About Your Benefits: Post-Employment

SUMMARY PLAN DESCRIPTION

112

Effective Date: January 1, 2026

This Summary Plan Description

This is intended to provide summary plan descriptions of the following benefit plans and programs in which you may be eligible to participate:

- IBM Personal Benefits Program
- IBM Benefits Plan for Retired Employees, referred to herein as the "Plan" and which includes the following components:
  - For Participants who are not Medicare-eligible:
    - Medical benefits include the following options:
      - IBM PPO Options
      - IBM Exclusive Provider Organization (EPO)
      - IBM Managed Pharmacy Program
    - Dental benefits include the following options
      - IBM Dental Basic
      - IBM Dental Plus
    - Vision benefits include the following options:
      - IBM Anthem Blue View Vision
      - EyeMed Vision Discount
    - IBM Employee Assistance Program (EAP)
    - Future Health Account
  - For Participants who are Medicare-eligible
    - Group Medicare Advantage PPO options
      - Essential Plan
      - Enhanced Plan
    - Health Reimbursement Arrangement (HRA)
    - Special Health Assistance Provision (SHAP)
  - All Participants
    - Retiree Group Life Insurance (pre-2015 retirees)
- Special Care for Children Assistance Plan (SCCAP)

The official plan documents are the final authority and will govern in all cases. The Plan Administrator retains exclusive authority and discretion to interpret the terms of the benefit plans described herein. IBM reserves the right, at its discretion, to amend, change or terminate any of its benefits plans, programs, practices or policies, as the Company requires. The Company does not have any obligation to, and nothing contained in this book shall be construed as creating an express or implied obligation on the part of IBM to maintain such benefits plans, programs, practices or policies.

Eligibility to participate in a plan or program or receipt of benefits does not render any person an employee or retiree of IBM or constitute any commitment by IBM to continue any plan or benefit. IBM and its affiliated companies do not endorse any HMO or other provider, or represent or warrant the quality of the care they provide. The decision to choose any health plan option or use any provider is your responsibility.

Because of the need for confidentiality, decisions regarding changes to IBM's benefits plans, programs, practices or policies are generally not discussed or evaluated below the highest levels of management. Managers and their representatives below such levels do not know whether IBM will or will not change or adopt, for example, any particular benefit. Nor are they in a position to advise any employee or retiree on, or speculate about, future plans. Employees and retirees should make no assumptions about future changes or the impact changes may have on their personal situation until any such change is formally announced by IBM.

Edition Notice:
This book supersedes all Summary Plan Descriptions found in prior versions of *About Your Benefits: Post-Enrollment,* as well as their supplements. It provides cumulative, updated information as of January 1, 2026.

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PLAN	CONTACT	PHONE NUMBERS	WEBSITE
NON-MEDICARE-ELIGIBLE PARTICIPANTS			
MEDICAL OPTIONS			
IBM Low Deductible PPO IBM Medium Deductible PPO IBM High Deductible PPO IBM Exclusive Provider Organization IBM High Deductible PPO with HSA *Health Plan Administrators are based on your home state. See* Health Plans by State *for details*.	Aetna Inc.	888-725-1841 International: 855-888-9046 TTY: 877-301-5038	www.aetna.com
	Elevance Health/Anthem Blue Cross and Blue Shield	800-238-6597 International: 845-695-4505 Hearing impaired members can dial 711 and provide the Anthem Customer Service number to the relay operator	www.anthem.com
MEDICAL OUT-OF-AREA OPTIONS			
IBM Low Deductible PPO IBM Medium Deductible PPO IBM High Deductible PPO IBM High Deductible PPO with HSA	Aetna	888-725-1841 International: 860-273-0123 TTY: 800-628-3323	www.aetna.com
MEDICAL HEALTH MAINTENANCE ORGANIZATIONS			
Health Maintenance Organizations (HMOs)	Kaiser	800-514-0985	https://healthy.kaiserpermanente.org/
MEDICAL: PRESCRIPTION DRUGS			
IBM Managed Pharmacy Program	CVS Caremark	855-465-0030 International: 855-465-0030 TTY: 800-863-5488	www.caremark.com
MEDICAL: EMPLOYEE ASSISTANCE PROGRAM			
Employee Assistance Program	Resources for Living	866-317-8870 TTY Dial 711	www.resourcesforliving.com user name: IBM Password: “rfl”

PLAN	CONTACT	PHONE NUMBERS	WEBSITE
DENTAL OPTIONS			
IBM Dental Plus IBM Dental Basic IBM Dental Option A IBM Dental Option B IBM MetLife Preferred Dentist Program (PDP)	MetLife	800-872-6963 International: AT&T Access Code + 800-962-1401 TTY: 800-843-2896	www.metlife.com/mybenefits
VISION OPTIONS			
Vision Plan EyeMed Vision Discount Program	Anthem Blue View Vision EyeMed Vision Care	855-765-4552 TTY: 866-308-5375 855-245-0621	www.anthem.com
MEDICARE-ELIGIBLE PARTICIPANTS			
MEDICAL OPTIONS			
Group Medicare Advantage Essential Plan Enhanced Plan	UnitedHealthcare	877-852-0641 TTY: 711	https://retiree.uhc.com/ibm
Health Reimbursement Arrangement (HRA)	Optum Financial	866-882-0397 TTY: 711	https://my.optum.com/ibm.html
SPECIAL HEALTH ASSISTANCE PROVISION (SHAP)			
IBM Special Health Assistance Provision (SHAP)	Acclaris	888-880-2775 Fax: 813-830-7900	www.viabenefitsaccounts.com
OPTIONS FOR ALL PARTICIPANTS (MEDICARE-ELIGILBLE AND NON-MEDICARE-ELIGIBLE)			
COBRA			
COBRA (applies to Non-Medicare-Eligible Medical, Dental and Vision benefits)	IBM Benefits Center – Provided by Fidelity	866-937-0720 International: Dial AT&T Direct Service Access number, then 866-937-0720 TTY: 711	www.netbenefits.com
COBRA (applies to HRA and Group Medicare Advantage Plan Options)	UMR (a UnitedHealthcare company)	800-207-1824	MyCOBRA@umr.com
LIFE INSURANCE: GROUP LIFE INSURANCE OPTIONS			
Group Life Insurance (pre-2015 retirees)	MetLife	833-543-3426	https://www.metlife.com/IBM/post-employment/
SPECIAL CARE FOR CHILDREN ASSISTANCE PLAN (SCCAP)			
IBM Special Care for Children Assistance Plan	IBM Benefits Center – Provided by Fidelity	866-937-0720 International: Dial AT&T Direct Service Access number, then 866-937-0720 TTY: 711	www.netbenefits.com

CONTACT INFORMATION

For Non-Medicare-Eligible Participants:

Contact the IBM Benefits Center – Provided by Fidelity at 866-937-0720 (TTY: 711) with respect to all benefit related inquiries (retiree medical, SCCAP, Pension, 401(k), etc.). Outside the U.S. dial your country's toll-free AT&T Direct® access number, then enter 866-937-0720. IBM Benefits Center representatives are available weekdays (excluding New York Stock Exchange holidays except Good Friday) from 8:30 a.m. to 8:30 p.m. Eastern time. The text telephone (TTY) is available from 8:30 a.m. to 6:00 p.m.

For Medicare-Eligible Participants:

Contact the IBM Retiree Call Center administered by UnitedHealthcare at 877-852-0641 (TTY: 711) with respect to the Group Medicare Advantage plan options – Enhanced or Essential.

The Enhanced and Essential plan options are administered through two separate plans: the Group Medicare Advantage (PPO) plan and the Medicare Rx for Groups (PDP) plan. Enrollment in both plans is required.

If you disenroll from either the Group Medicare Advantage (PPO) plan or the Medicare Rx for Groups (PDP) plan, you will automatically be disenrolled from both. For example, if you lose Medicare Part B coverage, you will be automatically disenrolled from both your Group Medicare Advantage (PPO) and Medicare Rx for Groups (PDP) coverage.

IBM Retiree Call Center representatives are available weekdays 8:00 a.m. – 8:00 p.m. local time 7 days a week.

Contact Optum Financial at 866-882-0397 (TTY: 711) with respect to the Health Reimbursement Arrangement (HRA).

Contact Acclaris at 888-880-2775 (TTY: 711) with respect to the Special Health Assistance Provision (SHAP).

Contact the IBM Benefits Center – Provided by Fidelity at 866-937-0720 (TTY: 711) with respect to all other benefit inquiries (SCCAP, Pension, 401(k), etc.). Outside the U.S. dial your country's toll-free AT&T Direct® access number, then enter 866-937-0720. IBM Benefits Center representatives are available weekdays (excluding New York Stock Exchange holidays except Good Friday) from 8:30 a.m. to 8:30 p.m. Eastern time. The text telephone (TTY) is available from 8:30 a.m. to 6:00 p.m.

VOICE RESPONSE UNITS AND CUSTOMER SERVICE REPRESENTATIVES

The Voice Response Units (VRUs) and toll-free numbers for customer service representatives are provided as a convenience. While there is every intention to answer your questions accurately, responses are necessarily given in summary form and may not fully anticipate or describe all nuances surrounding each question. Errors due to miscommunication by either party or other causes are also possible. In any event, neither the VRUs nor the customer service representatives are authorized to give you binding advice or to change the terms of the plans.

All details furnished by the VRUs or customer service representatives, including eligibility for benefits, must necessarily be governed by the availability of correct personnel data and the provisions contained in *About Your Benefits* and other plan documents, as they might be amended and in effect on the date for which benefit coverage is sought. Plan documents, insurance policies, IBM's corrected records, other controlling documents or the applicable law will control in the event of any conflict between the terms of the Plans and the information provided by the VRUs or customer service representatives.

Before calling a customer service center or making a decision based on information you receive from the VRUs or customer service representatives, you should review *About Your Benefits,* your employment records and other plan documents which are available upon request. You may request written information from the Office of the Plan Administrator, IBM Benefits Center, PO Box 770003, Cincinnati, OH 45277-1060.

IBM Benefits Plan for Retired Employees

About the Personal Benefits Program

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About the Personal Benefits Program

ADMINISTRATIVE INFORMATION FOR NON-MEDICARE-ELIGIBLE PARTICIPANTS

Option	Description
MEDICAL COVERAGE	
Medical Options If You Are Not Eligible for Medicare — All options (except No Coverage) include Mental Health/Substance Use and Prescription Drug Coverage	
IBM Low Deductible PPO	Coverage for eligible medical, surgical and hospitalization expenses from in-network providers only. Out-of-network services will generally not be covered (for more details, see "*Out-Of-Network Medical Coverage*"). You pay higher contributions in exchange for a low deductible.
IBM Medium Deductible PPO **IBM has determined that this plan does not provide creditable prescription drug coverage	Coverage for eligible medical, surgical and hospitalization expenses from in-network providers only. Out-of-network services will generally not be covered (for more details see "*Out-Of-Network Medical Coverage*"). You pay moderate contributions in exchange for a mid-range deductible. There is an annual pharmacy benefit maximum (amount IBM will pay) of $2,500.
IBM High Deductible PPO **IBM has determined that this plan does not provide creditable prescription drug coverage	Coverage for eligible medical, surgical and hospitalization expenses from in-network providers only. Out-of-network services will generally not be covered (for more details see "*Out-Of-Network Medical Coverage*"). You may pay a small contribution for self only coverage in exchange for a high deductible. There is an annual pharmacy benefit maximum (amount IBM will pay) of $1,000.
IBM Exclusive Provider Organization (EPO)	Coverage for eligible medical, surgical and hospitalization expenses from in-network providers only; out-of-network services will generally not be covered.
IBM High Deductible PPO with HSA	Coverage for eligible medical, surgical and hospitalization expenses from in--network providers (out-of-network services will generally not be covered – for more details see *Out-of-Network Medical Coverage*) after you meet a high annual/family deductible; also allows you to contribute to a Health Savings Account (HSA).
Health Maintenance Organization (HMO) *Depending on geographic location*	A managed care option that provides insured coverage for eligible medical, surgical and hospitalization expenses from in-network providers only; out-of-network services will generally not be covered
No Coverage	Waive coverage for the plan year*
DENTAL COVERAGE	
Dental Options if You Retired (or Became Eligible for LTD Benefits) Before January 1, 2000, and Are Not a Medicare-Eligible Retiree or Dependent	
Dental Option A	Comprehensive coverage for preventive/diagnostic treatment, basic and major restorative care, and orthodontia services
Dental Option B	Basic coverage for preventive/diagnostic treatment and basic restorative care only
MetLife Preferred Dentist Program (PDP)	Comprehensive coverage for preventive/diagnostic treatment, basic and major restorative care and orthodontia services at a percentage of the dentist's negotiated fee when you use a participating dentist, and a fixed amount on limited services for non-participating dentists
No Coverage	Waive coverage for the plan year*

Option	Description
Dental Options if You Retired (or Became Eligible for LTD Benefits) On or After January 1, 2000, and Are Not a Medicare-Eligible Retiree or Dependent	
IBM Dental Plus	Comprehensive coverage for preventive and diagnostic treatment, basic and major restorative and orthodontia up to an annual maximum benefit of $2,000 per covered individual
IBM Dental Basic	Basic coverage for preventive and diagnostic treatment and basic restorative only, up to an annual maximum benefit of $500 per covered individual
No Coverage	Waive coverage for the plan year*
VISION COVERAGE if You Are Not a Medicare-Eligible Retiree	
Anthem Blue View Vision Plan	Coverage for routine eye exams and eyewear both in and out of the Anthem Blue View Vision network.
EyeMed Vision Discount Program	A discount program, provided at no cost to you, for eye exams, eyewear and other vision care services from EyeMed Vision Care network providers
No Coverage	Waive coverage for the plan year*

* Non-Medicare-eligible participants in the Special Retiree Medical Option and in Access Only who do not enroll in an IBM retiree medical, dental and/or vision plan option permanently waive their eligibility to enroll in the Plan again in the future.

** IBM has determined that the Plan prescription drug coverage for the IBM High Deductible PPO and the IBM Medium Deductible PPO are, on average for all Plan participants, not expected to pay out as much as the standard Medicare prescription drug coverage will pay. Therefore, these coverage options are considered Non-Creditable Coverage. This is important because, for most people, enrolling in Medicare prescription drug coverage means you will get more assistance with drug costs than if you enrolled in one of these Plan options. This is also important because it may mean that you may pay a higher premium (a penalty) when you become eligible for Medicare and if you join a Medicare prescription drug plan after you first become eligible.

ADMINISTRATIVE INFORMATION FOR MEDICARE-ELIGIBLE PARTICIPANTS

IBM offers two Group Medicare Advantage plan options. Both are administered by UnitedHealthcare.

Option	Description
MEDICAL, PHARMACY, DENTAL & VISION COVERAGE	
Plan Options If You Are Eligible for Medicare — All options (except No Coverage) include Medical, Prescription Drug, Dental and Vision Coverage	
Essential Plan Option – Group Medicare Advantage	Coverage for eligible medical, prescription drug, dental, and vision coverage. Coverage for in-network providers and out-of-network providers. Higher annual medical out-of-pocket maximum and higher copays for services compared to the Enhanced Plan option. For more information call UnitedHealthcare or refer to the Evidence of Coverage (EOC) at https://www.medicare.uhc.com/retiree
Enhanced Plan Option – Group Medicare Advantage	Coverage for eligible medical, prescription drug, dental, and vision coverage. Coverage for in-network providers and out-of-network providers. Lowest annual medical out-of-pocket maximum and lower copays for services compared to the Essential Plan option. For more information call UnitedHealthcare or refer to the Evidence of Coverage (EOC) at https://www.medicare.uhc.com/retiree

ELIGIBILITY

The following individuals (and their eligible dependents) are eligible for the Plan:

- Employees who retired before July 1, 1999, under the IBM Personal Pension Plan – Prior Plan
- Employees who, as of June 30, 1999, were within five years of meeting one of the following retirement criteria, and who did meet at least one of these retirement criteria upon termination:
  - 30 years of service with IBM at any age (subsidized coverage)
  - 15 years of service with IBM and age 55 (subsidized coverage)
  - 5 years of service with IBM and age 62 (unsubsidized coverage)
  - 1 year of service with IBM and age 65 (unsubsidized coverage)
- Eligible former employees who meet the requirements described in the *"Future Health Account" (FHA)* section in Annex 1 for eligibility to withdraw from their FHA accounts.
- Eligible individuals receiving monthly benefits under the IBM Medical Disability Income Plan (MDIP) or the IBM Long-Term Disability Plan (LTD Plan) but only while they remain an employee in LTD Leave status.

  ***Note**: Employees whose LTD Plan effective date is January 1, 2016, or later will be eligible for benefits under the Plan while they remain in LTD Leave status. Those approved under the LTD Plan on or after January 1, 2016, and who remain approved for two years will have their LTD leave status end and be separated from IBM.*

  Once LTD Leave status ends, the individual is will no longer eligible for the Plan unless they meet another eligibility status listed in this section. If not eligible based on any other status, the individual will be eligible for COBRA continuation under this Plan. (Individuals who return to work after LTD leave you will become eligible for coverage under the IBM medical plan for active employees).
- Medicare-eligible participants who lose LTD Leave status and who do not meet any other eligibility requirements listed in this section will be deemed eligible for Access Only coverage (see Annex 2 for *Access Only*).
- Individuals eligible for SRMO. Certain employees who were hired August 1, 1990, or later, and were retirement eligible or within five years of earliest retirement eligibility as of June 30, 1999, and who retire under the terms of the prior IBM Retirement Plan with less than 15 years of service may be eligible for post-employment participation in IBM's health plans in accordance with the Special Retiree Medical Option (SRMO).
- Employees who were on a retirement bridge leave as of March 1, 1996, and are eligible for the SRMO continue to be eligible for SRMO.
- IBM may offer SRMO eligibility where it otherwise would not apply when the Company considers this necessary to support business needs. SRMO is administered by the IBM Benefits Center – Provided by Fidelity. Information concerning coverage and eligibility may be obtained by contacting the IBM Benefits Center.
- Individuals eligible for Access Only coverage. Access Only coverage allows them to be covered under the Plan without any IBM subsidy (see Annex 2 for *Access Only*).

Opting Out of the Plan and Eligibility to Re-Enroll

Non-Medicare-Eligible Participants

Eligible for IBM Subsidized Coverage (other than FHA Withdrawal Eligible):
If, when you leave IBM, you are eligible for IBM subsidized coverage (other than FHA withdrawal eligible), you can opt out of the Plan during the annual benefits enrollment window or as the result of a qualified life event. You can re-enroll at a later date, either during the annual benefits enrollment window or as a result of a qualified life event if you qualify for the plan at the time.

Eligible for IBM Subsidized Coverage (FHA Withdrawal Eligible):
If, when you leave IBM, you are FHA withdrawal eligible, you can opt out of the Plan during the annual benefits enrollment window or as the result of a qualified life event. You can re-enroll at a later date, either during the annual benefits enrollment window or as a result of a qualified life event, only if you have maintained other health coverage in the interim.'

Eligible for Access Only Coverage:
If, when you leave IBM, you are eligible for Access Only coverage, you will lose eligibility if you do not enroll in an IBM retiree medical, dental and/or vision plan option when it is first offered. If you decline coverage when it is first offered, you permanently waive your ability to enroll in the Plan again in the future.

Medicare-Eligible Participants

Whether you are eligible for IBM subsidized coverage or Access Only, you can enroll/re-enroll in or opt out of the Plan during the annual benefits enrollment window or as the result of a qualified life event.

Coverage for Eligible Family Members

Effective January 1, 2005, the eligibility requirements for retirees who enroll dependents in IBM medical, dental and vision coverage, are as follows.

If You Retired from IBM On or Before December 31, 2004
You may only enroll those dependents who met eligibility guidelines as of December 31, 2004. Any new dependents — such as those you gain through marriage/domestic partnership, birth or adoption — after December 31, 2004, are not eligible.

If you have a dependent who met eligibility requirements as of December 31, 2004, but who is not currently enrolled, that individual may enroll for coverage under the Plan as long as he or she continues to meet dependent eligibility guidelines.

If You Retired from IBM On or After January 1, 2005
You may enroll only those dependents who meet dependent eligibility guidelines as of your retirement date. You may not enroll dependents you gain after your retirement date — for example, a new spouse/domestic partner or a dependent child acquired by birth, adoption or marriage.

IBM requires Social Security numbers be provided for all retirees and dependents in order to be enrolled in under the Plans so IBM or its Plan Administrators can perform Coordination of Benefits validations and report data to the Centers for Medicare and Medicaid Services as required.

Eligible Spouse

- Your spouse, if the marriage met the laws of the jurisdiction in which it was entered into.
- Your common-law spouse may be eligible in certain circumstances. To meet the eligibility criteria to add a common-law spouse to your health coverage, you must:
  - Live in a state that recognizes common-law marriage
  - Openly represent yourselves as husband and wife to government and tax authorities as well as to your relatives, friends, neighbors, coworkers and acquaintances with whom you associate. It is expected that you file your income taxes as "married"
  - Change your status to "married" at IBM and ensure that your IRS form W-4 reflects "married"
  - Not be legally married to another person

Eligibility for a Domestic Partner

You may enroll your domestic partner (either of the same or opposite sex) if you and your partner:

- Have registered as domestic partners with a state or local government domestic partnership registry, or you are entered into a civil union (where applicable) and/or
- Both meet all of the following requirements:
  - You share an intimate and committed relationship with each other and intend to do so indefinitely;
  - Neither of you are married to or in a domestic partnership with another person;
  - You are jointly responsible or one another's welfare and financial obligations;
  - You live in the same household;
  - You are not related by blood to a degree of kinship that would prevent marriage from being recognized under the law of the state where you live; and
  - You are each at least age 18, of legal age under applicable state law, and mentally competent to enter a contract

You may only cover one individual under the Plan as your domestic partner.

You may be asked to submit proof that your domestic partner was eligible for coverage on the date he or she first became covered as a dependent under the Plan. Therefore, it is strongly recommended that you complete an Affidavit of Domestic Partnership indicating the date your domestic partnership began. More information, including a sample Affidavit of Domestic Partnership, is available by contacting the IBM Benefits Center – Provided by Fidelity or reviewing a copy of the "*Domestic Partner Information Guide*," available from NetBenefits®.

Please note that enrolling a domestic partner has certain tax implications. For details, see *A Note About Taxes and Imputed Income*.

Eligible Children

An eligible child remains eligible as long as he or she continues to meet all other eligibility requirements. In no event will any child who is a ward of the state or a foster child be eligible under the Plan.

Your eligible children include:

- Your biological and legally adopted unmarried children to age 19
- Your biological and legally adopted unmarried children aged 19 – 23 if they are full-time students at a qualified educational organization, receive over 50% of their support from you, the retiree, for maintenance and support and are not employed full-time
- A child of minor dependent until the dependent turns 18. Note that you cannot cover your grandchild unless you are also covering the child's parent.
- Your unmarried stepchildren (that is, the natural or legally adopted children of your spouse or your eligible domestic partner) under age 23 who:
  - If age 19-23, are full-time students at a qualified educational organization
  - Are not employed full-time
  - Receive over 50% of their support from you, the retiree, for maintenance and support
  - When not in attendance at school, are "permanently residing" in your household
  - Permanently residing in your household means that the retiree's household is the permanent, principal residence of the child. In situations where a child is away at school overnight (e.g., boarding school, college), the retiree's household must be maintained as the child's legal and principal residence. More information may be obtained from the IBM Benefits Center – Provided by Fidelity
- Other unmarried children under age 23 will be considered eligible if IBM determines that they:
  - If age 19-23, are full-time students at a qualified educational organization
  - Are not employed full-time
  - Receive over 50% of their support from you, the retiree, for maintenance and support
  - Cannot be claimed as a "qualifying child" under Internal Revenue Code Section 152 by any other taxpayer
  - When not in attendance at school, are "permanently residing" in your household in what is considered a "parent/child relationship." Permanently residing in your household means that the retiree's household is the permanent, principal residence of the child. In situations where a child is away at school overnight (e.g., boarding school, college), the retiree's household must be maintained as the child's legal and principal residence. More information may be obtained from the IBM Benefits Center – provided by Fidelity
  - An "other child" up to age 23. An "other child" means a child for whom you have been granted legal guardianship by a court of law.

Note: *"Other unmarried children under age 23" determined to be eligible before January 1, 2009, remain eligible as long as they meet the requirements in effect when the child was first determined to be eligible.*

Full-time Student Status

Full-time student status requires that a student must satisfy either (1) full-time attendance as of the date enrolled for coverage and enrollment for at least five months, or (2) full-time on-farm training.

Full-time Attendance as of Date Enrolled for Coverage
Full-time attendance requires enrollment as a full-time student at a qualified educational organization.
For purposes of eligibility, a child must be a full-time student at the time he or she is enrolled for coverage, or if enrolled for coverage during Annual Enrollment, must be a full-time student as of January 1 of the following plan (calendar) year.

A qualified educational organization maintains a regular faculty and curriculum with a regularly scheduled enrolled body of students in attendance at the place where its educational activities are carried on.
Qualified educational organizations may include elementary schools, junior and senior high schools, colleges, universities, and vocational, technical, trade or mechanical schools.

Qualified educational organizations do not include on-the-job training, correspondence schools, night schools, schools offering course only through the Internet, or non-educational institutions (e.g., general hospitals that provide training programs for medical students, interns and residents).

Enrollment for At Least Five Months
A child is eligible for coverage if he or she meets the full-time attendance requirement above (is a full-time student at the time he or she is enrolled for coverage, or if enrolled for coverage during Annual Enrollment, is a full-time student as of January 1 of the following plan (calendar) year), AND is enrolled for some part of five calendar months for the number of hours or courses considered to be full-time attendance by the institution. The five calendar months need not be consecutive.

Enrollment begins in the month in which registration occurs, even if classes do not commence until the following month.

Following are special rules regarding coverage for the entire plan (calendar) year where the child is enrolled for at least five months during the plan (calendar) year:

- In some situations, the child may be enrolled for five months, but for less than the entire plan (calendar) year, or enrolled in a non-traditional educational setting, and may still be eligible for coverage for the entire plan (calendar) year. The following are guidelines used to determine whether a child enrolled for less than the entire plan (calendar) year can remain eligible for the remainder of the plan (calendar) year after having five calendar months as a full-time student.
- A child is eligible to be enrolled for the entire plan (calendar) year if he or she is a full-time student enrolled for some part of five calendar months, and will remain eligible for the remainder of the calendar year, if the child meets all other eligibility requirements (e.g., is under age 23) and
  - Moves from full-time to part-time status
  - Takes a semester off from school
  - Graduates

  For example, if a child is enrolled for coverage during Annual Enrollment for the 2025 plan (calendar) year, is graduating college in May 2026, and is enrolled as a full-time student on January 1, 2026, through May 2026, he or she is eligible for coverage through the end of 2026 (as long as the child meets all other eligibility requirements).

Following are special rules regarding coverage where the child is enrolled in a Non-Traditional Educational Setting:

- School attendance solely at night is not full-time attendance. However, full-time attendance may include some attendance at night in connection with a full-time course of study
- School attendance that includes a cooperative job in private industry may be full-time attendance if the job is part of the regular course of classroom and practical training

If, during the plan (calendar) year, your child ceases to be eligible based on enrollment for less than five months of the plan (calendar) year or in non-traditional educational settings as described above, for example, if your child withdraws from school with no intention to return after taking a semester off, you must notify the IBM Benefits Center – Provided by Fidelity and make arrangements for the child to be dropped from coverage.

Full-time On-Farm Training
Full-time on-farm training requires enrollment in a full-time course of institutional on-farm training under the supervision of an accredited agent of a qualified educational organization or of a state or political subdivision of a state.

Special Rule for Unable to Attend School Because of Illness or Accident
"Michelle's Law" provides for continuation of a dependent child's coverage for up to 12 months for a medical leave of absence from post-secondary education. Under the IBM Plan, a dependent child, age 19-23, who is temporarily unable to attend school full-time as a result of an illness or accident, may be considered for continued coverage during the period in which he/she is unable to attend school (even if greater than the 12-month period in Michelle's Law). You should contact the IBM Benefits Center – Provided by Fidelity if you have a dependent child who is unable to continue as a full-time student due to temporary disability.

A child who meets the above eligibility requirements must also meet certain tax requirements in order for their coverage to be provided to you tax-free. Refer to the *"IRS Requirements Regarding the Tax-Free Status of Health Benefits Coverage for Enrolled Children"* section for further information regarding an enrolled child's status for tax-free coverage. It is your responsibility to notify the IBM Benefits Center if any enrolled child does not meet the IRS requirements as stated in the above referenced section.

If You Have a Child with a Disability

Your mentally or physically disabled child who was covered under the Plans immediately before reaching age 19 may be eligible for coverage beyond age 19 if, at the time the child turns age 19, IBM determines on the basis of the child's condition at that time, your child is:

- Mentally or physically disabled and the disability existed before the child's 19th birthday
- Incapable of self-support due to the mental or physical disability
- Unmarried
- Receiving over 50% of support from you, the retiree, for maintenance and support (any SSI or SSDI income your child receives must be used in determining whether your child is principally dependent upon you)
- Receiving mental health treatment if the disability is for a mental health condition

If you think your child will meet the above criteria at age 19, you *must* request continuation of IBM health benefits by completing the "Application for Coverage of Disabled Dependent Child" and submitting it to the IBM Benefits Center – Provided by Fidelity within the window of time that begins 60 days before the child's 19th birthday and ends no later than 60 days after the child's 19th birthday. Applications are available by calling the IBM Benefits Center – Provided by Fidelity.

If you have a disabled dependent who was not covered under any of the IBM Plans at the time that the dependent turned age 19, you can request coverage for the disabled dependent under the IBM Plan if you experience a qualified life event or during Annual Enrollment, as long as the disabled dependent would have met the five eligibility conditions (outlined in the bullets above) had they been covered under the Plan when they turned age 19, and, at present, continue to meet these conditions.

If you have an eligible dependent child, age 19-23, who becomes permanently disabled while a full-time student, the child may be eligible for continued coverage, including coverage after age 23, if IBM determines on the basis of the child's condition, that he/she meets the following conditions:

- Mentally or physically disabled
- Incapable of self-support due to the mental or physical disability
- Unmarried
- Receives over 50% of support from you, the retiree, for maintenance and support (including any SSI or SSDI income to be used in determining whether your child is principally dependent upon you)

If you think your child meets the above criteria, you must request continuation of IBM health benefits by completing the "*Over Age 19 Disabled Child Application*" and submitting it to the IBM Benefits Center – Provided by Fidelity as soon as possible after the child becomes disabled. Applications are available on NetBenefits or by calling the IBM Benefits Center.

Once your application is approved, coverage will remain in effect for either a specified time or as long as your dependent meets the eligibility criteria as determined by the Plan and as may be modified thereafter. It is the retiree's responsibility to notify the IBM Benefits Center to remove their child if he or she no longer meets the eligibility criteria for continued coverage beyond age 19.

You may opt out or waive coverage for any particular year for your dependent child and re-enroll your child during the next or subsequent Annual Enrollment period as long as they continue to meet the eligibility criteria. Once any of the four conditions is not met by a child over the age of 19, coverage is discontinued and will not be reinstated, even if later the child again meets all or any of the four conditions.

Your Responsibilities Regarding Eligibility

As a condition of eligibility for benefits, you must follow and allow the Plan Administrator and health plan administrators to follow the operating procedures established for the functioning of the Plans. This includes, for example, the furnishing of Social Security numbers to health plan administrators.

It is your responsibility to ensure the data on your eligibility record is current. This includes notifying IBM of a change in a family member's eligibility status as well as address updates. You must enroll new eligible family members and/or notify IBM of a change in a family member's eligibility status within 60 days of the event.

To update your address or notify IBM of a change in a family member's status, call an IBM Benefits Center representative. Other group or individual coverage information should be updated through the administrator of the plan option in which you are enrolled.

IBM's Right to Verify Eligibility

IBM reserves the right to require documentation to support the eligibility of any dependent enrolled in the Plan. If the Plan Administrator learns you have not notified the IBM Benefits Center – Provided by Fidelity about an enrolled dependent who does not meet IBM's eligibility criteria for coverage or does not meet IRS eligibility requirements for tax-free coverage, that dependent will be removed from coverage and will remain ineligible for future coverage.

If you are enrolled in an IBM-sponsored Group Medicare Advantage plan option, you must notify UnitedHealthcare of any changes to eligibility. The Plan Administrator has the right to take additional actions, as explained in "*Fraudulent Enrollments*," below.

The Plan Administrator has the sole discretion to make the final decision with respect to eligibility under the Plan. The decision will take into account any factors determined to be relevant within the intent of the Plan and consistent with the tax-qualified status of the Plan.

Fraudulent Enrollments

It is a crime to knowingly, and with intent to injure, defraud, or deceive the company, provide any fraudulent information, including enrolling an individual whom you know is not eligible to participate in the Plans or continuing to maintain coverage for an individual whom you know is not eligible. These actions, as well as the submission of materially false information, may result in rescinding your coverage under the Plans, retroactive to the date of the fraudulent act, and you may be subject to prosecution and punishment under state and/or federal law. The Plans would terminate coverage of a participant or beneficiary for a reason such as fraud.

ENROLLING IN YOUR BENEFITS BEFORE YOU BECOME MEDICARE-ELIGIBLE

Coverage Categories

All eligible former employees, retirees, surviving spouses and domestic partners, and dependents must be enrolled in order to receive IBM medical, dental and vision benefits. You may elect different coverage levels for one type of coverage (medical, dental or vision), but you may only cover eligible family member(s) in a plan option in which you are also enrolled. Each plan option and coverage level available to you will have a monthly contribution amount, which will vary based on the type of coverage and number of family members (called the "coverage category") you designate in your election.

Coverage Categories:

- Self only — retiree only
- Self plus one — the retiree plus an eligible spouse, domestic partner or child
- Self plus two or more — the retiree plus two or more eligible family members (spouse or domestic partner and children)
- Dependent only — for non-Medicare-eligible dependent(s) of a Medicare-eligible retiree

You elect the coverage option you want to enroll in and the coverage category for each, then add up the individual monthly contribution amounts. Additional coverage categories may apply depending on Medicare eligibility. Please note monthly charges will not be prorated. For example, if you increase your coverage category at any time during the month, you will pay the full month's contribution amount for the increased coverage.

IBM requires Social Security numbers be provided for all retirees and dependents in order to be enrolled in the plans so IBM or its Plan Administrators can perform Coordination of Benefits validations and report data to the Centers for Medicare and Medicaid Services as required.

Enrolling in SRMO Coverage

Your Enrollment Choices

If you meet the Special Retiree Medical Option (SRMO) eligibility requirements and are also eligible for COBRA continuation coverage under the Active Medical Plan at separation, you have two enrollment choices upon separation (only if you are a non-Medicare-eligible retiree):

- Enroll in SRMO coverage under the Plan immediately.
- Enroll in COBRA coverage under the Active Medical Plan first. When COBRA coverage under the Active Medical Plan ends, you may then elect to begin coverage under the Plan through SRMO. For a description of COBRA eligibility, see "*COBRA Continuation Coverage*" in the "*Administrative Information*" section of the "*About Your Benefits"* book for the Active Medical Plan. For more information contact the IBM Benefits Center – Provided by Fidelity.

Timely payment of the applicable monthly cost of coverage must be made on an ongoing basis in order to maintain SRMO eligibility and coverage.

You Must Enroll Within 60 Days

You must enroll in SRMO coverage within 60 days immediately following separation from IBM, or within 60 days following the date your COBRA coverage under the Active Medical Plan ceases, if elected first. If you do not elect SRMO coverage within this time period, you are considered to have declined coverage and you waive the right to any future election of SRMO coverage.

If you enroll in SRMO coverage, your elections will remain in effect until the end of the plan year. You may not change your elections until the next Annual Enrollment unless you experience a qualified life event (see "*Changing Coverage Due to a Qualified Life Event"* in the "*Administrative Information*" section). However, you may cancel your coverage at any time during the year, effective the first of the month following your request, but you will not be allowed to re-enroll in the future.

If You Are an IBM Couple

Married couples, or couples in an eligible domestic partnership, each of whom is eligible for the Plan in his or her own right and is not yet a Medicare-eligible retiree or dependent, will have to choose each plan year whether to enroll separately, each as a participant, or whether one will enroll as a participant and include the other as an eligible family member under the participant's coverage. IBM couples cannot have dual coverage under the Plans – you cannot enroll in your own right and also be covered as a dependent in Plans.

Annual Enrollment for Non-Medicare-Eligible Participants

Each year during Annual Enrollment, usually held in the fall, you will have the opportunity to review your benefit elections and make changes to coverage for yourself and your eligible dependents.

Your new elections will remain in effect for the upcoming plan year (normally January 1st through December 31st), unless you experience a qualified life event which permits you to make a change during the year. Permissible changes outside of the Annual Enrollment period, such as adding a new dependent, must be made within 60 days of the event by contacting the IBM Benefits Center – Provided by Fidelity. Any changes are generally effective the first of the month following your enrollment call. If you do not make the election within 60 days of the event, you will have to wait until the next Annual Enrollment period. For more information about qualified life events, see "*Changing Coverage Due to a Qualified Life Event*" in the "*Administrative Information*" section.

If you do not make an election during Annual Enrollment, you will automatically be enrolled in the same plan options you had in the plan year just ending (provided the same plan options continue to be available).

When you become Medicare-eligible, your eligible dependents who are not eligible for Medicare will be eligible to elect coverage in plan options under the Plan to non-Medicare participants. You can expect to receive an IBM enrollment kit each fall until your eligible dependents become Medicare-eligible.

IBM'S CONTRIBUTIONS FOR COVERAGE

IBM's contributions cover a portion of the benefits under the Plan. The total amount of IBM's contribution to the Plan is limited, or "capped." IBM contributes an amount for each of the following groups as follows:

IBM Contributions for Retirees and LTD Participants (Non-Medicare-Eligible)

IBM's total aggregate contribution for this group (including for eligible dependents) is determined as an average amount per retiree in the following chart multiplied by the number of retirees in this cohort that are expected to enroll in the Plan:

Retirement Date	IBM's Contribution
Before Jan. 1, 1992	$7,500
On or after Jan. 1, 1992	$7,000

IBM's contribution is determined without regard to retirees covered by the Special Retiree Medical Option ("SRMO"), Access Only, the Future Health Account, or retirees and LTD Participants eligible for Medicare.

While IBM's contribution is expressed as an amount multiplied by the number of retirees that are expected to enroll in the Plan, it does not limit the total coverage or the level of reimbursement available to each retiree and eligible dependent. Total eligible expenses will be reimbursed according to Plan provisions.

IBM contributes an additional amount to the Plan for LTD Participants who are not Medicare-eligible (including for eligible dependents).

IBM Contributions for Retirees and LTD Participants (Medicare-Eligible)

IBM's contribution for this group differs by the population cohort and the IBM Group Medicare Advantage plan option selected. Please refer to the "*IBM Subsidy/Health Reimbursement Arrangement*" section for more details. IBM's contribution remains subject to IBM's overall limits on aggregate contributions to the Plan for Medicare-eligible participants.

Retirement Date	IBM's Contribution
Before Jan. 1, 1992	$3,500
On or after Jan. 1, 1992	$3,000

IBM contributes an additional amount to the Plan for non-Medicare-eligible dependents and for administrative expenses of the Plan.

Retirees Who Have Future Health Accounts
IBM's aggregate contribution for this group (including for eligible dependents) is the amount of withdrawals from the Future Health Accounts. For more information about the Future Health Account, and how it works please see the "*Future Health Account*" *(FHA)* section in Annex 1.

Retirees in SRMO and Access Only Options
IBM does not contribute any amount toward the cost of benefits for retirees and their dependents who participate in the SRMO or Access Only options under the Plan. Those who participate in the SRMO or Access Only options pay the full cost of the coverage.

The remainder of the costs of benefits and administrative expenses under the Plan are covered by premiums to be paid by retirees and other Plan participants. The premium for each participant varies depending on the coverage option selected.

The amounts described above do not preclude IBM from instituting further cost-sharing based on business conditions.

A Note About Taxes and Imputed Income

Tax Implications of Enrolling a Domestic Partner
If you elect to cover your eligible domestic partner (or his or her children) and he or she does not qualify as a dependent under Internal Revenue Code (IRC) Section 152, you generally must pay federal income and payroll taxes (and, in most states, state taxes) on a portion of the applicable premium. This is called imputed income, and that value will be reported on your Form W-2.

If you think your domestic partner would qualify as your eligible family member, please contact the IBM Benefits Center – Provided by Fidelity for more information or review a copy of the "*Spouse and Domestic Partner Information Guide*," available through NetBenefits, which contains information on eligibility, tax implications, enrollment, etc.

Important Note: *This information applies to federal tax implications only— not for state taxes. IBM will apply your state's rules for any state obligation. If you have questions about your state's tax rules, you should contact your local state tax department or your personal tax advisor.*

For information about the tax implications of covering expenses for a same-sex spouse or same-sex domestic partner under the Health Reimbursement Arrangement for Medicare-eligible retirees, refer to the "*Health Reimbursement Arrangement*" section of this document.

Generally, a domestic partner is considered to be “qualified” as a “dependent relative” and therefore eligible for benefits under the Plan on a tax-free basis (so no imputed income will apply) only if more than half of the partner’s support for the year comes from the employee, and the partner resides in and is a member of the household maintained and occupied by the employee for the entire tax year and the domestic partner cannot be claimed as a dependent relative of another taxpayer. (You may wish to consult your personal tax advisor regarding tax consequences.)

IRS Requirements Regarding the Tax-Free Status of Health Benefits for Enrolled Children
According to federal tax laws, enrolled children must meet certain tax requirements for their health coverage under the IBM Plan to be provided on a tax-free basis. Children who do not meet these requirements may still be enrolled in IBM health coverage if eligible; however, the value of their coverage will be considered imputed income to you, and you will be taxed accordingly.

Most children who can be enrolled for health coverage under the Plan also meet the federal income tax law requirements. Enrolled children who do not meet the federal income tax law requirements for tax-free health coverage may include stepchildren (including children of an eligible domestic partner) whom you have not legally adopted, or other certain other children (as described above).

It is your responsibility to notify the IBM Benefits Center – Provided by Fidelity if for any reason your enrolled children do not meet the requirements for tax-free health coverage.

You should consult Internal Revenue Service rules or your personal tax advisor if you have questions concerning the tax dependent status of your enrolled children.

IBM Benefits Plan for Retired Employees

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Administrative Information

ID CARDS

Non-Medicare-eligible retirees enrolled in the following plan options will receive one ID card for hospital and medical coverage as well as a separate ID card for prescription drug coverage:

- IBM Low, Medium or High Deductible PPO options
- IBM Exclusive Provider Organization
- IBM High Deductible PPO with HSA

The ID card contains information to ensure you receive the correct negotiated rates from participating providers and facilities. Your ID card must be presented to all providers at the time of appointment or when you receive services, or to a participating pharmacy at the time of prescription drug purchase. Failure to show your ID card may cause you and IBM to lose access to any applicable discount fee arrangements.

If you and your spouse/domestic partner are each eligible for IBM benefits and one of you is enrolled as a dependent of the other, only the Plan participant's ID card should be presented.

You may request additional ID cards for your family members — and view digital versions of your ID cards — on your health plan's administrator's website or app.

Once your enrollment in one of the Group Medicare Advantage plan options is processed, a Quick Start Guide will be mailed to you in 7–10 business days along with your UnitedHealthcare member ID card.

QUALITY CARE INITIATIVE

IBM and the Plan participate in various programs designed to encourage health care providers to deliver efficient, safe, effective, quality care to IBM employees and retirees and their spouses and dependents. Under these programs, health care providers who are determined to employ recommended practices in their administration of health care generally are rewarded through per capita incentives paid from the Plan's trust as additional fees for services provided. IBM employees and retirees are not responsible for payment of the quality care incentives. From time to time, pilot programs may be introduced for all plan participants or for certain participants determined on a random basis. To the extent the pilot program provides for benefits that differ from those available under the Plan, the decision of any participant to participate in the pilot program will be voluntary.

HOW TO FILE A CLAIM

Medical Claims if You Are a Non-Medicare-Eligible Retiree

In-Network Medical Claims

If you receive care from an in-network provider, you generally do not have to file any claims. Your network provider will file all claims for you. Simply show your medical ID card at the time you receive services. Your network provider bills the health plan directly. Once the claim is processed by the medical plan, payment will be made directly to the network provider. Subsequently, your provider will bill you for your remaining share of the cost (e.g., coinsurance or deductible).

Claims for Secondary Coverage after Medicare Pays Primary Coverage

Dependents eligible for Original Medicare and enrolled in one of the plan options under the Plan must also be enrolled in Original Medicare Part A and Part B. Original Medicare has responsibility for primary payment of claims to your providers and the Plan coverage is secondary.

Since Original Medicare pays primary, medical claims must be filed with Original Medicare first and then the result of the claim processing must be submitted to the administrator of your plan option for secondary processing.

Generally, the medical provider (doctor, hospital, etc.) will file claims (for the covered services and supplies you received) to Original Medicare for you. If the administrator of your plan option coordinates benefits with Original Medicare and this process is set up for the Medicare-eligible dependent, Original Medicare will automatically send the claims information to the administrator of your plan option to credit your annual deductible and out-of-pocket maximum and determine if additional benefits are payable under the Plan. Contact the administrator of your plan option to determine if they coordinate benefits with Original Medicare and confirm the process is set up for the Medicare-eligible dependent. If this process is not set up, you may need to submit the proof of your Original Medicare claims to the administrator of your plan option.

You will receive a Medicare Summary Notice (MSN) in the mail every three months that lists all the services billed to Original Medicare. Make sure you review this information along with the Explanation of Benefits (EOB) you received from the Plan. Note that if your provider does not accept Original Medicare, you may need to file claims with Medicare and the Plan yourself.

If you have other primary medical coverage, and the Plan is secondary, your claims must be filed with the primary plan first and then submitted to the Plan for secondary processing. For more information when you have other coverage, see "*Coordinating Coverage*" later in this section.

EXPLANATION OF BENEFITS (EOB)

In most cases, you will receive an Explanation of Benefits (EOB) statement from the health plan. In certain circumstances where there is no member liability, an EOB may not be produced.

If you receive EOB statements from your health plan, it is your responsibility to:

- Verify the EOB statements for medical, surgical and hospital care accurately reflect services rendered, e.g., patient, dates of service, charges and provider. (Due to negotiated or discounted rates with respect to hospital services, it may not be possible to verify dollar or rate amounts reflected on the statement.)
- Retain copies of claims and EOB statements for your records.

Out-of-Network Medical Claims for Mental Health Claims and Other Services (with Approved Exceptions)

The IBM Plan only allows payment for out-of-network claims for mental health/substance use claims (for PPO plan options only) and certain other situations such as medical emergencies, services incurred while traveling outside of the U.S. and services received by those enrolled in an Out-of-Area (OOA) plan option. See the full list of approved exceptions in the "*Out-of-Network Medical Coverage*" section. If your claim falls under one of these categories (except OOA), the IBM Plan will pay for these approved services based on the usual and customary rates.

Out-of-network services received by those enrolled in an OOA option are paid based on the billed amount (or lower negotiated amount, if applicable). All services are paid as if they were received by an in-network provider, using the in-network deductible and out-of-pocket maximum that would have applied if the services were provided by an in-network provider.

You must pay the difference between the amount the Plan pays in benefits and the amount billed by the out-of-network provider.

Some providers will submit your claim to the medical plan administrator on your behalf, other providers may request payment in full and submit a claim to your medical plan administrator for reimbursement. In certain circumstances (i.e., high-cost hospital bills), your medical plan administrator will not want you to pay for services until they have had the opportunity to negotiate a lower cost with the provider.

The provider will be reimbursed directly if authorization for assignment is indicated on the form. Generally, if benefits are not assigned, payment from the health plan administrator will be made to you.

Out-of-Area Medical Options

In certain geographies where there is not a robust network of medical providers, affected employees will be offered Out-of-Area (OOA) plan options, administered by Aetna. The IBM EPO is not available to those who are offered OOA plan options. If this situation applies to you, it will be indicated in your enrollment materials.

Those enrolled in an OOA plan option can choose to use either in- or out-of-network providers without needing to ensure the service falls under the category of an approved exception. You will pay less out-of-pocket if you use provider's that participate with Aetna's provider network. Under the OOA plan options the IBM Plan will pay benefits for eligible services as if the provider was in-network, based on the billed amount (or lower negotiated amount, if applicable) using the in-network coinsurance or copayment, along with the in-network deductible and out-of-pocket maximum.

Providers who do not participate with your plan administrator's network may submit the claims on your behalf or they may request payment in full and ask you to file the claim with your medical plan administrator for reimbursement. See the "*How to File an Out-of-Network Claims*" section for more information.

Note: *Do not pay in advance for high-cost services received from non-participating providers (for example, inpatient hospital bills) until your plan administrator has had the opportunity to negotiate a lower cost with the provider.*

The provider will be reimbursed directly if authorization for assignment is indicated on the form. Generally, if benefits are not assigned, payment from the plan administrator will be made to you.

You can submit OOA plan option claims to the Plan as described in the "*How to File Out-of-Network Medical Claims*" section.

Prescription drug and mental health/substance use benefits under the OOA plan options are the same as under the standard plan options and remain subject to the in-network and out-of-network requirements, as described in the "*IBM Managed Pharmacy Program*" and "*Medical Coverage*" sections of this book.

Medical Expenses Incurred While Traveling Outside of the U.S.
Medical expenses incurred while outside of the United States are eligible for consideration as long as they are rendered in accordance with all Plan provisions. All bills or invoices should be legible and in English, if possible. If translation to English is not possible, the health plan administrator will perform the translation services when the bill is submitted. All bills should be sent to the appropriate health plan administrator. All claims will be reimbursed in U.S. dollars. The exchange rate will be taken from a recognized publication as selected by the health plan administrator, using the rate effective on the date of discharge for inpatient hospital charges, and the date the service was rendered for all other eligible charges.

Generally, you will pay for charges at the time service is rendered, and then submit your claims for reimbursement. When medical services are received outside the US, except in limited (emergency situations), these services are not covered by Medicare. When eligible services under the Plan are not covered by Medicare the Plan will pay primary over Medicare (for Medicare-eligible dependents of non-Medicare-eligible participants).

How to File Out-of-Network Medical Claims
Payment for "approved" services received out-of-network is based on the in-network rate. See the section "*Out-of-Network Medical Coverage*" for a description of these services.

Contact your medical plan administrator for instructions on how to submit claims from out-of-network providers. A separate claim form is required for each family member. You will receive an Explanation of Benefits (EOB) statement from the health plan administrator detailing the services rendered. You should obtain a copy of the bill from the provider to enable accurate verification of the EOB statement. You must verify the information contained on the EOB statement received from the health plan administrator against the actual charges, dates of service, etc. If any discrepancies are found, you must advise the health plan.

Note: *Be sure not to pre-pay for high-cost services received from out-of-network providers (for example, inpatient hospital expenses). By submitting a claim, your plan administrator will have the opportunity to negotiate a lower cost with the provider.*

Complete and sign the appropriate Plan claim form, available from the IBM Benefits Center – Provided by Fidelity, on NetBenefits or directly from your carrier. Ensure all required information, including your member ID number, is provided on the claim form and accompanying bills. Only you have the authority to sign the form certifying the validity of the claim.

The provider will be reimbursed directly if authorization for assignment is indicated on the form. Generally, if benefits are not assigned, payment from the health plan administrator will be made to you.

- Attach itemized bills and EOB statements from other insurance coverage (if applicable) to the claim form and mail to the health plan administrator at the address on the claim form. Canceled checks or cash register receipts will not be accepted. Ensure the accuracy and validity of all bills submitted for payment and make sure there is a specific treatment or diagnosis written on the bill. See the reverse side of the claim form which lists the information that must be included on the bills to avoid possible suspension or rejection of your claims.
- Advise the health plan administrator of your plan option if charges submitted for reimbursement are eligible for coverage under another employer's plan. Respond promptly to the health plan administrator's inquiries concerning the possibility of other coverage.

- If you have a written predetermination of benefits from the health plan administrator of your plan option, attach a copy to your claim form.
- In determining the appropriate reimbursement for surgical claims, the health plan administrator may request a copy of the surgeon's operative report.
- For services rendered outside of the US, include the English translation of diagnosis, fees and treatment for services rendered, if available. If the provider or facility is not able to provide a bill or claim information in English, the health plan administrator of your plan option will perform translation and currency exchange services for you.
- In most instances, the claim will be processed and payment mailed within 30 days of receipt. Therefore, you should allow for mailing time plus the 30 days needed for processing before calling to follow-up on the status of a claim. In some circumstances, however, due to the complexity of the claim, additional medical and technical reviews may be necessary resulting in a longer than normal processing time.

In determining whether a benefit is payable (and, if so, the benefit amount), the Plan Administrator and the health plan administrator may consult physicians, dentists and other experts selected by IBM for advice on medical necessity and other pertinent factors and may require that the patient be personally examined by those expert(s). For determination of medical appropriateness, the health plan administrator may also contact your physician as needed.

The benefit on any assigned claim will be calculated the same way as if the claim had not been assigned; for example, in calculating the amount due, the Plan will take credit for any benefit advances or overpayments previously paid for charges by the same or any other provider. In certain circumstances where there is no member liability under the Plan option, an Explanation of Benefits will not be produced.

Deadline for Submitting Claims
Charges are considered incurred on the date the service, hospitalization, supply, surgery or other treatment is rendered. All claims must be received by the health plan administrator no later than December 31st of the year following the year in which the charges are incurred; otherwise, there will be no benefit payable. For example, if a charge is incurred on July 1, 2025, the claim must be received by December 31, 2026. You are responsible for ensuring claims are submitted on time even if the provider is filing the claim on your behalf. IBM cannot accept any responsibility for post office deliveries or claims mailed via internal mail from an IBM location.

Keep Copies for Your Records
Keep a copy of the claim form and bills for your records. You are responsible for reconciling submitted charges with claims paid as reported on the EOB statement from the health plan administrator. Copies will *not* be provided by the health plan.

Your Responsibility
It is your responsibility to follow the Applicable Claim filing procedures, and to advise the health plan administrator of any discounts or price adjustments made by the provider. A provider who waives or refunds deductibles, copayments and/or coinsurance amounts is entering into a discount arrangement with the employee. The benefit payment is calculated based on the amount actually charged after any discounts, rebates, waivers or refunds of copayments or deductibles. Thus, failure to notify the health plan administrator of such a price adjustment may result in an overpayment of benefits. It therefore

constitutes a serious violation of the provisions of the Plan and may be grounds for disciplinary action, including termination of coverage.

It is a crime to knowingly, and with intent to injure, defraud, or deceive the company, provide any fraudulent information, including filing a claim that contains any false, incomplete, or misleading information. These actions, as well as the submission of materially false information, may result in rescinding your coverage under the Plan, retroactive to the date of the fraudulent act, and you may be subject to prosecution and punishment under state and/or federal law. The IBM health plan(s) would terminate coverage of a participant or beneficiary for a reason such as fraud.

Hospital/Facility Billing

Inpatient and outpatient hospital claims cannot be reimbursed directly to you. Negotiated prices, which create savings for you and IBM, will only take effect if the health plan administrator pays hospitals directly for covered charges. Present your identification card at the time services are rendered; do not pay up front. Hospital inquiries should be referred directly to the health plan administrator. If you pay a hospital for outpatient and inpatient services, the health plan administrator will reimburse the hospital for the eligible covered charges and you will have to obtain a refund directly from the hospital.

Note: *IBM recommends that you do not pay the hospital any amounts other than copayments until you receive your EOB. You may not receive the discounted rate if you pay the hospital directly.*

- *Inpatient Charges:* Hospitals will send a bill for charges directly to the health plan administrator and then bill you for any balance remaining after benefits have been paid to the facility by the health plan administrator.
- *Outpatient Charges:* In most cases, facilities will send a bill for eligible charges to the health plan administrator and then bill you for any balance remaining after benefits have been paid to the facility. If hospitals request a payment at the time of service, they may request the coinsurance payment (the amount not reimbursable by the Plan) and not the total charges. It is the hospital's own particular billing practices which determine whether payment will be required at the time of service or at a later date. In certain circumstances, such as a mother and newborn child, billing may be separate.

Hospital Bill Reconciliation

As a result of applicable state laws and/or contracts between some facilities and the health plan administrator, actual payments that a facility will accept as payment in full may vary from the facility's nominal charges. For example, in some areas of the country, payments to hospitals for inpatient stays are based on a patient's medical diagnosis rather than on the fee-for-service and per diem charges which appear on the hospital's invoices. This payment methodology is referred to as a DRG (Diagnosis Related Group) methodology. Under a DRG system, a hospital receives a predetermined amount for the care of a patient with a specific diagnosis. Length of stay and non-operative services rendered to the patient while in the hospital do not affect the payment amount. A hospital's bill, nevertheless, will show charges at the hospital's standard rates on a fee-for-service basis, even if the DRG methodology actually applies instead. Similarly, a negotiated or discounted rate may apply at times, but might not be reflected on the billing you receive from the hospital.

In these situations, the benefit which the Plan pays may equal a different percent of the total amount the facility accepts as payment in full than that specified under the IBM Plan. In any case, the amount of your coinsurance will never be more that it would have been had the hospital required payment for the services at its full nominal rates.

Any questions about specific charges and reimbursements should be directed to the health plan administrator.

Filing Claims If You Are a Medicare-Eligible Retiree

When you obtain services from a network provider, the provider will submit the claim directly to UnitedHealthcare for reimbursement.

Some out-of-network providers will also submit claims on your behalf to UnitedHealthcare. If the out-of-network provider does not do so, you can pay the provider and then submit your claim to UnitedHealthcare at:

Medical claims payment requests:
UnitedHealthcare
P.O. Box 31362
Salt Lake City, UT 84131-0362

Part D prescription drug payment requests:
OptumRx
P.O. Box 650287
Dallas, TX 75265-0287

Dental payment requests:
UnitedHealthcare
P O Box 30567
Salt Lake City, UT 84130-0567

Deadlines to submit claims:

- Medicare Advantage (aka Part C) (medical) claims - within 12 months of the date you received the service, item, or Part B drug.
- Part D (prescription drug) claims - within 36 months of the date you received the service, item, or drug.
- Dental claims - within 12 months of the date you received the service or item.

CHANGING COVERAGE DUE TO A QUALIFIED LIFE EVENT

The following information applies to coverage under the Plan until you reach age 65 or otherwise become Medicare-eligible.

Generally, you cannot change your coverage during the plan year. However, in the case of certain events that affect a family's benefits options or needs, the Plan allows you to make certain limited changes. These changes must be consistent with the qualified life event and are subject to dependent eligibility provisions under the Plan.

As of January 1, 2005, IBM changed the eligibility requirements for retirees who enroll dependents in IBM medical, dental and vision coverage. These requirements may affect your ability to make a change during the year. Refer to the "*Eligibility*" section for details.

Examples of qualified life events for which the Personal Benefits Program allows a change are:

- Certain eligible changes in marital status
- Death of your eligible spouse/domestic partner or dependent
- Gain or loss of other coverage

You Must Request Your Change within 60 Days

If you have a qualified life event during the plan year, you must call the IBM Benefits Center – Provided by Fidelity to make eligible changes to your coverage within 60 days of the date of the qualified life event. Otherwise, you will not be able to make changes until the next Annual Enrollment period and your changes will not take effect until the next plan year. If you make your change within 60 days of the event, Plan changes are generally effective on the first of the month following your request. Please note, you can make changes online during the first 30 days, but must call the IBM Benefits Center during the last 30 days to make any changes.

Changing a Family Member's Eligibility Status

You must call the IBM Benefits Center within 60 days of any event that causes an enrolled family member to become ineligible for coverage under the provisions of the Plan (for example, your child marries). The individual losing coverage may be eligible to elect continuation coverage under COBRA.

Qualified Life Events At A Glance

The following chart shows some of the more common events for which you can make changes in coverage.

Event	Medical/Dental/Vision
Add an Eligible Dependent Applies only to dependents who met eligibility requirements *before* your retirement date or January 1, 2005.	May increase coverage category. May not change plan options.
Lose a Dependent ▪ Divorce ▪ Death ▪ Dependent loses eligibility ▪ Termination of domestic partnership	May decrease coverage category. May not change options (see medical and dental "No Coverage" options for exceptions).
Spouse/Domestic Partner Loses or Gains Health & Welfare Coverage Elsewhere Applies only to spouses/domestic partners who met eligibility requirements *before* your retirement date.	May increase coverage category. May elect medical and dental coverage if you previously waived coverage and were covered by your spouse/domestic partner.
Move Out of the HMO Service Area	May not change coverage category.

Events that Do Not Count as Qualified Life Events

Only events that are considered qualified life events permit you to make certain changes to your benefits during the year. The following events do not qualify as qualified life events:

- A mistake in enrollment, such as selection of the wrong plan
- Attaining an annual or lifetime maximum during the plan year
- Your physician or hospital does not participate or stops participating in the plan's network

If You Change Medical Options During or After the Plan Year

If you experience a qualified life event and change your medical plan options during the year, amounts accrued toward satisfying your prior option's annual deductibles and out-of-pocket maximums for that year will be applied toward satisfying the new option's annual deductibles and out-of-pocket maximums — but only up to the amounts of the deductible and out-of-pocket maximum of the plan option in which you have newly enrolled. Excess amounts will not be reimbursed. If you are enrolled in a plan option with an annual benefit maximum on prescription drugs and change to another plan option with an annual benefit maximum, amounts accrued toward meeting the annual benefit maximum will be applied toward satisfying the new plan option's annual benefit maximum.

You must notify the administrator of your plan option for your new option directly to receive any applicable credits. You will be asked to provide a copy of the latest Explanation of Benefits statement from the prior administrator of your plan option. (If you and your spouse are both eligible for IBM coverage in your own right, and as a result of a qualified life event, you change your enrollment from being primary to being a dependent of your spouse, deductibles and out-of-pocket maximums are not transferable.) There will be no carryover of credits against deductibles from one plan year to another. Changing from one medical plan option administered by an administrator to another medical plan option administered by the same administrator generally does not reduce or reset the cumulative benefit amounts that were incurred against a medical plan option's lifetime maximums.

If you leave a medical plan option which does not have a deductible and change to a medical plan option that has a deductible, you must meet the new plan's deductible before you become eligible to receive benefits. Alternatively, if you leave a medical plan option where you have accumulated amounts toward or have met the deductible and change to a plan that does not have a deductible, there is no deductible transfer or credit.

For more details about qualified life events, call the IBM Benefits Center – Provided by Fidelity or, for Medicare-eligible participants, call the IBM Retiree Call Center administered by UnitedHealthcare.

COORDINATING COVERAGE

IBM Couples

If you and your spouse/domestic partner are both eligible to participate in the Plan (and are not Medicare-eligible), you must choose each plan year whether to enroll for individual coverage separately or as an eligible family member under the other's coverage, and under which IBM Plan (active or retiree plan) where applicable.

Because of the special federal and/or state tax consequences for same-sex spouse/domestic partner benefits, you should consider the financial effects of your enrollment decisions. Please see the "*Domestic Partner Information Guide,"* available on NetBenefits.

As an IBM couple, you can enroll for coverage in one of two ways:

- You and your spouse/domestic partner can enroll individually, and each of you can choose your own options. However, each of you will pay your own contributions and will need to satisfy separate deductibles and out-of-pocket maximums based on the options you choose. Eligible family members may be covered by you or your spouse/domestic partner. An employee or retiree can enroll:
  - All dependent children together under one employee or retiree, or
  - Split the children between each employee or retiree parent.

Enrollment does not have to be the same for medical, dental and vision — different combinations of enrollment can be used; however, the children can never be enrolled twice.

- One of you can enroll for coverage as a plan participant and cover the other as a family member, along with any eligible children. The IBM spouse/domestic partner who is covered as a family member would elect no coverage.

No Duplicate IBM Coverage

A person who has IBM medical, dental or vision coverage in one capacity will not have further IBM coverage under the same or any other IBM-sponsored medical, dental or vision benefits Plan in any other capacity. For example:

- A person covered by the Active Medical Plan will not also be covered by the Plan.
- A person covered as the spouse/domestic partner of an IBM employee or retiree will not also be covered as the surviving spouse or as the surviving domestic partner of a deceased IBM employee or retiree.
- A person covered as an eligible dependent child of one IBM parent will not also be covered as an eligible dependent child of the other IBM parent.
- A person who has coverage as an eligible dependent child of a parent will not also be covered as an eligible dependent child of a stepparent, or as an eligible surviving child of a deceased parent.

As explained previously under *IBM Couples*, special rules apply in the case of spouses/domestic partners who each have individual IBM coverage in their own right (that is, on account of being an active, inactive or retired IBM employee, or an MDIP or LTD benefits recipient). Neither will have secondary IBM coverage as the spouse/domestic partner of the other. Likewise, there is no duplication of Plan maximums. Charges will only be eligible under and applied to the primary participant's maximums.

If you have a qualified life event and change your enrollment from being primary to being a dependent of your spouse/domestic partner, deductibles and out-of-pocket maximums do not transfer even if you stay in the same Plan option.

Coverage for Medicare-Eligible Dependents or Non-Medicare-Eligible Dependents

The following charts show when the Plan pays primary over Medicare, when Medicare pays primary over the Plan for your Medicare-eligible and non-Medicare-eligible dependents, along with the type of coverage for your non-Medicare-eligible dependents, as applicable.

The information in these charts apply to your (and your dependent's) coverage as:

- A non-Medicare-eligible retiree (with dependents*) or
- A non-Medicare-eligible dependent* of a Medicare-eligible retiree.

* If there are more than one non-Medicare-eligible dependents for the same Medicare-eligible retiree, they will all be enrolled as a family, with one individual (spouse or oldest child) designated as the primary enrollee.

("Primary" means that the plan determines its benefit payment amounts for the particular beneficiary without regard to the other coverage the person also has. If a plan takes into account the amount of another plan's benefit in calculating its own benefit, that plan is said to be "secondary" relative to the other plan.)

	Type of Coverage			
	Medicare-Eligible Dependents		**Non-Medicare-Eligible Dependents**	
	Medical Services	**Prescription Drugs**	**Medical Services**	**Prescription Drugs**
IBM Low Deductible PPO	Secondary coverage, after Medicare	Primary coverage	Primary coverage	Primary coverage
IBM Medium Deductible PPO	Secondary coverage, after Medicare	Primary coverage	Primary coverage	Primary coverage
IBM High Deductible PPO	Secondary coverage, after Medicare	Primary coverage	Primary coverage	Primary coverage
IBM High Deductible PPO with Health Savings Account	Secondary coverage, after Medicare	Primary coverage	Primary coverage	Primary coverage
IBM EPO	Secondary coverage, after Medicare	Primary coverage	Primary coverage	Primary coverage
Typical HMO	No Coverage	No Coverage	Primary Coverage	Primary coverage

If You or a Family Member Have Additional Coverage (other than Medicare)

If you or an eligible family member have other group coverage in addition to IBM group coverage, IBM medical and dental benefits will be coordinated with the other coverage to avoid duplication of payment. When the Plan's responsibility for benefits is secondary to that of the other coverage, the Plan will not pay a benefit for an eligible expense until the other coverage has paid, and the IBM benefit amount which would normally apply will be reduced by the amount the other coverage paid.

It is your responsibility to keep your other coverage information current by promptly reporting changes to the health plan you are enrolled in. It is your responsibility to provide updates to your other health coverage information. If you do not respond to a request(s) by your health plan to update your other coverage information, your claims may be denied until the plan receives your information.

Some providers give a discount when the Plan has primary responsibility for payment. If you use one of these providers, the IBM benefit will be calculated using the discounted price, even if in your case the Plan was not primary and you therefore did not receive the discount.

For Medicare-eligible dependents of non-Medicare-eligible retirees, in order to receive the highest level of reimbursement, the facility/provider must accept Medicare and be in your plan's network.

If Original Medicare is your primary coverage you must use providers and facilities that accept Medicare. When you obtain services, such as mental health and/or substance use services from a provider or facility that does not accept Medicare, those services are not eligible for any reimbursement under the Plan. Refer to "*Coordinating Plan Medical Coverage with Medicare*" in the "*Administrative Information*" section for more information about Coordination of Benefits with Medicare.

Even when Plan coverage is secondary, the Plan will not pay benefits for ineligible expenses, such as the difference between private room charges and semi-private room charges. Likewise, the Plan will not waive deductibles or out-of-pocket copayment requirements, even in situations where IBM coverage is secondary.

Coordinating Benefits with Another Health Plan (As Long As You Are Not a Medicare-Eligible Retiree)

If you or your eligible family members are covered by the Plan and by certain other types of group coverage, the IBM plans will coordinate your benefits with other health coverage. The plan that pays first depends on which plan is primary and which plan is secondary. The primary plan pays first. A plan without a Coordination of Benefits (COB) provision pays before a plan that has a COB provision. Generally, the Plan is primary for a covered retiree and secondary for a spouse who also is covered by his or her own employer's plan.

The primary plan for your covered eligible dependent children is determined by the birthday rule — the plan of the parent whose birthday occurs first during the calendar year pays first. For example, if you and your spouse are covered by different group plans and you each cover your dependent children and your birthday is in June and your spouse's birthday is in October, your plan is the primary plan for your children and your spouse's plan is the secondary plan. If both parents have the same birthday (based on month and day only), primary coverage is from the plan of the parent who has had coverage longer. See below for special rules if the child's parents are divorced or legally separated.

When filing claims, you should always file the claim with the primary plan first. If you are unsure which plan is primary and which is secondary, contact the IBM Benefits Center – Provided by Fidelity.

The Plan Is Primary to Another Plan When the Patient Has…

IBM Coverage as	And, the Other Coverage as
▪ A retired IBM employee, or an MDIP or LTD benefits recipient and is not Medicare-eligible. ▪ The eligible dependent child of his or her parent with the earlier birthday (based on month and day only).	▪ The eligible spouse/domestic partner or surviving spouse/surviving domestic partner of an employee of another employer. ▪ The eligible dependent child of his or her parent with the later birthday (based on month and day only).

The Plan Is Secondary to Another Plan When the Patient Has …

IBM Coverage as	And, the Other Coverage as
▪ The spouse/domestic partner of a retiree or of an MDIP or LTD benefits recipient and is eligible for Medicare (as long as the retiree is not eligible for Medicare). ▪ The eligible dependent child of his or her parent with the later birthday (based on month and day only). ▪ An MDIP, LTD benefits recipient. ▪ The spouse/domestic partner or eligible dependent child of an MDIP or LTD benefits recipient and is eligible for Medicare (as long as the retiree is not eligible for Medicare).	▪ An employee or retiree of another employer in their own right. ▪ The eligible dependent child of his or her parent with the earlier birthday (based on month and day only). ▪ An active employee of another employer. ▪ The spouse/domestic partner or eligible dependent child of an active employee of another employer.

Coordinating Benefits in the Situation of Divorce or Separation

If a child's natural parents are legally separated or divorced, and the child is covered under one employer's plan or retiree plan as the child of one natural parent and under another employer's plan or retiree plan as the child of the other natural parent or stepparent, (or, if both parents have coverage under the Plan), the order of responsibility for payment of benefits will be determined in accordance with the following rules:

- A court decree stating that the Plan or the IBM employee's or retiree's coverage is primary will not be controlling.
- If a court decree specifically designates one of the child's natural parents as having financial responsibility for the child, then the plan of the natural parent having financial responsibility for the child under the court decree is primary over the other natural parent's plan.
- If the court decree does not specifically designate one parent as having financial responsibility, or if the court decree provides for any form of joint or shared financial responsibility, then the plan of the natural parent with whom the child resides for the majority of the calendar year is primary. If custody is joint, and the child is not determined to reside with one parent for the majority of the calendar year, the plan of the natural parent with the earlier birthday (month and day only) is primary.
- The plan of a natural parent with custody of the child normally is primary over the plan of a stepparent married to that natural parent.
- The plan of a natural parent who is neither specifically designated in the court order as having financial responsibility nor has custody of the child, normally has last responsibility for benefits.

"Financial responsibility" means that the parent having financial responsibility for the child provides more than half of the child's financial support each year.

The Plan Does Not Coordinate When Benefits Are Provided from Other Sources

- Benefits will not be payable when charges for treatment of an illness or injury are compensable under a workers' compensation law.
- Benefits will not be payable when any of the charges for treatment of an illness or injury are provided for under federal, state or municipal laws or regulations other than Original Medicare or Medicaid.
- No benefits are payable when any of the charges for treatment of an illness or injury are provided in hospitals of the federal, state or municipal governments unless the amount charged would be payable by the individual irrespective of the existence of the Plan.
- If a child becomes a ward of the state, the child is no longer an eligible dependent, and benefits are not payable by the Plan.
- If payments are received from such other sources as described above after payment of benefits from the Plan, the Plan will expect reimbursement when the payment by the other source is made. Please refer to "Recovery Provisions."

PLAN COVERAGE AND MEDICAID

Effect of Medicaid on IBM Coverage

The Plan will enroll participants and eligible family members, and determine and pay benefits, without taking into account their receipt of, or eligibility for, medical assistance under a federally approved state Medicaid program. However, the Plan will honor:

- Any assignment of rights which was made by or on behalf of a participant or eligible family member if the assignment was legally required by a federally approved state Medicaid program.
- Any rights which a state has under state law to be reimbursed from benefits legally owed by the Plan for items or services for a participant or eligible family member, to the extent the state's Medicaid program has paid for those items or services.

Medicaid/State Child Health Insurance Plans (CHIP)

Eligible retirees and their eligible dependents are allowed to enroll in the Plan mid-year if:

- Their coverage is lost under their respective state Medicaid or CHIP; or
- They become eligible for premium assistance under their respective state Medicaid or CHIP.

If you are not already enrolled in the Plan when one of the above events occurs, you will be able to enroll yourself and your eligible dependent(s) within 60 days of the date of the event.

Coverage will be effective retroactive to the date of the loss of Medicaid or CHIP coverage or the date you become eligible for premium assistance under Medicaid or CHIP, as applicable.

Enrollment requests received later than 60 days after one of the above events will not be accepted. However, you will have an opportunity to enroll during the next Annual Enrollment period.

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed on the following page, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of March 3, 2026. Contact your State for more information on eligibility.

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since March 3, 2026, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 1/31/2026)

Special rules apply to covered retirees and their covered dependents who are enrolled in Medicaid or a state children's health insurance plan (CHIP) as well as the IBM health benefits plan. Generally, the IBM health benefits plan will be the primary payer and Medicaid or CHIP will be the secondary payer.

COORDINATING PLAN MEDICAL COVERAGE WITH MEDICARE

When you or a family member who is covered under the Plan become eligible for Medicare coverage (due to attainment of age 65 or disability), Medicare becomes an important part of your protection against medical expenses. It will also affect the plan options for which you are eligible.

The following participants will remain eligible for coverage under the Plan options for non-Medicare-eligible participants:

- Non- Medicare-eligible dependents of: Medicare-eligible IBM retirees, Medicare-eligible individuals receiving Medical Disability Income Plan (MDIP) and on IBM Long-Term Disability (LTD) leave status. The IB Plan will be primary for these non-Medicare-eligible participants.
- Medicare-eligible dependents of non-Medicare-eligible IBM retirees, non-Medicare-eligible individuals receiving Medical Disability Income Plan (MDIP) or on IBM Long-Term Disability (LTD) leave status. Medicare will be primary and the Plan will be secondary.

Understanding Medicare

Information about Medicare is available from your local Social Security office. It is important not to miss a deadline for applying for enrollment in Medicare. A late application may result in mandatory postponement of the start of coverage and higher premiums than would otherwise apply. The Medicare program and laws are subject to change. Also, the Medicare laws are quite complex and subject to government interpretation. You should consult your local Social Security office for more detailed or current information about Medicare.

Eligibility for Medicare

The federal government's Medicare Health Insurance ("Medicare") consists of three parts:

- Part A (Hospital Insurance) helps pay for inpatient hospital care, inpatient care in a skilled nursing facility, home health care and hospice care.
- Part B (Medical Insurance) helps pay for doctors' services, outpatient hospital services, durable medical equipment and a number of other medical services and supplies that are not covered by Part A of Medicare.
- Part D (Prescription Drug Insurance) helps pay for prescription drugs.

Generally, the following persons may be eligible for enrollment in Medicare (subject, in some cases, to a waiting period, limit on length of Medicare eligibility or other conditions):

- Persons age 65 or older.
- Persons who are, and for more than 24 months have been, eligible for disability income benefit payments under Social Security or railroad retirement. (Also, certain government employees and certain members of their families when they are disabled for more than 29 months.)
- Persons who, because of permanent kidney failure, have been receiving continuing dialysis or have had a kidney transplant.

Note: *If you and/or your eligible dependents become eligible for Medicare due to disability, you must contact the IBM Benefits Center – Provided by Fidelity directly and report the Medicare Part A and B effective dates. You must also be enrolled in Medicare Part A and Part B to be able to enroll in the IBM-sponsored Group Medicare Advantage plan options (if eligible).*

Enrollment in Medicare

If you are, or your spouse is, actively employed and you have coverage through an active group health plan, you do not have to enroll in Medicare until such time as employment ends. If you do choose to enroll in Medicare, then Medicare will be secondary to your active group health plan as long as you, or your spouse, are actively employed.

Once you retire, IBM requires all those who are eligible for Medicare and are covered under the Plan to enroll in Medicare Parts A and B as soon as they become eligible for Medicare on the basis of age or disability. Such Medicare coverage is considered primary over the Plan regardless of any other coverage you or your dependent may have.
During your retirement planning, you should call Social Security about enrollment in Medicare Parts A and B for you (and any Medicare-eligible dependents) and enroll as early as possible so your coverage will be effective when you retire. This will ensure you don't have a gap in coverage since your eligibility to enroll in plan options under the Plan will end when you retire and you may become eligible for an IBM premium subsidy or a Health Reimbursement Arrangement (HRA) subsidy if you enroll in an IBM-sponsored Group Medicare Advantage plan option administered by UnitedHealthcare.

You can enroll in coverage through UnitedHealthcare a few months before retiring with a future effective date when your Medicare becomes effective and you retire, as long as you are enrolled in Medicare Parts A and B. You will need to enroll before your intended coverage effective date, as all coverage takes effect on the first of the month after enrollment.

Enrollment in Medicare Parts A and B

Enrollment in Medicare Part A occurs automatically for some people who have been receiving monthly income benefits from Social Security before age 65, and you must accept and sign up for Medicare Part B. Anyone else will not be enrolled in Medicare unless he or she applies. If enrollment is not automatic in your case, it is important to enroll in a timely manner; otherwise, your coverage may be delayed, you may incur a surcharge on your Medicare monthly premiums as a penalty for late enrollment and you may have a gap in coverage. Contact Medicare directly at 800-MEDICARE (800-633-4227) with any questions you may have.

Enrollment in Medicare Part D (for Medicare-eligible Dependents of a Non-Medicare-eligible Retiree)

Enrollment in a Medicare Part D prescription drug plan is voluntary. IBM has determined that many plan options under the Plan are, on average for all Plan participants enrolled in that plan option, expected to pay out as much as the standard Medicare Part D prescription drug coverage will pay. (See "*IBM Notice of Creditable Coverage*" in this section for more information). The Plan will not coordinate with Medicare Part D plans, so you should not enroll in both a plan option under the Plan that provides prescription drug coverage and a Medicare Part D prescription drug plan. This is true even if you enroll in Medicare Parts A and B. See "*IBM Medicare Coverage and Medicare Part D* in *Coordination of Benefits with the IBM Plan and Medicare*" for more information concerning Part D coverage.

Again, if you enroll in a plan option under the Plan that offers Creditable Prescription Drug Coverage and a non-IBM Part D Plan, and CMS informs the Plan of the conflict in enrollment, the Plan will be forced to drop you from Prescription Drug coverage as Medicare rules do not permit dual enrollments in Part D plans. In addition, the efforts necessary to correct this situation will be the responsibility of the member since the Plan cannot intercede on your behalf with the other Plan.

Coordination of Benefits with the Plan and Medicare (for Medicare-eligible Dependents of a Non-Medicare-eligible Retiree)

If a person is enrolled in both a plan option under the IBM Retiree Plan and Medicare, the IBM Retiree Plan coverage is secondary to Medicare except where the Plan is legally required to provide primary coverage.

The IBM Retiree Plan is legally required to provide primary coverage if:

- The person is eligible for Plan coverage by virtue of his or her own current active employment status or
- The person is enrolled in the Plan as an eligible family member of a participant who is eligible for IBM Retiree Plan coverage by virtue of the participant's current active employment status.
- A person is enrolled in Medicare on the basis of permanent kidney failure unless the person has not been eligible for or entitled to Medicare on that basis for more than 30 months.

Under federal law, where an individual's Medicare coverage would be secondary to that of the IBM Retiree Plan because of the cases noted above, the individual can receive Medicare as primary coverage by specifically opting out of IBM Retiree Plan coverage. However, if the individual chooses to have Medicare as primary coverage, no secondary or supplementary coverage will be available for the individual under the IBM Retiree Plan.

The federal government has indicated an employee is considered to be in current employment status if the employee is working for the employer or is receiving payments from the employer which are subject to FICA tax.

The Balanced Budget Act of 1997 allows physicians or practitioners to sign "private contracts" with Medicare beneficiaries for which no claim can be submitted to Medicare by either the provider or beneficiary.

Services provided under "private contracts" are not covered by Medicare. If eligible individuals enroll in Medicare Part B, and choose to enter into a "private contract" arrangement with one or more providers, they have, in effect, "opted out" of Medicare for the services provided by these providers. No benefits will be paid by the IBM Plan for services rendered by providers with whom such "private contracts" have been made.

In addition, if a service is normally covered by Medicare, and is received from a provider who is not enrolled in the Medicare program, those services are not eligible for reimbursement under the Plan.

The following describes how Coordination of Benefits works under the Plan when Medicare is primary over the Plan.

Coordination of Benefits with the Plan when Medicare Is Primary (for Medicare-eligible Dependents of a Non-Medicare-Eligible Retiree)

Inpatient Hospital Services – Part A

Medicare currently pays the cost of covered hospital inpatient services (e.g., room and board, operating room, drugs) less the Medicare inpatient deductible.

Outpatient Hospital Services – Part B

If you receive outpatient services at a hospital, you are responsible for paying the facility after Medicare, as shown on the Medicare Summary Notice.

Prescription Drugs – Part D
IBM will not coordinate with Medicare Part D plans. If you enroll in both a plan option under the Plan that includes prescription drug coverage and a Medicare Part D plan, you should be aware that this may affect your IBM coverage.

IBM Medical Services – Part B (for Medicare-eligible Dependents of a Non-Medicare-Eligible Retiree)

In evaluating claims under Medicare Part B, Medicare approves only those amounts it considers reasonable for the specific treatment. In some cases, the amount considered reasonable by Medicare may be less than the amounts billed by physicians and suppliers. Where the physician or supplier charges more than Medicare's "approved" amount, Medicare pays 80% of the "reasonable" or "approved" amount only (after satisfaction of the Medicare deductible), not 80% of the actual charge.

Physicians and suppliers may accept this approved amount as payment in full, which is commonly known as "accepting assignment." The employee or retiree is still responsible for the annual Medicare deductible and the appropriate copayment portion of the approved amount. To protect patients from high charges, Medicare imposes an upper limit, called the "limiting charge," on how much a physician or a supplier can charge when the patient is a Medicare beneficiary and the provider does not accept assignment.

Deductibles
When an individual is covered by Original Medicare Part B insurance and Medicare is primary, Medicare-eligible charges are subject to the Original Medicare Part B deductible. Charges for medical and surgical services are also subject to the Plan's applicable annual deductible.

Medical Services with Medicare
Generally, Original Medicare pays 80% of what Medicare determines to be the "reasonable" fees (Medicare approved amount) after satisfaction of the Original Medicare Part B deductible. As secondary payer, the Plan will coordinate benefits with Medicare, up to a maximum of Medicare's approved amount or the 15% "limiting charge" under the Plan, after satisfaction of the annual deductible.

If the doctor accepts assignment, Medicare will have paid 80% of the approved amount and no additional reimbursement will be made by the Plan until you reach your out-of-pocket maximum. At that time, IBM will reimburse 100% of the difference between Medicare's payment and Medicare's coinsurance.

If the doctor does not accept assignment, the Plan will reimburse 80% of the Medicare "limiting charge" or 100% if the annual out-of-pocket maximum is reached.

In cases where the provider does not accept Medicare assignment, the Plan will pay 80% (or 100% if the annual out-of-pocket maximum is reached) of the difference between Medicare's "limiting charge" and the amount approved by Medicare.

Reimbursement for Prescription Drugs
The IBM Managed Pharmacy Program will pay benefits for eligible prescription drug charges which are also covered by Medicare (but not by a Medicare Part D plan), such as diabetic supplies and chemotherapy drugs. Benefits will be paid at the reimbursement rates based on the medical option you have chosen.

Coordination of Benefits for Prescription Drugs (for Medicare-eligible Dependents of a Non-Medicare-eligible Retiree)

CVS Caremark does not coordinate benefits with Medicare or Medigap plans. If you have coverage under a Medigap Plan and under a plan option under the Plan that includes prescription drug coverage, and a Medigap Plan reimbursement check is forwarded to CVS Caremark, the check will be returned to the Medigap Plan which is responsible for reimbursing the member. It is also important to note that the member is responsible for paying the coinsurance amount up front at the time the mail service order is placed and then working with the Medigap Plan for reimbursement.

Medicare Part B Premium Reimbursement for Pre-1991 Retirees (for Medicare-Eligible Dependents of a Non-Medicare-Eligible Retiree)

Individuals who retired on or before December 31, 1990 (and their Medicare Part B-enrolled eligible dependents) and who qualify for Medicare on the basis of age or due to disability, are eligible for reimbursement of the first $24.80 per person of the standard monthly Medicare Part B premium in their monthly pension or separate check if not receiving a pension.

A one-time enrollment application must be completed and submitted to the IBM Benefits Center to receive the $24.80 ($18.60 for part-time retirees). The balance, up to the full standard monthly Medicare Part B premium, is eligible for reimbursement at 80% through IBM's Special Health Assistance Provision (SHAP). The maximum annual family Medicare Part B premium reimbursement is $900 ($675 for part-time) which includes the amount reimbursed in your pension plus any balance claimed under SHAP. Please note, if you prefer to opt out of this reimbursement, you must contact Acclaris to do so.

The Medicare Part B premium reimbursement is not taxable income.

If you or your eligible dependents are receiving Medicare Part B premium assistance from another source, IBM will deduct the amount you are receiving from what IBM would pay if you were not receiving other reimbursement.

Medicare Part B Premium Assistance for Pre-1997 Retirees

For employees who retired before 1997 (and eligible dependents), and for participants who are Medicare-eligible due to disability, IBM provides financial assistance toward the standard monthly premiums for Medicare Part B premiums, if the participant is enrolled in Medicare and if Medicare's coverage is primary over Plan coverage for that participant.

Special Health Assistance Provision (SHAP)

This provision is available to pre-1997 Medicare-eligible retirees and participants under age 65 who are enrolled in Medicare due to disability. IBM reimburses 80% of the standard Medicare B premiums up to the annual maximum benefit of $900 per family. If you retired as a regular part-time employee, your maximum annual reimbursement is $675. There is no annual deductible and benefits are not subject to a lifetime maximum. Medicare Part B reimbursements through SHAP are available on a quarterly basis only and you must submit your claims after the quarter is completed. If Medicare charges you an excess premium for late Medicare enrollment, the excess premium is not reimbursable, nor is the income related premium. Retirees and their eligible dependents do not have to be enrolled in the Plan for SHAP eligibility.

Individuals who retire after December 31, 1996 (and their eligible family members) and qualify for Medicare on the basis of age are not eligible for SHAP. However, IBM will provide financial assistance of up to $900 per family toward the cost of Medicare Part B premiums through SHAP when an employee or retiree under age 65, or an eligible dependent of an employee or retiree under age 65, is covered under Medicare on the basis of disability and Medicare is primary over the Plan. Eligibility ends at age 65.

Note: *Employees receiving benefits under the IBM Medical Disability Income Plan or IBM Long-Term Disability Plan with a disability effective date before December 31, 1996, will continue SHAP eligibility when their status changes to IBM retiree.*

The administrator for SHAP is Acclaris. (See the "*Contacts*" section for contact information.)

SHAP claims must be submitted no more frequently than quarterly and after the quarter is completed. Claims must be received by the contract administrator no later than December 31st of the year following the year in which the Medicare Part B premium expense was incurred.

The SHAP reimbursement is not taxable income.

Medicare "Carve Out" (for Medicare-eligible Dependents of a Non-Medicare-eligible Retiree)

If an eligible patient fails to enroll in Medicare Part A or Part B and if, under Plan rules or applicable law, Medicare Part A or Part B would have been primary to the Plan, the Plan will pay benefits based on a "carve out" methodology for any treatment, service, supply or equipment that is covered by Medicare and rendered, performed or supplied in the United States by a provider located in the United States.

In effect, the otherwise applicable Plan benefit amount will be reduced by an amount that the Plan assumes Medicare Part A or Part B would have paid had the patient enrolled in Medicare Part A or Part B. The assumed amount will be calculated by subtracting the appropriate Medicare deductible(s) and co-payment amounts (as published in the relevant edition of the United States Department of Health and Human Services' Medicare Handbook) from the provider's actual charge for the treatment, service, supply or equipment.

The Medicare "carve out" does not apply to individuals who are enrolled in Medicare Part B but choose to "opt out" of Medicare coverage by entering into private contract arrangements with one or more providers. In these cases, no benefits will be payable by the Plan for services rendered by providers with whom such "private contracts" have been made.

Services provided by a provider who is not enrolled in the Medicare program are not eligible for reimbursement under the Plan.

To protect your coverage under the Plan, information given to you by the Social Security Administration, or other employers, concerning Medicare enrollment as it applies to your IBM coverage (particularly if this information conflicts with IBM's information) should be verified with IBM.

IBM Notice of Creditable Coverage

All of the medical options under the Plan are reviewed annually to determine if they do or do not provide creditable coverage. Creditable coverage means that the medical plan option, on average for all participants, is expected to pay out as much as the standard Medicare prescription drug coverage will pay.

The "*IBM Notice of Creditable Coverage"* is mailed to you annually and can also be found on NetBenefits in the Health and Insurance Reference Library. You can also request a copy by calling the IBM Benefits Center. You should consult that document to determine the status of your specific plan option under the Plan.

If you are eligible for Medicare but do not enroll in Medicare prescription drug coverage right away but decide to enroll in a Medicare prescription drug plan at a future time, you will not pay a higher premium penalty if you have evidence that you were enrolled in a plan with Creditable Coverage while you were Medicare-eligible.

OVERPAYMENT OF BENEFITS

The Claims Administrator will determine in its sole discretion whether an overpayment has been made to a participant or on a participant's behalf. An overpayment described in this section may occur for any reason, including because of fraud against the plan or because of a mistake made by the Claims Administrator.

If a benefit payment is made by the Plan, to you, or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right to require the return of the overpayment. The Plan has the right to reduce, by the amount of the overpayment, any future benefit payment made to, or on behalf of, a Participant in the Plan.

IF YOU RECEIVE AN OVERPAYMENT OF BENEFITS

It is your responsibility to reimburse the Plan if you and/or your covered family members receive an IBM benefit payment to which you (or they) are not entitled — for example, because of an administrative error, dental or health plan processing error, Workers' Compensation payments, payment from another benefit plan, Medicare or other source primary over the IBM coverage (e.g., automobile insurance or proceeds from litigation). If such an overpayment occurs for any reason, you are obligated to reimburse the IBM Plan for the amount of the overpayment.

Failure to reimburse IBM may result in any or all of the following actions: Collection measures by IBM and/or a debt collector, application of all or any portion of an overpayment toward satisfaction of other claims for benefits, loss of eligibility under the IBM Plans, termination of IBM employment, civil litigation and criminal prosecution. See "*Recovery Provisions" on the following page* for more information.

If a Third Party Receives an Overpayment of Benefits

If the Claims Administrator, in its discretion, paid benefits on behalf of a participant directly to a provider, the Claims Administrator may recover an overpayment that the Plan makes to such provider on such participant's behalf by reducing future payments to the provider by the amount of the overpayment. These future payments may be benefits payable to such participant, to other participants in this Plan, or to participants in other health plans that are administered by the Claims Administrator. If these future payments are benefits payable to participants under a health plan other than this Plan, the Claims Administrator will credit this Plan with the amount of the future payments that such other health plan makes. However, the Claims Administrator will not offset future payments that it would otherwise make to a provider on behalf of a participant in another plan by an overpayment the Claims Administrator has made to the provider under the Plan unless the provider has affirmatively consented in writing to repay overpayments through offsets and agreed not to attempt to recover such offsets from affected participants through balance billing or otherwise.

Conversely, if the Claims Administrator determines in its sole discretion that a self-insured health plan that the Claims Administrator administers, other than this Plan, has overpaid a provider, the Claims Administrator has the right to reduce, by the amount of such overpayment, any future payments that the Claims Administrator would otherwise make to such provider on behalf of a participant in this Plan. In this situation, the Claims Administrator credits the other self-insured health plan that previously overpaid the provider with the amount of the future payments that this Plan makes on behalf of participants in this Plan. However, the Claims Administrator will not offset future payments that it would otherwise make to a provider on behalf of a Participant in the Plan by an overpayment the Claims Administrator has made to the provider under another plan unless the provider has affirmatively consented in writing to repay overpayments through offsets and agreed not to attempt to recover such offsets from affected participants through balance billing or otherwise.

THIS RIGHT DOES NOT AFFECT ANY OTHER RIGHT OF RECOVERY THE PLAN MAY HAVE WITH RESPECT TO OVERPAYMENTS

RECOVERY PROVISIONS

Benefits under the Plan are coordinated not only with other group and benefit plans and individual insurance coverage, but also with other sources of payment. “Other sources of payment” include, but are not limited to, automobile insurance, awards, judgments or settlements in connection with tort claims, malpractice claims, product liability claims or contract claims, regardless of whether any portion of the award, judgment or settlement is specifically allocated or attributed to health or medical care expenses. Plan coverage is secondary, to the fullest legally permissible extent, to such other sources of payment. If you or your covered dependent have a claim for benefits under an auto insurance policy or health insurance policy, you or the covered dependent should submit a claim under that policy before submitting a claim under the Plan.

If payment(s) from the other source(s) plus payment(s) by the Plan exceed 100% of the medical expense incurred, the excess is an overpayment of Plan benefits and is subject to the provisions of this section. You or the covered dependent or the legal representatives, estate or heirs of you or the covered dependent, shall promptly reimburse to the Plan from any settlement, verdict or insurance proceeds received by you or the covered dependent (or by their legal representatives, estate or heirs), the amount of such overpayment.

In order to secure the rights of the Plan under this section, you or the covered dependent hereby: (1) grants to the Plan a first priority equity lien against the proceeds of any such settlement, verdict or other amounts received by you or the covered dependent; (2) assigns to the Plan any benefits you or the covered dependent may have under any automobile policy or other coverage, to the extent of the Plan’s claim for reimbursement; and (3) holds any payment received from a third party arising from an illness, injury, or condition, whether recovered through a settlement, judgment, or otherwise, in a constructive trust for the benefit of the Plan, until the Plan releases its rights to the funds. You or the covered dependent (or his or her legal representatives, heirs or estate) will sign and deliver, at the request of the Plan or its agents, any documents needed to protect such lien or to make such assignment of benefits.

The Plan is entitled to full reimbursement of its overpayment on a first-dollar basis from any third party payments (before subtraction of attorneys' fees and other expenses), even if payment to the Plan results in a recovery to you or the covered dependent that is insufficient to make him whole (i.e., the "make whole" and "common fund" doctrines do not apply). In addition, the Plan is entitled to full recovery regardless of whether any liability for the payment is admitted by the third party and regardless of whether the settlement or judgment received by you or the covered dependent identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only.

You or the covered dependent will cooperate with the Plan and its agents and will sign and deliver any documents the Plan or its agents reasonably request to protect the Plan's right of reimbursement, provide any relevant information and take such actions as the Plan or its agents reasonably request to assist the Plan in making a full recovery of the amount of the overpayment described previously. You or the covered dependent will not take any action that prejudices the Plan's right of reimbursement.

The Plan will be responsible for only those legal fees and expenses to which it agrees in writing. If the Plan must institute legal action against you or the covered dependent to recover the overpayment, you or the covered dependent will be liable for all costs of collection, including reasonable attorney's fees.

When another party is, or may be considered, liable for your or the covered dependent's injury, sickness or other condition (including insurance carriers who are so liable) for which the Plan has made an overpayment as described above, the Plan is subrogated to all of the rights of you or the covered dependent against any party liable for your or the covered dependent's injury or illness or for the payment for the medical treatment of such injury or occupational illness (including any insurance carrier), to the extent of the overpayment. The Plan may assert this right independently of you or the covered dependent.

You or the covered dependent are obligated to cooperate with the Plan and its agents in order to protect the Plan's subrogation rights. Cooperation means providing the Plan or its agents with any relevant information requested by them, signing and delivering such documents as the Plan or its agents reasonably request to secure the Plan's subrogation claim and obtaining the consent of the Plan or its agents before releasing any party from liability for payment of medical expenses.

If you or the covered dependent enters into litigation or settlement negotiations regarding the obligations of other parties, you or the covered dependent must not prejudice, in any way, the subrogation rights of the Plan under this section.

WHEN COVERAGE ENDS

Coverage generally terminates when you or a covered family member cease to satisfy the eligibility criteria for the Plan. Coverage ends on the last day of the month in which either of you request that your coverage be canceled or an individual loses eligibility for coverage — for example, you divorce, or your child reaches age 19 or age 23, as applicable, marries, commences full-time employment or otherwise ceases to meet the criteria for eligible dependent status.

Expenses incurred after the time coverage ceases are not eligible for benefits. There are alternatives available to you, your spouse/domestic partner or your eligible family members for continuing coverage after eligibility ends under the Plan, under COBRA continuation coverage (COBRA), as described in the following section.

COBRA CONTINUATION COVERAGE

To continue coverage under the Plan, you have the option to purchase continuation coverage for a limited time (generally up to 18 months or up to 36 months depending on the event that caused termination of benefits) at group rates through the *Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA*. COBRA continuation coverage is a temporary continuation of health care coverage when coverage would end because of a life event, known as a "qualifying event."

Qualified Beneficiaries

COBRA continuation coverage must be offered to each "qualified beneficiary." A qualified beneficiary is any individual who, on the day before the qualifying event, is covered under the Plan because he or she is a covered retiree or dependent of a covered retiree. You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Qualified beneficiaries also include any children born to you or placed for adoption with you during the COBRA continuation coverage period.

You may be able to purchase COBRA if:

- Your employment terminates (including retirement) other than for gross misconduct.
- You experience a substantial elimination of coverage under the Plan within 12 months before or after the date that IBM commences a bankruptcy proceeding under Title 11 of the United States Code. You must have retired on or before the date of the substantial elimination of coverage under the Plan.
- Your dependents are qualified to purchase COBRA if they lose coverage under Plan for any of the following reasons:
  - You and your spouse divorce.
  - Your child loses eligible dependent child status (e.g., due to age, marriage or full-time employment).
  - Your dependents experience a substantial elimination of coverage under the IBM group administrator of your plan option(s) within 12 months before or after the date that IBM commences a bankruptcy proceeding under Title 11 of the United States Code. Your dependents must have been enrolled under the Plan on the day before the bankruptcy qualifying event.
  - Your death.

If you are Medicare-eligible, Medicare will become your primary coverage. If you enroll in COBRA coverage under the IBM medical plan for active employees upon termination of employment with IBM, COBRA coverage will be secondary.

Once you become a Medicare-eligible retiree, you will have the option of dropping COBRA continuation coverage and enrolling in available plan options. You can also choose to continue COBRA coverage until it ends.

Domestic Partners
Although not legally required to do so, IBM has decided to make continuation coverage available for purchase by a former domestic partner. The same rules (for example, the rules regarding notification of qualifying events and election of continuation coverage) apply for a spouse.

When Continuation Coverage Is Available
The Plan offers continuation coverage to qualified beneficiaries through COBRA *only after* the COBRA administrator has been notified that a qualifying event has occurred.

Notification of Qualifying Events
When the qualifying event is the employer's commencement of a Title 11 bankruptcy proceeding, the employer must notify the COBRA administrator of the qualifying event.

The retiree, qualified beneficiary or representative must notify the COBRA administrator by calling a service representative at the IBM Benefits Center when the qualifying event is:

- Divorce of the covered employee and his or her spouse.
- Dependent child losing eligible dependent child status.

Timing of Notification of a Qualifying Event
With respect to divorce and a child losing eligible dependent child status, the covered employee (retiree), qualified beneficiary or representative must notify the COBRA administrator within 60 days from the later of:

- The date of the qualifying event or
- The date that the qualified beneficiary loses (or would lose) coverage as a result of the qualifying event.

If notification of the qualifying event is not provided within the time period set out above, the individual affected will lose his or her right to COBRA continuation coverage. The individual affected will not be able to enroll in COBRA coverage and will be responsible for all health care expenses incurred after medical coverage ends.

How to Elect COBRA Continuation Coverage
The time for enrolling in COBRA continuation coverage expires 60 days after the date of the official COBRA notification from the IBM Benefits Center or 60 days after the individual's IBM coverage ceases, whichever is later.

To enroll in COBRA continuation coverage, log on to NetBenefits or call the IBM Benefits Center – Provided by Fidelity. The election can be changed or revoked until the election period expires.

If COBRA continuation coverage is not elected within the time period set out above, the individual affected will lose his or her right to COBRA continuation coverage. The individual affected will not be able to enroll in COBRA and will be responsible for all health care expenses incurred after medical coverage ends.

No physical examination or other evidence of insurability is required to enroll in COBRA coverage.

How COBRA Continuation Coverage Is Offered

After the COBRA administrator receives notice that a qualifying event has occurred, COBRA continuation coverage is offered to each qualified beneficiary. The COBRA administrator provides a COBRA enrollment notice by mail within 14 days after receiving notice of the qualifying event and each qualified beneficiary has an independent right to elect COBRA continuation coverage.

Covered retirees may elect COBRA continuation coverage on behalf of their spouses, and parents or legal guardians may elect COBRA continuation coverage on behalf of their children. In addition, the legal representative of an incapacitated participant may elect COBRA coverage on behalf of the incapacitated person. Any such election or rejection of coverage by a retiree, parent, legal guardian, or legal representative is binding on the person on whose behalf the election is made. It is critical that you (or anyone who may become a qualified beneficiary) maintain a current address with the COBRA administrator to ensure that you receive a COBRA enrollment notice following a qualifying event and to protect your family's rights.

Duration of COBRA Continuation Coverage

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

- The divorce of the covered retiree and his or her spouse.
- A dependent child losing eligible dependent child status.

COBRA Qualifying Events

Qualifying Event	Maximum Continuation Period		
	You	Your Spouse	Your Covered Children
You terminate employment for any reason, including retirement (except gross misconduct)	18 months	18 months	18 months
Your covered child loses eligible dependent child status	N/A	N/A	36 months
You and your spouse divorce	N/A	36 months	36 months
Your death	N/A	36 months	36 months
You enroll in Medicare and your spouse/dependents lose coverage under the IBM group health plan	N/A	36 months	36 months

Special COBRA continuation coverage periods apply to retired employees and their dependents if the plan sponsor declares bankruptcy under Title 11 of the United States Code, and the retired employees and their dependents lose substantial coverage within one year before or after the date that the bankrupt-cy proceedings commenced. Retired covered employees may continue their coverage until their death. For a spouse, surviving spouse or dependent child of the retired employee, coverage will end at the earlier of the qualified beneficiary's death or 36 months past the date of the death of the retired covered employee.

What COBRA Coverage Costs

COBRA participants who elect coverage must pay monthly premiums for this coverage. The cost of COBRA continuation coverage is 102% of the applicable premium for the plan(s) for the current plan year. Premiums are based on the full premium cost per covered person set at the beginning of the year, plus 2% for administrative costs.

Payment is due at enrollment, but there is a 60-day grace period from the date you elect COBRA continuation coverage to make the initial payment. The initial payment includes:

- Payments for coverage from the date of your loss of coverage through to the date you elect COBRA coverage and
- Any regularly scheduled monthly payment(s) that become(s) due between the date that you elected COBRA coverage and the end of the 60-day period.

Ongoing monthly payments are due on the first of each month, but there is a 30-day grace period (for example, June payment is due June 1st, but will be accepted if postmarked by June 30th). If payment is not received within this grace period, coverage will be terminated as of the end of the last month in which full payment was received. Please note payment must be submitted even if an invoice is not received.

Additional Information

If your dependent elects COBRA continuation coverage:

- Your dependent's coverage is effective as of the date of the qualifying event unless your dependent waives COBRA coverage and revokes the waiver within the 60-day election period. In this case, the elected coverage begins on the date your dependent revokes his or her waiver.
- Your dependent may change his or her coverage if your dependent has a qualified change in status or another change in circumstance recognized by the Internal Revenue Service (IRS) and the Plan.

When COBRA Coverage Ends

COBRA continuation coverage will end on the earliest of the following dates:

- The date the applicable period of COBRA continuation coverage is exhausted.
- The date that you, your spouse or any of your covered dependents (including any domestic partner or children of a domestic partner) become covered under another health benefits plan not offered by IBM, provided the plan does not have a legally valid pre-existing condition exclusion or limitation affecting the qualified beneficiary. If it does, COBRA coverage for that pre-existing condition continues as long as you pay the premium.
- The date that you or your covered dependent fails to make timely premium payments or contributions as required.
- The date IBM stops providing group health coverage to any employee.

Continuation coverage also may be terminated for any reason that the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

To voluntarily terminate COBRA coverage, you must call the IBM Benefits Center – Provided by Fidelity. The effective date will be the first of the month following the call.

If You Have Questions

If you have questions about COBRA, please call the IBM Benefits Center – Provided by Fidelity.

You may also write to:

IBM Benefits Center
COBRA Administration
P.O. Box 77003
Cincinnati, OH 45277-0065

For more information about your rights under the Employee Retirement Income Security Act of 1974 (ERISA), including COBRA, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other laws affecting group coverage, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and telephone numbers of Regional and District EBSA Offices are available through EBSA's website.

IBM Benefits Plan for Retired Employees

Medical Coverage

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Medical Coverage

ABOUT YOUR MEDICAL COVERAGE

IBM offers eligible retirees, and their eligible family members, medical benefits coverage through the Plan. No pre-existing condition exclusion applies to coverage under any of the Plan options.

Non-Medicare-Eligible Retirees

For non-Medicare-eligible retirees, all IBM medical options available to you provide comprehensive coverage for:

- Eligible medical services — including deductible-free in-network coverage for eligible preventive care. Other out-of-network services are generally not covered.
- Prescription drugs when purchased through CVS Caremark (mail order or retail) or through a pharmacy in the CVS Caremark network.
- Mental health/substance use care (out-of-network non-urgent residential and day rehabilitation services that are out of state or the immediate bordering state are generally not covered).
- Care management and Disease Management.

In addition, precertification is required for major diagnostic services such as the following outpatient, non-emergency major diagnostic services and procedures: CT/CTA Scan, MRI/MRA, PET scan, nuclear medicine, echocardiogram (including stress echocardiogram), sleep studies, cardiac catheterization, electrophysiology implants. Since the exact list of services varies by plan option, you or your physician should call the administrator of your plan option under the Plan for more information before any major diagnostic services, including those tests or procedures listed above, are scheduled.

Coverage for Your Eligible Family Members

Keep in mind that your covered spouse/domestic partner and other covered dependents must be enrolled in the same IBM retiree medical option that you elect — even if your eligibility for Medicare is different. For more information about coordinating your dependents' medical coverage, see *Coverage for Medicare-Eligible Dependents* in the "*Administrative Information*" section.

Medical Options for Non-Medicare-Eligible Retirees

OVERVIEW OF OPTIONS FOR NON-MEDICARE-ELIGIBLE RETIREES AND NON-MEDICARE-ELIGIBLE DEPENDENTS

IBM Low Deductible PPO

With the IBM Low Deductible PPO option, you pay a higher contribution rate in exchange for a lower annual deductible before the Plan pays for most eligible medical expenses. This option provides coverage for preventive and routine care, medical, surgical and hospitalization expenses, prescription drugs and mental health/substance use services. There is no primary care physician (PCP) requirement, and you may see any provider you choose without a referral. Generally, out-of-network coverage is only available for emergencies, mental health/substance use services and a few other approved exceptions. (See "*Out-of-Network Medical Coverage*" for more details.) If you choose to use an out-of-network provider (for services not detailed under "*Out-of-Network Medical Coverage*"), you must pay the full cost of the services you receive.

The IBM Low Deductible PPO option also includes coverage for prescription drugs under the IBM Managed Pharmacy Program. If your medical provider/facility provides a medication as part of an office visit, inpatient stay or outpatient procedure, this medication is covered under the medical benefit, subject to the medical plan's cost-sharing provisions.

Preventive services and preventive medications are covered at 100% when received from in-network providers. A service or medication is "preventive" if it is required as preventive services or medication by the Affordable Care Act for plans that are subject to ACA requirements.

IBM Medium Deductible PPO

With the IBM Medium Deductible PPO option, you pay a moderate contribution rate and a mid-range annual deductible before the Plan pays for most eligible medical expenses (eligible preventive and routine services do not require a deductible). This option provides coverage for preventive and routine care, medical, surgical and hospitalization expenses, prescription drugs and mental health/substance use services. There is no primary care physician (PCP) requirement, and you may see any provider you choose without a referral. Generally, out-of-network coverage is only available for emergencies, mental health/substance use services and a few other approved exceptions (see "*Out-of-Network Medical Coverage*" for more details.) If you choose to use a provider who does not participate in the network (for services other than those detailed under "*Out-of-Network Medical Coverage*"), you must pay the full cost of the services you receive.

The IBM Medium Deductible PPO option includes coverage for prescription drugs under the IBM Managed Pharmacy Program. There is an annual pharmacy benefit maximum (the amount paid by the IBM Plan) through the IBM Managed Pharmacy Program of $2,500.

If your medical provider/facility provides a medication as part of an office visit, inpatient stay or outpatient procedure, this medication is covered under the medical benefit, subject to the medical plan's cost-sharing provisions.

IBM High Deductible PPO

With the IBM High Deductible PPO option, you must meet a higher annual deductible before the Plan pays for most eligible medical expenses (eligible preventive and routine services do not require a deductible). This option provides coverage for preventive and routine care, medical, surgical and hospitalization expenses, prescription drugs and mental health/substance use services. There is no primary care physician (PCP) requirement, and you may see any provider you choose without a referral.

Generally, out-of-network coverage is only available for emergencies, mental health/substance use services and a few other approved exceptions (see "*Out-of-Network Medical Coverage*" for more details). If you choose to use a provider who does not participate in the network (other than for services detailed under "*Out-of-Network Medical Coverage*", you must pay the full cost of the services you receive.

The IBM High Deductible PPO option also includes coverage for prescription drugs under the IBM Managed Pharmacy Program. There is an annual pharmacy benefit maximum through the IBM Managed Pharmacy Program of $1,000.

If your medical provider/facility provides a medication as part of an office visit, inpatient stay or outpatient procedure, this medication is covered under the medical benefit, subject to the medical plan's cost-sharing provisions.

IBM Exclusive Provider Organization (EPO)

The IBM EPO option provides coverage for preventive and routine care, medical, surgical and hospitalization expenses, prescription drugs and mental health/substance use services. The IBM EPO is an "in-network" only option, which means benefits are payable only if participants seek care exclusively from eligible doctors, hospitals and other providers that belong to the health plan's provider network. There is no coverage for services received outside the network except in emergencies. There is no primary care physician (PCP) requirement, and you may see any network provider you choose without a referral. There is a small deductible, and there are fixed copayments for hospital outpatient surgery, emergency room visits and inpatient admissions for surgery or rehabilitation.

The IBM EPO option also includes coverage for prescription drugs under the IBM Managed Pharmacy Program. If your medical provider/facility provides a medication as part of an office visit, inpatient stay or outpatient procedure, this medication is covered under the medical benefit, subject to the medical plan's cost-sharing provisions.

Preventive services and preventive medications are covered at 100% when received from in-network providers. A service or medication is "preventive" if it is required as preventive services or medication by the Affordable Care Act for plans that are subject to ACA requirements.

IBM High Deductible PPO with HSA

The IBM High Deductible PPO with HSA option provides coverage for preventive and routine care, medical, surgical, mental health/substance use and hospitalization expenses, and prescription drugs. There is no primary care physician (PCP) requirement, and you may see any eligible provider you choose without a referral. You must meet the deductible before the Plan will provide medical, mental health/substance use or pharmacy benefits. Please note that the deductible and out-of-pocket maximum work differently with this plan option when more than one person is enrolled. The family deductible must be met before any family member is eligible to receive a benefit, and the family out-of-pocket maximum must be met before the Plan will pay 100% of the cost of eligible covered services for any covered family members. Generally, out-of-network coverage is only available in emergencies, for mental health/substance use services and a few other approved exceptions (see "*Out-of-Network Medical Coverage*" for more details). If you choose to use a provider who does not participate in the network (other than for services detailed under "*Out-of-Network Medical Coverage*"), you must pay the full cost of the services you receive.

Preventive services and preventive medications are covered at 100% when received from in-network providers. A service or medication is "preventive" if it is required as preventive services or medication by the Affordable Care Act for plans that are subject to ACA requirements.

The IBM High Deductible PPO with HSA includes coverage for prescription drugs under the IBM Managed Pharmacy Program. Prescription drugs (*except preventive medications*) are *subject to the annual deductible.* If your medical provider/facility provides a medication as part of an office visit, inpatient stay or outpatient procedure, this medication is covered under the medical benefit, subject to the medical plan's cost-sharing provisions. You pay 100% of the cost for all services and prescription drugs until you satisfy the annual deductible. If more than one person is enrolled, the entire family deductible must be met before anyone is eligible to receive a benefit. Preventive drugs are not subject to the deductible when the plan option has a Health Savings Account (HSA).

Health Savings Account (HSA)

The IBM High Deductible PPO with HSA option is a high deductible health plan that allows you to create and contribute to a tax-advantaged Health Savings Account (HSA). The HSA is not part of the IBM Plan. The HSA provides a savings mechanism for both current and future health care needs, as unused contributions accumulate over time and can be used for future medical expenses. The HSA is your personal account and unused balances remaining at the end of the plan year remain in your account. You own your HSA.

Note: *In order to make HSA contributions, you may not have other health coverage. For this purpose, "other health coverage" generally includes medical plans, flexible spending accounts (such as the IBM Health Care Spending Account), healthcare reimbursement arrangements, Medicaid and Medicare coverage. Other health coverage also includes coverage provided to you through your spouse's plan. For example, you would have impermissible other coverage (and you would not be eligible to contribute to an HSA) if your spouse enrolls in family coverage in a medical plan that is not a qualifying HDHP (unless your spouse's plan does not cover you); or your spouse enrolls in a general purpose flexible spending account that may be used to reimburse your expenses.*

Health Maintenance Organization (HMO)

An HMO is a managed care option. You generally use the HMO's providers for all of your care, and typically pay a flat dollar copayment or fee for each service. Generally, care is coordinated through a primary care physician who refers you to a specialist or hospital as needed. Depending on the

geographic area in which you live, you may have the choice of enrolling in an HMO for the plan year. Each year, before the Annual Enrollment period, eligible retirees will receive a list of HMOs offered under the Plan and available in their area. Retirees should contact the HMO's membership services department for detailed information on specific HMO benefits.

IBM's dependent eligibility pertains to all benefit plan options under the IBM Plan, including HMOs, and are not subject to any state laws mandating coverage for anyone not included in IBM's list of eligible dependents.
The HMOs offered through IBM are fully insured by the insurance company that maintains the HMO network. When you join an HMO, you are electing an alternative to IBM medical coverage and you are agreeing to obtain your coverage from that organization, not from an IBM Plan option. Claims, disputes and appeals are handled by the HMO. If you enroll in an HMO, you will receive a summary plan description (which may be referred to as a "*Group Service Agreement* "or "*Certificate of Coverage"*) directly from the HMO. If you don't receive one, contact the HMO to request a copy.

No Coverage

If you have medical coverage elsewhere (for example, under your spouse's plan), you can elect "No Coverage" for the plan year and pay no monthly contribution. If you elect this option, you will be required to confirm that you have other coverage when you enroll *and* you will not be able to request coverage from IBM once the plan year starts unless you lose the coverage you had elsewhere as a result of a qualified life event.

NON-MEDICARE-ELIGIBLE RETIREE OPTIONS AT A GLANCE

The chart below and on the following page provides an overview of the key features of the plan options under the Plan for non-Medicare-eligible retirees and what you pay for covered services. Information about the HMOs that are available to IBM retirees in certain geographic areas can be obtained directly from the HMO.

	IBM Low Deductible PPO (In-Network)	IBM Low Deductible PPO (Out-of-Network)**	IBM Medium Deductible PPO (In-Network)	IBM Medium Deductible PPO (Out-of-Network)**	IBM High Deductible PPO (In-Network)	IBM High Deductible PPO (Out-of-Network)**
Annual Deductible	Individual: $550 Family: $1,650[1] In- and out-of-network combined		Individual: $1,050 Family: $3,150[1] In- and out-of-network combined		Individual: $3,550 Family: $10,650[1] In- and out-of-network combined	
Annual Out-of-Pocket Maximum	Individual: $3,250 Family: $6,500[2] In- and out-of-network combined		Individual: $4,250 Family: $8,500[2] In- and out-of-network combined		Individual: $6,850 Family: $13,700[2] In- and out-of-network combined	
Annual Pharmacy Benefit Maximum	N/A		$2,500		$1,000	
Lifetime Benefit Maximum (per person)	Unlimited		Unlimited		Unlimited	
Routine Preventive Services	0%, no deductible	N/A	20%, no deductible	N/A	30%, no deductible	N/A

	IBM Low Deductible PPO (In-Network)	IBM Low Deductible PPO (Out-of-Network)**	IBM Medium Deductible PPO (In-Network)	IBM Medium Deductible PPO (Out-of-Network)**	IBM High Deductible PPO (In-Network)	IBM High Deductible PPO (Out-of-Network)**
Other Office Visits	20%, after deductible[6]	N/A	20%, after deductible[6]	N/A	30%, after deductible[6]	N/A
Lab Services	20%, after deductible	N/A	20%, after deductible	N/A	30%, after deductible	N/A
Hospitals and Surgery (Inpatient including maternity)	20%, after deductible[3, 4]	N/A	20%, after deductible[3, 4]	N/A	30%, after deductible[3, 4]	N/A
Hospitals and Surgery (Outpatient, including maternity)	20%, after deductible[4]	N/A	20%, after deductible[4]	N/A	30%, after deductible[4]	N/A
Emergency Room	20%, after in-network deductible	20%, after in-network deductible until member is medically able to be moved to an in-network facility. Once member can be moved, out-of-network expenses will no longer be covered.	20%, after in-network deductible	20%, after in-network deductible until member is medically able to be moved to an in-network facility. Once member can be moved, out-of-network expenses will no longer be covered.	30%, after in-network deductible	30%, after in-network deductible until member is medically able to be moved to an in-network facility. Once member can be moved, out-of-network expenses will no longer be covered.
Other Services (including x-rays, imaging, durable medical equipment (DME) and prosthetics)	20%, after deductible[5]	N/A	20%, after deductible[5]	N/A	30%, after deductible[5]	N/A

Note: *For out-of-area options, benefits for medical services will be paid at the in-network level for all IBM PPO options based on the amount billed (or the negotiated amount, if applicable). Mental health/substance use care will be paid at the in-network level if care is pre-certified and provided by an in-network provider (or other provider if there is no in-network provider at your location).*

1 Annual deductible applies to medical and mental health/substance use services combined.

2 Amount applied to your medical deductible will also be applied toward your annual out-of-pocket maximum. Prescription drug charges do not accumulate to your out-of-pocket maximum.

3 All inpatient care must be pre-certified or $150 penalty applies.

4 Transplant, bariatric, infertility and orthopedic services must be received at a Center of Excellence (COE) to receive the highest benefit level.

5 Other Services include imaging, X-rays, durable medical equipment (DME), prosthetics and lab services; precertification is required for non-emergency high-cost diagnostic services such as CT scans, MRIs, PET scans, sleep studies, and cardiac studies for the IBM Plan to pay a benefit.

6 All charges associated with surgical procedures performed in a physician's office are reimbursed at the physician's office visit coinsurance rate level.

	IBM EPO (In-Network Only)	IBM High Deductible PPO with HSA (In-Network)	IBM High Deductible PPO with HSA (Out-of-Network)**
Annual Deductible	Individual: $150 Family: $300[1]	Individual: $1,700 Family: $3,400[7] In-network and out-of-network deductible combined.	Individual: $1,700 Family: $3,400[7] In-network and out-of-network deductible combined.
Annual Out-of-Pocket Maximum	Individual: $3,950 Family: $7,100[2]	Individual: $5,300 Family: $7,950[8]	Individual: $5,300 Family: $7,950[8]
Lifetime Benefit Maximum (per person)	Unlimited	Unlimited	Unlimited
Annual Pharmacy Benefit Maximum	N/A	N/A	N/A
Routine Preventive Services	0%, no deductible Primary Care Physician (PCP) 0,% no deductible Specialty Care Physician (SCP)	0%, no deductible	N/A
Other Office Visits	20% after deductible Primary Care Physician (PCP)[8] 25% after deductible Specialty Care Physician (SCP)[8]	20%, after deductible[9]	N/A
Lab Services	20% after deductible	30%, after deductible	N/A
Hospitals and Surgery (Inpatient including maternity)	Inpatient: $370 copayment after deductible[3, 4, 5]	30%, after deductible[3, 4]	N/A
Hospitals and Surgery (Outpatient, including maternity)	Outpatient surgery: $185 copayment after deductible[2] Outpatient non-surgical: Facility charges 20% after deductible Professional fees: 20% Primary Care Physician (PCP) after deductible 25% Specialty Care Physician (SCP) after deductible[9]	30%, after deductible[9]	N/A
Emergency Room	100% after deductible and $80 emergency room copay	30%, after in-network deductible	30%, after in-network deductible until member is medically able to be moved to an in-network facility. Once member can be moved, out-of-network expenses will no longer be covered.
Other Services (including x-rays, imaging, durable medical equipment (DME) and prosthetics)	Labs: 20%, after deductible, X-ray, DME, other imaging: $0, after deductible[6]	30%, after deductible[6]	N/A

	IBM EPO (In-Network Only)	IBM High Deductible PPO with HSA (In-Network)	IBM High Deductible PPO with HSA (Out-of-Network)**

Note: *For out-of-area options, benefits for medical services will be paid at the in-network level for all IBM PPO options. Mental health/substance use care will be paid at the in-network level if care is pre-certified and provided by an in-network provider (or other provider if there is no in-network provider at your location).*

[1] Annual deductible applies to medical and mental health/substance use services combined.

[2] Amount applied to your medical deductible will also be applied toward your annual out-of-pocket maximum. Under the IBM EPO plan option, copayments for outpatient surgery, hospital inpatient and emergency room admissions and prescription drug charges do not accumulate to your out-of-pocket maximum.

[3] All inpatient care must be pre-certified or $150 penalty applies.

[4] Transplant, bariatric, infertility and orthopedic services must be received at a Center of Excellence (COE) to receive the highest benefit level.

[5] All emergency care is treated as in-network until individual is medically able to be moved to an in-network facility. Once individual is able to be moved, out-of-network coverage applies.

[6] Other Services include imaging, X-rays, durable medical equipment (DME), prosthetics and lab services; precertification is required for non-emergency high-cost diagnostic services such as CT scans, MRIs, PET scans, sleep studies, and cardiac studies for the IBM Plan to pay a benefit.

[7] Annual deductible applies to medical, mental health/substance use and prescription drugs (excluding preventive services/preventive drugs) in the IBM High Deductible PPO with HSA plan option. Combined deductible includes both in- and out-of-network eligible expenses. If you enroll in Family coverage under an HSA-eligible medical plan option, you must meet the family deductible before the plan begins to pay benefits. Individual deductibles do not apply.

[8] Amount applied to your medical deductible will also be applied toward your annual out-of-pocket maximum. Under the HSA plan option, prescription drug charges accumulate to the out-of-pocket maximum (except the penalty for purchasing a brand medication when a generic equivalent is available). If you enroll in Family coverage under an HSA-eligible medical plan option, you must meet the family out-of-pocket maximum before the plan begins to pay 100% of eligible expenses for any individual, the individual out-of-pocket maximum does not apply.

[9] All charges associated with surgical procedures performed in a physician's office are reimbursed at the physician's office visit coinsurance rate level.

IMPORTANT TERMS

- *Annual Benefit Maximum:* The maximum dollar amount or number of treatments that a plan (not you) will cover in a calendar year. If your expenses exceed the maximum, you will pay the rest. Different types of services may have individual annual maximums. There are separate annual benefit maximums for each covered family member.
- *Annual Deductible:* The annual deductible is the amount you must pay each calendar year before the Plan begins to pay benefits for covered medical, mental health and substance use expenses for you or your covered family members. There are two types of annual deductibles: individual and family. If more than one person is enrolled the family deductible must be met before the Plan begins to provide coverage. The annual deductible is applied to the out-of-pocket maximum. The annual deductible for health plans with an HSA also includes non-preventive prescription drug expenses.
- *Annual Out-of-Pocket Maximum:* The maximum amount you will pay for eligible medical, mental health/substance use and prescription drug expenses under your health plan in a calendar year. If more than one person is enrolled, the family out-of-pocket maximum must be met before the Plan pays 100% of eligible expenses for the rest of the plan year. When the annual out-of-pocket maximum is reached, if the annual deductible is not satisfied, it will be deemed to be satisfied.
- *Center of Excellence:* A medical facility recognized for delivering a best-in-class member experience for specific conditions, with more successful health outcomes.
- *Coinsurance:* Coinsurance is the amount of the medical, mental health or substance use expenses that you pay after you have met the annual deductible, expressed as a percentage of

the provider's negotiated fee or actual charge. Coinsurance amounts count toward your out-of-pocket maximum.

- *Copayment:* Copayment is the amount you pay for medical, mental health or substance use services or prescription drugs, expressed as a flat dollar amount.
- *Formulary:* A list of preferred prescription drugs reviewed and approved for clinical effectiveness by an independent panel of doctors and pharmacists at the organization providing the prescription drug coverage. If your drug is on the formulary, the plan will pay a greater benefit than for a drug that is not on the formulary.
- *Intensive outpatient treatment:* A structured outpatient mental health or substance-related and addictive disorders treatment program. The program may be freestanding or hospital-based and provides services for at least three hours per day, two or more days per week.
- *Lifetime Benefit Maximum:* The maximum amount a health plan will pay in benefits for an insured individual during that individual's lifetime.
- *Maximum Allowable Benefit:* The maximum amount the Plan will cover for pharmacy services (applies to the IBM Medium Deductible PPO and IBM High Deductible PPO plan options only).
- *Medicare-Eligible Dependent:* A Medicare-eligible dependent of a retiree who is eligible under the Plan.
- *Medicare-Eligible Retiree:* A former IBM employee who is eligible for Medicare.
- *Mental health care services:* Covered health care services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM TR-5).* The fact that a condition is listed in this publication does not mean that treatment for the condition is a covered health care service.
- *Out-of-Network Provider:* Sometimes referred to as a non-network provider or non-participating provider, these are doctors, hospitals, specialists, labs, retail pharmacies and other health care professionals or facilities that do not participate in your health plan's network. Generally, the Plan does not cover services provided by out-of-network providers.
- *Out-of-Pocket Costs:* The amount you pay with your own money for covered expenses. This includes deductibles, coinsurance and copayments.
- *Partial hospitalization/day treatment:* A structured ambulatory program. The program may be freestanding or hospital-based and provides services for at least 20 hours per week.
- *Preauthorization.* Certain medical treatments need prior approval before the plan will cover them. This requirement is to ensure the treatment is appropriate, effective and medically necessary for the condition or diagnosis. If you do not receive approval, you will be responsible for paying the full cost of the treatment. Contact the health plan administrator for details.
- *Precertification:* Advance notification required by the Plan for approval of services such as certain major diagnostic services, CT scans and MTAs, a scheduled inpatient hospital stay, inpatient surgery, bariatric surgery, organ transplant, , certain orthopedic surgeries, infertility treatment, extended care (skilled nursing facility), rehabilitation facility admissions and certain ambulance services (refer to the Ambulance service "Air or Ground" for more information). For an inpatient admission following an emergency room visit, notification must be made to the health plan administrator within 48 hours of the admission.
- *Predetermination of Benefits:* Medical information (Current Procedural Terminology (CPT) codes; amount of charges; diagnosis; doctor's zip code and, if required, clinical documentation)

submitted to the health plan for the purpose of determining eligibility of treatment ahead of time, as well as anticipated out-of-pocket expenses.

- *Primary Care Physician (PCP).* A physician (MD or DO) who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, pediatric medicine; or, physician assistant or nurse practitioner, who provides care in an outpatient setting that promotes ongoing care such as an office, outpatient surgery, retail walk-in clinic, nursing facility or home. Physician assistants and nurse practitioners are considered PCPs as long as they are employed and supervised by a licensed physician and submit charges through a PCP.
- *Prior Authorization.* Certain prescription drugs require your physician to obtain approval from the Pharmacy plan administrator to ensure the Plan will provide coverage for the specific medication for the patient. If you fail to obtain prior authorization, you will be responsible for the entire non-negotiated cost of the prescription drug.
- *Residential treatment:* Treatment in a facility established and operated as required by law, which provides mental health care services or substance-related and addictive disorders services. It must:
  - Provide a program of treatment, approved by the mental health/substance-related and addictive disorders designee, under the active participation and direction of a physician and, approved by the mental health/substance-related and addictive disorder designee;
  - Have or maintain a written, specific and detailed treatment program requiring your full-time residence and participation; and
  - Provide at least the following basic services in a 24-hour per day, structured setting:
    - Room and board.
    - Evaluation and diagnosis.
    - Counseling.
    - Referral and orientation to specialized community resources.

  A residential treatment facility that qualifies as a hospital is considered a hospital.
- Substance *use services:* Covered health care services to diagnose and treat alcoholism and substance-related and addictive disorders listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM TR-5)*. The fact that a disorder is listed in this publication does not mean that treatment of the disorder is a covered health care service.

HOW THE PLAN OPTIONS FOR NON-MEDICARE-ELIGIBLE RETIREES WORKS

In-Network Benefits

IBM's PPO and EPO options have provider networks containing hospitals, facilities, physicians and other health care providers. These options provide coverage for in-network medical and pharmacy services only, there is no coverage for most non-emergency out-of-network services [however, the PPO options (not the EPO option) also provide coverage for most out-of-network behavioral health and substance use services]. There are exceptions where out-of-network care for medical services will continue to be covered at the in-network rate, see "*Out-of-Network Medical Coverage*" for more details. Since the network providers' fees are negotiated (and generally lower), you are charged less. (Network fees are negotiated directly between the providers and the health plan administrators.) Your network provider files claims for you so you don't have to do the paperwork.

Please refer to your HMO's (Kaiser) Benefits Booklet for information on out-of-network coverage in emergency situations.

Generally, you must meet the deductible for your plan option before the Plan provides coverage; routine preventive care is covered in full with no deductible. After you meet the in-network annual deductible, other services may require you to pay a coinsurance amount until you reach the annual out-of-pocket maximum. Once you reach the out-of-pocket maximum, the IBM Medical Plan options pay 100% of the negotiated rate for eligible expenses received in-network for the remainder of the plan year. When the annual out-of-pocket maximum is reached, if the annual deductible is not met, it will be deemed to be satisfied.

Medications purchased through the IBM Managed Pharmacy Program are not subject to the deductible and do not accumulate to the out-of-pocket maximum under the IBM Low Deductible PPO, IBM Medium Deductible PPO, IBM High Deductible PPO or the IBM EPO. Generally, medications purchased under the IBM High Deductible PPO with HSA plan option are subject to the deductible (except preventive medications) and the amount you pay for pharmacy coverage accumulates to the out-of-pocket maximum.

Out-of-Network Medical Coverage

Generally, the IBM Plan does not cover services received from out-of-network providers. Each time you need care, you can choose to see a provider who does not belong to the health plan's network. However, if you choose to see an out-of-network provider, you will be responsible for the full cost of the services. The Plan does not cover out-of-network medical expenses except in the following approved exceptions:

- **In an emergency.** An emergency is defined as the sudden onset of an acute medical condition that, without immediate medical care, could result in serious harm to your health, bodily functions or body parts (for example, sudden shortness of breath, uncontrolled bleeding, sudden severe intractable pain or any sudden onset of symptoms or illnesses a reasonable person would consider an emergency).
- **If you do not have the ability to choose an in-network provider**—for example, if you're receiving care at an in-network facility like a hospital, but select services are only available through an out-of-network provider (such as anesthesiology or pathology/laboratory services).
- **For most mental health and substance use services, under the PPO options, with a few important exceptions.** There is no coverage for mental health/substance use services received out-of-network for those enrolled in the EPO plan option.
- **If there isn't an in-**network provider within a reasonable distance. If you think this applies to you, be sure to obtain approval from your medical plan before making an appointment with any out-of-network provider.
- **When a patient truly needs a hospital or provider for a unique condition that cannot be serviced by in-network providers.** If there are no in-network providers for the care you need, your medical plan will review the medical necessity of using out-of-network care. If the medical necessity for using out-of-network care is approved, an exception will be granted and the care will be covered as in-network. This is called a "Gap in Care" exception, and it requires approval before you seek out-of-network services. You will need to initiate that review process with your medical plan directly.
- **If you travel outside of the U.S., eligible charges incurred will be considered in-network.** Generally, you will pay for medical expenses incurred outside the U.S. at the time of service and then submit your claim for reimbursement, along with your itemized bill and other supporting documentation to your medical plan.
- **You are enrolled in an Out-of-Area (OOA) medical plan option** administered by Aetna.

Note: *Out-of-network lab or radiology services used by your provider will NOT be covered. This is the case even if your provider is in-network. It's important to inform your providers (physician, specialist, labs, pharmacies, etc.) that your plan only covers services received from in-network providers. If your provider recommends you have a diagnostic test, see a specialist, get lab work done, have surgery etc.,* ***it is your responsibility to make sure you use an in-network provider. If you do not use an in-network provider, the plan will not pay any benefits (other than those listed above) and you will be responsible for paying the full amount of the bill.***

If you have an out-of-network claim for one of the above circumstances, please refer to the section on "Out-of-Network Medical Claims for Mental Health Claims and Other Services (with Approved Exceptions)" for additional details on how your claim will be paid.

IF YOU LIVE OUTSIDE THE NETWORK AREA

In certain limited areas, a robust provider network is not available. Affected employees will be eligible for an Out-of-Area option administered by Aetna which provides the same benefits coverage described in this Summary Plan Description, but will provide reimbursement for covered services at the in-network level, based on the provider's actual charge. If this situation applies to you, it will be indicated in your enrollment materials.

Those living in areas designated as Out-of-Area are offered the same PPO plan options offered to all US plan members. The IBM EPO is not available in Out-of-Area areas.

Prescription drug benefits remain subject to the in-network and out-of-network requirements, as described in the "*IBM Managed Pharmacy Program*" section of this book.

Provider Networks

If You Travel Within the U.S.

The health plan administrators have national networks that also cover areas outside of the regional areas in which the health plan options are offered. If you are traveling, or have a child away at school, there may be network providers available so you can take advantage of the in-network level of benefit. You should contact your health plan administrator for assistance in identifying these in-network providers.

If You Travel Outside of the U.S.

Eligible charges incurred while traveling outside of the United States will be paid at the in-network reimbursement level of benefits. Exchange rates will be taken from a recognized exchange rate publication selected by the health plan. The exchange rate used for reimbursement will be the rate effective on the date the service was rendered.

Generally, you will pay for medical expenses incurred outside the United States at the time of service and then submit your claim for reimbursement along with your itemized bill and other supporting documentation to your administrator of your plan option. If you are a non-Medicare-eligible retiree and your Medicare-eligible dependent receives medical services outside the US, except in limited emergency situations these services are not covered by Medicare. When eligible services under the Plan are not covered by Medicare because they were received outside the U.S., the Plan will pay primary over Medicare.

Health Plan Administrators

For non-Medicare-eligible retirees, plan options are administered on a regional basis, where the health plan administrator was selected based on a "best in market" approach. That means your health plan

administrator depends on where you live, regardless of the option in which you are enrolled. The following chart lists each health plan administrator and their assigned regional areas.

Health Plan Administrators by Regional Location			
AETNA*		ANTHEM	
▪ Alaska ▪ Arizona ▪ Colorado ▪ Delaware ▪ District of Columbia ▪ Florida ▪ Georgia ▪ Illinois ▪ Kansas ▪ Maine ▪ Maryland ▪ Montana	▪ Nebraska ▪ Nevada ▪ New Jersey ▪ New Mexico ▪ New York ▪ North Carolina ▪ Oklahoma ▪ Oregon ▪ Utah ▪ Washington ▪ Wyoming	▪ Alabama ▪ Arkansas ▪ California ▪ Connecticut ▪ Hawaii ▪ Idaho ▪ Indiana ▪ Iowa ▪ Kentucky ▪ Louisiana ▪ Massachusetts ▪ Michigan ▪ Minnesota ▪ Mississippi	▪ Missouri ▪ New Hampshire ▪ North Dakota ▪ Ohio ▪ Pennsylvania ▪ Rhode Island ▪ South Carolina ▪ South Dakota ▪ Tennessee ▪ Texas ▪ Vermont ▪ Virginia ▪ West Virginia ▪ Wisconsin

* Those who live in rural areas or outside the 50 states (and Washington, D.C.) may be offered Out-of-Area plan options administered by Aetna.

Note: *For non-Medicare-eligible retirees: If you reside in an Anthem market area, certain areas utilize an Alternate Network, and you must use an Alternate Network provider to obtain the in-network benefit level. These areas are:*

Area	Alternate Network Name
Kansas City, Kansas	Preferred Care Blue PPO
Kansas City, Missouri	Preferred Care Blue PPO
St. Louis, Missouri	Blue Access Choice
New Hampshire	BlueChoice Open Access POS
Tennessee	Network S

The Snowbird Rule

If you have residences in multiple states, you can now choose which address you would like to use for benefit purposes. If you choose to enroll using an address that is not your primary address on file with the IBM Benefits Center, you and any family members you cover must receive care from providers who are members of your secondary address's health plan network. You must call the IBM Benefits Center to enroll in the plan available at your secondary address location; you cannot enroll in a secondary address plan using NetBenefits.

Note that you will need to process an address change each time you change your location, as this address on file will determine the network you are eligible for. In addition, these elections will not carry over from plan year to plan year.

Mental Health/Substance Use Services

The health plan administrators maintain a nationwide network of participating providers. The contracted network includes (but is not limited to) licensed psychiatrists (Board-Certified preferred), doctoral-level licensed psychologists, licensed masters-level social workers, licensed professional counselors (LPC), marriage and family counselors and licensed masters-level psychiatric nurses for outpatient care, as well as treatment programs and facilities which provide a full continuum of intensive treatment. All in-network clinicians providing outpatient treatment must be licensed at the highest independent practice level, and clinicians, treatment programs and facilities must meet credentialing requirements.

You are responsible for ensuring the out-of-network provider/facility and treatment plan are eligible for reimbursement under the Plan. Upon request, out-of-network programs will be reviewed by the health plan administrator to determine if the program is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission for Accreditation of Rehabilitation Facilities (CARF) as either a hospital or freestanding substance use program or accredited by the appropriate state agency as a substance use program. Programs and facilities not meeting either of these criteria will not be eligible for benefit coverage under the Plan.

There is no out-of-network coverage for those enrolled in the IBM EPO plan option.

PRECERTIFICATION

All inpatient hospitalizations, treatment at extended care facilities, certain outpatient mental health/substance use treatment and other services listed on the following pages must be pre-certified and approved by the health plan administrator.

In most cases, your provider is responsible for precertifying in-network care. You should check with your provider to determine if they will do this precertification for you. In all other cases, including for any covered out-of-network services, *you* must obtain the required precertification. You (or your attending physician's office or your representative, such as a family member or friend) *must* call to precertify your stay.

You must precertify the following services:

- Outpatient, non-emergency major diagnostic services and procedures (see list in the *"Pre-certification for Major Diagnostic Services"* section)
- Inpatient hospital admissions/surgeries
- Inpatient hospital stays for childbirth that exceeds 48 hours after a normal delivery or 96 hours after a Cesarean delivery
- Inpatient emergency admissions in the United States and Puerto Rico, precertification must be obtained within 48 hours of admission **(if the 48 hours ends on Saturday or Sunday, then the next business day-past 48 hours-is the deadline)**
- Admissions to non-hospital facilities such as
  - Birthing centers
  - Skilled nursing facility admissions and
  - Rehabilitation facility admissions

INPATIENT MATERNITY ADMISSIONS

Under federal law, group health plans and insurance issuers may not 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 delivery. 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 for prescribing a length of stay not in excess of 48 hours or 96 hours as applicable. You must call to precertify your hospital stay if it goes beyond the minimum length of stay as defined by law or you will be subject to a $150 penalty or more if the stay is determined not to be medically necessary.

Although not mandatory, it is strongly recommended that expectant mothers continue to notify their Nurse Advocate about their pregnancy to ensure the wellbeing of both the mother and baby, as it provides them an opportunity to obtain valuable literature, speak with a Registered Nurse and ask questions that may not have occurred during an office visit with their doctor. This is especially important if it is a high-risk pregnancy.

Precertification for Inpatient Hospital Admissions (Non-Medicare-Eligible Retirees and Dependents)

- If you are not eligible for Medicare, all scheduled inpatient hospital admissions and surgeries must be pre-certified by calling the health plan administrator. The precertification line is available 24 hours a day. In the event of an emergency admission, you or your representative (such as a family member or friend) must contact the health plan within 48 hours of the emergency admission. If the hospital offers to precertify on your behalf, they must call within 48 hours of the emergency admission **(if the 48 hours ends on Saturday or Sunday, then the next business day-past 48 hours is the deadline).**

If you fail to precertify a non-mental health inpatient hospital admission or fail to notify the health plan within 48 hours of an emergency admission, you will be charged a penalty of $150, even if your care is determined to be medically necessary and eligible for coverage. In addition, if some or all of your care is subsequently determined not to be eligible under the terms of the IBM Plan (for example, if it is not medically necessary), you will be responsible for paying the cost of the stay and treatment deemed not medically necessary. Only days that are medically necessary will be eligible for benefits consideration.

Note: *This inpatient hospital precertification requirement does not apply to mental health/ substance use admissions or to admissions that occur outside of the United States and Puerto Rico. If IBM is not your primary source of coverage this requirement does not apply.*

If the Plan is not your primary source of coverage, e.g., you are Medicare-eligible, this requirement also does not apply.

Precertification for Non-Hospital Facilities, Extended Care and Organ Transplants

If your physician has ordered any of the above services, you must contact your health plan to determine eligibility. The health plan's Nurse Advocate is required to perform a medical care (utilization) review and obtain medical information from your treating physician in order to determine if the services are medically necessary and eligible for coverage. Claims received for these services that have not been authorized will be denied.

If some or all of the services are subsequently determined not to be eligible under the terms of the Plan (for example, if it is not medically necessary), you must pay the full cost of the services or care deemed not medically necessary. **You must obtain transplant services from a Center of Excellence in your health plan's network to receive the highest level of benefit.**

Precertification for Bariatric (Gastric Bypass) Surgery

Precertification from your health plan administrator is required in order to obtain approval for bariatric (gastric bypass) surgery. If you, or a covered family member, are seeking approval for bariatric (gastric bypass) surgery, you should contact your health plan for a predetermination of benefits before scheduling the surgery. To receive approval for bariatric (gastric bypass) surgery, very specific medical guidelines and criteria *must* be met, and your physician must provide all appropriate medical documentation and information. A physician's summary letter, without evidence of concurrent oversight, is not sufficient. Medical records must include documentation of the physician's concurrent assessment of your progress throughout the course of treatment. **You must obtain bariatric services from a Center of Excellence in your health plan's network to receive the highest level of benefit. For those who are covered under the EPO plan option, you must obtain bariatric services from a Center of Excellence to receive coverage.**

Precertification for Major Diagnostic Services

Precertification is required for the following outpatient, non-emergency major diagnostic services and procedures:

- CT/CTA Scan
- MRI/MRA
- PET scan
- Nuclear medicine
- Echocardiogram (including stress echocardiogram)
- Sleep studies
- Cardiac catheterization
- Cardiac studies
- Electrophysiology implants
- Arterial ultrasound

Since the exact list of services varies by plan, please ensure that you or your physician calls your health plan administrator for more information before any of the listed tests or procedures are scheduled.

Precertification for Mental Health/Substance Use Services

IBM PPO, IBM PPO Plus, IBM EPO, IBM PPO with HSA and IBM Enhanced PPO with HSA Options
Under the IBM Low Deductible PPO, IBM Medium Deductible PPO, IBM High Deductible PPO, IBM EPO, and the IBM High Deductible PPO with HSA options, you must call your health plan before obtaining inpatient and non-routine outpatient mental health/substance use treatment. Routine outpatient care does not require precertification. When you call, the health plan will recommend and certify benefits for treatment which is determined to be clinically appropriate and medically necessary. This decision is based on medical necessity guidelines. Your health plan can also help you determine if outpatient care is routine or non-routine.

Please note that if you are enrolled in the IBM EPO, the plan only allows in-network care.

If you do not precertify inpatient or non-routine outpatient care, you will receive no benefits. Only care that is medically necessary will be covered. If the care is determined not to be medically necessary, you will not receive benefits under the Plan.

MEDICAL NECESSITY
The health plan administrator certifies treatment for benefit coverage only if it's considered to be medically necessary. To be medically necessary treatment must:

- Be medically required.
- Have a strong likelihood of improving your diagnosed psychiatric or substance use condition.
- Be the least intensive level of appropriate care for your diagnosed condition in accordance with:
  - Generally accepted psychiatric and mental health practices.
  - The professional and technical standards adopted by the mental health plan.
- Not be rendered mainly for the convenience of the member, the member's family or the provider.
- Not be custodial care. (See *What the IBM Medical Plan Does Not Cover* for a definition of custodial care.)

Note: Determination of medical necessity does not guarantee benefit reimbursement. Benefit reimbursements subject to plan provisions, member eligibility at the time services are rendered, annual deductibles, facility/treatment eligibility and lifetime maximums.

Precertifying Additional Sessions/Days
When you, or a treatment provider/facility, call to precertify inpatient care, the health plan will certify benefits coverage with a specified start and end date to be paid at the in-network benefit level.

If you require additional treatment at the time that your precertification for non-routine outpatient visits or inpatient days have been exhausted, or the certification end date occurs, your provider must contact the plan to certify the additional treatment. See *Health Plan Administrator's Clinical Staff and Ongoing Reviews* for more information.
The additional treatment will be reviewed by the plan to determine continuing medical necessity. If ongoing care is deemed medically necessary, it will be certified by the mental health plan. Please keep in mind that certification does not guarantee benefits are available; the member must be eligible at the time of treatment.

When the IBM Medical Plan Is Secondary

If you have medical coverage through another group health plan or other coverage and the IBM Medical Plan is secondary to that other coverage, you do not need to precertify care. For Medicare-eligible participants, in order to receive the highest level of reimbursement, the facility/provider must accept Medicare *and* be in your health plan's network.

If Medicare is your primary coverage you must use providers and facilities that accept Medicare. When you obtain services, such as mental health and/or substance use services from a provider or facility that does not accept Medicare, those services are not eligible for any reimbursement under the IBM Plan.

Note: *Refer to "Coordinating Plan Medical Coverage with Medicare" in the "Administrative Information" section for more information about Coordination of Benefits with Medicare.*

Precertification for Orthopedic Surgery

Precertification from your health plan administrator is required in order to obtain approval for orthopedic surgery. If you or a covered family member are seeking approval for orthopedic surgery, you should contact your health plan for a predetermination of benefits before scheduling the surgery. **For certain orthopedic procedures such as knee replacement, hip replacement and spinal fusion, you must obtain services from a Center of Excellence in your health plan's network to receive the highest level of benefit.**

Precertification for Infertility Services

Precertification from your health plan administrator is required in order to obtain approval for infertility services. If you or a covered family member are seeking approval for infertility services, you should contact your health plan for a predetermination of benefits.

How to Obtain Precertification

- Generally, your in-network provider will precertify your care for you. If you are receiving care out-of-network, you, your attending physician's office or personal representative such as a family member or friend must call the health plan to precertify an inpatient hospital admission or high-cost imaging procedure or notify the health plan within 48 hours of an emergency admission **(if the 48 hours end on a Saturday or Sunday, then the next business day-past 48 hours is the deadline)**. To precertify all other services, contact the health plan as soon as possible in advance of the service to determine eligibility. In some cases, the provider may be responsible for precertifying in-network care. You should check with your health plan to determine if your provider will do this precertification for you. In all other cases, including for any covered out-of-network services, you must obtain the required precertification.

Utilization Reviews

The Plan requires the health plan administrators to perform utilization reviews to determine the medical necessity of an inpatient hospitalization, certain treatments or services obtained either in the hospital or outside a hospital, or eligibility of ongoing treatments or services.
This review may require a letter of medical necessity to determine eligibility. When a utilization review is performed, you and your health care providers must allow the health plan's Nurse Advocates access to the patient's medical records and otherwise cooperate with the review procedures in order for benefits to be paid under the Plan. IBM may require such review before, during and/or after the inpatient hospitalization, treatment or other service.

Utilization reviews are performed by the health plan's Nurse Advocates or their agents. IBM has no access to this information except with permission from you and/or the patient, or when necessary for the Plan Administrator to review a claim, or for statistical purposes in a form not identifying individuals or patients.

PREDETERMINATION OF BENEFITS FOR INDIVIDUALS NOT ELIGIBLE FOR MEDICARE

The plan options under the Plan for individuals not eligible for Medicare provide benefits only for eligible covered services detailed in the "*What's Covered Under the Medical Plan Options for Individuals Who Are Not Eligible for Medicare*" section. Guidelines have also been established on appropriate treatment for therapies which are reasonably necessary for the care and treatment of a medical condition when rendered by an eligible provider.

You are strongly urged to determine eligibility of services and fees before receiving treatment to ensure a clear understanding of all charges and reimbursements in advance. You should contact the health plan to obtain a predetermination of coverage, particularly when any proposed treatment is expected to continue for any length of time. You or your doctor may be required to submit clinical data for the administrator of the plan option under the Plan in which you are enrolled to determine eligibility of services.

Note: *The summary below does not apply to any HMO, Medicare Advantage Plan or other insured option under the Plan. If you are covered under an insured option, you should refer to the applicable Certificate of Coverage for more information*.

The following is only a sample of the treatment and therapies that might continue for a period of time, as well as an example of the typical duration of treatment:

- Biofeedback Therapy — up to a maximum of 20 visits
- Cardiac Rehab Therapy — up to a maximum of six months
- Continuous Passive Motion Therapy — up to a maximum of two weeks, must be utilized on a daily basis (for example: major knee or shoulder surgery)
- IV Therapy for Lyme Disease — up to a maximum of 28 days
- Physical Therapy* – up to a maximum of 40 visits per year
- Chiropractic Services – up to a maximum of 40 visits per year
- Occupational Therapy* – up to a maximum of 40 visits per year
- Speech Therapy* – up to a maximum of 40 visits per year.

** Medical Necessity review required for > 40 visits per year. Additional visits will be approved if medically necessary.*

To request a predetermination of benefits coverage, call your health plan and provide any relevant information such as:

- Current Procedural Terminology (CPT) code (medical coding used to describe the particular service/procedure, available from your physician), or codes (if multiple surgical procedures are involved)
- Amount of charges (for out-of-network mental health services only)
- Clinical information/medical records and
- ZIP code where treatment will be provided (for surgical services, the surgeon's ZIP code).

IBM LOW, MEDIUM AND HIGH DEDUCTIBLE PPO OPTIONS

The IBM PPO options cover you for a range of services, including preventive care, medical care, surgery, hospitalizations (including drugs and medication dispensed by the facility for use in the facility) and emergency care. There is an annual pharmacy benefit maximum for medications covered under the IBM Managed Pharmacy Program for the IBM Medium and IBM High Deductible PPO options. Generally, you must satisfy an annual deductible before the Plan pays benefits for most eligible services. Under the IBM PPO options, you don't need to select a primary care physician (PCP) and you don't need a referral to see a specialist. The administrator for the IBM PPO plan options under the Plan varies by geographic location (see *Health Plan Administrators*).

Annual Deductible

The IBM PPO options require you to meet an annual deductible before the Plan pays benefits. The annual deductible also counts toward the annual out-of-pocket maximum. The annual medical deductible *does not* apply to the following services:

- Eligible routine preventive services.
- Prescription drug charges.

	IBM Low Deductible PPO (In-Network)	IBM Low Deductible PPO (Out-of-Network)	IBM Medium Deductible PPO (In-Network)	IBM Medium Deductible PPO (Out-of-Network)
Annual Deductible[1]	Individual: $550 Family: $1,650[1]	Individual: $800 Family: $2,400[2]	Individual: $1,050 Family: $3,150[2]	Individual: $1,550 Family: $4,650[2]
Annual Out-of-Pocket Maximum[1]	Individual: $3,250 Family: $6,500	Individual: $4,550 Family: $9,100	Individual: $4,250 Family: $8,500	Individual: $6,350 Family: $12,700

[1]Shared with mental health/substance use services.

[2] Once the family deductible is met, it is met for all covered individuals, even if they have not met their individual deductible.

	IBM High Deductible PPO (In-Network)	IBM High Deductible PPO (Out-of-Network)
Annual Deductible[1]	Individual: $3,550 Family: $10,650[2]	Individual: $4,250 Family: $12,750[2]
Annual Out-of-Pocket Maximum[1]	Individual: $6,850 Family: $13,700	Individual: $10,550 Family: $21,100

[1] Shared with mental health/substance use services.

[2] Once the family deductible is met, it is met for all covered individuals, even if they have not met their individual deductible.

In-Network Annual Deductible

Once you, or your covered family member, satisfy the individual deductible, the Plan will pay the following amounts:

- IBM Low Deductible PPO: 80% of eligible expenses, based on the negotiated fee.
- IBM Medium Deductible PPO: 80% of eligible expenses, based on the negotiated fee.
- IBM High Deductible PPO: 70% of eligible expenses, based on the negotiated fee.

As soon as any covered family member meets the individual deductible, the Plan will begin to pay for eligible expenses incurred for that person. The annual deductible counts toward the annual in-network out-of-pocket maximum.

To limit a family's total deductible expenses during the year, a family need not satisfy more than three individual deductibles before benefits are paid for the entire family. Once the family deductible is reached, the Plan will pay eligible expenses for every covered family member at the applicable percentage, based on the type of service. Therefore, for families of four or more, it is possible to reach the family deductible before every person meets the individual deductible.

Example: Meeting the IBM Medium Deductible PPO Family Deductible	
Annual Family Deductible	$3,150
Retiree incurs eligible expenses	$1,700; *Because the individual deductible is $1,050, it is now considered satisfied for the retiree. The plan will pay the applicable coinsurance of $650 of the expenses.*
Spouse incurs eligible expenses	$1,200; $1,050 is applied to the spouse's deductible and the plan will pay the applicable coinsurance of $150 of the expense
Child incurs eligible expenses	$1,400; $1,050 is applied to the child's deductible, thus satisfying the family deductible as well. The plan will pay the applicable coinsurance for $350 of the expense.
	$3,150 Family Deductible is now met
Since the family deductible has been met, the Plan will now pay the applicable percentage of the negotiated fee for all further eligible in-network expenses for every covered family member.	

Expenses That Do Not Count Toward the IBM PPO Annual Deductible

- Prescription drug charges under the IBM Managed Pharmacy Program
- Eligible routine preventive services
- Mental health and substance use charges that exceed 80% of the U&P rate

Annual Out-of-Pocket Maximum

The IBM PPO plan options under the Plan limit how much you and your covered family members have to pay out of your own pocket each year for eligible medical expenses. This is known as your annual out-of-pocket maximum. Once you reach the out-of-pocket maximum, the Plan will pay 100% of the negotiated fee or actual charges for any additional eligible expenses for the remainder of the plan year.

Expenses That Do Not Count Toward the IBM PPO Annual Out-of-Pocket Maximum

- All benefits under the IBM Managed Pharmacy Program.
- Mental health and substance use charges that exceed 80% of the U&P rate under the IBM Plan.

Lifetime Maximum Benefits

There is no lifetime maximum for benefits paid.

Annual Maximum Allowable Benefit for Pharmacy

The IBM Medium Deductible PPO and the IBM High Deductible PPO plan options have a maximum amount of coverage under the IBM Managed Pharmacy Program. This is the maximum amount the IBM Plan will pay for pharmacy medications and supplies. The maximums are as follows:

- IBM Medium Deductible PPO: $2,500 maximum allowable benefit
- IBM High Deductible PPO: $1,000 maximum allowable benefit

IBM EXCLUSIVE PROVIDER ORGANIZATION (EPO)

The IBM Exclusive Provider Organization (EPO) option under the Plan is available only to retirees who live within the network area. This option covers you for a range of services, including preventive care, medical care, prescription drugs, mental health/substance use, surgery and hospitalizations that you receive in-network only. Benefits are payable only if participants seek care exclusively from doctors, hospitals and other facilities that belong to the Plan's provider network.

There is no coverage for services received outside the network, except in emergencies.

Under the IBM EPO you meet a small annual deductible before the Plan pays benefits. You don't need to select a primary care physician (PCP) or obtain a referral to see a specialist.

A NOTE ABOUT PRESCRIPTION DRUG BENEFITS.

Prescription drug benefits are subject to the in-network and out-of-network requirements of these plans as described in the "*IBM Managed Pharmacy Program*" section of this book.

Annual Deductible

The IBM EPO option requires you to meet a small annual deductible before the Plan pays benefits. The annual deductible also counts toward the annual out-of-pocket maximum. The annual medical deductible *does not* apply to the following services:

- Eligible routine preventive services
- Prescription drug charges.

	EPO
Annual Deductible	Individual: $150; Family: $300
Annual Out-of-Pocket Maximum*	Individual: $3,950 Family: $7,100

Annual Out-of-Pocket Maximum

The IBM EPO limits how much you and your covered family members have to pay out of your own pocket each year. This is known as your annual out-of-pocket maximum. Once you reach the out-of-pocket maximum, the Plan will pay 100% of the negotiated rate for any additional eligible expenses for the remainder of the plan year (see *Non-Medicare-Eligible Retiree Options At A Glance* for specific coverage information). This applies to all medical expenses that require coinsurance. However, even if you meet your out-of-pocket maximum, you will still be responsible for paying any applicable flat dollar copayments. The out-of-pocket maximum is shared with mental health/substance use services.

Expenses That Do Not Count Toward the IBM EPO Out-of-Pocket Maximum

- All copayments for inpatient hospitalization, outpatient surgery, and emergency room.
- All benefits under the IBM Managed Pharmacy Program.

In Case of an Emergency

The IBM Exclusive Provider Organization option does not provide coverage for out-of-network medical services unless they are received on an emergency basis. Emergency services received out-of-network will be paid at the in-network level. In case of an emergency, seek medical help first and then contact the administrator within 48 hours. Failure to contact the administrator may affect your coverage for out-of-network services.

Lifetime Maximum Benefits

There is no lifetime maximum benefit payment under the IBM Plan.

IBM HIGH DEDUCTIBLE PPO WITH HSA FOR NON-MEDICARE-ELIGIBLE RETIREES

Overview of the IBM High Deductible PPO with HSA

Like the other IBM PPO plan options under the Plan, the IBM High Deductible PPO with HSA provides coverage for preventive care, medical, surgical, hospitalization, prescription drug and mental health and substance use care services. However, this plan also meets the Internal Revenue Service (IRS) definition of a High Deductible Health Plan (HDHP) and allows a qualifying participant to open his or her own Health Savings Account (HSA). An HSA enables you to set aside pretax dollars to pay for current and future eligible medical expenses.

Generally, you must meet an annual deductible before the Plan pays benefits for most eligible services (except for eligible routine preventive services). If more than one person is enrolled in this Plan option, the entire family deductible must be met before anyone is eligible to receive a benefit. In addition, prescription drug and mental health/substance use coinsurances are subject to the deductible. Preventive drugs are not subject to the deductible.

Under the IBM High Deductible PPO with HSA you don’t need to select a primary care physician (PCP) and you don’t need a referral to see a specialist. The administrator for the IBM High Deductible PPO with HSA varies by geographic location (see *Health Plan Administrators*).

Prescription drug coverage is provided under the IBM Managed Pharmacy Program administered by CVS Caremark.

Under the IBM High Deductible PPO with HSA, you have the freedom to select any eligible provider) and facility of your choice, each time you obtain care. However, you generally will be required to pay the full cost of services received if you use an out-of-network provider and the amount you pay will not accumulate toward your deductible or out-of-pocket maximum.

Health Savings Account (HSA)

A Health Savings Account (HSA) offers a unique, tax-advantaged way to pay for current eligible expenses and save for future health care expenses. The HSA is your own personal account; you never forfeit unused balances.

The HSA is *not* a benefit plan sponsored by IBM. Rather, it is a separate feature that can work together with the IBM High Deductible PPO with HSA. If you enroll in the IBM High Deductible PPO with HSA, you will receive information from the trustee about opening an HSA at a participating bank or other institution.

Contributions to the HSA

Pre-65 retirees can make their own tax-deductible contributions to an HSA account. In order to make HSA contributions, you may not have other health coverage. For this purpose, "other health coverage" generally includes any health plan other than a High Deductible Health Plan (HDHP), including medical plans, healthcare reimbursement arrangements and Medicare coverage. Other health coverage also includes coverage provided to you through your spouse's plan. For example, you would have impermissible other coverage (and you would not be eligible to contribute to an HSA) if your spouse enrolls in family coverage in a medical plan that is not a qualifying HDHP (unless your spouse's plan does not cover you.

A participant in the IBM High Deductible PPO with HSA must meet certain conditions and requirements to be eligible to establish an HSA. For more information about eligibility and the HSA in general, please refer to the *Health Savings Account Participant Information for Retired Employees* pamphlet available on NetBenefits at **www.netbenefits.com**.

Please note that if you are a retiree supplemental, you are only eligible to receive the employer contribution directly to your HSA account. You will need to contribute any of your own funds directly to the HSA account. Your own contributions cannot be made through your monthly payment for benefits, regardless of whether the payment method is invoice, pension deduction, or automatic bank withdrawal.

HSA and Taxes

State laws for HSAs vary. Consult your personal tax advisor regarding HSA tax implications in your state. Distributions you take that are not used for eligible medical expenses will be subject to taxes and may include a 20% penalty.

Annual Deductible

The annual deductible for the IBM High Deductible PPO with HSA works differently than it does under the other IBM PPO options. Here's how the annual deductible under this option works:

- In all situations involving the enrollment of one or more dependents, the entire family deductible must be met before benefits are paid to any individual family member.
- The annual deductible counts toward the annual out-of-pocket maximum.
- Prescription drugs are subject to the plan deductible with the exception of preventive drugs.

- Mental health and substance use services are subject to the annual deductible.
- The annual deductible does not apply to eligible routine preventive services.

	IBM High Deductible PPO with HSA (In-Network)
Annual Deductible*	Individual: $1,700 Family: $3,400[1]
Annual Out-of-Pocket Maximum*	Individual: $5,300 Family: $7,950[1]

* Shared with prescription drug and mental health/substance use services.

[1] When more than one individual is enrolled, the family deductible must be met before the Plan begins to pay for services and the family out-of-pocket must be met before the Plan pays 100% for eligible covered expenses. The individual deductible and the individual out-of-pocket maximum do not apply when more than one family member is enrolled.

Individual Deductible (applies only to participant enrolled in self only coverage)
Once you satisfy the individual annual deductible, the Plan will pay the applicable percentage of eligible expenses, based on the negotiated rate or provider's actual charge, depending on the type of service.

Family Deductible (applies to a participant enrolled with one or more family members)
The entire family deductible must be met before the Plan will pay benefits for any covered individual. As soon as the family deductible has been satisfied (by one or more person's eligible expenses), the Plan will pay the applicable percentage of eligible expenses, based on the negotiated rate or provider's actual charge depending on the type of service. If one individual meets the individual deductible but the family deductible is not yet met, benefits will not be paid to that individual (or to the other family members) until the family deductible is satisfied.

Keep in mind that one person's eligible expenses can be used to satisfy the family deductible.

Annual Out-of-Pocket Maximum

The IBM High Deductible PPO with HSA limits how much you and your covered family members have to pay out of your own pocket each year for eligible medical expenses. This is known as your annual out-of-pocket maximum. Once you reach the annual out-of-pocket maximum, the Plan will pay 100% of the negotiated rate or provider's actual charges depending on the type of service for any additional eligible expenses for the remainder of the plan year. If you enroll a spouse or dependent, you have to meet the family annual out-of-pocket maximum before benefits will be paid at 100%.

Lifetime Maximum Benefits

There is no lifetime maximum for benefits paid under the IBM Plan.

Care Management for Individuals Who Are Not Medicare-Eligible

Each of the medical plan administrators have Care Management, which provides targeted outreach by registered nurses who will provide assistance and support to participants with general health concerns, chronic medical conditions and complex medical issues.

CARE MANAGEMENT

Care Management is a voluntary service available to non-Medicare-eligible participants enrolled in the IBM Low, Medium and High Deductible PPO options, IBM Exclusive Provider Organization and IBM High Deductible PPO with HSA.

Care Management is performed by registered nurses (called Nurse Advocates) and designed to assist you and your enrolled family members. It is not the Nurse Advocate's role to recommend specific physicians but rather to provide general medical information.

A Nurse Advocate may contact your physician to obtain additional information about your condition. The Nurse Advocate confirms if hospital stays are medically necessary and the proposed treatment is medically necessary for the diagnosis and will also review opportunities for treatment to be received in a more cost-effective setting. The Nurse Advocate will confirm the number of inpatient days for your specific medical condition with your physician and review your physician's treatment plan for medical necessity and appropriateness. The Nurse Advocate will then follow-up with your physician and/or hospital about your condition before discharge to determine if additional days are needed and to help ensure that plans are made for your post-hospital care (if appropriate). They can also help you understand your medical condition and the level of care you and your non-Medicare-eligible dependents need.

Care Management includes the following features for medical care provided in the United States:

- Coordination of medical treatment and assistance in arranging necessary medical resources.
- Support and information on up-to-date treatment programs and medical technology.
- Assistance with catastrophic medical conditions and situations such as cancer, traumatic head and spinal injuries and extensive burns.
- Guidance and Care Management involving a need for skilled medical care, including referrals to nationwide specialty centers for bariatric surgery, infertility services, orthopedic surgeries (such as hip and knee replacement) and transplants. These facilities are among the most prominent in their field and offer sophisticated medical technology.
- Establishment of appropriate medical follow-up care.
- Health promotion.
- Monitoring of participants understanding of their medical condition and treatment plan.
- Educational materials.
- Hospital discharge planning.

Based upon the level of severity of the condition, ongoing telephone contact will be scheduled with a Nurse Advocate. Participants may also contact the health plan administrator's Nurse Advocate directly

to request assistance. In some instances (skilled nursing facility admissions, rehabilitation facility admissions; bariatric surgery orthopedic surgeries (such as hip and knee replacement) and organ transplants, skilled home health care), participation in Care Management is required.

Voluntary Nurse Helpline

If you are enrolled in the IBM Low, Medium and High Deductible PPO options, IBM Exclusive Provider Organization or IBM High Deductible PPO with HSA option, you may also take advantage of the Voluntary Nurse Helpline.

The Voluntary Helpline provides you with an opportunity to talk to a registered nurse who can provide timely health information on a wide variety of topics to help you make informed and appropriate decisions. It is available 24 hours a day, 7 days a week, within the United States.

Examples of the support available include:

- Suggestions for self-care
- Information on prevention of disease
- Discussion about symptoms and courses of treatment
- Personalized education about new, ongoing or recurring health problems
- Questions to ask your physician
- Pediatric health questions
- Geriatric health care issues
- Information about diagnostic tests such as MRIs and CAT scans.

Care Coordination for Transplants

Guidance and care coordination include referrals to nationwide specialty centers for transplants and establishment of appropriate medical follow-up care. These facilities offer sophisticated medical technology and have established financially advantageous contracted agreements.

For certain services such as a transplant, you *must* use one of the hospitals specified as a transplant Center of Excellence (COE) facility. If you use any other facility, even one that participates in the health plan's overall network, a lower level of benefits or no benefits will be paid under the IBM Low, Medium and High Deductible PPO options, IBM EPO, and IBM High Deductible PPO with HSA options. If you are enrolled in the IBM EPO plan and do not use a COE, you will have no medical coverage for the procedure. Please call your health plan administrator for additional information.

Note: *In some cases, a transplant unit within a network hospital facility may not be part of the facility and may bill for services separately. You are strongly urged to contact the health plan administrator to ensure the transplant unit is approved and a network provider so you will have a clear understanding of the benefits before seeking services.*

When medical precertification has been obtained from the specialty center under this program and as specified by the health plan administrator under this program, lodging (up to $50 a day) and travel expenses, if more than a 50-mile drive for the patient and one family member, may be eligible for reimbursement in accordance with established guidelines. In order for the benefit to be payable, members must use a Center of Excellence facility. Unreimbursed expenses will not apply toward the out-of-pocket maximum.

In order to perform Care Management services, it is necessary for the health plan administrator's Nurse Advocates to receive medical information about the patient from the patient's health care providers. The patient or an authorized representative of the patient may therefore be required to provide written consent to release medical information.

Centers of Excellence for Bariatric, Infertility, Orthopedic and Spine Services

IBM's health plan administrators have Centers of Excellence (COEs), facilities and providers that meet certain quality standards of care. In general, these providers' outcomes are better than others. Any member seeking care for the following surgeries or procedures must use a COE **in your health plan's network** for the highest level of coverage.

These services include:

- Infertility services, including, but not limited to, artificial insemination or in vitro fertilization (enrollment in a Care Management program also is required.)
- Orthopedic and spine surgery, including, but not limited to, knee or hip replacement or spinal fusion
- Bariatric surgery

You may qualify for travel and lodging benefits related to orthopedic and bariatric services.

If you choose not to use a COE or enroll in the required program, your benefit for using an in-network, non-COE provider will be the following:

- Infertility and bariatric:
  - IBM EPO: No coverage
  - IBM Low Deductible, Medium Deductible and High Deductible: You pay 40% of the negotiated cost for in-network non-COE providers.
- Orthopedic surgery: You pay an additional 10% of the negotiated cost for your plan option

Please call your health plan administrator before seeking any of these types of services.

When medical precertification has been obtained for a bariatric or orthopedic COE, lodging and travel expenses (up to $50 a day), if more than a 50-mile drive for the patient and one family member, may be eligible for reimbursement in accordance with established guidelines. In order for the benefit to be payable, members must utilize an in-network Center of Excellence facility. Unreimbursed expenses will not apply toward the out-of-pocket maximum. The health plan's Nurse Advocate reviews the physician's treatment plan for medical necessity and appropriateness and provides authorization for claims submitted for certain items and services to the health plan administering the IBM Medical Plans.

Extraordinary Coverage

In certain circumstances, the health plan administrators are authorized to approve coverage under the IBM Plan for charges not generally covered. These may include charges in life-or-death situations, for treatments as a last resort, for treatments which are not otherwise eligible or charges for a greater quantity of services or treatments than would otherwise be covered.

In no event, however, coverage by authorized for care which is primarily custodial in nature. And, in no event, is authorization provided to approve lifetime benefits beyond the maximum per family for medical, mental health/substance use or pharmacy benefit payments.

Approvals for extraordinary coverage are given only on a case-by-case basis. A case must be managed by a Nurse Advocate and be in case management in order to be considered for such an approval. The same reimbursement rates which apply to services that are similar but are generally covered under a plan will apply to charges for which extraordinary coverage under a plan is approved; this works within the IBM Plan and does not provide additional financial assistance. Approval of extraordinary coverage must be obtained before the charges are incurred, otherwise such coverage will not be available, and benefits will not be payable.

Referrals from Other Health Plan Administrators

Cases may also be brought to the Nurse Advocate's attention by other administrators, such as, CVS Caremark, as a result of information obtained during normal medical utilization reviews. In order for the Nurse Advocate to complete an assessment of the situation, your attending physician may be contacted to review the medical details of the case. If it is determined that the program would be helpful, the individual will be offered this voluntary service.

Memorial Sloan Kettering Cancer Center (MSK)

If you're facing a cancer diagnosis, you can access certain services provided by the Memorial Sloan Kettering Cancer Center (MSK), including access to second opinions, local referrals, and more.

MSK Direct is offered to IBMers, retirees and extended family members, including but not limited to your spouse or domestic partner, children, parents, grandparents, siblings, aunts/uncles, cousins, nieces/nephews and in-laws. Services include:

- **MSK Direct guided access**. IBMers, retirees and extended family members worldwide can get an in-person appointment at one of MSK's New York or New Jersey facilities to meet with an oncologist and dedicated team of cancer specialists within two business days of the initial phone call.[1]
- **MSK Remote Consultations.** The ability to receive a comprehensive remote consultation which includes a review of pathology slides, radiology imaging and an oncology treatment plan, if you cannot travel to MSK's facilities for in-person care. Fees apply for this service.
- **MSK Care Finder.** MSK Direct can help you locate a high-quality cancer care facility closer to where you live (available only for those in the US) if you cannot travel to MSK's facilities for in-person care.

[1] Subject to availability of your medical records, your ability to travel to MSK, clinical considerations, and health insurance coverage for care at MSK.

The MSK hospital location is on the Upper East Side of Manhattan, New York. The state-of-the-art outpatient facilities are in New York City (Manhattan, Brooklyn), Long Island, Westchester and New Jersey.

For more information, visit www.mskcc.org/ibm. To request an appointment or to contact the MSK Direct Care Advisors, call 844-350-5032, Monday through Friday, between 8:30 a.m. to 5:30 p.m. Eastern time. Messages left outside of these hours will be returned the next business day.

Information and Support Line

You can call the toll-free Information and Support Line — 24 hours a day, 365 days per year — to talk to a Registered Nurse about your condition, depending on the nature of your inquiry.

Confidentiality

The health plan administrator maintains the confidentiality of all patient-specific clinical information received from patients, their family members and their health care providers. Confidential information will not be disclosed to IBM or others without your express written consent except when required by law, or (subject to applicable law) to a third party contracted by the Plan to review the program practices, including its clinical records, to evaluate the program administrator.

Following IBM's strict employee health privacy and confidentiality guidelines and subject to applicable law, our health benefits vendors will share data with each other to help identify individuals who will be specifically and overtly contacted by a health benefits vendor(s) and ask them to participate in certain programs, specific to their medical conditions, like disease management programs. These services are provided as a voluntary benefit, providing intervention and educational strategies to help those with chronic illness. Data sharing among the health benefits vendor(s) is conducted in accordance with the IBM Plan's strict medical privacy and confidentiality guidelines and will remain confidential and will not be shared outside the administration of the Plan.

What's Covered Under the Medical Plan Options for Individuals Who Are Not Eligible for Medicare

MEDICAL NECESSITY

All treatments, services or supplies must be medically necessary and appropriate for the condition being treated, as determined by or on behalf of the plan administrator. Except where state law or regulation requires a different definition, "Medically Necessary" or "Medical Necessity" shall mean those health care services rendered in accordance with generally accepted standards of practice in the medical or dental professions, which are:

- Required to diagnose or treat an illness, injury, disease or its symptoms.
- Considered effective for the patient's medical condition, illness, injury or disease.
- Clinically appropriate, in terms of type, frequency, extent, site and duration.
- Not primarily for the convenience of the patient, patient's family or healthcare provider, a physician or any other healthcare provider.
- Rendered in the least intensive setting that is appropriate for the safe delivery of the services and supplies.
- Rendered in the most efficient and economical way; not more costly than an alternative service or sequence of services which would produce equivalent therapeutic or diagnostic results beneficial to the diagnosis or treatment of the covered person's illness, injury or disease.

- Based on credible scientifically based guidelines of national medical, research or governmental agencies.

The fact that a physician or medical professional has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness or mental illness does not mean it is a medically necessary covered health service under the IBM Plan.

ELIGIBLE PRACTITIONERS AND FACILITIES

- "Acupuncturist" — A person licensed as such by the state in which he or she practices.
- "Ambulatory Surgical Center" — A facility in which minor surgery is performed and the patient is released the same day. Facilities must meet the health plan's accreditation criteria. Prior review of accreditation criteria with the health plan is advised to ensure coverage.
- "Birthing Center" — An alternative facility for women with low-risk pregnancies who do not wish a hospital confinement. Facilities must meet the health plan's accreditation criteria. Prior review of accreditation criteria with the health plan is advised to ensure coverage.
- "Certified Registered Nurse Anesthetist" (CRNA) — A person licensed as such by the state in which he or she practices in the administration of general anesthesia services.
- "Certified Nurse-Midwife" — A practitioner certified as a nurse-midwife by the state in which he or she practices and is licensed by such state to perform obstetrical services within the scope of practice.
- "Chiropractor" — A person licensed as such by the state in which he or she practices.
- "Christian Science Practitioner" and "Christian Science Nurse" — A person certified as such by the Christian Science Mother Church in Boston, Massachusetts.

  Note: *All mental health coverage must meet the criteria of eligible providers under the IBM Managed Mental Health Program.*
- "Dentist" — A person licensed as such by the state in which he or she practices.
- "Extended Care (Skilled Nursing) Facility" — An extended care facility must meet one or more of the following requirements to be eligible for coverage: approval by Medicare; approval by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); acceptance by the health plan under criteria it adopts to carry out the intent of hospital services.

  Note: *Nursing homes, assisted living, convalescent homes and care which are primarily custodial are not eligible for coverage. Custodial care or care received in these facilities may be covered under Long-Term Care Insurance.*
- "Hospice" — Hospice care is a program of comprehensive services provided to the terminally ill. While medical care is one component, the emphasis is placed on making the person comfortable, both physically and mentally, in his or her last days. The care can be rendered either in a hospice facility or at home. Although the principal intent is to help terminal patients cope with illness while in the home, the agency will arrange, when necessary, for admission to an accredited hospice facility.
- "Hospital" — Any institution operating, according to law, to provide for a fee medical, diagnostic and surgical facilities for patients. The hospital must provide supervision by a staff of physicians and 24-hour nursing service by registered graduate nurses.

- Christian Science Sanatoriums are considered eligible for confinements which would require a hospital confinement if treatment were being rendered under the supervision of a physician. Such Sanatoriums must be certified by The Commission for Accreditation of Christian Science Nursing Organizations/ Facilities, Inc.
- "Licensed Nutritionist" – A person licensed by the American Clinical Board of Nutritionists and the state in which he/she provides general nutrition services.
- "Licensed Pharmacist" – for administration of flu, shingles and COVID-19 vaccines only.
- "Nurse" — A registered nurse (RN), licensed practical nurse (LPN), Christian Science nurse or other registered graduate nurse.
- "Nurse Practitioner" — A person licensed as such by the state in which he or she practices and who is employed and supervised by a licensed physician as defined by the IBM Plan. Physician assistants and nurse practitioners are considered PCPs as long as they are employed and supervised by a licensed physician and submit charges through a PCP.
- "Occupational Therapist" — A person licensed/certified as such by the state in which he or she practices, or a person who is certified as such by the American Occupational Therapy Association.
- "Physical Therapist" — A certified physiotherapist.
- "Physician" — A person licensed by the state in which he or she is practices medicine and performs surgery.
- "Primary Care Physician" (PCP) — A physician (MD or DO) who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, pediatric medicine; or, physician assistant or nurse practitioner, who provides care in an outpatient setting that promotes ongoing care such as an office, outpatient surgery, retail walk-in clinic, nursing facility or home.

  Note: *Physician services rendered in an urgent care facility or inpatient setting are not considered PCP services.*
- "Physician Assistant" — A person licensed by the state in which he or she practices and who is employed and supervised by a licensed physician as defined by the IBM Plan. Physician assistants and nurse practitioners are considered PCPs as long as they are employed and supervised by a licensed physician and submit charges through a PCP.
- "Registered Dietitian" — A person licensed by the state in which he or she practices by the Commission of Dietetic Registration (CDR). See *Nutritional Counseling* in *What's Covered Under the IBM Medical Plan* for coverage information.
- "Speech-Language Pathologist or Audiologist" — A person who (1) holds a certificate of clinical competence in speech-language pathology or audiology from the American Speech-Language-Hearing Association and/or (2) is licensed by the state in which he or she practices to provide speech-language pathology or audiology.

For purposes of mental health/substance use services, eligible providers include:

- Licensed psychiatrists (MD-Board-Certified preferred)
- Doctoral-level licensed psychologists (PhD, PsyD, EdD)
- Licensed professional counselors (LPC)
- Licensed masters-level social workers (LCSW/LICSW)
- Licensed mental health counselors (LMHC)

- Licensed marriage and family therapists (LMFT and
- Licensed masters-level psychiatric nurses (APRN/RNCS).

Due to the varying nature of provider credentials, you should call your health plan administrator to verify that an out-of-network provider is eligible for reimbursement under the Plan. Claims are processed based on the actual provider of services, not on any supervision arrangement with another mental health care provider.

Note: *Pastoral counselors are not eligible for reimbursement under the Plan.*

COVERED SERVICES

The Plan covers medical services deemed necessary in the diagnosis and treatment of injury, illness and/or pregnancy, as well as certain preventive care services, when rendered by eligible providers. Specific covered services are listed in the sections that follow.

Accidental Injury to Sound Natural Teeth

Treatment for accidental injury to sound natural teeth is covered under the IBM Low/Medium/High Deductible PPO, IBM EPO and IBM High Deductible PPO with HSA provided the services are rendered within one year of the date of the accident. Treatment for accidental injury to sound natural teeth is covered if services have commenced within one year of the date of the accident. The purpose of this coverage is to permit the restoration of function to the accidentally injured sound and natural teeth. Treatment must be medically necessary as determined by the health plan administrator and a continuous course of dental treatment for care resulting from and directly related to the accident.

Note: *An "accidental injury" is defined as an injury caused by external force or through abnormal force exerted by a hard, sometimes foreign, object in the mouth. In neither case can the injury be brought about as part of the prevention or treatment of a health problem. For other treatment of the mouth, jaws and teeth, see* Oral and Maxillofacial Treatment.

Acupuncture

Acupuncture is covered when rendered for treatment of an eligible medical condition and *only* by a licensed provider. Acupuncture services for routine preventive care and maintenance are *not* eligible for reimbursement.

Alternative Levels of Care

Alternative levels of care may be approved in lieu of inpatient treatment for mental health/substance use issues as clinically appropriate and cost effective. Alternative levels of care include residential treatment, partial hospitalization or intensive outpatient treatment.

Note: *Wilderness programs, therapeutic schools, and non-medical facilities or their component services are not eligible for reimbursement under the IBM Plan nor are they eligible for alternative level of care.*

If an alternative level of treatment care is proposed, the plan will:

- Determine if an alternative level of care is medically necessary.
- Determine if alternative care is a clinically appropriate alternative to hospitalization.
- Approve an appropriate facility that meets the credentialing criteria for in-network reimbursement.

To be eligible for the highest level of reimbursement, alternative levels of care must be pre-certified and must receive case management review by the plan. If precertification is not obtained, you will receive no benefits. Out-of-network services are subject to a $150.00 penalty if not pre-certified and deemed to be medically necessary. Alternative levels of care are only available in-network for IBM EPO option.

Relationship to the IBM Special Care for Children Assistance Plan
The IBM Special Care for Children Assistance Plan is a separate program focused on the developmental problems of children with mental, physical, or developmental disabilities. The IBM Medical Plan focuses on the treatment of diagnosed mental health and substance use problems. See "IBM Special Care for Children Assistance Plan" for details.

Ambulance Service (Air or Ground)

Eligible ambulance services will be considered at the in-network level and are covered only:

- When it is medically required emergency transportation to the closest hospital with necessary medical facilities for care
- When it is medically required transportation from an out-of-network hospital to an in-network hospital, as determined by the health plan or
- When it involves transportation from an out-of-network hospital to an in-network hospital for mental health/substance use treatment, as determined and recommended by the mental health care Plan Administrator.

Ambulance service from the hospital to your home, rehabilitation center, nursing home, skilled nursing facility, residential treatment center or other step-down care facility or for non-emergency situations will only be covered where considered medically necessary and with the prior approval from the health plan administrators.

Anesthesiology and Surgery

Anesthesiology and surgery are eligible when performed by a physician in a hospital (inpatient or outpatient), clinic, ambulatory surgical facility, birthing center or at home. Surgical procedures performed as part of an office visit will be subject to the surgical charge and not considered separately. Services provided by a physician acting as an assistant surgeon in complex procedures may also be eligible if determined to be medically necessary by the health plan.

Except in certain cases involving accidental injury (see *Accidental Injury to Sound Natural Teeth*, above), charges for oral surgery are not eligible for benefits under the IBM medical plan options but may be eligible under the applicable dental plan option (see the "*Dental Coverage*" section for information).

Assistant Surgeons

Assistant surgeons' fees are eligible only for complex surgical procedures where their services are determined to be medically necessary. Since there are limited circumstances where the services of an assistant surgeon are considered medically necessary, you are urged, before scheduled surgery, to contact the health plan for a predetermination. You should discuss with your surgeon whether or not assistant surgeons will be used and understand what you will be reimbursed.

Where an assistant is medically necessary, physician services are eligible. Services of nurses or other non-physician personnel practicing independently are not eligible for coverage.

Autism Spectrum Disorder/Rett Syndrome

Services and supplies provided by a physician or behavioral health provider to diagnose or treat autism spectrum disorder or Rett Syndrome, only if ordered as part of a treatment plan. Covered services include:

- Adaptive Behavioral Treatment (ABT) such as applied behavioral analysis (ABA), when pre-certified by the plan administrator. Your network provider is responsible for obtaining precertification and ongoing necessity review.
- Physical therapy (except for services provide in an educational or training setting) if it is expected to develop any impaired function.
- Occupational therapy (except for vocational rehabilitation or employment counseling, or services provided in an educational or training setting) if it is expected to develop any impaired function.
- Speech therapy (except for services provided in an educational or training setting or to teach sign language) as long as the therapy is expected to develop speech function as a result of delayed development. (Speech function is the ability to express thoughts, speak words and form sentences.)
- Habilitation therapy services performed by a licensed or certified physical, occupational or speech therapist; a hospital, skilled nursing facility or hospice facility; a home health care agency; or a physician to help patient keep, learn or improve skills and functioning for daily living.

Chemotherapy/Radiation Treatment

Chemotherapy and radiation therapy are eligible when they are provided and billed by a physician or an eligible facility. To be eligible for coverage, the following criteria must be met:

- Treatment must be rendered by the attending physician (e.g., treating oncologist/radiologist) responsible for the overall treatment plan.
- Laboratory and x-ray services necessary for the preparation or administration of the treatment protocol which are ordered by the attending physician.
- Chemotherapy drugs and certain supplies must have FDA approval as chemotherapy agents and be prescribed by the attending physician. When purchased at a pharmacy for outpatient use, the drugs and certain supplies will be covered under the IBM Managed Pharmacy Program.

CVS SPECIALTY PHARMACY

If you need covered prescription medications which require special handling or administration, like chemotherapy, and are currently receiving these medications through your doctor's office or other treatment center, you may want to consider ordering them through the CVS Specialty Pharmacy, part of the IBM Managed Pharmacy Program. By receiving covered prescription medications this way, you may pay less for them overall. Additionally, you may be able to have them shipped directly to you or your doctor's office at no additional charge. Contact CVS Caremark Customer Care for more details.

Chiropractic Care

Chiropractic care rendered by a licensed provider in the treatment of a medical condition is covered, subject to determination of medical necessity. Chiropractic treatment is limited to no more than 40 visits annually per individual. Routine preventive care, spinal subluxation and maintenance are not eligible for reimbursement.

Contraceptive Devices

Contraceptive devices and implants are eligible for coverage. Prescribed contraceptive drugs, devices or implants methods are covered in full and are not subject to the deductible or coinsurance. Contraceptive procedures (such as sterilization) will be covered medical services subject to applicable deductibles and coinsurance of the plan option.

Cosmetic Surgery

Cosmetic surgery is eligible for children under the age of 13 if the surgery is necessary to ameliorate a deformity arising from or directly related to a congenital abnormality, a personal injury resulting from accident or trauma or a disfiguring disease. Cosmetic surgery for patients over the age of 13 is eligible only when the surgery is necessary to correct a functional and/or physical disability resulting from deformity at birth or a condition arising as a result of accidental injury. The surgery must begin within six months of the accident unless it is not medically advisable to do so. Other cosmetic surgery is not eligible.

Electroconvulsive Therapy (ECT)

Inpatient and outpatient ECT may be covered when pre-certified both in- and out-of-network.

Emergency Treatment

Coverage for emergency room visits for medical emergencies as a result of a sudden and serious illness or accidental injury is covered. An emergency is the sudden onset of an acute medical condition that, without immediate medical care, could result in serious harm to your health, bodily functions or body parts (for example, sudden shortness of breath, uncontrolled bleeding, sudden severe intractable pain or any sudden onset of symptoms or illness a reasonable person would consider an emergency). Emergencies are covered by the IBM Plan at the in-network benefit level.

All emergency care is treated as in-network until the individual is medically able to be moved to an in-network facility. Once the individual is able to be moved, medical services received at the out-of-network facility are no longer covered.

Extended Care (Skilled Nursing) Facilities

This benefit is based on medical necessity as determined by a Nurse Advocate's review for medical necessity. Eligible expenses include charges for room and board at the semi-private room rate, skilled nursing, physical therapy, drugs and medical supplies.

To be eligible, the patient must require full-time nursing or skilled rehabilitative services, as certified by the patient's physician in writing. Precertification is required for benefits to be eligible. Nurse Advocates are required to perform a medical review and obtain medical information from your treating physician for skilled nursing facility admissions to determine if the services requested are eligible for coverage. Claims received for skilled nursing facility admissions that have not been authorized will be denied. See "*Pre-certification*" earlier in this section for more information.

In Vitro Fertilization/Artificial Insemination

- Up to three attempts per lifetime of In Vitro Fertilization (GIFT, ZIFT), per health plan administrator, whether or not successful, are eligible. An attempt is defined as the actual procedures for retrieval, fertilization and transfer, and each of the three attempts is eligible for coverage.

- Eligible charges billed by an approved facility will be covered (if the facility is not an approved facility, the charges are not eligible).
- Eligible pre-IVF treatment (i.e., administration of fertility drugs, ultrasounds, lab tests) is also covered.
- Fertility drugs require prior authorization through CVS Caremark (see *Prior Authorization Program* in the "*IBM Managed Pharmacy Program*" section). To determine eligibility of fertility drugs, you should contact CVS Caremark, the administrator for the IBM Managed Pharmacy Program.
- Artificial insemination is also covered. There is no limit to the number of attempts.
- Surrogate Parenting is not covered.

Note: *You are strongly urged to obtain a predetermination of benefits from the health plan administrator before incurring charges for In Vitro Fertilization to ensure the facility is approved and you have a clear prior understanding of reimbursements. Call the health plan administrator for eligibility of donors for egg/sperm, as well as circumstances where freezing/banking/storage of sperm/embryo and guidelines where ICSI and assisted hatching may be covered. Surrogate parenting is not covered.*

Hearing Care

Cochlear implants and post-cochlear implant aural therapy are eligible for coverage. Hearing aids and devices prescribed by a physician or licensed audiologist for the correction of hearing deficiencies are covered.

For children up to the age of six, the IBM Plan will cover the first set of hearing aids at 100% after the annual deductible is satisfied (there is no maximum reimbursement and copays and coinsurance do not apply). Any additional sets of hearing aids (up to the age of 6) will be covered subject to the annual deductible, coinsurance and copays. Maximum reimbursement is $2,000 ($1,000 per ear). For all other patients, the maximum reimbursement is $1,500 ($750 per ear) for each individual per year for hearing devices, including repairs and batteries. If you are enrolled in an HMO, review the summary benefit description of the HMO to understand how hearing aids are covered.

Home Dialysis

Under Social Security Administration regulations, you or your eligible dependents undergoing treatment for permanent kidney failure become eligible for Medicare coverage of home dialysis, regardless of age, after undergoing home dialysis treatment for a certain period of time. Contact your local Social Security office for information on this Medicare coverage.

Until the patient becomes eligible for Medicare coverage, home dialysis treatment for kidney failure is eligible under the Plan. Once Medicare becomes the primary coverage, the Plan will provide secondary benefits coverage (see "*Coordinating Plan Medical Coverage with Medicare*" in the "*Administrative Information*" section for more details).

Home Health Care

You are eligible for home health care services if you are enrolled in the IBM Low, Medium or High Deductible PPO options, IBM Exclusive Provider Organization, or IBM High Deductible PPO with HSA.

Note: *If your primary medical coverage is through Medicare, you must contact the health plan administrator in which you are enrolled if services have been denied by Medicare to ensure the services are eligible for coverage under the Plan.*

Before arranging for skilled home health care or outpatient nursing services, you must contact your health plan administrator to determine if the services are eligible for coverage. If they are determined to be eligible, the health plan administrator will work with your physician to provide home health care by arranging for the prescribed services and supplies. The health plan administrator is required to perform a skilled home health care review and obtain medical information from your physician in order to determine if the services requested are eligible for coverage. This review is intended to ensure that the skilled home health care services are medically necessary and appropriate for the medical condition.

Only skilled home health care services are eligible for coverage. In such cases, the Plan will allow assignment of these benefits directly to the provider of service and you will receive a copy of the Explanation of Benefits (EOB) statement to allow you to verify the charges and reimbursement amount. Any discrepancies should be reported to the health plan administrator immediately.

A utilization review to determine if the treatments or services are medically necessary and eligible for reimbursement will be required. If some or all of the home health services are subsequently determined not to be eligible under the terms of the IBM Plan (for example, if it is not medically necessary), you will be responsible for paying the cost of the services deemed not medically necessary. Only skilled home health care services approved by the health plan administrator are medically necessary and meet criteria are eligible for benefits consideration.

Eligible services include:

- Laboratory services
- Medical supplies
- Medications as part of infusion therapy under case management
- Part-time skilled home health nursing care services provided by a licensed nursing agency (nonagency nurses are not eligible for coverage)
- Prescription medicines (other than maintenance type medications routinely prescribed by the physician) and
- Speech, occupational, physical and respiratory therapy.

The following may be eligible under the normal provisions of the IBM Plan:

- Physician visits and
- Skilled follow-up care after hospitalization.

Skilled home health nursing care services consist of those services that must be performed by a registered nurse or licensed practical nurse and meet all of the following criteria for skilled nursing services:

- The service(s) must be ordered by a physician.
- The complexity of the service(s) requires a licensed professional nurse in order to be safely and effectively performed and to achieve the desired medical result.

- The skilled nursing service(s) must be reasonable and necessary for the treatment of the illness or injury, and accepted standards of medical and nursing practice.
- The skilled nursing service(s) is not custodial in nature.

The following home health care services are *not eligible* for coverage under the IBM Plan:

- Care that provides a level of routine maintenance for the purpose of meeting personal needs and which can be provided by a layperson who does not have licensed or professional qualifications, skill or training.
- Homemaking services, such as meal preparation and housecleaning.
- Custodial care, such as but is not limited to, activities of daily living, help in walking, dressing, eating and routine care of a patient.
- Care of colostomy and ileostomy bags and indwelling catheters, gastrostomy tubes and routine tracheotomies.
- Routine dressing changes, cast care and routine care in connection with braces and similar devices.
- Respiratory therapy — gases (including oxygen), routine administration of medical gases after a regimen of therapy has been established.

Home Hemophilia Treatment

Covered treatments include:

- Blood products, plasma and therapeutic blood concentrator or anti-hemophilia factors and
- Home therapy kits, infusion supplies, syringes, needles, etc. required for home care.

Hospitals should be advised to bill the health plan for these fees.

Note: *Any portion of the charges paid by government or non-governmental agencies will not be considered for reimbursement.*

Hospice Care

Eligibility for hospice care is based on a written statement from the attending physician that the patient's illness is terminal and that further medical care is only supportive in nature. Hospice care is provided under the direction of a hospice care agency and is generally eligible for consideration up to a maximum of six months. Hospice care beyond six months is provided as directed by the hospice care agency.

Eligible services billed by an approved hospice program include palliative care, medications that require administration by a registered nurse, licensed practical nurse or home health aide (if approved and charged through hospice), physicians and intermittent nursing visits, respiratory equipment and therapy, speech and physical therapy, medical supplies, rental of medical equipment, emotional support services by accredited pastoral counselors and social workers, as well as transportation between the home, hospice facility and hospital as necessary.

Hospice care is covered both at an inpatient or home health care setting.

Note*: Services by volunteers and private duty nursing are ineligible under Hospice Care.*

Immunizations/Vaccinations

Immunizations, whether required as the result of an accident or treatment of a medical condition (for example, allergies, rabies) or for prevention (for example, measles, hepatitis, and so on), are covered when the immunization is administered in the doctor's office or another medical facility.

***Note**: Influenza virus vaccine (flu vaccine) and the COVID vaccine/immunizations are covered in-network regardless of the place of service (doctor's office, clinic, local pharmacy/drug store, health department, etc.) if administered by an eligible provider (nurse, nurse practitioner, physician or pharmacist). For influenza virus vaccine (flu vaccine) administered outside of a doctor's office or another medical facility you must submit with the claim for benefits, the ICD10 or CPT/diagnosis code and signature of who administered the vaccine (nurse, nurse practitioner, physician or pharmacist). See* How to File a Claim *for reimbursement criteria. (**Note:** For the flu, shingles and COVID-19 vaccines only, a licensed pharmacist will be considered an eligible provider.)*

Immunizations are excluded from coverage under the IBM Managed Pharmacy Program with the following three exceptions.

- Flu vaccines administered by a retail pharmacist participating in the CVS Caremark vaccine network are covered under the pharmacy benefit.
- The zoster vaccine (shingles vaccine) administered by a retail pharmacist participating in the CVS Caremark vaccine network will be covered under the pharmacy benefit.
- The COVID vaccine administered by a retail pharmacist participating in the CVS Caremark vaccine network will be covered under the pharmacy benefit.

Please contact CVS Caremark to check if your pharmacy is in their network.

Inpatient Hospital Services

Coverage under hospital services is for confinement in a hospital or medical care in other eligible facilities. Confinement must be medically necessary and ordered by a physician. If you or a family member is admitted as an inpatient to a hospital while eligible for coverage under the IBM Low, Medium and High Deductible PPO options, IBM Exclusive Provider Organization, or IBM High Deductible PPO with HSA options and coverage changes during that stay (e.g., dependent reaches age 23), all charges otherwise eligible under the Plan which are incurred up until the date of discharge will continue to be eligible for benefits.

Hospital Room

- Meals and general nursing services.
- Semi-private room or ward. If the hospital has private room facilities only, the health plan administrator will determine the average semi-private room rate for the area and benefits will be paid based on that rate.
- Private rooms only when the confinement is required for patients with certain communicable diseases as determined by the health plan. (Private room coverage for reverse isolation is not considered eligible.) Also, if you voluntarily choose a private room, or your physician moves you to a private room from a semi-private, reimbursement will be limited to and based on the most common semi-private room rate of the facility and the specific private room rate charged.

  The IBM EPO Plan copayment is for a semi-private room. If the hospital bills the higher private room rate, the patient is responsible for paying the difference between the semi-private room

rate and private room rate in addition to the IBM EPO copayment. If the hospital does not bill the higher private room rate, the IBM EPO copayment is all the member is responsible for.

Christian Science Sanatoriums
Benefits are based on the prevailing semi-private room rate of general purpose hospitals in the same geographic area in which the Christian Science Sanatorium is located. *Personal items — guest meals, radio, television, telephone, etc. — are not covered. Private and special duty nurses are not covered.*

Medical Services and Supplies in Connection with Hospital Services
The following inpatient services and supplies are eligible regardless of the type of accommodation occupied, when the services and supplies are ordered by a physician and approved by the hospital in the normal course of diagnosis or treatment of an illness or injury:

- Anesthetic supplies and equipment
- Chemotherapy
- Dressings, plaster casts, splints, trusses, braces and crutches
- Drugs and medication for use in the hospital including radium and radioactive substances
- Electrocardiograph and electroencephalograph equipment
- Intensive care units or coronary care facilities
- Laboratory examinations
- Nursery and premature nursery service, including infant identification bracelet, for eligible family members
- Operating, cystoscopic, delivery and recovery rooms and equipment
- Oxygen
- Physiotherapeutic equipment; physiotherapy
- Prosthetic, orthopedic or other devices such as bone plates and screws, tantalum mesh, nails, pins, bone replacement prostheses, pacemakers, heart valves, vascular tubes and laryngectomy tubes requiring internal fixation by a physician, not removable by the patient at will, for which hospitalization would be required for removal, replacement or repair
- Radiation therapy
- Sera, biologicals, vaccines, intravenous preparations and visualizing dyes, including human blood or blood plasma or other human blood derivatives (this benefit includes the processing, storage and administration)
- Special equipment, including but not limited to special beds and custom-made appliances for use in the hospital, X-ray/Imaging diagnosis, supplies and equipment.

Pre-Admission Testing
Standard hospital pre-admission tests billed by the hospital.

Inpatient Professional Fees
If eligible professional services are rendered by a salaried staff employee of the hospital and are billed by the hospital, charges will be reimbursed under hospital services.

Other professional services billed by independent physicians or other providers who are not salaried staff employees of the hospital, for the administration, interpretation or operation of eligible medical

supplies and treatments may be eligible for coverage under medical services and reimbursed by the Plan at the applicable primary care physician or physician specialist rate.

Marriage and Family Counseling

Marriage counseling is only covered under the Employee Assistance Program. No reimbursement is available through the IBM Medical Plan. Family counseling is covered under the EAP and is eligible for reimbursement through the IBM Medical Plan.

Medical Equipment

Basic medical equipment or devices are considered eligible if they are prescribed by a physician and are medically necessary for proper care and treatment of a condition. Examples of items that may be eligible include shoe orthotics, artificial limbs, various aids to impaired organs (such as wheelchairs, heart pacemakers, oxygen equipment and, in some cases, hospital beds) and certain types of monitoring devices. Coverage is provided for standard equipment and only when it is medically necessary. “Take-home” items from a hospital, resulting from an inpatient stay or outpatient treatment, may be eligible under the IBM Plan.
Rental of durable items should be the general practice. However, if there is evidence that the equipment will be required long enough to justify purchase, reimbursement will be limited to the purchase price.

Certain items not necessarily therapeutic in nature, but that allow for increased safety and help prevent injury in “activities of daily living” for individuals who are physically challenged as a result of serious injury or illness, may be considered eligible if prescribed for such an individual by a physician.

These items include:

- Bath/bed/chair lifts which enable a bedridden or wheelchair-bound patient to more readily move to and from the bed or bath
- Bath/shower/tub rails or grab bars which promote safer use of bathing facilities by bedridden or wheelchair-bound patients
- Bedside safety rails as an attachment to prevent falling by a bedridden individual

Medication Management Sessions

Medication management visits for mental health services are covered through the IBM Medical Plan.

Mental Health Care and Substance Use

OUT-OF-NETWORK SERVICES
Mental health services will generally be covered out-of-network for those enrolled in one of the PPO plan options; out-of-network benefits are not available under the IBM EPO plan option. The Plan will not cover out-of-network, non-urgent residential and day rehabilitation services received outside your state of residence, or immediate bordering state. (This will not apply to urgent care, students attending out of state schools or those with dual addresses.)

Contact your health plan administrator to learn more.

Covered mental health care and substance use services include those received on an inpatient or outpatient basis in a hospital, an alternative facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits are payable for:

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

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

Covered services include:

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

The Plan covers both routine and non-routine outpatient treatment, non-routine outpatient care must be pre-certified. To determine if care is routine or non-routine, call your medical plan administrator.

OUTPATIENT BENEFITS IF YOU ARE ELIGIBLE FOR MEDICARE

You must use a provider who accepts Medicare to receive a benefit from the Plan. You will not receive a benefit if you receive care from a provider who does not accept Medicare.

Because Medicare provides your primary coverage for most mental health services, all of your claims must first be considered by Medicare. In general, Medicare pays 50% of the Medicare-allowed amount for Medicare Part B mental health services. If you go to a provider in your plan's network who accepts Medicare, you will receive in-network benefits.

If you receive treatment from a provider who accepts Medicare but is not in the MMHC administrators network, you will receive the out-of-network outpatient benefit.

Relationship to the IBM Special Care for Children Assistance Plan
The IBM Special Care for Children Assistance Plan is a separate program focused on the developmental problems of children with mental, physical, or developmental disabilities. The Managed Mental Health Care Program focuses on the treatment of diagnosed mental health and substance use problems. See "IBM Special Care for Children Assistance Plan" for details.

Emergency Care Coverage

If you have a mental health emergency, you should call 911 or immediately go to the nearest emergency room. You, or your representative such as a family member or friend, must present your medical plan ID card to identify yourself as a Plan participant. In an emergency, a network hospital must seek certification of the care within 48 hours. If you go to an out-of-network hospital, either you or your attending physician's office, or your representative such as a family member or friend, must call your health plan to seek certification of care within 48 hours.

Failure to notify the health plan administrator of an admission to an out-of-network facility will result in an additional $150. In addition, you must pay for all charges for care deemed not medically necessary by the Plan.

HOW A MENTAL HEALTH EMERGENCY IS DEFINED

"A mental health emergency" is defined as a severe psychiatric or substance use condition which renders you incapable of providing accurate benefits information when you are admitted to the hospital or incapable of following the provisions of the Plan. Your Medical Plan will authorize benefit coverage for medically necessary hospital admissions.

In these severe situations, administering appropriate treatment should occur immediately to ensure safety before determining whether care is eligible under the Plan.

Out-of-Network Emergency Care
Care at an out-of-network hospital will be certified as "in-network" during the stabilization period for an emergency admission *only* following notification. Once the patient is stabilized, the patient will be moved to an in-network facility and coverage will not be provided.

Multiple Simultaneous Surgical Procedures

If more than one eligible surgical procedure is performed at the same time, reimbursement for the most extensive procedure is based on the full negotiated rate or provider's actual charge, whichever is less, and reimbursement for the additional procedures is based on half of the negotiated rate or the provider's actual charge, whichever is less.

Surgical procedures considered "incidental" to the principal surgery are not eligible for benefit reimbursement. (An "incidental" surgical procedure is one that is performed at the same time as a more complex primary procedure and requires little additional physician resources, or is identified in the primary procedure code.)

Surgical procedures that are mutually exclusive are not eligible ("mutually exclusive" procedures are procedures that, according to medical practice standards, should not be performed on the same patient on the same date of service). You are urged to contact the health plan administrator regarding questions on multiple, simultaneous surgical procedures before the surgery or to obtain a predetermination of benefits.

Nursing Care

Nursing care services must be skilled, provided through a licensed nursing agency, medically necessary and ordered by a physician. Nonagency nurses are not eligible for coverage. Skilled home health nursing care services consist of those services that must be performed by a registered nurse or licensed practical nurse and meet all of the following criteria for skilled nursing services:

- The service(s) must be ordered by a physician.
- The complexity of the service(s) requires a licensed, professional nurse in order to be safely and effectively performed and to achieve the desired medical result.
- The skilled nursing service(s) must be reasonable and necessary for the treatment of the illness or injury, and accepted standards of medical and nursing practice.
- The skilled nursing service(s) is not custodial in nature.

Only services that cannot be performed by a layperson are eligible, such as administration of medications and monitoring of medical support systems or intravenous systems. Services considered primarily custodial in nature by the health plan are not eligible. Custodial care includes:

- Care that provides a level of routine maintenance for the purpose of meeting personal needs and which can be provided by a layperson who does not have licensed or professional qualifications, skill or training.
- Homemaking services, such as meal preparation and housecleaning.
- Custodial care, such as but is not limited to, activities of daily living, help in walking, dressing, eating and routine care of a patient.
- Care of colostomy and ileostomy bags and indwelling catheters, gastrostomy tubes and routine tracheotomies.
- Routine dressing changes, cast care and routine care in connection with braces and similar devices.
- Respiratory therapy— gases (oxygen), routine administration of medical gases after a regimen of therapy has been established.

***Note**: Private duty nursing services rendered in a hospital setting are not covered.*

For the IBM Low, Medium and High Deductible PPO options, IBM Exclusive Provider Organization, and IBM High Deductible PPO with HSA, nursing services rendered in the home are not covered unless approved by the health plan administrator. A utilization review to determine if the treatments or services are medically necessary and eligible for reimbursement will be required. If some or all of the home health services are subsequently determined not to be eligible under the terms of the Plan (for example, if it is not medically necessary), you will be responsible for paying the cost of the services deemed not medically necessary. Only skilled home health care services that are approved by the health plan administrator are medically necessary and meet criteria are eligible for benefits consideration. See "*Pre-certification*" earlier in this section for more details.

Nutritional Counseling

Nutritional counseling provided by a Registered Dietitian or Licensed Nutritionist is covered for one visit upon the initial diagnosis of diabetes. No further visits will be covered. Nutritional counseling for any other condition or diagnosis will not be covered.

Obstetrics

Obstetrics is eligible when performed by a physician in a hospital (inpatient or outpatient), clinic, ambulatory surgical facility, birthing center or at home. Surgical procedures performed as part of an office visit will be subject to the surgical charge and not considered separately. Services provided by a physician acting as an assistant surgeon in complex procedures may also be eligible if determined to be medically necessary by the health plan.

Medical benefits for maternity charges billed by the attending physician/obstetrician for prenatal visits as well as the delivery fee are not reimbursable until after the termination of pregnancy.

Occupational Therapy

Occupational therapy provided by a certified occupational therapist is covered up to a maximum of 40 visits per calendar year when it is prescribed by a physician and necessary for the restoration of an individual's ability to satisfactorily perform daily tasks when this ability was lost due to injury, illness or surgery. Visits beyond 40 are subject to medical necessity review and must be pre-approved by the health plan administrator. You should contact your health plan administrator before your 40th visit so that medical necessity can be determined for future visits.

Claims received for more than 40 visits that have not been authorized will be denied. A utilization review to determine if the treatments or services are medically necessary and eligible for reimbursement will be required. If some or all of the services are subsequently determined not to be eligible under the terms of the Plan (for example, if it is not medically necessary), you will be responsible for paying the cost of the services deemed ineligible, including those services which are deemed not medically necessary.

Occupational therapy is not covered when it cannot reasonably be expected to be significantly restorative when a maintenance level has been achieved, or for developmental delays. However, occupational therapy is covered for autism spectrum disorder and Rett syndrome.

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)

Eligible health services include the following oral and maxillofacial treatment (mouth, jaws and teeth) provided by a physician, a dentist and hospital:

- Non-surgical treatment of infections or diseases.
- Surgery needed to:
  - Treat a fracture, dislocation, or wound.
  - Cut out cysts, tumors, or other diseased tissues.
  - Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth.
  - Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.
- Hospital services and supplies received for a stay required because of your condition.
- Dental work, surgery and orthodontic treatment needed to remove, repair, restore or reposition:
  - Natural teeth damaged, lost, or removed. Your teeth must be free from decay or in good repair and are firmly attached to your jawbone at the time of your injury.
  - Other body tissues of the mouth fractured or cut due to injury.
  - Crowns, dentures, bridges, or in-mouth appliances only for:
    - The first denture or fixed bridgework to replace lost teeth.
    - The first crown needed to repair each damaged tooth.
    - An in-mouth appliance used in the first course of orthodontic treatment after an injury.

Outpatient Hospital Services

Coverage is provided for eligible outpatient services performed in a hospital or approved ambulatory surgical facilities. In some cases, laboratories and surgical or diagnostic suites within a hospital building/complex may be privately owned and operated. Facility fees incurred at these privately owned and operated suites are not eligible for coverage. You are urged to verify eligibility by contacting the health plan administrator before obtaining services.

When you receive services from a hospital, but are not admitted as a registered bed patient, the services listed below are generally eligible:

- Surgical procedures performed on an outpatient basis in the operating room or other surgical facility such as the emergency room of a hospital or an eligible ambulatory surgical center
- Emergency room visits for medical emergencies as the result of a sudden and serious illness (cardiac arrest, convulsions, stomach pains, etc.) or accidental injury
- Diagnostic testing
- Physical therapy
- Observation room stays
- Chemotherapy/radiation
- Home dialysis for kidney failure will be eligible for consideration under hospital services subject to the same guidelines listed in "*Medical Services and Supplies in Connection with Hospital Services*" if the service is billed by an approved hospital and
- Fees incurred by the actual donor for bone marrow transplants (after coordination with other plans) if the transplant procedure is not considered experimental or investigational.

  ***Note**: Registry fees for bone marrow transplants and testing for suitable bone marrow transplant candidates are not covered. Precertification, evaluation (to determine procedure is not considered experimental or investigational) and approvals are required before transplant. After approval, coverage begins and donor search/fees would be covered. If the person does not get prior approval from the health plan administrator for the transplant, and the claims are submitted to the health plan administrator, the claims will be denied.*

Pathology and Radiology (Lab and X-rays)

Eligible pathology and radiology services are covered when necessary for the diagnosis and treatment of an illness or injury and rendered by an eligible provider.

Physical Therapy

Physical therapy rendered by a certified physiotherapist is covered up to a maximum of 40 visits per calendar year when the treatment is prescribed by a physician and necessary for the restoration of function that was lost due to injury, illness or surgery. Therapeutic massage is eligible when rendered as a component of physical therapy in the treatment of a medical condition and when performed by a licensed provider.

Visits beyond 40 are subject to medical necessity review and must be pre-approved by the health plan administrator. You should contact your health plan administrator before your 40th visit so that medical necessity can be determined for future visits. Claims received for more than 40 visits that have not been authorized will be denied.

A utilization review to determine if the treatments or services are medically necessary and eligible for reimbursement will be required. If some or all of the services are subsequently determined not to be eligible under the terms of the Plan (for example, if it is not medically necessary), you will be responsible for paying the cost of the services deemed ineligible, including those services which are deemed not medically necessary to determine continued eligibility for benefits.

Physical therapy is not covered when it is provided to treat a chronic condition where rehabilitation is not the goal or when the therapy has reached the maintenance stage or for developmental delays. However, physical therapy is covered for autism spectrum disorder and Rett syndrome.

Pre-Admission Testing

Pre-admission tests required by hospitals before an inpatient confinement (e.g., chest x-ray, urinalysis, CBC) as well as tests related to outpatient surgery are eligible if they are performed and billed by an eligible provider.

Preventive Care Services

Preventive care and screenings are covered and charges for routine screenings and checkups are not subject to the Plan's deductible.

***Note**: Any subsequent or follow-up diagnostic testing, performed as a result of findings indicated by the routine/preventive screenings, will not be eligible for waiver of the deductible. To be covered at the preventive benefit level eligible for waiver of the deductible, the service billed must be one of the services listed on the following pages AND not have a diagnosis included on the claim.*

The IBM preventive services list is derived from expert consensus and/or advisory groups, including the U.S. Preventive Services Task Force (USPSTF), National Cancer Institute (NCI), American Academy of Pediatrics, Agency for Healthcare Research and Quality, Center for Disease Control (CDC) and Advisory Committee on Immunization Practices (ACIP). This list of preventive services may not cover all tests that could be considered preventive. Services received that are not on this list, and that are not eligible for waiver of deductible, may be eligible for coverage under normal plan provisions.

***Note:** Routine eye examinations, including preventive tests for visual acuity (refraction), color vision, glaucoma, cataracts and field of vision by an eligible provider (ophthalmologist, optometrist or optician) and expenses for de-vices (for example, prescription eyeglasses, contact lenses) associated with correction of deficiencies, are not eligible, but may be covered under the Anthem Blue View Vision Plan.*

Charges for the following routine preventive care services are eligible for coverage:

PHYSICAL EXAMS AND TESTS	IMMUNIZATIONS/VACCINATIONS
Newborn	
Newborn Exam: State required congenital screenings, hearing testing, PKU Screening, sickle cell, hemoglobin and hematocrit, glucose, bilirubin and galactose	
Child	
Well-Child Exam: Hemoglobin and/or Hematocrit, TB, Lead, Urinalysis	
Adolescent	
Well-Adolescent Exam: Cervical (PAP) test starting at 18	

PHYSICAL EXAMS AND TESTS	IMMUNIZATIONS/VACCINATIONS
Well Woman	▪ Cholera vaccine ▪ COVID-19 (Corona virus) vaccine ▪ Diphtheria ▪ (DTP) Diphtheria, Tetanus, Pertussis ▪ Hemophilus influenza B vaccine (HIB) ▪ Hepatitis A and Hepatitis B (HepA-HepB) ▪ Hepatitis A vaccine ▪ Hepatitis B vaccine ▪ Human papilloma virus (HPV) vaccine (e.g., Gardasil) ▪ Influenza virus vaccine ▪ Measles vaccine ▪ (MMR) Measles, Mumps, Rubella ▪ Meningococcal polysaccharide vaccine ▪ Mumps vaccine ▪ Pertussis ▪ Pneumococcal vaccine ▪ Poliovirus vaccine ▪ Rotavirus vaccine (e.g., Rotateq) ▪ Rubella vaccine ▪ Shingles vaccine ▪ Tetanus ▪ Typhoid vaccine ▪ Varicella vaccine ▪ Yellow fever vaccine
Well Woman Exam: Cervical (PAP) test	
General Adult	
Well-Adult Exam: Lipid profile, CBC, Routine Multi-Channel Blood Test, Glucose, EKG, hearing screening (excludes audiometric testing)	
Cholesterol Screening with or without general adult exam	
Hypertension Screening with or without general adult exam	
Osteoporosis Screening Exam: Including Bone Mineral Density Tests	
Adult Cancer Screening	
Fecal occult blood testing	
Sigmoidoscopy & Screening biopsy, and polyp removal: Including anesthesia and facility charges	
Colonoscopy & Screening biopsy, and polyp removal: Including anesthesia and facility charges	
Prostate Cancer screening PSA & Digital Rectal Exam (DRE)	
Mammography	
Skin Cancer Screening	

Psychological Testing

Pre-certified outpatient psychological testing is covered. If psychological testing is not pre-certified, no benefits will be payable.

Psychological testing must be provided by a licensed doctoral-level psychologist (Ph.D.) or with the exception and/or certification of the mental health plan. Psychological testing for developmental, education or learning disabilities is not eligible under the IBM Medical Plan. (Refer to the "*Special Care for Children Assistance Program*" for possible coverage.)

Psychotherapy

Only one session for psychotherapy per day is eligible for payment under the Plan. When a claim is submitted for psychotherapy provided on an outpatient or an inpatient basis, benefits are payable for up to one session (maximum) for the same service on any given day. A session is defined by the Current Procedural Terminology (CPT) code billed by the provider. Most CPT procedure codes describe the service provided and the amount of time recommended for the session or service.

However, benefits are payable for two different services on the same day.

Reconstructive Surgery after Mastectomy

Coverage applies when the mastectomy itself is covered by the Plan and includes reconstructive surgery of the breast on which the mastectomy is performed, reconstructive surgery of the other breast to

produce a symmetrical appearance and prostheses and complications of mastectomies, such as lymphedema.

Self-Donated Blood Donations

Processing, storage and administration charges for up to three pints of the patient's self-donated blood for potential transfusion to the patient are eligible for coverage when the patient is scheduled for surgery.

Series of Surgical Treatments

In some instances, it may be necessary to receive a series of surgical treatments or several stages of treatment in order to accomplish total repair or correction. You are urged to obtain a predetermination of benefits from the health plan administrator in advance of each stage of treatment.

Speech Therapy

Speech therapy rendered by an eligible speech pathologist which is prescribed by a physician and an integral part of a total rehabilitation program necessitated either by traumatic injury to the brain (for example, accidental injury, stroke or brain surgery) or by the loss of or injury to an individual's larynx is covered up to a maximum of 40 visits per calendar year. Visits beyond 40 are subject to medical necessity review and must be pre-approved by the health plan administrator. You should contact your health plan administrator before your 40th visit so that medical necessity can be determined for future visits. Claims received for more than 40 visits that have not been authorized will be denied.

A utilization review to determine if the treatments or services are medically necessary and eligible for reimbursement will be required. If some or all of the services are subsequently determined not to be eligible under the terms of the Plan (for example, if it is not medically necessary), you will be responsible for paying the cost of the services deemed ineligible, including those services which are deemed not medically necessary.

Note: *Speech therapy to refine an individual's existing speech or to educate an individual whose speech has not yet developed is not covered, nor is myofunctional therapy. However, speech therapy is covered for autism spectrum disorder and Rett syndrome.*

Temporomandibular Joint Dysfunction (TMJ)

In certain rare circumstances, surgical procedures for temporomandibular joint dysfunction (TMJ) may be required and recommended by your provider. Generally, this will only be the case when conventional dental treatment has already been tried and failed to correct the TMJ dysfunction. In such cases, certain surgical procedures may be eligible for coverage under the medical plan options. To determine if medical benefits would apply for TMJ expenses in your particular circumstance, you should consult the health plan administrator before you incur any expenses. All other TMJ-related services are not eligible for coverage under the Plan.

Virtual Visits and Telemedicine

Virtual care provided through Teladoc or LiveHealthOnline is covered in-network with no charge (if you participate in an HSA plan option, you must meet the deductible first).

Vision Therapy

Visual therapy services rendered by an optometrist to correct faulty optical fusion or poor coordination of ocular muscles are eligible for coverage. Eligible charges for optometric services include:

- Therapy directed at restoring eye muscle tone and movement after surgery.

- Therapy for faulty optical fusion to muscular imbalance.
- Therapy for amblyopia.
- Therapy for various forms of eye muscle derangement resulting in the diagnosis of diplopia, heterophoria or esotropia.

Visual training administered to improve perceptive powers, either from the standpoint of concentration or comprehension, without the objective of correcting an organic impairment, are not eligible.

Wigs and Toupees

Coverage for wigs and toupees, up to an annual maximum of $2,000 per individual after the annual deductible has been met, only for covered individuals who:

- Have suffered traumatic injuries, including serious burns.
- Have certain medical conditions, such as alopecia (areata, totalis or universalis) and lupus.
- Have experienced hair loss resulting from medical treatment, such as chemotherapy and radiation treatment.

Exclusions: What the Plan Does Not Cover

While the medical plan options cover many services, there are some that are not covered even if your physician or professional provider approves or recommends them. To ascertain if a service is covered, you should call the health plan administrator to verify benefits. Services that are not covered by the medical plan options include, but are not limited to, the following:

- Services received out-of-network, except in an emergency or as described under "*Out-of-Network Medical Coverage*."
- Expenses related to the completion of your claim form by a third party, medical testimony or medical records.
- Cosmetic services are not eligible under the Plan, except for certain cosmetic surgeries and reconstructive surgery after mastectomy, as specified in *What's Covered Under the Plan*.
- Custodial care services are not covered under the Plan. "Custodial" is defined as care that provides a level of routine maintenance for the purpose of meeting personal needs, and which can be provided by a layperson that does not have professional qualifications, skills or training. Custodial care also includes, but is not limited to:
  - Care that does not require a licensed, skilled professional.
  - Homemaking services such as meal preparation and housecleaning.
  - Activities of daily living, including assistance in bathing, dressing, eating or toileting.
  - Routine care such as help in transferring, walking, dressing or eating.
  - Care of colostomy and ileostomy bags, indwelling catheters, gastrostomy tubes, routine tracheotomies, routine dressing changes, cast care and routine care in connection with braces and similar devices.
  - Respiratory therapy — gases (oxygen), routine administration of medical gases after a regimen of therapy has been established.

- Procedures that are *dental* in nature are not covered under the medical plan options, except in the case of treatment for accidental injury to sound natural teeth if the health plan administrator determines that accidental injury coverage applies. Non-surgical TMJ services are not covered under the medical plan options. A procedure is considered "dental in nature" if it primarily is concerned with the teeth, oral cavity and associated supporting structures of the teeth. It includes the prevention, diagnosis and treatment of diseases and injuries of this area. The service may be covered under your dental option (if any). See the "*Dental Coverage*" section for more information.
- *Educational or training services or supplies.* A charge for a service or supply is not covered to the extent that it is determined by the health plan administrator to be educational or training in nature. Charges in connection with such a service or supply are also not covered. "Educational" includes, but is not limited to
  - Services or supplies for which the primary purpose is to provide the person with any of the following:
    - Training in the activities of daily living — does not include training directly related to the treatment of a sickness or injury that resulted from a previously demonstrated ability to perform those activities, which may be eligible for coverage
    - Instruction in scholastic skills such as reading and writing
    - Preparation for an occupation and
    - Treatment for learning disabilities;
  - Cognitive therapy;
  - Services or supplies provided to promote development beyond any level of function previously demonstrated; and
  - Services or supplies related to lifestyle or wellness programs.
- Out-of-network mental health and substance use charges in excess of the 80th percentile of the U&P rate. Any amount of the charges in excess of the U&P rate as determined by the health plan will not be considered in calculating benefits.
- Any *excluded drug or service* listed under the section "*Exclusions Under the IBM Managed Pharmacy Program*."
- *Experimental or investigational services or supplies.* A treatment or other service or supply (and any other services, supplies or equipment it requires) will generally not be covered if it is experimental or investigational. "Experimental or investigational" means the medical use of a service or supply is still under study and/or is not yet recognized or accepted throughout the medical profession in the United States as safe and effective for diagnosis or treatment of the diagnosed condition. This includes, but is not limited to:
  - All phases of clinical trials.
  - All treatment protocols based on or similar to those used in clinical trials.
  - Federal Food and Drug Administration (FDA) approved drugs, FDA treatment "investigational new drugs" and National Cancer Institute Group C drugs, when used for treatment indications other than those for which the drug's use is recognized throughout the medical profession in the United States.
- Routine *foot care* for removal of corns and calluses.
- *Hair growth* medications or treatments for the restoring, promotion or discouragement of hair growth (e.g., electrolysis) are not eligible.

- *Homeopathic and naturopathic treatments.*
- Incontinence *supplies* are not eligible (e.g., Depends, diapers, etc.).
- Charges incurred at an *ineligible facility* and special units within facilities, including educational facilities, custodial care facilities, special schools, therapeutic schools, wilderness programs, nursing homes, rest homes and homes for the aged or other similar institutions. Charges for room and board in these facilities are not eligible under the Plan. Consult *What's Covered Under the Plan* to see if any charges incurred for medical services while in the facility are eligible for benefits.

  Other facility fees may not be eligible, including:

  - Facility charges incurred as a result of treatment received from a freestanding pain management clinic or pain management departments affiliated/associated with an acute care hospital are not eligible for coverage. Certain medical components may be eligible under "Medical Services" (e.g., physical therapy, etc.). You should contact your health plan to verify eligibility of such charges before incurring the expense.
  - Facility fees incurred at privately owned and operated laboratories and surgical or diagnostic suites within a hospital building/complex may not be eligible for coverage. You are urged to verify eligibility by contacting your health plan administrator before obtaining services.
- Charges for services which are *not medically necessary*. A charge for a service or supply is not covered to the extent that it is not medically necessary for the treatment or diagnosis of an injury, illness or pregnancy or within the intent of the Plan provisions. Charges in connection with such a service or supply are also not covered. See *What's Covered Under the Plan* for the definition of medically necessary.
- *Marital therapy* is not eligible except through the Employee Assistance Program. See the "*Mental Health Care and Substance Use*" section for coverage details.
- *Massage Therapy* is not eligible, unless provided as part of physical therapy or chiropractic care.
- *Medical equipment* not eligible for coverage:
  - Medical equipment that is deluxe rather than standard and features that are not medically necessary. Allowance for standard equipment will not be applied toward the cost of deluxe equipment or features.
  - Items that are of general use for non-therapeutic purposes (such as air conditioners, air or water purifiers, mattress/pillow covers, and so on), even if, in your case, it is prescribed for a medical condition.
  - Items that are of general use for physical fitness (such as rowing machines, exercise bicycles, barbells, treadmills and so on), even if, in your case, it is prescribed for a medical condition.
  - Homes, vehicles (other than wheelchairs) or improvements or modifications to a home or vehicle.
  - Common household first-aid items (such as gauze, adhesive tape, heating pads, hot water bottles and so on).
  - Cosmetic items. Wigs and other hair pieces may be covered under certain circumstances as specified in *What's Covered Under the Plan*.
  - Equipment and supplies the health plan administrator determines are not within the intended scope of coverage or are otherwise ineligible.

  - Back-up equipment is not eligible.
- Mental Health/Substance Use Exclusions:
  - Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM TR-5)*.
  - Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5)*.
  - Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder, and paraphilic disorder.
  - Educational services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
  - Out-of-network, non-urgent residential and day rehabilitation services received outside the IBMer's state of residence or immediate bordering state. This exclusion does not apply to urgent care, students attending school out of state or those with dual addresses.
  - Tuition or services that are school based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act.
  - Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5)*.
- *Occupational injuries or illnesses* that are covered under Workers' Compensation.
- *Pain Management Clinics.* Facility charges incurred as a result of treatment received from a freestanding pain management clinic or pain management departments affiliated/associated with an acute care hospital are *not* eligible for coverage. Certain medical components may be eligible under medical services (e.g., physical therapy, etc.). You should contact the health plan administrator to verify eligibility of such charges before incurring the expense.
- *Private duty nursing services rendered in a hospital setting* are not covered, since the hospital is expected to provide 24-hour medically necessary nursing care as a part of the services covered by the hospital's room charges.
- *Rest cures, or illness or injury arising from an act of war* if such act occurs while the patient is covered under the Plan. This provision does not apply to eligible care and services furnished in a Veterans Administration hospital in connection with a non-service-related disability.
- *Surrogate Parenting* is not covered.
- *Technology-enabled psychotherapy sessions conducted via telephone, video conference, Skype or other mobile technology* are not a covered benefit under the IBM Managed Mental Health Care Program without the prior approval of the health plan administrator.
- Vision exams, services and procedures for changes to *visual refraction*, including LASIK surgery or other eye surgeries, when the primary purpose is to correct myopia, hyperopia or astigmatism. (See the "*Vision Coverage*" section for information about the Anthem Blue View Vision Plan.)

Medical Options for Medicare-Eligible Retirees

Medicare-eligible retirees, Medicare-eligible individuals receiving Medical Disability Income Plan (MDIP) or IBM Long-Term Disability (LTD) Plan benefits, and their Medicare-eligible dependents are not eligible to enroll in coverage under the options for Non-Medicare-Eligible retirees.

Medicare-eligible retirees may enroll in one of the IBM-sponsored Group Medicare Advantage plan options administered by United Healthcare: the Essential Plan option and the Enhanced Plan option.

The IBM-sponsored Group Medicare Advantage plan options have all the benefits of Medicare Part A (hospital coverage), Medicare Part B (doctor and outpatient care) and Medicare Part D (prescription drugs) plus extra features and enhancements designed exclusively for IBM Medicare-eligible participants. These extra features and benefits include routine dental and vision care, discounts on hearing aids, clinical programs, removal of certain lifetime maximums, and more.

The group nature of the IBM Group Medicare Advantage plan options provide certain enhancements and protections outside of just the custom plan designs. For more information call the IBM Retiree Call Center administered by UnitedHealthcare or visit https://retiree.uhc.com/ibm.

IBM Benefits Plan for Retired Employees

IBM Employee Assistance Program (EAP)

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IBM Employee Assistance Program (EAP)

ABOUT THE EMPLOYEE ASSISTANCE PROGRAM

The EAP can help when you need assistance with a personal or family related problem. In most cases, issues can be resolved effectively within the EAP. Some people will require more specialized or longer-term treatment. In these situations, the EAP clinician will help connect you with an appropriate mental health care provider through your medical plan, if eligible, or with your HMO or other group health coverage.

EAP clinicians are independently licensed mental health/substance use-disorder treatment professionals who are contracted with the EAP administrator.

Resources for Living (RFL) is available--free of charge—to you and all members who live in your household. All eligible dependents under the plan including dependent children up to age 26 are eligible, whether or not they live at home. Services are confidential and available 24 hours a day, 7 days a week.

Aetna is the Plan Administrator for the EAP, known as Resources for Living (RFL) EAP Plan. You must call to authorize care and ensure costs are covered.

To access EAP services, contact Resources for Living at 866-317-8870, TTY:711 or at resourcesforliving.com, Username: IBM, Password: RFL

HOW THE EAP WORKS

You can access up to 12 counseling sessions per issue by calling RFL at 866-317-8870 to precertify EAP sessions. While you can find a provider on resourcesforliving.com, you still must call RFL to precertify before your first visit. You can also call RFL 24 hours a day for in-the-moment emotional wellbeing support.

Secure counseling sessions are available face-to-face, via video chat, or online with Talkspace. RFL can help you find a counselor in your area and even make appointments for you for a wide range of issues including:

- Relationship support
- Stress management
- Work/Life balance
- Family issues
- Grief and loss
- Depression
- Anxiety
- Substance misuse
- Self-esteem and personal development

TALKSPACE

Talkspace is an online therapy service that provides convenient and confidential mental healthcare through a secure and HIPAA-compliant mobile app and web platform. Talkspace allows you to send a dedicated therapist unlimited text, video, and audio messages from anywhere, at any time — via web browser or the Talkspace mobile app. Therapists engage daily, five days a week.

Participants provide information about their needs and preferences through a matching questionnaire. Talkspace suggests three therapist matches for each participant based on their unique needs and preferences. Talkspace is not a live-chatting service, but participants can engage at their own pace, on a flexible schedule. Each week that the participant engages in Talkspace counts as one EAP visit.

- Other resources available through RFL include Mind Companion Self-Care, a digital self-guided tool focused on improving mental well-being.
- Assistance with Daily Living resources such as child and elder care referrals. Legal and financial services.

You can visit resourcesforliving.com for a complete list of resources available.

IF YOU NEED TREATMENT BEYOND THE MAXIMUM NUMBER OF EAP SESSIONS

If you are covered under the IBM Low Deductible PPO, IBM Medium Deductible PPO, IBM High Deductible PPO, IBM EPO options or IBM High Deductible PPO with HSA and require further assistance beyond the EAP assessment, you should contact your health plan administrator to find a provider in the MMHC provider network.

The decision to use a provider to whom you are referred through the EAP is your responsibility. EAP is not intended for long-term treatment of an ongoing problem.

If you are enrolled in an HMO or opt out of IBM coverage, you will need to contact your HMO administrator or the administrator of any other group medical coverage available to you, for additional treatment assistance beyond the EAP maximum number of allowed visits and/or EAP assessment, whichever occurs first.

IBM Benefits Plan for Retired Employees

IBM Managed Pharmacy Program for Non-Medicare Participants

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IBM Managed Pharmacy Program for Non-Medicare Participants

ABOUT YOUR PRESCRIPTION DRUG COVERAGE

The IBM Managed Pharmacy Program is designed to help you control medical costs by providing you and your eligible family members with specially negotiated prices on prescription medications at participating network pharmacies and through a mail order service. The IBM Managed Pharmacy Program is administered by CVS Caremark. This coverage applies only to the pre-Medicare Retiree Medical Plan options.

IBM's prescription drug program is designed to help you save on out-of-pocket costs when you choose generic over brand name drugs, an effective way to slow the rise in prescription drug costs.

When you buy prescription drugs, you will pay a percentage of the negotiated cost, up to a per prescription maximum dollar limit (if applicable). Limits vary by plan option under the Plan and whether you purchase a generic or brand name drug. If your doctor prescribes medicines from a list of preferred brand name and generic medications, called the Formulary Drug List, you will pay a lower percentage of the cost than if you purchase non-formulary drugs. The negotiated drug cost may be reduced if there is a manufacturer's rebate for that medication. There is no annual deductible under the IBM Managed Pharmacy Program except for those enrolled in the IBM High Deductible PPO with HSA Option.

There is a maximum allowable benefit for pharmacy coverage under the IBM Medium Deductible PPO and the IBM High Deductible PPO. This is the maximum amount the Plan will pay toward pharmacy coverage. Once the maximum allowable benefit is met, you are responsible for 100% of the cost. Out-of-pocket amounts which exceed the maximum allowable benefit do not accumulate toward the out-of-pocket maximum.

The Plan does not pay benefits for prescriptions purchased from an out-of-network pharmacy except those purchased outside the US. The majority of pharmacies in the US participate in CVS Caremark's pharmacy network. Visit www.caremark.com or the Caremark app, or call CVS Caremark Customer Care to find a participating pharmacy.

You can estimate your out-of-pocket costs for medication by using the Check Drug Cost tool on info.caremark.com/IBMretirees, or by calling CVS Caremark Customer Support. You may also want to ask your doctor about lower cost medications available to you.

IBM continues to offer *GenericsAdvantage,* which is designed to help you take advantage of cost-saving alternatives to brand name prescription drugs.

- If you fill a prescription with a brand name drug when a generic with the identical active ingredient (called a generic equivalent) is available, you will pay the generic coinsurance plus the difference in cost between the brand name drug and the generic drug. (The per prescription maximum will not apply as it usually would for CVS Caremark participating pharmacies and mail order prescriptions.) This additional cost will apply even if your doctor has indicated "DAW" ("dispense as written") on the prescription.
- If your doctor believes that there is a medical reason for you to use the brand name drug instead of the generic and if you want to avoid paying the additional cost, your doctor can request a review by calling 800-294-5979, Monday through Friday, 9:00 a.m. to 7:00 p.m., Eastern time.

If the review is approved, you will pay the usual brand name coinsurance, not the difference in cost.

GenericsAdvantage has a feature for some brand name drugs. In some cases where a particular brand name drug is comparably priced with a generic in the same class of drugs, prior authorization will not be required for that brand drug and you will only pay the regular coinsurance for that medication. Prior authorization will still be required for other brand name drugs in that class; otherwise they will not be covered. Members impacted by this feature will receive communication from CVS Caremark as new drugs are added.

The eligibility of a prescription medication is subject to the terms of the IBM Managed Pharmacy Program. Covered and excluded medications under the Managed Pharmacy Program are defined later in this section.

There are three ways to purchase prescription drugs:

- At a CVS Caremark participating retail pharmacy
- Through the CVS Caremark Mail Order Pharmacy and
- Through a CVS retail pharmacy (CVS Pharmacy) or other participating pharmacy under Maintenance Choice®

IBM MANAGED PHARMACY PROGRAM ADMINISTRATOR

The IBM Managed Pharmacy Program is administered by CVS Caremark.

Customer Service Availability
Representatives are available to assist you with claim questions or other inquiries 24 hours a day, 365 days a year. You can reach CVS Caremark Customer Care at 855-465-0030 TTY: 800-863-5488. The CVS Caremark website is www.caremark.com.

For the fully insured HMOs, the health plan is the administrator for prescription drug benefits.

WHO IS ELIGIBLE

Non-Medicare-eligible retirees and their eligible dependents, and non-Medicare-eligible dependents of Medicare-eligible retirees (as described in "*Eligibility*" in the "*Personal Benefits Program*" section of this summary plan description) enrolled in one of the following plan options are eligible for coverage under the IBM Managed Pharmacy Program:

- IBM Low, Medium and High Deductible PPO options
- IBM High Deductible PPO with Health Savings Account
- IBM EPO

Retirees enrolled in an HMO are not eligible for the IBM Managed Pharmacy Program.

ID Card

If you are eligible for the IBM Managed Pharmacy Program, you will receive a set of ID cards for prescription drug coverage. The ID cards contain a unique member ID number — which is not your Social Security number. To ensure pharmacy benefit coverage use your card when purchasing drugs from participating retail pharmacies or through the CVS Caremark Mail Order Pharmacy, when calling Customer Care or accessing the CVS Caremark website.

Digital versions of ID cards are available on the Caremark website (www.caremark.com), the CVS Caremark app or by calling CVS Caremark Customer Care.
The IBM Managed Pharmacy Program ID cards are in the name of the primary covered person. In most cases this will be the non-Medicare-eligible retiree. Exceptions are ID cards for non-Medicare-eligible dependents of Medicare-eligible retirees, and surviving spouses.

IBM MANAGED PHARMACY PROGRAM AT A GLANCE

Coverage for Non-Medicare-Eligible Retirees

The following chart shows what you pay for prescription drugs:

	IBM Low Deductible PPO and IBM Medium Deductible PPO Benefits	IBM High Deductible PPO Benefits	IBM High Deductible PPO with HSA Benefits**	IBM EPO Benefits
Participating Pharmacies - up to a 30 day Supply (up to three fills)				
Generic	35% of discounted cost, up to $40	50% of discounted cost	20% of discounted cost, after deductible, up to $30	20% of discounted cost, up to $30
Formulary Brand name	35% of discounted cost, up to $75*	50% of discounted cost	20% of discounted cost, after deductible, up to $55*	20% of discounted cost, up to $55*
Non-Formulary Brand name	60% of discounted cost, up to $150*	50% of discounted cost	45% of discounted cost, after deductible, up to $105*	45% of discounted cost, up to $105*
Claim Forms	Claims are filed automatically if you present your ID card; however, you must file a claim if you do not present your ID card.	Claims are filed automatically if you present your ID card; however, you must file a claim if you do not present your ID card.	Claims are filed automatically if you present your ID card; however, you must file a claim if you do not present your ID card.	Claims are filed automatically if you present your ID card; however, you must file a claim if you do not present your ID card.
Retail Pharmacies	Coverage only provided if purchased from CVS Caremark pharmacies or pharmacies in their retail network.	Coverage only provided if purchased from CVS Caremark pharmacies or pharmacies in their retail network.	Coverage only provided if purchased from CVS Caremark pharmacies or pharmacies in their retail network.	Coverage only provided if purchased from CVS Caremark pharmacies or pharmacies in their retail network.
CVS Caremark Mail Service, Specialty Pharmacy* or Maintenance Choice - up to a 90-day supply**				
Generic	35% of discounted cost, up to $40	50% of discounted cost	20% of discounted cost, after deductible, up to $30	20% of discounted cost, up to $30
Formulary Brand name	35% of discounted cost, up to $75*	50% of discounted cost	20% of discounted cost, after deductible, up to $55*	20% of discounted cost, up to $55*
Non-Formulary Brand name	60% of discounted cost, up to $150*	50% of discounted cost	45% of discounted cost, after deductible, up to $105*	45% of discounted cost, up to $105*
Claim Forms	Claims filed automatically	Claims filed automatically	Claims filed automatically	Claims filed automatically

	IBM Low Deductible PPO and IBM Medium Deductible PPO Benefits	IBM High Deductible PPO Benefits	IBM High Deductible PPO with HSA Benefits**	IBM EPO Benefits
Annual Benefit Maximum				
Annual Benefit Maximum	Low Deductible: No limit Medium Deductible: $2,500	$1,000	No limit	No limit

* Generics Advantage: If a generic equivalent is available and you choose the brand name drug instead, you will pay the full generic coinsurance PLUS the cost difference between the generic and brand name drug. This additional cost does not accumulate to the out-of-pocket maximum.

** High Deductible PPO with HSA cost information: You pay 100% of the cost until you satisfy the Plan's shared medical annual deductible or the family deductible (if more than one person is enrolled in this option). Amounts paid out-of-pocket apply to the medical out-of-pocket maximum. Preventive drugs are not subject to the deductible.

*** Benefits for prescription drugs purchased at non-participating pharmacies count toward the plan's $1 million per person lifetime benefit maximum.

**** Specialty Medications - Prescription medications that require special handling or administration (such as chemotherapy) must be ordered through CVS Caremark Specialty Pharmacy. You may be able to have the medication shipped to you or your doctor's office at no additional charge. Your CVS Pharmacy will transfer your prescription to CVS Specialty for you.

IBM HIGH DEDUCTIBLE PPO WITH HSA PREVENTIVE DRUG BENEFIT

The IBM High Deductible PPO with HSA has a high deductible health plan (HDHP) preventive drug benefit applicable to those drugs listed on the CVS Caremark HDHP Preventive Drug List. Enrollees in this option will pay the usual coinsurance for preventive medications (those used to prevent a condition from occurring), even if the plan's deductible has not been met. The list of drugs considered preventive for the HDHP plan options is available online at www.caremark.com or by calling CVS Caremark Customer Care.

The CVS Caremark HDHP Preventive Drug List is designed to comply with the safe harbor established in the Internal Revenue Service (IRS) safe harbor for high deductible health plans and guidance from the U.S. Department of the Treasury, which permit the coverage of preventive care before your deductible is met. Under this guidance, a drug or medication is regarded as preventive if it meets any one of the following criteria:

- It is taken by a person who has developed risk factors for a disease, but is not yet showing symptoms of that disease. For example, the treatment of high cholesterol with cholesterol-lowering medications such as statins to prevent heart disease.
- It is used to prevent the reoccurrence of a disease from which a person has recovered. For example, the treatment of recovered heart attack or stroke victims with angiotensin-converting enzyme (ACE) inhibitors to prevent a reoccurrence.
- It is used as part of specified preventive care procedures, including obesity weight-loss and tobacco cessation programs.
- It is included in the preventive health services required to be covered with no cost-sharing under the Affordable Care Act or any associated regulations or guidance.

For more information, refer to IRS Notices 2004-23, 2004-50, 2013-57, 2018-12 and the Appendix to Notice 2019-45 and the Preventive Care Safe Harbor USC §223(c)(2).

Medicare Part D Creditable Coverage

IBM has determined that many plan options under the Plan that provide prescription drug benefits meet Medicare's "creditable coverage" standard. This means that for those options, IBM's coverage, on average for all plan participants enrolled in one of those plan options, is expected to pay out as much as the standard Medicare Part D prescription drug coverage. See "*IBM Notice of Creditable Coverage*" in the "*Administrative Information*" section.

The following IBM Plan options under the Plan provide creditable coverage in 2026:

- IBM Low PPO option
- IBM EPO option
- IBM High Deductible PPO with HSA

RETAIL PHARMACY PROGRAM

You may purchase up to three 30-day supplies of a covered medication from any retail pharmacy that participates in CVS Caremark's national retail network. This is not an annual limit, it does not reset each year. After the third 30-day fill, you generally must order 90-day supplies of your medication through CVS Caremark, either through their mail order program or at a participating retail network pharmacy, or you will pay 100% of the cost yourself. There is no coverage for prescriptions filled at pharmacies that do not participate in CVS Caremark's retail network.

Under CVS Caremark's Maintenance Choice program, participants can receive their 90-day prescriptions for maintenance medications through the mail, at one of the CVS Pharmacy retail locations nationwide or other participating pharmacy for the same price as mail order.

Medications that are exempted from the mail order program requirement are Schedule 2 Controlled Substances, such as narcotics or drugs used to treat Attention Deficit Disorder, and compound medications. These types of medications can be purchased at a retail pharmacy even if you take them on a long-term basis, subject to the 30-day limit. Patients in nursing homes are also exempt from the mail order program requirement. However, you must contact CVS Caremark to establish the exemption.

A NOTE ABOUT FORMULARY DRUGS

You will pay a lower percentage of the cost if your doctor prescribes a medication from this list of preferred drugs. You'll still be able to purchase non-preferred brand name medications but you will pay a greater share of the cost. For more information about the formulary, or to learn which drugs are preventive or require prior authorization or Step Therapy, sign into www.caremark.com or download the CVS Caremark app or call CVS Caremark Customer Support at 855-465-0030.

Participating Network Pharmacies

CVS Caremark contracts with a large network of chain and independent pharmacies across the United States. These pharmacies agree to accept specially negotiated prices on prescription drugs. When you and your eligible family members use a participating pharmacy and show your pharmacy ID card, there are no claim forms to file. All you have to do is pay your portion of coinsurance. There is no annual deductible under the IBM Managed Pharmacy Program unless you are enrolled in the IBM High Deductible PPO with HSA plan option. Except for the IBM High Deductible PPO with HSA plan option, benefits do not apply to the annual out-of-pocket medical plan maximum.

To find a participating pharmacy in your area, log on to www.caremark.com, access the CVS Caremark or CVS Pharmacy app, or call CVS Caremark Customer Care. Individuals who live in an area without convenient access to a network pharmacy can ask their pharmacist to call CVS Caremark Customer Care to get information about joining the network.

How to Fill Your Prescription Under the Retail Program

When you need to fill a prescription at a participating retail pharmacy, simply follow these steps:

- Present your ID card to the pharmacist before the prescription is dispensed to ensure that your claim will be processed automatically and that you will be charged the correct coinsurance amount.
- Pay the pharmacist for your portion of the prescription at the time of purchase.
- If you fill a new prescription with a brand name drug when a generic with the identical active ingredient (called a generic equivalent) is available, you will pay the generic coinsurance plus the difference in cost between the brand name drug and the generic drug. This additional cost will apply even if your doctor has indicated "DAW" ("dispense as written") on the prescription.

If You Don't Use Your ID Card at a Participating Pharmacy

If you do not show your ID card at a participating pharmacy, you will pay for the prescription in full and submit a claim form to CVS Caremark for reimbursement. Your reimbursement will be based on the negotiated price for the applicable type of medication (generic/formulary brand name or non-formulary brand name) and *not* the price you paid. You may ask the pharmacist to contact CVS Caremark to confirm your eligibility. To file a claim, follow the directions under "How to File a Paper Claim."

Non-participating Pharmacies

If you choose to have a prescription filled at a pharmacy in the U.S. that does not participate in CVS Caremark's network (a non-participating pharmacy), you must pay 100% of the pharmacy's actual charge at the time you receive your medication. The Plan will not provide benefits for these expenses.

MAIL ORDER PHARMACY PROGRAM

The CVS Caremark Mail Order Pharmacy home-delivery program provides a convenient, cost-effective way to purchase long-term prescription medications. If you have a chronic condition, such as high blood pressure, high cholesterol, heart conditions, arthritis, ulcers, asthma and diabetes, you should use the mail program to purchase your long-term prescriptions. Through the mail order program, you may receive up to a 90-day supply of the prescription medication. Orders will be delivered by mail, postage paid, anywhere in the United States. You can request expedited shipping (for an additional fee) at the time you place your order.

Please note that you can use the CVS Caremark Mail Order Pharmacy and receive up to 90 days of medication or you can get your 90-day supply at a retail CVS Pharmacy or other participating pharmacy through Maintenance Choice. All other mail service programs, such as AARP and online pharmacies, if part of the CVS Caremark pharmacy network, will be treated as retail pharmacies and only 30 days of your medication will be reimbursed, even if you purchase a greater quantity.

IF YOU TRAVEL OR RESIDE OUTSIDE THE U.S.

If you are planning on being out of the country for an extended period of time and you need an additional supply of medications before you leave the country, the Managed Pharmacy Program allows for a vacation supply of medication (up to 60 days through retail and 180 days through the mail program). Additional supplies beyond 60 days are only covered through the mail order program. If you are using the mail order program for the first time, you should allow for up to 14 days for delivery after receipt of your prescription by the Mail Order Pharmacy.

There are no participating pharmacies located outside the U.S. Therefore, if you purchase medications while outside the U.S. you must submit a paper claim to receive reimbursement and will be subject to the following level of reimbursement. Drugs purchased outside the U.S. must have an exact American equivalent to be eligible for reimbursement. You will be reimbursed as follows:

IBM EPO
- Generic medications: 30% of the full cost of the medication, up to a 30 day supply
- Brand name formulary medications: 30% of the full cost of the medication, up to a 30 day supply
- Brand name non-formulary medications: 55% of the full cost of the medication, up to a 30 day supply

IBM Low Deductible PPO and IBM Medium Deductible PPO
- Generic medications: 45% of the full cost of the medication, up to a 30 day supply
- Brand name formulary medications: 45% of the full cost of the medication, up to a 30 day supply
- Brand name non-formulary medications: 70% of the full cost of the medication, up to a 30 day supply

IBM High Deductible PPO
- Generic medications: 50% of the full cost of the medication, up to a 30 day supply
- Brand name formulary medications: 50% of the full cost of the medication, up to a 30 day supply
- Brand name non-formulary medications: 50% of the full cost of the medication, up to a 30 day supply

IBM High Deductible Health Plan with HSA
- Generic medications: 30% of the full cost of the medication, up to a 30 day supply, after deductible
- Brand name formulary medications: 30% of the full cost of the medication, up to a 30 day supply, after deductible
- Brand name non-formulary medications: 55% of the full cost of the medication, up to a 30 day supply, after deductible

Retirees living overseas are eligible to be reimbursed for up to a 90-day supply purchased at retail pharmacies overseas at in-network levels.

***NOTE**: Not all medications can be taken or delivered into other countries. Please review limitations in the non-US country before leaving.*

How to Order New Prescriptions

- If you need your prescription immediately, and wish to obtain your long-term medication:
  - Your doctor may ePrescribe the prescription directly to a participating retail pharmacy. Be sure your doctor has your Member ID number, which can be found on your ID card.
  - Through mail order: Ask your physician to write two prescriptions — one for a 14-day supply to be filled at your retail participating pharmacy and a second to be filled by the CVS Caremark Mail Order Pharmacy (for up to a 90-day supply), with three refills.
  - At a local CVS Pharmacy or participating retail network pharmacy: You can take advantage of the Maintenance Choice® feature and fill your 90-day prescription there (with up to three refills), often picking up the prescription the same day.
- Or, you may mail your original prescription or refill slips together with the completed order form and required payment to the Mail Order Pharmacy. If you mail more than one prescription in the same envelope, be sure to include the correct coinsurance amount for each. Order forms and envelopes are available from CVS Caremark Customer Care. You can also print your order form on www.caremark.com.

- CVS Caremark will bill you for your coinsurance unless you are set up for automatic payment. CVS Caremark will promptly process your order and send your medications, along with your invoice, to your home within approximately 14 days through U.S. Mail or United Parcel Service (UPS) along with instructions for refills. Medications requiring special handling will be shipped in accordance with established safety and security procedures. A signature may be required for certain medications. Check with CVS Caremark Customer Care at the time you order.

How to Order Refills

- You may reorder your prescription on or after the refill date indicated on the refill slip of your medication container or when you have used 75% of your medication for non-controlled substances. The refill threshold is set to 80% for controlled (CII) substances. At no time can you refill if you have more than 30 days of medication on hand (mail and retail fills combined). You may order refills online through www.caremark.com, on the CVS Caremark or CVS Pharmacy app, by phone or by mail. You'll need your Member ID number, the prescription number, your credit card number and the expiration date to order a refill.
- To determine the amount of your payment, you can call CVS Caremark Customer Care or log on to www.caremark.com.

You will need to provide the number of days' supply, dosage, strength, exact drug name and quantity.

COMPOUND MEDICATIONS

Please note when purchasing a compound medication, claims are adjudicated using a different formula. Please contact CVS Caremark for specific details.

If you submit a paper claim for one of these medications, you will need to include an itemized list of each ingredient including its name, National Drug Code, price and quantity used. Formulary and non-formulary reimbursement levels apply. Formulary status is determined by the status of the largest component in the compound. There is a separate Compound Claim Form available from CVS Caremark.

Note
- all compound prescriptions greater than $300 in cost will require prior authorization
- costly proprietary topical compounding bases and bulk powders (that have not been proven to have additional benefits) will be excluded from coverage
- coverage for compounds will be limited to 30-day supplies

If the compound ingredients are not covered, you will be responsible for the full cost of the prescription. If the compound ingredients are covered through prior authorization, you will pay your usual cost share. This is particularly important to remember if the compounding pharmacy suggests you pay out-of-pocket for compounded prescriptions, then submit the claim through your benefit plan for reimbursement. Please be aware that these claims also will be subject to review, and reimbursement is not guaranteed.

Paying for Prescriptions Through the Mail Order Program

You may pay your coinsurance by check, credit card, debit card, money order, e-check or your Health Savings Account Debit Card (be sure to sign the mail order form if paying by credit card). If your physician ePrescribes or faxes the prescription to the Mail Order Pharmacy on your behalf, CVS Caremark will bill you later for your coinsurance unless you set up automatic payment.

Note that if you have an outstanding mail account balance of $300 or more, CVS Caremark cannot ship your medication until you pay your balance. To set up automatic payment, simply provide your credit or debit card number on the mail order form and complete the applicable information. It is important to keep your contact information up-to-date with CVS Caremark in your profile at www.caremark.com or in the CVS Caremark app. If your order exceeds $500, even if you have an automatic payment in place, CVS Caremark will contact you (using the contact information in your profile) for confirmation of the order before shipping the medication.

How to File a Paper Claim

There is no coverage for prescription drugs purchased from U.S. pharmacies that do not participate in the CVS Caremark pharmacy network. You should only need to file a paper claim if you purchase:

- A compounded medication,
- A medication from a pharmacy that participates with the CVS Caremark pharmacy network, but you did not use your ID card when you purchased the drug, or
- A medication while traveling outside the US.

The www.caremark.com site and the CVS Caremark app enable you to file an electronic claim for quicker turnaround time. In order to file your claim electronically, you will need to log onto www.caremark.com or the CVS Caremark app and select the "Submit Prescription Claim" link under the Plan and Benefits tab, populate the online form with your information, and upload your prescription receipts to the tool. You can also print a blank form that you can fill out manually and mail it to CVS Caremark. This form can be found by clicking the "Print Plan Forms" link under the Plan & Benefits tab on www.caremark.com.

CVS CAREMARK MAINTENANCE CHOICE®

Maintenance Choice® is a feature of the IBM Managed Pharmacy Program. You can continue to have your 90-day supply of medications shipped directly to your home through mail order, pick them up at your local CVS Pharmacy retail location or other participating pharmacy for the same coinsurance. The choice is yours.

All of the medications, with an 84- to 90-day supply that you currently order through mail service are eligible for this program.

If you take several long-term medications, you have the flexibility to receive some through mail and others at retail pickup through your local CVS Pharmacy. You can transfer your mail service prescriptions to your local CVS Pharmacy by calling Customer Care at 855-465-0030.

If you need to obtain a new prescription, you can have the pharmacist at your local CVS Pharmacy or participating retail network pharmacy contact your doctor for a 90-day prescription. You can also ask your doctor to ePrescribe (or call) the CVS Pharmacy with a 90-day prescription. Let the pharmacist know that your prescription benefit program includes the Maintenance Choice® feature.

Please note: *some medications may not be eligible for 90-day supplies through Maintenance Choice due to state regulations, such as Schedule 2 Controlled Substances (e.g., narcotics or drugs used to treat Attention Deficit Disorder). Contact CVS Caremark Customer Care for more details.*

COST SAVER PROGRAM

You have access to the Cost Saver program through CVS Caremark. Through the program, you have access to GoodRx's prescription pricing to allow you to pay lower prices, when available, on many non-specialty generic medications in a seamless experience at the pharmacy counter.

The amount paid will automatically be applied to your deductible and out-of-pocket maximum. You only need to show your existing RX card at your preferred in-network pharmacy.

- If you take a Specialty medication, you must obtain the medication through CVS Specialty and they will assist with researching any available discounts or assistance.
- If you take a medication that is not a Specialty medication, know that the CVS Mail Order Pharmacy cannot accept coupon programs. You can, however, use manufacturer's coupons at retail pharmacies (including retail CVS Pharmacies).
- If you are enrolled in the IBM High Deductible Health Plan with HSA but have not yet met your deductible, you can receive up to 3 30-day fills of your medication at a pharmacy that participates in CVS Caremark's retail pharmacy network using the Cost Saver program.
  - After the first 3 fills, you must obtain your 90-day fills through CVS Caremark.

    Note: *All plan rules apply, if you have not obtained a prior authorization for the medication and it is required under your IBM coverage, the cost of the medication will not be applied to your deductible or out-of-pocket maximum. Similarly, if there is a quantity limit under the plan, you will only be reimbursed for up to the quantity limit.*

COVERED MEDICATIONS

The following items are covered when prescribed by a physician and medically necessary:

- Federal legend drugs
- State restricted drugs
- Compounded medications of which at least one ingredient is a legend drug; *(**Note:** new coverage rules apply; please see "Compound Medications" for details)*
- Oral contraceptives, the contraceptive patch (Ortho EVRA), contraceptive devices and implants; contraceptive jellies, creams and foams with a prescription *(**Note:** Contraceptive devices and implants not available through the IBM Managed Pharmacy Program may be covered under the IBM Medical Plan.)*
- Insulin and all diabetic supplies except insulin pumps (*note that insulin pumps are covered under the IBM Medical Plan)*
- Needles and syringes
- Certain over-the-counter diabetic supplies with a prescription
- Retin-A and Avita cream through age 34 (may be eligible beyond age 34 with prior authorization)
- Legend prenatal vitamins
- Legend vitamin D and K
- Legend folic acid
- Hematinic vitamins and
- Legend vitamin B12/Cyanocobalamin.

Exclusions Under the Managed Pharmacy Program

- Non-federal legend drugs
- Contraceptive jellies, creams or foams
- Topical fluoride products
- Anabolic steroids
- Yohimbine
- Allergy sera
- Therapeutic devices or appliances
- Drugs which are not considered medically necessary
- Drugs whose sole purpose is to promote or stimulate hair growth (for example, Rogaine, Propecia) or drugs for cosmetic purposes only (for example, Renova)Blood or blood plasma
- Drugs labeled "Caution — limited by federal law to investigational use," or experimental drugs, even though a charge is made to the individual
- Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any State or Governmental Agency or medication furnished by any other Drug or Medical Service for which no charge is made to the member
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows it to be operated on its premises, a facility for dispensing pharmaceuticals (covered under the IBM Medical Plan)
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order
- Charges for the administration or injection of any drug
- Medical devices and appliances (including insulin pumps)
- Vitamins and minerals — except the following, which are covered: hematinics for the treatment of anemia, prenatal vitamins, legend folic acid, legend vitamin B12/Cyanocobalamin and legend vitamin D and K
- Over-the-counter medications, even when prescribed (except for certain diabetic supplies)
- Certain over-the-counter, non-essential medical supplies, including alcohol wipes and insulin pump batteries. For a complete list of excluded supplies, please contact CVS Caremark Customer Care
- Any other exclusions listed under *Exclusions: What the IBM Medical Plan Does Not Cover*
- Homeopathic, naturopathic treatments, minerals, nutritional supplements, dietetic foods, etc.
- Prescription drugs for which there is an over-the-counter equivalent available in the same strength and preparation, such as meclizine and ranitidine (Contact CVS Caremark Customer Care for a complete list)
- Drugs purchased in foreign countries which do not have an exact American equivalent
- Bulk chemicals which have not been determined to be safe and effective or medically necessary for topical administration (Contact CVS Caremark Customer Care for a complete list) and
- Nasal steroids

FORMULARY DRUG LIST

The IBM Managed Pharmacy Program uses the CVS Caremark Formulary Drug List. A formulary is a list of commonly prescribed medications that have been shown to be clinically effective as well as cost effective. If your doctor prescribes formulary medications, you can help control rising health care costs while still maintaining high-quality care. The Formulary Drug List is available online at www.caremark.com, through the CVS Caremark app or by calling CVS Customer Care.

The CVS Caremark Formulary Drug List is reviewed and updated on a quarterly basis. Products with egregious cost inflation that have readily available, clinically appropriate and more cost-effective alternatives may be evaluated and potentially removed from the formulary.

Because the formulary list is subject to change, you should consult CVS Caremark before filling a prescription to ensure you have the most current information.

If you choose to purchase a brand medication not on the formulary, you will be responsible for paying a higher coinsurance. If there is a clinical reason why you cannot take the formulary medication, you can request an appeal through CVS Caremark by calling Customer Care. If the appeal is approved, you will only be charged the formulary coinsurance. This approval is valid for as long as you are taking the prescription.

Under the IBM Managed Pharmacy Program there may be times when you use a participating pharmacy and are filling a prescription with a non-formulary brand name drug. The pharmacist will receive a message stating the status of the medication is non-formulary (or non-preferred). Your retail pharmacist may decide to discuss with your physician whether an alternative drug listed on the formulary might be appropriate for you. If your physician agrees, your prescription will be filled with the alternative drug. If you prefer to have the originally prescribed medication, you have the option to refuse the alternative medication before it is filled and to request the pharmacist fill the prescription as it was originally written. However, you will be responsible for paying the higher, non-formulary brand name coinsurance.

When you order through the mail order program, the pharmacist may also decide to discuss with your physician whether an alternative medication listed on the formulary might be appropriate for you. If your physician agrees, your prescription will be filled with the alternative medication and a confirmation letter will be sent to you and your physician explaining the change.

Let your physician know if you have any questions about a change in prescription. Your physician always makes the final decision about what medication to prescribe for you.

GENERIC DRUGS

Generic equivalent medications contain the same active ingredients and are subject to the same rigid Food and Drug Administration (FDA) standards for quality, strength and purity as their brand name counterparts. Generally, generic drugs cost less than brand name drugs because they don’t require the same level of sales, advertising and development which are expenses associated with brand name drugs.

Under the IBM Managed Pharmacy Program, CVS Caremark will periodically review medications and if there is a generic available for the brand name medication you are currently using, you may receive a letter advising you of the generic availability.

G*enericsAdvantage* is a voluntary program and if you prefer to continue using the brand name drug you may do so. Your doctor should write "DAW" ("dispense as written") on the prescription to prevent a switch being made. Please note the specifics of this requirement may vary by state. Check with your doctor. If you switch to a generic medication your coinsurance will be based on the generic price. If you remain on the brand name drug, your coinsurance will be based on the *GenericsAdvantage* cost share provisions described previously. Additionally, the amount you pay out-of-pocket equal to the difference in price of the brand and generic medications will not accumulate to your deductible or out-of-pocket maximum.

For certain therapeutic classes, you may be required to try generic medications before the plan covers more expensive brand name alternatives. This will apply even if you have been taking the brand name medication for some time. Please contact CVS Caremark Customer Care for a complete list of drugs in this Generic Step Therapy Program.

If you switch to a generic medication your coinsurance will be based on the generic price. If you choose to stay on the brand name medication, you will have to pay the medication's full price if you have not tried the generic option(s) available to treat your condition. If your doctor feels you have a unique medical situation that requires you to keep taking the brand name medication, ask them to call CVS Caremark at 800-294-5979 to request prior authorization.

Please note for all brand name drugs not on the Generic Step Therapy Program list, unless your doctor writes "DAW" ("dispense as written") on your prescription, state laws may permit (or require) the pharmacist to substitute a generic version of the prescribed drug if all prescription requirements are met.

DRUG MANAGEMENT PROGRAMS

Prior Authorization Program

The IBM Managed Pharmacy Program provides coverage for some medications only if they are prescribed for certain uses. These medications must receive "prior authorization" before they can be covered under the IBM Managed Pharmacy Program. The list of drugs requiring prior authorization changes periodically. If you have a question on drug coverage, please call CVS Caremark Customer Care.

If you require a new prescription for a specialty medication, your doctor will first need to contact CVS Caremark for authorization to confirm the treatment complies with standard clinical guidelines. This requirement will help ensure you receive the proper drug, dose and treatment based on your diagnosis.

If the medication prescribed for you requires prior authorization, ask your physician to call the Authorization Unit at CVS Caremark for instructions on how to initiate the review process. You can obtain the phone number by calling CVS Caremark Customer Care. Otherwise, if you take a prescription for one of these medications to a participating pharmacy without prior approval, the pharmacist can initiate the review process on your behalf, or will provide you with the telephone number for your doctor to call. This process typically takes two business days to complete. You and your physician will be notified by mail when the review process has been completed.

If your medication is not approved for coverage under the IBM Managed Pharmacy Program, you will be responsible for paying the full cost of the drug.

CVS Specialty Pharmacy

If you need covered prescription medications that require special handling or administration, like infused medications, you will need to order them through CVS Specialty Pharmacy or the CVS Site of Care Program, part of the IBM Managed Pharmacy Program. By receiving covered prescription medications this way, you may pay less for them overall. Additionally, you may be able to have them shipped directly to you or your doctor's office at no additional charge. Contact CVS Specialty Customer Service at 888-346-6578 to transfer a prescription or obtain more details.

Note: *Specialty drugs purchased at a retail pharmacy will not be covered. All specialty drugs must be obtained through the CVS Specialty Pharmacy except as follows:*

- *The initial fill of your specialty medication may be filled at a retail CVS Pharmacy while the second fill will be transferred to CVS Specialty Pharmacy*
- *Specialty medications provided by your medical provider can be billed as part of your office visit*
- *If a medication's manufacturer has an exclusive arrangement with a specialty pharmacy other than CVS Caremark, that pharmacy will fulfill your medication instead of CVS Specialty Pharmacy and you will have coverage under the Plan.*

In addition, CVS Specialty's Drug Step Therapy program promotes the use of safe, equally effective, and lower cost preferred medications before using a higher-cost, non-preferred medication. You will be required to try the preferred medication first. If you decide to take the non-preferred medication without trying the preferred, you will have to pay the full price for the non-preferred medication. This rule covers drugs to treat rheumatoid arthritis, multiple sclerosis, and infertility.

Keep in mind, some specialty medications require a clinical review to be used for continued treatment or when they are first prescribed. Contact CVS Caremark Customer Care for more information.

The IBM Managed Pharmacy Program includes CVS Caremark's Specialty Guideline Management Program. For continued coverage of a medication in this program, a clinical review is required. CVS Specialty will obtain the necessary clinical information from your doctor's office and conduct the review. There is a chance the review will identify other options for treating your condition. If so, you and your doctor will be notified.

Infusion Therapy

Certain infused specialty therapy medications (e.g., Remicade and IVIG drugs), are covered under the IBM Managed Pharmacy Program and obtained through CVS Specialty Pharmacy. CVS Specialty Pharmacy will work with you and your physician to deliver your medication to where it is being administered such as your home or a cost-efficient outpatient infusion center. Note that this excludes chemotherapies, except Blincyto.

Dose Optimization Program

Certain long-term medications will be covered by the IBM Managed Pharmacy Program's dose optimization feature, which makes prescriptions available in a more convenient dosing regimen. For example, you may be taking a 50 mg dose of a certain medication two times a day when there may be a 100 mg dose of the same medication that can be taken once a day.

Changing to one dose each day, when appropriate, can result in greater convenience and lower costs for participants. CVS Caremark will contact your doctor and ask if dose optimization is right for you. If your doctor approves, you will receive the optimized dose.

Drug Utilization Review — Safe and Appropriate Use of Medications

By continually using participating pharmacies or by using the Mail Order Pharmacy, you also gain the advantage of a prescription review. This confidential online system allows the pharmacist access to important information, such as your individual drug history, the possibilities of interaction among various drugs and how long it has been since your last prescription was filled. If the potential for drug-related illness or incompatibility is flagged, an alert message is sent to the pharmacist who can then inform you to check with your doctor or make a professional judgment whether to dispense your prescription.

Under the IBM Managed Pharmacy Retail Program there is a "refill-too-soon" feature which does not allow a refill of medication until 75% of the original prescription has been used for non-controlled substances. The refill threshold is set to 80% for controlled (CII) substances. This feature helps to prevent overuse of medication and purchase of more medication than is necessary. Additionally, under the mail order program your refill slip will indicate your earliest refill date. If you request a refill before the earliest refill date, your refill request will be held and sent on the appropriate refill date.

There is also a coverage management program which has established appropriate threshold levels of utilization (e.g., limit on number of doses) for specific drug therapy categories and payment will be rejected at the point of sale (retail or mail) whenever the drugs being dispensed exceed those predetermined limits or if you do not meet the clinical criteria to receive the medication (determined by the prior authorization review).

COORDINATION OF BENEFITS

It is a requirement under the Plan to provide information regarding any other coverage they may have. If there is an indication that there is other primary coverage, payment in full will be required at the time of purchase from a retail pharmacy and from the mail order program. You must first file a claim with the primary plan. When you receive the Explanation of Benefits (EOB) statement from the primary plan, fill out the IBM Managed Pharmacy Claim Coordination of Benefits/Out-of-Network Claims form and attach a copy of the EOB and your receipt and mail these documents to CVS Caremark at the address on the form. Your claim will be processed according to the Plan's Coordination of Benefits provisions. See "*Coordinating Coverage*" in the "*Administrative Information*" section.

If the primary coverage is also a card program, you should attach your receipt to a copy of the claim form and mail to CVS Caremark for consideration of any additional benefit.

Special rules apply for coordination with Medicare Part D prescription drug plans. See "*Coordinating Plan Medical Coverage with Medicare*."

OTHER IMPORTANT INFORMATION

Other features of the IBM Managed Pharmacy Program include keeping a profile of your medication history and providing a toll-free number to speak with a pharmacist.

Prescription information of retirees and their dependents is used by CVS Caremark and its affiliates to administer the IBM Managed Pharmacy Program. As part of this administration, CVS Caremark generally reports that information to the administrator of the IBM medical plan option that you selected, and your Medical Plan administrator reports your medical information to CVS Caremark. Your prescription and medical data is used to identify potential overuse, abuse and waste of particular medications as well as appropriateness of the medications prescribed. CVS Caremark may send alerts to prescribing physicians and dispensing pharmacists about the situations it identifies. CVS Caremark also uses the prescription

data gathered from claims submitted nationwide for reporting and analysis without identifying individual patients.

CVS Caremark may also take other actions to address concerns it identifies with utilization of the IBM Managed Pharmacy Program, including limiting you to the use of one retail pharmacy if your pattern of utilization for a particular medication warrants it.

IBM Benefits Plan for Retired Employees

IBM Dental Coverage

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IBM Dental Coverage

ABOUT YOUR DENTAL BENEFITS FOR PRE-MEDICARE RETIREES

IBM's dental coverage offers you a choice of options, depending on your retirement date and Medicare eligibility status. You will receive information about the options available to you when you first become eligible for the Plan, and during each Annual Enrollment period.

The "*Dental Coverage*" section of this summary plan description covers the details of the IBM Dental Option A, Dental Option B, PDP, IBM Dental Plus and IBM Dental Basic options for participants who are not Medicare-eligible.

Medicare-eligible retiree plan participants are eligible for dental coverage through the IBM-sponsored Group Medicare Advantage plan options. For more information, see "*Coverage for Medicare-Eligible Retirees*" section.

The options available depend on the retiree's retirement date and Medicare eligibility status:

- **If you retired or otherwise first became eligible for post-employment benefits under this Plan before January 1, 2000, and are not Medicare-eligible**, your choices for dental coverage are: Dental Option A, Dental Option B, MetLife Preferred Dentist Program (PDP), or you can waive coverage, as explained below.
- **If you retired or otherwise first became eligible for post-employment benefits under this Plan on or after January 1, 2000, and are not Medicare-eligible, or if you are enrolled in the Aetna Medicare Plan (PPO) or Aetna Medicare Plan (HMO) as of August 1, 2013**, your choices for dental coverage are: IBM Dental Plus, IBM Dental Basic, or you can waive coverage, as explained below.

IBM DENTAL PLAN ADMINISTRATOR

The IBM Dental Plan options are administered by MetLife.

Customer Service Availability
Representatives are available to assist you with claim questions or other inquiries Monday through Friday from 8 a.m. to 11 p.m. Eastern time. The Voice Response Unit (VRU) for claims inquiries is available 24 hours a day, 7 days a week.

You can reach MetLife at 800-872-6963 (TTY: 800-843-2896) or www.metlife.com/mybenefits.

You can elect "no coverage" for the plan year and pay no contribution. If you waive dental coverage because you have coverage elsewhere, you will not be allowed to request coverage under the Plan during the plan year unless you lose the coverage you had elsewhere as a result of a qualified life event. This could happen, for example, if you were covered under your spouse's employer-sponsored plan, and your spouse loses his or her job.

Who Is Eligible

Retirees who are not Medicare-eligible, their eligible dependents, non-Medicare-eligible dependents of Medicare-eligible retirees or participants in the "*About the Personal Benefits Program*" section of this summary plan description) are eligible to enroll in dental coverage under the Plan.

If you and your eligible family members are living outside of the U.S. and Puerto Rico, you will be eligible for dental benefits reimbursement for eligible services but at the out-of-network level only since there are no network providers outside of the U.S. and Puerto Rico.

Note that once you (and/or your eligible dependent(s)) reach age 65 or become eligible for Medicare, you will no longer be eligible for dental coverage under the Plan.

ID Card

If you enroll in a dental option administered by MetLife, you will receive an ID card, which will remain good for as long as you are enrolled in any dental option administered by MetLife. New cards will not be sent each year. If your card is lost or damaged, call MetLife member services to request a replacement card or log onto www.metlife.com/mybenefits to print one.

Dental Options If You Retired Before January 1, 2000, and Are Not Medicare-Eligible

- **Dental Option A** — This option provides assistance for expenses relating to a full range of services, from preventive and diagnostic services, such as checkups and x-rays, to basic and major procedures, such as fillings, root canals and orthodontics. Services are reimbursed according to a fixed fee schedule after you satisfy a $40 annual deductible per covered individual. There is a lifetime maximum of $9,000 per covered individual under this Plan, which includes a $1,500 orthodontia lifetime maximum.
- **Dental Option B** — This option provides assistance for expenses relating only to preventive and diagnostic services and some basic treatment procedures, such as fillings. Services are reimbursed according to the same allowance schedule as Dental Option A. There is no annual deductible per covered individual. This Plan is subject to the same lifetime maximum of $9,000 per covered individual. Orthodontia services are not covered under this Plan. Benefits used toward the $9,000 lifetime maximum will be counted even if you elect to change plans and later re-enroll in Option A or Option B.
- **MetLife Preferred Dentist Program (PDP)** —The PDP provides financial assistance toward the expenses of dental care and treatment for preventive, diagnostic, basic and major procedures and orthodontia. The PDP reimburses a percentage of the dentist's negotiated fee when you use a participating dentist, and a fixed amount on limited services for non-participating dentists (same coverage as Dental Option B, Schedule III). There is no annual deductible and no lifetime maximum, with the exception of orthodontics, where there is a $1,500 lifetime maximum.

Dental Options If You Retired On or After January 1, 2000, and Are Not Medicare-Eligible or Enrolled in Aetna Medicare Plan (PPO) or Aetna Medicare Plan (HMO)

- **IBM Dental Basic option** — The Dental Basic option provides a basic level of coverage for preventive, diagnostic and basic restorative care only, up to a $500 annual maximum benefit limit per covered person. If you use an in-network dentist, the Plan covers preventive and diagnostic care at 100% of eligible charges. There is no annual deductible for this option.

- **IBM Dental Plus option** —The IBM Dental Plus option offers you the opportunity to increase your dental benefits to cover more extensive dental treatment, including preventive, diagnostic, basic restorative, major restorative and orthodontia care. Benefits under the Dental Plus option are limited to $2,000 per covered person per year; orthodontia care is limited to a lifetime maximum up to $1,500 per covered person.

Dental Options for Retirees Who Retired Before January 1, 2000

Retirees who are not eligible for Medicare, non-Medicare-eligible dependents of Medicare-eligible retirees can enroll in the dental plans described below.

IBM DENTAL PLAN OPTIONS AT A GLANCE FOR PRE-2000 RETIREES

	Dental Option A	Dental Option B	MetLife PDP
Annual Deductible	$40 per covered person	None	None
Annual Maximum Benefit	No limit	No limit	No limit
Lifetime Maximum Benefit	$9,000 per covered person Combined for Dental Option A and Dental Option B (includes orthodontia maximum)	$9,000 per covered person Combined for Dental Option A and Dental Option B	No limit (except orthodontia)
Orthodontia Lifetime Maximum	$1,500 per covered person	Not applicable	$1,500 per covered person
Services	▪ Preventive/ diagnostic ▪ Basic restorative ▪ Major restorative ▪ Orthodontia ▪ Dental implants	▪ Preventive/ diagnostic ▪ Basic restorative	▪ Preventive/ diagnostic ▪ Basic restorative ▪ Major restorative (in-network only) ▪ Orthodontia (in-network only)

HOW THE IBM DENTAL OPTION A AND OPTION B PLANS WORK

The IBM Dental Option A and Option B Plans are available to pre-2000 eligible retirees who are not Medicare-eligible, their eligible family members who are not Medicare-eligible. They provide financial assistance, based on four geographic schedules, toward the expenses of dental care and treatment. Each dental option makes benefit payments as assistance toward actual charges for dental care and treatment up to the amount of the applicable benefit allowance. These allowances apply to eligible services wherever they are performed, such as the dentist's office or the hospital. The most common procedures for each dental option are included in the partial schedules that follow. Additional information not included in these schedules can be obtained from MetLife.

In cases of Coordination of Benefits, if the primary plan benefit issued is equal to or exceeds the scheduled benefit under the Plan, there will be no payment made by the Plan as secondary coverage.

If a retiree switches plans from Dental Option A to Dental Option B, any dental treatment "in progress" at the time of the retiree's enrollment change will become ineligible for coverage 60 days from your coverage end date under the IBM Dental Option A, unless the services continue to be eligible under Dental Option B. Also, benefits paid toward the $9,000 lifetime maximum carry over from Dental Option A to Dental Option B, and vice versa, if the retiree changes plans.

Annual Deductible

- **Dental Option A:** Each covered individual must satisfy a $40 annual deductible before Dental Option A pays benefits for covered services. Charges used to satisfy the deductible will not be eligible for reimbursement under any other IBM benefit plan. Each family member must satisfy the deductible once each calendar year.
- **Dental Option B:** There is no annual deductible for Dental Option B.

Lifetime Maximum Benefit

You and your eligible family members may receive benefit payments up to a lifetime maximum of $9,000 for each individual. Benefits paid under both Dental Options A and B contribute to the lifetime maximum. Under Dental Option A, there is a lifetime benefit maximum of up to $1,500 for orthodontic services for each eligible family member, which is included in the overall $9,000 lifetime maximum.

If you, the retiree, reach the $9,000 lifetime maximum under Dental Options A or B, this is considered a qualified life event. You have the option to opt out of dental coverage for the remainder of the plan year and save the monthly contribution. However, you will have to wait until the next annual open enrollment period to select a new dental option (for example, the PDP). If you choose to opt out of coverage, any eligible family members you cover will also lose their dental coverage for the rest of the plan year. Also, if dependents reach their $9,000 lifetime maximum, the retiree can drop them from coverage the first of the following month in which the retiree notifies the IBM Benefits Center – Provided by Fidelity.

For more information about making a qualified life event change, see "*Changing Coverage Due to a Qualified Life Event*" in the "*Administrative Information*" section.

There is no duplication of plan maximums. Lifetime maximums cannot be combined and apply to the dental plan option selected. If you reach your lifetime maximum in one option you cannot enroll in that option again, regardless of the ID number used. You may enroll in another dental option during the next Annual Enrollment period. If you have a qualified life event change and change your enrollment from being primary to being a dependent of your spouse, deductibles do not transfer even if you stay in the same plan.

Geographic Areas

The benefit allowance under Dental Option A and Dental Option B is based on specific schedules and reflects differences in dental charges by geographic area. To find scheduled allowances in your area, follow these steps:

- Consult the location lists that follow to determine which schedule applies to your dentist (it is keyed to the dentist's office location where work is provided based on the first three digits of the ZIP Code).

- Refer to the appropriate benefit allowance schedule that follows to determine the benefits that are payable under Option A or B, as appropriate. Note that all foreign claims will be processed according to Schedule III.

Geographic Schedule	
Dentist's Office Location	**Schedule**
Alabama	II
Alaska	IV
Arizona	II
Arkansas	
– Little Rock (ZIP Codes beginning with 722 only)	II
– Remainder of State	I
California	IV
Colorado	
– Denver, Boulder Area (ZIP Codes beginning with 800 – 806)	III
– Remainder of State	II
Connecticut	
West (ZIP Codes beginning with 060, 061, 064 – 069)	IV
East (ZIP Codes beginning with 062 – 063	III
Delaware	III
District of Columbia	III
Florida	
– Miami, Ft. Lauderdale, Boca Raton (ZIP Codes beginning with 330 – 334 and 349 only)	III
– Remainder of State	II
Georgia	
– Atlanta Area (ZIP Codes beginning with 300 – 303 only)	II
– Remainder of State	I
Guam	II
Hawaii	III
Idaho	II
Illinois	
– Chicago Area (ZIP Codes beginning with 600 – 606 only)	III
– Remainder of State	II
Indiana	II
Iowa	I
Kansas	II
Kentucky	I
Louisiana	II
Maine	I
Maryland	
– Washington, D.C. Area (ZIP Codes beginning with 206 – 209 only)	III
– Remainder of State	II
Massachusetts	
– Boston (ZIP Codes beginning with 020 – 022 only)	IV
– Remainder of State	III
Michigan	
– Detroit and Area (ZIP Codes beginning with 480 – 483 only)	III
– Flint (ZIP Codes beginning with 485 only)	III
– Lansing (ZIP Codes beginning with 489 only)	III
– Grand Rapids (ZIP Codes beginning with 495 only)	III
– Remainder of State	II
Minnesota	
– Minneapolis – St. Paul and Rochester (ZIP Codes beginning with 550, 551, 553, 554 and 559 only)	II
– Remainder of State	I
Mississippi	II

Geographic Schedule	
Dentist's Office Location	**Schedule**
Missouri	
– St. Louis Area (ZIP Codes beginning with 630 – 633 only)	II
– Kansas City Area (ZIP Codes beginning with 640 – 641 only)	II
– Remainder of State	I
Montana	II
Nebraska	I
Nevada	III
New Hampshire	II
New Jersey	
– Northern New Jersey (ZIP Codes beginning with 070 – 079, 085, 086, 088 and 089)	IV
– Remainder of State	III
New Mexico	II
New York	
– Westchester, Putnam and Rockland Counties, New York City, Long Island (ZIP Codes beginning with 100 – 119 only)	IV
– Albany, Kingston, Poughkeepsie, Buffalo and Rochester Areas (ZIP Codes beginning with 120 – 126 and 140 – 146 only)	II
– Remainder of State	I
North Carolina	
– Winston-Salem, Raleigh-Durham, Greensboro Area/Charlotte (ZIP Codes beginning with 270 – 277 and 280 – 282 only)	II
– Remainder of State	I
North Dakota	I
Ohio	
– Cleveland (ZIP Codes beginning with 440 – 441 only)	II
– Columbus (ZIP Codes beginning with 430 – 432 only)	II
– Dayton (ZIP Codes beginning with 453 – 454 only)	II
– Toledo (ZIP Codes beginning with 434 – 436 only)	II
– Youngstown (ZIP Codes beginning with 444 – 454 only)	II
– Remainder of State	I
Oklahoma	II
Oregon	II
Pennsylvania	
– Philadelphia (ZIP Codes beginning with 190 – 191 only)	III
– Pittsburgh (ZIP Codes beginning with 150 – 152 only)	III
– Remainder of State	II
Puerto Rico	III
Rhode Island	III
South Carolina	I
South Dakota	I
Tennessee	
– Nashville (ZIP Codes beginning with 372 only)	III
– Memphis and Knoxville (ZIP Codes beginning with 379 and 381 only)	II
– Remainder of State	I
Texas	
– Houston Area (ZIP Codes beginning with 770 – 772 and 774 – 775 only)	III
– Dallas, Fort Worth Areas (ZIP Codes beginning with 750 – 753 and 760 – 761 only)	III
– Corpus Christi Area (ZIP Codes beginning with 783 – 784 only)	
– Austin Area (ZIP Codes beginning with 786 – 787 and 789 only)	III
– Remainder of State	III
	II
Utah	I
Vermont	II
Virginia	
– Washington, D.C. Area (ZIP Codes beginning with 220 – 223 only)	III
– Remainder of State	II
Virgin Islands	II

Geographic Schedule	
Dentist's Office Location	**Schedule**
Washington – Seattle and Tacoma Areas (ZIP Codes beginning with 980 – 984 only) – Remainder of State	 III II
West Virginia	I
Wisconsin	II
Wyoming	II
Outside of the United States and not listed above	III

WHAT'S COVERED UNDER DENTAL OPTION A AND DENTAL OPTION B

Generally, dental services (including most oral surgery) are eligible for benefits to the extent they are necessary and appropriate for dental health and are considered eligible procedures under the appropriate schedule of services. To verify coverage and for specific information on any procedure, you should contact a MetLife customer service representative, as there are replacement and frequency limitations that may apply.

Dental Option A and Dental Option B					
		Benefit Allowance Schedule			
Procedure Code	**Service**	**I**	**II**	**III**	**IV**
Oral Examination (up to 2 for each covered individual per calendar year)1[1]					
0150	Comprehensive Oral Evaluation	$15	$17	$19	$21
0120	Periodic Oral Evaluation	$14	$16	$18	$20
X-Rays and Diagnostic Imaging					
0210	Complete mouth series, single or multiple films (limit one complete mouth series or panoramic x-ray per 36 months)	$41	$46	$52	$57
0220	Single periapical, first film	$7	$7	$8	$9
0230	Periapical, each additional film	$3	$4	$4	$4
0270	Bitewing – Single film (limit 2 times per calendar year)	$9	$10	$11	$12
0272	Bite-wings – Two films (limit 2 times per calendar year)	$12	$13	$14	$15
0273	Bite-wings – Three films (limit 2 times per calendar year)	$12	$13	$14	$15
0274	Bite-wings – Four to six films (limit 2 times per calendar year)	$16	$18	$20	$22
0277	Bite-wings – Seven to eight films (limit 2 times per calendar year)	$18	$20	$22	$24
0330	Panoramic x-ray (limit one complete mouth series or panoramic x-ray per 36 months)	$35	$39	$43	$48
Prophylaxis cleaning and polishing (up to 2 for each covered individual per calendar year)					
1110	Adult	$29	$33	$38	$42
1120	Child until reaching 15th birthday	$20	$22	$25	$27
Topical Fluoride Treatments (limit once per calendar year)					

[1] Additional oral exams may be allowed for coverage upon appeal to the contract administrator if deemed medically necessary by the contract administrator.

Dental Option A and Dental Option B					
		Benefit Allowance Schedule			
Procedure Code	Service	I	II	III	IV
1206	One Treatment with Varnish – Child or Adult	$24	$27	$30	$33
1208	One Treatment without Varnish – Child or Adult	$16	$18	$20	$22
Sealants					
1351	Sealant – Per Tooth	$10	$11	$12	$13
Space Maintainers					
1510	Fixed - Unilateral	$108	$122	$138	$151
1516, 1517	Fixed – Bilateral	$155	$175	$197	$218
1520	Removable – Unilateral	$121	$138	$154	$171
1526, 1527	Removable – Bilateral	$162	$183	$205	$227
Amalgam Filling (primary and permanent teeth)					
2140	Amalgam filling (primary and permanent teeth) – one surface	$18	$21	$23	$25
2150	Amalgam filling (primary and permanent teeth) – two surfaces	$28	$31	$34	$37
2160	Amalgam filling (primary and permanent teeth) – three surfaces	$34	$39	$43	$47
2161	Amalgam filling (primary and permanent teeth) – four or more surfaces	$40	$44	$50	$55
Composite Filling (primary and permanent teeth)					
2330	One surface – anterior	$26	$29	$33	$36
2331	Two surfaces – anterior	$32	$35	$39	$43
2332	Three surfaces – anterior	$38	$42	$47	$53
2335	Four or more surfaces – anterior	$44	$49	$55	$60
Crowns (includes temporary crown) – Replacement limited to once every 5 years (Option A only)					
2722	Resin with noble metal	$208	$235	$263	$291
2740	Porcelain/ceramic substrate	$219	$250	$279	$310
2750	Porcelain fused to high noble metal	$239	$272	$305	$337
2790	Full cast, high noble metal	$232	$264	$295	$327
Root canal therapy (removal of pulp and canal filling, excluding final restoration) (Option A only)					
3310	Anterior tooth	$129	$147	$164	$182
3320	Bicuspid tooth	$162	$184	$206	$227
3330	Molar tooth	$196	$223	$250	$277
Gingivectomy or Gingivoplasty (Option A only)					
4210	Four or more contiguous teeth per quadrant	$86	$98	$110	$122
4211	One to three contiguous teeth per quadrant	$17	$19	$22	$24

Dental Option A and Dental Option B					
		Benefit Allowance Schedule			
Procedure Code	Service	I	II	III	IV
4260	Osseous surgery – four or more contiguous teeth per quadrant (limit 4 per 36 months)	$219	$250	$279	$310
4261	Osseous surgery – one to three contiguous teeth per quadrant (limit 4 per 36 months)	$131	$150	$167	$186
Periodontal Scaling and Root Planing – These schedule amounts apply only when fewer than four quadrants (full-mouth) are treated in one visit. Specific criteria may apply depending on pocket of depth and loss of attachment (bone loss).					
4341	Per quadrant (limit eight per calendar year)	$34	$38	$42	$47
4910	Periodontal Maintenance – four per calendar year (including 1110/1120)	$34	$38	$42	$47
Dentures[2] (including six months post-placement care, limit one per five years to include bridgework) (Option A only)					
5110, 5120	Complete upper or lower	$278	$316	$353	$392
5211, 5212	Partial, upper or lower	$232	$265	$296	$328
5421, 5422	Adjust partial denture, upper or lower	$14	$16	$18	$20
Implant[3] (Option A only)					
6010	Endosteal implant	$404	$457	$509	$567
Extraction-simple and surgical[3] (including local anesthesia and routine postoperative care) (Option A only)					
7210	Surgical extraction single erupted tooth	$37	$41	$46	$50
7220	Surgical extraction single impacted tooth (soft tissue)	$57	$64	$71	$79
7140	A simple extraction of an erupted tooth or exposed root	$20	$22	$25	$28
Temporomandibular Joint Dysfunction (TMJ)[2] (Option A only)					
0320	TMJ Arthrogram	$105	$118	$132	$146
0321	X-ray up to six views	$35	$39	$44	$49
0368, 0384	Cone Beam – TMJ	$180	$210	$230	$255
7880	TMJ appliance	$208	$235	$263	$291
9130	TMJ non-invasive physical therapies (per session)	$21	$24	$26	$29
7899	Office visit/treatment (limit 10)	$53	$59	$65	$72
Orthodontics – Comprehensive treatment (Option A only)					
	Initial payment	$384	$384	$384	$384
	Monthly payments (during active treatment period)	$62	$62	$62	$62
	Orthodontic workup	$100	$100	$100	$100

[2] Benefits are available for dental implants; however, a preauthorization is required for implants and other related services. No benefits are available without preauthorization.
[3] Generally, services for anesthesia/analgesia will be reviewed by MetLife for dental necessity. Also, reimbursement for anesthesia/analgesia will be combined with the benefit for other services rendered on the same day.

TMJ Treatment (Dental Option A)

Where there is a temporomandibular joint dysfunction (TMJ) diagnosis, related charges are reimbursed in accordance with the benefit allowance schedule on the previous page. Services related to TMJ which are not listed in the schedule are not eligible for benefits under the IBM Dental Option A or Option B. A maximum of 10 office visits per year is allowed, including eligible services of other providers for associated treatment.

TMJ-related charges that are not covered under the IBM Dental Option A — such as an MRI for diagnostic purposes or TMJ surgery — may be eligible for IBM medical benefits in certain rare circumstances. If you wish to know whether medical benefits would apply for TMJ expenses in your particular circumstances, you should consult the health plan before you incur the expense.

There is no TMJ coverage under Dental Option B.

Orthodontic Treatment (Dental Option A)

Typically, orthodontics is performed over a number of visits, and the services are charged as a lump-sum fee that covers the entire process. The administration of the comprehensive orthodontic benefit differs from that of other dental services. After the active treatment phase has commenced — after placement of the bands upon the teeth — an initial comprehensive treatment payment will be made to you upon submission of the IBM Dental Plan claim form. This payment is for the necessary appliances, diagnostic casts, x-rays and subsequent retention visits during active treatment (while the bands are on the teeth). Active treatment will end when the bands are removed and no further reimbursement for retention visits will be made.

You will also be entitled to receive monthly payments up to a maximum benefit (for all orthodontic care) of $1,500 for the duration of active treatment or until the completion of the treatment plan, whichever comes first. Treatments will be recertified periodically. The orthodontics benefit allowance schedule is the same for all geographic areas. Do not wait for treatment to end before submitting claims to MetLife as the claim filing submission deadline applies. For more information, see *How to File a Claim* in the "*Administrative Information*" section.

Eligible services considered orthodontic in nature include removable/permanent appliances, minor or intermediate. These appliances are not considered comprehensive orthodontic treatment. Unlike comprehensive orthodontic treatment, these appliances will be reimbursed like any other dental services. Reimbursement for both will be paid in one lump-sum payment. However, such orthodontic appliances are included in the $1,500 lifetime maximum.

Retainers are not covered as a separate benefit.

There is no orthodontia coverage under Dental Option B.

Replacement of Dentures or Bridgework (Dental Option A)

Benefits for the replacement of existing dentures or bridgework will be provided only under the following conditions:

- The existing denture or bridgework was installed at least five years before its replacement, and the existing denture or bridgework cannot be made serviceable, or

- The replacement is required to replace one or more natural teeth extracted after placement of the original denture/bridge, or
- The existing denture or bridgework is temporary and cannot be made permanent, and replacement by a permanent denture/bridge occurs within 12 months from the date of initial installation of the temporary denture/bridge.
- Relines and rebases will not be eligible for coverage until six months after insertion of prosthesis; then no limit.

Any dental treatment for dentures or bridgework received under the IBM Dental Plan will be treated as if it was received under the IBM Dental Plan Option A. For example, if a covered individual received dentures or bridgework less than five years ago under the IBM Dental Plan and that individual is now covered under the IBM Dental Plan Option A, new dentures or bridgework may not be replaced unless the existing denture or bridgework cannot be made serviceable.

Pretreatment Estimate of Benefits

Upon request, MetLife will provide an estimate of benefits based on anticipated dental treatment. This should be done if your dentist recommends a dental procedure that exceeds $200. To obtain this estimate of benefits, have your dentist submit a claim form reflecting the proposed treatment plan and relevant clinical information, e.g., x-rays or narrative. MetLife will estimate your eligible benefits in advance, and may also suggest an alternative treatment method. A MetLife pretreatment estimate is valid for one year from the date issued. Estimates and authorizations must be in writing from MetLife and will not be given over the phone by Customer Service Representatives. Estimates will assume no other coverage and will not include information about prior services that may impact benefits reimbursements because of frequency limits or plan limitations.

Please note that a pretreatment estimate is not a claim determination or a guarantee of payment, which cannot be made until after a claim is submitted and processed. For example, actual payment for dental work you receive may be less than the pretreatment estimate because of Plan limitations (such as frequency limits and annual and lifetime maximums) in effect when services are performed. Pretreatment estimates assume you do not have any other dental coverage — actual payments will be less if there is other dental coverage that is primary. No benefits are payable for services performed after termination of coverage.

Alternative Benefits

MetLife reserves the right to suggest an alternative treatment method if their review determines that there is more than one appropriate method to treat the patient's condition than the one being recommended or performed by the dentist. If an alternative method is identified, benefits will be based on the least costly generally acceptable procedure for a specific treatment (i.e., restoring tooth to original function without incurring additional expense).

Examples of alternative benefits include, but are not limited to, the following services. Other services may also be subject to this provision:

Dental Service	Alternative Treatment
Fillings, Inlays, Onlays and Crowns	If a tooth can be repaired by a less costly method than an inlay, onlay or crown, the dental benefits will be based on the least costly generally accepted method of repair. Replacement of existing crowns, inlays and onlays – once every five years – may be waived for dental necessity. When fillings with contiguous surfaces (surfaces that touch) are rendered on the same day, the contiguous surface(s) will only receive one benefit per tooth.
Crowns, Pontics and Abutments	Veneer materials may be used for front teeth or bicuspids; however, the dental benefits for molars will be based on a full cast restoration.
Bridgework and Dentures	Dental benefits will be based on the least costly method of treating the entire dental arch which still provides a functioning level. In some cases, removable dentures may serve as well as fixed bridgework. If dentures are replaced by fixed bridgework, the dental benefits will be based on the cost of a replacement denture unless adequate results can be achieved only with fixed bridgework.
Implants and Related Services	Due to the fact that implants and related services are costly, a pretreatment estimate is recommended before work is done in order to be eligible for any benefits. The first phase of this type of work is generally not subject to the alternative benefit provisions; benefits will either be approved or denied. The second phase of treatment generally is subject to the alternative benefit provision. An alternative benefit for the final restoration over the implant will be determined and may be reimbursed upon final completion of the work.

Dental Claims

Generally, your network dentist will submit your claim directly to MetLife on your behalf. However, if you need to submit a claim for dental treatment to MetLife, you can do so by obtaining a claim form or via MetLife's online portal, MyBenefits.

To file a claim for dental treatment via a paper form, follow these steps:

- Obtain an IBM MetLife Dental Claim Form from www.metlife.com/mybenefits, NetBenefits® or by calling MetLife at 800-872-6963.
- Bring the claim form with you to the dental appointment.
- Complete and sign the IBM MetLife Dental Claim Form at the time services are provided. The IBM employee must sign the claim form certifying the validity of the claim. Claims will only be processed for covered eligible family members who are listed on your benefits on file with IBM.
- Ask your dentist to complete the "Dentist Section" on the claim form and return it to MetLife at the address on the form. You may also submit the claim form yourself with the appropriate supporting documentation (e.g., itemized bill).
- Your dentist may submit an electronic claim only if they maintain the appropriate "signature on file."
- Payment will be made to you or your dentist as indicated on the claim form.

To file a claim for dental treatment via a MetLife's online portal, MyBenefits, follow these steps:

- Obtain an invoice of services rendered from your dental provider. This must include:

  The provider's contact information,
  An itemized description of all services rendered, and
  A printed receipt of payment.
- Open MetLife's online portal, MyBenefits by visiting the URL: www.metlife.com/mybenefits.
- Navigate to the Claim Center and click on the "Complete Form" button and follow the instructions and guidance.
- Payment will be made to you or your dentist as indicated on the electronic form.

Claims for services must be received at the MetLife claim office no later than December 31st of the year following the year charges are incurred.

Note that if you and your spouse/domestic partner are eligible for IBM dental coverage each in your own right and one of you is enrolled as a dependent of the other, all claims must be filed by the Plan participant only.

How to File a Claim for Orthodontic Treatment

When submitting a claim for comprehensive orthodontic treatment, it is only necessary to submit the claim once, at the beginning of the active treatment period. However, MetLife may request additional information periodically to verify that you or your dependent is still receiving active treatment. Payment will be made to you or the dentist, as indicated on the claim form. You must remain enrolled in the Dental Plus option while undergoing orthodontic treatment to continue to be eligible for the benefit.

Dental Claim Review Procedures

Dental claim review procedures have been established to ensure that the reimbursements accurately reflect the services performed. In certain cases, x-rays and other diagnostic and evaluation materials may be requested to assist in the review.

HOW THE METLIFE PREFERRED DENTIST PROGRAM (PDP) WORKS

The MetLife Preferred Dentist Program (PDP) is available to pre-2000 eligible retirees who are not Medicare-eligible, and their eligible family members who are not Medicare-eligible. The PDP provides financial assistance toward the expenses of dental care and treatment. Under the PDP option, you can visit any licensed dentist of your choice, but you will receive the highest level of coverage when you obtain services from a dentist who is a member of MetLife's network. (Major restorative and orthodontic services are not eligible for reimbursement when using an out-of-network dentist.)

Annual Deductible

There is no annual deductible under the PDP option. Also, you do not have to choose a primary care dentist, nor do you need authorization to switch dentists or to seek specialty care, although specialists must be participating PDP providers in order for expenses to be eligible for reimbursement.

Lifetime Maximum

Under the PDP there is no lifetime maximum, except for orthodontic treatment which has a lifetime maximum of $1,500 for each covered person.

In-Network Providers

You can take advantage of negotiated rates when you receive treatment from a participating PDP network dentist. When you receive services from a PDP participating dentist, benefit payments are based on a percentage of the dentist's negotiated fees. The percentage reimbursed varies for procedures received (see *What's Covered Under the Preferred Dentist Program* for details). Also, the negotiated rates vary by geographic location and are agreed to by the PDP Dentist and MetLife in advance. The reimbursements apply to eligible services performed by a PDP participating dentist wherever they are performed, such as the dentist's office or the hospital. Please check with your medical plan regarding precertification of your hospital stay.

If you use a provider who practices at more than one location, the provider may not participate in the network in all of their locations. Before obtaining any dental service, you should verify the provider's network participation at the location you visit by contacting MetLife. Also, if a member of a dental practice is a participating MetLife network dentist, it is possible that other dentists in that practice are not. You should check with MetLife whether other dentists are in-network before receiving treatment.

IF YOU RELOCATE OR YOUR PROVIDER LEAVES THE NETWORK

If you relocate or your provider leaves the PDP network, you are not eligible to change your dental plan options during the year as these events are not considered qualified life events. You may change dental options only during the annual benefit enrollment period or if you have a qualified life event.

When making an appointment, tell the dentist's office that you are a MetLife PDP dental plan participant. By making the dentist's office aware that you are a network plan participant, you will receive the negotiated rates and avoid later billing adjustments.

Since participating providers can join and leave the network at any time, it's a good idea to confirm that your dentist is currently a network provider before receiving treatment. You can obtain a list of current network participating providers through www.metlife.com/mybenefits or by calling MetLife.

Geographic Areas

The negotiated fees charged by participating dentists reflect differences in negotiated dental charges by geographic area. Each participating PDP network dentist agrees to accept a geographically based negotiated rate as payment in full. That fee determines what the dentist will charge for services to eligible IBM retirees. These geographically based negotiated rates are not published to retirees, but you may contact MetLife for reimbursement rates for specific procedures.

Out-of-Network Providers

You may visit any appropriately licensed dentist of your choice. However, if that dentist is not a participating PDP network dentist, eligible services are limited to preventive, diagnostic and some basic services only. Major restorative and orthodontic services are not eligible for reimbursement when using an out-of-network dentist.

The out-of-network reimbursement is based on a fixed dollar amount, and follows the same benefit allowance as Schedule III of Dental Option A and Dental Option B (see *What's Covered Under Dental Option A and Dental Option B* charts).

If you cannot locate a PDP provider within a reasonable distance from your home or work, you must contact MetLife before services are rendered. A Customer Service Representative will help you determine your alternatives by checking to see if additional dentists were added to the PDP network in your area.

Filing Claims

You should bring a PDP claim form to all dental appointments, whether you receive services in-network or out-of-network. You can obtain PDP claim forms on MetLife's website or by calling MetLife. See *How to File a Claim* in the "*Administrative Information*" section for more information.

Pretreatment Estimate of Benefits

If your dentist recommends substantial treatment (in excess of $200), you should request a pretreatment estimate of benefits from MetLife by having your dentist submit a claim form with an explanation of the treatment plan and relevant clinical information, e.g., x-rays or narrative.

MetLife will estimate your eligible benefits in advance, and may also suggest an alternative treatment method (see next page). A MetLife pretreatment estimate is valid for one year from the date issued. Estimates and authorizations must be in writing from MetLife and will not be given over the phone by Customer Service Representatives. Estimates will assume no other coverage and will not include information about prior services that may impact benefits reimbursements because of frequency limits or plan limitations.

PAYING FOR DENTALSERVICES BY IN- AND OUT-OF-NETWORK DENTISTS

At the time you receive dental services, your dentist may require you to pay the amount of your copayment or the full negotiated fee. Your copayment is the difference between the amount of the dentist's charges and the percentage paid by MetLife for that type of service.

Please note that a pretreatment estimate is not a claim determination or a guarantee of payment, which cannot be made until after a claim is submitted and processed. For example, actual payment for dental work you receive may be less than the pretreatment estimate because of Plan limitations (such as frequency limits and Plan maximums) in effect when services are performed. Pretreatment estimates assume you do not have any other dental coverage — actual payments will be less if there is other dental coverage that is primary.

If you do not obtain a pretreatment estimate, or choose a treatment not authorized for benefits by Metlife, you will be responsible for any difference in cost between the suggested alternative treatment, if any, and the treatment you receive.

No benefits are payable for services performed after termination of coverage, unless the course of treatment associated with the procedure commenced before termination of coverage and is categorized as major restorative. In that event, benefits are only payable for procedures performed within 60 days after termination of coverage.

Alternative Benefits

MetLife PDP reserves the right to suggest an alternative treatment method if their review determines that there is more than one appropriate method to treat the patient's condition than the one being recommended or performed by the dentist. If an alternative method is identified, benefits will be based on the least costly professionally acceptable procedure for a specific treatment (i.e., restoring tooth to original function without incurring additional expense).

Examples of alternative benefits include, but are not limited to, the following services. Other services may also be subject to this provision:

Dental Service	Alternative Treatment
Fillings: Inlays, Onlays and Crowns	If a tooth can be repaired by a less costly method than an inlay, onlay or crown, the dental benefits will be based on the least costly generally accepted method of repair. Replacement of existing crowns, inlays and onlays — once every 5 years — may be waived for dental necessity. Composite fillings on molar teeth are subject to the alternative benefit provision. When fillings with contiguous surfaces (surfaces that touch) are rendered on the same day, the contiguous surface(s) will only receive one benefit per tooth.

Dental Service	Alternative Treatment
Crowns, Pontics and Abutments	Veneer materials may be used for front teeth or bicuspids; however, the dental benefits for molars will be based on a full cast restoration.
Bridgework and Dentures	Dental benefits will be based on the least costly method of treating the entire dental arch which still provides a functioning level. In some cases, removable dentures may serve as well as fixed bridgework. If dentures are replaced by fixed bridgework, the dental benefits will be based on the cost of a replacement denture unless adequate results can be achieved only with fixed bridgework.
Implants and Related Services	Due to the fact that implants and related services are costly, a pretreatment estimate is recommended before work is done in order to be eligible for any benefits. The first phase of this type of work is generally not subject to the alternative benefit provisions; benefits will either be approved or denied. The second phase of treatment generally is subject to the alternative benefit provision. An alternative benefit for the final restoration over the implant will be determined and may be reimbursed upon final completion of the work.

Emergency Care under the MetLife PDP

If emergency dental treatment is required, contact your PDP dentist. If your PDP dentist is not available, you should go to another PDP dentist. However, if a PDP dentist is not available, it is understandable that treatment may be sought from a non-PDP dentist for palliative care (to alleviate pain).

In a case when emergency dental treatment is required and you have gone to an out-of-network dentist, benefits to alleviate the pain which led to the emergency will be considered for reimbursement. Supporting documentation will be required from you and your dentist; the documentation should fully explain why a PDP dentist was not visited and the nature of the dental emergency.

When using a non-PDP dentist, reimbursement is not guaranteed, therefore sufficient supporting documentation must be submitted with the claim since each case will receive individual consideration. This documentation along with the bill for services is to be submitted with the PDP claim form to MetLife. MetLife will then review documentation and determine eligibility for reimbursement.

WHAT'S COVERED UNDER THE METLIFE PREFERRED DENTIST PROGRAM

Generally, dental services (including most oral surgery) are eligible for benefits to the extent they are necessary and appropriate for dental health and are considered eligible procedures under the appropriate schedule of services. To verify coverage and for specific information on any procedure, you should contact a MetLife customer service representative, as there are replacement and frequency limitations that may apply.

Procedure Code	Service	Reimbursement: In-Network	Reimbursement: Out-of-Network
Oral Examination[1] (up to 2 for each individual per calendar year)			
0150	Comprehensive	100%	$19
0120	Periodic	100%	$18
X-Rays			
0210	Complete mouth series, single or multiple films (limit 1 complete mouth series or panoramic x-ray per 36 months)[2]	80%	$52

Procedure Code	Service	Reimbursement: In-Network	Reimbursement: Out-of-Network
0220	Single periapical, first film	80%	$8
0230	Periapical, each additional film	80%	$4
Bitewing (limit 2 times per calendar year)			
0270	Single film	80%	$11
0272	Two films	80%	$14
0273	Three films	80%	$18
0274	Four to six films	80%	$20
0277	Seven to eight films	80%	$22
0330	Panoramic x-ray (limit 1 complete mouth series or panoramic x-ray per 36 months)	80%	$43
Prophylaxis — Cleaning and Polishing **(up to 2 for each individual per calendar year)**			
1110	Adult	80%	$38
1120	Child until reaching 15th birthday	80%	$25
Topical Fluoride Treatments **(limit once per calendar year)**			
1206	One treatment – with varnish – child or adult	80%	$30
1208	One treatment – without varnish – child or adult	80%	$20
Sealants			
1351	Sealant – per tooth	80%	$12
Space Maintainers			
1510	Fixed - unilateral	80%	$138
1516, 1517	Fixed – bilateral	80%	$197
1520	Removable – unilateral	80%	$154
1526, 1527	Removable – bilateral	80%	$205
Amalgam Filling **(primary and permanent tooth)**			
2140	One surface	50%	$23
2150	Two surfaces	50%	$34
2160	Three surfaces	50%	$43
2161	Four or more surfaces	50%	$50
Composite Filling			
2330	One surface – anterior	50%	$33
2391	One surface – posterior	50%	$37
2331	Two surfaces – anterior	50%	$39
2392	Two surfaces – posterior	50%	$44
2332	Three surfaces – anterior	50%	$47
2393	Three surfaces – posterior	50%	$53
2335	Four or more surfaces – anterior	50%	$55
2394	Four or more surfaces – posterior	50%	$57

What's Covered under the Preferred Dentist Program – In-Network Coverage Only

Service[3]	Reimbursement: In-Network
Major Restorative Treatment	
▪ Crowns and bridgework ▪ Dentures ▪ Extractions ▪ Implants[3] ▪ Inlays and onlays ▪ Oral surgery that is dental in nature ▪ Periodontal services, including periodontal scaling and root planning ▪ Endodontics, including root canals	50%
Orthodontia	
▪ Examinations ▪ Diagnostic procedures ▪ Appliances, including removable, fixed and minor or intermediate appliances	50%

1. Additional oral exams may be allowed for coverage upon appeal to the contract administrator if deemed medically necessary by the dental plan.

2. The limitation on receiving complete mouth series x-rays and panoramic x-rays in a 36-month period will be carried over from any other IBM Dental Plan to the PDP. For example, if you or a covered dependent have received a complete mouth x-ray series within the last 36-months under IBM Dental Plan A or B, you or the covered dependent will have to wait until the 36-month period has been reached before receiving a complete mouth x-ray series or panoramic x-ray series under the PDP.

3. Benefits are available for dental implants; however, a preauthorization is recommended for implants and other related services.

Major Restorative Treatment (In-Network only)

- General ***anesthesia/analgesia***, treatment will be reviewed by MetLife for dental necessity. Coverage may be combined with the benefit for other services rendered on the same day.
- Caps, crowns, inlays and onlays.
- ***Replacement of existing crowns,*** inlays or onlays, once every five years, unless waived for medical necessity.
- ***Endodontic treatment,*** including root canals.
- ***Extractions***, including anesthesia and routine postoperative care.
- ***Implants.*** A pretreatment estimate is recommended for implants and other related services before work being done, in order to be eligible for any benefits. You and your dentist will each receive written notification of the benefits available for these services under the IBM Dental Plan.
- ***Replacement of existing implants,*** once every seven years.

BENEFIT DETERMINATION GUIDELINES FOR GENERAL ANESTHESIA/IV SEDATION

Benefits may be available, as determined by the dental plan, for general anesthesia/IV sedation when it is performed in conjunction with the following dental procedures:

- The surgical extraction of two or more teeth completed on the same date.
- When three or more standard extractions of teeth are completed on the same date.
- The closure of an oral antral fistula.
- The surgical exposure of an impacted tooth that is to be retained for orthodontic purposes if orthodontics is covered by the Plan.
- When two or more implants are placed and the implants have been approved for benefits.
- When a standard tooth extraction and a surgical tooth extraction are completed on the same date.

There may be occasions where benefits for general anesthesia/IV sedation are available when a patient has unique needs or where there are clinical situations that warrant its use because local anesthesia administration would not suffice. Some examples include:

- Mentally or physically disabled covered individuals.
- Age of patient - up to seven years - unmanageable
- Patient with spastic disease.
- Infection at injection site where local anesthetic would normally be administered.
- Allergy to local anesthesia.
- Failure of local anesthesia to control pain.
- Extent of surgery - complicated surgical procedures that occur in multiple quadrants of the oral cavity on the same date.

- ***Periodontal treatment***:
  - Scaling and root planing are limited to eight quadrants per calendar year.
  - Osseous surgery once per quadrant per 36-months.
  - Periodontal maintenance is limited to four per calendar year (this includes adult and child prophylaxis) and is only payable when there is a history of qualifying periodontal therapy, in at least two different quadrants.
  - Local chemotherapy agents used in conjunction with non-surgical periodontal therapy (root scaling and planing) are limited to one per tooth, and for a limited number of teeth that have pocket depth between 6 mm and 8 mm and bleed probing and have had no chemotherapeutic agent applied for at least the prior 12-month period, as determined by the Plan's Dentist Consultants.
  - Local chemotherapy agents used in conjunction with periodontal maintenance therapy (post scaling and root planing or osseous surgery) are limited to one per tooth for a limited number of teeth that show increasing pocket depths between 5 mm and 8 mm and have had no chemotherapeutic agent applied for at least the prior 12-month period. Benefits may be available based on review of the clinical documentation by the Plan's Dentist Consultants when there is a history of completed active periodontal therapy.
- ***Creation of bridgework and dentures***, ***dentures,*** no coverage is available during the first six months following the date of the insertion of the prosthesis; thereafter, no limit.
- ***Relining existing bridgework or dentures,*** coverage is available only after six months following the date of the insertion of the prosthesis; then no limit.
- ***Replacement of existing dentures or bridgework.*** For treatment to be eligible the following conditions must be met
  - The existing denture or bridgework was installed at least five years before its replacement, and the existing denture or bridgework cannot be made serviceable or

- The replacement is required to replace one or more natural teeth extracted after placement of the original denture/bridge and the appliance cannot be made serviceable or
- The existing denture or bridgework is temporary and cannot be made permanent, and replacement by a permanent denture/bridge occurs within 12 months from the date of initial installation of the temporary denture/bridge.

Note: *Any dental treatment for dentures or bridgework received under the dental plan options will be treated as if it was received under the IBM MetLife Preferred Dental Plan option. For example, if a covered individual received dentures or bridgework less than five years ago under the dental plan options and that individual is now covered under the IBM MetLife Preferred Dental Plan option, new dentures or bridgework may not be replaced until five years have passed unless the existing denture or bridgework cannot be made serviceable. Temporary and interim dentures are not a covered expense.*

- ***Temporomandibular joint dysfunction*** (TMJ)-related charges are covered at 50% unless noted otherwise below:
  - X-rays, up to six views, (considered a diagnostic procedure and are covered at 80%)
  - TMJ appliance
  - TMJ office visits/treatments, up to 10 per year, including eligible services of other providers for associated treatment

TMJ Treatment (In-Network Coverage Only)

Where there is a temporomandibular joint dysfunction (TMJ) diagnosis, in-network related charges are reimbursed in accordance with the following reimbursement percentages. You are strongly urged to contact MetLife to be aware of what the IBM MetLife Preferred Dental Plan option will cover before you or your eligible dependent receive services in conjunction with TMJ.

TMJ-related charges not covered under the MetLife PDP may be eligible for IBM medical benefits in certain rare circumstances. If you wish to know whether medical benefits would apply for TMJ expenses in your particular circumstances, you should consult with your medical plan before you incur the expense.

Orthodontic Treatment (In-Network Coverage Only)

Orthodontic treatment that commences on or after the effective date of coverage in the PDP will be covered for eligible PDP participants, up to a lifetime maximum of $1,500 per covered person. The administration of the orthodontic benefit differs from that of other dental services. Here's how:

- When submitting a claim for comprehensive orthodontic treatment, it is only necessary to submit the claim once, at the beginning of the active treatment period. However, additional information may be requested periodically to verify that you or your dependent is still receiving active treatment. Payment will be made to you or the dentist, as indicated on the claim form.
- After the active treatment phase has commenced — placement of the bands upon the teeth — 25% of the total orthodontic charge will be considered the banding fee. Benefits will be paid at 50% of the banding fee, or up to the U&P rate, and will be made upon submission of the claim form.
- After subtracting the banding fee, the remaining charge for eligible services while the bands are on the teeth will be divided by the number of months of treatment that the orthodontist indicates is required. (Charges include necessary appliances, diagnostic casts, x-rays and subsequent monthly visits while the bands are on the teeth.)

- You will receive a monthly reimbursement check equal to 50% of this calculated monthly amount. Payment for active treatment will end when bands are removed or the patient reaches the lifetime orthodontia maximum, whichever occurs first, and no further reimbursement will be made.
- Reimbursement will be paid in monthly installments over the course of the treatment, thus the full reimbursement will not be received until conclusion of the active treatment has been reached. Monthly benefits will be sent automatically to you or to your dentist, per your designation on the claim form. (Automatic payment will cease if you or your covered family member are no longer covered by the PDP.)
- Do not wait for treatment to be completed to submit orthodontia claims as the claim submission deadlines apply. For more information, see *How to File a Claim* in the "*Administrative Information*" section.
- MetLife will confirm treatment periodically.

Eligible Orthodontic Services
Eligible services considered orthodontic in nature include removable or fixed appliances and minor or intermediate appliances. All orthodontic appliances are included in the $1,500 lifetime maximum. Retainers are not covered as a separate benefit. There is no coverage for orthodontic treatment if services are rendered by an orthodontist who is not a PDP participating provider.

Orthodontic Benefits that Began Before Enrollment in the MetLife PDP Plan
If an individual covered under the IBM Dental MetLife PDP begins orthodontic services before the effective date of coverage, reimbursement of orthodontic expenses for patients whose treatment started before their MetLife coverage start date will be prorated based on the remaining number of treatment months after coverage became effective and the total fee charged, as long as Orthodontic services are rendered with and in-Network provider.

Orthodontic Benefits If You Received Services under IBM Dental Option A
If an individual covered under the PDP commences orthodontic services on or after the effective date of coverage and had previously received orthodontic services under IBM Dental Plan Option A, any amount reimbursed to the retiree for orthodontic services while under the IBM Dental Plan will be deducted from the $1,500 PDP orthodontic lifetime maximum. The covered individual will only be reimbursed at the 50% level up to the remaining balance of the $1,500 maximum.

Treatment for the Replacement of Dentures or Bridgework (In-Network Coverage Only)
Benefits for the replacement of existing dentures or bridgework will be provided only under the following conditions:

- The existing denture or bridgework was installed at least five years before its replacement, and the existing denture or bridgework cannot be made serviceable or
- The replacement is required to replace one or more natural teeth extracted after placement of the original denture/bridge and the appliance cannot be made serviceable or
- The existing denture or bridgework is temporary and cannot be made permanent, and replacement by a permanent denture/bridge occurs within 12 months from the date of initial installation of the temporary denture/bridge.

- Relines and rebases will not be eligible for coverage until six months after insertion of prosthesis; then no limit.

Any dental treatment for dentures or bridgework received under the IBM Dental Plan will be treated as if it was received under the PDP. For example, if a covered individual received dentures or bridgework less than five years ago under the IBM Dental Plan and that individual is now covered under the PDP, new dentures or bridgework may not be replaced unless the existing denture or bridgework cannot be made serviceable.

Dental Claim Review Procedures

Dental claim review procedures have been established to ensure that the reimbursements accurately reflect the services performed. In certain cases, x-rays and other diagnostic and evaluation materials may be requested to assist in the review.

Reimbursement of orthodontic expenses or other courses of treatment for patients whose treatment started before their PDP coverage began will be reviewed by MetLife for any eligible benefits.

Benefit Guidelines for General Anesthesia/IV Sedation

Benefits may be available, as determined by the contract administrator, for general anesthesia/IV sedation when it is performed in conjunction with the following dental procedures:

- The surgical extraction of two or more teeth completed on the same date.
- When three or more standard extractions of teeth are completed on the same date.
- The closure of an oral antral fistula.
- The surgical exposure of an impacted tooth that is to be retained for orthodontic purposes if orthodontics is covered by the Plan.
- When two or more implants are placed and the implants have been approved for benefits.
- When a standard tooth extraction and a surgical tooth extraction are completed on the same day.

There may be occasions where benefits for general anesthesia/IV sedation are available when a patient has unique needs or where there are clinical situations that warrant its use because local anesthesia administration would not suffice. Some examples include:

- Mentally or physically disabled covered individuals.
- Age of patient — up to seven years — unmanageable.
- Patient with spastic disease.
- Infection at injection site where local anesthetic would normally be administered.
- Allergy to local anesthesia.
- Failure of local anesthesia to control pain.
- Extent of surgery — complicated surgical procedures that occur in multiple quadrants of the oral cavity on the same date.

Benefit Guidelines for Local Chemotherapeutic Agents

In Conjunction with Non-Surgical Periodontal Therapy

Benefits for the application of local chemotherapeutic agents during non-surgical therapy are limited to one per tooth and for a limited number of teeth, determined by the dental administrator's Dentist Consultants, that have pocket depth between 6MM and 8MM and bleed on probing and have had no chemotherapeutic agent applied for at least the prior 12-month period.

In Conjunction with Periodontal Maintenance Therapy

Benefits for the application of local chemotherapeutic agents may be available based on review of the clinical documentation by the dental administrator's Dentist Consultants when there is a history of completed active periodontal therapy. The benefits are limited to one per tooth for a limited number of teeth that show increasing pocket depths between 5MM and 8MM and have had no chemotherapeutic agent applied for at least the prior 12-month period.

Dental Options for Non-Medicare-Eligible Retirees Who Retired On or After January 1, 2000

Retirees who are not eligible for Medicare, non-Medicare dependents of Medicare-eligible retirees can enroll in the dental plan options described below.

IBM DENTAL PLAN AT A GLANCE FOR POST-2000 RETIREES[1]

	IBM Dental Basic		IBM Dental Plus	
Annual Deductible *In-Network* *Out-of-Network*	None None		None $50 per person for basic and major restorative treatment; waived for preventive treatment;	
Annual Maximum Benefit	$500 per covered person		$2,000 per covered person[2]	
Lifetime Maximum Benefit	No limit		No limit	
Orthodontia Lifetime Maximum	Not applicable		Up to $1,500 per covered person in- and out-of-network combined	
Level of Care	**The Plan Pays**			
	In-Network	***Out-of-Network[3, 6]***	***In-Network***	***Out-of-Network[3, 6]***
Preventive Treatment ▪ Routine oral exams ▪ Routine cleanings ▪ X-rays ▪ Fluoride treatments ▪ Space maintainers ▪ Sealants	100% of the negotiated fee for eligible charges	80% of usual & prevailing rate	100% of the negotiated fee for eligible charges	80% of usual & prevailing rate[7]
Basic Restorative Treatment ▪ Amalgam and composite fillings	80% of the negotiated fee for eligible charges	80% of usual & prevailing rate, after deductible	80% of the negotiated fee for eligible charges	80% of usual & prevailing rate, after deductible[7]

	IBM Dental Basic		IBM Dental Plus	
Level of Care	**The Plan Pays**			
	In-Network	***Out-of-Network[3, 6]***	***In-Network***	***Out-of-Network[3, 6]***
Major Restorative Treatment[5] ▪ Crowns and bridgework ▪ Dentures ▪ Extractions ▪ Implants[4] ▪ Inlays and onlays ▪ Oral surgery that is dental in nature ▪ Periodontal services, including periodontal scaling and root planing ▪ Endodontics, including root canals	Not covered	Not covered	50% of the negotiated fee for eligible charges	50% of usual & prevailing rate, after deductible[7]
Orthodontia ▪ Examinations ▪ Diagnostic procedures ▪ Appliances, including removable, fixed and minor or intermediate appliances	Not covered	Not covered	50% of the negotiated fee for eligible charges	50% of billed fee[8]

1 *If you became eligible for LTD benefits on or after January 1, 2000, special provisions apply under IBM Dental Plus. See your Health Plan Detail Sheets for details.*
2 *Orthodontia charges do not count toward the annual maximum benefit.*
3 *You are responsible for 100% of any charges above the U&P rate.*
4 *A pretreatment estimate is recommended for implants and implant-related services before work being done.*
5 *There are replacement and frequency limitations for some of the above services. Refer to "What's Covered under the IBM Dental Plan."*
6. *The Usual & Prevailing (U&P) charges are calculated at the 70% percentile.*
7 *You pay any amount over the U&P rate for all eligible charges.*
8 *You pay any amount that exceeds the lifetime maximum,*

Usual and Prevailing (U&P) Rate

The usual and prevailing rate for out-of-network dental services is defined as the maximum fee taking into consideration the following:

- The fee that an individual dentist most frequently charges the majority of patients for a similar service or dental procedure.
- The range of usual fees charged for the service or procedure by dentists for the performance of a similar service or dental procedure within the same locality.
- Special circumstances or complications requiring additional time, skill and experience in connection with that particular dental service or procedure.

MetLife shall determine U&P rate information in all cases. Keep in mind the U&P rate may be different than the amount charged by an out-of-network dental provider. If the charge for services is more than the U&P rate set by the Plan, you will have to pay your provider the amount that exceeds the U&P rate, in addition to the applicable deductible and coinsurance.

HOW THE IBM DENTAL PLAN WORKS

Under the IBM Dental Basic and IBM Dental Plus options, you can visit any licensed dentist of your choice, but you will receive the highest level of coverage when you obtain services from a dentist who is a member of MetLife's network. Charges used to satisfy the deductible will not be eligible for reimbursement under any other dental benefit plan. Under IBM Dental Plus each member must satisfy the deductible each calendar year if seeing a provider outside of MetLife's network for Basic and Major Restorative services.

IF YOU SWITCH FROM THE IBM DENTAL PLUS TO THE IBM DENTAL BASIC OPTION

If you change your enrollment from the IBM Dental Plus option to the IBM Dental Basic option during Annual Enrollment or in the middle of the year due to a qualified life event, dental treatment "in progress" at the time of your enrollment change will become ineligible for coverage unless the services continue to be eligible under the IBM Dental Basic option.

For example, if your child is receiving orthodontia treatment under the IBM Dental Plus and you change enrollment to the IBM Dental Basic, that treatment will no longer be covered since orthodontia care is not a covered service under the IBM Dental Basic option.

The applicable annual maximum, amounts contributed to a deductible, and procedure history carries over to/ from Dental Basic and Dental Plus when plan changes occur during the same calendar year. For example, if you make a mid-year plan change to Dental Basic from Dental Plus and you've already used $200 toward your annual maximum under Dental Plus, you will have $300 remaining toward your new annual maximum under Dental Basic ($500) for the remainder of the plan year. This is also applicable if you switch from the Active Employee Dental Basic or Dental Plus plans to the Retiree Dental Basic or Dental Plus plans at retirement.

In-Network Providers

You can take advantage of negotiated rates when you receive treatment from a participating MetLife network dentist. Plus, your network dentist will submit your claim to MetLife for you so there are no claim forms to fill out. Additionally, you are not required to pay an annual deductible for in-network treatment.

When you receive services from a MetLife participating dentist, benefit payments are based on the dentist's negotiated fees. When making an appointment, tell the dentist's office that you are a MetLife dental plan participant. By making the dentist's office aware that you are a network plan participant, you will receive the negotiated rates and avoid later billing adjustments from an in-network provider.
If you use a provider who practices at more than one location, the provider may not participate in the network in all of their locations. Before obtaining any dental service, you should verify the provider's network participation at the location you visit by contacting MetLife. Also, if a member of a dental practice is a participating MetLife network dentist, it is possible that other dentists in that practice are not.

Since participating providers can join and leave the network at any time, it's a good idea to confirm that your dentist is currently a network provider before receiving treatment. You can obtain a list of current network participating providers through www.metlife.com/mybenefits or by calling MetLife.

Geographic Areas

The negotiated fees charged by participating dentists reflect differences in negotiated dental charges by geographic area. Each participating MetLife network dentist agrees to accept a geographically based negotiated rate as payment in full. That fee determines what the dentist will charge for services to eligible IBM employees. These geographically based negotiated rates are not published to employees, but you may contact MetLife for reimbursement rates for specific procedures.

Out-of-Network Providers

You may visit any appropriately licensed dentist of your choice. However, if that dentist is not a participating MetLife network dentist, reimbursement will be based on a percentage of the U&P rate. Additionally, if you are enrolled in the Dental Plus plan, you must satisfy a $50 per person annual deductible when utilizing an out-of-network dentist for basic and major restorative treatment. The out-of-network annual deductible does not apply to preventive care or orthodontia treatment. If you receive treatment from an out-of-network dentist, you may be responsible for filing your own claims. See "*How to File Out-of-Network Claims*" in the "*Administrative Information*" section for more information.

Charges used to satisfy the deductible will not be eligible for reimbursement under any other dental benefit plan. Each member must satisfy the deductible each calendar year.

Pretreatment Estimate of Benefits

If your dentist recommends substantial treatment (in excess of $200), you should request a pretreatment estimate of benefits from MetLife by having your dentist submit a claim form with an explanation of the treatment plan and relevant clinical information, e.g., x-rays or narrative. MetLife will estimate your eligible benefits in advance, and may also suggest an alternative treatment method (see next page). A MetLife pretreatment estimate is valid for one year from the date issued. Estimates and authorizations must be in writing from MetLife and will not be given over the phone by Customer Service Representatives. Estimates will assume no other coverage and will not include information about prior services that may impact benefits reimbursements because of frequency limits or plan limitations.

Please note that a pretreatment estimate is not a claim determination or a guarantee of payment, which cannot be made until after a claim is submitted and processed. For example, actual payment for dental work you receive may be less than the pretreatment estimate, because of Plan limitations (such as frequency limits and annual and lifetime maximums) in effect when services are performed. Pretreatment estimates assume you do not have any other dental coverage — actual payments will be less if there is other dental coverage that is primary. No benefits are payable for services performed after termination of coverage.

If you do not obtain a pretreatment estimate, or choose a treatment not authorized for benefits by MetLife, you will be responsible for any difference in cost between the suggested alternative treatment, if any, and the treatment you receive.

PRETREATMENT ESTIMATE FOR IMPLANTS AND RELATED SERVICES

A pretreatment estimate is recommended for implants and other related services before work being done, in order to be eligible for any benefits. You and your dentist will each receive written notification of the benefits available for these services under the IBM Dental Plan.

Alternative Benefits

MetLife reserves the right to suggest an alternative treatment method if their review determines that there is more than one appropriate method to treat the patient's condition than the one being recommended or performed by the dentist. If an alternative method is identified, benefits will be based on the least costly generally acceptable procedure for a specific treatment (i.e., restoring tooth to original function without incurring additional expense).

Examples of alternative benefits include, but are not limited to, the following services. Other services may also be subject to this provision:

Dental Service	Alternative Treatment
Fillings: Inlays, Onlays and Crowns	If a tooth can be repaired by a less costly method than an inlay, onlay or crown, the dental benefits will be based on the least costly generally accepted method of repair. Replacement of existing crowns, inlays and onlays – once every seven years. When fillings with contiguous surfaces (surfaces that touch) are rendered on the same day, the contiguous surface(s) will only receive one benefit per tooth.
Crowns, Pontics and Abutments	Veneer materials may be used for front teeth or bicuspids; however, the dental benefits for molars will be based on a full cast restoration.
Bridgework and Dentures	Dental benefits will be based on the least costly method of treating the entire dental arch which still provides a functioning level. In some cases, removable dentures may serve as well as fixed bridgework. If dentures are replaced by fixed bridgework, the dental benefits will be based on the cost of a replacement denture unless adequate results can be achieved only with fixed bridgework.
Implants and Related Services	Due to the fact that implants and related services are costly, a pretreatment estimate is recommended before work being done in order to be eligible for any benefits. The first phase of this type of work is generally not subject to the alternative benefit provisions; benefits will either be approved or denied. The second phase of treatment generally is subject to the alternative benefit provision. An alternative benefit for the final restoration over the implant will be determined and may be reimbursed upon final completion of the work.

Emergency Care Under the IBM Dental Plan

If emergency dental treatment is required, contact your dentist. Charges will be considered for reimbursement in accordance with the percentage rates previously described if eligible under your dental option.

WHAT'S COVERED UNDER THE IBM DENTAL PLAN

Generally, dental services (including most oral surgery) are eligible for benefits to the extent that they are necessary and appropriate for dental health and are considered eligible procedures under the IBM Dental Basic and IBM Dental Plus options. The most common procedures for each dental service type are included in the summary that follows. To verify coverage and for specific information on any procedure, especially those not noted in this SPD, you should contact a MetLife customer service representative, as there are replacement and frequency limitations that may apply.

All eligible services will be reimbursed by the Plan you are enrolled in at the time the service is completed. These payments apply to eligible services wherever they are performed, such as the dentist's office or the hospital. Please check with your health plan regarding precertification of your hospital stay.

The annual maximum benefit carries over to/from Dental Plus and Dental Basic when plan changes occur during the same calendar year. Once you reach your annual maximum benefit, the plan will not pay any more dental benefits claims for that year. The annual maximum benefit restarts on January 1st of the following year for services incurred during that same year.

Preventive Treatment

- ***Cleanings,*** two per calendar year. Additional cleanings may be allowed if deemed medically necessary by the dental plan.
- ***Oral examinations, including but not limited to routine or problem focused examinations,*** two per calendar year.
- Additional oral exams may be allowed if deemed medically necessary by the dental plan.
- ***X-rays,*** one complete full-mouth x-ray series or panoramic x-ray per 60 months.
- ***Topical fluoride treatments,*** once per calendar year.
- ***Sealants,*** one per tooth per lifetime***.***

Basic Restorative Treatment

- Amalgam and composite fillings.

Major Restorative Treatment (Dental Plus only)

- General ***anesthesia,*** treatment will be reviewed by MetLife for dental necessity. Coverage may be combined with the benefit for other services provided on the same day.

BENEFIT DETERMINATION GUIDELINES FOR GENERAL ANESTHESIA/IV SEDATION

Benefits may be available, as determined by the dental plan, for general anesthesia/IV sedation when it is performed in conjunction with the following dental procedures:

- The surgical extraction of two or more teeth completed on the same date.
- When three or more standard extractions of teeth are completed on the same date.
- The closure of an oral antral fistula.
- The surgical exposure of an impacted tooth that is to be retained for orthodontic purposes if orthodontics is covered by the Plan.
- When two or more implants are placed and the implants have been approved for benefits.
- When a standard tooth extraction and a surgical tooth extraction are completed on the same date.

There may be occasions where benefits for general anesthesia/IV sedation are available when a patient has unique needs or where there are clinical situations that warrant its use because local anesthesia administration would not suffice. Some examples include:

- Mentally or physically disabled covered individuals.
- Age of patient – up to seven years – unmanageable
- Patient with spastic disease.
- Infection at injection site where local anesthetic would normally be administered.
- Allergy to local anesthesia.
- Failure of local anesthesia to control pain.
- Extent of surgery – complicated surgical procedures that occur in multiple quadrants of the oral cavity on the same date.

- ***Caps, crowns, inlays and onlays***.
- ***Replacement of existing crowns***, inlays or onlays, once every seven years unless waived for medical necessity.
- ***Endodontic treatment,*** including root canals.
- ***Extractions,*** including anesthesia and routine postoperative care.
- ***Implants.*** A pretreatment estimate is recommended for implants and other related services before work being done, in order to be eligible for any benefits. You and your dentist will each receive written notification of the benefits available for these services under the IBM Dental Plan.
- ***Periodontal treatment:***
  - Scaling and root planing are limited to eight quadrants per calendar year. The clinical parameters used for rendering a benefit determination, based on submitted documentation, are as follows: pathologic periodontal pocket depth of 4 mm or greater and evidence of the loss of periodontal ligament attachment (bone loss).
  - Osseous surgery up to four quadrants within a 36-month period.
  - Periodontal maintenance) is limited to four per calendar year (this includes adult and child prophylaxis) and is only payable when there is a history of qualifying periodontal therapy, in at least two different quadrants.
  - Local chemotherapy agents used in conjunction with non-surgical periodontal therapy (scaling and root planing). Are limited to one per tooth, and for a limited number of teeth that have pocket depth between 6 mm and 8 mm and bleed probing, as determined by the Plan's Dentist Consultants.
  - Local chemotherapy agents used in conjunction with periodontal maintenance therapy (post scaling and root planing or osseous surgery) are limited to one per tooth for a limited number of teeth that show increasing pocket depths between 5 mm and 8 mm and have had no chemotherapeutic agent applied for at least the prior 12-month period. Benefits may be available based on review of the clinical documentation by the Plan's Dentist Consultants when there is a history of completed active periodontal therapy.
- ***Creation of bridgework and dentures***, ***dentures,*** no coverage is available during the first six months following the date of the insertion of the prosthesis; thereafter, no limit.
- ***Relining existing bridgework or dentures,*** coverage is available only after six months following the date of the insertion of the prosthesis; then no limit.
- ***Replacement of existing dentures or bridgework.*** For treatment to be eligible the following conditions must be met
  - The existing denture or bridgework was installed at least seven years before its replacement and the existing denture or bridgework cannot be made serviceable or
  - The replacement is required to replace one or more natural teeth extracted after placement of the original denture/bridge and the appliance cannot be made serviceable or
  - The existing denture or bridgework is temporary and cannot be made permanent, and replacement by a permanent denture/bridge occurs within 12 months from the date of initial installation of the temporary denture/bridge.

***Note**: Any dental treatment for dentures or bridgework received under the dental plan options will be treated as if it was received under the IBM Dental Plus option. For example, if a covered individual received dentures or bridgework less than seven years ago under the dental plan options and that individual is now covered under the IBM Dental Plus option, new dentures or bridgework may not be replaced until seven years have passed. Temporary and interim dentures are not a covered expense.*

- ***Temporomandibular joint dysfunction*** (TMJ)-related charges are covered at 50% unless noted otherwise below:
  - X-rays, up to six views, (considered a diagnostic procedure and are covered at 80%)
  - TMJ appliance
  - TMJ office visits/treatments, up to 10 per year, including eligible services of other providers for associated treatment

You are strongly urged to contact MetLife to be aware of what the IBM Dental Plus option will cover before you or your eligible dependent receive services in conjunction with TMJ. TMJ-related charges not covered under the IBM Dental Plus option may be under medical plan benefits in certain rare circumstances. See *What's Covered Under the Medical Plan Options*.

Major Restorative Benefits In Progress When You Retire

If you retire while covered under the IBM Dental Plus option, you and each covered individual will be eligible for 50% reimbursement for major restorative services. If you are retiring and have work in progress, your services will be reimbursed based on the plan you are enrolled in and your employment status (active or retired) at the time the service is completed. You may want to check with MetLife regarding your individual circumstances.

ORTHODONTIC TREATMENT (IBM DENTAL PLUS)

Orthodontic treatment is covered under the IBM Dental Plus option for each eligible covered individual up to a lifetime maximum of $1,500. The administration of the orthodontic benefit differs from that of other dental services. Here's how:

- When submitting a claim for comprehensive orthodontic treatment, it is only necessary to submit the claim once, at the beginning of the active treatment period. However, additional information may be requested periodically to verify that you or your dependent is still receiving active treatment. Payment will be made to you or the dentist, as indicated on the claim form. Don't wait for orthodontia treatment to be completed before submitting claims to MetLife as the claim filing submission deadline applies. For more information, see "*How to File a Claim for Orthodontic Treatment*" in the "*Administrative Information*" section.
- After the active treatment phase has commenced — placement of the bands upon the teeth — 25% of the total orthodontic charge will be considered the banding fee. Benefits will be paid at 50% of the banding fee and will be made upon submission of the claim form.
- After subtracting the banding fee, the remaining charge for eligible services while the bands are on the teeth will be divided by the number of months of treatment that the orthodontist indicates is required. (Charges include necessary appliances, diagnostic casts, x-rays and subsequent monthly visits while the bands are on the teeth.)
- You will receive a monthly reimbursement check equal to 50% of this calculated monthly amount. Payment for active treatment will end when bands are removed, the patient reaches the lifetime orthodontia maximum or if no longer covered by the IBM Dental Plus option, whichever occurs first, and no further reimbursement will be made.

- Reimbursement will be paid in monthly installments over the course of the treatment, thus the full reimbursement will not be received until conclusion of the active treatment has been reached. Monthly benefits will be sent automatically to you or to your dentist, per your designation on the claim form.
- MetLife will confirm treatment periodically.

Automatic payment will cease if you or your covered family member are no longer covered by the IBM Dental Plus option.

Eligible Orthodontic Services

Eligible services considered orthodontic in nature include removable or fixed appliances and minor or intermediate appliances. All orthodontic appliances are included in the $1,500 lifetime maximum. Retainers are not covered as a separate benefit.

Orthodontic Benefits that Began Before Enrollment in the IBM Dental Plus Plan

If an individual covered under the IBM Dental Plus plan commences orthodontic services before the effective date of coverage, reimbursement of orthodontic expenses for patients whose treatment started before their MetLife coverage start date will be prorated based on the remaining number of treatment months after coverage became effective and the total fee charged.

Orthodontic Benefits If You Participated in a Former IBM Dental Plan

If an individual covered under IBM Dental Plus commences orthodontic services on or after the effective date of coverage and had previously received orthodontic services under IBM Dental Plan Option A and/or the MetLife PDP Plan, any amount reimbursed to the retiree for orthodontic services while under these dental plan options will be applied to the $1,500 orthodontic lifetime maximum. The covered individual will only be reimbursed at the 50% level up to the remaining balance of the $1,500 maximum.

Orthodontic Benefits in Progress When You Retire (and are not Medicare-eligible)

If you retire while covered under the IBM Dental Plus option (and are not Medicare-eligible), you and each covered individual will be eligible for orthodontia benefits up to the $1,500 lifetime maximum. If you are retiring and have work in progress (and are not Medicare-eligible), your services will be reimbursed based on the plan you are enrolled in and your employment status (active or retired (and not Medicare-eligible)) at the time the service is completed. You may want to check with MetLife regarding your individual circumstances.

WHAT THE IBM DENTAL PLAN OPTIONS DO NOT COVER

- Treatment for accidental injury to sound natural teeth is not covered by MetLife. However, if you are enrolled in the IBM Low, Medium, or High Deductible PPO Plans, IBM EPO, or IBM High Deductible PPO with HSA, you may be eligible for medical benefits if the health plan determines that accidental injury coverage applies.
- Charges for cosmetic dental services.
- Charges for educational programs (such as training in plaque control, nutritional guidance or myofunctional therapy).
- Experimental, investigational or unproven treatment or procedures.

- Incidental dental procedures. An incidental dental procedure is one that is performed at the same time as a more complex primary procedure and requires little additional dental resources, and in the dental industry, generally identified to be part of the primary procedure code.
- When multiple procedures are done on the same tooth on the same day, MetLife will reimburse only for the most complex procedure done for that date of service.
- Nitrous oxide.
- Prescription drugs are not covered under the dental plan options; however, eligible medications prescribed by your dentist may be covered under the IBM medical plan options (IBM Low, Medium, High Deductible PPO, IBM EPO and IBM High Deductible PPO with HSA). If you are enrolled in an HMO, contact your HMO to determine how prescriptions for dental treatment are covered.
- Protective athletic mouth guards.
- The cost of replacing lost or stolen prosthetic devices, including space maintainers.
- Charges for repair or replacement of an orthodontic appliance.
- Retainers are not covered as a separate benefit, but are included under orthodontia services.
- Reimbursement of orthodontic expenses incurred before their coverage began is not covered.
- Charges for oral surgery that are determined to be dental in nature, and exceed covered expense, are not eligible for reimbursement under the IBM Medical Plan options.
- Temporary dentures.
- Services not provided or prescribed by a licensed dentist.

COORDINATION OF BENEFITS

If you or an eligible family member has other coverage in addition to Plan coverage, Plan benefits will be coordinated with the other coverage to avoid duplication of payment. When the Plan's responsibility for benefits is secondary to that of the other coverage, the Plan will not pay a benefit for an eligible expense until the other coverage has paid, and the benefit amount which would normally apply will be reduced by the amount the other coverage paid.

In cases of Coordination of Benefits, if the primary plan benefit issued is equal to or exceeds the scheduled benefit, there will be no payment made by the Plan. See "*Coordinating Coverage*" in the "*Administrative Information*" section for more information.

WHEN COVERAGE ENDS

When a person ceases to be eligible for dental coverage through IBM, continuation coverage can be obtained, in certain circumstances, COBRA for a limited time. See "*COBRA Continuation of Coverage*" in the "*Administrative Information*" section for more details.

IBM Benefits Plan for Retired Employees

IBM Vision Coverage for Non-Medicare Retirees

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IBM Vision Coverage for Non-Medicare Participants

ABOUT YOUR VISION BENEFITS

If you are eligible, you can enroll in the Anthem Blue View Vision Plan. If you do not enroll in the Anthem Blue View Vision Plan, you can access discounts through the EyeMed Vision Discount Program.

Medicare-eligible retiree plan participants are eligible for vision coverage through the IBM-sponsored Group Medicare Advantage plan options. For more information contact the IBM Retiree Call Center administered by UnitedHealthcare.

ANTHEM BLUE VIEW VISION PLAN ADMINISTRATOR

Anthem Blue View Vision is the administrator of the Anthem Blue View Vision Plan.

You can reach Anthem Blue View Vision at 855-765-4552

EYEMED VISION DISCOUNT PROGRAM

You can reach EyeMed Vision Care at 855-245-0621.

WHO IS ELIGIBLE

Retirees who are not Medicare-eligible and their eligible dependents; non-Medicare-eligible dependents of Medicare-eligible retirees (as described in "*Eligibility"* in the "*Personal Benefits Program*" section of this summary plan description) and those enrolled in the Aetna Medicare Plan (PPO) or Aetna Medicare Plan (HMO) are eligible to enroll in the Anthem Blue View Vision Plan under the IBM Medical and Dental Benefits Plan for Retired Employees. IBM's dependent eligibility guidelines pertain to all benefit options under the IBM Medical and Dental Benefits Plan for Retired Employees, including vision, and are not subject to any state laws mandating coverage for anyone not included in IBM's list of eligible dependents.

Note that once you reach age 65 or become eligible for Medicare, coverage will be provided through the IBM-sponsored Group Medicare Advantage plan options administered by UnitedHealthcare.

ID Card

If you enroll in the Anthem Blue View Vision Plan, you will receive an ID card, which will remain good for as long as you are enrolled in this plan. New cards will not be sent each year. If your card is lost or damaged, call member services to request a replacement card.

There is no ID card needed to participate in the EyeMed Vision Discount Program.

ANTHEM BLUE VIEW VISION PLAN

The Anthem Blue View Vision Plan is designed to encourage you to maintain your vision through regular eye examinations and to help you with vision care expenses for required glasses or contact lenses. The routine eye exams covered through the Anthem Blue View Vision Plan are designed to maintain your visual health as well as detect health conditions that could impact your overall health. The routine eye exams through the Anthem Blue View Vision Plan are not designed to cover the treatment or monitoring of existing health conditions.

Benefits for the Anthem Blue View Vision Plan are provided by Anthem BlueView Vision through a fully insured vision policy, which offers coverage for services from both network providers and vision providers who are not in the network.

Enrollment in the Anthem Blue View Vision Plan provides benefits for eye exams and eyewear both within and outside the Anthem Blue View Vision network.

EYEMED VISION DISCOUNT PROGRAM

The EyeMed Vision Discount Program, provided by EyeMed Vision Care™ is available to you and your eligible dependents at no cost. This program gives you access to savings of up to 40% on frames, lenses, lens options and contact lenses, and a discount on an annual eye exam at EyeMed Vision Care network provider locations. To find an EyeMed provider, visit www.eyemed.com (select “Access network”) or call 1-855-245-0621.

No enrollment or ID card is required to access the discounts, you just need to go to a participating provider and ask for the EyeMed Discount. (Give the provider the IBM EyeMed Vision Discount group number 9245416.) For more information, visit www.eyemed.com. Select Member Login, scroll down to Discount Plan Members and choose letter "I" for the IBM Discounts, then select the IBM Vision Discounts link.

WHEN COVERAGE ENDS

If an enrolled family member ceases to be eligible for vision coverage through IBM, continuation coverage can be obtained, in certain circumstances, through COBRA for a limited time. See “*COBRA Continuation Coverage*” in the “*Administrative Information*” section for more details.

IBM Benefits Plan for Retired Employees

Medicare-Eligible Participants

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Coverage for Medicare-Eligible Retirees

Medicare-eligible retirees* and their Medicare-eligible dependents** are eligible to enroll in IBM-sponsored Group Medicare Advantage plan options administered by UnitedHealthcare. Non-Medicare-eligible dependents of Medicare-eligible retirees may enroll in coverage through the plan options described in this document. If there is more than one non-Medicare-eligible dependent, they must all be enrolled in the same option under one dependent (spouse or oldest child).

Important Note: *Medicare-eligible retirees* and their Medicare-eligible dependents are referred to throughout this SPD as "Medicare-eligible retirees" and "Medicare-eligible dependents."*

* The term "retiree" also includes Medicare-eligible individuals who are: surviving spouses; receiving IBM Medical Disability Income Plan (MDIP) benefits or IBM Long-Term Disability (LTD) Plan benefits; or eligible for benefits under the Future Health Account (FHA), the Special Retiree Medical Option (SRMO) and Access Only. "Retiree" does not necessarily mean that you have met the requirements to officially retire from IBM, just that you are eligible for post-employment medical coverage. Not everyone who leaves IBM with status as an IBM Retiree will be a "retiree" for purposes of this SPD. Only those individuals who leave IBM with the required age and service, without regard to whether they have status as an IBM Retiree, and without regard to whether they retire from working, or continue to work, will be considered a "retiree" for purposes of this this SPD.

** The term "dependent" includes Medicare-eligible individuals to the extent they are eligible dependents under the Plan as defined in the section "*Medical Options for Medicare-Eligible Retirees*" in this document.

Medicare-eligible retirees are not eligible to enroll in coverage under the Plan options for non-Medicare-eligible retirees. Medicare-eligible retirees may enroll in one of the IBM-sponsored Group Medicare Advantage plan options administered by UnitedHealthcare. These plan options are the Essential Plan option and the Enhanced Plan option.

The IBM-sponsored Group Medicare Advantage plan options have all the benefits of Medicare Part A (hospital coverage), Medicare Part B (doctor and outpatient care) and Medicare Part D (prescription drugs) plus extra features and enhancements designed exclusively for IBM Medicare-eligible participants. These extra features and benefits include routine dental and vision care, discounts on hearing aids, clinical programs, removal of certain lifetime maximums, and more.

Details and more information about the administration of these plan options can be found within the Evidence of Coverage (EOC) for the applicable plan year posted and maintained by UnitedHealthcare.

For more information call the IBM Retiree Call Center administered by UnitedHealthcare at 877-852-0641, TTY 711 or visit https://retiree.uhc.com/ibm.

IBM SUBSIDY/HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

Each year, IBM contributes to (or subsidizes) the cost of benefits and administrative expenses under the Plan for eligible participants.

For more information about the IBM subsidy/HRA, see the "*IBM Subsidy/Health Reimbursement Arrangement (HRA)*" section of this document.

ENROLLING IN COVERAGE AND ONGOING SUPPORT

All Medicare-eligible retirees and their Medicare-eligible dependents can enroll in the IBM-sponsored Group Medicare Advantage Plan options administered by UnitedHealthcare.

To learn more or to enroll in an IBM-sponsored Group Medicare Advantage Plan option, contact the IBM Retiree Call Center administered by UnitedHealthcare or visit https://retiree.uhc.com/ibm.

For retirees who become Medicare-eligible during the year (due to turning age 65, retiring, or otherwise becoming Medicare-eligible), you must first take steps to enroll in Medicare Parts A and B. You (and your Medicare-eligible dependents) can then enroll in the IBM-sponsored Group Medicare Advantage Plan options administered by UnitedHealthcare.

You may call the IBM Retiree Call Center – administered by UnitedHealthcare at 1-877-852-0641, TTY 711 or visit https://retiree.uhc.com/ibm.

Important Note: *The IBM-sponsored Group Medicare Advantage plan options are governed by the Centers for Medicare and Medicaid Services.*

HOW TO SUBMIT OUT-OF-NETWORK MEDICAL CLAIMS TO THE IBM-SPONSORED GROUP MEDICARE ADVANTAGE PLAN OPTIONS

Some out-of-network providers will also submit claims on your behalf to UnitedHealthcare. If the out-of-network provider does not do so, you can pay the provider and then submit your claim to UnitedHealthcare at:

Medical claims payment requests
UnitedHealthcare
P.O. Box 31362
Salt Lake City, UT 84131-0362

Note: *If you receive a covered service from an out-of-network provider who is unwilling to bill the Plan, that provider may require you to pay the entire amount yourself at the time you receive the care. You can ask UnitedHealthcare for reimbursement as described in Chapter 7 of the Evidence of Coverage titled "Asking us to pay our share of a bill you have received for covered medical services or drugs." UnitedHealthcare will reimburse its share of the cost. . You may be responsible for the difference after your cost share has been applied to the provider's total billed charges.*

DENTAL COVERAGE UNDER THE GROUP MEDICARE ADVANTAGE PLAN OPTIONS

Please refer to your Evidence of Coverage for details on your dental benefit coverage via https://retiree.uhc.com/ibm.

Individual annual deductible

For services other than preventive care, you will pay a $50 individual annual deductible before the plan begins to pay.

Coinsurance

Once you reach your deductible, your plan starts to share a percentage of the costs with you.
Plan year limit: Your Plan pays for services up to $1,000 annual maximum, this is called a plan year limit. Preventive services, including routine dental checkups, may count toward it. If you reach the limit, you'll need to pay the entire cost of any additional dental care you receive that year.

- Out-of-network services: If you use a dentist out-of-network, you may need to pay the difference between what the plan covers and what your dentist charges for the services.

- Estimate your costs: If you're planning to have a procedure that costs more than $500, ask your dentist to send UnitedHealthcare the X-rays and notes about your condition. The treatment will be reviewed to make sure it's clinically appropriate. After review, you and your dentist will get an estimate of what the Plan will pay and what your out-of-pocket costs will be.

Submit claims requests for claim reimbursement with itemized receipt and member information, including member ID, can be submitted to:

UnitedHealthcare
P.O. Box 30567
Salt Lake City, UT 84130-0567 S

See plan documents or call the dental number on the back of your member ID card for a detailed list of required information for submission.

The administrator for dental benefits under the IBM-Sponsored Group Medicare Advantage plan options is UnitedHealthcare®.

Customer Service Availability
Representatives are available to assist you with dental claim questions or other inquiries Monday through Friday from 7 a.m. to 10 p.m. Central time.

You can reach UnitedHealthcare® Dental at 1-800-445-9090 (TTY: 711) or https://retiree.uhc.com/ibm.

Dental contact information can be found on your member ID card.

IBM Benefits Plan for Retired Employees

IBM Subsidy/Health Reimbursement Arrangement (HRA)

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IBM Subsidy/Health Reimbursement Arrangement (HRA)

Introduction

IBM provides a subsidy to certain participants in this Plan. The subsidy may be in the form of an offset to, or reduction in, the premium a participant has to pay for coverage or a Health Reimbursement Arrangement ("HRA") for the benefit of certain of its Medicare-eligible retirees who are eligible for subsidized coverage under the Plan, and who enroll in IBM-sponsored Group Medicare Advantage plan options. The purpose of the HRA is to subsidize the cost of medical coverage in retirement or otherwise reimburse Medicare-eligible retirees for eligible substantiated expenses, such as premiums for coverage, out-of-pocket expenses (i.e., deductibles, copays and coinsurance), and certain eligible health care expenses, which are not otherwise reimbursed. The HRA is intended to qualify as a self-insured medical reimbursement plan for purposes of Sections 105 and 106 of the Internal Revenue Code, as amended ("Code"), as well as a health reimbursement arrangement as defined in IRS Notice 2002-45.

Eligibility for an IBM Subsidy/HRA

RETIREES ELIGIBLE FOR AN IBM SUBSIDY/HRA

You are eligible for an IBM Subsidy/HRA if you are either:

- A Medicare-eligible retiree (or are receiving benefits under the IBM Medical Disability Income Plan (MDIP) or IBM Long-Term Disability (LTD) Plan*) or
- A Medicare-eligible surviving spouse/dependent and are eligible for subsidized coverage under the Plan.

*LTD participants subsidy is aligned to their LTD Leave status as an IBM employee. Once the LTD Leave status ends, the IBM subsidy ends, even if the participant is still receiving LTD Plan benefits. Eligibility for an IBM subsidy for these individuals after their LTD Leave status ends, if any, will be based on their retiree status

You are a retiree eligible for a subsidy under the Plan if:

- You retired from IBM before July 1, 1999, and, on your last day of employment, you met the following retirement criteria:
  - Completed 30 or more years of IBM service regardless of your age
  - Completed at least 15 years of IBM service and were at least age 55
- As of June 30, 1999, you were within 5 years of meeting any of the following retirement criteria:
  - Completing 30 or more years of IBM service regardless of your age
  - Completing 15 years of IBM service and reaching at least age 55
  - Completing 5 years of IBM service and reaching at least age 62 or

  - Completing at least 1 year of IBM service and reaching at least age 65 and
  - You retired from IBM, and, on your last day of employment, you had completed 30 or more years of service regardless of your age, or you had completed at least 15 years of service and reached at least age 55
- You retired from IBM, and, on your last day of employment, you were withdrawal eligible under the IBM Future Health Account (FHA) or
- You are receiving benefits under the IBM Medical Disability Income Plan (MDIP), or IBM Long-Term Disability (LTD) Plan and you are an IBM employee in LTD Leave status.

You are a surviving spouse/dependent eligible for a subsidy/HRA under the Plan if:

- You were a surviving spouse/dependent eligible for an IBM subsidy as of December 31, 2013
- You were not a surviving spouse/dependent eligible for an IBM subsidy as of December 31, 2013, but:
  - You are a surviving spouse/dependent of a retiree who retired from IBM meeting the retirement criteria listed above (other than a retiree who is withdrawal eligible under the IBM FHA or is an individual receiving MDIP or LTD Plan benefits) and the retiree elected survivor coverage
  - You are the surviving spouse/dependent of a retiree who retired from IBM who is withdrawal eligible under the FHA.

Important Note: Surviving Spouse IBM Subsidy/HRA
If you are not eligible for an FHA, and in connection with 2014 enrollment under the Plan, or when you became or become Medicare-eligible, you elected or elect Surviving Spouse coverage, your surviving spouse will be eligible to enroll in one of the options available under the Plan. If they do, they will receive the IBM subsidy/HRA based on the option selected. The election or waiver of Surviving Spouse benefits is irrevocable, even if your spouse dies before you do. Your Surviving Spouse must be enrolled in eligible coverage to be eligible for the IBM subsidy/HRA.

Note: If you did not (or do not in the future) elect Surviving Spouse coverage, your eligible surviving spouse will be eligible to enroll by paying the full premium cost/no IBM subsidy similar to an Access Only participant.
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To be eligible for the IBM subsidy/HRA you must enroll in an IBM-sponsored Group Medicare Advantage plan option. To enroll in the Group Medicare Advantage plan options, you must be enrolled in Medicare Part A and Part B. If one of the Special Considerations below applies, the requirement to enroll in an IBM-sponsored option does not apply, and you will be eligible for the HRA.

Special Considerations

For those who would be eligible for an IBM subsidy/HRA if they enrolled in one of the IBM-sponsored options, the requirement to enroll an IBM-sponsored option in order to be eligible for your IBM subsidy/HRA does not apply if, and you will be eligible for an HRA, if:

- Your coverage under the Plan ends because you're Medicare-eligible (either on December 31, 2013, or the later date that you become Medicare-eligible) and at that time you're enrolled in a Kaiser Permanente plan option under the IBM medical plan for active employees or this Plan, you then enroll in individual Kaiser medical or prescription drug insurance coverage, and you maintain this coverage
- You are a Medicare-eligible retiree living outside of the United States or in a United States Territory

- You are a U.S. Veteran as well as a Medicare-eligible retiree who is enrolled in health coverage through TRICARE for Life or eligible to obtain services from the Veterans Administration (VA).
- You are on Medicaid.

In these circumstances, you must contact UnitedHealthcare to activate your HRA.

When You Will Cease Being Eligible for the IBM Subsidy/HRA

You will cease being eligible for the IBM subsidy/HRA on the earlier of:

- The date you are no longer eligible for benefits under the MDIP or lose LTD Leave status as an IBM employee (unless on that date you are otherwise eligible as a retiree)
- The date you are rehired by IBM or any subsidiary of IBM as an active employee (regular or supplemental) and for the duration of your active employment
- The date you cease to be eligible for Medicare (unless your loss of eligibility is due to your living outside of the United States)
- The day after your date of death
- The date you are no longer enrolled in an IBM-sponsored Group Medicare Advantage plan option (unless special considerations apply)
- The effective date of any amendment terminating your eligibility or
- The date the IBM subsidy/HRA is terminated.

You may not obtain reimbursement of any eligible expenses incurred from your HRA after the date your eligibility ceases. Similarly, you may not obtain reimbursement of any eligible expenses incurred before the effective date of coverage under the IBM-sponsored Group Medicare Advantage plan. The HRA is administered by Optum, a UnitedHealthcare company.

DEPENDENT EXPENSES ELIGIBLE FOR REIMBURSEMENT FROM THE HRA

Your dependents' eligible expenses can be reimbursed through your HRA.

An eligible dependent is anyone you claim as a dependent on your federal tax return, including: your spouse (regardless of sex); your domestic partner; your dependent children.

When Dependent Expenses Will Cease Being Eligible for Reimbursement from the HRA

Your eligible dependents' expenses will cease being eligible for reimbursement under the HRA on the earlier of:

- The date your dependent(s) ceases to be an eligible dependent for any reason
- The date you and your spouse divorce
- The last day of the year of your death, if you have not elected to provide survivor coverage, as described in the "*IBM Subsidy/Health Reimbursement Arrangement (HRA)*" section in this document
- The effective date of any amendment terminating your dependent(s) eligibility under the HRA
- The date the HRA is terminated
- The date you are no longer eligible for the HRA
- The date HRA funds are exhausted

You may submit an eligible expense for reimbursement if it meets the following criteria:

- The expense incurred was for services or supplies received by you or your eligible dependents under the plan on or after its effective date
- The expense has not been reimbursed in any other way from any other source and will not be submitted for future reimbursement
- The expense does not include any amounts that are otherwise payable by plans for which you or your dependents are eligible
- The expense has not been previously tax-advantaged through another source (for example, if you received a premium subsidy for coverage obtained from a public exchange under the Affordable Care Act, the subsidy is not eligible for reimbursement under the HRA).

You are responsible for submitting claims in compliance with these criteria. Claim decisions will be made in accordance with the provisions of the plan. Health care reimbursements are not eligible deductions or credits on your individual tax return.

Your dependent(s) may not obtain reimbursement of any eligible medical expenses incurred after the date their eligibility ceases. Similarly, you may not obtain reimbursement of any eligible expenses incurred before the effective date of coverage.

CONTINUATION OF COVERAGE FROM THE HRA

The HRA is subject to the Consolidated Omnibus Budget Reconciliation Act (COBRA). Eligible participants who experience a COBRA qualifying event will be offered the opportunity to continue their HRA as a COBRA participant at the full COBRA rate. In most cases, the rate will be based on the date of the qualifying event. Qualifying events include for example, the death of a retiree who elected no survivor coverage; a qualifying event will be considered to have occurred when the eligible surviving dependent no longer has access to the deceased retiree's HRA.

RETIREES NOT ELIGIBLE FOR THE IBM SUBSIDY/HRA

You are not eligible to receive an IBM subsidy/HRA if any of the following applies:

- You terminated employment with IBM eligible for Access Only coverage
- You terminated employment with IBM eligible for the Special Retiree Medical Option (SRMO)
- You do not enroll in an IBM -sponsored Group Medicare Advantage plan option (unless the Special Considerations described above apply)

You are not eligible to participate in the Plan unless you are classified by IBM as a former employee or an employee on the Medical Disability Income Plan (MDIP) or the IBM Long-Term Disability (LTD) Plan who is in LTD status as an IBM employee, who meets the eligibility requirements, even if you are later determined by a court or governmental agency to be or to have been a former common-law employee of IBM.

Understanding the IBM Subsidy/HRA

Each year, IBM contributes to (or subsidizes) the cost of benefits and administrative expenses under the IBM retiree medical plan. There are two types of Medicare-eligible retirees eligible for an IBM subsidy.

- If you receive your IBM subsidy annually (Annual HRA), IBM's subsidy will either be a premium subsidy or HRA credit, depending on which Group Medicare Advantage plan option you enroll in.
- If you have a Future Health Account (FHA) that accumulated during your IBM service, and your FHA was converted to an HRA, you will be able to access your entire balance to pay for eligible Section 213(d) expenses and your balance will earn monthly interest.

To access your IBM subsidy or HRA you must be enrolled in an IBM-sponsored Group Medicare Advantage plan option. Note that special rules apply to those currently enrolled in Medicaid, TRICARE or VA benefits; those living abroad, or those who have transitioned from the active or pre-65 retiree medical plan as a Kaiser participant and maintain Kaiser coverage. Call the IBM Retiree Call Center at 877-852-0641 for details.

If you are eligible for coverage, but do not currently have an HRA (e.g., you have Access Only status), you will be able to enroll in an IBM-sponsored Group Medicare Advantage plan option by paying any premium cost.

If you are eligible for an IBM subsidy/HRA but do not enroll in one of the IBM-sponsored Group Medicare Advantage plan options, you may enroll at a future date. When you enroll, you will be eligible for the applicable IBM subsidy at that time.

2026 IBM SUBSIDY/HRA OVERVIEW

Population Segment	Population Segment Cohort	Enhanced Plan Option		Essential Plan Option	
		Monthly Premium	Annual HRA	Monthly Premium	Annual HRA + Part B Credit
Annual HRA	Retirees without Survivor benefit (retired on or after Jan 1,1992); LTD and MDIP	$37.63	N/A	$0	$3,000 + $300
	Retirees without survivor benefit (retired before Jan 1,1992)	$0.00	N/A	$0	$3,400 + $300
	Retirees with survivor benefit (retired on or after Jan 1, 1992)	$89.80	N/A	$0	$2,374 + $300
	Retirees with survivor benefit (retired before Jan 1, 1992)	$70.96	N/A	$0	$2,600 + $300
	Surviving Spouse of Retiree with survivor benefit (retired on or after Jan 1, 1992)	$188.71	N/A	$0	$1,187 + $300
	Surviving Spouse of Retiree with survivor benefit (retired before Jan 1, 1992)	$179.30	N/A	$0	$1,300 + $300
FHA/HRA	FHA converted to HRA	$287.63	Access to HRA	$0	Access to HRA + $300
Access Only or Spouses/ Dependents	Eligible for coverage, no IBM subsidy (Access Only)	$287.63	N/A	$0	$0 + $300

Upon enrollment in an IBM-sponsored Group Medicare Advantage plan option, your IBM subsidy/HRA will be applied, as shown above, factoring in your eligibility and plan election.

The Enhanced and Essential plan options are administered through two separate plans: the Group Medicare Advantage (PPO) plan and the Medicare Rx for Groups (PDP) plan. Enrollment in both plans is required.

Upon enrollment you may receive two separate invoices for the Group Medicare Advantage (PPO) plan and the Medicare Rx for Groups (PDP) plan.

Optum will set up an HRA for those who receive an Annual HRA and are enrolled in the Essential Plan option, and for FHA participants when the FHA is converted to an HRA once they become Medicare-eligible. The HRA will be established in the retiree's name (or the name of the surviving spouse, if applicable). Once set up, the HRA can be used to reimburse eligible expenses on behalf of the retiree (or surviving spouse) and their eligible dependents. A dependent's enrollment in IBM-sponsored Group Medicare Advantage plan is not required for their eligible expenses to be reimbursed from the HRA.

Note that the HRA is a "notional" account that's tracked for record-keeping purposes only. There are no actual funds held in your name, and the account is not portable. When the time comes to pay benefits on your behalf, the benefits are paid out of the Plan trust or IBM's operating funds.

IBM'S CONTRIBUTION TO THE HRA

For participants eligible for an Annual HRA (but not eligible for an FHA)

The first day of each plan year (or during the year when you become Medicare-eligible), a fixed dollar allocation will be made to your HRA. The amount of your HRA contribution will vary based on your eligibility (and in some cases whether you elect or elected survivor coverage or no survivor coverage, and which plan option you selected as shown above):

- Those who retired on or before December 31, 1991
- Those who retired on or after January 1, 1992
- Those receiving benefits under the IBM Medical Disability Income Plan (MDIP) or IBM Long-Term Disability (LTD) Plan and who are in LTD Leave status as an IBM employee, and
- Surviving spouse/dependent(s) of the retirees listed above.

The amount of the contribution to your HRA is determined each plan year in IBM's sole discretion as sponsor of the Plan. You can call Optum directly at 866-882-0397 (TTY: 711) or visit https://my.optum.com/ibm o review the amount of the contribution to your HRA.

Your HRA will be reduced by the amount of any eligible medical expenses for which you are reimbursed from the HRA during the plan year. At any time, you may receive reimbursement for eligible substantiated expenses up to the amount in your HRA account.

***Note**: you are not permitted to make any contributions to your HRA account.*

You may submit claims for reimbursement incurred in any plan year through December 31 of the following year. Any balance in your HRA for any plan year will be forfeited.

For retirees with a Future Health Account (FHA)

If you are eligible for the Future Health Account (FHA), you will not receive an Annual HRA. Once you become Medicare-eligible, your FHA balance will be transferred to an HRA administered by Optum.

For more information about how your FHA balance is determined and how it can be used before you become eligible for Medicare, refer to the "*Future Health Account*" *(FHA*) section in Annex 1.

Your HRA Grows With Interest
For FHA-eligible retirees, your HRA will be credited with interest. The interest will be added to your account on a monthly basis, as long as a balance remains in your account.

The interest rate is fixed each January 1 at the average of the annual interest rates on one year U.S. Treasury Constant Maturities, during the preceding months of August, September and October, rounded to the nearest 10th of a percent plus 1%.

For Your Survivors (if you are not eligible for an FHA)

When you became (or become) eligible for an Annual HRA you will receive a form from IBM's administrator of the HRA survivor election option. You will need to indicate on the form whether you elect to provide survivor coverage after your death. If you choose to provide survivor coverage, the amount of your HRA contribution will be adjusted so that your HRA will be available to your surviving spouse or other eligible dependents (see the section, "*Continuation of Coverage From the HRA*" in this document) after your death.

Every retiree with the opportunity to elect survivor coverage must fill out and submit the survivor coverage election form even if you do not have a spouse/dependent(s)—and return the form by the timeline provided in the correspondence. Your survivor benefit decision is irrevocable, even if your spouse pre-deceases you.

If you did not, or do not, respond to the survivor election form, your election will default to the survivor coverage option.

Regardless of your choice, your decision does not affect coverage for your eligible dependents. As long as your dependents remain eligible, they may be enrolled in an IBM-sponsored Group Medicare Advantage plan option after your death.

If you elect or elected survivor coverage, and your surviving spouse/dependent is not Medicare-eligible at the time of your death, your surviving spouse/dependent will receive survivor coverage under the Plan for non-Medicare-eligible retirees until they become Medicare-eligible or they cease to be eligible under the Plan, whichever occurs first.

If you elect or elected survivor coverage, after your death, your eligible surviving spouse/dependent, who is Medicare-eligible, will receive an HRA contribution. The amount will vary based on the plan option in which they are enrolled. See the table above for the HRA contribution amounts.

If You and Your Spouse are Both IBM Retirees

If you and your spouse are both IBM retirees eligible for an HRA, you will each receive an IBM contribution and have separate HRAs while you are both living. Each IBM retiree who is eligible to elect survivor coverage must do so. You cannot elect the survivor option to provide coverage for your spouse, because he/she will receive their own HRA contribution.

If you have one eligible child, only one of you may elect survivor coverage for that child. If you have two or more eligible children, each of you may elect survivor coverage. Keep in mind, your child will only be eligible for an HRA if he or she is Medicare-eligible. Only one of you has to elect survivor coverage for your non-Medicare-eligible child(ren) to be covered under the Plan for non-Medicare-eligible participants. If you elect such coverage, after you die, your child will be able to be covered under the Plan until he or she is no longer eligible for the Plan (that is, he or she reaches age 19 or up to age 23 if enrolled in school full-time).

Important Notes:

- *If you elect survivor coverage and one of your children later becomes Medicare-eligible due to disability and is approved for continued coverage under the Plan, he or she will then be eligible for an HRA with a contribution amount for a surviving dependent.*

- *Retirees eligible for an FHA do not make a survivor coverage election. Any amounts remaining in your HRA at the time of your death will be able to be used by your eligible dependents (see the section "Continuation of Coverage From the HRA" in this document).*

ELIGIBLE EXPENSES

You can use the amounts in the HRA to reimburse any IRS 213(d) eligible expenses you or your eligible dependents incur, including:

- All (or a portion of) the monthly premiums for you (and your tax-qualified dependents)
- Medicare Part B or D premiums (if any), for you and your Tax-qualified dependents
- Eligible medical and out-of-pocket expenses such as coinsurance, co-payments and deductibles, for you and your tax-qualified dependents
- Any "eligible medical expense" Including copays and out-of-pocket costs for services such as dental and vision care.

Some out-of-pocket expenses may not be eligible for reimbursement through the HRA. Please contact Optum to ask about specific expenses. An "eligible medical expense" is an expense incurred by you or any tax-qualified dependent for health care, as defined in Internal Revenue Code Section 213(d) (generally, expenses related to the diagnosis, care, mitigation, treatment or prevention of disease).

If you need more information regarding whether an expense is an "eligible medical expense," refer to IRS Section 213(d), call Optum at 866-882-0397 (TTY: 711), or visit https://ibm.optum.com to view examples of eligible and ineligible expenses.

Only "eligible medical expenses" incurred while you are an eligible retiree with an HRA can be reimbursed from your HRA. Similarly, only "eligible medical expenses" incurred while your eligible dependent remains eligible to be covered under the HRA may be reimbursed from your HRA. Medical expenses are "incurred" when the medical care is provided, not when you or your eligible dependent is billed, charged or pays for services. Thus, an expense that has been paid but not incurred (e.g., pre-payment to a physician) will not be reimbursed until the service or treatment giving rise to the expense has been provided.

REIMBURSEMENT FROM YOUR HRA

You may submit claims online at https://ibm.optum.com or mail or fax a paper reimbursement form to Optum Financial. Reimbursement forms are available online and can be found by visiting https://my.optum.com/ibm.html or by calling Optum at 866-882-0397 (TTY: 711).

Your reimbursement request must include the required fields as outlined within the reimbursement form. Additionally, Optum may request or require additional information to substantiate your claim including but not limited to a copy of any supporting documentation for eligible expenses, such as a third party itemized receipt or Explanation of Benefits (EOB) that contain the following information:

- Date(s) of service (or date expense was incurred, such a product purchase date);
- Itemized list of purchases, or detailed description of services;
- Name of the merchant or health care professional;
- Dollar amount(s) (after insurance, if applicable); and

- Name of patient who incurred service of expense

You must submit requests for reimbursement of eligible substantiated expenses to Optum Financial no later than December 31 of the year following the calendar year in which the expense was incurred. The claims submission deadline may be extended for extenuating circumstances (e.g., serious illness/hospitalization, or claim submission by Power of Attorney following a death of a retiree). Please contact Optum Financial to receive a one-time, 90-day extension.

If your claim for reimbursement is approved, you will be provided reimbursement as soon as reasonably possible following approval. Claims are paid in the order in which they are received by Optum Financial.

Note: *Individuals who are Medicare-eligible and eligible for a Health Reimbursement Arrangement (HRA), and who are also eligible for the IBM Special Health Assistance Provision (SHAP) should give careful consideration to the order in which you submit claims for reimbursement of your Medicare Part B premium expense.*

To make optimal use of the SHAP benefit, we recommend that you first submit your Medicare Part B premium expense to SHAP, then submit the remaining premium balance against the Health Reimbursement Arrangement (HRA).

Keep in mind that you may not submit the full Part B Premium to both SHAP and your HRA because you are allowed to be reimbursed for the full amount only once. If you submit your Part B Premium to your HRA first, you risk losing eligibility to be reimbursed through your SHAP benefit for any amount your HRA does not pay. Before submitting an expense for an HRA reimbursement, you are required to certify on the claim form that the expense has not been reimbursed from any other source and will not be submitted for future reimbursement.

Recurring Claim Reimbursement

Optum offers recurring claim reimbursements to IBM retirees, which requires a form (along with supporting documentation) each plan year and re-submitted each plan year to confirm reimbursement amounts.

Once the form is received by Optum Financial, it is processed and updated into the Optum Financial system so monthly recurring reimbursement will be processed on behalf of the retiree & delivered via mailed check or direct deposit.

If you'd like to take advantage of the convenience of automatic reimbursement, contact Optum Financial or visit https://my.optum.com/ibm.html.

If Your Claim for Benefits is Denied

For information on what to do if a claim for benefits is denied, see the section, "*Legal Information*" in this document.

ACCESS AND MANAGE YOUR HRA ONLINE

Once your HRA is activated, you can access and manage your funding information online. To access or create an online account, go to https://my.optum.com/ibm.html. If you're a first time visitor, fill out the required information to create your account. If you're a returning visitor, enter your username and password.

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Once you've logged in or created your account, you can:

- Access your funding information, including your current funding allocation, funding frequency, available balance, recent claims and the histories of your claims and allocations;
- Find relevant phone numbers, answers to frequently asked questions and links that allow you to file claims or appeals; and
- Download a Recurring Reimbursement Claim Request form.

IBM Benefits Plan for Retired Employees

IBM Special Care for Children Assistance Plan

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IBM Special Care for Children Assistance Plan

ABOUT THE SPECIAL CARE FOR CHILDREN ASSISTANCE PLAN

The IBM Special Care for Children Assistance Plan (SCCAP) is a plan separate from the IBM Benefits Plan for Retired Employees and is designed to help you meet expenses for certain treatment and therapy outside the scope of the coverage available under the IBM Plan for eligible children with mental, physical or developmental disabilities. "Outside the scope of coverage available" is treatment ineligible for any coverage under the IBM medical and dental plan options, the Managed Mental Health Care Program, or other coverage such as an HMO. In some cases, it is difficult to determine if services are outside the scope of coverage. In such cases, an Explanation of Benefits (EOB) indicating services are not covered services under the medical, dental or vision plans may be required for new or renewal requests for services.

You are eligible for this assistance only after you have received all aid available to you and your child from federal, state and other sources and that aid has been exhausted. Each case is individually reviewed to determine eligibility for assistance. If there is a mental health component of your child's developmental diagnosis, it should first be reviewed by the mental health Claims Administrator of your medical plan.

FOR MORE INFORMATION ABOUT SCCAP

Call the IBM Benefits Center to request a Special Care for Children Assistance Plan brochure and application package, which includes information on SCCAP, instructions for completing your application and the required forms.

Upon approval, SCCAP will cover a portion of the eligible charges incurred, up to a $50,000 lifetime maximum benefit, until the last day of the month in which the child turns age 23 or is no longer eligible under the IBM Plan, whichever occurs first.

WHO IS ELIGIBLE

Dependent children, as defined by the IBM Benefits Plan for Retired Employees, are eligible for benefits under SCCAP. For a definition of dependent children, see *Eligibility* in the "*About the Personal Benefits Program*" section. Please note that if your child becomes a ward of the state, the child is no longer considered an eligible dependent, and benefits are not payable.

When Your Child Turns Age 23

Even if a child is eligible for continuous coverage under the IBM Plan beyond the age of 23, the child will not be eligible for benefits under SCCAP beyond midnight on the last day of the month in which the child's 23rd birthday occurs.

HOW THE PLAN WORKS

Reimbursement under SCCAP will be determined as follows:

Reimbursement Rates	
Annual Family Deductible* *Separate from the IBM Medical Plan deductible*	$150
Lifetime Maximum	$50,000 per eligible child
Treatment or Service	Reimbursement
Day Care or Residential Care Facility	80% of 75% of eligible charges
Outpatient Facility, Clinic or Independent Practitioner	80% of eligible charges
Special Devices	80% of eligible charges

* A $150 annual family deductible is applied after the reimbursement amount is established. Only expenses incurred in the same calendar year can be applied to your annual deductible, and all claims must be approved and received by the health plan by December 31st of the following year.

Medical and dental copays, coinsurance, deductibles, out-of-network charges, etc. are not eligible for reimbursement under SCCAP.

Outside Assistance

Outside assistance may be available from federal, state or other sources (such as a local school district or county department of social services). Such assistance is generally funded by tax revenues to which both you and the Company contribute. Therefore, the objective of SCCAP is to provide an extra benefit after you have received all other assistance to which you are already entitled.

In applying for such assistance, IBM benefits under SCCAP should not be considered in calculating the amount to be paid by you. Eligible charges will be reimbursed under SCCAP only if those charges are payable by you irrespective of the existence of SCCAP.

The following calculations are used to determine benefit reimbursement when outside assistance is received:

How SCCAP Reimbursement Is Calculated When There's Outside Assistance	
Treatment	Reimbursement Calculation
Clinic and Outpatient Services *Reimbursed at 80% of eligible charges*	Eligible charges *minus* the amount of outside assistance received
Day and Residential Special Facilities Care *Reimbursed at 80% of 75% of eligible charges*	If outside assistance equals or exceeds the initial 25% reduction: ▪ Eligible charges minus the amount of outside assistance received, and the 25% reduction will not be applied If outside assistance is less than the initial 25% reduction: ▪ Outside assistance will not be used in the reimbursement calculation, and the initial 25% reduction will be applied to the entire amount of eligible charges

WHAT IS COVERED UNDER THE PLAN

Eligible Treatment Facilities

Eligible treatment facilities may include licensed clinics, day or residential special care facilities, special education facilities for the child with learning disabilities and camps (where the program offered is medically oriented and is part of the child's continued treatment for mental, physical or developmental disabilities). In order to be eligible for reimbursement, the care must be determined to be appropriate, and the facility must meet both "1" and "2," and either "3" or "4" below:

1. Is medically oriented and operated under the supervision of a physician, psychiatrist or licensed Ph.D. clinical psychologist primarily for the rehabilitation or remediation of the child's condition of mental, physical or developmental disability.
2. Has a planned program for the rehabilitation or remediation of the diagnosed mental, physical, developmental or learning disability which has been reviewed and approved and is supervised by a physician, psychiatrist or licensed Ph.D. clinical psychologist.
3. Has the approval of or meets minimum standards of applicable professional associations (for example, American Medical Association, American Psychiatric Association).
4. Is licensed or certified by or has the specific approval of applicable governmental agencies (for example, state or federal departments of health and/or mental hygiene).

Note: *If a facility's program is not under the direct supervision of a physician, psychiatrist or clinical psychologist, the child's physician or psychiatrist must provide a letter of supervision indicating they will continue to be involved with the supervision of the child's treatment and review the child's progress on a regular basis.-For a school to be eligible, the school must offer a bona fide learning disability program.*

Treatment for Autism Spectrum Disorder & Rett Syndrome

Applied Behavior Analysis (ABA) therapy, physical therapy, occupational therapy and speech therapy for autism spectrum disorder and Rett Syndrome are covered under the IBM medical plan and will no longer be covered under the SCCAP. Please see the "*Medical Coverage*" section for details.

Independent Practitioners and Eligible Conditions

Charges for necessary care and treatment by an independent practitioner will be considered for reimbursement when the practitioner is licensed or certified to practice in his or her particular field and is providing services that treat the diagnosed disability. The following are examples of some typical practitioners whose services are eligible under SCCAP along with some typical conditions they may treat:

- Independent speech pathologist or audiologist who holds a certificate of clinical competence in speech-language pathology or audiology from the American Speech-Language-Hearing Association and/or licensed by the state to practice speech-language pathology or audiology. Typical conditions requiring treatment from a speech pathologist or audiologist are speech impairments, articulation disorders, myofunctional disabilities and tongue thrust associated with orthodontia.
- Nutritionists or dietitians who are certified as Registered Dietitians (RD) by the American Dietetic Association. Typical conditions requiring treatment from a nutritionist or dietitian are eating disorders such as anorexia nervosa and bulimia nervosa.
- Licensed/Certified/Registered physical or occupational therapists. Typical conditions requiring treatment from a licensed/certified/registered physical or occupational therapist are cerebral palsy and other related neuromuscular disorders with functional impairment or "developmental delay."

- Treatment by an orthodontist, when the orthodontia is part of an overall treatment program which includes the surgical correction of orthognathic or orofacial abnormalities.
- Treatment by an optometrist for visual impairments, where the condition is diagnosed as progressive myopia.
- Treatment for a diagnosed learning disability when rendered by a learning disability specialist. The practitioner must have a degree in education, hold a state license or certification to teach, with a background in special education and working with special needs children for a minimum of five years or have a master's degree in special education and hold a state license or certification to teach.
- Academic tutoring is not eligible for coverage under the Plan. Therefore, in order to make a distinction between a bona fide learning disability of a slow learner who may require academic tutoring, it is a requirement of the Plan that the child undergoes psychological or psych-educational testing to support the learning disability condition. The results of this evaluation must be submitted as part of the Special Care application before any treatment program can be approved for benefits.
  - The psychological testing must be administered by an independent psychiatrist, psychologist or school psychologist who is not affiliated with the provider of services and must include a diagnosis.
  - Approved cases require periodic psychological or psycho-educational testing every three years to evaluate the necessity for continuance of coverage.
  - Charges for the psychological testing are eligible for benefits under the Plan if the reason for the testing is to determine whether a learning disability exists, regardless of the test results. If the reason for the psychological testing is other than to ascertain whether the child is learning disabled, charges may be eligible for benefits under the Managed Mental Health Care Program under the IBM Plan or any other health coverage you may have.

Note: *Claims for psychological testing must first be submitted to the Managed Mental Health Care Program to determine if any charges are eligible under this program. Charges not eligible under the Managed Mental Health Care Program that are determined to be related to a learning disability can then be considered under SCCAP. SCCAP will not reimburse the deductible or the difference between in-network and out-of-network charges deemed to be eligible under the Managed Mental Health Care Program.*

Note: *Holistic, homeopathic and naturopathic treatments are not eligible under the SCCAP. Wilderness Programs are also not eligible for reimbursement under the SCAAP or the IBM Plan*

Special Devices

Special devices will be considered for eligibility under SCCAP only if the devices are:

- Prescribed by a physician and
- Provide either direct medical treatment of the child's condition of mental, physical or developmental disability or the device must improve the life functioning of the child by enhancing the ability to see, communicate or use his or her limbs.

For example, charges for a special vision aid (such as a prism) for severe loss or impairment of sight will be considered for reimbursement if ineligible under the retiree's medical plan option. Charges for correction of nearsightedness, farsightedness or astigmatism are not eligible. (See the "*IBM Vision Coverage*" section regarding routine examinations for the prescription or fitting of eyeglasses.)

Hearing Aids

Hearing aid devices may be eligible for IBM medical plan coverage as described in the "*Medical Coverage*" section.

If a hearing aid benefit is not available through the retiree's medical coverage (including the IBM Plan), hearing aids are eligible for coverage under SCCAP. Hearing aids will be reimbursed under SCCAP at 80%, after a $150 annual deductible, up to an individual annual maximum of $400, including repairs and batteries.

HOW TO APPLY FOR SPECIAL CARE BENEFITS

- To apply for Special Care for Children Assistance Plan benefits, contact the IBM Benefits Center – Provided by Fidelity and request a SCCAP application package, which includes information on SCCAP, instructions for completing your application and the required forms. SCCAP claim forms are available on NetBenefits. You must apply for coverage before submitting any claims.
- Once you receive the application package, complete, sign and submit the following forms:
  - Statement of Child's Physician, Psychiatrist or Clinical Psychologist — this form is required and must include a diagnosis. This is sometimes called the doctor's recommendation form.
  - Statement of Independent Practitioner or Special Care Facility — this form is completed by the independent provider or facility providing the treatment.
- It may be necessary to provide additional documentation depending on the services being rendered:
  - For remediation for a child with learning disabilities a psychological or psycho-educational evaluation must be submitted. These evaluations are considered valid for three years from the date of testing, and reevaluations must be presented for continuation of assistance. Psychological evaluations are employed to assess the cognitive development of children and to determine if a delay in development or a learning disability exists. Some of the tests included in a psychological evaluation are Stanford-Binet Form L-M (S-B), Wechsler Intelligence Scale for Children-Revised (WISC-R), Wechsler Preschool and Primary Scale of Intelligence (WPPSI) and the Bender Visual Motor Gestalt Test and Woodcock-Johnson.
  - When service is being rendered by a clinic, day or educational facility, a brochure describing the facility program and services must be provided and must demonstrate the facility has a program to treat the diagnosis.
  - The license or certificate of clinical competence is required for speech therapists/pathologists or audiologists who are in independent practice.
  - A brochure describing the device and its usage, and documenting that the device treats the diagnosis is required when applying for special devices.
- Complete all forms and send them together with any required additional documentation to the IBM Benefits Center at the address listed on the forms in the application package. Incomplete forms or missing information (missing signature, diagnosis, date of service, provider credentials, etc.) will be returned. This will delay the review process.

- Special Care for Children Assistance Plan benefits are considered on an annual basis. You must reapply for coverage each year.

If approved, you will receive an authorization for benefits. You may submit bills for charges before services are rendered when payment in advance is a requirement of the facility. However, you should not submit bills before 30 days from the start date or 30 days before the date the fees are due.

Once approved, please complete the Special Care for Children Assistance Plan claim form and forward all authorized claims directly to Anthem BlueCross BlueShield for processing. Please include on all invoices or receipts the authorized provider(s) name or signature, address, child's name, cost, treatment and date of service. All claims which are submitted without prior authorization will be rejected.

Only expenses incurred in the same calendar year can be applied to the annual deductible. All approved claims for benefits and supporting documentation must be received by Anthem Blue Cross and Blue Shield by December 31st of the year after the charges were incurred. It is the employee's responsibility to submit claims to Anthem.

Where advance reimbursement has been made and your child is subsequently withdrawn from the program or where fees are reduced, you must advise the IBM Benefits Center, since you are responsible for any overpayments made.

You have a responsibility to ensure the accuracy and validity of all bills submitted for payment, to pay the providers of service the amount due them on a timely basis and to advise IBM of any discounts or price adjustments made by the providers.

Note: *Eligibility of services other than those described above should be discussed with the SCCAP Administrator at the IBM Benefits Center – Provided by Fidelity.*

The chart below documents which forms need to be completed for various services.

SERVICES	SCCAP FORMS
Psychological Evaluation	▪ Doctor Form ▪ Provider Form and/or paid invoice ▪ EOB (Explanation of Benefits) denying services from Behavioral Benefits Carrier, OR Preauthorization Denial Letter from the Carrier
Occupational, Physical Therapy or Speech Therapy/Evaluation	▪ Doctor Form ▪ Provider Form ▪ EOB (Explanation of Benefits) from Medical Carrier
Treatment for a learning disability	▪ Doctor Form ▪ Provider Form ▪ Current Neuro-Psych Evaluation
Therapy for a developmental disorder*	▪ Physician Form ▪ Practitioner Form ▪ Other documents may be required upon review
Therapy when diagnosis is both developmental and mental disorders	▪ Doctor Form ▪ Provider Form ▪ EOB (Explanation of Benefits) from mental health carrier

SERVICES	SCCAP FORMS
Special Care Facility	▪ Doctor Form ▪ Provider Form ▪ Evaluation (if facility is for treatment of learning disability, an evaluation is also required) ▪ Documentation on how the facility treats the diagnosis ▪ Other documents may be required upon view
Special Device	▪ Doctor Form ▪ Provider Form and/or Invoice ▪ Documentation on how the device treats the diagnosis ▪ Other documents may be required upon review

* Note that treatments for autism spectrum disorder and Rett syndrome are covered under the Medical Plan and Managed Mental Health Care Program, not SCCAP.

CONVERTING YOUR COVERAGE

There is no conversion privilege under the SCCAP. Individuals who lose eligibility for SCCAP coverage may purchase equivalent coverage for a time through COBRA administered by the IBM Benefits Center – Provided by Fidelity. For more information, see "*COBRA Continuation Coverage*" in the "*Administrative Information*" section or contact the IBM Benefits Center.

STATUS UNDER PATIENT PROTECTION AND AFFORDABLE CARE ACT

IBM continues to consult with the applicable regulatory agencies to evaluate whether the health reform legislation — the Patient Protection and Affordable Care Act (the "Affordable Care Act") — applies to SCCAP. The SCCAP is a separate plan from the other health plans IBM sponsors.
IBM treats SCCAP as a "grandfathered plan" subject to the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. A grandfathered health plan means that the plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost-sharing.

Grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, such as the elimination of lifetime limits on essential health benefits. However, SCCAP is not intended to provide "essential health benefits" under the Affordable Care Act as described in FAQ #3 of the "FAQs About the Affordable Care Act Implementation Part IV" available at http://www.dol.gov/ebsa/faqs/faq-aca4.html. Therefore the $50,000 lifetime limit that each eligible child may receive under SCCAP continues to apply to all benefits under SCCAP. SCCAP will, however, comply with the other consumer protections that apply to grandfathered plans, such as extending coverage to certain children regardless of their residency, their financial dependency on you, the availability of other coverage or their student, employment, tax dependency or marital status.

If you have questions about which protections apply and which protections do not apply to a grandfathered health plan, and what might cause a plan to change from grandfathered health plan status, please contact the health plan directly; contact information is available in the Contact Directory on Netbenefits (or on your Health Plan Detail Sheets if you receive print enrollment materials by mail). You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866-444-3272 or http://www.dol.gov/ebsa/healthreform. This Website has a table summarizing which protections do and do not apply to grandfathered health plans.

IBM Benefits Plan for Retired Employees

IBM Group Life Insurance

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IBM Group Life Insurance

GROUP LIFE INSURANCE COVERAGE UNDER THE PLAN

To help supplement your personal life insurance program, IBM provides group life insurance (GLI) coverage under the Plan. IBM retirees and other eligible former employees (see "*Who Is Eligible*" below) are eligible for post-employment GLI coverage under the Plan with some changes.

Who Is Eligible

The following individuals are eligible for the GLI under the Plan:

- Employees who retired before January 1, 2015, under the terms of the prior IBM Retirement Plan.
- Former employees who were not participants in the prior IBM Retirement Plan at separation but who separated from IBM before January 1, 2015, after satisfying the prior IBM Retirement Plan criteria:
  - 30 years of service or
  - Age 55 with at least 15 years of service or
  - Age 62 with at least 5 years of service or
  - Age 65 with at least 1 year of service

References to "retiree" in this program description refer to a retiree, former employee, employee on MDIP who is eligible to enroll in medical benefits under the IBM Benefits Plan for Retired Employees, as described in "*Eligibility*" in the "*About Your Personal Benefits Program*" section of this summary plan description.

Employees hired on or after January 1, 2004, and those who separate from IBM on or after January 1, 2015, are not eligible for post-employment GLI coverage under the Plan but are eligible for Voluntary Retiree Life (VRL) insurance directly from MetLife (for more information contact MetLife at 833-LIFE IBM (833-543-3426). VRL is not provided under the Plan.

HOW GROUP LIFE INSURANCE WORKS

GLI coverage as an active employee (under the IBM Group Life Insurance Plan) ceases after you terminate employment with IBM (via retirement or otherwise). The amount of life insurance coverage you are eligible for depends on your age.

Note: *For employees hired before January 1, 2004, who remain continuously employed by IBM and retire from IBM before January 1, 2015 (as defined under the IBM Personal Pension Plan), GLI coverage during retirement (until age 65) is equal to one-half of the amount that was in effect immediately before retirement, to a maximum of $25,000. Once you reach age 65 (either at or during retirement), GLI coverage is then reduced to $5,000 and will remain at that level throughout the retirement period.*

Employees hired on or after January 1, 2004, and those that separate from IBM on or after January 1, 2015, are not eligible for GLI coverage after they terminate their employment with IBM even if they retire (as defined under the IBM Personal Pension Plan).

IBM GROUP LIFE INSURANCE ADMINISTRATOR

The administrator for the GLI coverage under the Plan is MetLife.

If you have a question about your coverage, contact the IBM Benefits Center – Provided by Fidelity at 866-937-0720(TTY: 711). If you are a beneficiary or next of kin, once you have initiated a claim with the IBM Benefits Center, you can contact a MetLife representative at 833-LIFE-IBM (833-543-3426). You can also contact MetLife to discuss conversion options available to you.

If You Are Age 65 or Older

If you retired (or otherwise terminate employment with eligibility for retiree GLI coverage) at or after age 65 before January 1, 2015, your GLI coverage is reduced to $5,000.

If You Are Younger Than Age 65

If you retired (or otherwise terminate employment with eligibility for retiree GLI coverage) before age 65, before January 1, 2015, your life insurance coverage is equal to 50% of the amount that was in effect immediately before your retirement/termination, up to a maximum of $25,000. When you reach age 65, your insurance will then be reduced to $5,000 and remain at that level.

Eligibility for the accelerated death benefit ends on the date you retire or terminate from IBM.

Designating a Beneficiary

You can choose your beneficiary and change your beneficiary at any time online on **www.netbenefits.com**. You may also make updates by completing the paper beneficiary designation form available on **www.netbenefits.com** or from the IBM Benefits Center – Provided by Fidelity. If you make a change, your new beneficiary designation becomes effective when the update has been completed on NetBenefits or when the completed form is approved by the IBM Benefits Center.
If a beneficiary form is received and dated after the death of the retiree, if MetLife has already paid out the GLI benefit, this beneficiary change will not be valid.

If you do not name a beneficiary, or if your beneficiary dies before you and a new beneficiary is not chosen, payments will be made to your spouse, if living; otherwise in equal shares to your surviving children or, if none survives, to your surviving parents, equally. If no spouse, child or parent is then living, payments are made to the executors or administrators of your estate.

It is important to remember that if a retiree designates his or her spouse as the beneficiary, and the employee and spouse are later divorced, this former spouse will remain the retiree's beneficiary until and unless the retiree makes a change.

Be sure you review your copy of your beneficiary designation periodically to make sure your choice is current. If you are in doubt as to who your beneficiary is, submit a new beneficiary designation to the IBM Benefits Center. The most recent form received by the IBM Benefits Center will always be used to determine designated beneficiaries.

If you wish to receive verification of beneficiary information, you must send either a written and signed request or an e-mail to the IBM Benefits Center. Your request (whether written or e-mail) should include your return address, employee serial number, Social Security number and signature. The IBM Benefits Center – Provided by Fidelity address for written beneficiary verification is:

IBM Benefits Center – Provided by Fidelity
P.O. Box 5000
Cincinnati, OH 45273-8637

Form of Benefit Payment (Mode of Settlement)

You may choose a mode of settlement by making a request to MetLife. If you have not chosen a mode of settlement before you die, your beneficiary may enter into an agreement with MetLife as to how the group life insurance benefits will be paid.

Benefit payment options include:

- A lump-sum payment.
- A Total Control Account (TCA), which is a draft account that works like a checking account. When a TCA account is opened, MetLife will send your beneficiary a package which includes additional details about the TCA. MetLife pays the full amount owed to your beneficiary by placing the proceeds into the TCA and providing your beneficiary with a book of drafts and, on request, a Visa® debit card. Your beneficiary can use the Visa debit card as one would a bank debit card and drafts as one would use checks. Your beneficiary can use a single draft to access the entire proceeds or several drafts for smaller amounts (as little as $250). There are no limits on the number of drafts your beneficiary can write. Processing time is similar to check processing. Your beneficiary also may conveniently use the TCA as a source of funds to pay bills online, by phone, or by an electronic mobile payment application (no minimum payment amount). The account earns interest on the money in the account from the date it is opened. TCA is generally not available if the claim is less than $5,000 or if your beneficiary lives in a foreign country.

CONVERTING GROUP LIFE INSURANCE

Whenever your life insurance is reduced, you can convert a portion, or the entire amount discontinued into an individual policy of life insurance.

Your coverage will be reduced, effective 31 days after the last workday of the month in which you turn 65. After this 31-day waiting period, you will have 31 days to convert the amount of the reduction to an individual policy. (The conversion period begins on the date the conversion notice is mailed to you.) If you die after you turn 65 and before the end of the conversion period, your beneficiary will be paid the full amount of insurance in effective before your death.

If you wish to exercise the conversion privilege available under this policy, you must do so within 31 days of the date your insurance ends, is reduced or as otherwise noted in your conversion notice. The individual policy will take effect as noted in the conversion notice.

As part of the conversion process, you may apply for an individually underwritten policy at the same time. If you apply for such a policy and show satisfactory evidence of good health, it is possible that you may qualify for preferred rates. The process by which one applies for a conversion policy and an individually underwritten policy at the same time is called the Dual Application Process. Under this process, if the evidence of good health is satisfactory, you will be issued the individually underwritten policy; otherwise, you will automatically be issued a conversion policy. The advantages of an individually underwritten policy include the possibility of more favorable rates, a larger selection of plans and the option, at certain ages, of an Accidental Death Benefit in addition to the usual death benefits.

It is important to note, however, that the conversion policy must be issued and delivered within the United States. If you live outside the United States (this includes Puerto Rico, but not the Virgin Islands or Guam) and wish to convert an individual policy, you must either:

- Physically apply for and receive the policy in the United States or
- Designate a person in the United States with the Power of Attorney to apply for the conversion on your behalf.

HOW TO FILE A CLAIM

Your beneficiary should contact the IBM Benefits Center to initiate a claim. MetLife will provide your beneficiary with the necessary forms and instructions for filing a claim, including the mode of payment of the life insurance. Upon receipt of the completed forms and documentation, MetLife will consider the claim for processing and payment of the life insurance proceeds. If the life insurance beneficiary is legally incapable of handling his or her affairs, payments will be made to the responsible entity appointed by the courts.

This is only a summary of GLI coverage under the Plan and does not cover all the details. In the event a claim is made, the actual wording of the policy will govern.

IF A CLAIM IS DENIED

Your beneficiary must exhaust the claim and appeal procedures established by the Plan Administrator before initiating litigation.

If your claim is denied (in whole or in part), the written notice of the denial will:

- Describe the specific reason(s) your claim was denied;
- Refer to the Plan provisions on which the denial is based;
- Describe additional information needed to perfect your claim, if any, and why that information is needed; and
- Explain the Plan appeal procedure, including relevant time limits applicable to such procedures.

If your claim is denied in whole or in part, you (or your authorized representative) have the right to submit a written appeal to the IBM Plan Administrator, MetLife, for a full and fair review of the denied claim. Your appeal must be sent to the following address within 60 days after you receive the notice that your claim was denied:

Metropolitan Life Insurance Company
Group Life Claims
P.O. Box 6100
Scranton, PA 18505

In any such request you should include the following:

- Quote the specific Plan provisions upon which you base your claim for benefits. If the reason for the denial was that certain information, documentation, or evidence necessary to establish the validity of your claim had not been furnished, provide that information, documentation or evidence.

- If any of the facts given as a basis for denying your claim were incorrect, state what the true facts are and provide supporting documentation.
- State any other information; issues or comments you feel may be helpful to MetLife in the evaluation of your claim.
- Enclose copies of all prior correspondence you have received in connection with the processing of your claim. Also enclose copies of all prior correspondence which you have sent to IBM and the Plan Administrator in connection with your claim.

To the extent that you provide information in 1, 2, 3 and 4 above, it will be taken into consideration when your claim is reviewed. Additional information may be requested in reviewing your claim or in considering any request you may make for plan descriptions or other pertinent documents.

If the denial is timely appealed, the Plan Administrator shall conduct a full and fair review of the claim and the claim denial. You may, upon request and free of charge, receive copies of all documents, records and other information relevant to your claim for benefits. Whether a document, record or other information is relevant for purposes hereof shall be determined by the Plan Administrator in its sole discretion in accordance with DOL Reg. § 2560.503-1(m)(8). The Plan Administrator shall conduct a review that takes into account all comments, documents, records and other information submitted by you or your beneficiary relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

You will receive a written decision on the appeal of your claim within 60 days after your appeal is received, unless the Plan Administrator determines that an extension of time is required to review your appeal. If such an extension is required, which in no event will be longer than 60 days (for a total of 120 days from the date your claim appeal is received), you will receive a written notice of the extension within the initial 60-day period. Such notice shall indicate the special circumstances requiring the extension and the date by which the Plan Administrator expects to render its decision on your appeal.

The period for deciding your appeal begins on the date your appeal letter is received at the Plan Administrator's address, even if all the necessary information is not sent with your letter. However, if the Plan Administrator cannot decide your appeal because you have not submitted necessary information, the period for the Plan Administrator to decide the appeal will be automatically extended by the amount of time between (1) the date the Plan Administrator sends you written notice that additional information is required and (2) the date on which you provide the information (or, if you fail to respond, the date by which you were requested to provide the information).

You will receive a written decision on your appeal. If your appeal is denied (in whole or in part), the decision will:

- Describe the specific reason(s) your appeal was denied;
- Refer to the relevant provisions on which the denial is based; and
- Notify you that you have a right to bring a lawsuit under section 502 of ERISA.

Any decision of the Plan Administrator is final and binding. This is the final level of appeal.

Before you or your beneficiary, as appropriate, may file a lawsuit to recover benefits or enforce or clarify your rights under the plan or that otherwise relates to the plan or any Plan fiduciary or party in interest, you must exhaust the claim and appeal process above. Specifically, you must file an initial claim with the IBM Benefits Center and, if your initial claim is denied, you must file an appeal with the Plan Administrator.

IBM RETIRED REGULAR PART-TIME EMPLOYEE GROUP LIFE INSURANCE COVERAGE

The provisions and coverage described in this section apply to regular part-time employees who retire or otherwise terminate employment with eligibility for GLI coverage under the Plan (see *Who Is Eligible*), except that the benefit is 75% of the dollar amounts stated, for those who retired/terminated on or before December 31, 1996. For those part-time employees who retire/terminate after December 31, 1996, the provisions and coverage described in this section apply and there is no reduction of the dollar amounts stated.

Note: If you retire on or after January 1, 2015, you are eligible for MetLife's Voluntary Retiree Life (VRL) insurance directly from MetLife. For more information, contact MetLife at 833-LIFE IBM (1-833-543-3426). VRL is not provided under the Plan.

IBM Benefits Plan for Retired Employees

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Legal Information

YOUR RIGHTS UNDER HIPAA

The Department of Health and Human Services has issued federal regulations regarding the privacy of individual health records. These regulations are part of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The purposes of this law (referred to as the "Privacy Rule") are to standardize and safeguard the transmission of protected health information, to protect the privacy of individual health information and to allow individuals to access their medical records.

The HIPAA Privacy Rule applies to the IBM Benefits Plan for Retired Employees (referred to as the "Plan"), including the Plan's medical, dental, vision and employee assistance program coverages. The Privacy Rule was effective as of April 14, 2003.

Health Information Protected by the HIPAA Privacy Rule

The HIPAA Privacy Rule applies to "Protected Health Information" (PHI). PHI is individually identifiable health information that is created or received as part of administering the Plan. PHI includes information that (1) identifies, or can be used to identify, you, (2) is created or received by a health care provider, health plan, or employer, and (3) relates to your past, present and future physical or mental condition, and the provision of health care and payment for that care.

Uses and Disclosures of Protected Health Information by the Plan

The Plan may use or disclose PHI for purposes of treatment, payment, health care operations or as authorized by you. Information may also be disclosed in order to comply with federal, state or local law and to avert a safety threat to you or the public. When protected information is used or disclosed, even for purposes of treatment, payment or health care operations, only the minimum amount of information determined necessary to achieve the task will be used or disclosed.

Your Rights Under the HIPAA Privacy Rule

- Your protected health information will be kept private and will not be used or disclosed other than as permitted under the HIPAA Privacy Rule or as required by law.
- Your protected health information will not be used for unrelated purposes, such as making employment-related decisions or decisions related to other IBM benefit plans, unless specifically authorized by you or as required by law. (You may limit or revoke an authorization at a later time.)
- You have the right to inspect and obtain a copy of certain designated medical records, if such records are maintained by the Plan, and to request changes to those records.
- You have the right to request a listing of the Plan's uses and disclosures of your PHI (other than for purposes of treatment, payment and healthcare operations as described above).
- You have the right to request a restriction or limitation on how the Plan can use or disclose your private medical information for purposes of treatment, payment or health care operations. The Plan will consider but is not required to agree to your request.
- You have the right to request that the Plan's communications with you about your PHI are made in a certain way or at a certain location if your request states that communication in another manner may endanger you. The Plan will accommodate reasonable requests.
- You have the right to be notified if the plan discovers a breach of unsecured PHI.

If you wish to request an opportunity to inspect or obtain a copy of your PHI, an amendment of your PHI, a listing of the Plan's uses and disclosures of your PHI, a restriction or limitation on uses and disclosures of your PHI or a particular means of communication, and your request pertains to PHI maintained by the Plan at the IBM Benefits Center – Provided by Fidelity, submit your request in writing to:

IBM Benefits Center
PO Box 770003
Cincinnati OH 45277-1060

For requests pertaining to PHI maintained by a health plan for a medical, dental, vision or other option within the Plan, submit your request in writing to the applicable Claims Administrator at their address listed in "*Plan Funding and Administration Chart*" later in this section.

IBM's Responsibilities Under the HIPAA Privacy Rule

The Plan may disclose PHI to IBM, as the Plan Sponsor, for purposes of administering the Plan. In order to receive this information, IBM must certify to the Plan that it will: (a) comply with the HIPAA Privacy Rule, (b) only use and disclose PHI as required by law or for the permitted purposes described on the previous page, (c) only use and disclose the minimum amount of information determined necessary to achieve the task and (d) report to the Plan any violations of these requirements.

Any disclosure of PHI by the Plan to IBM will be limited to only those IBM employees who are directly involved in the administration of the Plan (which may include employees in the Human Resources/ Benefits, Internal Audit/Business Controls and Legal functions with responsibility for matters relating to Plan administration) and to those subcontractors of IBM who have been retained for purposes of administering the Plan (such as a health Plan Administrator for one of the Plan options). Unless authorized by you or required by law, these employees and subcontractors will only use or disclose PHI for purposes related to treatment, payment or health care operations under the Plan and will implement reasonable and appropriate security measures to protect the information. Any employee who uses or discloses PHI for any other purpose will be subject to disciplinary action. The Plan will notify you in the event of any breach involving unsecured PHI. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

Additionally, IBM has agreed to: (a) make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rule, and (b) if feasible, return or destroy all PHI received from the Plan and retain no copies of PHI when it is no longer needed or, if not feasible to return or destroy PHI, to safeguard and limit the use and disclosure of the PHI as required by law and (c) implement administrative, physical, and technical safeguards (within the meaning of 45 C.F.R. § 164.304) that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI (as defined in 45 C.F.R. § 160.103) that IBM creates, receives, maintains, or transmits on behalf of the Plan.

Notification of a Breach

We are required to notify you in the event that we (or one of our business associates providing services to the Plan) discover a breach of your unsecured PHI, as defined by HIPAA.

Authorizations

Other uses or disclosures of your PHI not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and before receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Concerns About the Handling of Your Protected Health Information

If you believe your rights under the HIPAA Privacy Rule have been violated, you may file a written complaint with the Plan or with the Department of Health and Human Services.

The plan has designated a Chief Privacy Officer at IBM, who is responsible for developing, communicating and enforcing the necessary procedures for ensuring the privacy of PHI. The IBM Chief Privacy Officer is the Plan's first point of contact for handling a complaint. The IBM Chief Privacy Officer will investigate the details of your complaint and will respond to you with the results of the investigation. To file a complaint with the Plan, please contact: IBM Chief Privacy Officer 1 New Orchard Road, Armonk NY 10504 Attn: HIPAA Privacy. All complaints must be submitted in writing. You will not be penalized or otherwise retaliated against for filing a complaint.

You may also contact the Department of Health and Human Services at the Office of Civil Rights for the region where the alleged violation occurred. Contact information for regional offices of the Office of Civil Rights is available at http://www.hhs.gov/ocr/office/about/rgn-hqaddresses.html.

Additional Information

A complete description of your rights under the HIPAA Privacy Rule, including examples of permitted uses and disclosures of PHI, can be found in the Plan's Health Information Privacy Notice. The Notice was distributed to all retirees covered by the Plan on October 11, 2013 (or upon becoming eligible, whichever is later). A copy of the Notice is available on NetBenefits or by calling the IBM Benefits Center – Provided by Fidelity.

CLAIMS

See the "*Plan Funding and Administration Chart*" at the end of this section for the name and address of Claims Administrators and Appeals Administrators.

In order to receive benefits under the plans described in this book, you or your health care provider must submit a claim to the Claims Administrator for the applicable health plan under which you are seeking a benefit.

For the IBM Benefits Plan for Retired Employees, you must submit your claim to the Claims Administrator for the particular medical, vision, dental option or HRA under which you are seeking a benefit. For ease of discussion in this section, these plan options are also referred to as "plans."

For purposes of this section, a "claim" means (1) a request for a plan to pay benefits covered under the plan or (2) a request for the plan to reinstate your coverage after a rescission of coverage (i.e., a retroactive cancellation of your coverage for reasons other than your failure to timely pay contributions toward the cost of coverage). Requests for a determination regarding whether you or another person are eligible to participate in a plan must be submitted to the Plan Administrator in accordance with the procedures described in *Eligibility*.

Each plan described in this book provides an internal claim and appeal process administered by the Claims Administrator and Appeals Administrator for the particular plan and the IBM Plan Administrator.

Please note: The IBM-sponsored Group Medicare Advantage plan options administered by UnitedHealthcare follow the Medicare claims and appeal process. For more information, visit https://www.medicare.gov/claims-appeals or https://retiree.uhc.com/ibm.

Claims for Non-Health Benefits

For claims for benefits that are not health benefits, unless special circumstances require an extension of time for processing the claim, the Claims Administrator will notify you or your authorized representative of its decision within 90 days after the Claims Administrator receives the claim. If an extension is necessary, the Claims Administrator will notify you or your authorized representative before the expiration of the initial 90-day period. The notice will indicate the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. In no event may the extension exceed 90 days from the end of the initial period.

You or your authorized representative may file a written appeal with the Appeals Administrator for the plan within 60 days after receiving notice of a denied claim for non-health benefits. (See "*Plan Funding and Administration Chart*" for the plans' appeals addresses.) Appeals received after this time will not be eligible for review under the internal appeals procedures.

"Post-Service" Health Claims

Post-service health claims are claims for health benefits that did not require advance approval from the plan.

The Claims Administrator will provide notice of the plan's final decision within 30 days after receipt of a post-service health claim. However, if the Claims Administrator needs more time to make a determination due to matters beyond its control, the Claims Administrator will notify you or your representative of the need for additional time within 30 days after receiving the claim. This notice will include the reason for the extension and the date a determination can be expected, which will be no more than 45 days after receipt of the claim. If more time is needed because necessary information is missing from the claim, the notice will also specify what information is needed, and you or your representative must provide the specified information within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Administrator sends such a notice of missing information and will resume on the date you or your representative responds to the notice.

You or your authorized representative may file a written appeal with the Appeals Administrator for the plan within 180 days after receiving notice of a denied post-service health claim. (See "*Plan Funding and Administration Chart*" for the plans' appeals addresses.) Appeals received after this time will not be eligible for review under the internal appeals procedures.

"Pre-Service" Health Claims

Pre-service health claims are claims for health benefits that require advance approval from the plan.

The Claims Administrator will provide notice of the plan's final decision within 15 days after receipt of the pre-service health claim. However, if the Claims Administrator needs more time to make a determination due to matters beyond its control, the Claims Administrator will notify you or your representative of the need for additional time within 15 days after receiving the claim. This notice will include the reason for the extension and the date a determination can be expected, which will be no more than 30 days after receipt of the claim. If more time is needed because necessary information is missing from the claim, the notice will also specify what information is needed, and you or your representative must provide the specified information within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Administrator sends such a notice of missing information and will resume on the date you or your representative responds to the notice.

You or your authorized representative may file a written appeal with the Appeals Administrator for the plan within 180 days after receiving notice of a denied pre-service health claim. (See "*Plan Funding and Administration Chart*" for the plans' appeals addresses.) Appeals received after this time will not be eligible for review under the internal appeals procedures.

"Urgent Care" Health Claims

Urgent care health claims are claims for health benefits which if not received (1) could seriously jeopardize your life, health, or ability to regain maximum function or (2) in the opinion of the attending physician, cause you severe pain which cannot be managed without the requested services. If the attending physician determines the claim is an urgent care health claim, the Claims Administrator will treat the claim as an urgent care health claim.

The Claims Administrator will evaluate and respond to urgent care health claims within 72 hours after receiving the urgent care health claim. However, if necessary, information is missing from the claim, the Claims Administrator will notify you or your representative within 24 hours after receiving the claim to specify the information that is needed. You or your representative must provide the specified information to the Claims Administrator 48 hours after receiving the notice. The Claims Administrator will notify you or your representative of the expedited benefit determination within 48 hours after you or your representative responds to the notice or within 48 hours after requesting the information, whichever occurs first. Expedited notices of determinations may be provided orally, followed within three days by written or electronic notification.

Upon receiving notice of a denied claim for urgent health benefits, you or your authorized representative may file an expedited appeal with the Appeals Administrator of the applicable plan orally, by phone or by facsimile.

Concurrent Care Health Claims

These are health claims to extend the approval for an ongoing course of treatment that has already been approved. You or your representative must submit a concurrent care health claim to the Claims Administrator at least 24 hours before the expiration of the approved period of time or number of treatments. When you or your representative submits a concurrent care health claim, the Claims Administrator will notify you or your representative of the determination within 24 hours after receiving the request.

You or your authorized representative may file a written appeal with the Appeals Administrator for the plan within 180 days after receiving notice of a denied concurrent care health claim. Appeals received after this time will not be eligible for review under the internal appeals procedures.

Notification of Denial

If a claim for plan benefits is denied in whole or in part, the Claims Administrator for the applicable plan denying the claim will send you a written notice of the denial. This notice will include (1) the specific reasons for the denial; (2) references to the provisions of the plan on which the denial is based; (3) a description of additional material or information necessary to perfect the claim and an explanation of why the material or information is needed; and (4) an explanation of the procedure to appeal the denial, including the time limit applicable to such procedure, and a statement of your right to bring a civil action under section 502(a) of ERISA if the claim is denied upon review.

In addition to the information required above, a notice denying a claim for health benefits will include the following additional information: (i) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit, (ii) in the case of a health claim involving urgent care, a description of the expedited review process applicable to such claim, and (iii) such other information as the Claims Administrator determines is required by applicable law.

If Your Claim for Benefits is Denied Under Your HRA

If your claim for reimbursement is wholly or partially denied, you will be notified in writing within 30 days after Optum Financial receives your claim. If Optum Financial determines that an extension of this time period is necessary due to matters beyond the control of the Plan, Optum Financial will notify you within the initial 30-day period that an extension of up to an additional 15 days will be required. If the extension is necessary because you failed to provide sufficient information to allow the claim to be decided, you will be notified and you will have at least 45 days to provide the additional information. The notice of denial will contain:

- The reason(s) for the denial and the provisions on which the denial is based
- A description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information
- A description of the appeal procedures and the time limits applicable to such procedures and
- A description of your right to request all documentation relevant to your claim.

If your request for reimbursement under the HRA is denied in whole or in part and you do not agree with the decision of Optum Financial, you may file a written appeal. Your appeals (first and second level appeals) should be sent to following:

Optum Health Financial Services
Attn: Appeals Department, Optum Bank
P.O. Box 30516
Salt Lake City, UT 84130
EMAIL: optumclaims@optumbank.com
FAX: 1- 844- 822- 2881

Note that you cannot file suit in federal court until you have exhausted these appeals procedures.

APPEALS

If your claim for benefits is denied, in whole or in part, you have the right to appeal the denial. An authorized representative may file the appeal on your behalf. There are different appeals processes (typically called "levels") depending on the type of claim.

- There is only one level of appeal for denials of:
  - urgent care health claims and
    claims that are not for health benefits.
- For all health benefit claims that are not for urgent care, IBM uses a two-step appeals procedure, divided into level-one and level-two steps.

  If your claim is subject to two levels of appeal, then:
  - The level-one appeal follows your initial claim denial and the level-two appeal follows the level-one appellate decision, and
  - Except for claims under SCCAP, you must exhaust both levels of appeal before you have a right to bring a civil action.
  - For claims under SCCAP you must exhaust only the level-one appeal before you have a right to bring a civil action.

The level-one appeal or level-two appeal (or the appeal for claims that are entitled to only one appellate review) will be administered by the Appeals Administrator for the applicable plan identified on the "*Plan Funding and Administration Chart*"

For those enrolled in a plan option through UnitedHealthcare, all appeals (first and second level appeals) regarding HRA claim denials or other HRA-related disputes will be handled by Optum Financial. Appeal instructions will be sent to you by Optum Financial. For all other appeals, those should be directed to UnitedHealthcare.

Please note: The IBM-sponsored Group Medicare Advantage plan options administered by UnitedHealthcare follow the Medicare claims and appeal process. For more information, visit https://www.medicare.gov/claims-appeals or https://retiree.uhc.com/ibm.

Filing An Appeal

A request for appeal must be filed with the Appeals Administrator or the IBM Plan Administrator, as applicable. Except as described in the following paragraph for appeals regarding urgent care health claims, the request for appeal must be in writing and include the reason why you feel your claim should be approved, any information supporting your appeal, and any information required by the Appeals Administrator or the IBM Plan Administrator, as applicable. You may submit written comments, documents, records, and other information relating to the claim. The Claims Administrator or Appeals Administrator, as applicable, will provide you, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

You may submit an oral or written request for an expedited appeal of a denial of an urgent care health claim. For an expedited appeal of an urgent care health claim, all necessary information will be transmitted between you and the Appeals Administrator by telephone, facsimile, electronic mail, or other available similarly expeditious methods.

Deadline for Filing An Appeal

An appeal for a claim denial for benefits other than health benefits must be filed within 60 days after you or your authorized representative receives notice of the initial claim denial. For an appeal related to a claim for health benefits, the 60-day period will be extended to 180 days. If you (or your authorized representative) fail to file a request for an appeal by the applicable deadline, you will have waived your right to appeal the denial.

Appeal for Denial of Non-Health Benefits

For appeals for benefits that are not health benefits, unless special circumstances require an extension of time for processing the appeal, the Appeals Administrator will notify you or your authorized representative of its decision within 60 days after the Appeals Administrator receives the written request for appeal. If an extension is necessary, the Appeals Administrator will notify you or your authorized representative before the expiration of the initial 60-day period. The notice will indicate the circumstances requiring the extension and the date by which the Appeals Administrator expects to render a decision. In no event may the extension exceed 60 days from the end of the initial period.

Appeal for Denial of Health Benefits

Post-Service Health Appeals

The Appeals Administrator will respond in writing with a decision within 30 calendar days after it receives an appeal for a post-service health claim determination. After receiving notice of a denied post-service health claim on appeal, you or your authorized representative may file a written appeal with the IBM Plan Administrator within 180 days. Notification of the final decision by the IBM Plan Administrator will be provided within 30 calendar days after it receives the request for appeal.

Pre-Service Health Appeals

The Appeals Administrator will respond in writing with a decision within 15 calendar days after it receives an appeal for a required pre-service health claim. After receiving notice of a denied pre-service health claim on appeal, you or your authorized representative may file a written appeal with the IBM Plan Administrator within 180 days. Notification of the final decision by the IBM Plan Administrator will be provided within 15 days after receipt of the request for appeal.

Urgent Care Health Appeals

The Appeals Administrator will respond orally to an appeal of an urgent care health claim with a decision within 72 hours, followed up in writing. This is the final step in IBM's internal appeals process for urgent care health claims.

Concurrent Care Appeal

An appeal of a concurrent care health claim denial will be classified as either an urgent care health claim, a post-service health claim, or a pre-service health claim, depending on the nature of the claim. Based on this classification, the applicable deadlines described above for urgent care health claims, post-service health claims, or pre-service health claims will apply to the concurrent claim appeal.

Procedures for Making Decision on Appeal

A decision on appeal will take into account all comments, documents, records, and other information submitted by you or your authorized representative relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination or level-one appeal decision. The Appeals Administrator's or IBM Plan Administrator's, as applicable, review of a claim will not afford deference to the initial claim denial decision or any level-one appeal decision and will be made by someone who was not involved in the initial claim decision.

If the plan has denied an appeal for health benefits based on a medical judgment (e.g., medical necessity, experimental/investigational), the Appeals Administrator or IBM Plan Administrator, as applicable, will consult with a health care professional with appropriate training and experience in the relevant field, who is not the individual who was consulted in connection with the initial claim denial or level-one decision regarding the claim or a subordinate of such individual. In this case, you may be asked to complete a Release of Information (ROI) allowing the health care professional to review your medical records and contact your physician.

By filing an appeal for health benefits with the IBM Plan Administrator (or, as a result of a filing on your behalf by your authorized representative), you acknowledge that the IBM Plan Administrator may receive and use information from the applicable plans related to your claim for benefits, for purposes of reviewing and rendering a decision on your appeal. The Health Insurance Portability and Accountability Act (HIPAA) rules will apply to the IBM Plan Administrator's use of such information (see *Your Rights Under HIPAA*).

Effect of Decision on Appeal

The decision of the Appeals Administrator for (1) urgent care health claims, (2) claims that are not for health benefits, and (3) appeals for benefits under SCCAP (if you choose not to pursue a level-two appeal for your SCCAP claim), is final and binding on all parties, including you and any of your beneficiaries under the plan. The decision of the IBM Plan Administrator for non-urgent care appeals or voluntary level-two appeals for benefits under SCCAP is final and binding on all parties, including you and any of your beneficiaries under the plan.

Notification of Determination on Appeal

If an appeal for plan benefits is denied in whole or in part, the Appeals Administrator for the applicable plan deciding a single level or level-one appeal or the IBM Plan Administrator deciding a level-two appeal will send you a written notice of its determination. This notice will include (1) the specific reasons for the decision, (2) references to the provisions of the plan on which the decision is based, (3) 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, and (4) a statement that you might have a right to bring a civil action under section 502(a) of ERISA after exhaustion of the final appeal.

In addition to the information required above, a notice denying an appeal for health benefits will include the following additional information: (i) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit, (ii) if required under section 503 of ERISA, the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and our state insurance regulatory agency," and (iii) such other information as the Appeals Administrator or IBM Plan Administrator determines is required by applicable law.

Legal Action

Subject to the limitations described in the "*Time Limit on Commencing Litigation and Forum for Litigation*" section, below, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the internal appeals process. Before bringing an action, you generally must have submitted both a level-one and level-two appeal for non-urgent care health claims and a level-one appeal for urgent care health claims and claims under SCCAP. However, if the Claims Administrator, Appeals Administrator, or IBM Plan Administrator fails to follow the internal claims and appeals procedures, in certain circumstances you will be deemed to have exhausted the internal claims and appeals process before receiving a final decision on appeal. If you believe such a failure has occurred, within 60 days of the failure you must notify the administrator your health claims and you may request an explanation of whether the violation is insignificant or otherwise would not result in a deemed exhaustion of the internal claims and appeals procedures.

The health plan administrator may also offer you other voluntary alternative dispute resolution options, such as mediation.

Time Limit on Commencing Litigation and Forum for Litigation

No Applicable Claim (as defined in Paragraph (A), below) may be filed in any court or in any other forum until you have exhausted the claims procedures described in the "*Appeals*" section. An Applicable Claim must be filed in a court described in Paragraph (B), below, within the Applicable Limitations Period prescribed by Paragraphs (C) and (D), on the following page. No Applicable Claim may be filed after the Applicable Limitations Period.

(A) An "Applicable Claim" is:

(1) A claim or action to recover benefits allegedly due under the provisions of a plan or plan option covered under this book (hereinafter, a "Plan") or by reason of any law

(2) A claim or action to clarify rights to future benefits under the terms of a Plan

(3) A claim or action to enforce rights under a Plan or

(4) Any other claim or action brought by a person who is, seeks to be, or is a successor to a current or former (I) employee (within the meaning of ERISA section 3(6)) of the Company, (II) participant (within the meaning of ERISA section 3(7)), or (III) beneficiary (within the meaning of ERISA section 3(8)) that—

(a) Relates to a Plan and

(b) Seeks a remedy, ruling, or judgment of any kind against a Plan, the Plan Administrator, the Company, or a fiduciary (within the meaning of ERISA section 3(21)) or a party in interest (within the meaning of ERISA section 3(14)) with respect to the Plan.

(B) A court described in this Paragraph (B) includes one of the following courts:

(1) The United States District Court for the district in which the Plan is principally administered, which is currently New York State

(2) In the case of an action brought by an individual plaintiff, the United States District Court for the district in which the plaintiff resides or

(3) In the case of an action brought by more than one plaintiff, the United States District Court for the district in which the largest number of plaintiffs (or in the case of a putative class action, the district in which the largest number of putative class members) reside (or if that district cannot be determined, the district in which the largest number of class members is reasonably believed to reside).

If an Applicable Claim is filed in a court other than a court described in this Paragraph (B), the Plan, all parties to such action that are related to the Plan (such as Plan fiduciaries, administrators, or parties in interest), and the alleged Plan participants and beneficiaries must take all necessary steps to have the action removed to, transferred to, or re-filed in a court described in this Paragraph (B). This Paragraph (B) is waived if no party invokes it within 120 days of the filing of a putative class action or the assertion of class action allegations.

(C) The "Applicable Limitations Period" for any Applicable Claim will begin on the following date (the "Limitations Start Date"):

(1) In the case of an Applicable Claim to recover benefits allegedly due under the Plan or to clarify rights to future benefits from the Plan, the earliest of (I) the date the first benefit payment was actually made, (II) the date the first benefit payment was allegedly due, or (III) the date the Company, the Plan, or the Plan Administrator first repudiated the alleged obligation to provide such benefits. A repudiation described in clause (III) may be made in the form of a direct communication to you or your beneficiary (*e.g.,* a denial of a claim under administrative review as described in the "*Appeals*" section or a more general oral or written communication related to benefits payable under the Plan (for example, the SPD, a benefit statement, or an agreement).

(2) In the case of any other Applicable Claim, the earliest date on which you or your beneficiary, if applicable, knew or should have known of the material facts on which such claim or action is based, regardless of whether you or your beneficiary was aware of the legal theory underlying the Applicable Claim.

(D) The Applicable Limitations Period for any Applicable Claim will end on the second anniversary of the Limitations Start Date for such Applicable Claim; provided, however, that:

(1) if a request for administrative review pursuant to the "*Appeals*" section is pending when the Applicable Limitations Period expires, the deadline for filing such Applicable Claim shall be extended to the date that is 60 calendar days after the final denial (including a deemed denial) of such claim on administrative review and

(2) if paragraph (C)(2), above, applies, the Applicable Limitations Period shall end no later than six years after (i) the date the last action on which such claim or action is based or (ii) in the case of an omission, the latest date on which such omission could have been cured, without regard to whether you or your beneficiary know or should have known the material facts on which the claim or action is based.

(E) The Applicable Limitations Period replaces and supersedes any limitations period that otherwise might be deemed applicable under state or federal law in the absence of this section ("*Time Limit on Commencing Litigation and Forum for Litigation*"). A claim or action filed after the expiration of the Applicable Limitations Period shall be deemed time-barred, except that:

(1) The Plan Administrator has discretion to extend the Applicable Limitations Period upon a showing of exceptional circumstances that, in the opinion of the Plan Administrator, provide good cause for an extension. The exercise of this discretion is committed solely to the Plan Administrator and is not subject to review.

(2) The Applicable Limitations Period will apply to a claim governed by section 413 of ERISA only to the extent permitted by law.

(F) In the event an Applicable Claim is brought by or on behalf of two or more claimants, the requirements of this section ("*Time Limit on Commencing Litigation and Forum for Litigation*") will apply separately with respect to each claimant.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

If not otherwise provided for herein, the IBM Medical and Dental Benefits Plan for Retired Employees shall provide coverage to a child solely to the extent required by a qualified medical child support order under ERISA section 609(a) or to an adoptive child solely to the extent required by ERISA section 609(c). Further, the Plan shall be interpreted and administered as necessary to comply with the requirements of ERISA section 609. Any coverage provided as a result of a qualified medical child support order shall be conditioned on payment of required contributions, if any, by or with respect to you.

Federal law requires that a child support notice, judgment, or order must meet certain form and content requirements to be a QMCSO. The Plan Administrator follows certain procedures to determine if a child support notice, judgment, or order meets these requirements. You may request a copy of these procedures at no charge. If you have any questions or would like a copy of the QMCSO administrative procedures, please contact the IBM Benefits Center – Provided by Fidelity.

FEDERAL LAWS

The IBM Benefits Plan for Retired Employees shall be interpreted and administered in accordance with the intent to comply with the applicable requirements of the Newborns' and Mothers' Health Protection Act of 1996 and the Genetic Information Nondiscrimination Act of 2008 ("GINA"), each as amended. If the Plan Administrator determines that any provision of the Plan or an Incorporated Document does not comply with a requirement described in the immediately preceding sentence, such provision shall be deemed to be reformed in a manner that the Plan Administrator determines (A) reasonably effectuates the intent of such provision and (B) is consistent with the applicable law. For the avoidance of doubt, the decision of whether reformation is required by this section and the extent of any such reformation shall be made by the Plan Administrator and not by any court, arbitrator, regulator, or other individual or entity.

The IBM Benefits Plan for Retired Employees does not cover any active employees. Accordingly, the Plan is not subject to

- the special enrollment, pre-existing condition, and nondiscrimination requirements (other than those relating to GINA) of the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA");

- the Women's Health and Cancer Rights Act of 1998, as amended, with respect to post-mastectomy reconstructive surgery;
- the Mental Health Parity Act of 1996, as amended, or the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, with respect to mental health benefits; or
- the coverage mandates and prohibitions for group health plans under the Patient Protection and Affordable Care Act, as amended ("PPACA").

YOUR RIGHTS UNDER ERISA

On September 2, 1974, the Employee Retirement Income Security Act of 1974 ("ERISA") was enacted, establishing federal controls over most employee pension and welfare benefit Plans. As a participant in the plans covered in this book, you are entitled to certain rights and protections under ERISA.

Receive Information About Your Plan and Benefits

ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites, 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 the latest annual report (Form 5500 series) and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report for plans that are required to have such a report. The Plan Administrator is required by law to furnish each participant with a copy of this annual summary report for plans that are required to have such a report.

Continue Group Health Care

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plans covered in this book which are governed by ERISA. The people who operate the 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 welfare benefit or exercising your rights under ERISA.

Enforcing Your Rights

If your claim for a welfare benefit is ignored or denied, 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. You cannot sell, transfer or assign the value of your benefit under the health plan.

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 Plan Administrator.

If you have a claim for benefits which is ignored or denied, 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 medical child support order (QMSCO), 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 at:

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.

It is anticipated that most questions can be answered by the IBM Benefits Center – Provided by Fidelity.

YOUR RIGHTS UNDER NMHPA

The Newborns' and Mothers' Health Protection Act provides that 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 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 provider to obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

YOUR RIGHTS UNDER WHCRA

The Women's Health and Cancer Rights Act (WHCRA) requires that all group health plans that provide medical and surgical benefits with respect to a mastectomy to provide coverage for:

- 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 all stages of mastectomy, including lymphedema.

These services must be provided in a manner determined in consultation with the attending physician and the patient. This coverage may be subject to annual deductibles, copayments and coinsurance provisions applicable to other such medical and surgical benefits provided under the applicable IBM Medical Plan option. Please refer to the applicable At A Glance chart for information regarding deductibles, copayments and coinsurance under the IBM Medical Plan option in which you are enrolled.

For information regarding the HMO options, please contact the HMO directly. If you would like more information on the Women's Health and Cancer Rights Act benefits, call the IBM Benefits Center.

YOUR RIGHTS UNDER USERRA

If you are serving in the military and are covered under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), you will continue to participate and be eligible to receive benefits under the Plan in accordance with USERRA rules and regulations.

PLAN DISCLOSURE INFORMATION

ERISA also requires companies to disclose certain detailed information to you so that you have it available for reference purposes. If you need additional information, you are encouraged to call the IBM Benefits Center – Provided by Fidelity. If you have questions regarding coverage and claim payments, you can obtain more information from the individual Claim Administrators.

Plan Year

The records of all of the plans covered in this book are kept on a calendar year basis, beginning January 1st and ending December 31st of each year, which is in each case, the plan year.

Plan Documents

This book is intended merely as a summary of the official plan document(s). The official plan documents are the final authority and shall govern in all cases. The Plan Administrator retains exclusive authority and discretion to interpret the terms of the benefits plans described herein.

Plan **Sponsor**

The Plans covered in this summary plan description are sponsored and maintained by the International Business Machines Corporation. The Plans covered in this book have been established by International Business Machines Corporation, Armonk, NY. The Employer Identification Number (EIN) assigned to IBM is #13-0871985.

Plan Administrator

The Plan Administrator for each of the plans covered in this book is a committee which consists of three or more executive level employees appointed by action of the IBM Retirement Plans Committee. The address for the Plan Administrator is:

Office of the Plan Administrator
IBM Benefits Center – Provided by Fidelity
PO Box 770003
Cincinnati, OH 45277-1060

Telephone: 866-937-0720 (TTY: 711).

Agent for Service of Legal Process

Service of legal process may be made upon the Plan Administrator.

Plan Funding and Administration

The IBM Benefits Plan for Retired Employees (the "Plan") includes components, some which are self-funded and others which are insured and is regulated by federal law. Except where noted on the Plan Funding and Administration Chart, the role of the companies that administer the components within the Plan that are insurance companies, is not to insure the Plan but to provide administrative services under contracts with IBM and the Plan. These companies are referred to in this document as "health plan," "health plan administrator," "medical plan," "dental plan" or "contract administrator." Eligibility for coverage of dependents, health care providers, facilities and treatments and supplies are determined solely by the provisions of the Plan. State or local laws mandating coverage for certain dependents, providers, facilities, treatments, etc., do not apply to the Plan. Final discretion and authority to interpret the provisions of the Plan rest with the Plan Administrator.

See the chart under *Plan Funding and Administration* for more details on the Plan as well as the other plans covered by this booklet.

Trustee for the IBM Benefits Plans for Retired Employees

The Plan trustee is:

JPMorgan Chase Bank
4 New York Plaza, 17th Floor
New York, NY 10004

RIGHT TO MODIFY OR TERMINATE IBM BENEFIT PLANS

IBM reserves the right, at its discretion, to amend, change or terminate any of its benefits plans, programs, practices or policies, as the Company requires. Nothing contained in this book shall be construed as creating an express or implied obligation on the part of IBM to maintain such benefits plans, programs, practices or policies.

IBM's benefit plans may be amended by written resolution of the Board of Directors or any Committee to which the Board has delegated power. The Retirement Plans Committee is authorized to amend any plan which is funded through a trust, including the IBM Plan. All other benefit plans may be amended by the IBM chief human resources officer or other IBM executive by means of a written instrument, such as the text of a plan, a summary plan description, a trust agreement, an insurance contract or insurance certificate, an administrative services contract, the administrative documents and procedures for a plan, an electronic medium notice, a hard copy bulletin board notice or an announcement letter or written materials that are approved by said chief human resources officer or other IBM executive and maintained with the records of the affected benefit plan.

PLAN FUNDING AND ADMINISTRATION CHART

The chart below lists the Claims Administrator and Appeals Administrator for the Plans covered in this About Your Benefits Booklet. Except as otherwise indicated, if your claim is subject to two levels of appeal, the Appeals Administrator for second-level appeal is the same as the Appeals Administrator for a first-level appeal.

Chart of Claims Administrators and Appeals Administrators for the Plan Components

Plan and Plan Component	Claims Administrator	Appeals Administrator
IBM Medical and Dental Benefits Plan for Retired Employees		
Medical – Pre Medicare-Eligible		
Anthem Blue Cross and Blue Shield 120 Monument Circle Indianapolis, IN 46204	Anthem Blue Cross and Blue Shield P.O. Box 105568 Atlanta, GA 30348	First Level Appeals: Anthem Blue Cross and Blue Shield P.O. Box 105568 Atlanta, GA 30348 Second Level Appeals IBM Plan Administrator IBM Benefits Center PO Box 770003 Cincinnati OH 45277-1060
Aetna, Inc. Attn: IBM Account Manager 151 Farmington Ave. Hartford, CT 06115	Aetna, Inc. Attn: IBM Appeals Unit P.O. Box 14463 Lexington, KY 40512	First Level Appeals Aetna, Inc. Attn: IBM Appeals Unit P.O. Box 14463 Lexington, KY 40512 Second Level Appeals IBM Plan Administrator IBM Benefits Center PO Box 770003 Cincinnati OH 45277-1060
Medical Out-of-Area Pre Medicare-Eligible		
Aetna, Inc. Attn: IBM Account Manager 151 Farmington Ave. Hartford, CT 06115	Aetna, Inc. Attn: IBM Account Manager 151 Farmington Ave. Hartford, CT 06115	First Level Appeals Aetna, Inc. Attn: IBM Appeals Unit P.O. Box 14463 Lexington, KY 40512 Second Level Appeals IBM Plan Administrator IBM Benefits Center PO Box 770003 Cincinnati OH 45277-1060

Plan and Plan Component	Claims Administrator	Appeals Administrator
Employee Assistance Program Pre and Post Medicare-Eligible		
Aetna, Inc. Attn: IBM Account Manager 151 Farmington Ave. Hartford, CT 06115	Aetna, Inc. Attn: IBM Appeals Unit P.O. Box 14463 Lexington, KY 40512	First Level Appeals Aetna, Inc. Attn: IBM Appeals Unit P.O. Box 14463 Lexington, KY 40512 Second Level Appeals IBM Plan Administrator IBM Benefits Center PO Box 770003 Cincinnati OH 45277-1060
Medical: IBM Managed Pharmacy Program: Pre Medicare-Eligible		
CVS Caremark	Appeals Department MC 109 P.O. Box 52084 Phoenix, AZ 85072-3092 Fax: 1-866-443-1172	First Level Appeals Appeals Department MC 109 P.O. Box 52084 Phoenix, AZ 85072-3092 Fax: 1-866-443-1172 Second Level Appeals IBM Plan Administrator IBM Benefits Center PO Box 770003 Cincinnati OH 45277-1060
Dental: IBM Dental Plus and Dental Basic Plans Pre Medicare-Eligible		
Metropolitan Life Insurance Company (MetLife) 200 Park Ave. New York, NY 10166	MetLife Group Claims Review P.O. Box 14589 Lexington, KY 40512	First Level Appeals MetLife Group Claims Review P.O. Box 14589 Lexington, KY 40512 Second Level Appeals IBM Plan Administrator IBM Benefits Center PO Box 770003 Cincinnati OH 45277-1060
Vision: Anthem Blue View Vision Plan Pre Medicare-Eligible		
Anthem BlueView Vision 555 Middle Creek Parkway Colorado Springs, CO 80921	Anthem Blue View Vision Attention: Appeals P.O. Box 9304 Minneapolis, MN 55440-9304	Anthem Blue View Vision Attention: Appeals P.O. Box 9304 Minneapolis, MN 55440-9304

Plan and Plan Component	Claims Administrator	Appeals Administrator
Medical: Health Reimbursement Arrangement (HRA) – Post Medicare-Eligible		
Optum Financial	Optum (HRA administrator): Optum Financial P.O. Box 30516 Salt Lake City, UT 84130	First Level Appeals Optum Health Financial Services Attn: Appeals Department, Optum Bank P.O. Box 30516 Salt Lake City, UT 84130 EMAIL: optumclaims@optumbank.com FAX: 1- 844- 822- 2881 Second Level Appeals IBM Plan Administrator IBM Benefits Center PO Box 770003 Cincinnati OH 45277-1060
Medical: Medicare Advantage Plans – Post Medicare-Eligible		
UnitedHealthcare	UnitedHealthcare P.O. Box 30770 Salt Lake City, UT 84130-0770	**Medical** UnitedHealthcare Appeals and Grievances Department P.O. Box 6103, MS CA124-0157 Cypress, CA 90630-0023 FAX: 1-844-226-0356 **Part D prescription drugs** UnitedHealthcare Part D Appeal and Grievance Department P.O. Box 6103, MS CA124-0197 Cypress, CA 90630-0023 FAX: 1-877-960-8235
Life Insurance: Group Life Insurance – Pre- and Post Medicare-Eligible		
Metropolitan Life Insurance Company (MetLife) 200 Park Ave. New York, NY 10166	MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505	MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505
IBM Special Care for Children Assistance Plan (SCCAP)		
Anthem Blue Cross and Blue Shield 120 Monument Circle Indianapolis, IN 46204	Anthem Blue Cross and Blue Shield P.O. Box 5012 Middletown, NY 10940-9021	Anthem Blue Cross and Blue Shield P.O. Box 5012 Middletown, NY 10940-9021 Second Level Appeals IBM Plan Administrator IBM Benefits Center PO Box 770003 Cincinnati OH 45277-1060

The chart below lists, for the plans covered under this About Your Benefits Booklet which are governed by the Employee Retirement and Income Security Act of 1974 (ERISA), certain information required by ERISA.

Official Plan Name and Type	Plan Number	Type of Administration	Plan Type	Claims Administrator	Funding
Plan Name: IBM Benefits Plan for Retired Employees	518	Plan Administration and Contract Administration	Medical, Dental, Vision, Life Insurance	Various	Some components are self-insured by IBM and others are insured. Plan components are funded by IBM contributions only, by IBM and participant contributions, or by participant contributions only
Plan Name: IBM Special Care for Children Assistance Plan	508	Plan Administration and Contract Administration	Special Care for Children Assistance Plan	Anthem Blue Cross and Blue Shield	Self-insured by IBM and funded by IBM contributions only

Annex 1

About Your Benefits - Future Health Account

The information contained herein has been provided by IBM and is the responsibility of IBM.

NOTICES

This document is a summary of the key features of the IBM Future Health Account which was established as of July 1, 1999.

Complete details of the IBM Future Health Account can be found in the official plan documents, which remain the final authority and, in the event of a conflict with this summary, shall govern in all cases.

IBM reserves the right, at its discretion, to amend, change or terminate any of its benefits plans, programs, practices or policies, as the company requires. Nothing contained in this summary shall be construed as creating an express or implied obligation on the part of IBM to maintain such benefits plans, programs, practices or policies. Your benefits at or after retirement may be different from those described herein due to changes made to, or the termination of, the IBM Future Health Account.

Because of the need for confidentiality, decisions regarding changes to IBM's benefits plans, programs, practices or policies are generally not discussed or evaluated below the highest levels of management. Managers and their representatives below such levels do not know whether IBM will or will not change or adopt, for example, any particular retirement plan. Nor are they in a position to advise any employee on, or speculate about, the future. Employees should make no assumptions about future changes, or the impact changes may have on their personal situation until any such change is formally announced by IBM.

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INTRODUCTION

The IBM Future Health Account (FHA) is a component of the IBM Benefits Plan for Retired Employees (Plan). After you leave the company, if you meet certain age and service requirements, the FHA provides you with funds to help pay for medical, dental and vision benefits under the Plan or with funds for your Health Reimbursement Arrangement (HRA) under the Plan.

For those employees who are eligible, IBM will set up a Future Health Account once you reach age 40, as long as you've been employed by the company for at least one year at that time. Your account grows steadily in two ways: monthly credits for up to 10 years while you work for IBM and interest as long as there is a balance in your account.

Note that the Future Health Account is a "notional" account that's tracked for record-keeping purposes only. There are no actual funds held in your name. When the time comes to pay benefits on your behalf, the money comes out of the Plan Trust or IBM's operating funds. This is the same way IBM pays for retiree health care benefits for participants eligible for a subsidy (other than the FHA) under the Plan.

This summary describes the IBM Future Health Account. It is also available electronically on the IBM intranet in the "*Legal Notices/Formal HR Documents*" section of the "You and IBM" home page at www.netbenefits.com or you may request a copy by calling the IBM Benefits Center – Provided by Fidelity at 866-937-0720 (TTY: 711); Outside the U.S. dial your country's toll-free AT&T Direct® access number, then enter 866-937-0720.

ELIGIBILITY

You're eligible for credits to an IBM Future Health Account if you are a regular full-time or part-time employee of International Business Machines Corporation, or, at the discretion of International Business Machines Corporation, a domestic subsidiary (such entities referred to herein as the company or IBM) receiving wages reportable on Form W-2 through IBM payroll; and are covered by provisions of the United States Social Security Act, and you are 40 years old or older; and

- You've been employed by the company for at least one year.
- You were hired on or before December 31, 2003 (If rehired after December 31, 2003, your eligibility is determined by your most recent date of hire; for such individuals, IBM service before 2004 (including service as a regular employee of IBM, as well as foreign service – or service as a supplemental employee) does not count for any other purposes under the Future Health Account.)

You also are eligible for credits to the Future Health Account (once you meet the age and service requirements) during the period you take a paid or unpaid leave of absence (see details below). Please see the special rules below regarding Future Health Account eligibility for employees receiving benefits under the IBM Long-Term Disability Plan.

Some employees (e.g., those who have joined IBM as a result of certain acquisitions) are subject to special rules for the Future Health Account that differ from those described in this summary.

The provisions of the Future Health Account do not apply to employees who retired from IBM before July 1, 1999, or who were continuously employed by IBM for at least one year immediately before June 30, 1999, and within five years of their earliest retirement eligibility under the prior IBM Retirement Plan as of June 30, 1999.

HOW THE FUTURE HEALTH ACCOUNT WORKS

Your Account Builds During Your IBM Career

If eligible, your IBM Future Health Account builds throughout your career with the company starting at age 40 after you have completed at least one year of service. The company will create a Future Health Account in your name when you become eligible. The company will credit you with a maximum of $2,500 a year for 10 years, or until you leave IBM, whichever comes first. At the same time, IBM also credits monthly interest to your account, and keeps crediting interest even after the 10-year crediting period ends, as long as there is a balance in your Future Health Account.

If you met certain age and service requirements as of July 1, 1999, you may be eligible for a one-time only immediate starting sum or opening account balance. Any opening account balance and interest credits do not apply toward the $25,000 credit maximum.

***Note**: No credits are applied to your account for the month in which you leave or retire from IBM.*

Each of these account features is described in the following sections.

You may use the amounts in your account after you leave the company, if you leave at age 55 or older with at least 15 years of service. In addition, if you were age 40 with one year of service on June 30, 1999, you can use the amounts in your account after you leave the company, if you leave with at least 30 years of service, regardless of your age. See the "*Using Your Future Health Account*" section.

Opening Account Balance for Certain Employees on July 1, 1999

IBM has provided a one-time only immediate opening account balance in your Future Health Account as of July 1, 1999, if:

- You were at least 40 years old on June 30, 1999, and
- You were actively employed by IBM for at least one year immediately before June 30, 1999 (i.e., June 30, 1998 - June 30, 1999)

The amount of your opening account balance was based on your current age and IBM service since age 40 as of June 30, 1999. Your age qualified you for a set dollar amount, as shown in the following chart. That dollar amount is then multiplied by each year of your post-40 service (and additionally prorated by any remaining months) for up to 10 years to determine your opening account balance.

If, on June 30, 1999, you have at least one year of IBM service **AND** your age was	This is the set dollar amount that you will receive based upon your age and 1 year of IBM service.
40	$1,450.00
41	$1,475.00
42	$1,520.00
43	$1,580.00
44	$1,645.00
45	$1,710.00
46	$1,775.00
47	$1,845.00
48	$1,925.00
49	$2,145.00
50 and older	$2,370.00

An Example of an Opening Account Balance

Suppose that on June 30, 1999, an employee was 46 and had four years and nine months of IBM service. This employee's Future Health Account opens July 1, 1999, with a balance of $8,431. This was determined by multiplying $1,775 (since the employee is 46 years old) by 57 (the lesser of the employee's total months of service; in this case, 57, or the employee's months of age over 40; in this case, 72) and dividing the result by 12.

Future Health Account Credits

Future Health Account credits are the contributions that IBM adds to your account each month. Once you reach age 40 with at least one year of service and become eligible for an account, IBM starts tracking Future Health Account credits on your behalf. IBM's contribution is $2,500 per year for full-time employees (employees who work at least 33 hours per week), credited in monthly increments.

Employees who are classified as part-time employees receive a smaller monthly credit according to the following schedule:

- Half ($1,250 annually) for employees who work 20 to 26 or fewer hours a week or who are on the Personal LOA Work Option.
- Three-fourths ($1,875 annually) for employees who work 27 to 32 hours a week

However, these employees are still eligible to receive an amount that is equivalent to $25,000 ($2,500 for full-time employees, for 10 years), so they can receive these reduced amounts for a longer period of time than full employees can (i.e., beyond 10 years but in no event greater than $25,000).

Interest Credits

Your account also will grow with interest, added to your balance each month.

For Plan Years 1999 to 2001: The annual FHA Interest Crediting Rate was the average of the interest rates for 1-year Treasury bills, secondary market, for the months of August, September and October immediately preceding the first day of the Plan Year plus 1.0%.

For Plan Years 2002 forward: The plan's interest rate is fixed each January 1 at the average of the annual interest rates on one year U.S. Treasury Constant Maturities, during the preceding months of August, September and October, rounded to the nearest 10th of a percent plus 1%.

Interest is added to your account monthly. IBM will keep contributing interest even after the 10-year crediting period ends, as long as a balance remains in your account.

Watch Your Account Grow

Your account balance will grow each month through Future Health Account credits and interest credits. Eligible participants can view their FHA personalized account information online at the NetBenefits Website netbenefits.com). Available account information includes current balance, quarterly and year to date information, as well as account activity from previous years.

No Vested Rights

IBM reserves the right, at its discretion, to amend, change or terminate any of its benefits plans, programs, practices or policies, as the company requires. Nothing contained in this summary shall be construed as creating an express or implied obligation on the part of IBM to maintain such benefits plans, programs, practices or policies. Your benefits at or after retirement may be different from those described herein due to changes made to or the termination of the IBM Future Health Account or the Retiree Medical Plan.

Using Your Future Health Account
You will be able to use the amounts in your account after you leave IBM, if you leave with at least 15 years of service and at or after age 55 (or, if you were at least 40 years old with one year of service as of June 30, 1999, if you leave with at least 30 years of service, regardless of your age). You may not use the amounts in your account while you are still working at IBM.

The FHA works differently for Non-Medicare-Eligible Retirees and Medicare-Eligible Retirees.

Non-Medicare-Eligible Retirees
Before Medicare eligibility, you may use the amounts in your account to pay premiums for coverage under the Plan after you leave IBM, to cover yourself and eligible family members. You cannot use the amounts in your account for any other expenses, such as a spouse's or another employer's plan, or other health care expenses, such as deductibles, copayments and prescription drugs. You cannot take the amounts in your account in cash at any time.

Each year, during the Annual Enrollment period, you determine the coverage you want under the Plan and how you want to pay for the premiums, using a combination of your Future Health Account and your own funds. You'll choose what percentage of your premiums (from 0% to 100%, in 10% increments) you want paid from your Future Health Account.

If you leave IBM and are eligible to use your Future Health Account, it is not necessary that you begin using it right away. However, you do have to maintain health plan coverage through IBM or elsewhere

(for example, another employer's plan) to remain eligible. In addition, you must start using your account no later than the year in which the 25th anniversary of the date you leave IBM occurs, or you will forfeit your Future Health Account balance.

Your account will continue to earn interest until you have used up the entire balance.

If you deplete your Future Health Account balance, you will be considered the same as an Access Only participant.

Medicare-Eligible Retirees
As of January 1, 2014, retirees who have a remaining balance in their FHA when they become Medicare-eligible, will have their FHA balance converted to a Health Reimbursement Arrangement (HRA). For FHA balances converted to HRA balances during the period of January 1, 2014, to November 30, 2022, the eligible retiree's opening HRA balance shall not be less than the dollar amount credited to the individual's HRA account by the HRA recordkeeper based on the information transmitted by the FHA recordkeeper (Fidelity). The provisions applicable to FHA balances converted to an HRA are described in the summary plan description for the Plan, which can be found in "*About Your Benefits: Post-Employment.*"

If you leave IBM and are eligible to use your Future Health Account or HRA, it is not necessary that you begin using it right away. However, you do have to maintain health plan coverage (for example, Medicare or another employer's plan) to remain eligible. In addition, you must start using your account no later than the year in which occurs the 25th anniversary of the date you leave IBM.

If you deplete your Future Health Account balance (including any balance converted to an HRA when you become Medicare-eligible), you will be considered the same as an Access Only participant.

Situations That Affect Your Plan Participation

If You Leave and Return

If you leave IBM and are later rehired, how you'll be treated under the Future Health Account will depend on your age, your length of service and when you leave, as described below.

If You Left Before July 1, 1999, and Return After That Date

If you left IBM before July 1, 1999, and return on or before December 31, 2003, you'll begin credits to a Future Health Account once you become eligible. Your previous periods of service will count toward the one year-of-service eligibility requirement and the 15-years of service requirement for receiving benefits.

If You Leave and Return After July 1, 1999

If, after July 1, 1999, you are over age 40 and leave IBM before you've reached age 55 with 15 years of service, you forfeit your account at the time you leave. If you're rehired on or before December 31, 2003, you'll begin a new account. Your previous periods of service will count toward the one year of service eligibility requirement and the 15-years of service requirement for receiving benefits.

If, after July 1, 1999, you leave IBM after reaching age 55 with at least 15 years of service (or after reaching 30 years of service, regardless of age, if you were eligible for an opening account balance on July 1, 1999), your account will continue to earn interest credits as long as you have a balance. If you're rehired on or before 12/31/2003, Future Health Account credits (along with interest credits) will be credited to that same account, except that you cannot receive more than 10 years' worth of full-time Future Health Account credits in total. Note that you will not be able to access your balance once you return as an active employee.

If You Leave As Part of a Business Arrangement

If you leave IBM as part of a business arrangement where the new employer credits your IBM service under a program similar to the FHA, and later return to IBM, prior IBM service is not counted toward the one year of service eligibility requirement, or the 15 years of service requirement for accessing your account.

Long-Term Disability Benefits

If You Are Receiving IBM Long-Term Disability (LTD) Plan Benefits

If you begin receiving LTD Plan benefits on or after July 1, 1999, and:

- You already have a Future Health Account; you are eligible for up to five additional years of annual Future Health Account credits while you are receiving LTD Plan benefits.
- You are younger than age 40 when you begin receiving LTD Plan benefits, you will not receive a Future Health Account benefit unless you return to work at IBM and become eligible for the account.

If, on June 30, 1999, you were receiving LTD Plan benefits that began on or after January 1, 1995, and you were:

- Within five years of earliest retirement eligibility under the prior IBM Retirement Plan, you will remain eligible for a subsidy under the Plan (but not for an FHA);
- •More than five years away from earliest retirement eligibility and age 40 or older, you are eligible for an FHA opening account balance on July 1, 1999, plus up to five additional years of annual Future Health Account credits while you are receiving LTD Plan benefits; or
- More than five years away from earliest retirement eligibility and younger than age 40, you will not receive a Future Health Account benefit unless you return to work at IBM and become eligible for the account.

If you began receiving LTD Plan benefits before January 1, 1995, you will remain eligible for a subsidy (but not FHA) under the Plan. The provisions of the Future Health Account will not apply to you. If you return to work at IBM before age 40, the provisions of the Future Health Account will apply to you.

If You Take a Leave of Absence

If You Go on a Paid Leave of Absence

If you take a paid leave of absence, you'll be treated as an active employee for the purposes of the Future Health Account. If you're eligible, you'll receive Future Health Account credits and interest

credits. The time you're on leave will count toward the one year of service eligibility requirement and the 15-years-ofservice requirement for receiving benefits.

If You Go on an Unpaid Leave of Absence

If you take an unpaid leave of absence, you will not receive Future Health Account credits. However, you'll receive interest credits on your account balance, if any. The time you're on leave will count toward the one year of service eligibility requirement and the 15-years of service requirement for receiving benefits, provided you return to IBM. You will still have the opportunity to receive 10 years of IBM credits provided you are actively at work for 10 years after becoming eligible.

If You Leave IBM

If you leave IBM after you become withdrawal eligible, you can begin accessing your account. Your account will continue to earn interest until you have used up the entire balance.

You are withdrawal eligible (eligible to withdraw) from the balance in your account to help pay for coverage under the Plan if:

- You leave IBM after the date on which you are age 55 with at least 15 years of service; OR
- You were at least 40 years old with at least one year of service on June 30, 1999, and you leave IBM after the date on which you have 30 years of service, regardless of age.

See *Using Your Future Health Account* for details on what you can do with your account if you leave IBM and are withdrawal eligible.

***Note**: If you are not withdrawal eligible on the date you leave IBM, your Future Health Account is forfeited.*

If You Die

Whether you're actively employed or have left IBM, as long as you've met the eligibility criteria for access to the Future Health Account (age 55 with 15 years of service or, if you were at least 40 years old with one year of service as of June 30, 1999, 30 years of service, regardless of age), when you die, your eligible dependents can access your Future Health Account balance. Eligible dependents have one year from your death to identify themselves to IBM as your dependents to access your Future Health Account balance.

If you die before reaching age 55 with at least 15 years of service (or, if you were at least 40 years old with one year of service as of June 30, 1999, before reaching 30 years of service, regardless of age), your account is not available to your survivors.

If You Decline IBM Health Coverage
When you leave IBM, if you are withdrawal eligible from the FHA or are eligible for an HRA, but decline coverage under the Plan in any given year or years (or decline coverage outside the Plan that qualifies you for an HRA contribution), you will be allowed to return to the Plan if you have maintained other health coverage in the interim. If you don't maintain coverage elsewhere in the interim, you will not be eligible for coverage under the Plan and your balance will be forfeited.

Foreign Service
Special provisions apply to employees who receive IBM U.S. credit for periods of service with a foreign branch or subsidiary of IBM. Foreign service is counted toward the one year of service eligibility requirement, as well as the 15-years of service requirement for account withdrawal eligibility. If you were age 40 on June 30, 1999, and were an active U.S. employee with one year of U.S. service immediately before June 30, 1999, you may meet the criteria for accessing your account when you leave the company with 30 years of service, regardless of age. In addition, you may meet the criteria for receiving an Opening Account Balance (see *How the Plan Works* for details).

Tax Considerations
Because the amounts in the Future Health Account are used exclusively to pay for Plan coverage, the Future Health Account remains tax-free to you at all times, under current IRS rules, even when you access it to apply toward premiums for Plan coverage.

Legal Information
The Future Health Account (FHA) is a component of the Plan. Please reference the "*Legal Information*" section of this SPD for information about the Claims and Appeal Process.

Annex 2

Access Only

To be eligible for Access Only, you must be at least age 55, have at least five years of IBM service, and your age plus service must equal 65 or greater at the time you leave IBM. Examples of age and service combinations that meet these criteria are:

Age/Service	Age/Service
55/10	58/7
56/9	59/6
57/8	60/5

IBM may also offer Access Only eligibility where it otherwise would not apply when the Company considers this necessary to support business needs.

Keep in mind:

- Non-Medicare-eligible participants who meet Access Only eligibility who do not enroll in an IBM retiree medical, dental and/or vision plan option when they first become eligible, and maintain continuous enrollment, permanently waive their eligibility to enroll in the Plan again in the future.
- Non-Medicare-eligible participants who maintain Access Only status until reaching Medicare eligibility will retain Access Only status once they become Medicare-eligible whether or not they enroll in coverage under the Plan in any enrollment period.

FHA Withdrawal Eligible Individuals who deplete their FHA or HRA Account Balance. While you are pre-Medicare-eligible as an FHA participant you are strongly encouraged to leave a balance in your FHA to avoid being converted to Access Only eligibility.