BROADCOM

2017 Benefits Enrollment Guide

To help you make informed benefit choices!

COBRA Enrollment Period October 24 - November 7, 2016

Your Enrollment Checklist

- ☐ Read this Guide for a COBRA benefits overview
- ☐ On Oct. 24, visit the enrollment website for 2017, www.mybenefits.conexis.com to learn more about your benefits options
- ☐ Select your benefits for 2017 using the Conexis website
- ☐ Call Conexis at 1-866-206-5751, if you have questions

How to Enroll in 2017 COBRA Benefits

COBRA BENEFITS THROUGH BROADCOM

Conexis is Broadcom's COBRA Administrator and you should have received a letter indicating that you will be able to enroll in COBRA benefits using the Conexis website at www.mybenefits.conexis.com. Instructions on how to enroll are provided in the packet you received from Conexis.

This COBRA Benefits Enrollment Guide contains important COBRA plan information. **Please review the contents carefully.** If you have questions, please call Conexis at 1-866-206-5751, and a representative can assist you.

Need Help? If you have questions or need assistance enrolling in your benefits, call Conexis at 1-866-206-5751, starting October 24.

Visit the Conexis COBRA enrollment website at www.mybenefits.conexis.com to enroll in your benefits beginning Oct. 24.

During COBRA Benefits Enrollment You May:

- Enroll in or opt out of a COBRA medical, dental or vision plan
- Add or drop eligible dependents to your plan
- Change your plan elections

CHANGING YOUR BENEFIT SELECTIONS

You can change any of your benefit selections before the COBRA Enrollment deadline. Simply return to the Conexis website to make changes.

After the enrollment deadline, you may be able to make changes to some of your benefits in certain situations. Under IRS rules, you can only make changes to some benefits (such as medical and dental insurance) if you have a change in personal circumstances. For example, if you get married or have a baby, you can add coverage for your spouse or new child. You can learn more about which situations allow you to change your benefits and how to make changes by calling Conexis at 1-866-206-5751.

COBRA Benefits through the Public Exchange may be a Lower Cost Alternative

Under the Affordable Care Act, participants eligible for COBRA can now also access public exchanges, where they may qualify for tax credits that immediately lower health insurance costs. This means that you may qualify for Public Exchange Insurance that costs less than COBRA benefits through the company.

DOMESTIC PARTNER BENEFITS

The company offers benefits for domestic partners or civil union partners of the same or opposite sex that are currently registered as such with any governmental body, pursuant to state or local law.

This benefit extends to the children of domestic partners, assuming the parent is also enrolled under the plan.

You may enroll your domestic partner upon your initial eligibility for benefits or during the COBRA benefits enrollment period if he or she meets the eligibility requirements.

Inside this guide

This Guide provides an overview of the COBRA benefits available to you, information to help you make benefits decisions and instructions on how to enroll in the 2017 plans.

IF YOU (AND/OR YOUR DEPENDENTS) HAVE MEDICARE OR WILL BECOME ELIGIBLE FOR MEDICARE IN THE NEXT 12 MONTHS, FEDERAL LAW GIVES YOU MORE CHOICES ABOUT YOUR PRESCRIPTION DRUG COVERAGE. PLEASE REFER TO THE LEGAL NOTICES IN THIS GUIDE FOR MORE DETAILS.

2017 COBRA Plan Changes

CLASSIC BROADCOM – ACTION ITEMS

In 2017 there are many changes we want to make you aware of as a COBRA participant including new medical plan options. The changes listed below provide only high-level plan information. To ensure you make the best selections to meet the needs of you and your family, you are encouraged to carefully read this Guide.

Classic Broadcom health plans will be terminating on December 31, 2016. If you wish to enroll in the Broadcom COBRA plans, you must do so during this Enrollment period to obtain coverage.

The benefits you select this fall will be effective January 1, 2017. In addition, the information below provides actions former Broadcom employees need to take during this COBRA enrollment period. **COBRA participants who wish to continue their COBRA coverage effective January 1, 2017, must enroll in the Broadcom COBRA benefit plans during this enrollment period to obtain coverage.**

- **You will need to make an active election by enrolling in a medical plan.**

  Classic Broadcom COBRA participants should be aware that if you do not access the Conexis system and make elections during this COBRA enrollment period, you will not have coverage in 2017.

  › **If you wish to have vision or dental coverage, you will need to enroll in each plan separately.**

Medical Plans

On the following pages, you will find information on the medical plans offered for 2017.

ANTHEM PLANS

- **$250 Anthem PPO –** Details for this plan follow for in network services. Please see the Medical Plan Options at a Glance section of this Guide for more information.
  - Deductible: $250 individual /$500 family, in network
  - Out of pocket maximum: $1,500 individual/ $3,000 family, in network
  - Coinsurance: The plan provides 90% plan coinsurance/10% participant coinsurance for in-network services
  - In-network office visit copays are $20 for a primary care physician visit and $30 for a specialist visit
- **Two HSA-eligible plans –** the $1,500 Deductible Anthem PPO plan and the $4,000 Deductible Anthem PPO plan.
  - Both plans provide 90% plan coinsurance/10% participant coinsurance for in-network services, after the deductible has been met.
- **$1,500 Deductible Anthem PPO plan with HRA –** This plan is closed to new enrollment for 2017. If you are a classic Avago employee and are currently enrolled in this plan, you may continue with this plan for 2017. If you have a remaining balance in your HRA from 2016, these funds will be rolled over ($750 for individual coverage, $1,500 for family) to 2017.
  - Your Anthem ID card will include information for Express Scripts (prescription). You should present your Anthem ID card when filing prescriptions at retail locations.

KAISER PLANS

- The Kaiser office visit copays are $20 for visits to a primary care physician (PCP) and $30 for specialists. Prescription drug copays are $10/$30 for retail and $20/$60 for mail order.

VISION SERVICE PLAN (VSP)

- The allowance for a standard frame is $150 for in-network. The allowance for contact lenses (in lieu of frames) is also $150. Frame replacement is every January.

NEW MEDICAL AND DENTAL IDENTIFICATION (ID) CARDS

- If you are a Classic Broadcom COBRA participant or if you change plans, new Identification (ID) Cards for the medical plans (with the exception of Kaiser CA) will be mailed to your home in mid December. Classic Broadcom COBRA participants will receive new dental ID cards for 2017. You should present your new medical and dental ID card the first time you receive service from your providers after January 1, 2017.

IRS FORM REQUIREMENT - FORM 1095C

- As part of Health Care Reform under the Affordable Care Act, you will receive a form 1095-C (Employer-Provided Health Insurance Offer and Coverage) for coverage held in 2016.

  Classic Broadcom employees will receive their forms from Broadcom Corporation by January 31, 2017.

  Classic Avago will mail the 1095c form to you by January 31, 2017. The form will provide information about the health insurance coverage offered to you by Avago.

  If you were covered under multiple plans during the year, you may receive more than one form. Please contact your tax advisor if you have questions.

  Please note: *you are responsible for ensuring your social security number and date of birth, along with that of your dependents is accurate to ensure proper filing with the IRS. Incorrect data could result in delays with filing your taxes.*

Medical Insurance

Medical coverage provides important benefits to help you stay healthy and help pay for care if you or your covered family members become sick or injured. It's also required as part of the health care reform law. Most Americans must enroll in medical insurance or pay a federal tax penalty. It's important to ensure you have coverage, either through COBRA or through another option available to you, such as your spouse's employer benefits or a government program like Medicare or Medicaid.

SELECTING A MEDICAL PLAN FOR 2017

The medical plans available to you include a range of coverage levels and costs, giving you the flexibility to select the plan that is right for you. You'll find a summary of each plan's benefits on the **Your Medical Plan Options at a Glance page. Plan costs can be found on page 10 of this guide.**

Classic Broadcom COBRA participants should be aware that if you do not access the Conexis website and make elections during this COBRA enrollment period, you will not have coverage.

CHOOSING A PLAN TO SUIT YOUR NEEDS

Consider the following when deciding on the most cost-effective medical option to meet the needs of you and your family:

Would you rather pay less monthly and more if you need care? If so, select a plan with a higher deductible and lower monthly contribution, such as the Anthem $4,000 Deductible PPO Plan with HSA.

Would you rather pay more monthly and less if you need care? If so, select a plan with a lower deductible and higher plan cost, such as the Anthem $1,500 Deductible PPO Plan with HSA.

KEY WORDS YOU SHOULD KNOW

Navigating the healthcare landscape can be challenging and it's helpful to become familiar with certain terms to understand the available plans and their design.

Copay: An amount you pay for a covered service each time you use that service. Note, all plans have a deductible. Copays do not apply toward the deductible.

Member Coinsurance: The portion of health care costs that you are responsible for once you've paid any copay and have met your deductible. Coinsurance is usually a percentage of the total medical bill. For example, if your bill is $100, and your coinsurance is 20%, you will pay $20 for your medical services if you have already met your deductible.

Deductible: The amount of money that you may need to pay out-of-pocket before your health insurance plan begins to pay for health care services. For example, if your deductible is $50, your plan won't pay for anything until you've paid the $50 deductible. Deductibles vary by health insurance plan and may not apply for every service.

Health Savings Account (HSA): An account funded by you through your own financial institution: you may be able to claim your after tax contributions on your taxes. You should consult with your tax advisor. You can continue to use the funds in your HSA to pay for qualified medical expenses in the future, even if you stop participating in COBRA through Broadcom.

Out-of-Pocket Costs: Expenses you pay yourself for health care services, including deductibles, copays and uncovered services.

Out-of-Pocket Maximum: The maximum amount you could pay for covered services in a plan year.

Plan Coinsurance: The percentage of a medical charge that your plan will pay.

Prescriptions:

- Generic medications are similar to more costly alternatives, but are not sold under a brand name.
- Formulary medications are available at a lower cost to you.
- Non-formulary medications may be purchased at a higher cost to you.

Preventive Services: Medical services and tests that keep you healthy before you become sick. These include routine check-ups, screening tests, and immunizations.

Qualifying Life Event: A change in your life that can qualify you for a special enrollment period to enroll in a health insurance plan. Examples of qualifying life events are moving to a new state, certain changes in your income, and changes in your family size (for example, if you marry, divorce or have a baby).

YOUR MEDICAL PLAN OPTIONS AT A GLANCE

The following medical plans are available to you as a COBRA participant for the January 1, 2017 through December 31, 2017 plan year.

	ANTHEM $250 DEDUCTIBLE PPO	ANTHEM $1,500 DEDUCTIBLE PPO with HRA*	ANTHEM $1,500 DEDUCTIBLE PPO with HSA	ANTHEM $4,000 DEDUCTIBLE PPO with HSA
HSA/HRA Eligible	No	Yes (HRA)	Yes (HSA)	Yes (HSA)
HSA Funding by Broadcom	N/A	N/A	No	No
HRA Funding by Broadcom	N/A	$750 employee only $1,500 family	N/A	N/A
Preventive Doctor's Visit	Covered at 100% in-network			
Prescription Drug Coverage	Provided by Express Scripts			
IN-NETWORK BENEFITS				
Individual/family Deductible	$250/$500	$1,500/$3,000	$1,500/$3,000[2]	$4,000/$8,000
Individual/family Out-of-Pocket Max	$1,500/$3,000	$3,000/$6,000	$3,000/$6,000	$6,550[3]/$13,100
Plan Coinsurance	90%	80%	90%	90%
Office Visit (Primary Care/ Specialist)	$20/$30 copay	80% after deductible	90% after deductible	90% after deductible
Retail Prescriptions - You pay [4, 5, 6]				
Generic	$10 copay	20%[1]	10% after deductible	10% after deductible
Formulary	$25 copay	20%[1]	10% after deductible	10% after deductible
Non-Formulary	$50 copay	20%[1]	10% after deductible	10% after deductible
Mail Order Prescriptions - You pay [4, 5, 6]				
Generic	$25 copay	20%[1]	10% after deductible	10% after deductible
Formulary	$62.50 copay	20%[1]	10% after deductible	10% after deductible
Non-Formulary	$125 copay	20%[1]	10% after deductible	10% after deductible
OUT-OF-NETWORK BENEFITS				
Individual/Family Deductible	$500/$1,000	$3,000/$6,000	$3,000/$6,000	$8,000/$16,000
Individual/Family Out-of-Pocket Max	$3,000/$6,000	$6,000/$12,000	$6,000/$12,000	$13,100/$26,200
Plan Coinsurance	70%	60%	70%	70%
Office Visit (Primary Care/ Specialist)	70% after deductible	60% after deductible	70% after deductible	70% after deductible
Retail Prescriptions - You pay [4, 5, 6] **(Mail Order Not Covered)**				
Generic	$10 copay[1]	20%[1]	10% after deductible	10% after deductible
Formulary	$25 copay[1]	20%[1]	10% after deductible	10% after deductible
Non-Formulary	$50 copay[1]	20%[1]	10% after deductible	10% after deductible

*** Closed to new enrollment in 2017**

1 Deductible does not apply.

2 "True family" Deductible and "True family" Out-of-Pocket Maximum applies. The family deductible must be satisfied before benefits start for any member (one family member or a combination of family members can incur expenses that add up to the deductible). In addition, the family Out-of-Pocket Maximum must be satisfied before any member is covered at 100%.

3 For family in-network coverage, the Out-of-Pocket maximum per individual is $6,550. The plan then pays at 100% for that individual. The remaining family members would pay $1,450 to meet the family deductible, then the plan would pay at 90% for the remaining family members.

4 Mandatory Generic and Exclusive Specialty provisions apply.

5 PPACA-Defined Preventive Prescription Drugs: Covered at 100% (deductible does not apply for any plan).

6 Preventive Maintenance Prescription Drugs are all subject to the applicable copay/cost sharing (deductible does not apply for any plan).

YOUR MEDICAL PLAN OPTIONS AT A GLANCE (cont.)

In addition, the following Kaiser $0 Deductible plan will be offered in California and Georgia only. Please note; there are no out-of-network benefits under this plan.

	KAISER $0 DEDUCTIBLE CALIFORNIA AND GEORGIA
HSA/HRA Eligible	No
HSA Funding by Broadcom	N/A
HRA Funding by Broadcom	N/A
Preventive Doctor's Visit	Covered at 100% in-network
Prescription Drug Coverage	Provided by Kaiser
IN-NETWORK BENEFITS	
Individual/Family Deductible	$0/$0
Individual/Family Out-of-Pocket Max	$1,500/$3,000
Plan Coinsurance	100%
Office Visit (Primary Care/Specialist)	$20/$30 copay
Retail Prescriptions [1, 2]	
Generic	$10 copay
Formulary	$30 copay
Mail Order Prescriptions [1, 2]	
Generic	$20 copay
Formulary	$60 copay
OUT-OF-NETWORK BENEFITS	**Not covered**

1 PPACA-Defined Preventive Prescription Drugs: Covered at 100%
2 Preventive Maintenance Prescription Drugs are all subject to the applicable copay/cost sharing

COST OF YOUR MEDICAL INSURANCE OPTIONS

MEDICAL – COBRA MONTHLY CONTRIBUTION

	ANTHEM $250 DEDUCTIBLE PPO	ANTHEM $1,500 DEDUCTIBLE PPO with HRA*	ANTHEM $1,500 DEDUCTIBLE PPO with HSA	ANTHEM $4,000 DEDUCTIBLE PPO with HSA	KAISER $0 DEDUCTIBLE CA	KAISER $0 DEDUCTIBLE GA
Employee	$667.36	$594.68	$558.46	$444.94	$481.53	$521.77
EE + Spouse	$1,334.71	$1,189.36	$1,116.92	$889.89	$963.05	$1,043.55
EE + Children	$1,201.23	$1,070.42	$1,005.23	$800.90	$866.76	$939.20
Family	$1,868.59	$1,665.10	$1,563.69	$1,245.85	$1,348.28	$1,460.97

*** Closed to new enrollment in 2017**

Important Prescription Drug Coverage Information for the Anthem Plans

It's important that you're aware of the following prescription information under the Anthem PPO plans.

- The formulary lists are updated on an ongoing basis and may change from the current list.
- Mandatory generic and exclusive specialty provisions apply to prescription drug coverage for all of the Anthem medical plans offered:
  - **Mandatory generic provision—**When you fill a brand drug where there is a generic equivalent, you will pay a) the difference in cost between the brand and generic drug and b) the generic copay/cost share.
  - **Mail order provision—**Mail order is the preferred method for maintenance medications. If you choose to fill your maintenance prescriptions at a retail pharmacy, you will have the ability to opt out of mail order. You will need to contact Express Scripts to make this election.
  - **Exclusive specialty provision—**Two fills are allowed at retail for specialty medications, then use of specialty pharmacy is required, or you will be required to pay 100% of the cost at retail.

HSA-eligible plans

- If you enroll in the Anthem $1,500 or $4,000 Deductible PPO plan with HSA, you must fulfill the deductible before the plan will begin to cover a portion of your prescription costs. Through our agreement with Express Scripts, the network discount will still be applied. If you have HSA funds available, they can be used to cover prescription costs and the costs will apply toward meeting your deductible.
- The Anthem $1,500 Deductible PPO plan with HSA has a "True Family" deductible which means if you elect to cover dependents (i.e., family coverage) under this plan, you must meet the entire family deductible ($3,000 per family) before the plan begins paying benefits, including prescription costs.
- Under the Anthem $4,000 PPO plan with HSA, if you are enrolled in the plan with no dependents, the $4,000 deductible must be met before plan coverage begins, including prescription benefits. If you are covering dependents, $6,550 of the $8,000 family deductible can be met by one individual. The plan would then start paying 100% of eligible in network expenses for that individual. The remaining family members will be responsible for making up the difference to reach the full family deductible of $8,000. Once the deductible is met, the plan will pay 90% of in-network, eligible medical expenses for the remaining family, until the out-of-pocket maximum has been reached.

HRA & HSA Account

The medical plans available to you include a range of coverage levels and costs, giving you the flexibility to select the plan that is right for you. You'll find a summary of each plan's features on the next page. See page 10 in this Guide for plan costs.

IMPORTANT NOTE ABOUT PLANS WITH HSAs

In 2017, Broadcom will offer two High Deductible Health Plan (HDHP) Options, the Anthem $1,500 Deductible and $4,000 Deductible PPO plans "with HSA". As a COBRA participant, you may choose any medical plan you wish, but you are not eligible to make or receive Health Savings Account (HSA) contributions through COBRA (you may be eligible to open an HSA independently through a qualified financial institution).

HEALTH REIMBURSEMENT ACCOUNT (HRA)

Available to Classic Avago COBRA members currently enrolled. Closed to new enrollment for 2017.

Details on the 2017 HRA option follow:

- Available only to participants in the Anthem $1,500 Deductible PPO with HRA plan.
- The company will provide the notional dollars towards the $1,500 Deductible PPO with HRA in the amount of $750 for individual coverage or $1,500 for family coverage. Once you are no longer enrolled in the HRA plan, you will lose access to these funds.
- Unused funds can carry over for a maximum of one (1) year while you are enrolled in the Anthem $1,500 PPO with HRA. **The company will allow you to roll over up to $750 per individual ($1,500 per family) of unused HRA funds from one plan year to the next. For example, if you participated in this plan in 2016, the funds will rollover to your HRA in 2017. Once COBRA coverage has ended, unused HRA funds will be forfeited and you will no longer have access to them.**

Dental and Vision Insurance

DENTAL

As a COBRA participant, you are eligible for two plans through Delta Dental – the Premier Plan with Orthodontia and the Standard Dental Plan. Note: If you or a family member have already reached the orthodontia maximum lifetime limit under any Delta Dental or Aetna plan, benefits will not restart for that individual.

	DELTA DENTAL PREMIER PLAN with Orthodontia	DELTA DENTAL STANDARD PLAN
Annual Maximum Benefit	$2,500	$1,500
IN-NETWORK		
Individual/family Deductible (waived for Preventive Services)	$25/$75	$50/$150
Preventive Services	Plan pays 100%	Plan pays 100%
Basic Services	Plan pays 80%	Plan pays 80%
Major Services	Plan pays 50%	Plan pays 50%
Orthodontia Services	Plan pays 50%	Not covered
Orthodontia Lifetime Maximum (in-network and out-of-network)	$2,500 (Adults and Children)	Not covered

USEFUL TERMS TO KNOW

Deductible: A dollar amount that must be paid for certain covered services before the plan begins paying benefits.

Preventive Services: Services designed to prevent or diagnose dental conditions, including oral evaluations, routine cleanings, X-rays and fluoride treatments.

Basic Services: Services such as basic restorations, some oral surgery, endodontics, periodontics and sealants.

Lifetime Maximum: The dollar amount that a plan will pay for dental care incurred by an individual enrollee or family (under a family plan) for the life of the enrollee or the plan. For example, a lifetime maximums applied to orthodontic treatment.

Major Services: Services such as crowns, dentures, implants and some oral surgery.

Orthodontia Services: Services such as straightening or moving misaligned teeth and/or jaws with braces and/or surgery.

DENTAL – COBRA MONTHLY CONTRIBUTION		
	DELTA DENTAL STANDARD PLAN	DELTA DENTAL PREMIER PLAN with Orthodontia
Employee	**$52.38**	**$60.23**
EE + Spouse	**$104.75**	**$120.46**
EE + Children	**$109.99**	**$126.49**
Family	**$162.36**	**$186.72**

VISION

You have the option to enroll in a Vision Service Plan (VSP) to keep your eyes healthy and save on eligible vision care expenses, such as eye exams, glasses and contact lenses.

VSP STANDARD PLAN		
IN-NETWORK	COPAY	FREQUENCY
Exam	$10	Every January
Contact Lens Fitting	Not to exceed $60	Every January
	RETAIL ALLOWANCE	FREQUENCY
Frames	$150; 20% off any amount over	Every January
Contact Lenses (in lieu of Frames & Lenses)	Up to $150	Every January

VISION – COBRA MONTHLY CONTRIBUTION	
	VSP STANDARD PLAN
Employee	**$10.53**
EE + Spouse	**$21.06**
EE + Children	**$22.53**
Family	**$36.00**

USEFUL TERMS TO KNOW

Copay: A specific amount you pay your VSP doctor for a service such as an exam and/or eyewear at your appointment.
Retail Allowance: The maximum amount VSP provides toward the cost of your eyewear.

Additional Benefits

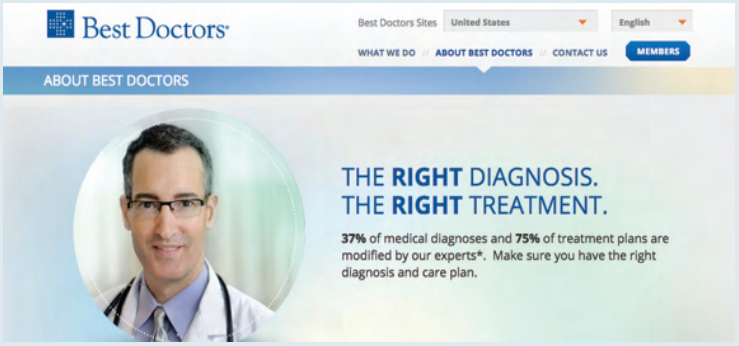
ANTHEM EMPLOYEE ASSISTANCE PROGRAM

All COBRA members and their eligible dependents are automatically covered by the Employee Assistance Program (EAP) regardless of whether they are enrolled in a Broadcom health plan. If unresolved issues are affecting the quality of your personal or professional life, it may be a signal to call the EAP at 1-800-999-7222. You can call any time day or night. A specially trained Anthem intake counselor will take your call and help you obtain the care you need with a licensed counselor in the Anthem network. You may obtain additional information on the EAP through www.anthemEAP.com, use code Broadcom.

Broadcom EAP services include (but are not limited to):

- 24/7 telephone consultation and referral
- Eight face-to-face counseling visits per employee/household member per issue
- Legal, financial and identity protection
- Tobacco cessation coaching
- Substance abuse policy consultation and recommendations
- Supervisor/manager telephone consultation

BEST DOCTORS FOR EXPERT MEDICAL ADVICE WHEN YOU NEED IT



Best Doctors is available at no cost to COBRA members and their dependents regardless of whether they are enrolled in a Broadcom health plan. The program provides confidential access to expert medical advice from more than 48,000 world-renowned doctors when you are uncertain about a medical diagnosis or treatment.

For more information or to speak with an expert, contact Best Doctors at 1-866-904-0910 or visit members.bestdoctors.com.

Members who take part in Best Doctors comprehensive case review process obtain an expert physician's medical report and benefit from the collaboration between the expert and the treating physician. Whether you're dealing with a chronic condition, questioning surgery or facing a life-threatening illness, Best Doctors can guide you in the right direction.

ACCESS TO ONLINE DOCTORS AVAILABLE THROUGH LIVEHEALTH ONLINE

Medical help is a few clicks or phone call away through the telemedicine benefit under the Anthem medical plans. Even if you, family or friends are not enrolled in an Anthem plan, LiveHealth Online is available; the full $49 cost of the visit would be payable.

The service provides convenient and affordable online medical care for non-urgent conditions like colds, aches, allergies, infections, and wellness or nutrition advice. You can meet with a doctor via video, chat or phone anytime, anywhere by accessing livehealthonline.com. No appointments are required and a record of the consultation can be forwarded to your primary care physician. Doctors in most states also can prescribe medications to local pharmacies.

Anthem members: Access livehealthonline.com. Follow the instructions to set up your account and profile. When prompted for the plan type, select Anthem Blue Cross (CA).

Non-Anthem plan members: You can set up an account by accessing livehealthonline.com. If you have questions, contact customersupport@livehealthonline.com or call 1-855-603-7985 toll free.

Contact Information

To contact a carrier or plan administrator directly, refer to the chart below.

CARRIER	COVERAGE	GROUP NUMBER	TOLL-FREE NUMBER
Anthem	Medical	Non-Colorado $250 Deductible: 174205-M1C1 $1,500 Deductible w/HRA: 174205-M3C1 $1,500 Deductible w/HSA: 174205- M2C1 $4,000 Deductible w/HSA: 174205-M4C1 Colorado Only $250 Deductible: 174205-M1C2 $1,500 Deductible w/HRA: 174205-M3C2 $1,500 Deductible w/HSA: 174205-M2C2 $4,000 Deductible w/HSA: 174205-M4C2	1-877-244-3593
Kaiser	Medical	N-CA 601092 S-CA 229295 GA 10180	1-800-464-4000
Express Scripts	Prescription	4368	1-844-595-4160
Anthem	Employee Assistance Program	174205-E1A1	1-800-999-7222
Delta Dental	Dental	02836	1-800-765-6003
VSP	Vision	30061077 0002	1-800-877-7195
Broadcom HR Information Center (HRIC)	Broadcom Human Resources	N/A	1-877-574-5463
Conexis	COBRA Administrator	N/A	1-866-206-5751

Legal Notices

Broadcom reserves the right to change, amend or terminate any benefits plan at any time for any reason. Participation in a benefits plan is not a promise or guarantee of future employment. Receipt of benefits documents does not constitute eligibility.

The COBRA Benefits Enrollment Guide (2017) combined with these legal notices, provides an overview of the benefits available to you and your family. In the event of a discrepancy between the information presented in the COBRA Guide and official plan documents, the official plan documents will govern.

STATEMENT OF MATERIAL MODIFICATIONS (ERISA PLANS)

This COBRA Benefits Enrollment Guide (2017) constitutes a summary of modifications to the employer's group health plan. It is meant to supplement and/or replace certain information in the existing plan descriptions. Please share these materials with your covered family members.

IMPORTANT NOTICE FROM BROADCOM ABOUT CREDITABLE PRESCRIPTION DRUG COVERAGE AND MEDICARE

The purpose of this notice is to advise you that the prescription drug coverage listed below under the Broadcom medical plan is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2016. This is known as "creditable coverage."

Why this is important: if you or your covered dependent(s) are enrolled in any prescription drug coverage during 2016 listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty – as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

If you or your family members aren't currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice doesn't apply to you.

Please read the notice carefully. It has information about prescription drug coverage with Broadcom and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

Notice of creditable coverage

You may have heard about Medicare's prescription drug coverage (called Part D) and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered by one of the prescription drug plans listed below, you'll be interested to know that coverage is, on average, at least as good as standard Medicare prescription drug coverage for 2016. This is called creditable coverage. Coverage under one of these plans will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

Anthem $250 Deductible PPO Plan
Anthem $1,500 Deductible PPO Plan with HSA
Anthem $4,000 Deductible PPO Plan with HSA
Anthem $1,500 Deductible PPO Plan with HRA
Kaiser California $0 Deductible Plan
Kaiser Georgia $0 Deductible Plan

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage. In this case, the employer plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop coverage, Medicare will be your only payer. You can re-enroll in the employer plan at annual enrollment or if you have a special enrollment event for the Broadcom plan.

You should know that if you waive or leave coverage with the company and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future – such as before the next period you can enroll in Medicare prescription drug coverage, if this coverage changes, or upon your request.

For more information about your options under Medicare prescription drug coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the Medicare & You handbook. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

Visit www.medicare.gov for personalized help.

Call your state Health Insurance Assistance Program (see a copy of the Medicare & You handbook for the telephone number).

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

For more information about this notice or your prescription drug coverage, contact:

HR Information Center (HRIC)
1-877-574-5463
HRIC@Broadcom.com

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS

This notice describes special circumstances which may allow you and your eligible dependents to enroll in Broadcom's group health coverage during the year. Please review it carefully.

Broadcom sponsors a group health plan (the "Plan") to provide coverage for health care services for our employees and their eligible dependents. Our records show that you are eligible to participate, which requires that you complete enrollment in the Plan and pay your portion of the cost of coverage through the company's COBRA administrator or decline coverage. A federal law called HIPAA requires we notify you about your right to later enroll yourself and eligible dependents for coverage in the Plan under "special enrollment provisions" described below.

Special Enrollment Provisions

Loss of Other Coverage. If you decline enrollment for an eligible dependent because they had other group health plan coverage or other health insurance, you may be able to enroll your dependents in the Plan if your dependents lose eligibility for that other coverage, or if the other employer stops contributing toward your dependents' other coverage. You must request enrollment within 31 days after your dependents' other coverage ends, or after the other employer stops contributing toward the other coverage. Please contact the Broadcom HR Information Center (HRIC) for details, including the effective date of coverage added under this special enrollment provision (contact information provided below).

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you gain a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll your new dependents in the Plan. You must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. In the event you acquire a new dependent by birth, adoption, or placement for adoption, you may also be able to enroll your spouse in the Plan, if your spouse was not previously covered. Please contact the HRIC for details, including the effective date of coverage added under this special enrollment provision (contact information provided below).

Contact Information:

HR Information Center (HRIC)
1-877-574-5463
HRIC@Broadcom.com

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) NOTICE

Women's Health and Cancer Rights Act Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your medical plan provider, Anthem or Kaiser.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA OR "NEWBORNS' ACT") NOTICE

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

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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 below, 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, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW or www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your 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 **1-866-444-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 July 31, 2016. Contact your State for more information on eligibility.

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: www.myalhipp.com Phone: 1-855-692-5447	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ALASKA – Medicaid	**INDIANA – Medicaid**
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Medicaid	IOWA – Medicaid

COLORADO – Medicaid	IOWA – Medicaid
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	**KANSAS – Medicaid**
Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/publicassistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
SOUTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/ index.aspx Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)

BROADCOM HIPAA PRIVACY NOTICE

Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by health plans. This information, known as protected health information (PHI), includes almost all individually identifiable health information held by a plan — whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of these plans:

Medical: Anthem $250 Deductible PPO Plan, Anthem $1,500 Deductible PPO Plan w/ HRA, Anthem $1,500 Deductible PPO Plan w/ HSA, Anthem $4,000 Deductible PPO Plan w/ HSA
Pharmacy: Express Scripts Pharmacy Benefits
Dental: Delta Dental Standard and Premier PPO Plans
Health Care Flexible Spending Account Plan
Limited-Use Flexible Spending Account Plan

The plans covered by this notice may share health information with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

The Plan's duties with respect to health information about you

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not Broadcom as an employer – that's the way the HIPAA rules work. Different policies may apply to other company programs or to data unrelated to the Plan.

How the Plan may use or disclose your health information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- **Treatment** includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.

- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing "behind the scenes" plan functions, such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.

- **Health care operations** include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include evaluating vendors; engaging in credentialing, training, and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

How the Plan may share your health information with Broadcom

The Plan, or its health insurer, may disclose your health information without your written authorization to the company for plan administration purposes. The company may need your health information to administer benefits under the Plan. The company agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Benefits, payroll, and/or finance staff are the only employees who will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Plan and Broadcom, as allowed under the HIPAA rules:

- The Plan, or its insurer, may disclose "summary health information" to the company, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.

- The Plan, or its insurer, may disclose to the company information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option offered by the Plan.

In addition, you should know that Broadcom cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by the company from other sources – for example, under the family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs – is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative. The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, If made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the plan's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death

Research purposes	Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are armed forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or programs if the Plan is being paid to make those communications. If we keep psychotherapy notes in our records, we will obtain your authorization in some cases before we release those records. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use, or disclosure of your unsecured health information as required by law.

The Plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

Your individual rights

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right.

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death – or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid out of pocket and in full for the item or service.

Right to receive confidential communications of your health information

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible on site), the Plan will provide you with one of these responses:

- The access or copies you requested.
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint.
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous, and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous, and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan's cost.

Right to amend your health information that is inaccurate or incomplete

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).• Incidental to other permitted or required disclosures.

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

- Make the amendment as requested.
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint.
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- For treatment, payment, or health care operations.
- To you about your own health information.
- Incidental to other permitted or required disclosures.
- Where authorization was provided.
- To family members or friends involved in your care (where disclosure is permitted without authorization).
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances.
- As part of a "limited data set" (health information that excludes certain identifying information).

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the Plan upon request

You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the information in this notice

The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on January 1, 2017. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice.

Complaints

If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint, contact:

Anthem Medical Plans
Anthem Blue Cross Life and Health Insurance Company
Attn: Customer Service Department
21555 Oxnard St.
Woodland Hills, CA 91367
(877) 244-3593

Delta Dental Plans
Delta Dental
c/o Compliance
P.O. Box 997330
Sacramento, CA 95899-7330
(800) 765-6003

Express Scripts
Privacy@Express-Scripts.com

Contact

For more information on the Plan's privacy policies or your rights under HIPAA, contact the plan administrator or a representative from the plans listed below:

Plan Sponsor/Administrator
Avago Technologies
1320 Ridder Park Drive
San Jose, CA 95131
(877) 574-5463
Email: HRIC@Broadcom

Anthem Medical Plans
Anthem Blue Cross Life and Health Insurance Company
Attn: Customer Service Department
21555 Oxnard St.
Woodland Hills, CA 91367
(877) 244-3593

Express Scripts
Privacy@Express-Scripts.com

Delta Dental Plans
Delta Dental
c/o Compliance
P.O. Box 997330
Sacramento, CA 95899-7330
(800) 765-6003

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