance company. It does not reduce the total lifetime benefit.

20.2.19 Inflation Protection

At least once every three years, you will be given the option to increase coverage without providing proof of good health. The amount of the increase to the daily benefit amount will be 5% compounded annually. The purpose of this protection is to keep pace with the rising cost of care.

20.2.20 Nonforfeiture Coverage

Insureds who have paid contributions for at least three years and elect to stop making payments will be entitled to receive some coverage.

Nonforfeiture Coverage takes effect on the "Nonforfeiture Date". **"Nonforfeiture Date"** means the 1st day following the end of the period covered by your last paid contribution. Once you receive Nonforfeiture Coverage, you cannot change your benefits.

The same benefits will be payable under nonforfeiture Coverage except that the total lifetime benefit will be the greater of (a) the sum of all paid contributions or (b) 30 times the daily nursing home benefit in effect immediately prior to the Nonforfeiture Date. The total benefits paid prior to and after the Nonforfeiture Date will not exceed the total lifetime benefit in effect immediately prior to the Nonforfeiture Date.

20.2.21 Coordination of Benefits

Benefits will be reduced by the dollar amount payable by any of the following, to the extent that the combination of your benefit and amounts payable or which would be payable by any of the following exceed 100% of the actual charge for the covered expenses:

- Any federal, state or other governmental health care plan or law (except Medicaid or Medicare)
- Any state or federal workers' compensation law
- Any employer's liability or occupational disease law
- Any motor vehicle no-fault law
- Any other plan which any employer contributes to or sponsors

20.2.22 Exclusions

The plan does not provide benefits for any of the following:

- Care in a facility that provides services primarily for detoxification of or rehabilitation for alcoholism or drug addiction (chemical dependency), except drug addiction sustained at the hands of or while being treated by a Physician for an injury or sickness.
- Any service or supply received outside the United States or its territories.
- Illness, treatment or medical condition arising out of:
    - war or act of war (whether declared or undeclared);
    - participation in a felony, riot or insurrection;
    - service in the armed forces or auxiliary units;
    - attempted suicide (while sane or insane) or intentionally self-inflicted injury; or
    - Treatment provided in a government facility, unless otherwise required by law.
- Any care provided while in a hospital, except for confinement in a distinct part of a hospital that is licensed as a nursing home or hospice.
- Any service provided by your immediate family, unless the service is a covered service from an informal caregiver.
- Any service or supply to the extent that such expenses are reimbursable under Medicare, or would be so reimbursable but for the application of a deductible or coinsurance or copayment amount. This exclusion will not apply in those instances where Medicare is determined to be secondary payer under applicable law.

Services for which no charge is normally made in the absence of insurance.

20.2.23 When Does Coverage End?

Your coverage will end on the earliest of:

- The last day of the month in which you notify the insurance company that you wish to cancel your coverage
- The date of your death
- 35 days after the insurance company sends a written notice of termination of your coverage
- The date you have received benefits equal to your total lifetime benefit
- The date the group policy ends, subject to the provisions in "Continuation Coverage"
- The date your employment with Intel terminates, subject to the provisions in "Continuation Coverage"
- If you are an eligible employee or eligible family member of an eligible employee, the date the eligible employee's employment with Intel terminates along with a group of employees as a result of corporate restructuring, acquisition, spinoff or similar circumstances, subject to the provisions in "Continuation Coverage"
- If you are an eligible retiree or eligible family member of an eligible retiree, the date Intel no longer considers that class of retirees to be eligible retirees as a result of corporate restructuring, acquisition, spinoff or similar circumstances, subject to the provisions in "Continuation Coverage"

If your eligibility for coverage was based upon your relationship to another person, your coverage will not end if that relationship terminates by death or dissolution of marriage.

20.2.24 Continuation of Coverage

You have the right to continue coverage even if your coverage ends, except as stated below. This is called "Continuation Coverage" and it requires that you pay contributions to the insurance company directly when they are due. The insurance company will automatically provide Continuation Coverage unless you or your representative notifies the insurance company that you do not want it.

Continuation Coverage is not available to the following categories of persons:

Category 1: Your coverage ends because you failed to make any required payment of contribution when due or you notified the insurance company that you want to end your coverage; or

Category 2: You have already received benefits that count toward your total lifetime benefit that are equal to your total lifetime benefit; or

Category 3: The group policy terminates and coverage is replaced (within 31 days after termination) by other group coverage that:

- Is effective on the day following termination of coverage; and provides benefits which are identical to or are determined, as required under applicable law, to be substantially equivalent to

or exceed those provided by the group policy; and
- Calculates premium based on your age at inception of coverage under the group policy.

Category 4: Your employment with Intel terminates or, if you are an eligible family member of an eligible employee, that eligible employee's employment with Intel terminates along with a group of employees as a result of corporate restructuring, acquisition, spinoff or similar circumstances and Coverage is replaced (within 31 days after termination) by other group coverage that:

- Is effective on the day following your termination of Coverage; and
- Provides benefits which are identical to or are determined, as required under applicable law, to be substantially equivalent to or exceed those provided by the Group Policy; and
- Calculates premium based on your age at inception of Coverage under the Group Policy.

Category 5: You are an eligible retiree, or an eligible family member of an eligible retiree, whose coverage terminates because Intel no longer considers that class of retirees to be eligible retirees and coverage is replaced (within 31 days after termination) by other group coverage that:

- Is effective on the day following your termination of coverage; and
- Provides benefits which are identical to or are determined, as required under applicable law, to be substantially equivalent to or exceed those provided by the group policy; and
- Calculates premium based on your age at inception of coverage under the group policy.

The insurance company may, in their discretion, offer Continuation Coverage to all persons in Categories 3, 4 and/or 5. In this event, you will be notified in writing.

20.3 Prepaid Legal Services Plan

Topics

20.3.1 Overview

Prepaid Legal Services (the "Legal Plan") provides personal legal services for you, your spouse and dependent children. This chapter provides important information about the Legal Plan If you have any questions that are not answered, please call MetLife's Customer Service Center for Intel Employees at (877)770-4638 and select 'Hyatt Legal'.

Hyatt Legal Plans, Inc., a MetLife company, has been selected to provide Legal Plan benefits. The Legal Plan benefits are provided through a network of Participating Law Firms. Lawyers in this network are called Legal Plan Attorneys.

The listing of plan attorneys can be obtained via the website (info.legalplans.com) or by calling (877) 770-4638. The listing can be mailed, emailed or faxed to the employee.

In case of a conflict between the terms contained in this Summary Plan Description and the terms provided by Hyatt Legal, the Hyatt Legal terms will govern.

20.3.2 Eligibility

You are eligible to enroll in the Legal Plan for yourself if you are a full-time or part-time employee. Once you are enrolled, your eligible dependents may also receive benefits under the Legal Plan. Eligible dependents include your lawful spouse*/domestic partner* and your unmarried child (or children) up to the age of 26 provided he or she depends on you for support and is listed as a dependent on member's tax return.

*Spouse includes a same sex spouse provided the couple was married in a state that recognizes same sex marriage even if you reside in a state that does not recognize the validity of same-sex marriages.

*A Domestic partner means is an individual you:

- have established a domestic partnership pursuant to Section 297 of the California Family Code; or
- have a mutually dependent relationship so that each has an insurable interest in the life of the other. Each person must be:
    - 18 years of age or older;
    - unmarried;
    - the sole domestic partner of the other;
    - sharing a primary residence with the other;
    - not related to the other in a manner that would bar their marriage in the jurisdiction in which they reside.

20.3.3 Participation

The Legal Plan has a minimum participation period of one year, and you must maintain the coverage for the entire Legal Plan year, which is January 1 through December 31. If you enroll in the Legal Plan as a New Hire, you must maintain the coverage from your enrollment date through December 31.

Once Enrolled, your enrollment status will automatically renew each year. You have the option to cancel enrollment during the Annual Enrollment period.

20.3.4 Cost of the Legal Plan

You pay the cost of the Legal Plan through after-tax payroll deductions. The current cost is $18.50 per month.

20.3.5 Premium Payment While on Leave of Absence

Once on leave of absence, if applicable to you, your Hyatt Legal Insurance coverage will continued to be covered. You will not be directly billed to your home address nor payroll deducted. Once you return from your leave, payroll deductions will begin automatically.

20.3.6 How to Obtain Legal Services

You may access the Legal Plan through info.legalplans.com (select "Member Login". Those not yet enrolled can select "Thinking About Enrolling" and use access code GetLaw to review the plan

or through the Client Service Center by calling (877) 770-4638**,** Monday – Friday 8 a.m. to 8 p.m., (Eastern). Be prepared to give your Membership Number (which Hyatt Legal Plans will mail to you after annual enrollment). If you are a spouse or an eligible dependent child of an eligible person, you will need the Membership Number of the employee through whom you are eligible. You may then call the Legal Plan Attorney provided by the Web or Client Services to schedule an appointment at a time convenient to you. Evening and Saturday appointments are available.

If you choose, you may select your own attorney. Also, where there are no Participating Law Firms, you will be asked to select your own attorney. In both of these circumstances, the Legal Plans will reimburse you for these non-Legal Plan attorneys' fees in accordance with a set fee schedule.

For services to be covered, you or your eligible dependents must have obtained a Case Number, retained an attorney and the attorney must begin work on the covered legal matter while you are an eligible member of the Legal Plan.

20.3.7 What Services are Covered?

The Legal Plan entitles you and your eligible dependents (the “Participant” or “Participants”) to receive certain personal legal services. The available benefits are very comprehensive, but there are limitations and other conditions which must be met. Please take time for yourself and your family to read the description of benefits carefully.

All benefits are available to you and your spouse and dependents, unless otherwise noted.

20.3.8 Advice and Consultation

Through an office or telephone consultation, you have the opportunity to discuss with an attorney any personal legal problems that are not specifically excluded. The Legal Plan Attorney will explain the Participant's rights, point out your options and recommend a course of action. The Legal Plan Attorney will identify any further coverage available under the Legal Plan, and will undertake representation if requested. If representation is covered by the Legal Plan, there is no charge for the Legal Plan Attorney's services. If representation is recommended, but is not covered by the Legal Plan, the Legal Plan Attorney will provide a written fee statement in advance. You may choose whether to retain the Legal Plan Attorney at your own expense, seek outside counsel, or do nothing. There are no restrictions on the number of times per year a Participant may use this service; however, for a non-covered matter, this service is not intended to provide the Participant with a Legal Plan Attorney for more than consultation. If you decide that you would like to pursue a course of action that requires legal representation, and such services are not covered by the Legal Plan, the Legal Plan Attorney would need to be retained for representation.

20.3.9 Consumer Protection

Consumer Protection Matters
This service covers the Participant as a plaintiff, for representation, including trial, in disputes over consumer goods and services where the amount being contested exceeds the small claims court limit in the applicable court jurisdiction and is documented in writing. This service does

not include disputes over real estate, construction, insurance or collection activities after a judgment.

Small Claims Assistance
This service covers counseling the Participant on prosecuting a small claims action; helping the Participant prepare documents; advising the Participant on evidence, documentation and witnesses; and preparing the Participant for trial. The service does not include the Legal Plan Attorney's attendance or representation at the small claims trial, collection activities after a judgment or any services relating to post-judgment actions.

Personal Property Protection
This service covers counseling the Participant over the phone or in the office on any personal property issue such as consumer credit reports, contracts for the purchase of personal property, consumer credit agreements or installment sales agreements. Counseling on whether and how to pursue or defend small claims actions is also included. The service also includes reviewing any personal legal documents and preparing promissory notes, affidavits and demand letters.

20.3.10 Debt Matters

Debt Collection Defense
This benefit provides Participants with an attorney's services for negotiating with creditors for a repayment schedule and to limit creditor harassment, and representation in defense of any action for personal debt collection, tax agency debt collection, foreclosure, repossession or garnishment, up to and including trial if necessary. It does not include vacating a judgment; counter, cross or third party claims; bankruptcy, any action arising out of family law matters including support and post decree issues; or any matter where the creditor is affiliated with Intel Corporation as the sponsor of the Legal Plan.

Identity Theft Defense
This service provides you with consultations with an attorney regarding potential creditor actions resulting from identity theft and attorney services as needed to contact creditors, credit bureaus and financial institutions. It also provides defense services for specific creditor actions over disputed accounts. The defense services include limiting creditor harassment and representation in defense of any action that arises out of the identity theft such as foreclosure, repossession or garnishment, up to and including trial if necessary. The service also provides the Participant with online help and information about identity theft and prevention. It does not include counter claims, cross claims, bankruptcy, any action arising out of divorce or post decree matters, or any matter where the creditor is affiliated with Intel Corporation as the sponsor of the Legal Plan.

Personal Bankruptcy or Wage Earner Legal Plan
This service covers the Participant in pre-bankruptcy planning, the preparation and filing of a personal bankruptcy or Wage Earner petition, and representation at all court hearings and trials. This service is not available if a creditor is affiliated with the Employer, even if the Participant chooses to reaffirm that specific debt.

Tax Audits
This service covers reviewing tax returns and answering questions the IRS, or a state or local taxing authority has concerning the Participant's tax return; negotiating with the agency;

advising the Participant on necessary documentation; and attending an IRS or a state or local taxing authority audit. The service does not include prosecuting a claim for the return of overpaid taxes or the preparation of any tax returns.

20.3.11 Defense of Civil Lawsuits

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

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

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

20.3.12 Document Preparation

Affidavits
This service covers preparation of any affidavit in which the Participant is the person making the statement.

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

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

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

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

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

20.3.13 Elder Law Matters

This service covers counseling the Participant over the phone or in the office on any personal issues relating to the Participant's parents as they affect the Participant. The service includes reviewing documents of the parents to advise the Participant on the effect on the Participant. The documents include Medicare or Medicaid materials, prescription plans, leases, nursing home agreements, powers of attorney, living wills and wills. The service also includes preparing deeds involving the parents when the Participant is either the grantor or grantee; and preparing promissory notes involving the parents when the Participant is the payer or payee.

20.3.14 Family Law

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

Prenuptial Agreement
This service covers the preparation of an agreement by you and your fiancé/partner prior to your marriage or legal union (where allowed by law), outlining how property is to be divided in the event of separation, divorce or death of a spouse. Representation is provided only to you. Your fiancé/partner must have separate counsel or must waive representation.

Protection from Domestic Violence
This service covers you only, not your spouse or dependents, as the victim of domestic violence. It provides you with representation to obtain a protective order, including all required paperwork and attendance at all court appearances. The service does not include representation in suits for damages, defense of any action, or representation for the offender.

Adoption and Legitimization (Contested and Uncontested)
This service covers all legal services and court work in a state or federal court for an adoption for the Participant. Legitimization of a child for the Participant, including reformation of a birth certificate, is also covered.

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

Immigration
This service covers advice and consultation, preparation of affidavits and powers of attorney, review of any immigration documents and helping the Participant prepare for hearings.

Personal Injury
Subject to applicable law and court rules, Legal Plan Attorneys will handle personal injury matters (where the Participant is the plaintiff) at a maximum fee of 25% of the gross award. It is the Participant's responsibility to pay this fee and all costs.

20.3.15 Real Estate Matters

Boundary or Title Disputes (Primary Residence)
This service covers negotiations and litigation arising from boundary or title disputes involving a Participant's primary residence, where coverage is not available under the Participant's homeowner or title insurance policies.

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

Security Deposit Assistance (Primary Residence – Tenant Only)
This service covers counseling the Participant as a tenant in recovering a security deposit from the Participant's residential landlord for the Participant's primary residence; reviewing the lease and other relevant documents; and preparing a demand letter to the landlord for the return of the deposit. It also covers assisting the Participant in prosecuting a small claims action; helping prepare documents; advising on evidence, documentation and witnesses; and preparing the Participant for the small claims trial. The service does not include the Legal Plan Attorney's attendance or representation at small claims trial, collection activities after a judgment or any services relating to post-judgment actions.

Home Equity Loans (Primary Residence)
This service covers the review or preparation of a home equity loan on the Participant's primary residence.

Property Tax Assessment (Primary Residence)
This service covers the Participant for review and advice on a property tax assessment on the Participant's primary residence. It also includes filing the paperwork; gathering the evidence; negotiating a settlement; and attending the hearing necessary to seek a reduction of the assessment.

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

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

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

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

Zoning Applications
This service provides the Participant with the services of a lawyer to help get a zoning change or variance for the Participant's primary residence. Services include reviewing the law, reviewing the surveys, advising the Participant, preparing applications, and preparing for and attending the hearing to change zoning.

20.3.16 Traffic and Criminal Matters

Juvenile Court Defense
This service covers the defense of the Participant employee and the Participant employee's dependent child in any juvenile court matter, provided there is no conflict of interest between the Participant employee and child. In that event the service provides an attorney for the Participant employee only including service for Parental Responsibility.

Traffic Ticket Defense (No DUI)
This service covers representation of the Participant in defense of any traffic ticket including traffic misdemeanor offenses, except driving under influence or vehicular homicide, including court hearings, negotiation with the prosecutor and trial.

Restoration of Driving Privileges
This service covers the Participant with representation in proceedings to restore the Participant's driving license.

20.3.17 Wills and Estate Planning

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

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

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

Probate (10% Network Discount)
Subject to applicable law and court rules, Legal Plan Attorneys will handle probate matters at a fee 10% less than the Legal Plan Attorney's normal fee. It is the Participant's responsibility to pay this reduced fee and all costs.

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

20.3.18 Exclusions

Excluded services are those legal services that are not provided under the Legal Plan. No services, not even a consultation, can be provided for the following matters:

- Employment-related matters, including company or statutory benefits
- Matters involving Intel Corporation as the employer, MetLife® and affiliates, and Legal Plan Attorneys
- Matters in which there is a conflict of interest between you and your spouse or dependents in which case services are excluded for the spouse and dependents
- Appeals and class actions
- Farm and business matters, including rental issues when the Participant is the landlord
- Patent, trademark and copyright matters
- Costs or fines
- Frivolous or unethical matters
- Matters for which an attorney-client relationship exists prior to the Participant

becoming eligible for Legal Plan benefits

20.3.19 Legal Plan Confidentiality, Ethics and Independent Judgment

Your use of the Legal Plan and the legal services is confidential. The Legal Plan Attorney will maintain strict confidentiality of the traditional lawyer-client relationship. Intel will know nothing about your legal problems or the services you use under the Legal Plan. Legal Plan administrators will have access only to limited statistical information needed for orderly administration of the Legal Plan.

No one will interfere with your Legal Plan Attorney's independent exercise of professional judgment when representing you. All attorneys' services provided under the Legal Plan are subject to ethical rules established by the courts for lawyers. The Legal Plan Attorney will adhere to the rules of the Legal Plan and he or she will not receive any further instructions, direction or interference from anyone else connected with the Legal Plan. The attorney's obligations are exclusively to you. The attorney's relationship is exclusively with you. Hyatt Legal Plans, Inc., or the law firm providing services under the Legal Plan is responsible for all services provided by their attorneys.

You should understand that the Legal Plan has no liability for the conduct of any Legal Plan Attorney. You have the right to file a complaint with the state bar concerning attorney conduct pursuant to the Legal Plan. You have the right to retain at your own expense any attorney authorized to practice law in the applicable state.

Legal Plan Attorneys will refuse to provide services if the matter is clearly without merit, frivolous or for the purpose of harassing another person. If you have a complaint about the legal services you have received or the conduct of an attorney, call Hyatt Legal Plans at **(800) 821-6400**. Your complaint will be reviewed, and you will receive a response within two business days of your call.

You have the right to retain at your own expense any attorney authorized to practice law in the state. You have the right to file a complaint with the state bar concerning attorney conduct pursuant to the Legal Plan.

20.3.20 Other Special Rules

In addition to the coverages and exclusions listed, there are certain rules for special situations. Please read this section carefully.

What if other coverage is available to you?
If you are entitled to receive legal representation provided by any other organization such as an insurance company or a government agency, or if you are entitled to legal services under any other legal plan, coverage will not be provided under this Legal Plan. However, if you are eligible for legal aid or Public Defender services, you will still be eligible for benefits under this Legal Plan, so long as you meet the eligibility requirements.

What if you are involved in a legal dispute with your dependents?
You may need legal help with a problem involving your spouse or your children. In some cases, both you and your child may need an attorney. If it would be improper for one attorney to

represent both you and your dependent, only you will be entitled to representation by the Legal Plan Attorney, and your dependent will not be covered under the Legal Plan.

What if you are involved in a legal dispute with another employee?
If you or your dependents are involved in a dispute with another eligible employee or that employee's dependents, Hyatt Legal Plans, Inc., will arrange for legal representation with independent and separate counsel for both parties.

What if the court awards attorneys' fees as part of a settlement?
If you are awarded attorneys' fees as a part of a court settlement, the Legal Plan must be repaid from this award to the extent that it paid the fee for your attorney.

20.3.21 When Does Coverage End?

If you terminate from Intel your coverage ends on your termination date. If you are in the middle of a case, Hyatt Legal will complete the work that was started with the case number provided.

If you retire from Intel your coverage ends on your retirement date. Retirees do have the option to port their coverage. Contact Hyatt Legal Plans, Inc. within 30 days of the retirement date to request portability. If your coverage is ported, you will receive a 1 time invoice for 12 months to be paid up-front. Coverage would end after the 12 months.

20.3.22 Denial of Coverage

Please see the post-service claims information in the Pay, Stock and Benefits Handbook: Chapter 3, Administrative Information for the appeals process for the Hyatt Legal Plan.

20.4 Supplemental Long-Term Disability (SLTD)
(Also known as; Individual Disability Income – IDI)
This plan is closed to new enrollment effective 5/1/2016

Topics

20.4.1 Overview

Supplemental Long-Term Disability (SLTD) coverage is an individual disability income insurance policy that provides a monthly benefit payment in the event you experience a disability. You will receive benefits if you are disabled in accordance with the terms of the policy. This benefit is a supplement to Intel's Long-Term Disability plan. * The policy is underwritten by Metropolitan Life Insurance Company (MetLife).

Policy definitions and provisions may vary by state, please review your policy for its actual terms and provisions. In case of a conflict between the terms contained in this Summary Plan Description and the terms contained in the policy issued by MetLife, the policy will govern.

If you enrolled and were approved for coverage, you received a policy detailing your benefits and policy provisions. Once you are enrolled and have been approved for coverage, you may also request a copy by calling MetLife at (877) 770-4638.

***** Neither the Supplemental LTD nor the Intel LTD Plan cover all disabilities. Qualifications for each are based on different standards and qualifications and coverage under one is not binding on the other.

20.4.2 Definitions

For All Coverages	
Disability or Disabled	means Total or Residual/Partial Disability that starts while your policy is in force
Mental Disorders and/or Substance Use Disorders	means any and all disorders set forth in the diagnostic categories of the most recently published edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. Examples include, but are not limited to: 1. Depression/dysthymic disorder; 2. Obsessive compulsive disorder; 3. Any psychotic disorder; 4. Panic disorder/agoraphobia; 5. Bipolar disorder/cyclothymic disorder; 6. Anxiety disorder; 7. Diagnosed personality disorder; 8. Anorexia nervosa or bulimia; 9. Alcohol or substance abuse or dependency; 10. Post-traumatic stress disorder; and 11. Somatization disorder.
Presumptive Total Disability	means that you are presumed to be totally and permanently Disabled if an injury or sickness causes your complete, irrecoverable and irreparable loss of: 1. The use of both hands, or both feet, or one hand and one foot; 2. The sight in both eyes; 3. Speech; or 4. Hearing in both ears.

California Residents – Occupational Classes 3A and 2A*	
Total Disability or Totally Disabled	for California residents in occupational class 3A and 2A means that as a result of injury or sickness, you are: A. during the Usual Occupation period unable to perform with reasonable continuity the substantial and material acts necessary to pursue your Usual Occupation in the usual or customary way; and B. after the Usual Occupation period unable to engage with reasonable continuity in any occupation in which you could reasonably be expected to perform satisfactorily in light of your age, education, training, experience, station in life, and physical and mental capacity that exists within any of the following locations: i. a reasonable distance or travel time from your residence in light of the commuting practices of your community; or ii. a distance or travel time equivalent to the distance or travel time you traveled to work before becoming Disabled; or iii. the regional labor market, if you reside or resided prior to becoming Disabled in a metropolitan area.
Usual occupation	means any employment, business, trade or profession and the substantial and material acts of the occupation you were regularly performing when the Disability began. Usual Occupation is not necessarily limited to the specific job you performed. Occupational Classes 3A and 2A have a five year Usual Occupation period.
Partial Disability	means you are not Totally Disabled and that while actually working in an occupation, as a result of injury or sickness, you are unable to earn 80% or more of your prior earnings.
California Residents – Occupational Classes 6A, 5A and 4A**	
Total Disability or Totally Disabled	for California residents in occupational class 6A, 5A and 4A means that as a result of injury or sickness, you are unable to perform with reasonable continuity the Substantial and Material Acts necessary to pursue your Usual Occupation in the usual or customary way.
Usual Occupation	means any employment, business, trade or profession and the Substantial and Material Acts of the occupation you were regularly performing when the Disability began. Usual Occupation is not necessarily limited to the specific job you performed. Occupational Classes 6A, 5A and 4A have a Usual Occupation period that lasts as long as the maximum benefit period on the policy.

Partial Disability	means you are not Totally Disabled and that while actually working in an occupation, as a result of injury or sickness, you are unable to earn 80% or more of your prior earnings.
Substantial and Material Acts	means the important tasks, functions and operations generally required by employers from those engaged in your Usual Occupation that cannot be reasonably omitted or modified. In determining what Substantial and Material acts are necessary to pursue your Usual Occupation, MetLife will first look at the specific duties required by your job. If you are unable to perform one or more of these duties with reasonable continuity, MetLife will then determine whether those duties are customarily required of other individuals engaged in your Usual Occupation. If any specific, material duties required of you by your job differ from the material duties customarily required of other individuals engaged in your Usual Occupation, then MetLife will not consider those duties in determining what Substantial and Material Acts are necessary to pursue your Usual Occupation.
Non-California Residents – All Occupational Classes	
Total Disability or Totally Disabled	means that due solely to impairment caused by injury or sickness, you are: A. Before the end of the Regular Occupation period: i. Prevented from performing the material and substantial duties of your Regular Occupation; ii. Not Gainfully Employed; and iii. Receiving appropriate care from a physician who is appropriate to treat the condition causing the impairment. B. After the Regular Occupation period: i. Prevented from performing any occupation for which you are or become reasonably fitted by your education, training or experience; ii. Not Gainfully Employed; and iii. Receiving appropriate care from a physician who is appropriate to treat the condition causing the Impairment. MetLife may waive the requirement of care from a physician if your physician provides documentation acceptable to MetLife that continued care would be of no benefit to you.
Regular Occupation	means your usual occupation (or occupations, if more than one) in which you are Gainfully Employed at the time you become Disabled. If you are not Gainfully Employed at the time your Total Disability begins, Regular Occupation shall then mean any occupation(s) for which you are reasonably fitted by your education, training or experience.

	All employees except those in Occupational Class 2A have a Regular Occupation period that lasts as long as the maximum benefit period on the policy. Occupational Class 2A applies to occupations that require more physical activity and certain occupations which are not hazardous such as teachers and office managers. This occupation class has a Regular Occupation period of 5-years on a policy with a to age 65 maximum benefit period and 2-years if the policy is issued with a 2-year maximum benefit period. If you have questions regarding your occupational class, please contact MetLife at (877) 770-4638.
Residual Disability or Residually Disabled	means that due solely to impairment caused by injury or sickness: 1. Your earnings are reduced by at least 20% of your prior earnings; and 2. You are receiving appropriate care from a physician who is appropriate to treat the condition causing the impairment; and 3. You are not Totally Disabled, and are gainfully employed, but you are: a. Prevented from performing one or more of the material and substantial duties of Your Regular Occupation; or b. Performing the material and substantial duties of Your Regular Occupation, but are not able to perform them for more than 80% of the time normally required of you; or c. Engaged in another occupation.
Gainfully Employed means actively engaged in an occupation for remuneration or profit.	

* ***Note***: *Occupational Class 3A is the class that contains semi-professional occupations with primarily office duties and some types of sales duties. Occupational Class 2A is the class that includes occupations that require more physical activity than Class 3A and certain occupations that are not hazardous. If you have questions regarding your occupational class, please contact MetLife at (877) 770-4638.*

** ***Note****. Occupational Class 6A is the class that includes those persons in select professional occupations such as architects, CPAs and certain corporate executives. These risks qualify for preferential rating classification because they've demonstrated the most favorable experience. Occupational Class 5A is the class that primarily contains technical and managerial professionals but warrant slightly less preferential treatment than Class 6A. Occupational Class 4A is the class that contains other professionals including technical and managerial occupations that are not eligible for MetLife's most favorable classes. If you have questions regarding your occupational class, please contact MetLife at (877) 770-4638.*

20.4.3 Eligibility

This plan is no longer eligible for enrollment. In order to have been eligible for enrollment, you had to be an eligible individual who was a U.S. General Full-time (GFT) employee or U.S. Intel Contract Employees (ICE), earning a base salary of at least $18,000 per year, between the ages of 18 and 70.

Eligibility Requirements

- For the 90 days prior to and including your application date, you have: (a) been working for Intel or a previous employer doing all of the material duties of your occupation at: (i) the usual place of business; or (ii) some other location that the business requires or allows you to be; and (b) worked your usual number of hours, but not less than 32 hours per week as required by Intel.
- During the 90 days prior to and including your application date, you have been absent from work solely due to vacation days, holidays or sabbatical.
- You must be working at least 30 hours per week at the place of business of the employer named on the application as of the effective date of the policy or in school on a full-time basis if a student.
- You must be a U.S. GFT or U.S. ICE employee on the effective date of the policy for coverage to take effect.

20.4.4 Cost of Coverage

If you are issued a policy, you are required to pay the entire premium for SLTD coverage. Premiums are based on your age, health history, occupation, smoker status, your monthly benefit amount and the features included in your policy. Enrollment and premium information is available by calling (877) 770-4638.

Since you pay the entire cost of the coverage with after–tax income, benefits will be non-taxable to you.

20.4.5 Premium Payment While on Leave of Absence

Once on leave of absence, if applicable to you, MetLife will begin to bill you directly to your home address for your Critical Illness Insurance election. Once you return from your leave, payroll deductions will begin automatically.

20.4.6 Waiver of Premiums

California Residents
After you have been Disabled for a continuous period of 90 days, MetLife will waive any premium that becomes due while you remain Disabled. Your policy and its benefits will continue as if the premium had been paid.

MetLife will also refund any premium that became due during the first 90 days of Disability, and the pro rata portion of any previously paid premium applicable to that period of Disability.

The premium waived will be based on the frequency of payment in effect on the date your Disability starts.

After you are no longer Disabled, premiums will again become payable in order to keep the policy in force. If you do not pay the first premium due by the end of the grace period, your policy will end.

Non-California Residents
After you have been Disabled for a period of 90 consecutive days, MetLife will waive any premium that becomes due while you remain Disabled. Your policy and its benefits will continue as if the premium had been paid.

MetLife will also refund to you any premium that you paid that became due during the first 90 consecutive days of Disability. The premium waived will be based on the frequency of payment in effect on the date your Disability starts.

If premiums are being waived, and benefits have been payable for 12 months or more, any premiums due during the first 90 days after your Disability ends will be waived. This additional 90 day waiver of premium will apply only once during a period of Disability, including recurrent disabilities. Thereafter, premiums will again be required to be paid to keep the policy in force and if you do not pay the first premium due by the end of the grace period, your policy will end.

20.4.7 Monthly Benefit

MetLife determines the maximum monthly benefit amount you can purchase, up to a maximum monthly benefit of $15,000, based on the following calculation: up to 75% of your base salary plus 75% of your bonus, if applicable and as described below, minus the presumed benefit under the Intel LTD Plan* regardless of whether you qualify for benefits under the Intel LTD Plan.

If you have a minimum of 2 years of Intel bonus payments, the SLTD bonus calculation is based on the average of your APB and QPB for the previous two years.
If you have only one year of Intel bonus payments, the SLTD bonus calculation is based on the actual bonus amount.
If you have not received an Intel bonus, no bonus amount is considered in the SLTD bonus calculation.
If you were a McAfee employee who integrated with Intel on July 1, 2015 and enrolled in the SLTD plan during the special enrollment (August 10 – September 4, 2015), the SLTD bonus calculation is based on an estimated bonus amount only for the purposes of this SLTD special onetime offering. This estimated bonus amount is used to calculate your maximum SLTD monthly benefit and premium rate.

> **The Intel LTD benefit amount for individuals who are eligible is 65% of pre-Disability Earnings, as defined by the Intel LTD Plan, up to a maximum benefit of $10,000 per month. For complete information on the Intel LTD plan, refer to Chapter 14, Long-Term Disability section of the Pay, Stock and Benefits Handbook*.

Example of SLTD Monthly Benefit:

Base Salary is $200,000 a year
QPB + APR (average from 2012 and 2013 actuals) = $90,000

1. Intel LTD Benefit: $200,000 x .65 = $130,000
   $ 130,000/12 months = $10,000 monthly **max** benefit from Intel LTD (=$120,000 yearly benefit).
2. Supp LTD Benefit: $290,000 x .75= $217,500
   $217,500 – 120,000 (presumed Intel LTD benefit) = $97,500

$97,500/12 months = $8,125 (rounded up to $8150 because MetLife issues benefits in increments of $50) for a monthly benefit from SLTD.

The amount of SLTD benefit for which you are eligible may be reduced by the amount of other individual disability insurance in force or applied for. Please note that neither the Intel LTD plan nor the SLTD policy covers all disabilities. Qualifications for each are based on different standards. Qualifications and coverage under one is not binding on the other. For complete information on the Intel LTD Plan refer to Chapter 14, "Long-Term Disability" section of the Pay, Stock and Benefits Handbook.

20.4.8 Partial Disability Benefits – California Residents

While you are Partially Disabled, MetLife will pay a monthly benefit for Partial Disability, if the elimination period has been met (by Total Disability and/or Partial Disability).

Please refer to your policy for the Partial Disability monthly benefit calculation.

20.4.9 Residual Disability – Non-California Residents

While you are Residually Disabled, MetLife will pay a monthly benefit for Residual Disability, if the elimination period has been met (by Total Disability and/or Residual Disability).

Please refer to your policy for the Residual Disability monthly benefit calculation.

20.4.10 Benefit Elimination Period

- 365 days

The elimination period is the number of days of Disability which must elapse before benefits begin to accrue for that Disability. For policies issued in states other than California, these do not need to be consecutive days of Disability but must occur within the accumulation period for the same or related cause. No benefits are payable for the elimination period.

20.4.11 Accumulation Period*

- 545 days

The accumulation period is defined as the number of consecutive days during which the elimination period must be satisfied. The accumulation period begins on the first day that you are Disabled.

*** This does not apply to California residents.**

Maximum Benefit Period Based on Age When Disability Begins

For policies with a "to age 65" Maximum Benefit Period:

Age When Disability Begins	Maximum Benefit Period
Before age 61	to age 65
At age 61, before age 62	48 Months
At age 62, before age 63	42 Months
At age 63, before age 64	36 Months
At age 64, before age 65	30 Months
At age 65, before age 75	24 Months
At or after age 75	12 Months

For policies with a 2 year Maximum Benefit Period:

Age When Disability Begins	Maximum Benefit Period
Before Age 75	24 months
At or after Age 75	12 months

20.4.12 Payment of Benefits

All benefits will be paid in U.S. currency.

20.4.13 Limitation for Mental Disorders and/or Substance Use Disorders

The maximum benefit period is limited to 24 months for all periods of Disability during your lifetime if:

1. Such Disability is due to a Mental Disorder and/or Substance Use Disorder;
2. You otherwise qualify for Disability benefits; and
3. You are not confined in a hospital.

However, any time during which you are confined in a hospital does not count towards this 24-month limit.

20.4.14 Recurrent Disability

For policies with a "to age 65" maximum benefit period, if after the end of a period of Disability you become Disabled again from the same or a related cause within 12 months of the end of the prior period of Disability, MetLife will deem it a continuation of the previous period of Disability. Otherwise, we will deem your Disability a separate period of Disability and a new elimination period must be met.

For policies with a 2-year maximum benefit period, if after the end of a period of Disability you become Disabled again from the same or a related cause within 6 months of the end of the prior period of Disability, MetLife will deem it a continuation of the previous period of Disability.

Otherwise, MetLife will deem your Disability a separate period of Disability and a new elimination period must be met.

20.4.15 Concurrent Disability

If a Disability is caused by more than one injury or sickness, whether related or unrelated, which overlap for any time during a continuous period of Disability, MetLife will pay benefits as if the Disability were caused by one injury or sickness.

20.4.16 Presumptive Disability

If you are Totally Disabled according to the definition of "Presumptive Total Disability," MetLife will: (a) consider you to be Totally Disabled even if you are able to work and even if you are not receiving medical care by a physician; and (b) waive the elimination period.

Proof of good health is required for non-California residents in order for the Presumptive Disability Benefit Rider to be included in a policy.

20.4.17 Exclusions

MetLife will not pay benefits for a Disability:

1. Due to an act of war, whether declared or undeclared;
2. Due to Mental Disorder and/or Substance Use Disorder, except as provided for under the Mental Disorders and/or Substance Use Disorders provision;
3. Due to any loss MetLife has excluded by name or specific description;
4. Due to your committing, or attempting to commit, a felony; or
5. Caused by an intentionally self-inflicted injury; or
6. Existing while you are legally incarcerated or detained (does not apply to California residents).

20.4.18 Pre-existing Condition Exclusion

There is no pre-existing condition exclusion for policies prior to 1/1/2015.

Effective 1/1/2015 the pre-existing condition exclusion is:

Definition of a Pre-existing Condition:

For Non-California Residents

Preexisting Condition means a Sickness or Injury for which, in the 5 years prior to the Effective Date:

1. Medical advice or treatment or care was contemplated, or was recommended by or received from a Physician; or
2. Symptoms existed that would cause an ordinarily prudent person to seek diagnosis, care or treatment.

For California Residents:
Preexisting Condition means:

1. You:
    a. received medical treatment, care or services for a diagnosed condition or took prescribed medication for a diagnosed condition in the 24 months immediately prior to the effective date of coverage under this policy; or
    b. suffered from a physical or mental condition, whether diagnosed or undiagnosed, which was misrepresented or not disclosed in the application (i) for which you received a physician's advice or treatment within 24 months immediately prior to the effective date of coverage under this policy; or (ii) which caused symptoms within 12 months immediately prior to the effective date of coverage under this policy for which a prudent person would usually seek medical advice or treatment; and

2. The disability caused or substantially contributed to by the condition begins in the first 24 months after the effective date of coverage under this policy. "

Preexisting Conditions Exclusion:

For Non-California Residents:
We will not pay benefits for a Disability that starts during the first 2 years after the Effective Date if it was due to a Preexisting Condition. This exclusion does not apply to any condition that was disclosed, and that was not misrepresented, in the Application and was not excluded by name or specific description.

For California Residents:
Preexisting Conditions Exclusion. You are not covered for a disability caused or substantially contributed to by a preexisting condition or medical or surgical treatment of a preexisting condition. This exclusion does not apply to any condition that was disclosed and was not misrepresented in the application for this policy and was not excluded by name or specific description.

20.4.19 When Does Coverage End?

The policy is non-cancelable and guaranteed renewable to age 65 or 67 (depending on the state) or for 5 policy years if later*. This means as long as you pay the Premium on time, MetLife cannot change your policy, or its Premium rate until the first Premium Due Date on or after Your 65th (or 67th) birthday, or on the fifth policy anniversary if later*.
After age 65 or 67, or the fifth policy anniversary if later*, the policy becomes conditionally renewable exclusive of any riders if you are not Disabled and continue to work 32 hours per week and your premium is paid on time. Rates are subject to change during the conditionally renewable period and the maximum benefit period is 24 months for disabilities beginning before age 75 and 12 months for disabilities at or after age 75.

* California policies are non-cancelable and guaranteed renewable to age 65 and conditionally renewable thereafter.

20.4.20 Continuation of Coverage

If you are issued a SLTD policy, you are the owner of that policy and if you leave Intel, you can take your coverage (policy) with you. In order to continue coverage, you must make a request in writing to MetLife within a specified period after you leave Intel. You must also continue to pay your premiums to keep the coverage in force. Proof of good health will not be required to obtain continuation of coverage if you request continuation within the specified time period. If you would like to continue your coverage, please contact MetLife at (877) 770-4638.

20.4.21 Agent for Service of Legal Process

For disputes arising under those portions of the Plan insured by the policies issued by MetLife, service of legal process may be made upon MetLife by serving the supervisory official of the Insurance Department in the state in which you reside.

20.4.22 SLTD Termination or Changes

Your consent or the consent of your beneficiary is not required to terminate, modify, amend, or change the SLTD program. MetLife may terminate your policy in accordance with the Premium and Reinstatement section of your policy only if premiums are not received on time. You may be eligible to reinstate your policy under certain circumstances described in your policy.

20.4.23 Routine Questions

If there is any question about a claim payment under the policies, please call MetLife at (877) 770-4638.

20.4.24 Filing a Claim

For claims for SLTD benefits, the claimant must complete the appropriate claim form and submit the required proof as described in the “Claims” section of your policy. To file a claim for benefits, you must give MetLife notice of the claim and submit proof as described in your policy. Notice of claim and proof must be given to MetLife by following the steps set below:

You must give MetLife notice in writing to the address below, or call (877) 770-4638 within 30 days of the date your covered loss starts or as soon thereafter as reasonably possible.

Metropolitan Life Insurance Company
Disability Income Claims
P.O. Box 30429
Tampa, FL 33630-3429

MetLife will send claim forms to you and explain how to complete them. MetLife should send the claim forms to you within 15 days of your giving MetLife written notice of the claim.

When you receive the claim forms you must complete them as instructed and return them to MetLife. If you do not receive claim forms within 15 days after giving MetLife notice of claim, you may send MetLife a written statement of the nature and extent of your loss.

Written proof of loss satisfactory to MetLife must be sent to MetLife within 90 days after the end of each monthly period for which you claim benefits. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, such proof must be furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required. As often as is reasonably necessary, MetLife may require as part of the proof of loss financial proof such as personal and business income tax returns, income statements, accountant's statements and other proof acceptable to MetLife.

MetLife may also require on a monthly basis, that you, and any physician treating you, complete and sign supplemental statements of claim.

When the claim has been processed, you will be notified of the benefits paid. If any benefits have been denied, you will receive a written explanation.

20.4.25 Initial Determination

After you submit a claim for SLTD benefits to MetLife, MetLife will review your claim and notify you of its decision to approve or deny your claim. Such notification will be provided to you within a reasonable period, not to exceed 45 days from the date you submitted your claim; except for situations requiring an extension of time because of matters beyond the control of the Plan, in which case MetLife may have up to two (2) additional extensions of 30 days each to provide you such notification.

If MetLife needs an extension, it will notify you prior to the expiration of the initial 45 day period (or prior to the expiration of the first 30 day extension period if a second 30 day extension period is needed), state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of MetLife's notice requesting further information and the extension until MetLife receives the requested information does not count toward the time period MetLife is allowed to notify you as to its claim decision. You will have 45 days to provide the requested information from the date you receive the extension notice, requesting further information, from MetLife.

If MetLife denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific policy provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. Further, if an internal rule, protocol, guideline or other criterion was relied upon in making the denial, the claims decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy thereof free of charge.

20.4.26 Appealing a Denied Claim

If you need to appeal a denied claim, see the post-service appeals information in the Pay, Stock and Benefits Handbook: Chapter 3, "Administrative Information".

Chapter 21
Pay, Stock and Benefits Handbook Glossary

This chapter provides definitions of programs and terminology used within the Handbook.

A B C D E F G-H I-J L-M N-0 P Q R S T-V W-Z

A

Absolute Assignment
The ability to elect to permanently transfer the benefit ownership of your basic and supplemental life, basic and supplemental Accidental Death & Dismemberment (AD&D), and Business Travel Accident insurance policies.

Accelerated Death Benefit
Advance payment of a portion of a projected death benefit payable to a terminally ill insured.

AD&D Insurance
Accidental Death & Dismemberment insurance plan, which provides 24-hour protection anywhere in the world against accidents at home, at work, at school, or at play.

Americans with Disabilities Act (ADA)
The Americans with Disabilities Act (ADA) is a federal law governing the conduct of employers and businesses toward individuals who have "disabilities," as that term is defined by the statute. The ADA prohibits employers from discriminating on the basis of a disability, against otherwise qualified employees who are able to perform their jobs. The ADA also requires employers to provide reasonable accommodations, when requested by an employee with a disability, to allow that employee to perform the essential functions of the job.

Annual Enrollment
The annual period of time during which employees can change elections of medical, dental and vision plans, enroll or drop dependents in medical, dental and vision plans, and enroll and re-enroll in the HSA, DCAP, and Health FSA,. It is held annually (usually in October and November) with all elections effective Jan. 1 of the following year.

Annual Performance Bonus (APB)
A variable pay plan for all noncommissioned, regular Intel employees. The payout under the

program is determined by the size of the employee's bonus target, the performance of the company against strategic APB goals, and the adjusted earnings-per-share growth of Intel.

B

Base Pay
The foundation of Intel's direct cash compensation. It represents a fixed source of income for employees and a fixed expense to the company. As a fixed rate of pay for employees, it is typically expressed in an hourly or monthly amount.

Business Travel Accident Insurance (BTA)
Provided by Intel 24-hours a day while traveling on Intel business or work-related errands. Coverage is in effect from the time you leave your home or work location until you return, when you are on an authorized Intel business trip or business errand.

C

Calendar Year
Begins Jan.1 and ends Dec. 31.

Cash Compensation
A Pay, Stock and Benefits component that consists of base pay, the QPB, APB, and commissions.

Claims Administrator
Organizations contracted by Intel (e.g., Anthem) that provide administrative services for specific Intel benefit programs offered to Intel employees and their dependents.

Coinsurance Payments
Share of the covered benefit charges, usually a percentage, that the plan member and the plan each pay.

Commissions
Payments based on individual or team performance to quotas or achievement of strategic sales objectives. Quotas are set based on Intel's overall business plan. Performance exceeding quota or sales objectives results in commission payments above an individual's commission target.

Compressed Workweek
Any schedule that requires the employee to work 11.5 hours or greater in a day.

Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) A federal law that enables you or your enrolled dependents to continue medical and dental coverage in the event that you or they lose coverage as the result of certain qualifying events.

Continued Stay Review (CSR)
For inpatient hospital admissions for medical or mental health services.

Conversion
When you lose group life insurance coverage, you may be eligible to convert to an individual policy without the need to provide a Statement of Health (i.e., proof of good health).

Coordination of Benefits
Rules that determine the order in which health plans must reimburse claims when coverage is provided by multiple health plans. See Coordination of Benefits under the medical plan section of *Pay, Stock and Benefits Handbook* for more information.

Copayment
The fixed dollar fee you pay when seeking in-network care from a traditional health plan (e.g., HMO). The plan pays 100 percent after the copayment. The copayment amount varies by plan and service.

Covered Medical Service(s)
As defined in the medical plan section of the *Pay, Stock and Benefits Handbook*.

D

Deductible
The amount an individual or family must first pay for covered benefits before reimbursements from coinsurance are available to them.

Dependent Care Assistance Program (DCAP)
DCAP allows you to elect an annual election amount through pretax payroll deductions to pay for eligible dependent care expenses that enable you and your spouse, if married, to work, look for work, or attend school full time.

Dependent Life Insurance
You may purchase life insurance for your eligible dependents via the Spouse Life Plan and Child Life Plan.

Developmental Delay
A child who is developing slower than his or her peers and where there is no evidence of a specific medical condition that contributes to the slower rate of development in the child (e.g., ADD, dyslexia, or lisps).

Domestic Partner
Your domestic partner is eligible for Intel health and voluntary benefit programs if you are in a committed relationship and the domestic partner is 18 years or older, not related to you, has resided with you for greater than one year, and shares mutual obligation of support for the basic necessities of life.

E

Eligible Dependent
A person defined under the eligibility rules for whom you may elect coverage under the Intel plans offering dependent coverage.

Employee Assistance Program (EAP)
A program designed to identify and clarify any problem you or a family member may be facing. EAP counselors provide employees and their dependents confidential and convenient access to short-term professional counseling services at no cost to you.

Employee Retirement Income Security Act of 1974 (ERISA)
A federal law that provides certain rights and protections to which participants in Intel's employee benefit plans are entitled. The Act imposes duties upon the people who operate employee benefit plans to do so prudently and in the best interest of employees and other plan participants and beneficiaries.

Employee Services Contact Center
A resource center available to employees and retirees to answer a wide variety of questions regarding employee services and benefits. Employees can submit non urgent questions to the Employee Services Contact Center via *Get HR Help.* Employees can call an Employee Services representative at (800) 238-0486 for more urgent or complex issues.

Employee Services Representative
A knowledgeable Human Resources representative who provides answers to complex, urgent, or unique questions about employee services or benefits. These representatives are available to support your questions online via *Get HR Help* or by phone at (800) 238-0486.

Employee Stock Purchase Plan (ESPP)
Provides you the opportunity to purchase Intel common stock twice a year at a discount from the current market price through payroll deductions.

Equity Incentive Plan
The plan from which Intel grants stock options, restricted stock units, and other types of equity awards to employees.

Exempt Pay Structure
Work is paid on a salaried basis and is not subject to the overtime provisions of the Fair Labor Standards Act.

Expatriate
U.S. Employees on assignment outside of the United States for greater than 90 days. Such employees are also classified as general full-time employee, part-time employee, etc., in the U.S. (their home country).

ExtraBucks
An account established when a CDHP member with an HRA balance transfers to a HDHP. Any unused HRA funds transferred to an ExtraBucks account. These funds may be used toward qualified medical expenses as allowed by the high deductible health plan.

F

Fair Labor Standards Act (FLSA)
A federal law that applies to wages and hours of work.

Family Medical Leave Act (FMLA)
A federal law that provides eligible employees with 12 workweeks of job-protected leave during a rolling 12-month period. A leave can be to care for your own or a family member's serious health condition, or to bond with your newborn child or a child placed with you for foster care or adoption, or for other reasons as described by the law.

Federal Dependent Care Tax Credit
This credit reduces the amount of tax you pay on your income tax return.

Flexible Spending Accounts (FSAs)
Provide the opportunity to pay for eligible out-of-pocket health care and dependent care expenses with pretax dollars. Annual elections are deducted from your salary each pay period before federal, state, and FICA taxes are withheld, which may reduce the amount of income tax you pay. The Health FSA and DCAP are considered FSAs.

Focal
Intel's annual review of individual employee performance and compensation; focal reviews are effective for all employees on April 1.

Free$tock
If you were a participant in the Intel 401(k) Savings Plan prior to 1987, you may have contributions that were made solely in Intel stock and are referred to as Free$tock.

G

General Full-Time Employee (GFT)
For purposes of the *Pay, Stock and Benefits Handbook*, an Intel employee whose home country is the United States, is on the U.S. payroll, and who works at least 32 hours each week.

Get HR Help
A service that provides Intel employees online access to the employee services information they need most--available 24 hours per day, seven days per week. *Get HR Help* Q&A provides answers to most commonly asked questions. If an employee cannot find what they need in the *Get HR Help* Q&A, the *Get HR Help* "Submit My Question" service provides Intel employees a confidential way to get answers to complex, urgent, or unique questions. Questions are confidentially submitted online and go directly to an Employee Services representative, who will provide a response via e-mail. The *Get HR Help* service also provides a search tool and handy help reference that helps employees quickly get to the information they need, when they need it.

H

Health Care Benefits
A *Pay, Stock and Benefits* component that includes benefits for medically necessary and appropriate prescription drugs, medical, vision, chiropractic, mental health, substance abuse, and dental services.

Health Flexible Spending Account (Health FSA)
The Health FSA allows you to elect an annual amount through pretax payroll deductions to pay for eligible non-reimbursed medical, dental, and vision expenses.

Health for Life
Health for Life is a collection of programs, tools, and resources you can use to help manage your health and well-being.

Health for Life Centers
The Health for Life Centers provide employees (and dependents in some locations) access to an onsite, full-service medical clinic. The Health for Life Center provides convenient, cost-effective medical care that is personal and efficient. The Centers have a primary-care physician, a registered nurse, nurse practitioners, and other medical staff with the expertise needed to provide you with high-quality care. The Health for Life Centers are limited to designated sites in AZ, NM, and OR.

Health Maintenance Organization (HMO)
A managed health care plan that is available to you if you live or work within the HMO's service area. HMOs offer hospital, surgical, and medical services as well as other services from a specified network of physicians, clinics, and hospitals.

Health Plan Medical Director
A physician charged by each medical plan with responsibility for overseeing the delivery of health services and maintaining utilization review and quality assurance programs.

Health Plan Providers
Intel's national health plan providers are limited to the following licensed providers:

- Medical Doctors
- Ophthalmologists and optometrists
- Certified acupuncturists
- Naturopaths
- Osteopaths
- Chiropractors
- Podiatrists
- Physical and occupational therapist
- Midwives
- Speech Therapist
- Clinical psychologists
- Service provided by Christian Science practitioners (must be listed in the *Christian Science Journal* as a Christian Science Practitioner)

Provided they adhere to the following:

- Practice within the scope of their license.
- Practice within the scope of generally accepted medical practices.
- Are recognized by the state in which they practice.

Licensed clinical social workers and licensed marriage, family, and child counselors are also covered, provided they are the following:

- Licensed or certified by the appropriate governmental authority having jurisdiction over such licensure or certification in the jurisdiction where the provider renders service to an employee or spouse.
- A member or fellow of the American Psychological Association if there is no licensure or certification in the jurisdiction where that provider renders service to an employee or spouse.

Providers who are professionally registered in the state but do not meet these criteria will not be covered.

Health Savings Account (HSA)
Available to employees enrolled in a High Deductible Health Plan with Health Savings Account (HDHP). Upon enrollment in a HDHP, you have the opportunity to elect to make pretax contributions into an HSA. The HSA may be used to pay for your eligible health care expenses. The HSA is not an Intel-sponsored benefit.

Hire Date
The first day you are an active Intel employee.

Home Health Care Agency or Services
A hospital or a nonprofit or public agency that meets the following criteria:

- Primarily provides skilled nursing services and other therapeutic services under the supervision of a physician or a registered graduate nurse.
- Is run according to rules established by a group of medical professionals
- Maintains clinical records on all patients
- Does not primarily provide custodial care or care and treatment of the mentally ill
- Is licensed and runs according to the laws.

Hospice
A facility or program that offers home care, inpatient care, or both for a terminally ill patient and the patient's family. The program provides supportive care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses, which are experienced through the final stages of illness and bereavement.

Hospital
Services provided by an institution that meets one of the following criteria:

- Is licensed as a hospital, maintains on-the-premises facilities necessary for medical and surgical treatment, provides such treatment on an inpatient basis, for compensation, under the supervision of physicians, and provides 24-hour service by registered graduate nurses.
- Is accredited as a hospital by the Joint Commission on the Accreditation of Hospitals and is a provider of services under Medicare, such as a hospital, a psychiatric hospital, or a tuberculosis hospital, as those terms are defined by Medicare.
- Is licensed in accordance with the laws of the appropriate legally authorized agency for an institution that specializes in treatment of mental illness, alcohol, drug dependence, or other related illness and provides residential treatment programs.

I

Incapacity and Treatment
Incapacity and treatment entails a period of incapacity of more than three (3) full calendar days and subsequent treatment or incapacity that involves: (a) in-person treatment with a health care provider two (2) or more times within thirty (30) days of your first incapacity; or (b) in-person treatment with a health care provider at least once within the first sever (7) days of incapacity, which results in a regimen of continuing treatment under your health care provider's supervision.

In Loco Parentis
An individual who assumes the responsibilities of a parent with regard to a child by providing either day-to day care or financial support. The individual assumes the status of a parent toward the child.

In-Network Benefits
Services and supplies at discounted rates when provided by network physicians.

Inpatriate
Non-U.S. employees on assignment within the United States for greater than 90 days. Such employees may also be classified as a general full-time employee, part-time employee, etc., in their home country.

Intel Contract Employee (ICE)
An Intel employee hired by Intel to work, by contract, for a specified length of time. Intel manages the work and provides the tools. For purposes of the *Pay, Stock and Benefits Handbook*, an ICE's home country is the United States and the employee is on the U.S. payroll.

Intel Retirement Plans (IRP)
An employee retirement program that consists of three separate plans: the Intel 401(k) Savings Plan, the Intel Retirement Contribution Plan, and the Intel Minimum Pension Plan. It reflects a partnership between you and Intel to facilitate capital accumulation and help save for your retirement. See Chapter 18, Retirement Programs chapter for additional information.

Intern
An Intel employee on the U.S. payroll, hired to fulfill a short-term job assignment, usually for

the summer or holiday break from school. Requires a personnel requisition through the College Relations Program.

J

Job Protection
An entitlement under the certain federal and state leave of absence laws, as well as certain Company leave of absence policies that provide employees on a qualified leave of absence with job-protected during said leaves as required by law. The amount of job-protected leave you are entitled to depends on the amount required by law or Company policy.

Job protection means that Intel will reinstate you to the same job or a comparable position when you return from a leave. Intel will not reinstate you if, for reasons unrelated to your leave, your employment is terminated or your position is eliminated due to redeployment while you are on leave. Additionally, Intel will not count job-protected absences under Intel's attendance or performance guidelines.

L

Leave of Absence Programs
Intel provides leave programs to eligible employees who are unable to work due to serious health conditions impacting an employee or the employee's family; bonding time needed with a newborn, foster care or adopted child; military service; and other personal circumstances

Legend Drugs
FDA-labeled federal law prohibits dispensing without a prescription.

Limited Use Health Flexible Spending Account (FSA)
A flexible spending account that allows you to elect an annual maximum contribution through pretax payroll deductions to pay for eligible non-reimbursed dental, and vision expenses if you are enrolled in a Health Savings Account (HSA).

M

Maintenance Medication
Also known as long-term drugs are used to treat ongoing and chronic conditions such as cholesterol, asthma, acid reflux, and high blood pressure.

Maximum Allowed Amount (MAA)
The maximum amount of reimbursement allowed for services and supplies. For additional information on MAA go to Chapter 6, Medical Plans, General Provisions section.

Maximum Pay Rate
The most that Intel is willing to pay anyone to perform any of the jobs within the grade. Pay position within a range is based on the individual's education, skill, experience, and job performance.

Mid-Point Pay Rate
The average market rate of pay, based on annual market conditions, for jobs in a grade. Pay position within a range is based on the individual's education, skill, experience, and job performance.

Military Adjustment Pay
After active Intel employment of six months, U.S. employees who are on Military Leave are eligible for Military Adjustment Pay. See Military Leave for more details.

Military Leave
An approved leave for active duty or routine training in the U.S. armed forces, including annual military duty for reservists, examinations to determine fitness to perform military duty, and funeral honors performed by National Guard or reserve members.

Minimum Pay Rate
The least that Intel believes anyone performing any of the jobs within a grade should be paid. Pay position within a range is based on the individual's education, skill, expense, and job performance.

My Health Benefits Web site
An online tool that allows you to make benefit changes due to Intel initiated events (e.g., hire, transfer) and qualified status change-in-status events (e.g., marriage, birth). The Web site also allows you to make benefit changes during Annual Enrollment, as well as certain at-will changes (e.g., changing life insurance). It also allows you to view current coverage, compare benefit options and costs, and search for health providers and facilities.

N

Nonexempt Pay Structure(s)
Work is paid on an hourly basis and is subject to the overtime provisions of the Fair Labor Standards Act.

O

Out-of-Network Benefits
Services and supplies that are not provided or authorized by a network provider or the health plan medical director (or designee). Out-of-network benefits apply only to covered medical expenses. Reimbursement for covered services begins after the individual or family deductible is met. Payments are based upon the Maximum Allowed Amount (MAA) for the applicable geographic area and the course of treatment used. This also applies to Specialty Networks.

Out-of-Pocket Maximum
The maximum out-of-pocket expenses that a member incurs for covered benefits before

coverage is paid at 100 percent. Certain exclusions apply. See the medical plan section of the *Pay, Stock and Benefits Handbook*.

P

Paid Time Off
A Pay, Stock and Benefits benefit that assures you of regular and steady income when you are occasionally unable to work for a variety of reasons, such as vacations, holidays, and sabbatical as well as personal absences due to illness, jury duty, and bereavement.

Participating Provider
An institution, facility, agency, or health care professional who is under contractual agreement with Intel's health care suppliers to provide medical or dental coverage or supplies to members.

Part-Time Employee (PTE)
For purposes of the *Pay, Stock and Benefits Handbook*, an Intel employee whose home country is the United States, is on the U.S. payroll, and who works fewer than 32 hours each week.

Pay Grade
A grouping of jobs with comparable skill requirements and levels of responsibilities. Each job grade has a range of pay based on a minimum pay rate, a mid-point pay rate, and a maximum pay rate.

Portability
If enrolled in supplemental, spouse, or child life or AD&D insurance you have the opportunity to purchase term life insurance coverage at group rates without an Evidence of Insurability (EOI) at retirement, termination, or reclassification to an ineligible employee classification.

Primary Care Physician (PCP)
Generally a family practitioner, a general practice practitioner, a pediatrician, or an internist who has contracted with a health plan to manage and coordinate your health care.

Q

Qualified Domestic Relations Order (QDRO)
A court order that creates, recognizes, or assigns the right of an alternate payee to receive all or part of the benefits payable with respect to a plan participant.

Qualified Medical Child Support Order (QMCSO)
A court order that requires Intel to provide health care coverage to the dependent child, named in the order. It is not the equivalent of a divorce settlement requiring a named parent to provide health care insurance.

Qualified Medical Expenses (QME)
As defined under Section 213 of the Internal Revenue Code, services provided for the diagnosis, cure, mitigation, treatment, or prevention of disease, and for treatments affecting any part or function of the body. The medical care expenses must be primarily to alleviate or prevent a physical or mental defect or illness.

Qualified Status Change
Also referred to as qualified change-in-status event. See Qualified Status Change section of the *Pay, Stock and Benefits Handbook*.

Quarterly Profit Bonus (QPB)
A profit-sharing program based on corporate profitability.

R

Restricted Stock Unit
An agreement by Intel to issue you a share of stock once certain vesting requirements and applicable tax withholdings are satisfied.

Retail Refill Allowance
Allows Express Scripts plan participants to fill a maintenance medication prescription twice at retail pharmacies. This is a trial period to ensure the medication is effective with no adverse side effects. After the second fill, participants will pay a higher cost if they continue to fill maintenance prescription at retail. Participants may fill maintenance prescriptions through mail order to avoid paying the higher cost. Retail Refill Allowance applies only to Anthem plan.

Rolling 12-month Period
The 12-month period immediately preceding the date a leave of absence commences.

S

Sabbatical
A Pay, Stock and Benefits benefit that provides general full time employees the opportunity to enjoy an extended period of time away from work to rejuvenate.

Sabbatical Scheduler
An online tool used to schedule or change your sabbatical dates, after you have reached agreement with your manager on the dates.

Self-Funded Plans
A self-insurance arrangement whereby an employer provides health or disability benefits to employees by assuming the direct risk for payment of their claims for benefits.

Statement of Health (SOH)
Required form to be completed and submitted by employee to the life insurance provider when applying for certain plans or levels of coverage in Supplemental Life and Spouse Life insurance. The form requests a health history for evaluation to ensure that you and your are in good health at the time you enroll in the life insurance plans.

Stock Option
A stock option is the right to buy Intel stock sometime in the future at the option price specified on your Notice of Grant.

Stock Option Plan (SOP) -- Also see Equity Incentive Plan
The plan under which stock options have historically been granted. Until May 19, 2004, Intel granted stock options under two plans, the 1984 Stock Option Plan and the 1997 Stock Option Plan. After May 19, 2004, all stock option or equity grants will be made from the Intel Equity Incentive Plan. Consult your stock option Notice of Grant to determine the plan applicable to your stock option grant. Additionally, Intel has assumed stock option plans through mergers and acquisitions (M&A). If you have options granted pursuant to an M&A SOP, consult the plan terms for those stock options. You may find answers to your M&A converted stock option questions on Circuit.

T

Traditional Health Coverage
Under HDHP, the program offers additional health coverage after the deductible has been paid.

Tuition Assistance Program
This program encourages employees to continue formal education as part of their professional development by providing financial assistance for job-related education that is mutually advantageous to Intel and to the employee.

U

Undue Hardship
Undue hardship exists when keeping a job open significant difficulty or expense when considered in light of a number of factors. These factors include the nature and cost of the accommodation in relation to the size, resources, nature, and structure of the employer's operation. Undue hardship is determined on a case-by-case basis.

Urgent Care
Care for conditions that need immediate attention from a doctor or nurse, but are not critical or life threatening.

V

Voluntary Benefit Programs
Variety of employee paid programs offered through MetLife. Intel is not a plan sponsor for the voluntary benefits programs and does not subsidize the programs.

W

Workweek
The time you are normally scheduled to work in seven consecutive calendar days.