Capital One | Benefits

SUMMARY PLAN DESCRIPTION

Employee Welfare Benefits Plan

Effective January 1, 2024

CAPITAL ONE FINANCIAL CORPORATION

Benefits are an important part of your total rewards from Capital One. Our goal is to provide a comprehensive, balanced and competitive benefits program that offers flexibility and choice. Our benefits are intended to help you *Be Well* physically, financially, and emotionally.

The benefits program offers the opportunity for every regular, full-time and eligible part-time associate of Capital One (as defined in "Who Is Eligible for Plan Benefits") to participate in the various benefits offered by the program.

This summary document, along with the supporting documents included in the *Appendix*, serves as the Summary Plan Description (SPD) for the Capital One Financial Corporation Employee Welfare Benefits Plan (the "Welfare Plan" or the "Plan"). The SPD is intended to help you understand the terms of the Plan and use the Plan's benefits most effectively. This is designed to be easy to use — whether you read it cover to cover or simply use it as a reference when you have a specific question:

- Each section features a "Benefits at a Glance" summary
- This summary document provides an overview of each benefit plan while additional details can be found in the supporting documents as listed in the *Appendix*

We hope this helps you locate the information you need quickly and makes it easy to understand.

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WHERE TO GO WITH QUESTIONS

Each benefit under the Plan is explained in the applicable section of this SPD with additional supporting details located in the *Appendix*. Review this information to learn more about our benefits and how they can help you. If you still have questions, here is who to call for each benefit:

For Questions About	Contact
Enrolling in or Making Changes to Your Benefit Elections	Capital One HR Benefits Center 888-376-8836 www.mybewellbenefits.com
Medical Coverage	Anthem Blue Cross and Blue Shield (Anthem Health Guide) 844-390-4133 www.anthem.com/capitalone
Prescription Drug Coverage	CVS Member Services 877-210-3556 www.caremark.com
Wellness Programs	Evive https://capitalone.myevive.com
Be Well Health Center	For contact information on Health Center locations, visit the Health Center Pulse page www.mypremisehealth.com
Vision Coverage	Anthem Blue View Vision℠ 866-723-0515 www.anthem.com/capitalone
Dental Coverage	Delta Dental of Virginia 844-344-8006 www.deltadentalva.com/members/capital-one
Health Care and Dependent Care Flexible Spending Accounts/ Health Savings Account (HSA)	Anthem Spending Accounts 844-390-4133 www.anthem.com/capitalone
Employee Assistance Program	Anthem 855-383-7222 www.anthemeap.com (login: Capital One, no password required)

For Questions About	Contact
Life and AD&PL Insurance Associate / Dependent Business Travel Accident	The Hartford 877-867-4790 http://enroll.thehartfordatwork.com/Caponebene
Short-Term Disability	Capital One Leave and Accommodation Service Center, managed by Sedgwick 844-324-CAP1 (2271) https://claimlookup.com/capitalone.com
Long-Term Disability	NY Life 800-238-2125 https://www.mynylgbs.com/
Retiree Life and Medical Coverage	Mercer Marketplace 365+SM Retiree 855-207-1979 (For deaf or hard of hearing: Dial 711 for Telecommunications Relay Service) Fax: 857.362.2999 http://retiree.mercermarketplace.com/capitalone
Medicare	Medicare 800-MEDICARE (800-633-4227) www.medicare.gov
COBRA	Anthem Blue Cross Blue Shield (Health Equity) 877-775-9393 www.benefitadminsolutions.com (select Anthem Blue Cross Blue Shield [Anthem] from the drop-down)

IMPORTANT INFORMATION ABOUT THIS SPD

This SPD is designed to help you learn about and understand the benefits under the Plan, which include medical (including prescription drug coverage), wellness, dental and vision coverage (together, referred to as healthcare coverage), as well as flexible spending accounts, life, accidental death & personal loss (AD&PL), business travel accident (BTA), disability coverage, purchased time off and the health centers offered by Capital One to eligible associates.

This summary document, along with the supporting documents listed in the *Appendix*, serves as the Summary Plan Description (SPD) for the Capital One Financial Corporation Employee Welfare Benefits Plan (the "Welfare Plan" or the "Plan"). The Welfare Plan document together with this SPD and applicable contracts for benefits provided under the Plan constitute the official "plan documents" that govern Capital One's health and welfare benefits. If there is ever a conflict or a difference between what is written in this summary document and the supporting documents with respect to the specific benefits provided, the supporting documents shall govern unless otherwise provided by any federal and state law. If there is a conflict between the supporting documents and this summary document with respect to the legal compliance requirements of ERISA and any other federal law, this summary document will rule.

As you read through this SPD and supporting documents, keep in mind that as a matter of prudent business planning, Capital One continually reviews and evaluates proposals for changes in its benefits under the Plan. These proposals, if approved, could be more or less advantageous to you than the current benefits. Capital One reserves the right to end, suspend or amend the benefits under the Plan at any time, in whole or in part, for whatever reason. Until Capital One formally announces the changes in writing in the applicable plan documents, no one is authorized to give assurances that any changes will be or have been made.

In addition, please note that nothing in this document states or implies that participation in this Plan is a guarantee of employment with the company. Employment with Capital One is "at will," meaning that you or the company may end your employment at any time, for any reason, within the limitations of the law. Further, nothing in this document guarantees that benefit levels will remain unchanged in the future.

All references to "associates" refer to benefits available to full-time associates and eligible part-time associates (each as defined under "Who Is Eligible for Plan Benefits"), unless specifically designated as being available only to full-time associates or unless otherwise noted.

The benefits described in this SPD are effective January 1, 2024, unless otherwise noted.

IMPORTANT INFORMATION ABOUT THIS SPD

Benefits covered by the Health and Welfare plan

The Plan includes the following benefits:

- Medical Coverage, including Prescription Drug Coverage
- *Be Well* Program
- Health Centers
- Dental Coverage
- Vision Coverage
- Employee Assistance Program (EAP)
- Flexible Spending Accounts — Health Care and Dependent Care
- Health Savings Account (HSA)
- Basic Life and Accidental Death and Personal Loss (AD&PL)
- Supplemental Life and Accidental Death and Personal Loss (AD&PL)
- Dependent Life and Accidental Death and Personal Loss (AD&PL)
- Business Travel Accident (BTA)
- Short-Term Disability
- Long-Term Disability
- Purchased Time Off

Hawaii associates have access to health benefits (medical, dental and vision) through HMSA. See the *Hawaii Health Plan* documents in the *Appendix* for more information including enrollment and eligibility rules.

ELIGIBILITY

In this section

Who is eligible for plan benefits

The benefits provided by this plan are for full-time and eligible part-time U.S. based associates paid through Capital One's U.S. payroll, who are deemed by Capital One to be common law employees (or former employees, as applicable) of Capital One Financial Corporation, including any applicable U.S. subsidiaries.

Standard Hours are used to determine benefits eligibility and are maintained by people leaders in Workday as "Weekly Scheduled Hours." Standard Hours are the number of hours associates are scheduled to work each week, as maintained in Capital One's system of record (Workday), and may not be reflective of actual hours worked in any given week.

Full-Time Associates

If you are a full-time associate who has regularly scheduled Standard Hours in Capital One's system of record of 33 hours or more each week and you are designated by Capital One as a full-time associate, you are eligible for the following Capital One health and welfare benefits as of your date of hire (except as stated below):

- Medical and pharmacy benefits
- Wellness benefits
- Dental benefits
- Vision benefits
- Employee Assistance Program (EAP) benefits
- Flexible spending accounts
- Health Savings Account (HSA)
- Life/AD&PL insurance
- Business travel accident insurance
- Health center access
- Disability (short and long-term) benefits*
- Purchased Time Off

* If you are a full-time associate you are automatically covered for Short-Term Disability at no cost to you (1) after you have been employed for 90 calendar days or, (2) on your first day of employment in the event that you are diagnosed with a communicable or infectious disease in connection with a public health emergency, as defined by Capital One.

Part-Time Eligible Associates

If you are a part-time eligible associate who has Standard Hours in Capital One's system of record of at least 20 hours and less than 33 hours each week and are designated by Capital One as a part-time associate, you are eligible to participate in the following health and welfare benefits effective your date of hire or the date in which your standard hours met or exceeded 20 hours per week (except as noted below):

- Medical and pharmacy benefits
- Wellness benefits
- Dental benefits
- Vision benefits
- Employee Assistance Program (EAP) benefits
- Health Center Access
- Flexible spending accounts
- Health Savings Account (HSA)
- Life/AD&PL insurance
- Business Travel Accident insurance

- Long-Term Disability coverage*
- Purchased Time Off

* Part Time Eligible Associates are not eligible for Short-Term Disability coverage

Part-Time Associates with Less than 20 Standard Hours

If you're a part-time associate with fewer than 20 Standard Hours, you are eligible for Business Travel Accident insurance, EAP and health center access. However, you are generally ineligible for other benefits under the Plan.

Credited Service

For the purposes of determining your eligibility and participation in the benefits programs, your "service" generally means the length of time you actually work for Capital One. This includes:

- Service you earned with a predecessor employer whose stock or assets were acquired by Capital One, except with respect to the Retiree Medical and Life Insurance programs or to the extent the Board provides otherwise.
- Service you earned before you left employment with Capital One. See "Breaks in Service" below for more details.

Breaks in Service

If you leave Capital One and are later rehired, the period during which you were not working at Capital One is called a "break in service."

- If your break in service is one year or less, service will be credited as of your original date of hire.
- If your break in service is more than one year and less than five years, service will be calculated as your original date of hire, minus the elapsed time of any breaks in service (calculated to the day).
- If your break in service is more than one year and your employment ended due to restructuring as defined by the Capital One Executive Severance Plan or the Capital One Associate Severance Plan (whichever applies to you), your service will be calculated as the original date of hire, minus the elapsed time of any breaks in service (calculated to the day).
- Any break in service of greater than five years where the termination of employment was not due to retirement or restructuring will not be credited.

If you have questions about your individual situation, call the HR Help Center at 888-376-8836.

If your break in service is greater than 30 days, you must re-enroll to participate in any benefits offered under the program.

Expatriate Associates

If you are an expatriate associate (those living outside the U.S. but still on the U.S. payroll), you are eligible to participate in life and AD&PL Insurance, BTA, Flexible Spending Accounts, Short-Term Disability and Long-Term Disability coverage through the Plan. You are not eligible for health center

access or medical, dental or vision coverage under the U.S. Plan. However, medical (including prescription drug), dental and vision coverage, as well as the Employee Assistance Program (EAP) is offered to Expatriate Associates through Cigna. Global transfers who are not on U.S. payroll are not eligible to participate in U.S. benefits.

Eligible Dependents

- **For medical (including prescription drug), dental and vision benefits**, you may cover yourself, your spouse or domestic partner and your children as long as the eligibility criteria are met as described below. Your medical, dental and vision coverage choices apply to you and all of your enrolled dependents. You must be covered under the Plan in order to cover any eligible dependent. To cover your domestic partner's children under the medical, dental or vision plan, your domestic partner must also be enrolled in the plan.
- **For life and AD&PL insurance**, you may cover yourself, your spouse or domestic partner, and your dependent children (including the children of your domestic partner). Eligible members must be a citizen of the U.S. or a legal permanent resident of the U.S. and must not be actively enrolled in the military. In addition, the eligibility criteria described below must be met.
- **For short-term disability and long-term disability coverage**, you may cover yourself only.
- **For the EAP**, you and any members of your household may access services.
- **For the *Be Well* Health Centers**, you and any dependents (between the ages of 2 and 26) eligible for medical coverage are able to access services. Enrollment in the medical plan is not required to access services.

Note that additional eligibility requirements may apply as outlined in the carrier documents located in the *Appendix*.

Definitions of Eligible Dependents

- Spouse — Your spouse is the person to whom you are legally married, as recognized by the laws of at least one state, possession, or territory of the United States, regardless of where you live.
- Domestic Partner — A domestic partner is a person of the same or opposite gender as you, with whom you share your life. To be eligible, you and your domestic partner must both be at least 18 years of age and not related by blood. You and your domestic partner must satisfy these requirements:
    - You are each other's sole domestic partner and intend to remain so indefinitely
    - You reside in the same residence
    - You are financially interdependent
    - You are not legally married to anyone else

The tax implications of covering a domestic partner are detailed in the ***Participation*** section.

At any time, you cannot cover more than one person as your spouse/domestic partner.

- Eligible Children — Generally, children are considered eligible for applicable benefits if they are:

    - Your married or unmarried children (including adopted children, foster children in your care and stepchildren). Your children are eligible from the day they are born, adopted, or placed with you as a foster child until the end of the month in which they turn 26.
    - Your domestic partner's biological or adopted children, if
        - You cover your domestic partner
        - The children under 26 (eligible until the end of the month in which they turn 26)
        - They live in your household

- **Dependent children who are intellectually or physically disabled and cannot care for themselves may be covered beyond age 26** — A dependent child with an intellectual or physical disability that keeps them from self-sustaining employment may be eligible for coverage beyond age 26. You must provide written documentation to the appropriate carrier (e.g., Anthem Blue Cross and Blue Shield, Delta Dental, The Hartford, etc.) of your child's condition within 31 days of the child's 26th birthday or within 31 days of adding your child to the plan(s), and periodically thereafter as may be requested. Your child is fully disabled if they are unable to earn their own living because of an intellectual or physical disability that started before the date they reach the maximum age for dependent children, and they depend solely on you for support and maintenance. Approval from each carrier is required.

- **Other minor children** — If you are the legal guardian for a child who does not meet the criteria above, you may cover them under the Plan by providing the required documentation.

Proof of Eligibility

You may be required from time to time to provide proof of your dependents' eligibility upon request. False or misrepresented eligibility information may cause both your coverage and your dependents' coverage to be irrevocably terminated (retroactively to the extent permitted by law), and could be grounds for employee discipline — up to and including termination. Failure to provide timely notice of loss of eligibility will be considered intentional misrepresentation. If your coverage is terminated retroactively due to fraud or misrepresentation, you will forfeit any contributions made.

Special Eligibility Rules

Eligibility for COBRA

Continuation of some Capital One benefits may be available under COBRA when you lose eligibility for your benefits. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations, see "Group Health Continuation under COBRA — Coverage Rights".

If you and your spouse/domestic partner both work for Capital One

If you and your spouse or covered domestic partner are both associates of Capital One or one of its subsidiaries, you may each choose "associate-only" coverage under the medical, dental and/or

vision benefits, or one of you may cover yourself and your spouse or domestic partner under these benefits. If you both choose to cover yourself and your spouse or domestic partner, please note that there is no benefit of doing so.

You may cover your spouse or domestic partner for dependent life and AD&PL insurance even if he or she already has life and AD&PL insurance through Capital One. If you have children, you and your spouse or domestic partner may both cover the children for dependent life and AD&PL coverage.

Eligibility While on a Leave of Absence

When you are out of work on a leave of absence, you may be eligible to continue participation in the Plan. See “Leaves of Absence and Your Benefits" for more detailed information.

Who is not eligible for plan benefits

Non-eligible Capital One Associates

You are not eligible for benefits under the Plan if you:

- Are not on the Capital One’s U.S. payroll, or
- Are classified by Capital One as a contractor, leased employee or temporary employee (including for example summer interns not paid by Capital One or cooperative education student employees), even if you are on Capital One’s U.S. payroll, except to the extent required by law, or
- Are not deemed an eligible participant in the “Who Is Eligible for Plan Benefits” section.

It is solely within the authority of the Plan Administrator to determine whether you are eligible for Plan benefits. A person whom the Plan Administrator determines is not an employee will not be eligible to participate in the Plan regardless of whether a court or tax or regulatory authority determines that the person is an employee. A person the Plan Administrator determines is not an employee and who is later required to be reclassified as an employee will only be eligible prospectively, provided all other eligibility requirements are met.

Non-eligible Dependents

You may not cover anyone that does not meet the eligibility criteria described in this section including but not limited to, parents, divorced spouses or grandparents — even if they are your legal dependents. You may not cover grandchildren, unless you are their legal guardian. You may not cover children who are not related to you (other than stepchildren or the children of your covered domestic partner), unless you have legal guardianship.

PARTICIPATION

In this section

Enrollment

How to Enroll

As a new hire or newly benefits eligible associate, you will access the online enrollment process by going to Workday where you will have the opportunity to enroll yourself and your eligible dependents. Once a year during Open Enrollment, you may change your benefits coverage elections for the following year. You may change your benefits elections outside of the Open Enrollment window only if you have a qualifying life event.

If you do not enroll or make changes within 31 days of hire or the qualifying life event, you cannot enroll or make changes until Open Enrollment for the next Plan year unless you experience a qualifying life event.

Once you submit your enrollment, review your benefits confirmation statement. If you need to make any corrections, you must notify the HR Benefits Center within one business day. Requests for changes are subject to review.

What Happens If You Don't Enroll

If you do not enroll in benefits:

- In your first 31 days of your employment, or
- During the first 31 days that you are eligible to participate in benefits if you become eligible to participate for a reason other than your new employment

You will receive "default coverage," as shown in the following table. In some cases, default coverage means no coverage at all. It is in your best interest to meet enrollment deadlines to ensure that you get the coverage you and your family need.

Default Benefits Coverage

Benefits	Default Coverage
Medical, Vision, Dental, Flexible Spending Accounts (FSA), Health Savings Account (HSA)	No coverage.
Basic Life/AD&PL Insurance	You are automatically enrolled at one times your Annual Benefits Salary, rounded to the next higher $1,000, if not already a multiple of $1,000. Note: Executives (VP+) receive automatic ELIP coverage under a different formula.
Supplemental Life and AD&PL Insurance and Dependent Life and AD&PL Insurance	No coverage.
Business Travel Accident Insurance	You are automatically covered at 5 times your Annual Benefits Salary, rounded up to the nearest $1,000 if not already a multiple of $1,000.
Short-Term Disability (STD)	Full-time associates are automatically covered (1) after you have been employed for 90 calendar days, or, (2) on your first day of employment in the event that you are diagnosed with a communicable or infectious disease in connection with a public health emergency, as defined by Capital One. Part-time associates are not eligible for this coverage.
Basic Long-Term Disability (LTD)	You are automatically covered at 50% of your Annual Benefits Salary (Basic LTD).
Supplemental Long-Term Disability (LTD)	No coverage.
Employee Assistance Program (EAP)/Health Centers	Automatically covered — enrollment not required
Purchased Time Off	No coverage. Only available to elect during Annual Open Enrollment.

Paying for Benefits

General Information

Some of the benefits provided to eligible associates by Capital One are paid for entirely by the company, including EAP, Basic and ELIP Life/AD&PL Insurance, Business Travel Accident Insurance, and Short-Term and Basic Long-Term Disability. For other benefits that you elect, either you and Capital One share the cost of paying for this coverage or you may be responsible for the entire cost (as in, for example, supplemental life insurance or purchased time off). In accordance with your elections, you pay your portion of the cost for the following benefits with convenient, generally pre-tax, deductions directly from your paychecks:

- Medical
- Dental
- Vision
- Supplemental Life and AD&PL Insurance and Dependent Life and AD&PL Insurance*
- Supplemental Long-Term Disability*
- Purchased Time Off
- Health Savings Account contributions
- Flexible Spending Account contributions

* Your costs for Supplemental and Dependent Life and AD&PL Insurance, and Supplemental Long-Term Disability are after-tax, not pre-tax.

Pre-tax deductions are taken from your pay before federal, Social Security (FICA), and most state and local taxes are deducted. Pre-tax deductions reduce your taxable income, so you pay less in taxes.

Capital One makes no guarantees that your coverage elections will be excludable from your gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply.

Effect of pre-tax dollars on other benefits

Pre-tax dollars reduce your income for tax purposes only. They do not affect the pay level used to determine your pay-related benefits under any company-sponsored benefit option.

Using pre-tax dollars gives you immediate tax savings. Keep in mind, however, that using pre-tax dollars to pay for most of your benefits reduces the Social Security taxes you pay. Since you may be paying lower Social Security taxes, any future Social Security benefits you may be eligible to receive could be reduced. This is not a large reduction for most people.

Paying for Domestic Partner Coverage

Like the medical, dental, and vision coverage you purchase for yourself or another dependent, you pay your portion of the coverage premium(s) for domestic partner coverage through easy payroll deduction, and Capital One subsidizes the cost equal to that which it pays toward spouse coverage. However, unless your domestic partner and their dependent children, if any, are considered your federal tax dependents under the Internal Revenue Code for health benefit purposes, as described below, the Internal Revenue Service currently treats the value of this domestic partner coverage as imputed income to you (less any contributions paid by you on an after-tax basis for this coverage). Capital One will provide associates covering a domestic partner with a gross-up amount, to help cover the taxes owed on these benefits.

In general, a domestic partner or their child who is a member of your household qualifies as your tax dependent for medical, dental and vision coverage only if:

- They receive more than 50% of their financial support from you;
- They live with you (shares a personal residence) for the full tax year (except for temporary reasons such as vacation, military service or education);
- They are a citizen, national or legal resident of the United States; or a resident of Canada or Mexico; or is a child being adopted by a U.S. citizen or national;
- They are not a section 152 qualifying child dependent on another taxpayer's filed return or is a section 152 qualifying child dependent on another taxpayer's return where the filing is only to get a refund of withheld income taxes; and
- Your relationship is not in violation of any local law.

To comply with IRS requirements:

- The cost of your domestic partner's coverage is deducted from your pay on a post-tax basis (after taxes are taken); and
- Capital One's contribution toward your domestic partner's coverage is added to your earnings and taxed, then that amount is deducted after taxes are taken in order to determine your net pay.

You are advised to consult with your tax advisor to determine if your domestic partner or their dependent children are your federal tax dependents and to review the tax consequences of electing domestic partner benefit coverage.

In general, state income tax treatment of domestic partner benefits is the same as the federal income tax treatment. However, certain benefits for domestic partners and their children who are not your federal tax dependents may be eligible for special state income tax treatment in a few select states.

Changing Coverage Elections

Open Enrollment

Once a year, associates are given an opportunity to make changes to their coverage for the following Plan Year. Unless otherwise communicated during Open Enrollment, most coverage elections for the new Plan Year will default to the prior year's coverage if no elections are made. Elections for Flexible Spending Accounts, Health Savings Account and Purchased Time Off do not carry over to the following year and must be made annually during the Open Enrollment window.

In the event a plan is terminated for the following Plan Year, you may be defaulted into coverage that is most similar to your existing coverage, and communicated in Open Enrollment communication materials.

Please note that if you make a change to your benefit elections for the current year due to a qualifying life event after the Open Enrollment window has opened, some of your elections for the new plan year will not carry over. You will need to also make the changes to your Open Enrollment event.

Enrollment for benefits during Open Enrollment will take place in Workday. If you are unable to access Workday during the Open Enrollment window, you should make your elections by calling the HR Benefits Center at 888-376-8836.

Mid-Year Changes due to Qualifying Live Events

You may make changes to your benefit elections during the year (outside the Open Enrollment window) only if you experience an eligible status change. The most common status changes include:

- A change in legal marital status (marriage, divorce, legal separation, annulment or death of a spouse);
- A change in the number of dependents as a result of birth, adoption, change in guardianship, death, and establishment or dissolution of a domestic partnership;
- A change in employment status for you, your spouse, domestic partner or dependent (such as termination or commencement of employment; commencement of or return from an unpaid leave of absence);
- A gain or loss of coverage outside of Capital One's Health and Welfare plans;
- A change in place of residence for you, your spouse/domestic partner or dependent, where the change affects your access to the benefit, such as moving outside of the United States or moving to the United States from another country;

- A change in eligibility for coverage as a result of a judgment, decree or order (including a Qualified Medical Child Support Order); or
- Any event that causes a dependent to satisfy or cease to satisfy the requirements for coverage as specified in the plan(s).

IRS rules require that the change to your benefits be because of and consistent with the status change. For example, if you get married, you can enroll your new spouse in benefits for which spouses are eligible. Additionally, you may not switch medical or dental plans mid-year, but you may add/remove dependents or add/cancel coverage.

The benefits change is effective on the actual date of the event.

See the "Status Change Matrix" document noted in the *Appendix* for a summary of what changes can be made to your coverage based on various status changes.

All events are effective on the actual date of the event, and you must initiate your benefit change within 31 days of the event date (or 60 days in the event of birth/adoption or loss/gain of government sponsored medical coverage). If you do not enroll or make changes within the 31 day deadline (or 60 days in the event of birth/adoption or loss/gain of government sponsored medical coverage), you cannot enroll or make changes until Open Enrollment for the next Plan year or until you experience another qualifying life event.

Once you submit your enrollment, review your benefits confirmation statement. If you need to make any corrections, you must notify the HR Benefits Center within one business day. Requests for changes are subject to review.

HIPAA Special Enrollment

If you decline enrollment for Medical benefits for yourself or your eligible dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and your eligible dependents (including domestic partners) in the Medical benefits provided under this Plan if you or your eligible dependents lose eligibility for that other coverage (or if the other employer stops contributing towards your or your dependents' other, non-COBRA coverage). However, you must request enrollment within 31 days after your or your eligible dependents' other coverage ends (or after the other employer stops contributing toward the other, non-COBRA coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself, your spouse, and your new eligible dependent children in the Plan's Medical benefits. However, you must request enrollment within 31 days after the marriage OR 60 days after the birth, adoption, or placement for adoption.

If you have one of these events and notify Capital One within 31 days (60 days in the case of birth or adoption of a child) of the event, you can change your medical coverage election to:

- Add a new spouse or dependent
- Enroll in coverage
- Drop coverage

Capital One also will allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for your state's premium assistance program under Medicaid or Children's Health Insurance Program (CHIP).

For these enrollment opportunities, you will have 60 days — instead of 31 days — from the date of the Medicaid/CHIP eligibility change to request enrollment in a Capital One medical benefit option.

See "Your HIPAA Privacy and Security Rights" in the *Legal Notices* section for more about your rights under HIPAA.

Other Events that Allow You to Change Elections

- **QMCSOs**: If a Qualified Medical Child Support Order (QMCSO) requires the Plan to provide coverage to your child, then the Plan Administrator (as defined in the "Plan Administrator" section) may change your election under the Plan to provide coverage for that child. In addition, you may make corresponding election changes because of the QMCSO, if you desire. If the QMCSO requires another person (such as your spouse or former spouse) to provide coverage for the child, then you may cancel coverage for that child under the Plan if you provide proof to the Plan Administrator that such other person actually provides the coverage for the child.
- **Cost Changes**: If there is a significant increase or decrease in the cost of medical, dental or vision coverage, you may be permitted to revoke your election and make a corresponding new election. If you previously declined coverage, you may also make a corresponding new election. Any change in the cost of your benefit option that the Company determines is *not* significant will result in an automatic increase or decrease, as applicable, in your share of the total cost.
- **Coverage Changes**: The following are additional situations in which you may change your current coverage:
    - **Restriction or Loss of Coverage**: If your coverage is significantly restricted or ceases entirely, you may revoke your elections and elect coverage under another option that provides similar coverage. Coverage is considered "significantly restricted" if there is an overall reduction in benefits coverage.

- **Addition to or Improvement in Coverage**: If Capital One adds a coverage option or significantly improves a coverage option during the year, you may revoke your existing election and elect the newly added or newly improved option.

Health Savings Account Contribution Changes

If enrolled in the CDHP medical plan, you may change your Health Savings Account (HSA) contribution amount anytime throughout the year, without a qualifying life event.

Dependent Care Flexible Spending Account Cost or Coverage Changes

In addition to the changes described above, you may make mid-year election changes to your Dependent Care Flexible Spending Account if you have one of the following events:

- An increase or decrease in dependent care provider fees (except for increases by a provider who is related to you);
- You choose a different dependent care provider who charges a different amount;
- You make a change to you or your spouse's regular work schedule that increases or decreases your need for dependent care; or
- You enroll or remove your dependent from a dependent care provider.

How to Initiate a Change in Your Benefits

If you experience a qualifying change in status or a HIPAA special enrollment event and want to update your benefits coverage, you must initiate the process within 31 days (60 days for birth, adoption, Medicaid/CHIP eligibility changes, or Supplemental Life and AD&PL coverage), starting with and including the actual date of the event. The reason for making the change must be true and accurate.

If you miss the deadline, you cannot make any changes until the following Open Enrollment window. In addition, if you experience a status change, the changes you can make may be limited, so choose carefully.

Here are some examples that illustrate the process to make changes to your elections:

- Marriage: You are planning to get married on May 15 and want to add your spouse to your benefits coverage. You must initiate the status change within 31 days of the event, starting with and including May 15. Coverage will be effective on May 15, provided you give notice within the 31-day notification period. The coverage effective date also applies to any dependent children acquired through marriage.
- Birth of a Child: Your child is born on October 2, and you want to cover the child for benefits. You have 60 days to initiate the online status change. As long as you initiate the status change process within that 60-day period, your child's coverage will go into effect on the date of birth. Even if you wait until the 60th day, counting from the date of the birth,

your child will receive benefits coverage from the date of birth. Remember, you must complete the online status change within 60 days of the date of birth.

Visit the Workday benefits application to process your status change online. You must initiate your status change within 31 days of the date of the change in status (60 days for the birth/adoption of a child, or loss/gain of government-sponsored coverage). If you miss the enrollment window, you cannot make changes until the next Open Enrollment period unless you experience another qualifying life event.

If you submit your elections and need to make a change, you must notify the HR Benefits Center within one business day. Requests for changes are subject to review.

Leaves of Absence and Your Benefits

A leave of absence has different effects on your benefits, depending on whether your leave is on a paid or unpaid basis.

Paid Leave of Absence

If you take a paid leave of absence, such as parental leave or jury duty, your participation in the Capital One benefit options in which you are enrolled generally continues just as if you were working.

You are no longer eligible for Life Insurance benefits once you have been on a leave of absence for two consecutive years. If you lose Life Insurance benefits due to being on a leave of absence for over two consecutive years, you must request to re-enroll in any supplemental life coverage within 31 days of your return from leave by calling the HR Benefits Center at 888-376-8836.

Unpaid Leave of Absence

While you are on a leave of absence that is unpaid, (including Long-Term Disability and Workers Compensation, where payments to you are made through an insurance company or vendor), you won't be receiving a paycheck from the Company which means payments for your benefits will not automatically be made. You will need to pay for your benefits in order to continue receiving them.

- If you are on an unpaid leave which typically is longer-term*, meaning you miss more than a few paychecks, you may receive a bill from Anthem Blue Cross Blue Shield (BCBS) for your portion of benefit premiums. You are responsible for remitting timely payment directly to Anthem BCBS while you're out on leave in order to prevent any potential disruption to your coverage. Note that some of your supplemental life and disability benefits will not display on your bill. No action is required from you on these benefits, they will be collected from your paycheck when you return to work.

* Leaves that fall into this category include Long-Term Disability, Educational Leave, Personal Leave of Absence and Workers Compensation

- If your unpaid leave is short-term*, meaning only missing a couple of paychecks, you don't need to take any action. Any premiums that were not withheld during those paychecks will be deducted once you return to work.

*All other unpaid leaves not mentioned above fall into this category

Returning to work: Following your return to work, we will determine if you have any unpaid benefits and you will be caught up on any balance due through payroll. You will have your normal payroll deductions for benefits plus a portion of your missed deductions until your missed deductions have been paid and your balance is brought current.

Flexible Spending Accounts/Health Savings Account: If you are currently enrolled in a Flexible Spending Account or Health Savings Account, the account will remain active during your leave but your contributions will be stopped. Contributions will begin again once you return to work. Please note that you may not receive all Dependent Care FSA or HSA contributions for the calendar year if you don't return to work or if your deductions aren't fully recouped, as described above, once you return from your leave.

If you are on an approved unpaid leave of absence, you may stop your participation to certain benefits under the Plan by calling the HR Benefits Center at 888-376-8836 within 31 days of the day your leave begins.

You are not eligible for Short-Term or Long-Term Disability while on an approved unpaid leave, unless your leave qualifies as FMLA leave or military leave, or Capital One places you on administrative leave.

You are no longer eligible for Life Insurance benefits once you have been on a leave of absence for two consecutive years. If you lose Life Insurance benefits due to being on a leave of absence for over two consecutive years, you must request to re-enroll in any supplemental life coverage within 31 days of your return from leave by calling the HR Benefits Center at 888-376-8836.

If you elect to drop any group health coverage during an unpaid FMLA leave, you may re-enroll within 31 days of your return from your leave by calling the HR Benefits Center at 888-376-8836.

Active Military Duty

If you are on a qualified military leave, whether for active duty or for training, you are entitled to extend your medical, dental, vision, short-term disability, long-term disability, Health Care Flexible Spending Accounts and Health Savings Account (HSA). The benefits can be extended for the duration of your leave as long as you give Capital One advance notice of the leave (unless military necessity prevents this, or if providing notice would be otherwise impossible or unreasonable). This continuation coverage is pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Your Basic, Supplemental and Dependent Life and AD&PL can be extended for up to 24 months from your last day worked.

Your total leave, when added to any prior periods of military leave from Capital One, cannot exceed five years. There are a number of exceptions, however, such as types of service that are not counted toward the five-year limit — including situations where service members are involuntarily retained beyond their obligated service date; additional required training; federal service as a member of the National Guard; and service under orders during war or national emergencies declared by the President or Congress. Additionally, the maximum period may be extended due to hospitalization or convalescence following service-related injuries after your uniformed service ends.

If the entire length of the leave is:

- **30 days or less,** you will not be required to pay any more than the contributions required for active employees.
- **Longer than 31 days**, you may be required to pay up to 102% of the full amount necessary to cover an employee (including any amount for dependent coverage) who is not on military leave.

Coverage under the Plan will continue while you are on a military leave unless you actively decide to waive coverage. You may be required to elect coverage during the annual Open Enrollment period for coverage the following year for some plans.

If your leave is 180 days or longer, you will be able to take your unused Health Care FSA balance as a taxable cash distribution by the last day of the FSA plan year (extended for any grace period as defined below).

If you are on a military leave, but your coverage under the Plan is terminated — for instance, because you waived coverage — when you return to work, you will be treated as if you had been actively employed during your leave when determining whether a waiting period applies to health benefit coverages. USERRA permits a health plan to impose a waiting period to an illness or injury determined by the Secretary of Veterans Affairs to have been incurred or aggravated during performance of service in the uniformed services.

If you do not return to work at the end of your military leave, you may be entitled to purchase COBRA continuation coverage if you extended benefits for less than 18 months. However, your military leave benefits continuation period runs concurrently with your COBRA coverage period, subject to the limitation of COBRA. This means that COBRA coverage and USERRA coverage begin at the same time. If you do not return to work at the end of your military leave, you may be entitled to continue COBRA continuation coverage for the remainder of the COBRA continuation period, if any. In other words, any continuation of coverage under USERRA will reduce the maximum COBRA continuation period for which you and/or your dependents may be eligible. (See "Group Health Continuation under COBRA — Coverage Rights".) Your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to continuation coverage elected. If

COBRA and USERRA give you (or your covered spouse or dependent children) different rights or protections, the law that provides the greater benefit will apply.

When Coverage Ends

Your coverage under the Capital One benefits program ends when:

- Your employment with Capital One ends*;
- You transfer from an eligible status to a non-eligible status (such as from regular full-time to ineligible part-time with less than 20 Standard Hours per week);
- You do not make required contributions;
- You drop coverage due to a qualifying life event;
- You elect to drop healthcare benefits during Open Enrollment, on the December 31 following the Open Enrollment period;
- Capital One ends the contract for that coverage; or
- Capital One terminates the Plan, or any benefit thereunder and/or any coverage option.

In addition, dependent coverage also ends:

- On the date your coverage ends;
- On the last day of the month in which your dependent child turns age 26;
- On the date your dependent child otherwise ceases to qualify as a dependent under the plan;
- In the case of your spouse, on the date your divorce or annulment is final; and/or
- In the case of your domestic partner, on the date your domestic partnership is terminated.

When you terminate your employment or transfer from an eligible status to a non-eligible status, your medical, dental and vision coverage for you and your dependents will continue through the last day of the month in which you terminate. Applicable contributions will be deducted from your last paycheck. Employer contributions into a Health Savings Account will stop, but the account will remain open (see "Health Savings Account").

Coverage under Basic Life/AD&PL, Supplemental Life/AD&PL, Dependent Life/AD&PL, Supplemental Long-Term Disability, and Flexible Spending Accounts terminate on your last day of employment (or the last day in which you meet the eligibility requirements). You may choose to continue your medical, prescription drug, dental and vision coverage and Health Care FSA through COBRA. COBRA continuation may also be available when coverage ends for other reasons (see "Group Health Continuation under COBRA — Coverage Rights"). In addition, you may port or convert your Life/AD&PL coverage to a private individual policy if you leave Capital One. See the life insurance certificates in the ***Appendix*** for details about converting your Life/AD&PL coverage.

A dependent that is dropped from coverage due to divorce or dissolution of a domestic partnership will have medical, dental and vision coverage through the date in which the event occurred. A dependent that is dropped from coverage due to your death will have medical, dental and vision coverage through the last day of the month in which the event occurred.

*If you are disabled before termination of employment, you may continue receiving payments under Short- and Long-Term Disability coverage as long as you meet the terms and conditions for being disabled under that coverage. Payments for Short-Term Disability may continue after termination as long as the termination was not due to gross misconduct or ethical violations. Payments for Long-Term Disability will continue to be paid, as long as you meet the terms and conditions of being disabled.

Coordination of Benefits

Some associates have other medical and dental coverage, in addition to coverage under their Capital One Benefits. Under these circumstances, it is not intended for your plans to provide duplicate benefits. For this reason, many plans — including Capital One's — have a "coordination of benefits" provision. Medical coverage provided by the Capital One Plan follows Medicare's primary versus secondary payer rules when determining when Capital One's Plan pays as primary. If Medicare rules say Medicare is the primary payer for a covered person, the Capital One Plan will be the secondary payer. If Medicare rules say the Capital One Plan is the primary payer, Medicare will be the secondary payer. Visit medicare.gov for primary vs. secondary rules.

For more information, refer to the medical and dental booklets in the *Appendix*. You may also contact an Anthem Health Guide at 844-390-4133 or Delta Dental at 844-344-8006.

Additionally, please refer to additional Coordination of Benefits information if continuing Capital One medical coverage through COBRA in the "Group Health Continuation under COBRA — Coverage Rights" section under "Medicare and Other Coverage".

Acts of Third Parties (Subrogation)

When you or your covered dependent are injured, or become ill, because of the actions, or inactions of a third party, the Plan may cover your eligible health care (medical, dental and vision) expenses. However, to receive coverage, you must notify the Plan that your illness or injury was caused by a third party, and you must follow special Plan rules. This section describes the Plan's procedures with respect to subrogation and right of recovery.

Subrogation means that if an injury or illness is someone else's fault, the Plan has the right to seek expenses it pays for that illness or injury directly from the at-fault party or any of the sources of payment listed later in this section. A right of recovery means the Plan has the right to recover such

expenses indirectly out of any payment made on your behalf by the at-fault party or any other party related to the illness or injury.

By accepting Plan benefits to pay for treatments, devices, or other products or services related to such illness or injury, you agree that the Plan:

- Has an equitable lien on any and all monies paid to (or payable to) you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury;
- May appoint you as constructive trustee for any and all monies paid to (or payable to) you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury; and
- May bring an action on its own behalf or on the covered person's behalf, or intervene in any pending lawsuit, against any responsible party or third party involved in the sickness or injury.

If you (or your attorney or other representative) receive any payment from the sources listed later in this section — through a judgment, settlement or otherwise — when an illness or injury is a result of a third party, you agree to place the funds in a separate, identifiable account and that the plan has an equitable lien on the funds, and/or you agree to serve as a constructive trustee over the funds to the extent that the Plan has paid expenses related to that illness or injury. This means that you will be deemed to be in control of the funds.

You must pay the Plan back first, in full, out of such funds for any health care expenses the Plan has paid related to such illness or injury. You must pay the Plan back, up to the full amount of the compensation you receive from the responsible party, regardless of whether your settlement or judgment says that the money you receive (all or part of it) is for health care expenses. Furthermore, you must pay the Plan back regardless of whether the third party admits liability and regardless of whether you have been made whole or fully compensated for your injury. If any money is left over, you may keep it.

Additionally, the Plan is not required to participate in or contribute to any expenses or fees (including attorney's fees and costs) you incur in obtaining the funds.

The Plan's sources of payment through subrogation or recovery include (but are not limited to) the following:

- Money from a third party that you, your guardian or other representatives receive or are entitled to receive
- Any constructive or other trust that is imposed on the proceeds of any settlement, verdict or other amount that you, your guardian or other representatives receive
- Any equitable lien on the portion of the total recovery which is due the Plan for benefits it paid

- Any liability or other insurance (for example, uninsured motorist, underinsured motorist, medical payments, workers' compensation, no-fault, school, homeowners, or excess or umbrella coverage) that is paid or payable to you, your guardian or other representatives

As a Plan participant, you are required to:

- Provide proof, if requested by the Claims Administrator and in the form requested by the Claims Administrator, that you have not and will not discharge or release a claim against a third party without the written consent of the Claims Administrator;
- Execute a written agreement assigning your rights against a third party to the Plan and/or authorizing the Plan to sue, compromise or settle a cause of action against a third party, if requested by the Claims Administrator;
- Cooperate with the Plan's efforts to ensure a successful subrogation or recovery claim, including instituting a formal proceeding against a third party and/or setting funds aside in a particular account. This also includes doing nothing to prejudice the Plan's subrogation or recovery rights outlined in this Summary;
- Notify the Plan within 30 days of the date any notice is given by any party, including an attorney, of your intent to pursue or investigate a claim to recover damages or obtain compensation due to sustained injuries or illness; and
- Provide all information requested by the Plan, the Claims Administrator or their representatives, or the Plan Administrator or its representatives.

The Plan may terminate your Plan participation and/or offset your future benefits in the event that you fail to provide the information, authorizations, or to otherwise cooperate in a manner that the Plan considers necessary to exercise its rights or privileges under the Plan. If the Plan must institute proceedings against you for not honoring the Plan's recovery rights under this section, you will be responsible for the costs of collection, including reasonable attorney's fees.

If the "Acts of Third Party" provisions in this SPD conflict with provisions in a Benefit Booklet governing insured benefits, the Benefit Booklet will govern. If the Benefit Booklet for any self-insured benefit contains subrogation, reimbursement or recovery provisions, those provisions and the "Acts of Third Party" provisions in this SPD will both apply, so that the Plan has the maximum subrogation, reimbursement, and recovery rights.

Recovery of Overpayment

Whenever payments have been made exceeding the amount necessary to satisfy the provisions of this Plan, the Plan has the right to recover these expenses from any individual (including you, and the insurance company or any other organization receiving excess payments). The Plan may also withhold payment, if necessary, on future benefits until the overpayment is recovered. In addition, whenever payments have been made based on fraudulent information provided by you, the Plan will exercise the right to withhold payment on future benefits until the overpayment is recovered.

COBRA Coordination with Medicare

When you access Capital One's medical plans through COBRA, and you are eligible for Medicare, the Capital One benefits pay secondary, with Medicare Part A and Part B being the primary payer, even if you are not enrolled in Medicare Part A and Part B. If you are 65 and have COBRA coverage, you should be enrolled in Medicare Part A and Part B to ensure you are fully covered.

For Retirees: To enroll in a plan through Mercer Marketplace 365, individuals aged 65+ must be enrolled in Medicare Part A and Part B. When you and/or your eligible dependents are eligible for Medicare, Medicare becomes the primary payer and any other medical coverage you have becomes the secondary payer. This means that Medicare pays benefits before any other medical plan pays benefits. The primary plan pays benefits first, up to that plan's limits. The secondary plan will *not* pay benefits until the primary plan pays a portion or denies a claim. The total benefits paid from both plans cannot be greater than the benefits under the plan that provides the greater benefits.

Other Plans That May Not Coordinate Benefits

There is no coordination with individual policies such as critical illness or hospital indemnity.

MEDICAL BENEFITS

The health and well-being of you and your family are important. Capital One offers medical benefits to help you stay well and get well if you are ill or injured. Medical coverage is designed to give you financial protection towards the cost of most medical services you and your enrolled family members might need. Prescription drug coverage included in the medical plans is CVS Caremark.

Capital One offers a choice of three Anthem medical benefit options through Anthem Blue Cross and Blue Shield (Anthem) as further defined below:

- Basic PPO
- Enhanced PPO
- Consumer Driven Health Plan (CDHP)

For more information

This section provides an overview of your Anthem medical plan options. Please refer to the Anthem Medical Benefit Booklet for each plan available in the *Appendix*, or view the Summary of Benefits and Coverage (SBC) for each plan, available at www.anthem.com/capitalone for additional details including how the plan works, precertification requirements, covered and ineligible expenses, claims filing, as well as information about Anthem's managed care programs. The information in this summary document along with the supporting documents in the *Appendix* serve as the Summary Plan Description (SPD).

In this section

Medical Benefits at a Glance

All three Anthem medical plan options cover the same services and medications, and provide access to the same great network of providers and medical resources. In addition to common services, such as office visits, screenings, hospitalizations, etc., our medical plans also provide comprehensive coverage for ABA therapy, infertility treatments, gender-affirming surgery, and more.

You have the freedom to use the doctors and hospitals of your choice. If you are covered by one of the three medical benefit options, you receive higher benefits when you use doctors and hospitals

in the Anthem Blue Card PPO network. You can use out-of-network doctors or hospitals, but you will pay more for your care and may be subject to balance billing by the provider and/or facility.

The following chart provides a side-by-side comparison of the plans, including how much you pay for various services under each plan. For more information, please refer to the Anthem Medical Benefit Booklet for each plan available in the *Appendix*.

	CDHP		Basic PPO		Enhanced PPO	
	In-Network	*Out-of-Network*	*In-Network*	*Out-of-Network*	*In-Network*	*Out-of-Network*
Annual Deductible (individual/ family)	$2,000/ $3,200	$4,000/ $6,000	$1,000/ $2,000	$3,000/ $6,000	$500/ $1,000	$1,500/ $3,000
Annual Out-of-Pocket Maximum (individual/ family)	$3,400/ $6,400	$6,800/ $12,800	$4,000/ $8,000	$10,000/ $20,000	$3,000/ $6,000	$6,000/ $12,000
Coinsurance*	20%	40%	30%	50%	20%	40%
Preventive Care	No charge	No charge	No charge	No charge	No charge	No charge
Office Visits						
Primary Care	20% coinsurance after deductible	40% coinsurance after deductible	No charge	50% coinsurance after deductible	No charge	40% coinsurance after deductible
OB/GYN	20% coinsurance after deductible	40% coinsurance after deductible	$30 copay	50% coinsurance after deductible	$20 copay	40% coinsurance after deductible
Specialist	20% coinsurance after deductible	40% coinsurance after deductible	$60 copay	50% coinsurance after deductible	$40 copay	40% coinsurance after deductible
Behavioral Health including Psychiatrist / Psychologist	20% coinsurance after deductible	40% coinsurance after deductible	$30 copay	50% coinsurance	$20 copay	40% coinsurance

* Some treatments have a different coinsurance. See the specific benefit level option charts in the Anthem booklets available in the *Appendix* for specific details.

How the Medical Benefits Work

General Overview

In general, the three medical plans offer coverage for both in-network and out-of-network care. The options cover the same services and have the same network of providers, but differ in cost sharing features such as coinsurance and deductibles. To use these medical benefits to your best advantage, it is important to understand:

- How the deductible and out of pocket maximums work for each plan;
- Company funding toward the Health Savings Account;
- The difference between in-network and out-of-network coverage; and
- How to use primary care physicians (PCPs) and specialists.

In-Network vs. Out-of-Network Care

The three medical plans provide two levels of coverage: one for in-network care and one for out-of-network care. The options let you use any medical provider you want, but staying within the network is more cost effective.

Each time you need care, you can choose to use in-network or out-of-network doctors, hospitals or other medical care providers. When your care is provided by an Anthem network provider, you receive higher benefits. Plus, you do not need to file claims and your in-network provider will contact Anthem to get any required advance approval (precertification), in most cases.

If you prefer to use a doctor, hospital or other medical care provider that is out-of-network, your benefits will be reduced. Your out-of-pocket expenses will be higher, and you may have to submit a Claim Form for reimbursement. In addition, you are responsible for contacting Anthem to get advanced approval for certain types of care (precertification/preauthorization). The provider may also bill you for amounts over what Anthem provides in reimbursement — a practice known as "balance billing."

Here are some important points to know about in-network and out-of-network care:

- When you use an in-network provider, you are not responsible for charges that are more than the negotiated charge when you receive care from an in-network provider.
- For out-of-network care, you pay a percentage of the allowable charge after paying the annual out-of-network deductible. An out-of-network provider's fee for a service may be more than the allowable charge. You must pay the difference out of pocket which does not count toward meeting the annual deductible or out-of-pocket maximum. These charge differences, or balance billings can be substantial. Additionally, when submitting multiple

codes for a procedure, Anthem may require providers to write-off some of the codes. In-Network providers cannot bill you for these services (unless you sign a waiver indicating you will pay) but Out-of-Network providers will bill you for these services. Check with your provider before receiving care to avoid surprises.

- For out-of-network care for a true medical emergency in an emergency room setting, you will pay a percentage of the billed charges after paying the annual in-network deductible.

You can find information about in-network physicians by visiting Anthem's website at www.anthem.com/capitalone and selecting "Find a Doctor, Hospital or Urgent care." You can also contact an Anthem Health Guide at 844-390-4133.

Care outside of the United States

Associates and dependents enrolled in the medical plan are eligible for emergency medical services while traveling for leisure. Associates (and accompanying dependents) are also eligible for emergency medical coverage while traveling on Capital One business.

Before traveling, we recommend you:

- Call the Customer Service number on your ID card before leaving for coverage details;
- Always carry your current ID card; and
- In an emergency, go directly to the nearest hospital.

The Leisure Travel Abroad (Blue Cross Blue Shield Global Core)

- Who is covered: Associates and dependents enrolled in Anthem's medical plan on non-business travel
- Coverage: Emergency care only
- ID card: Carry your Anthem medical plan ID card that you typically show for care within the U.S.
- 24/7 support: Toll-free at 800-810-BLUE (2583) or collect at 804-673-1177
- Payment Information and claim filing: Participating hospital visits typically do not require a payment upfront (not including your coinsurance/copayment); all other services generally require you to pay up front and submit a claim form
- International claim forms: Available from Blue Cross and Blue Shield, the Blue Cross Blue Shield Global Core Service Center, or online at www.bcbsglobalcore.com

If you need inpatient hospital care, you or someone on your behalf, should contact the number on the back of your Anthem ID card for preauthorization. Keep in mind, if you need Emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

For Business Travel (Blue Cross Blue Shield GeoBlue)

- Who is covered: Associates and dependents on business travel or on a leisure trip directly connected before, after or during a business trip

- **ID card:** You must download and/or print a paper ID card from Pulse or register using the Geo-blue mobile app
- **Coverage**: Emergency care only
- **24/7 support**: Toll-free at 855-282-3517 or collect at 610-254-5304
- **Payment information and claim filing:** Participating hospital visits typically do not require a payment upfront (not including your coinsurance/copayment); all other services generally require you to pay up front and submit a claim form
- **International claim forms**: Available from Blue Cross and Blue Shield, the Blue Cross Blue Shield GeoBlue Service Center, or online at www.geo-blue.com

Using a Primary Care Physician

Although you are not required to select a primary care physician (PCP), you may wish to select a PCP to help you manage your care. A PCP is a doctor who provides all of your primary care including routine and preventive services. Your PCP can also refer you to a specialist if appropriate and coordinate your care with those specialists. Visits to an in-network PCP are covered at 100% under the Basic and Enhanced PPO plans.

You may choose a PCP from a network of doctors. Your PCP can be a:

- Family or general practitioner;
- Internist (for adults); or
- Pediatrician (for children).

To locate a PCP, contact an Anthem Health Guide at 844-390-4133 or visit Anthem's website at www.anthem.com/capitalone and select "Find Care."

Each covered person in your family can have a different PCP and you can change your PCP at any time.

Using a Specialist

Under the CDHP, Basic and Enhanced medical plans, PCP referrals are not required for you to receive benefits for care provided by specialists within the network. You may wish to have your PCP coordinate your care, or you may self-refer to a specialist of your choice. Using in-network specialists result in a higher level of benefits and lower out-of-pocket costs than using out-of-network specialists. It is always a good idea to contact an Anthem Health Guide at 844-390-4133 before your visit to any doctor to confirm if your specialist participates in the network.

WINFertility Program

The WINFertility Program helps you receive the highest quality care for fertility treatment services.

If you enroll in a medical benefit option, WINFertility will assist you in maximizing your benefits by explaining the most effective treatment options based on your individual treatment needs, helping select a high-quality in-network provider, and managing your infertility prescriptions to ensure you get the most out of your infertility medication benefit.

Key features of the WINFertility Program include:

- Help with provider selection;
- 24/7 access to education and emotional support provided by WIN's FertilityCoach℠ Nurses with decades of experience with infertility patients;
- Guidance to help increase efficient use of hormonal medications to avoid wastage and the risks of over-stimulation;
- Improved likelihood of successful outcomes through WIN's evidence-based protocols, expert clinical advice, and treatment by qualified subspecialists; and
- Complimentary supply of folic acid to help prevent neural tube defects.

If you have reached the maximum medical or prescription coverage and will need to pay out-of-pocket, the WIN consumer Program can provide 10–30% off retail prices and financing options to make paying for treatment more manageable.

Using the WINFertility Program

All services must be pre-authorized by calling the WIN Medical Management Program at 844-323-7539 at least two weeks before the initiation of hormone treatment services. No benefits will be paid if the services are not preauthorized.

Individuals are not required to meet the clinical definition of infertility before receiving services.

Please note: Individuals are not required to complete a full cycle in order to have services covered, but an incomplete cycle will still count towards the three-cycle limit. For example: A woman may participate in IVF services that include egg stimulation and retrieval (covered services) but may choose to freeze the eggs (generally not covered except in limited circumstances) instead of completing the IVF cycle through fertilization and implantation.

Covered services include:

- Artificial insemination cycles (natural cycles, clomid/letrazole cycles); the number of AI cycles is limited by clinical guidelines
- Up to three cycles of the following advanced reproductive treatment cycles and procedures:
    - In-vitro fertilization (IVF), including ICSI if medically appropriate;
    - Gamete Intrafallopian Cycle (GIFT);
    - Zygote Intrafallopian Transfer (ZIFT);
    - Donor oocyte cycle (medical expenses only);
    - PGD/PGS as directed by medical policy;

    - Cryo-preservation of blastocysts(s) and embryo(s) from covered IVF cycles only as directed by medical policy;
    - Cryo-preservation of oocytes only as directed by medical policy; and medically necessary and appropriate diagnostic workup and radiology services;
- Pathology and laboratory services, including, but not limited to:
    - Hormonal assays;
    - Semen analysis, as appropriate;
    - Ultrasound exams;
    - Fertilization and appropriate embryology services;
    - Ova retrieval; and
    - Embryo transfer.
- Medications necessary to the provision above, including parenteral injection and oral ovulation induction medications are included with no maximum but at a 50% benefit.

Please note that Frozen Embryo Transfer (FET) cycles do not count against the three-cycle benefit but are exhausted after the third retrieval attempt.

Fertility preservation cycle approvals require a fertility nurse consult with a WIN FertilityCoach℠ Nurse.

Travel Benefits

Travel and lodging expenses may be available for medical services when there is no in-network or out-of-network provider or facility within 100 miles of your home. For travel and lodging reimbursement, services must be received at an in-network facility. Expenses for travel and lodging for the recipient and a companion should be verified by Anthem and may be available as follows:

- Transportation is covered, including expenses for personal car mileage at the current Federal rate of reimbursement, of the patient and one companion who is traveling on the same day(s) to and/or from the site of the surgery for an evaluation, the procedure, or necessary post-discharge follow-up;
- Benefits are only available for members who are unable to obtain services from an in-network or out-of-network provider within 100 miles of their residence.
- Travel/Lodging benefit is only available if the patient is receiving services from an in-network provider.
- Travel and lodging is a combined limit up to $4,000 per procedure.

For information about the transportation and lodging benefits, please contact Anthem Member Services.

For more information about travel benefits, see the Anthem booklets available in the *Appendix*.

Health Management Programs

When you are enrolled in a Capital One medical benefit option, you have additional resources available to help you manage certain health conditions, such as pregnancy support, general health care support, disease management and advanced illness resources and transplant care.

For more information about these health management programs, see the Anthem booklets available in the *Appendix*.

Discount Programs

When you are enrolled in an Anthem medical plan option, you are eligible for discounts on products and services that help promote better health and wellbeing. Through Special Offers, discounts are available on things like:

- Vision and hearing
- Fitness and health
- Family and home
- Medicine and treatment

To find the discounts that are available to you, visit www.anthem.com/capitalone and select Discounts.

Tools and Resources from Anthem

When you enroll in an Anthem medical plan, you have access to a wide variety of tools and resources to help you manage your health care and take steps to improve your health, including:

- Anthem Mobile App — Sydney Health
- Online Find a Doctor at www.anthem.com/capitalone
- Anthem's 24/7 Nurseline at 1-800-700-9184

For more information about these tools and resources, see the Anthem booklets available in the medical section of the *Appendix*.

How Medical Claims (Benefits) Are Paid

If you use in-network providers, claims are filed automatically. However, if you decide not to use an in-network provider follow these procedures to file a claim:

- To find a Claim Form, log in to www.anthem.com/capitalone or call an Anthem Health Guide at 844-390-4133.
- Complete the Claim Form.

- Send the form and your billing statements and receipts to Anthem in accordance with the instructions on the Claim Form within 12 months of receiving care. (Do not forget to keep copies for yourself)

PRESCRIPTION DRUG BENEFITS

When you enroll in a Capital One Anthem medical plan, you automatically receive prescription drug benefits administered by CVS Caremark. In this section, you'll find an overview of how the prescription drug benefits work.

For more information

This section provides an overview of your prescription drug benefits. Please refer to the Prescription Drug Benefit summary in the *Appendix* for a detailed description of your prescription drug benefits, including how the program works, what is covered and not covered, required authorizations, quantity limits, and how to file claims. The information in this summary document, along with the supporting documents in the *Appendix*, serves as the Summary Plan Description (SPD).

Prescription Benefits at a Glance

You can fill your short-term prescriptions — generally those filled for a 30-day supply with up to one refill (for a total of 60 days or less) — at any of the more than 65,000 in-network pharmacies.

For maintenance medications — generally those taken longer than 60 days or more than two fills — must be filled as a 90-day supply either at your local retail CVS Caremark pharmacy or through the CVS Caremark Mail Order (Maintenance Choice Program) with exceptions for prescriptions filled in certain states*. All specialty medications, which are generally limited to 30 day supplies, must be filled through the CVS Specialty Pharmacy with exceptions for prescriptions filled in certain states*.

It's important to know that **benefits are only available when you use an in-network pharmacy or mail order**. The only exception is when you have an emergency while traveling in an area where no in-network pharmacy is available.

Your cost for a prescription drug varies depending on the length of the prescription and the type of drug, as well as where you have it filled. You'll pay less for prescriptions that are included on CVS Caremark's preferred drug list. You can view CVS Caremark's complete preferred drug list at www.caremark.com.

Note that under the PPO plans, the annual deductible does not apply to prescription drugs. Under the CDHP plan, the annual deductible must be met before coinsurance will begin paying for prescription drugs. The amount you pay for prescriptions when enrolled in the PPO or CDHP will apply towards the out-of-pocket maximum.

Up to a 30-day Supply at an In-network Retail Pharmacy or Specialty Pharmacy		
Plan	Basic/Enhanced PPO	CDHP
Generic or Tier 1 Brand	You pay $10 copay for each fill or refill	20% coinsurance after deductible
Preferred Brand	You pay $50 copay for each fill or refill	20% coinsurance after deductible
Non-Preferred Brand	You pay $100 copay for each fill or refill	20% coinsurance after deductible
Specialty Medications	You pay $200 for each fill or refill	20% coinsurance after deductible
Oral and Injectable Drugs Used to Treat Infertility	50% coinsurance	20% coinsurance after deductible
A 90-day Supply through the Maintenance Choice Program*		
Plan	Basic/Enhanced PPO	CDHP
Generic or Tier 1 Brand	You pay $20 copay for each fill or refill	20% coinsurance after deductible
Preferred Brand	You pay $100 copay for each fill or refill	20% coinsurance after deductible
Brand Non-Preferred	You pay $200 copay for each fill or refill	20% coinsurance after deductible

*Some state laws require broader pharmacy participation for 90 day maintenance fills, please check Caremark.com or contact Caremark customer service for in-network pharmacy participation.

Participating Pharmacies

In addition to CVS pharmacies, CVS Caremark provides a variety of participating retail chains, including Giant, Walgreens, Walmart, and independent pharmacies. These pharmacies are available for all short-term medications, which generally are those that are taken for less than 60 days or that require only two fills at retail.

For maintenance medications (those taken ongoing — generally longer than 60 days or require more than two fills at retail), you generally must have those filled as a 90-day supply at a local CVS or via CVS Caremark's mail-order program, Maintenance Choice*. Find a network pharmacy at www.caremark.com or call 877-210-3556.

Be Well Pharmacy Discount Program

The *Be Well* Pharmacy Discount Program is available for those who have chronic conditions and engage with Anthem nurses while enrolled in the Basic or Enhanced PPO. If you are managing a chronic condition, such as diabetes, hypertension, high cholesterol, COPD/asthma or congestive heart failure, contact the Anthem Nurse Line to see if you qualify for the discount. To reach the Anthem Nurse Line, call 844-465-1277; and ask to speak to a nurse when prompted.

Retail Pharmacy Vaccination Program

Participating pharmacies offer certain no cost preventive vaccinations for plan participants. Visit www.caremark.com to find a participating pharmacy and look for the syringe symbol next to the location description to identify which location has vaccination services. Contact the pharmacy or set an appointment online to ensure availability of vaccines before your arrival.

HEALTH AND WELLNESS RESOURCES

Through the Capital One benefits program, you have access to important tools and resources to help you and your family to get healthy and stay healthy. This section includes information about the *Be Well* Rewards Program.

In addition, if you are enrolled in a Capital One medical option, you have access to a number of wellness offerings through Anthem, including health management programs, discount programs and tools and resources. This section includes a brief summary of these programs.

For more information

This section provides an overview of the Capital One Health and Wellness Resources. The information in this summary document, along with the supporting documents in the *Appendix*, serves as the Summary Plan Description (SPD) for the Be Well Rewards Program. For more information about the health management programs and wellness resources provided through Anthem, see the Anthem booklets available in the medical section of the *Appendix*.

Be Well Rewards Program

All associates, as well as spouses or domestic partners who are enrolled in the medical plan, can each earn up to 350 points/dollars per year (a $700 combined household value) for completing health and well-being related activities and team challenges. One point equals $1. To learn more about the activities you can complete to earn points, log on to your account at capitalone.myevive.com.

Wellness Activity	Benefit Enrolled Point Value	Non-Benefit Enrolled Point Value	Spouse/DP Point Value
Non-Acute Doctors Visit - Annual visit/physical (general practice)	120	120	120
Commit to the Be Well, Eat Well 1.0 Program	40	40	N/A
Commit to the Be Well, Eat Well 2.0 Advanced Program	40	40	N/A
Commit to the Be Well, Be Mindful Program	25	25	N/A
Commit to the Be Well, Be Happy Program	25	25	N/A
Commit to the Be Well, Be Balanced Program	25	25	N/A
Commit to the Be Well with Diabetes Program	100	N/A	100
Premise Ergonomics Assessment	25	25	25
Be Well Webinar Attendance (Each webinar is worth 5 points)	60	60	60

Complete an Anthem or Premise Dietician call (Single visit is 15 points.)	45	N/A	45
Flu Vaccination (if you're not enrolled in a Capital One medical plan, must receive your flu vaccination through Premise Health to earn Be Well points)	30	30	30
Health Assessment (Evive Activity)	25	25	25
Dental Cleaning (can be redeemed 2 times annually 30 points each)	60	N/A	60
Complete a Health Quest (options available - list below). Each Health Quest can only be completed once. Max point value of 125 points.	125	125	125
Meet with a Fidelity Planning & Advice Consultant (must meet 3x to get the credit)	30	30	N/A
Fidelity Student Debt tool	20	20	N/A
Fidelity Financial Wellness Checkup	20	20	N/A
Fidelity Financial Retirement Goal Setting	20	20	N/A

Be Well Health Centers

Accessing the Health Centers

All Capital One associates (excluding Expatriates) are eligible for services offered by the *Be Well* Onsite Health Centers — even if they are not enrolled in Capital One medical benefits. To ensure compliance with IRS regulations on HSAs, individuals enrolled in the CDHP will be charged $35 for non-preventive visits. Associates and dependents not enrolled in our medical plans will also be charged $35 for non-preventive visits. Preventive visits will still be free of charge for all associates, and non-preventative services are available at no cost to patients enrolled in the Basic and Enhanced PPOs. **Unless urgent treatment is needed, patients are required to schedule appointments in advance.**

The following dependents and immediate family members also can use the Health Centers:

- A spouse or domestic partner
- Dependent child from age 2 up to the end of the month of their 26th birthday

A spouse, domestic partner, or dependent meeting the above criteria does not need to be enrolled in Capital One medical benefits to utilize the Health Centers.

In some locations, non-associates must be escorted to the center by an associate for appointments.

Who Is NOT Eligible to Use the Health Centers

- Dependents under age 2 and other dependents such as parents, grandparents and siblings
- Contractors (e.g., leased employees, independent contractors and other workers who are not classified as employees by Capital One), temporary associates, interns and similar categories of workers are not eligible for Capital One benefits, such as health and welfare, retirement, and leave and time off benefits
- Expatriates

Primary Care Services

All of the *Be Well* Onsite Health Centers serve as full service, primary care provider's offices where patients can be treated for acute illnesses and injuries as well as have physicals and be treated for ongoing health conditions such as diabetes, high cholesterol, etc.

The primary care model is designed to allow staff to answer questions, treat symptoms and discuss wellness and preventive measures. The physicians and nurse practitioners are board certified in family medicine.

These *Be Well* Onsite Health Centers offer services such as:

- Primary Care
- Acute Care
- Chronic Condition Management
- Immunizations and Vaccinations
- Physical Exams
- Lab Services and Drawing Station
- Allergy Shot Management
- Preventive Screenings
- Referral Management
- Over the Counter Medications
- Travel Medicine
- *Be Well*, Eat Well Program
- Nutrition Counseling

Some *Be Well* Onsite Health Centers offer the following services:

- Physical Therapy
- Pharmacy (costs may apply according to the individual's insurance coverage)
- Mental Health Services

Confidentiality

The *Be Well* Onsite Health Centers and its staff are managed by Premise Health, an independent medical organization bound by the same confidentiality laws that apply to all health care providers. Capital One does not have access to medical information provided to the *Be Well* Onsite Health Center by associates or their dependents.

For more information and contact information for *Be Well* Health Centers, please visit Health Centers on Pulse.

DENTAL BENEFITS

Healthy teeth and gums are important to your well-being. Dental coverage includes preventive care benefits to help you stay healthy and gives you financial protection when you or your covered family members need care.

For More Information

This section provides an overview of your Delta Dental plan options. Please refer to the Delta Dental Benefit Booklet for each plan available in the *Appendix*, or visit www.deltadentalva.com for additional details including how the plan works, covered and ineligible expenses, schedules of benefits, claims filing, etc. The information in this summary document, along with the supporting documents in the *Appendix*, serves as the Summary Plan Description (SPD).

In this section

Dental Benefits at a Glance

Capital One offers two dental benefit options through Delta Dental:

- Basic Level dental option
- Enhanced Level dental option

Both options pay the full cost of preventive care and provide coverage for basic and major services. The Enhanced Dental option also covers major care services and orthodontia for children and adults. You must be enrolled in the Enhanced option for the entire course of treatment to receive the full orthodontia benefits. Additionally, orthodontia is only covered when treatment is provided by a provider in an office setting. At home orthodontia is not covered.

You have the flexibility to receive care from any licensed dental provider, but your out-of-pocket costs will be lower when you use an in-network or participating dentist. Find an in-network dentist by going to www.deltadentalva.com.

The chart below provides a side-by-side comparison of the plans, including how much you pay for

various services under each plan. For more information, please refer to the Delta Dental Benefit Booklet available in the *Appendix*.

Benefits and Covered Services	Basic Plan	Enhanced Plan
Deductible	None	None
Annual Maximum	$1,000/person	$2,000/person
Preventive Care (routine exams, cleanings, X-rays)	Plan pays 100%	Plan pays 100%
Basic Care (fillings, root canals, periodontal therapy, oral surgery)	Plan pays 80%, subject to the annual maximum	Plan pays 80%, subject to the annual maximum
Major Care (bridges, crown, dentures, dental implants)	Plan pays 50% subject to the annual maximum	Plan pays 50% after the deductible, subject to the annual maximum
Orthodontia* for covered children and adults (braces, mouth guards, temporomandibular joint (TMJ) disorders)	Not covered	Plan pays 50% coinsurance The lifetime orthodontia benefit maximum is $2,500 per person.

* You must be enrolled in the Enhanced Plan for the entire course of orthodontia treatment to get full benefits. At-home orthodontia treatment is not covered.

How the Dental Benefits Work

General Overview

Both options provide coverage for most preventive and basic dental care, including check-ups and cleanings, X-rays, fillings, simple extractions, surgical extractions, impactions, and other oral surgical procedures, as well as major restorative services (such as inlays, bridges, crowns, dentures). The Enhanced plan also covers orthodontia services.

With both options, you have the freedom to see the dental provider of your choice. The plan covers the same services whether or not you use a network dentist, but your out-of-pocket costs will generally be lower when you use a network or participating dentist. When you enroll in either option, you will have access to two types of dentists — Delta Dental PPO and Delta Dental Premier.

When you enroll in the Basic Level or Enhanced Level dental option, you receive a dental membership ID card that you should present when you visit your dentist. See "How Dental Claims (Benefits) Are Paid" for details on filing claims.

Dental Network

You can contact Delta Dental at 844-344-8006 or www.deltadentalva.com. You may select the dentist of your choice. However, you will receive the highest level of benefits available in your group's program by choosing a Delta Dental PPO Dentist. Please review the chart below for more information on how Delta Dental bases its payment for both participating and non-participating dentists. In addition, your out-of-pocket costs will usually be lower if you use a participating dentist. If you choose a:

Delta Dental PPO Dentist	Delta Dental Premier Dentist who is not a Delta Dental PPO Dentist	Non-Participating Provider
Payment will be made directly to the dentist for covered benefits.	Payment will be made directly to the dentist for covered benefits.	Payment will be made directly to you.
Delta Dental's payment will be based on the Delta Dental PPO Allowance for covered benefits.	Delta Dental's payment will be based on the Delta Dental Premier Allowance for covered benefits.	Delta Dental's payment will be based on the Non-Participating Dentist Allowance for covered benefits.
The dentist will accept Delta Dental's payment, plus any required coinsurance and deductible (if applicable) as payment in full for covered benefits.	Delta Dental Premier Dentists have agreed to accept Delta Dental Premier Allowances, plus any required coinsurance and deductible (if applicable) as payment in full for covered benefits	You will be responsible for any required coinsurance and deductible (if applicable) as well as the difference between the non-participating dentist's charge and Delta Dental's payment for covered benefits.
	The amount you would owe a Delta Dental Premier Dentist who is not a Delta Dental PPO Dentist may be higher than the amount you would owe a Delta Dental PPO Dentist for the same covered benefits.	The amount you would owe a non-participating dentist may be higher than the amount you would owe a Delta Dental PPO or Delta Dental Premier Dentist for the same covered benefits.

To receive an estimate of what's covered, what Delta Dental will pay, and what your share of the cost is, you should request that your dentist submit a "Predetermination of Benefits" to Delta Dental when your dentist recommends dental services.

Advantage of Using In-Network Providers

To help save on your out-of-pocket dental costs, you can choose a Delta Dental PPO Dentist or Premier Dentist. Using the network is voluntary, but participating dentists offer services at the

negotiated charge, lowering your cost of care. Also, Delta Dental's in-network providers submit claims directly to Delta Dental for you.

To locate an in-network dentist or to determine if your dentist is part of Delta Dental's network, call 844-344-8006 or visit www.deltadentalva.com.

Using an Out-of-Network Provider

When you are enrolled in a dental benefit option and use an out-of-network provider, any amounts above what Delta Dental considers a reasonable charge are your responsibility — this means that any amount that the provider wishes to charge above what Delta Dental will pay may be billed to you by the provider.

Reasonable charges are charges for covered services and supplies that are no more than the amount normally charged by most providers in your area as determined by Delta Dental. You are also responsible for your share of reasonable charges.

Out-of-network providers may not submit your claims on your behalf which means that you may have to submit the claim to Delta Dental yourself to facilitate payment under the dental benefit terms. For assistance filing a dental claim, you may call Delta Dental at 844-344-8006 or visit www.deltadentalva.com.

Right Start 4 Kids®

Right Start 4 Kids from Delta Dental is a benefit that helps remove cost barriers to dental care for children up to age 13. This program provides 100% coverage for diagnostic and preventive and basic and major services, with no deductible, when you visit an in-network dentist.* Coinsurance levels apply when visiting an out-of-network dentist.**

*Right Start 4 Kids is subject to applicable limitations, exclusions, waiting periods and annual maximum. Check your plan details for specific coverage. ** Orthodontic services are not eligible for the 100% coverage level.

Healthy Smile, Healthy You® Program

Healthy Smile, Healthy You® offers additional benefits for four important health conditions connected to oral health:

- Pregnancy
- Diabetes
- Certain High Risk Cardiac Conditions
- Cancer being treated via radiation and/or chemotherapy

If you have one of these conditions, you can enroll in the program to become eligible for one additional cleaning and exam. For pregnant members, the additional service will be during the

term of their pregnancy. Cancer patients will also be eligible for an additional fluoride application beyond the age of 19. Visit www.deltadentalva.com/EmployeeBrochure to learn more.

Advanced Treatment Approval

If you think your dentist's charges will be more than $250 for a planned course of treatment, you are encouraged to submit a Predetermination of Benefits to Delta Dental before treatment starts. Before beginning treatment, have your dentist submit the treatment plan to Delta Dental for review and estimation of coverage. The treatment plan can be submitted electronically or on a standard claim form. Claim forms are available on our website at www.deltadentalva.com or by contacting our Benefit Service department at 844-344-8006.

How Dental Claims (Benefits) Are Paid

Claims incurred with an in-network dentist are filed with Delta Dental via the dentist. If you visit a nonparticipating dentist, you may have to submit the claim. If you need to file a claim manually, you need to first pay your dentist and then submit a Claim Form along with an itemized receipt to Delta Dental.

Claim Forms are available on the Delta Dental website at www.deltadentalva.com or by calling the Benefit Service Department at 844-344-8066 (this number is also on your ID card). Submit claims to:

Delta Dental of Virginia
4818 Starkey Road
Roanoke, VA 24018-8542

Claims for dental benefits must be submitted within twelve (12) months of the date services are completed. For orthodontic services, a claim for benefits should be filed at the time of the banding. New enrollees, who are already in orthodontic treatment when this coverage becomes effective, should file a claim upon enrollment.

If you contribute to a Health Care Flexible Spending Account, you can use these funds to reimburse yourself for any eligible charges the dental benefit options do not cover. Reimbursement occurs automatically when you submit your Claim Form.

VISION BENEFITS

If you are enrolled in one of the Anthem medical benefit options, annual eye exams are covered. As a supplement to the benefits provided under the medical options or if you are not enrolled in a medical benefit option, Capital One offers vision coverage through Anthem Blue View Vision℠ for eye exams, lenses and frames, and contacts. You have the freedom to see any vision care provider you want, but you will maximize your benefits by using an Anthem Blue View Vision℠ in-network provider. Contact Anthem Blue View Vision℠ (www.anthem.com/capitalone or 866-723-0515) for details on in-network providers.

If you do not enroll for coverage under Anthem Blue View Vision℠ but are covered under one of our medical benefit options, you will have coverage for eye exams only.

For More Information

This section provides an overview of your Anthem Blue View Vision℠ plan. Please refer to the vision plan certificate in the *Appendix* for additional details including how the plan works, covered and ineligible expenses, participating providers, claims filing, etc. The information in this summary document, along with the supporting documents in the *Appendix*, serves as the Summary Plan Description (SPD).

In this section

Vision Benefits at a Glance

The table below provides an overview of key features of Anthem Blue View Vision℠ benefits.

Benefits and Covered Services	In-Network	Out-of-Network*
Routine Eye Exam (once per calendar year)	$0 copay	$35 allowance
Eyeglass Frames (one pair of frames every two calendar years for adults and one pair of frames every calendar year for children under 19)	$130 allowance, then 20% off remaining balance	$45 allowance

Benefits and Covered Services	In-Network	Out-of-Network*
Eyeglass Lenses		
Single vision lenses	100% after $20 copay	$45 allowance
Bi-focal lenses		$55 allowance
Tri-focal lenses		$65 allowance
Contact Lenses		
Elective conventional lenses	$130 allowance, then 15% off remaining balance	$75 allowance
Elective disposable lenses	$130 allowance (no additional discount)	$75 allowance
Non-elective contact lenses	Covered in full	$90 allowance

Additional benefits are available for lens enhancements, lens upgrades and progressive lenses. See the Anthem Blue View Vision℠ certificate in the *Appendix* for details.

*For out-of-network services, members pay 100% of any remaining balance after the Plan allowance.

How the Vision Benefits Work

When you enroll in vision benefits, you and your dependents are eligible for one annual eye examination through an Anthem Blue View Vision℠ in-network provider — no referral is needed. You also have the freedom to use any provider of your choice. However, if you use an out-of-network provider please note that you will be reimbursed at a contracted out-of-network rate. In addition, the provider must be paid in full at the time you receive the service.

The plan will pay 100% of the cost of the eye exam when you receive your eye examination from an Anthem Blue View Vision℠ in-network provider. If you see a provider who is not part of the network, the vision benefits will pay up to $35 and you are responsible for paying the difference. When you use an out-of-network provider, you must pay the provider in full and then submit a claim to Anthem Blue View Vision℠ for reimbursement.

It is important to remember that *the vision benefits will not pay for both glasses and contacts in the same year.*

Vision Discounts

When you are enrolled in vision benefits, Anthem Blue View Vision℠ offers discounts on eyewear products and services including a second pair of prescription glasses, prescription sunglasses, disposable contacts and laser vision correction services at the Anthem Blue View Vision℠ network.

For a complete listing of what is and isn't covered under the vision benefits, see the Anthem Blue View Vision℠ certificate in the *Appendix*, or contact Anthem Blue View Vision℠ at www.anthem.com/capitalone or 866-723-0515.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The Anthem Employee Assistance Program (EAP) can help you deal with personal issues that affect your health, family life, and work life or job performance— confidentially. The EAP is available to all Capital One associates (excluding Expatriates and interns) as defined in the Eligibility section; you do not have to enroll in a medical benefit option to have access to the EAP. In general, household members — including your spouse/domestic partner or dependent children (up to age 26) — are also eligible.

Maintaining your privacy is a high priority. All contact with EAP is confidential to the extent permitted by law.

For more information

This section provides an overview of the Anthem Employee Assistance Program (EAP). For more information visit Anthem's EAP website at www.anthemeap.com and enter "Capital One" to log in. Your home page shows your EAP choices, so you can start getting the help you need.

In this section

EAP Benefits at a Glance

You can call the EAP at any time and there is no limit on the number of times you can call.

For counseling sessions, you and your dependents are eligible for up to five face-to-face or telemedicine sessions with a qualified professional per situation. There is no cost to you or your household members for these sessions. Just call 855-383-7222 to be referred to a counselor or get your free telemedicine therapy visit coupon code for LiveHealth Online or Talkspace and details to make your first appointment.

There are times when you may require ongoing counseling in addition to your EAP benefits. If you are enrolled in a medical benefit option, your mental health benefits may cover continued services or treatment with the same counselor, allowing continuity in the transition from the EAP to medical benefits.

There are also web-based tools and resources available on Anthem's EAP website at

www.anthemeap.com. To learn more, visit the site and enter “Capital One” to log in. Your home page shows your EAP choices, so you can start getting the help you need.

How the EAP Works

The EAP is available online and via phone 24 hours-a-day, 7 days-a-week.

- In an emergency*:* If you are experiencing severe symptoms or you are in crisis and need immediate assistance, call your local 911 service or go to the nearest hospital emergency room.
- For non-emergency situations*:* Call an Anthem Health Guide at 844-390-4133 or the EAP directly at 855-383-7222. The Health Guide will connect you with a clinician who will evaluate your situation, answer your questions and refer you to the appropriate resources, based on your need.

What the EAP Does Not Cover

After the maximum of five sessions per situation, the EAP does not cover additional face-to-face counseling. After five sessions, you will be responsible for the cost of all sessions in excess of the allowed limit. Remember that you may have coverage for additional sessions under your medical plan’s mental health benefits if you are enrolled in one of the options. See the medical plan booklets available in the *Appendix* for additional details.

FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts (FSAs) allow you to set aside pre-tax dollars from your paycheck to pay for eligible health care and dependent day care expenses not covered by other benefits — which means you keep more money in your pocket.

For more information

This section provides an overview of Capital One's Flexible Spending Accounts (FSAs). For additional details about how to use the accounts, eligible and ineligible expenses and filing claims, refer to the Flexible Spending Account summary in the *Appendix*. Information is also available online at qme.anthem.com. The information in this summary document, along with the supporting documents in the *Appendix*, serves as the Summary Plan Description (SPD).

In this section

FSA Benefits at a Glance

Capital One offers two types of FSAs:

- Health Care FSA
- Dependent Care FSA

When you contribute to an FSA, your taxable pay is reduced by the amount you set aside, so you may lower your income taxes and Social Security taxes. In addition, Capital One contributes up to $500 for the Health Care FSA and up to $500 for the Dependent Care FSA. Company contributions are prorated for mid-year enrollees based on your enrollment date. You will receive $19.23 in Capital One contributions each pay-period that you are actively contributing to your FSA(s).

You can choose to participate in one or both accounts. You decide whether you'd like to participate and how much money you'd like to set aside in each account each year. Here's an overview of how the FSAs work.

	Health Care FSA (HCFSA)	Dependent Care FSA (DCFSA)
Contribution Limits *(maximums includes your contribution + Capital One's matching contribution)*	Minimum: $500 Maximum: $3,050	Minimum: $500 Maximum: $5,000*
Capital One Contribution	Up to $500	Up to $500
Covered Expenses	You and your family members' eligible medical, prescription drug, dental, and vision expenses incurred during the Plan Year (January 1 to December 31)	Eligible child and/or adult day care expenses incurred January 1 of the current plan year to March 15 of the following plan year
Unused Funds	You may carry over up to $610 (may be indexed in future years) if you enroll in a HCFSA for 2025 during Open Enrollment	Forfeited
Claim Submission Deadline	April 30 of the following Plan Year	April 30 of the following Plan Year

*The DCFSA maximum contribution is $2,500 each year if you are married filing separate returns

If you are a Highly Compensated Employee (HCE), your contributions to the Dependent Care FSA may be reduced.

Note: When you are reimbursed for expenses from a Flexible Spending Account, you cannot claim those expenses as deductions on your federal income tax or claim them as a tax credit.

Limited Purpose FSA

If you are enrolled in a Health Care FSA and then enroll in the CDHP medical plan for the following year, Capital One will automatically transfer any remaining balance greater than $50 (up to $610) into a Limited Purpose FSA. Money in a Limited Purpose FSA can only be used for eligible dental and vision expenses. Funds will be transferred into the Limited Purpose FSA and available after February 15 and funds transferred will no longer be available for reimbursement for the prior year's claims.

The Limited Purpose FSA is not a benefit you can elect during the annual open enrollment period.

How the FSAs Work

Associate Contributions

You fund both your Health Care FSA and Dependent Care FSA through payroll deductions.

The Company Contribution

Capital One contributes up to $500 to your Health Care FSA and up to $500 to your Dependent Care FSA. If you are not enrolled in the account for the entire Plan Year, with deductions coming out of your paycheck each pay period, your company contribution will be reduced.

Availability of Funds in Your FSA

Your FSA is funded through payroll deductions and company matching contributions. The timing for accessing the funds in your account varies.

- With the Health Care FSA, you may be reimbursed immediately for eligible expenses incurred during the calendar year up to the amount you have chosen to contribute for the year (including company match), even if that amount has not been deducted from your pay yet.
- With the Dependent Care FSA, your first payroll deduction activates the account, and you may begin receiving reimbursements once the first payroll deduction is in your account. Unlike the Health Care FSA, you cannot be reimbursed for more than the amount in your account at that time. You should wait to file your first reimbursement request until you see the first Dependent Care FSA deduction on your pay stub. You must have received services before submitting a reimbursement form.
- In general, your contributions and company contributions to the Health Care FSA end when you leave the company. However, you may be able to continue to participate in a Health Care FSA through COBRA. You will be responsible for your contributions as well as a 2% administrative fee. See "Group Health Continuation under COBRA — Coverage Rights," for more information. Company contributions to the account do not continue while you are on COBRA.

If you do not have eligible expenses before your termination and you do not continue your Health Care FSA while on COBRA, you will lose the money that was contributed up to the point of your termination. You will still be able to submit expenses incurred before your termination for reimbursement from the Health Care FSA for up to 90 days after the termination of your account or the claims submittal deadline, whichever is later.

For the Dependent Care FSA, you can continue using any remaining balance for claims incurred through March 15th of the year following your loss of eligibility as long as the claims are submitted by 90 days past the termination of the account or year-end claims submittal deadline, whichever is later.

If you are on an unpaid leave of absence you will not have contributions withheld while you are not receiving a paycheck, and therefore may not reach your annual election amount.

Using Your FSA

To be eligible, expenses must have been incurred during the calendar year (or grace period, as defined below) and while you were covered under the FSA. Pre-paid expenses are not covered until the year the service is rendered. In order to be reimbursed for a health care expense, you must submit to the Administrator an itemized bill from the service provider. The Company will also provide you with a debit card to use to pay for qualified medical expenses. When using the debit card, the Administrator will try to automatically substantiate the expense by determining if there is a corresponding claim that was applied to your Capital One medical or dental plan. You should not assume your claim will be automatically substantiated even if it was used to pay an expense that was applied to your medical or dental coverage. Unsubstantiated expenses will require you to provide an itemized receipt. Failure to substantiate expenses will result in the suspension of your card, and will require you to reimburse the account or have the unsubstantiated values be treated as taxable income.

In general, your cost share of any services received through Capital One's medical, pharmacy, dental or vision plans are considered eligible. Many other expenses are also eligible, and you are not required to be enrolled in Capital One medical, pharmacy, dental or vision plans to have covered expenses. The full list of eligible expenses can be found at qme.anthem.com.

The Dependent Care FSA can be used to pay for out-of-pocket work-related dependent day care costs. If you are married, you can use the account if you and your spouse both work, or, in some situations, your spouse goes to school full-time or is otherwise unable to provide care. Eligible expenses include day care (including before and after school programs, and day camps) for children under the age 13, pre-school expenses, and adult day care expenses provided the individual is a tax dependent.

You will be given a debit card to use to pay for your Dependent Care expenses, and can also submit documentation for reimbursement. In both cases, you will be required to make sure you have provided sufficient documentation to substantiate the expenses. Failure to do so will result in the debit card being deactivated and will require you to refund the account for any amounts unsubstantiated or have that amount be considered taxable income.

Other Important Information about FSAs

Before you enroll in one or both of the FSAs, there are some important rules that you need to know and understand.

Timing of Expenses and Claims

Using Flexible Spending Accounts can save you money when you make eligible purchases. However, there are strict rules about the timing of expenses and claims.

- The FSAs can be used to pay for expenses incurred during a calendar year (January 1 through December 31), or, if less than a full year, while you are actively contributing to the account.
- Dependent Care FSA expenses can also be incurred during the grace period (January 1–March 15 of the following year) as long as the enrollee was actively contributing to the account through December 31. There is no carryover of unused Dependent Care FSA funds beyond the grace period (January 1–March 15 of the following year). Any unused funds will be forfeited.

Note: If you are out of work on a paid or unpaid absence for reasons other than FMLA, military or educational leave, you are generally not eligible for reimbursements from your Dependent Care FSA for expenses incurred during your absence.

- Health Care claims must be incurred by December 31 of the plan year. You can carry over up to $610 (may be indexed in future years) in unused funds from your Health Care FSA balance to the next calendar year as long as you actively enroll in the Health Care FSA for the upcoming year. Any additional unused funds (that exceed the $610 carry over amount) will be forfeited.
- You cannot be reimbursed for expenses incurred before or after you were actively contributing to the account or before your employment with Capital One.
- Claims must be received at Anthem by April 30 of the following year.
- An expense is considered incurred when the care or service is provided — not when your provider issues a bill, nor when you receive or pay that bill. For example, if you pay a deposit for eyeglasses you order in December, but do not receive the glasses until April, the services are incurred in April and would therefore not be eligible for payment under the prior year's Health Care FSA.
- If you receive payment for a claim that is not eligible for reimbursement or which requires documentation that is not provided, any improper payment will constitute a debt that you must repay.

Making Changes to Your FSA Contributions

You may be able to make changes to your Flexible Spending Accounts if you notify Capital One within 31 days of a qualifying status change. Refer to "Changing Coverage " in the *Participation* section. You can also visit www.mybewellbenefits.com or contact the HR Benefits Center for information about qualifying status changes and the types of changes you can make to your accounts. You may not reduce your FSA contributions to any value less than what both you and the company have contributed to your account, or have already spent, for the year.

HEALTH SAVINGS ACCOUNT

A Health Savings Account (HSA) is a special tax advantaged bank account owned by you to pay for current and future health care expenses. To contribute to the HSA, you must be enrolled in the Consumer-Driven Health Plan (CDHP). Unlike Flexible Spending Accounts (FSA), there is no "use-it-or lose-it" rule — any year-end balance is always yours to keep. Use your HSA to accumulate tax-free money you can spend on eligible medical, prescription, dental, and vision expenses anytime — even in retirement. The HSA is not available with the Basic or Enhanced PPO plans.

In this section

Eligibility to Establish an HSA

The IRS has specific rules about HSA participation. To be eligible you:

- Must be enrolled in a qualified Consumer-Driven Health Plan (the Capital One CDHP is a qualified plan)
- Cannot be claimed as a dependent on another person's tax return
- Cannot be enrolled in Medicare Part A or Part B or Tricare
- Cannot have any other health coverage that is not a qualified CDHP
    - Not covered by spouse's or parent's medical or pharmacy plan
    - Not covered through a Flexible Spending Account plan (either Employer's, Spouse's or parent's)

You are responsible for determining if you are eligible for an HSA and how much you can contribute. See full requirements on IRS Publication 969, *Health Savings Accounts and Other Tax-Favored Health Plans.*

Associate Contributions

You may contribute to the HSA on a pre-tax basis through payroll deductions or on an after-tax basis directly through Anthem Spending Accounts. You may contribute up the annual IRS limits. For 2024, you and Capital One can make combined HSA contributions up to $4,150 for individual coverage or $8,300 if you cover dependents. This does not mean that you and your spouse can contribute $8,300; it is a combined contribution amount.

You may contribute an additional $1,000 to the account as catch-up contributions, beginning in the year you turn 55.

If you contribute on an after-tax basis, you may be able to claim those contributions on your tax return and receive the tax benefit. If you want to contribute through Anthem Spending Accounts directly, go to anthem.com/capitalone.

If you are contributing through payroll deductions, you may change your annual contribution amount (within the IRS contribution limits) at any time by visiting the Benefits application in Workday, or by contacting the HR Benefits Center at 1-888-376-8836. Your election amount will be taken out of each paycheck before taxes are calculated so you'll end up reducing your taxable income. It is important to note if you reduce your contribution amount, your new election amount cannot be lower than what you have already contributed for the year.

Company Contribution

While actively employed with Capital One and enrolled in the CDHP medical plan, the company automatically contributes to your HSA* — $500 for individual coverage and $1,000 if you cover any dependents. The company contributions will be made per pay-period ($19.23 for individual coverage/$38.46 when you cover a dependent), and will be pro-rated for mid-year enrollments based on when you begin having payroll deductions for your medical coverage.

*Company funding will only be applied when your HSA is established, open, and you have not hit your annual contribution limit.

Availability of Funds in Your HSA

No pre-tax contributions or company contributions will be deposited to your HSA until the account is open. Your account will not be considered open until you have successfully passed the customer identification process required to open an HSA.

You may access HSA funds as soon as they are deposited into your account each pay-period. You will only be able to use the available funds that are in your HSA at any given time. You'll receive part of Capital One's HSA contribution with each paycheck ($19.23 for individuals, $38.46 for families). If you incur expenses prior to Capital One's deposit into your account, you can reimburse yourself for those expenses incurred prior to Capital One's contribution being deposited into your account. Note: eligible expenses must be incurred after your HSA is established.

If you are on an unpaid leave of absence you will not have contributions withheld while you are not receiving a paycheck, and therefore may not reach your annual election amount.

Using Your HSA

For tax-free distributions, HSA funds must be used on eligible health expenses for yourself and tax dependents. You cannot use HSA funds to pay for your domestic partner's health care expenses on a tax favored basis, unless they are a tax dependent.

The list of eligible health expenses is the same for both the Health Care FSA and HSA. The list of eligible expenses can be found on qme.anthem.com.

HSA funds used to pay for non IRS-qualified medical expenses are considered part of your gross income and subject to an additional 20% excise tax. Exceptions include HSA distributions made after an account holder's death, disability, or after you turn 65. After you turn 65, you won't pay the penalty, but the distribution for non-medical expenses will still be subject to income tax.

Other Important Information About HSAs

Before you enroll in the HSA, there are some important rules that you need to know and understand.

Making Changes to Your HSA Contributions

You are able to make changes to your Health Savings Accounts throughout the year without a qualifying event. You can visit the Benefits application in Workday, or contact the HR Benefits Center for information about changing your contribution amount.

Customer Identification Process (CIP)

When you elect the CDHP medical plan with HSA, Capital One will automatically submit an application to open your HSA. Under the USA Patriot Act, the financial custodian of the HSA will need to verify the identity of the participant. The majority of participants pass the verification process on the first review. If they are unable to verify your identity, they may contact you for additional information. Should you receive a request from Anthem or Wealthcare Saver, the financial custodian, promptly provide the requested information to help resolve the identification verification process. If you do not complete the steps required to open your account (or are not able to open an account), any funding from your paychecks will not get posted to your account and will be returned to you through payroll, with applicable taxes withheld by the end of the year. You also forfeit the per paycheck company HSA contributions until your account is established.

Closing your HSA or Contributing Over the Maximum

Should you close your Anthem HSA while enrolled in the CDHP, you forfeit all company HSA contributions until you re-establish your account. Additionally, if you contribute to your HSA outside of payroll and hit the annual IRS limit, your contributions from Payroll may not be deposited into your account and you will forfeit remaining company HSA contributions.

HSA Contributions while on International Business Travel

Federal rules determine whether or not you are eligible for an HSA. One requirement is that you are covered by a qualifying high deductible health plan, such as the Anthem Consumer Driven Health Plan (CDHP), and have no other impermissible, non-CDHP coverage. When you go on an international business trip, you are generally covered through Anthem's GeoBlue Business Traveler Plan. This GeoBlue plan, however, constitutes disqualifying coverage for HSA-eligibility purposes during the part(s) of the year in which you are covered. Therefore, you must carefully review your HSA contribution amounts to ensure that you do not exceed IRS limitations for the applicable tax year.

The IRS generally determines HSA eligibility as of the first day of each month. The HSA annual contribution limit is calculated each month based on the number of months in the year that you are HSA-eligible, and an HSA contribution can only be made for those months in which you meet all the HSA eligibility requirements.

Example 1. An associate went on an international business trip and was covered under the GeoBlue Business Traveler Plan from September 2 to October 31, the associate's HSA contribution limit would be reduced by (1/12) of the associate's annual HSA contribution limit due to ineligibility for the month of October.

Example 2. An associate was covered under the GeoBlue Business Traveler Plan from October 31 through November 1, the employee's HSA contribution limit would also be reduced by (1/12) of the employee's annual HSA contribution for the month of November.

Example 3. An associate was covered under the GeoBlue Business Traveler Plan from October 2 through October 31, the employee's HSA contribution limit would not be reduced.

Be sure to factor in the company HSA contribution in the proration calculation.

To avoid potential IRS excise taxes on excess contributions to your HSA, you may need to adjust your payroll contributions to ensure that your annual HSA contributions do not exceed the applicable pro-rated annual contribution maximum. Capital One cannot make this change for you. The HSA is your personal account, owned by you, and determining eligibility for any contributions to or withdrawals from the HSA is your responsibility.

Consult your tax advisor if you have questions about the amount to reduce your contributions based on your individual circumstances.

Over Contributing to your HSA

If you make or receive an ineligible contribution to your HSA, excise taxes may apply unless you remove the contribution by certain deadlines. For more information about HSA eligibility, or how to correct ineligible contributions, contact your tax advisor or review IRS Publication 969, *Health Savings Accounts and Other Tax-Favored Health Plans*.

LIFE AND ACCIDENT INSURANCE

Capital One offers life and accidental death and personal loss (AD&PL) insurance coverage that provides financial protection for you and your dependents. Generally, only full-time and eligible part-time associates may participate in these benefits. Some lines of coverage are automatically provided by Capital One at no cost to the associate. Other lines of coverage are optional and paid for by the associate. Evidence of insurability (EOI) may be required for certain types or levels of coverage. EOI must be completed within 90 days of your benefit election request.

All life, AD&PL and Business Travel Accident (BTA) insurance offered by Capital One is administered by The Hartford with the exception of the EBIP administered by the Newport Group.

For more information

This section provides an overview of your life and accidental death and personal loss (AD&PL) insurance coverage options. Please refer to the insurance certificates for each plan available in the *Appendix* for additional details including how benefits are paid, accelerated death benefits, benefits if you become disabled or leave the company, additional benefits and losses not covered, claims filing, etc. The information in this summary document, along with the supporting documents in the *Appendix*, serves as the Summary Plan Description (SPD).

Life and Accident Benefits at a Glance

	Capital One Provided Coverage	Voluntary Coverage
Life Insurance	Basic Employee Life – 1x Annual Benefits Salary, rounded to next $1,000*, up to $500,000	Supplemental Employee Life — 1–8× Annual Benefits Salary, up to $2 million Supplemental Spouse/Domestic Partner Life — up to $250,000 in multiples of $25,000 Supplemental Child Life — $10,000 or $20,000 per child
AD&PL Insurance	Basic Employee AD&PL — 1× Annual Benefits Salary, rounded to next $1,000*, up to $500,000	Supplemental Employee AD&PL — 1–8× Annual Benefits Salary, up to $2 million – You automatically receive the same amount of Supplemental Employee AD&PL when you elect Supplemental Employee Life Insurance

	Capital One Provided Coverage	Voluntary Coverage
Business Travel Accident (BTA)	5x Annual Benefits Salary, rounded to the next $1,000, up to $1,000,000	N/A

*For VP+ executives, your Executive Life Insurance Program (ELIP) and AD&PL is calculated separately.

Under IRS regulations, if you have Basic Life, ELIP or Spousal Life insurance worth more than $50,000, part of the premium paid for this coverage is considered taxable income (imputed income).

Eligible Compensation

All associate lines of coverage are based on Annual Benefits Salary except for Executive Life Insurance benefits.

An associate's Annual Benefits Salary is effective January 1 of each calendar year and is equal to their base salary as of September 1 of the prior year. If an associate receives commissions or sales incentives, their Annual Benefits Salary includes those amounts received during the 12 months preceding September of the prior year. Annual Benefits Salary does not include annual performance bonuses, long-term incentives, operational non-annual performance, or achievement awards. If an associate is hired after September 1 of the prior year, their Annual Benefits Salary is equal to their base salary as of the hire date and does not include any commissions or sales incentives. If a Draw associate does not have a base salary, then their Annual Benefits Salary defaults to $50,000.

Paying for Coverage

Basic Life, Basic AD&PL, Executive Life (ELIP), Executive AD&PL, and BTA are fully paid for by Capital One. If you choose Supplemental Life and Supplemental AD&PL insurance, you pay for that coverage through after-tax payroll deductions. The amount you pay is based on your age and the selected amount of coverage.

Under IRS regulations, if you have any line of life insurance worth more than $50,000, the value of the coverage (as determined by the IRS Publication 15-B) less the amount you paid for this coverage is considered taxable income (imputed income) to you.

How the Plan Pays Life Benefits

Your Basic/ELIP Life and any applicable Supplemental Life or BTA insurance benefit is paid to your beneficiary(ies) when you die, as long as you are covered by the plan at the time of your death.

Naming a Beneficiary

When you enroll for coverage, you are asked to name a beneficiary — someone who receives your benefits if you die. If you wish, you can name more than one beneficiary. Your beneficiary designations apply to all associate lines of coverage including Basic, ELIP, Supplemental, and BTA Life and AD&PL insurance. Because family situations change, you should review and update your beneficiary designations regularly to ensure the information remains up-to-date.

To designate or update your beneficiary(ies), log in to the Beneficiary Designation website at http://enroll.thehartfordatwork.com/Caponebene.

- Your User ID is your initials followed by the last four numbers of your Social Security Number

  Example: If your name is Jane A Smith and your Social Security Number is 123-45-6789, your User ID is js6789.

- Enter your password, which is your initials followed by your date of birth (MMDDYYYY)

  Example: If your name is Jane A Smith and you were born on May 1, 1990 your password is js05011990.

Filing a Claim for Benefits

To get benefits, you or your beneficiary must notify The Hartford by calling 877-867-4790.

DISABILITY COVERAGE

Capital One values you as an important part of our organization and recognizes your contributions. That is why we want to help you recover from an illness or injury and have you back on the job as soon as medically appropriate. Disability coverage provides income in the event you are unable to work due to an approved disability resulting from a non-work illness or injury.

For more information

This section provides an overview of your Short-Term Disability and Long-Term Disability insurance coverage. Please refer to the plan summaries and insurance certificates available in the *Appendix* for additional details including how benefits are paid, accelerated death benefits, benefits if you leave the company, additional benefits and losses not covered, claims filing, etc. The information in this summary document, along with the supporting documents in the *Appendix*, serves as the Summary Plan Description (SPD).

In this section

Disability Benefits at a Glance

Capital One offers two types of coverage:

- Short-Term Disability — managed by Sedgwick
- Long-Term Disability — managed by NY Life

	Short-Term Disability	Long-Term Disability
Who is eligible	Full-time associates	Full-time and benefits eligible part-time associates (see "Who Is Eligible for Plan Benefits" for definitions)
Who pays for coverage	Capital One	Basic coverage — Capital One Supplemental coverage — you
Benefit	100% of either your Base Salary or your Annual Benefits Salary for the first ten weeks, then 85% of either your Base Salary or your Annual Benefits Salary. If you receive commissions, your Short-Term Disability benefit will be determined based on a calculation which includes a portion of your base salary and your Annual Benefits Salary	Basic: 50% of your Annual Benefits Salary Minimum: $100 monthly Maximum: $12,500 monthly Supplemental: 70% of your Annual Benefits Salary Minimum: $100 monthly Maximum: $17,500 monthly

	Short-Term Disability	Long-Term Disability
When benefits begin	After seven calendar days, due to a nonwork illness or injury. You must use sick time (for exempt associates) or paid time off (PTO) (for non-exempt associates) in order to be paid for the first seven days of your absence due to illness or disability. If you do not have sick/ PTO available, your time will be unpaid.	After your Short-Term Disability benefits end
Duration of benefits	187 calendar days	Generally, up to the end of the month of your 65th birthday as long as you remain disabled as defined by this coverage
Benefits paid	Pursuant to Capital One normal payroll practices	Monthly by NY Life

Your Annual Benefits Salary

An associate's Annual Benefits Salary is effective January 1 of each calendar year and is equal to their base salary as of September 1 of the prior year. If an associate receives commissions or sales incentives, their Annual Benefits Salary includes those amounts received during the 12 months preceding September of the prior year. Annual Benefits Salary does not include annual performance bonuses, long-term incentives or operational nonannual performance or achievement awards. If an associate is hired after September 1 of the prior year, their Annual Benefits Salary is equal to thei base salary as of the hire date and does not include any commissions or sales incentives.

How Disability Coverage Works

General Overview

Disability coverage is designed to give income protection to eligible associates in the event they are unable to work due to an approved disability resulting from a non-work illness or injury including organ donation or any procedure covered under the medical plan. It's important to understand how disability is defined for purposes of this coverage (see below). Also, disability coverage is offset by other income benefits.

What Is a Disability?

You will be considered to be disabled under Short-Term and Long-Term Disability if:

- You provide a doctor's written certification that you are not able, because of a non-occupational disease or injury, or due to pregnancy, to perform all of the material duties of your own occupation;
- Your income is 80% or less of your pre-disability earnings solely because of your disability;

- You are not able to work at your own occupation*; and
- Sedgwick or NY Life, the administrators, approve your disability.

*After the first 24 months of your Long-Term Disability, you will no longer be considered disabled if you are able to work at any reasonable occupation. A "reasonable occupation" is any gainful activity for which you are, or may reasonably become, fitted by education, training, or experience, not including work under an approved rehabilitation program.

The loss of a professional or occupational license or certification required by your own occupation does not necessarily mean you are disabled. You will need to meet the coverage's test of disability to be considered disabled.

If Your Disability Is Related to Alcohol, Drug Abuse or a Mental Health Condition

A period of disability ends after you've received benefits for 24 months if your Long-Term Disability is caused primarily by:

- A mental health or psychiatric condition, including related physical conditions, but excluding conditions with structural brain damage; or
- Alcohol and/or drug abuse.

If, before reaching the lifetime maximum benefit, you are confined in a hospital for more than 14 consecutive days, that period of confinement will not count against your lifetime limit. The confinement must be for the appropriate care of the above conditions.

What Disability Coverage Does Not Cover

Elective procedures, such as, but not limited to, elective cosmetic surgery, do not meet the definition of disability under Capital One disability coverage.

When Disability Benefits Begin

To begin receiving disability benefits, you must meet the requirements outlined below.

Short-Term Disability Application Deadline

You must apply for Short-Term Disability (STD) benefits no later than 30 calendar days from your first day absent due to a non-work related illness or injury. You are responsible for submitting supporting medical documentation as part of your STD application. Delay in submitting supporting medical documentation or the Attending Physician Statement may cause you to miss pay and impact our ability to approve your benefits. To avoid impacts to your pay, you are encouraged to apply after being out for 7 calendar days. Capital One has the sole discretion to extend the 30-day deadline due to extenuating circumstances (i.e. medical incapacitation such as a coma) preventing associates from timely submitting an application for STD benefits.

Short-Term Disability Benefits

You must be actively employed and have met the eligibility requirements to begin receiving Short-Term Disability (STD) benefits. If you are on a leave of absence at the time of your disability, you cannot collect STD benefits until you work for one fully scheduled workday. If you have already received STD benefits for a specific illness or injury and then need to go out again, you will need to work for 30 fully scheduled workdays in order to receive STD benefits for the same illness or injury.

You are considered actively at work if you were actively working on the day immediately preceding:

- A weekend (except where one or both of these days are scheduled work days)
- Holidays (except when the holiday is a scheduled work day)
- Paid vacation/paid time off
- Any non-scheduled work day
- Unscheduled paid time off/sick day
- Approved company time off (bereavement, family care, due to business needs)
- Approved state sick time

In addition, you must be and remain under the care of a practitioner to be eligible for Short-Term Disability benefits. A practitioner means a person duly licensed or certified, acting within the scope of their license or certification who is a physician, dentist, psychologist, physician's assistant or a nurse practitioner, or as to normal pregnancy or childbirth, a midwife, nurse midwife or nurse practitioner. A chiropractor is excluded from certifying disability.

Supplemental Long-Term Disability (LTD)

Generally, if you are disabled at the time of initial election of supplemental coverage, the coverage does not take effect for the current disability.

If you have already received LTD benefits for a specific illness or injury and then need to go out again for the same illness or injury before you work for 30 fully scheduled workdays, your prior benefit amount would apply and any change to your supplemental benefits will not be paid.

How Short-Term Disability and Long-Term Disability Interact with Other Income Benefits

Other income benefits for which you are eligible while you are disabled can affect the Short-Term and Long-Term benefits paid by this disability coverage. When calculating the benefit that Short-Term and Long-Term Disability will pay, other income benefits for which you, your spouse, your children or your dependents are ***eligible*** because of your disability are taken into consideration. These other income benefits are considered when your benefits under this coverage are calculated, ***even if you haven't enrolled or applied for them.***
Note: It is your responsibility to enroll or apply for benefits from other sources if you are eligible.

If other income benefits are paid at a different frequency than the Short-Term or Long-Term Disability benefits, they will be prorated at the same frequency as your disability coverage benefits.

See the section below for a list of income sources that will offset your disability coverage benefits. The total amount of income replacement you receive, including these additional benefits, does not change. For Long-Term Disability, it is still a total of 50% (or 70% if you elected Supplemental coverage) of your Annual Benefits Salary.

State Disability Benefits, Workers' Compensation and Other Offsets

If you work in a state that provides paid benefits, it is your responsibility to apply for those benefits. However, whether or not you apply, your Short-Term ("STD") and Long-Term ("LTD") benefits will be offset/reduced by the maximum amount from the state. This offset/reduction of STD benefits will occur starting the first day you receive STD or LTD benefits. Once you apply and receive any state

paid benefits that are available, if the actual payment you receive from the state is less than the maximum amount that was used to offset/reduce your STD or LTD benefits, you are responsible for submitting the award/denial letter from the state to Sedgwick (STD) or NY Life (LTD). Once you submit, your STD or LTD benefits will be recalculated and you will receive any additional benefit payment due.

If you become eligible for Workers' Compensation benefits, those benefits are paid in place of Short-Term Disability benefits, and no Short-Term Disability benefits are paid while Workers' Compensation benefits are being paid. However, under Long-Term Disability, Workers' Compensation benefits become an offset for benefits versus an exclusion.

If you become eligible for insurance claim payments other than Workers' Compensation, those benefits offset your Disability benefits. The total amount of your pay replacement will never be more than the amount you are eligible for under Disability or the other insurance, whichever is higher.

If you receive severance or other separation pay following termination from Capital One, your Short-Term and Long-Term Disability (if applicable) will continue until such time you are no longer certified as disabled. No offset will occur.

Short-Term Disability Benefit Reductions for Partial Work

If you return to partial work while on Short-Term Disability, you will receive regular pay for time worked in accordance with Capital One's pay policies. If approved, your Short-Term Disability benefits will be prorated as follows:

Weeks 2-10	Weeks 11-26
paid 100% for hours not worked in connection with approved Short-Term Disability	paid 85% for hours not worked in connection with approved Short-Term Disability

Long-Term Disability Benefit Reductions for Partial Work

During the first 24 months you return to partial work, while on Long-Term Disability, and earn less than 80% of your monthly Indexed Earnings, you will be eligible to receive up to 100% of your monthly earnings. If your LTD benefit plus your monthly disability earnings exceed 100% of your monthly Indexed Earnings, NY Life will reduce your LTD benefit so that it does not exceed 100%.

After 24 months of receiving disability earnings and your LTD benefit, your LTD benefit will be reduced by other income benefits and 50% of your disability earnings.

Indexed Earnings means after 12 months of receiving your LTD benefit and disability earnings, your Indexed Earnings will equal these covered earnings, plus an increase applied on each anniversary of the date you began receiving disability earnings and your LTD benefit. The amount of each increase will be the lesser of:

- 10% of your Indexed Earnings during your preceding year of disability; or
- the rate of increase in the Consumer Price Index during the preceding calendar year.

PURCHASED TIME OFF

General Overview

Each year during the Open Enrollment period, associates with at least 20 standard hours in Capital One's system of record (Workday) may purchase additional vacation or PTO in increments of 20 or 40 hours (regardless of your full-time or part-time status) for the coming year. Granted time off must be used prior to purchased time, and unused purchased time off will not be paid out or carried over into another calendar year at year-end. New hires are not eligible to purchase time off for their initial calendar year of hire.

Cost of Purchasing Time Off

Capital One uses your annual base salary as of January 1 (of the given year) to calculate the value of the Purchased Time Off you buy. If you buy Purchased Time Off, the cost is deducted from your paycheck on a pre-tax basis in equal installments throughout the year.

If You Are Approved for Long-Term Disability Benefits

If you are approved for Long-Term Disability (LTD), you can no longer continue the Purchased Time Off program once your leave of absence begins and future payroll deductions will stop. If you paid for more purchased time off than you used, your accrual will be adjusted to what you paid for year-to-date or used year-to-date, whichever is greater. Capital One will not collect overpayments if you used more purchased time off than you paid for. If you are on LTD during Open Enrollment, you will not be able to purchase time off for the coming year.

When Your Employment Ends

If you sever employment with Capital One, you will be paid out for any unused, purchased time off that you have already paid for during that calendar year. Your total purchased time off is not fully paid for until the last payroll period of the year. However, if you have taken more time than you have actually purchased and paid for, you will need to reimburse Capital One for this amount.

Additionally, if you have taken a leave of absence during the year and did not have payroll deductions for purchased time off, the purchased time off to be considered for payout will be based only on the pay periods in which you actually contributed. You will not receive a payout for any payroll periods in which you did not actually purchase time off.

RETIREE HEALTHCARE AND LIFE INSURANCE BENEFITS

In this section

Your Healthcare Options

You and your eligible dependents will have access to a variety of health insurance options, including options for those under age 65 and options for those who are Medicare eligible (age 65 and over). Capital One has partnered with Mercer Marketplace 365+ Retiree to provide enrollment support and assistance.

About Mercer Marketplace 365+ Retiree

Mercer Marketplace 365+ Retiree, a trusted partner of Capital One, is a service that will assist you in choosing coverage from a variety of individual health insurance options based on where you live. National insurance companies and regional insurers administer these coverages. You and your eligible dependents will have:

- More than one option to choose from and may choose coverage that best meets your individual health needs.
- The opportunity to purchase additional benefits, such as dental and vision.
- Access to one-on-one help from a licensed Mercer Marketplace 365+ Retiree benefits counselor. Benefits counselors will walk you through the entire decision-making process and help you choose the coverage that best meets your needs and your budget, taking into account:

    - The area where you live;
    - The doctors you use;
    - The medications you take; and
    - Other healthcare needs and preferences.
- Access to Mercer Marketplace 365+ Retiree benefits counselors year round to answer any benefit questions.
- The opportunity to review your health insurance coverage choice annually through Mercer Marketplace 365+ Retiree.

Who Is Eligible

Capital One provides access to retiree healthcare benefits to associates who have met the age and service requirements described below.

For more information

This section provides an overview of your Retiree Healthcare Benefits. Please refer to the Medical Benefit Booklet for each plan available from your plan provider for additional details including how the plan works, precertification requirements, covered and ineligible expenses, claims filing, as well as information about managed care programs.

Eligibility for Retiree Medical Benefits

Capital One provides retiree medical benefits to associates who have met the age and service requirements described below. You must be enrolled in Capital One's medical plan and you must meet the following age and service requirements to have access to retiree health benefits when you retire from Capital One:

- You must be age 55 or over
- You must have completed 10 years of service after age 45. When a break-in-service has been incurred, please refer to "Credited Service" in the *Eligibility* section of the Employee Welfare Benefits Plan Summary Plan Description for details regarding how service is counted

You can also cover your eligible dependents that are enrolled in a Capital One medical plan at the time you retire as long as you enroll yourself. Keep in mind, if you do not elect retiree coverage when you are first eligible, you cannot add coverage at a later date (unless you were enrolled in Capital One medical plans through COBRA immediately prior to enrolling in the retiree coverage).

Surviving dependents (spouses and/or children) of retirees may continue coverage following a retiree's death; however, new dependents cannot be added.

Special benefits resulting from an acquisition

If you were a former Hibernia employee and retired prior to the acquisition by Capital One, you are covered under the Physician's Mutual Medical and CVS Prescription Drug plans as described under "Special Coverage Groups". Your retiree benefits are administered by Mercer Marketplace 365+ Retiree. Benefit Counselors are available to assist you at 855-207-1979 (For deaf or hard of hearing: Dial 711 for Telecommunications Relay Service)

Company Subsidy

In 2008, Capital One began transitioning to offer access-only coverage at group rates for eligible full time associates who met retiree eligibility after December 31, 2012. "Access-only" retiree medical coverage means you have access to the group plan at the current rates, but Capital One does not subsidize any portion of the cost. Beginning in January 2022, the subsidy is made in the form of a Company contribution to a Health Reimbursement Arrangement (HRA).

Health Reimbursement Account Funding

For individuals who were eligible to retire from Capital One prior to December 31, 2012 Health Reimbursement Account (HRA) funding is provided to retirees and their eligible dependents who were enrolled in the Capital One medical plans at the time of retirement. Your HRA funding is based on your age at the time of retirement and, if applicable, the age of any dependents, if covered. The HRA funding changes once a participant reaches age 65 and is subject to change each year.

One HRA account is set up per household and the full annual allocation of HRA funding is provided at the beginning of the year, or as soon as administratively feasible for a retiree who enrolls mid-year. Unused HRA funding remains accessible to the retiree and spouse, if enrolled, until no eligible members of the household remain enrolled through Mercer Marketplace 365.

The HRA funding is provided to assist in paying for the cost of the plan you selected through Mercer Marketplace 365+, or for your cost of care. See the HRA Booklet in the *Appendix* for more details about how you can use your HRA funds.

HRA Funding Eligibility

The table below shows the retiree groups eligible for the HRA and those who are eligible for Medical access only with no HRA. If you are eligible, the monthly amount credited to your or your spouse/domestic partner's HRA for 2024 is determined by the Company as shown in the chart below.

	2024 Pre-65 Monthly HRA Allocation	2024 Medicare Eligible Monthly HRA Allocation
Legacy Capital One		

Met retirement criteria on or before 12/31/10	Retiree or Spouse: $700 Retiree & Spouse: $1,400 Retiree or Spouse & Child: $1,000 Child only: $300 Family: $1,700	Retiree or Spouse: $157.58 Retiree & Spouse: $315.17
Met retirement criteria between 1/1/11-12/31/12	Retiree or Spouse: $250 Retiree & Spouse: $500 Retiree or Spouse & Child: $400 Child only: $150 Family: $650	Retiree or Spouse: $52.50 Retiree & Spouse: $105.00
Met retirement criteria after 12/31/12	Access Only	Access Only
North Fork Bank		
Met retirement criteria on or before 12/31/10	Retiree or Spouse: $700 Retiree & Spouse: $1,400 Retiree or Spouse & Child: $1,000 Child only: $300 Family: $1,700	Access Only
Met retirement criteria between 1/1/11-12/31/12	Retiree or Spouse: $250 Retiree & Spouse: $500 Retiree or Spouse & Child: $400 Child only: $150 Family: $650	Access Only
Met retirement criteria after 12/31/12	Access Only	Access Only

	2024 Pre-65 Monthly HRA Allocation	2024 Medicare Eligible Monthly HRA Allocation
HSBC		

Met retirement criteria on or before 12/31/12	Retiree or Spouse: $250 Retiree & Spouse: $500 Retiree or Spouse & Child: $400 Child only: $150 Family: $650	Retiree or Spouse: $52.50 Retiree & Spouse: $105.00
Met retirement criteria after 12/31/12	Access Only	Access Only
Other Acquisitions		
Hibernia Regular Employees	Access Only	Access Only
Chevy Chase Bank	Access Only	Access Only
Other Acquisitions	Access Only	Access Only

Enrollment

How to Enroll

You will shop for and enroll in your retiree healthcare coverage through Mercer Marketplace 365+ Retiree. You have several options to choose from to meet your healthcare and prescription drug needs. Mercer Marketplace 365+ Retiree and its benefits counselors are ready to support you before, during, and after enrollment. They will help you understand the different individual plans offered to you, assist you in determining which plans provide the coverage you need, and complete your enrollment when ready.

When you enroll in retiree medical coverage through Mercer Marketplace 365+ Retiree, you may also be eligible for an HRA (Health Reimbursement Arrangement) account to offset the cost of your healthcare plan. (See the HRA Funding Eligibility table to determine if you are eligible.) This HRA, set up in your name, is a special, tax-free account that you may use to reimburse yourself for eligible healthcare plan expenses as defined by your employer and the IRS. For a retiree and any applicable dependent(s) to be eligible for the HRA, you must enroll in medical coverage through Mercer Marketplace 365+ Retiree.

Benefits counselors are available to support you during your enrollment period. You may reach Mercer Marketplace 365+ Retiree:

- Online at mercermarketplace.com/capitalone at your convenience, 24 hours a day, seven days a week.
- Any business day, from 8:00 a.m. to 5:30 p.m. ET at 855-207-1979 toll-free (deaf or hard of hearing individuals should dial 711) to set up a consultation.

To enroll follow these simple steps:

- Review the Enrollment Guide provided to you through Mercer Marketplace 365+ Retiree as soon as you receive it after you retire.
- If you are 65 or older and Medicare eligible, be sure you have enrolled in coverage for Medicare Parts A and B. You must have already enrolled in both in order to enroll in healthcare coverage with Mercer Marketplace 365+ Retiree. Contact the Social Security Administration at www.ssa.gov or by calling 800-772-1213 (TTY 1-800-325-0778) if you have not yet enrolled in Medicare Part B.
- Schedule a consultation with a licensed benefits counselor at retiree.mercermarketplace.com. From the navigation bar at the top of the page, click "Schedule a Consultation." If you prefer, you may also call to schedule.
- Enroll in your plan with your benefits counselor. When you are ready to enroll in your plan(s), you will:
    - Have your benefits counselor complete your enrollment over the phone; online self-enrollment is available only with certain carriers.
    - Provide information to set up payment for your premium.
    - Be sent any forms that are required; please review, sign, date, and return promptly.

What Happens If You Don't Enroll

In order to avoid a gap in coverage, you must enroll before your current coverage ends. Depending on the type of coverage, you have a period of time after your health coverage ends (typically 60 days for pre-65 plans, two months for Medicare plans, up to 63 days for Medicare Supplement plans) to enroll, but you may experience a gap in coverage if you wait until after your current coverage ends to enroll and you may be without coverage for a period of time. You will not be able to enroll retroactively in coverage.

If you do not elect COBRA or a plan through Mercer Marketplace 365 within 60 days of retirement, you will forfeit any HRA funding and access to the Mercer Marketplace 365.

Paying for Benefits

You will pay your premiums directly to the insurance carrier for your retiree healthcare coverage. If you are eligible for the HRA, you may be reimbursed monthly by Mercer Marketplace 365+ Retiree from your HRA. You can be reimbursed for your premiums via direct deposit into your bank account or a paper check.

Changing Coverage Elections

Pre-65 Coverage

Outside of the annual Open Enrollment Period—typically November 1st through December 15th—the only way you can obtain health insurance through Mercer Marketplace 365+ is through qualifying for a special enrollment period if you lose job-based coverage (i.e., COBRA).

Coverage If You are Age 65 or Older

Medicare Supplement plans can be changed at any point during the course of the year, but may require underwriting to do so; underwriting is when an insurance carrier collects your medical history to determine whether or not to accept your application for insurance and how much to charge you. There is a one-time window of guaranteed insurability after your initial enrollment into Medicare or after you leave a terminating group plan. After that window closes, carriers may ask you underwriting questions if you are changing your plan. Each carrier has its own rules, so it is important to discuss any changes you may wish to make with your licensed benefits counselor. There is no medical underwriting for changing Medicare Advantage plans, however, Medicare Advantage and Medicare Advantage Prescription Drug plans only accept enrollments during the Annual Enrollment Period (October 15th–December 7th) for a January 1st effective date. Additionally, Part D prescription drug plans can only be changed during the same Annual Enrollment Period for a January 1st effective date.

How to Initiate a Change in Your Benefits

Visit retiree.mercermarketplace.com to process your status change online. You must initiate your status change through retiree.mercermarketplace.com within 31 days of the date of the change in status.. Remember, if you are changing plans due to turning 65, you must have your coverage in place prior to turning 65 to ensure you have no gap in coverage.

When Coverage Ends

Your coverage under the Capital One benefits program ends when:

- You do not make required contributions;
- You drop coverage;
- Mercer Marketplace 365+ Retiree ends the contract for that coverage;
- You are no longer living; or
- Capital One terminates the Plan, or any benefit thereunder and/or any coverage option.

In addition, dependent coverage also ends:

- On the date your coverage ends (unless your coverage ends due to your death);
- On the last day of the month in which your dependent child turns age 26;
- On the date your dependent child otherwise ceases to qualify as a dependent under the plan;
- When your dependent is no longer living;

- In the case of your spouse, on the date your divorce or annulment is final; and/or
- In the case of your domestic partner, on the date your domestic partnership is terminated.

You and your dependents may not be dropped from the medical plan when the coverage ends, however, your HRA funding, if applicable, will end.

Coordination of Benefits

For more information, refer to the provider documents for the plans in which you enroll, or contact Mercer Marketplace 365+ Retiree at 855-207-1979 toll-free (deaf or hard of hearing individuals should dial 711).

Coordination with Medicare

To enroll in a plan through Mercer Marketplace 365, individuals aged 65+ must be enrolled in Medicare Part A and Part B. When you and/or your eligible dependents are eligible for Medicare, Medicare becomes the primary payer and any other medical coverage you have becomes the secondary payer. This means that Medicare pays benefits before any other medical plan pays benefits. The primary plan pays benefits first, up to that plan's limits. The secondary plan will *not* pay benefits until the primary plan pays a portion or denies a claim. The total benefits paid from both plans cannot be greater than the benefits under the plan that provides the greater benefits.

Health Reimbursement Arrangement (HRA)

When you enroll in new medical coverage through Mercer Marketplace 365+ Retiree and meet the eligibility requirements, Capital One will provide you with an HRA (Health Reimbursement Arrangement) account to offset the cost of your healthcare plan. This HRA, set up in your name, is a special, tax-free account that you may use to reimburse yourself for eligible healthcare plan expenses as defined by the plan and the IRS.

Once you select your new plan(s), you will first pay your premium(s) directly to your insurance carrier(s), then you will be reimbursed by Mercer Marketplace 365+ Retiree with available funds from your HRA account.

How the HRA Works

The HRA is a notional account established in your name and separately in your spouse/domestic partner's name, if applicable. "Notional" means a bookkeeping entry will be established on your behalf or your spouse/domestic partner's behalf; no specific funds are set aside for you or your spouse/domestic partner and the account does not earn interest. If you meet the eligibility requirements, you or your eligible dependent will be reimbursed for eligible healthcare expenses up to the notional amount credited to the HRA. IRS rules prohibit individuals from making

contributions to the HRA; however, any reimbursements you receive from the HRA for eligible healthcare expenses are not taxable to you.

Under current tax laws, the Company's cost for providing the HRA to domestic partners may result in "imputed income" to you, and you must pay tax on this income The Company will provide you with the appropriate tax forms indicating the amount of any imputed income. It is your responsibility to file your tax return accordingly.

The Company will credit a notional amount of benefit dollars to an HRA in your name for both you and your spouse/domestic partner on January 1 of each year that the Company continues to maintain the HRA Plan and that you remain eligible.

Using Your HRA

The amount credited to your or your spouse/domestic partner's HRA is available only for reimbursement of eligible healthcare expenses, which includes certain premiums. Premiums eligible for reimbursement generally include:

- Health insurance premiums
- Prescription drug premiums
- Income-related monthly adjustment (IRMAA) on Prescription Drug premium, if applicable
- Capital One COBRA premiums
- Dental premiums
- Vision premiums
- Medicare Part B premiums
- Income-related monthly adjustment (IRMAA) on Medicare Part B premium, if applicable
- Out-of-Pocket Expenses, including non-premiums, allowed by IRS Code Section 213(d) in IRS
- Publication 502 available at https://www.irs.gov/pub/irs-pdf/p502.pdf
- Prescription Drug Expenses of Medicare Part D Prescription Drug Plan

Note: Any expense for which you or your spouse/domestic partner have received reimbursement through your HRA cannot be used as a healthcare expense deduction on your or your spouse/domestic partner's federal income tax return. Additionally, any expense for which you or your spouse/domestic partner have received reimbursement cannot be reimbursed under any plan covering health benefits, including a spouse's or eligible family member's plan. You should consult your tax advisor for more details.

Additional HRA Information

See the HRA Booklet in the *Appendix* for more details about how you can use your HRA funds.

Retiree Life Insurance

Capital One provides retiree life insurance to eligible retirees who meet the age and service requirements as described in this SPD.

Retiree Life Benefits at a Glance

Eligible Retirees	Plan Highlights
Legacy Capital One Retirees age 50 and employed by Legacy Capital One on December 21, 1995	• Are eligible to receive $15,000 Group Term Life Insurance (unless age 50 and employed by Legacy your coverage has already been reduced because of your age) at no cost when you leave the company. • This coverage begins on the first day after termination and continues for the rest of your life
Executive Retirees (retired prior to January 1, 2022)	• Capital One executives who retired and terminated employment prior to January 1, 2022 • This coverage begins on the first day of the month after the month in which you sever employment or your active coverage amount ceases (such as in cases of redeployment). In the event you retire with a severance agreement, you are eligible to continue ELIP coverage for 12 months after your last day. Once the 12-month period ends, you will be eligible for retiree coverage • Your ELIP Life coverage amount is based on your manager level as of the date you sever employment: ○ VP to SVP — 100% of their base salary as of their separation date. ○ EVP — 20% of total target ○ Compensation – EC — 15% of total target compensation – Coverage cannot exceed $5 million.

Paying for Coverage

Capital One pays the full cost of the premium for retiree life insurance coverage for eligible retirees. Imputed income will be assessed for coverage values above $50,000.

How the Plan Pays Life Benefits

Your retiree life insurance benefit is paid to your beneficiary(ies) when you die, as long as you are covered by the plan at the time of your death.

Naming a Beneficiary

When you enroll for coverage, you are asked to name a beneficiary — someone who receives your benefits if you die. If you wish, you can name more than one beneficiary. Because family situations change, you should review and update your beneficiary designations regularly to ensure the information remains up-to-date.

To designate or update your beneficiary(ies), contact the dedicated retiree customer service team at 855-207-1979, Monday through Friday from 8:00 a.m. to 5:30 p.m. Eastern Time; deaf or hard of hearing individuals should dial 711 for Telecommunications Relay Service.

When Coverage Begins

Coverage becomes effective as of your retirement date.

When Coverage Ends

Your coverage will end on the earliest of the following:

- The date the policy terminates
- The date you are no longer in a class eligible for coverage, or the class is canceled

Filing a Claim for Benefits

To get benefits, you or your beneficiary must notify Mercer Marketplace retiree customer service team at 855-207-1979, Monday through Friday from 8:00 a.m. to 5:30 p.m. Eastern Time; deaf or hard of hearing individuals should dial 711 for Telecommunications Relay Service. .

When Benefits Are Payable

If you die while covered under the plan, the Hartford will pay your life insurance benefit after they receive the required notification and proof of loss.

Proof of loss may include, but is not limited to, the following:

- A completed claim form
- A certified copy of the death certificate (if applicable)
- Your Beneficiary Designation (if applicable)
- Any additional information required by the insurer to adjudicate the claim
- All proof submitted must be satisfactory to The Hartford

Special Coverage Groups

Hibernia Bank Executives

Former Hibernia Executives who signed a Change In Control or had an employment agreement through Hibernia remain eligible to access health plans mirroring our coverage for Active associates. Individual agreements (CIC, SRA and/or Employment agreement) dictate the individual's

eligibility rules, coordination with Medicare, cost of coverage and taxation provisions. For those who remained enrolled in a Capital One medical plan, should see the Medical booklets included in the *Appendix* for details.

Additionally, some were covered by the Hibernia Executive Bonus Insurance Plan (EBIP). EBIP was a Whole Life Insurance Plan offered by Hibernia before the acquisition of Hibernia by Capital One. EBIP was frozen at the time of the Hibernia acquisition, so participation is limited to executives who were already in the program prior to the acquisition. Executives who participated in EBIP were not eligible to participate in ELIP.

Under EBIP, covered Capital One associates are considered retirement eligible once they have completed 15 years of service, including time with Hibernia, and have reached the age of 55, or reached age 65 and not been terminated for Cause.

A policy is released when the executive has reached the age of 65 and is no longer employed by Capital One; or the executive has assumed ownership of the policy upon separation from Capital One and has not reached the age of 65. Capital One will release the EBIP policy(s) if you retire on or after reaching the age of 65. Once Capital One has released the policy, the executive may choose to continue the policy or receive the cash surrender value of the policy.

Select Retired Hibernia Bank Associates Only

Certain retired associates from Hibernia Bank have medical coverage through Physicians Mutual. Associated drug coverage is provided through CVS Caremark and is described below. Drugs that you need while you are confined in a hospital or other covered health care facility may be covered as part of your medical plan's inpatient benefit.

How the Prescription Drug Benefits Work

The following chart shows you how the former Hibernia Prescription Drug Program covers different types of prescription drugs. You have two ways to fill a prescription — at a retail pharmacy or by mail order. You can use any retail pharmacy you choose.

	In-network	Out-of-network
Retail and Specialty Pharmacy (Up to a 31-day supply)*		
Generic	$8 copay	Not covered
Brand Formulary	$25 copay	Not covered
Brand Non-Formulary	$40 copay	Not covered
Drugs Used to Treat Infertility	50% coinsurance The plan covers infertility drugs only when purchased at a network pharmacy	Not covered

Mail Order (Up to 90-day supply)		
Generic	$16 copay	Not covered
Brand Formulary	$50 copay	Not covered
Brand Non-Formulary	$80 copay	Not covered

* You may purchase up to a 90-day supply of oral contraceptives at a retail pharmacy. A separate copay applies to each 30-day supply.

CVS Caremark Formulary

The plan pays at different levels, depending upon the type of drug. If you use a generic or formulary drug, your cost will be less. Your prescription drug coverage is based upon CVS Caremark's formulary. The formulary is a list of preferred drugs that includes both brand name and generic drugs. You can reduce your share of the cost by using a covered generic drug or a covered brand-name drug that appears on the formulary. Your cost will be highest if your physician prescribes a covered brand-name drug that does not appear on the formulary list.

You can find CVS Caremark's formulary online at www.caremark.com or call CVS Caremark at the number on your ID card to request a printed formulary guide without charge.

Using Retail Pharmacies

Your medical ID card includes information about the CVS Caremark prescription drug program. Just present this card when you fill your prescription at any pharmacy nationwide.

	In-network	Out-of-network
For Each Fill or Refill at a Retail and Specialty Pharmacy (Up to a 30-day supply)		
Generic	$8 copay	Not covered
Brand Formulary	$25 copay	Not covered
Brand Non-Formulary	$40 copay	Not covered
Drugs Used to Treat Infertility	50% coinsurance The plan covers infertility drugs only when purchased at a network pharmacy	Not covered

You do not need to file a claim if you choose a pharmacy that belongs to CVS Caremark's network. You can find a list of CVS Caremark network pharmacies at www.caremark.com or by calling CVS Caremark.

Using Mail Order

For medications taken on a long-term basis (such as those for high blood pressure, birth control, allergies or diabetes), you may want to use the mail order service to save money and to avoid trips to the pharmacy.

	In-network	Out-of-network
For Each Fill or Refill through Mail Order (Up-to 90-day supply)		
Generic	$16 copay	Not covered
Brand Formulary	$50 copay	Not covered
Brand Non-Formulary	$80 copay	Not covered

If you order less than a 90-day supply, your cost is still the same. Because it can take two to four weeks to fill a prescription by mail, place your order well in advance.

To be sure you can start your medication immediately and take advantage of mail order pharmacy pricing, ask your doctor to write two prescriptions for you at once: one for a 30-day supply and a second for a 90-day supply. (Make sure the second is for a full 90-day supply — not a 30-day supply and two refills.) Take the 30-day supply prescription to your local network pharmacy to be filled and send the 90-day prescription to the mail order pharmacy.

To get a mail order form or to learn more about the mail order service, go to www.caremark.com; or call CVS Caremark.

GROUP HEALTH CONTINUATION UNDER COBRA — COVERAGE RIGHTS

In this section

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of health care coverage under the plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace (healthcare.gov). By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

Note: COBRA applies only to medical, prescription drug, dental, vision, Health Care FSA and to CVS Minute Clinics (in lieu of the *Be Well* Health Centers). It does not apply to any other benefits.

The right to COBRA continuation coverage was created by the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the plan and under federal law, contact the Plan Administrator.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your dependent children could become qualified beneficiaries if coverage under the plan is lost because of the qualifying event.

COBRA coverage is the same coverage that the Plan provides to other participants or beneficiaries under the Plan. Each qualified beneficiary who elects COBRA will have the same rights under the Plan as other participants or beneficiaries covered under the Plan's group health coverage elected by the qualified beneficiaries, including Open Enrollment and special enrollment rights. Under the Plan, qualified beneficiaries who elect COBRA must pay the full cost for COBRA coverage.

Who Are Qualified Beneficiaries?

If you are an employee, you become a qualified beneficiary if you lose your coverage under the plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you become a qualified beneficiary if you lose your coverage under the plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than their gross misconduct; or
- You become divorced from your spouse.

Your dependent children become qualified beneficiaries if they lose coverage under the plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than their gross misconduct;
- The parents become divorced; or
- The child stops being eligible for coverage under the plan as a "dependent child".

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Capital One, and that

bankruptcy results in the loss of coverage of any retired employee covered under the plan, the retired associate becomes a qualified beneficiary with respect to the bankruptcy. The retired associate's spouse, surviving spouse and dependent children also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the plan.

Subject to the provisions of the plan regarding the addition of new dependents, coverage may also be provided for any dependent a covered employee (or former employee) acquires during a period of COBRA continuation coverage. If the new dependent is a child born to or placed for adoption with the covered employee during a COBRA continuation period, that new child is treated as a qualified beneficiary. Other new dependents, such as new spouses, do not have independent rights as qualified beneficiaries (such as the right to extended coverage due to a second qualifying event). A child of the covered employee who is receiving benefits under the plan due to a qualified medical child support order (QMCSO) received by Capital One during the covered employee's period of employment with Capital One is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

Each qualified beneficiary has an independent election right for COBRA coverage. For example, even if the employee does not elect COBRA coverage, other family members who are qualified beneficiaries may elect to be covered under COBRA. Also, if there is a choice among types of coverage, each qualified beneficiary who is eligible for COBRA continuation coverage is entitled to make a separate election among the types of coverage. Thus, a spouse or dependent child may elect different coverage than the employee elects.

A covered employee or spouse can also make the COBRA election on behalf of all qualified beneficiaries and a parent or legal guardian may make the election on behalf of a minor child. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period will lose their right to elect COBRA coverage.

Family and Medical Leave Act (FMLA)

If you take a leave of absence that qualified under the Family and Medical Leave Act (FMLA) and do not return to work at the end of the leave, you (and your spouse and dependent children, if any) will have the right to elect COBRA if:

- You were covered by group health coverage under the Plan on the day before the FMLA leave began; or
- You became covered by group health coverage under the Plan during the FMLA leave; and
- You lose group health coverage under the Plan because the employee does not return to work at the end of the leave

COBRA coverage will begin on the earliest of the following to occur:

- When you definitively inform Capital One that you are not returning at the end of the leave; or

- The end of the leave, assuming you do not return to work.

Medicare and Other Coverage

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, as discussed in more detail below, a qualified beneficiary's COBRA coverage for medical will terminate automatically if after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied). When you complete the election form, you must notify the COBRA administrator if any qualified beneficiary has become entitled to Medicare (Part A, Part B or both) and, if so, the date of Medicare entitlement.

Please note that in the event you are covered under COBRA for medical while eligible for Medicare, the medical benefits through COBRA will pay secondary to Medicare, even if you are not enrolled in Part A or Part B. COBRA coverage is not considered "Active" coverage for purposes of determining if you qualify for a Special Enrollment Period (SEP) for Medicare.

When Is COBRA Coverage Available?

The plan offers COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the associate, or commencement of a proceeding in bankruptcy with respect to the employer, the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), a COBRA election will be available to you only if you notify the Plan Administrator in writing within 60 days after the qualifying event occurs or, if later, within 60 days after the coverage would otherwise end due to the qualifying event. Either you are or a representative acting on your behalf (such as a family member) is responsible for providing the required notice. You must mail or hand deliver this notice to Capital One's Employee Welfare Benefits Plan Administrator at 15000 Capital One Drive, Richmond, VA 23238. If you do not provide this notice within the applicable 60-day period, your spouse and dependents lose their eligibility for COBRA continuation coverage.

The notice must include the following information:

- The name of the employee who is or was covered under the Plan;

- The name(s) and address(es) of all qualified beneficiary(ies) who lost (or will lose) coverage under the Plan due to the qualifying event;
- The qualifying event giving rise to COBRA coverage;
- The date of the qualifying event;
- The signature, name and contact information of the individual sending the notice.

In addition, you must provide documentation supporting the occurrence of the qualifying event, if the Plan Administrator requests it. Acceptable documentation includes a copy of the divorce decree or dependent child(ren)'s birth certificate(s), driver's license or marriage license.

If the above procedures are not followed or if the notice is not provided to the Plan Administrator within the 60-day notice period, you will lose your right to elect COBRA. In addition, if any claims are mistakenly paid for expenses incurred after the date coverage would normally be lost because of the qualifying event, you will be required to reimburse the Plan for any claims mistakenly paid.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage is offered to each of the qualified beneficiaries.

How Long Is COBRA Coverage Provided?

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the associate, your divorce, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the associate became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the associate lasts until 36 months after the date of Medicare entitlement. For example, if a covered associate becomes entitled to Medicare eight months before the date on which their employment terminates, COBRA continuation coverage for their spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Otherwise, when the qualifying event is the end of employment or reduction of the associate's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

- A 29-month qualifying event, due to disability; or
- A second qualifying event.

29-Month Qualifying Event (Due to Disability)

If the qualifying event that resulted in your COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled. If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, all the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total of 29 months. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours and must last until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above). Each qualified beneficiary will be entitled to the disability extension, even if only one of them qualifies.

To continue coverage for the additional 11 months, you or a representative acting on your behalf must notify the COBRA Administrator in writing of the Social Security Administration's determination within 60 days after the latest of:

- The date of the Social Security Administration's disability determination;
- The date of the covered employee's termination of employment or reduction of hours; and
- The date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan because of the covered employee's termination of employment or reduction of hours.

You must also provide this notice within 18 months after the covered employee's termination or reduction of hours in order to be entitled to a disability extension. The notice must be provided in writing and must include the following information:

- The name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;
- The name and address of the disabled qualified beneficiary;
- The date that the qualified beneficiary become disabled;
- The date that the Social Security Administration made its determination of disability;
- A statement as to whether or not the Social Security Administration has subsequently determined that the qualified beneficiary is no longer disabled; and
- The signature, name and contract information of the individual sending the notice.

Your notice must include a copy of the Social Security Administration's determination of disability. You must mail or hand deliver this notice to the Plan Administrator at the address listed below under Contact Information.

If the above procedures are not followed or if the notice is not provided to the COBRA Administrator within the 60-day notice period, there will be no disability extension of COBRA coverage.

If, during continued coverage, the Social Security Administration determines that the qualified beneficiary is no longer disabled, the individual must notify the Plan Administrator of this determination within 30 days of the date it is made. The COBRA coverage will then end no earlier than the first of the month that begins more than 30 days after the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled. The notice must be provided in the same manner as described above, and include the same information required for a notice of disability as described above.

Second Qualifying Event

An extension of coverage will be available to the spouse and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in case of a disability extension, the 29 months) following the covered employee's termination of employment or reduction in hours. Second qualifying events include an employee's death, divorce, or a child losing dependent status (if such qualifying event would have resulted in a loss of coverage under the plan for an active employee or dependent). If you experience a second qualifying event, COBRA coverage for a spouse or dependent child can be extended from 18-months (or 29 months in case of a disability extension) to 36 months. In no event will coverage last beyond 36 months from the initial qualifying event or the date coverage would have been lost due to the initial qualifying event.

This extension is only available if you or a representative acting on your behalf notify the Plan Administrator in writing of the second qualifying event within 60 days after the later of:

- The date of the second qualifying event, or
- The date on which the qualified beneficiary would have lost coverage under the terms of the Plan because of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan as an active participant).

The notice must include the following information:

- The name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;
- The second qualifying event;
- The date of the second qualifying event;
- The signature, name and contact information of the individual sending the notice.

In addition, you must provide documentation supporting the occurrence of the second qualifying event, if the Plan requests it. Acceptable documentation includes a copy of the divorce decree, death certificate or dependent child(ren)'s birth certificates, driver's license, marriage license or letter from a university or institution indicating a change in student status.

You must mail this notice to the COBRA Administrator at:

Anthem Blue Cross and Blue Shield
P.O. Box 66350
Dallas, TX 75266-0350

If the above procedures are not followed or if the notice is not provided to the COBRA Administrator within the 60-day notice period, there will be no extension of COBRA coverage due to a second qualifying event.

Early Termination of COBRA Coverage

In certain circumstances, COBRA continuation coverage may end before the expiration of the applicable 18-, 29- or 36-month period described above. COBRA continuation coverage ends on the earliest of the following:

- The date Capital One discontinues the plan. However, if Capital One sponsors another plan, coverage may be continued under the other plan;
- The date any required contributions are not made (subject to a 30-day grace period);
- The date after the date of the election that an individual is covered under another group health plan. However, continued coverage for a particular illness or injury does not terminate until such time that the individual is no longer affected by a pre-existing condition exclusion or limitation under such other group health plan;
- The date after the date of the election that the individual becomes entitled to benefits under Medicare; or
- The month that begins more than 30 days after the date of a final determination by the Social Security Administration that the individual whose disability gave rise to a 29-month continuation period is no longer disabled.

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant not receiving COBRA coverage (such as fraud). In addition, the Plan reserves the right to terminate your coverage retroactively, if the Plan determines you are not eligible for COBRA.

The Health Insurance Portability and Accountability Act (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated. However, if the other plan's pre-existing condition rule does not apply to you because of HIPAA's restrictions on pre-existing condition clauses, the Plan may terminate your COBRA coverage.

You must notify the COBRA Administrator in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any preexisting condition exclusions have been exhausted or

satisfied). COBRA coverage will terminate (retroactively, if applicable) as of the date of Medicare entitlement or as of the beginning date of other group health coverage (after exhaustion or satisfaction of any pre-existing condition limitation). Capital One, the insurance carriers and/or HMOs may require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide the required notice.

In addition, you must notify the COBRA Administrator in writing if, during a disability extension of COBRA coverage, the Social Security Administration determines that the qualified beneficiary is no longer disabled. See "29-Month Qualifying Event (Due to Disability)".

How Much Does COBRA Continuation Coverage Cost?

Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay the full premium amount for COBRA continuation coverage. The full premium is normally 102% of the plan's cost of the continued coverage. For an individual whose coverage is being extended to 29 months because of disability, the cost of COBRA coverage during the 11-month extension is 150% of the plan's full cost of the continued coverage. Payments for COBRA continuation coverage are due monthly, subject to a 30-day grace period.

The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

Your first premium is due within 45 days after you elect COBRA coverage. If you do not make your first payment for COBRA coverage within the 45 days after the date of your timely election, you will lose all COBRA rights under the Plan. Thereafter, payments are due by the first day of each month to which the payments apply (payments must be postmarked on or before the end of the 30-day grace period). If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.

All COBRA premiums must be paid by check, money order or electronic check online. Your first payment and all monthly payments for COBRA coverage can be mailed to the Plan Administrator, or by calling the Plan Administrator, or paid via electronic check on their member site. If mailed, your payment is considered to have been made on the date that it is postmarked. Payments made via phone or through the member site are typically one-time payments. If you choose to pay via these routes each month, you must call or go online each month before the 31st deadline. You will not be considered to have made any payment by mailing a check if your check is returned due to insufficient funds or otherwise.

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. You are responsible for making sure that the amount of your first payment is correct. You may contact the COBRA Administrator to confirm the correct amount of your first payment.

COBRA coverage is not effective until you elect it and make the required payment. Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

What Are COBRA's Election Requirements?

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Covered associates may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. You must elect to continue coverage within **60 days** of the later of either:

- The date coverage would terminate, or
- The date notification of your COBRA election rights is provided

If no election is made within the applicable 60-day period, you, your spouse and dependents permanently and irrevocably lose your COBRA rights.

If You Have Questions

Questions concerning your plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, 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 http://www.askebsa.dol.gov. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep the Administrator Informed of Address Changes

To protect your family's rights, keep the COBRA Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the COBRA Administrator.

Plan Contact Information

Information about the plan and COBRA continuation coverage can be obtained on request by contacting Capital One's HR Benefits Center at 888-376-8836 (option 2 — Benefits), (option 0 —

Representative) or by writing to Capital One's Employee Welfare Benefits Plan Administrator, 15000 Capital One Drive, Richmond, VA 23238.

APPEALING A DENIAL OF BENEFITS

In the section

If your benefit claim is denied (known as an adverse benefit determination) and you disagree with the determination, you may contact the appropriate Claims Administrator (listed in "Plan Sponsors and Administrators") in writing to formally request an appeal. This section gives an overview of how to file an appeal and the appeal process for the different types of claims.

Note: Unless the right to an external review applies under the Medical benefit option, all decisions regarding appeals under the Plans are final and binding unless determined to be arbitrary and capricious by a court of competent jurisdiction.

Eligibility and Enrollment Claims and Appeals

How to File an Appeal

If you believe your application to enroll in or change any of the health and welfare plans subject to ERISA and covered by the Summary Plan Description was incorrectly denied, you may request a review of an adverse benefit determination at any time within 90 days following the date you received written notice of the denial. A failure to file a request for review within 90 days constitutes a waiver of your right to request a review of the denial of your eligibility and enrollment-related claim.

Your petition for review should be made in writing to the Eligibility Appeals Committee and should state your name and address, the fact that you are disputing the denial of a claim, the date of the initial notice of denial, and the reason(s), in clear and concise terms, for disputing the denial.

Send your appeal to:

Capital One Financial Corp.
15000 Capital One Drive
Richmond, VA 23238
Attn: HR Benefits Operations

The Appeal Process

The review of the eligibility and enrollment-related claim will be conducted by the Eligibility Appeals Committee. The reviewer will not be the same individual who made the initial adverse benefit determination that is the subject of the review, nor the subordinate of such individual.

During the review process, the Eligibility Appeals Committee will:

- Provide, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim;
- Permit you to submit written comments, documents, records and other information relating to the claim;
- Provide a review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial determination;
- Provide a review that does not afford deference to the initial claim determination and that is conducted by a plan fiduciary other than the person who conducted the initial claim determination (or a subordinate of that person).

Written Notice of Appeal Denial

If your claim is denied (in whole or in part) upon appeal, the written information will contain the following information:

- The specific reason for the decision and specific reference to the provisions of the plan on which the decision is based;
- A statement that you are entitled to receive, upon request and free of charge, copies of all documents, records and other information relevant to the claim for benefits;
- A statement describing any voluntary appeal procedures offered by the plan (such as External Review, as described in the following section) and explaining your right to bring a civil action under Section 502(a) of ERISA following the denial; and

- If any internal rule, guideline, protocol, or other similar criteria were relied upon in denying your claim, an explanation of those criteria or a statement that such criteria will be provided to you free of charge, upon request.

Medical Claims

For information about Claims and Appeals under the medical plans, please see the Anthem booklets available in the *Appendix*.

Health Center Claims, *Be Well* Incentive Claims

Initial Claim Determination

The Plan has a specific amount of time, by law, to evaluate and respond to claims for benefits covered by the Employee Retirement Income Security Act of 1974 (ERISA). The period of time the Plan has to evaluate and respond to a claim begins on the date the Plan receives the claim. If you have any questions regarding how to file or appeal a claim, contact the Claims Administrator for the benefit at issue.

In the event of an adverse benefit determination, the claimant will receive notice of the determination. The notice will include:

- The specific reasons for the adverse determination;
- The specific plan provisions on which the determination is based;
- A request for any additional information needed to reconsider the claim and the reason this information is needed;
- A description of the plan's review procedures and the time limits applicable to such procedures; and
- A statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.

In the event of an adverse benefit determination for a claim under health benefits, the notice will also include:

- If any internal rules, guidelines, protocols or similar criteria was used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request; and
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request.

How to File an Appeal for Benefits

You may request a review of an adverse benefit determination at any time within 180 days following the date you received written notice of the denial. A failure to file a request for review within 180 days constitutes a waiver of your right to request a review of the denial of your claim.

Your petition for review should be made in writing to the Appeals Committee and should state your name and address, the fact that you are disputing the denial of a claim, the date of the initial notice of denial, and the reason(s), in clear and concise terms, for disputing the denial.

Send your appeal to:

Capital One Financial Corp.
15000 Capital One Drive
Richmond, VA 23238
Attn: HR Benefits Operations

The Appeal Process

The review of health center and *Be Well* incentive claims will be conducted by the Appeals Committee. The reviewer will not be the same individual who made the initial adverse benefit determination that is the subject of the review, nor the subordinate of such individual.

During the review process, the Appeals Committee will:

- Provide, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim;
- Permit you to submit written comments, documents, records and other information relating to the claim;
- Provide a review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial determination;
- Provide a review that does not afford deference to the initial claim determination and that is conducted by a plan fiduciary other than the person who conducted the initial claim determination (or a subordinate of that person).

Written Notice of Appeal Denial

If your claim is denied (in whole or in part) upon appeal, the written information will contain the following information:

- The specific reason for the decision and specific reference to the provisions of the plan on which the decision is based;
- A statement that you are entitled to receive, upon request and free of charge, copies of all documents, records and other information relevant to the claim for benefits;

- A statement describing any voluntary appeal procedures offered by the plan (such as External Review, as described in the following section) and explaining your right to bring a civil action under Section 502(a) of ERISA following the denial; and
- If any internal rule, guideline, protocol, or other similar criteria were relied upon in denying your claim, an explanation of those criteria or a statement that such criteria will be provided to you free of charge, upon request.

Prescription Drug Claims

Initial Claim Determination

The Plan has a specific amount of time, by law, to evaluate and respond to claims for benefits covered by the Employee Retirement Income Security Act of 1974 (ERISA). The period of time the Plan has to evaluate and respond to a claim begins on the date the Plan receives the claim. If you have any questions regarding how to file or appeal a claim, contact the Claims Administrator for the benefit at issue. The timeframes on the following pages apply to the various types of claims that you may make under the Plan, depending on the benefit at issue.

In the event of an adverse benefit determination, the claimant will receive notice of the determination. The notice will include:

- The specific reasons for the adverse determination;
- The specific plan provisions on which the determination is based;
- A request for any additional information needed to reconsider the claim and the reason this information is needed;
- A description of the plan's review procedures and the time limits applicable to such procedures; and
- A statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.

In the event of an adverse benefit determination for a claim under health benefits, the notice will also include:

- If any internal rules, guidelines, protocols or similar criteria was used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request; and
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request.

How to File an Appeal for Benefits

Once you are notified that a claim is wholly or partially denied, you have the right to appeal.

- The internal appeals process begins in the CVS Caremark Customer Service department. Once you contact CVS Caremark with a request to appeal, you will be instructed on how to submit an appeal.
- Acceptable submission methods include fax or mail. In the case of urgent appeals, your physician may make the request by phone.
- Appeals for prior authorization (PA) denials may be forwarded directly to the Appeals Department per the directions in the PA denial letters.
- A participant or their representative must submit an appeal to CVS Caremark in writing no later than 180 days after receiving an adverse decision notification.
- Completed appeals forms and supporting documentation should be sent directly to the Appeals Department for processing. Call CVS Caremark customer service to maintain a copy of the forms needed.
- Appeals are to be processed within the following time frames from the date complete information is received:
    - *Pre-Service Claims*: 15 days
    - *Urgent Care Claims*: 72 hours
    - *Post Service Claims*: 30 days
- First level appeals are performed based on the Capital One's prescription benefit plan and approved prior authorization criteria.

The Appeals Process

Initial Benefit Reconsideration: 1st Level Appeal

The review process includes the consideration of relevant and supporting documentation submitted by and for the claimant. Supporting documentation may include a letter written by the practitioner in support of the appeal, a copy of the denial letter sent by CVS Caremark, a copy of the participant's payment receipt or medical records, etc.

- You or your representative must submit an appeal to CVS Caremark in writing no later than 180 days after receiving an adverse decision notification.
- Appeals are to be processed within the following time frames from the date complete information is received:
    - *Pre-Service Claims:* 15 days
    - *Urgent Care Claims:* 72 hours
    - *Post Service Claims:* 30 days
- You will receive a written explanation of the final determination.
- You may request a copy of the criteria relied upon in making the determination and any other information relevant to the determination by calling Caremark customer service.

- First level appeals are performed based on the Capital One's prescription benefit plan and approved prior authorization criteria.

Send appeals to:

CVS Caremark
P.O. Box 52196
Phoenix, AZ 85072-2196
877-210-3556
Reference: Capital One

Upon receipt, an appeals analyst reviews and determines appeals relating to non-clinical benefits (e.g., eligibility determinations, copay issues, explicit exclusions under the prescription benefit plan). Appeals determinations regarding clinical knowledge (e.g., PA denials) are reviewed by an appeals pharmacist. All appeal determinations shall be final subject to any provisions for additional review by Capital One.

If the 1st level appeal is denied, you have the right to a second and final level appeal.

External Review

Medical Necessity Appeals/Independent Physician Specialist Review: 2nd Level Appeal

CVS Caremark has contracted with independent external review organizations (IRO) to conduct independent specialist physician reviews of denials of authorization of benefits when you or a beneficiary is entitled to get such a review. These reviews will only be performed for denials of PA requests upheld on Initial Benefit Reconsideration (1st Level Appeal). An additional request from the participant or their representative must be made for this review to occur.

For such appeals, the following will occur:

- CVS Caremark will forward or cause to have forwarded to the IRO applicable medical records, documentation, plan language and specific criteria.
- Examples of supporting documentation that you may also submit to CVS Caremark can include required lab tests, clarification from your doctor regarding the specific denial reason, clinical information regarding the medical necessity for the denied medication, etc.
- The independent specialist selected by IRO to conduct the review will review documentation received with the case. If IRO considers additional information necessary or potentially useful in its review, IRO may contact you or your beneficiary's provider to request such information.
- The independent specialist selected by IRO will review available medical records, review any additional information obtained from the provider, and will write an independent rationale in support of their final decision.

- The letter containing the rationale will be forwarded to CVS Caremark for communication to you or your representative.

Appeal Determination Process

- Reviews are conducted within the applicable periods listed above for the appeal type.
- Appeal forms and associated documentation are stamped with the date and time of receipt.
- The appeal determination is rendered, and pertinent information is entered into the database.
- The determination is then communicated in writing to you or your representative.
- Communication is written in a manner calculated to be understood by you or your representative.
    - Communication includes general information that states the decision rendered.
    - When the original determination is overturned, the communication explains the basic steps or process that either CVS Caremark or you would need to follow.
- When the original determination is upheld, the communication provides the specific reason for the denial, and references the section of the prescription benefit plan on which the denial was based.

Confidentiality

- All the appeal documentation is handled in a confidential manner and in accordance with applicable statutes and regulations to protect the participant's identity and their prescription history.
- To promote confidentiality, all appeal information becomes a part of a permanent case file. Case files are then:
    - Prepared for each appeal;
    - Retained in a locked filing cabinet; and
    - Kept on file at CVS Caremark for a period of two years and off site for an additional five years.

Dental Claims

You have the right to appeal a denied claim or adverse benefit determination. Adverse benefit determinations are decisions Delta Dental makes that result in denial, reduction or termination of a benefit or amount paid. It may also mean a decision not to provide a benefit or service. Adverse benefit determinations can result from one or more of the following:

- The individual is not eligible to participate in the dental plan; or
- Delta Dental determines that a benefit or service is not a covered benefit because:
    - It is not included in the list of covered benefits;
    - It is specifically excluded;

- A benefit limitation under the dental plan has been reached; or
- It is not necessary or customary for the diagnosis or treatment of your condition (Dental Necessity).

The Appeals Process

Delta Dental will provide you with written notices of adverse benefit determinations within the periods shown in the following chart.

Type of Claim		Claim Procedures and Appeal Process
Post-Service Health Claim A claim that is a request for payment under the plan for covered services already received.	Step 1:	The plan has 30 days after receiving your initial claim to notify you of the benefit determination. The plan can take a one-time extension of 15 days for matters beyond their control. The plan must notify you within the initial 30-day period of the extension and the reason for the extension.
	Step 2:	For a denied claim, you have 180 days to appeal the adverse benefit determination and 60 days from receipt of notice to appeal any subsequent determinations.
	Step 3:	The plan has 60 days after receiving your appeal (30 days if the group allows two (2) levels of appeal) to notify you of the appeal decision. Both levels of appeal must be completed within the 60-day deadline.
Improper or Incomplete Claim A claim that does not include enough information for the plan to make a determination.	Step 1:	The plan has 30 days after receiving your claim to notify you of its decision. The plan can take a one-time extension of 15 days if they are unable to make a benefit determination due to insufficient information received with the claim. After receipt of the initial claim, the plan must notify you within 15 days if an extension is necessary.
	Step 2:	You have 45 days after receiving the extension notice to provide additional information or complete the claim.
	Step 3:	For a denied claim, you have 180 days to appeal the adverse benefit determination and 60 days from receipt of notice to appeal any subsequent determinations.
	Step 4:	The plan has 60 days after receiving your appeal (30 days if the group allows two (2) levels of appeal) to notify you of the appeal decision. Both levels of appeal must be complete within the 60-day deadline.

Notice to Claimant of Adverse Benefit Determinations

Delta Dental will provide written or electronic notification of any denial or adverse benefit determination.

Authorized Representative

You may authorize a representative to act on your behalf in pursuing a claims review or claims appeal. Delta Dental may require that you identify your authorized representative in writing in advance. For an urgent care claim, you may designate a dental care professional, who is knowledgeable about your dental condition, to act on your behalf. Delta Dental will deal directly with your authorized representative, rather than you, for matters involving the claim or appeal.

How to File an Appeal for Benefits

You or your authorized representative must file the appeal in writing and explain why you believe Delta Dental's decision was incorrect. Your appeal should include the following information:

- Name, address, and daytime telephone number;
- The member number and group number (as shown on the ID card);
- The patient's name, address, and daytime telephone number, if applicable;
- The date of service and name and address of the Dentist who provided the service.

You may submit written comments, documents, records, and other information relating to the claim even though Delta Dental did not consider the information when making the initial decision. You may request, and Delta Dental will provide to you free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim.

Delta Dental will conduct the appeal without deferring to the original adverse decision. The individual who conducts the appeal will not be the person who made the initial decision or that person's subordinate. Delta Dental will consult a dental care professional who has appropriate training and experience in the field of dentistry involved if dental judgment is required. The dental care professional consulted for the appeal will not be the person who was consulted in making the initial decision or that person's subordinate. Upon request, Delta Dental will identify the dental professional who was consulted and whether or not it relied on their advice in reaching its adverse decision.

Requests for appeal of an adverse benefit determination should be sent to:

Delta Dental of Virginia
Attn: Appeal Review
4818 Starkey Road
Roanoke, Virginia 24018-8542

Benefit Service Representatives are available during regular business hours to answer your questions.

You can reach them at 800-237-6060 or the toll-free number on the bottom of your Delta Dental of

Virginia ID card. Individuals with special hearing requirements may call 877-287-9039 to reach the Delta Dental of Virginia TTY/TDD member care line. If a matter cannot be resolved to your satisfaction based on a telephone call, Delta Dental's internal appeals process is available to you. This is a mandatory process. This means that you must use Delta Dental's internal appeals process before taking any legal action.

Grievances

Delta Dental wants you to be completely satisfied with the dental care and services you receive but recognize that there are times you may have questions, concerns or complaints. If you are dissatisfied with the service received from Delta Dental or that of a Participating Dentist, you may file a grievance with Delta Dental. A grievance is a complaint about quality of care or operational issues such as waiting times at provider offices, adequacy of participating provider facilities and network adequacy.

Grievances should be sent to:

Delta Dental of Virginia
Attn: Grievance Review
4818 Starkey Road
Roanoke, Virginia 24018-8542

External Assistance

If you are unable to contact or obtain satisfaction from Delta Dental, you may contact the following state agencies for assistance. You may contact the agencies in any of the following ways:

Address	Office of Licensure and Certification Virginia Department of Health 9960 Mayland Drive, Suite 401 Richmond, Virginia 23233-1463	Consumer Service Section Virginia Bureau of Insurance P.O. Box 1157 Richmond, Virginia 23218
Telephone Toll-Free	800-955-1819	800-552-7945
Richmond	804-367-2106	804-371-9691
Fax	804-527-4503	804-371-9944
Email	mchip@vdh.virginia.gov	bureauofinsurance@scc.virginia.gov
Website	http://www.vdh.virginia.gov	https://www.scc.virginia.gov/boi

If you have any questions about an appeal or grievance involving a Dental Service that you received and Delta Dental has not satisfactorily addressed, you may contact the Office of Managed Care Ombudsman for assistance. You may contact this Office in any of the following ways:

Address	Office of Managed Care Ombudsman Virginia Bureau of Insurance P.O. Box 1157 Richmond, Virginia 23218
Telephone Toll-Free	877-310-6560
Richmond	804-371-9032
Email	ombudsman@scc.virginia.gov
Website	www.scc.virginia.gov

Vision Claims

For information about vision plan Claims and Appeals, please see the vision plan booklet available in the *Appendix*.

Flexible Spending Account Claims

For information about Claims and Appeals, please see the Flexible Spending Accounts summary available in the *Appendix*.

Disability Benefit Claims

If a claim for Short- or Long-Term Disability benefits is denied or reduced, you will receive written notice of the denial within 45 days after your claim was received. The 45-day response period may be extended for up to an additional 30 days for Long-Term Disability claims because of circumstances outside the plan's control. In that case, you will be notified of the extension before the end of the initial 45-day period. If a decision cannot be made within the 30-day extension due to circumstances outside the plan's control, the time period may be extended for an additional 30 days. When this occurs, you will be notified of the new extension before the end of the original 30-day extension. The notice of extension will explain:

- The standards used to determine entitlement to a benefit;
- The unresolved issue that prevents a decision; and
- The additional information needed to resolve the issue.

The 30-day extension does not apply to Short-Term Disability claims.

You will be given at least 45 days for Long-Term Disability claims after receiving the notice to provide the additional information.

If your claim is denied, the notice of the adverse benefit determination will describe the specific reasons for the denial and the plan provisions on which they are based. The notice also will describe how claims are reviewed, and the steps for an appeal.

The Appeals Process

If you want to appeal a denial or reduction of a disability benefit, you or your legal representative may ask for a full review of the decision by filing a written appeal with the Claims Administrator.

For Short-Term Disability, send appeals to:

Capital One Leave and Accommodation Service Center
National Appeals Unit (NAU)
P.O. Box 14446
Lexington, KY 40512-4446
Reference: Capital One

For Long-Term Disability, send appeals to:

Life Insurance Company of New York
2000 Park Lane
Pittsburgh, PA 15275
Reference: Capital One

The appeal must be received by the Claims Administrator within 180 days of your receipt of the initial notice of denial. You may review any documents related to the claim, and you may submit written comments, documents, records and other material related to your claim to the Claims Administrator, regardless of whether the comments, documents, records and other material were included with the initial claim. You may ask that the plan provide you, free of charge, with copies of all documents, records and other information relevant to the claim.

The Claims Administrator's decision regarding your appeal will be made within 45 days of its receipt of your appeal. If special circumstances arise, the Claims Administrator may take an additional 45 days to decide your appeal. In that case, you will be notified of the extension before the end of the initial 45-day period. The notice will explain the special circumstances and indicate an expected decision date.

You will receive written notice of the decision. If the appeal is denied, the notice explains the reasons for the denial. Decisions by the Claims Administrator are final. (See "Your Rights under ERISA" for information regarding your rights once a final decision has been made.)

For disability claims, the Claims Administrator will ensure that all claims and appeals are adjudicated in a manner designed to ensure there is no conflict of interest with regard to the individual making the decision. The Claims Administrator will ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support a denial of benefits. The Claims Administrator will ensure that health care professionals consulted are not chosen based on the expert's reputation for outcomes in contested cases, rather than based on the professional's qualifications.

For disability claims, prior to making a benefit determination on review, the Claims Administrator must provide you with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the Medical claim. This evidence will be provided at no cost to you, and will be given before the determination in order to give you a reasonable opportunity to respond. Prior to issuing a final internal adverse benefit determination on review based on a new or additional rationale, the rationale will be provided at no cost to you. It will be given before the determination in order to give you a reasonable opportunity to respond.

For a disability claim, if the Plan fails to strictly adhere to all the requirements of the disability claims and appeals process with respect to your disability benefit claim, you are deemed to have exhausted the internal claims and appeals process. In this case, you may pursue legal remedies (as discussed below) without waiting for further Plan action. However, this will not apply if the error was de minimis, if the error does not cause harm to the claimant, if the error was due to good cause or to matters beyond the Plan's control, if it occurs in context of good faith exchange of information, or if the error does not reflect a pattern or practice of noncompliance. If a court rejects your demand for immediate review based on the exceptions above, your claim will be considered as refiled on appeal upon receipt of the court's decision, and the plan will notify you of the resubmission.

For adverse benefit determinations on disability claims, the notice will also include:

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
    - The views of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
    - The views of medical or vocational experts obtained by the plan, without regard to whether the advice was relied upon for the adverse benefit determination; and
    - Any Social Security Administration disability determination regarding the claimant presented to the Plan;
- A description of any applicable contractual limitations period, including the date on which the claim expires;

- Either the specific rule, guideline, protocol, standards, or other similar criteria relied upon in making the adverse benefit determination, or a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist; and
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request.

Fully Insured Benefits

For the Long-Term Disability Plan, if there is a conflict between the claims procedure set forth in this document and the insurance company's procedures, the insurance company's claims and appeal procedures apply.

Life, Accidental Death and Personal Loss Claims (AD&PL)

For more information about Claims and Appeals under the Life, AD&PL plans, see the insurance booklets available in the *Appendix*.

Retiree Medical

For information about Claims and Appeals under the retiree medical plans, please refer to the carrier materials available through the plan you select.

Health Reimbursement Account (HRA) Claims

You must file an initial claim for reimbursement in accordance with Mercer's procedures and requirements. Claims and first-level appeals are handled by Mercer and must be filed in accordance with these Claims and Appeals Procedures. Claims for benefits under the HRA are considered "Post-service claims." You must follow and exhaust these Claims and Appeals Procedures before you may be eligible to bring a lawsuit relating to HRA benefits under the Plan.

If Your Claim Is Denied

If your claim for reimbursement is denied, in whole or in part, you will be notified in writing within 30 days after Mercer Marketplace 365+ Retiree (Mercer) receives your claim. If Mercer determines that an extension of this time period is necessary due to matters beyond the control of the Plan, it 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 specific reason(s) for the denial.
- Any additional information or material necessary to perfect the claim and an explanation of why such information or material is necessary.
- The process for requesting an appeal.

First-Level Mandatory Appeals

If your claim is denied, in whole or in part, you have the right to appeal the decision. Mercer is the first level appeals administrator.

Your written appeal should include the reasons why you believe the benefit should be paid and information that supports, or is relevant to, your claim (written comments, documents, records, etc). Your written appeal may also include a request for reasonable access to, and copies of, all documents, records and other information relevant to your claim. You must submit your written appeal within 180 days from the date of the notice of denial.

The review of your appeal will take into account all comments, documents, records and other information submitted relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. You will receive a response to the appeal within 60 days after Mercer receives your claim.

If Mercer determines that an extension of this time period is necessary due to matters beyond the control of the Plan, it will notify you within the initial 60-day period that an extension is needed. If your appeal is denied, you will receive written notice of the decision. The notice will set forth:

- The specific reason(s) for the denial and the Plan provisions upon which the denial is based.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the denial of your claim.
- A statement of the procedure to appeal the denial of your claim and your right to obtain information about such procedure.
- A statement of your right to bring an action under section 502(a) of ERISA.

Second-Level Voluntary Appeal

If your first-level appeal is denied, you may submit a final voluntary appeal with the Capital One Plan Administrative Committee within 30 days of the denial of your mandatory appeal. The final voluntary appeal should include any new information pertinent to the claim. You will be notified within 15 days after your request was received whether the information is considered new information.

If it is determined that there is no new information pertinent to your claim, you will be notified that your final appeal will not be considered. If it is determined that there is new information, a decision will be made within 60 days of the date the Plan Administrative Committee receives the voluntary appeal. The Plan Administrative Committee is entitled to obtain an extension of an additional 60 days for consideration of a voluntary appeal. You will be notified if such an extension is necessary.

Authorized Representative

A member may designate a designated representative, but only through procedures established by the Plan Administrator. The Plan Administrator will provide a form for designation of representative to the member upon the request of the member. This form will provide the instructions and procedures for properly submitting the valid designation. Only those designations duly made through this process will be valid under the terms of this Plan. Any other attempt of purported designation of a designated representative not submitted to the Plan Administrator in accordance with these procedures is not valid for any purposes under the Plan and will be considered invalid, null and void.

Lawsuits Relating to the Plan

You must follow and exhaust these Claims and Appeal Procedures before you bring legal action relating to HRA benefits under the Plan.

Deadline for Lawsuit

The Plan provides a deadline for filing a lawsuit under ERISA relating to your benefits under the Plan. You should refer to the Plan Document for more information about this deadline.

In general, the deadline for a lawsuit is one year after the earliest of:

- The date an underlying health expense was incurred;
- The date the first benefit payment was actually made or allegedly due (whichever is earlier);
- The date the Plan, Company, Plan Administrator, Mercer, or any other agent or service provider first repudiated the alleged obligation to provide benefits;
- The earliest date on which you or your beneficiary (if applicable) knew or should have known of the material facts on which such action is based, regardless of whether you (or your beneficiary) were aware of the legal theory underlying the claim.

However, if a request for administrative review pursuant to the Plan's Claims and Appeals Procedures is pending when the deadline occurs, the deadline for filing such claim will be extended to the date that is 60 calendar days after the final denial (or deemed denial) of such claim or appeal on administrative review.

The Plan's deadline replaces and supersedes any later limitations period that otherwise might apply under applicable federal or state law. In the event of a claim or lawsuit brought by more than one person, the Plan's deadline applies separately to each person.

The Plan Administrator has the discretion to extend this deadline upon a showing of exceptional circumstances that provide good cause for an extension, in the Plan Administrator's determination. This limitations period will apply to the full extent permissible under ERISA.

Retiree Life Insurance

Claims and appeals for benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

Claims for Benefits

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should contact the Insurance Company's claims department . The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 90 days after receipt of your properly filed claim. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 90 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 180 days after your claim was received. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

However, any adverse benefit determination will be in writing and include: 1) specific reasons for the decision; 2) specific references to Policy provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; 4) a description of the review procedures and time limits applicable to such, and 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal.

Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 60 days from the date you received your claim denial. As part of your appeal:

- You may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
- You may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Insurance Company will make a final decision no more than 60 days after it receives your timely appeal. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 60 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 120 days after your appeal was received. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision. However, any final adverse benefit determination on review will be in writing and include:

1. Specific reasons for the decision and specific references to the Policy provisions on which the decision is based,
2. 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 the claim,
3. A statement of your right to bring a civil action under section 502(a) of ERISA, and 4) any other notice(s), statement(s) or information required by applicable law.

ADMINISTRATIVE PLAN INFORMATION

In this section you can learn more about who sponsors and administers Capital One's benefit plans and how to contact them. You can also learn more about the Plan Administrator, as well as information regarding future amendment and termination of the Plan.

In this section

Plan Sponsors and Administrators

Capital One is required to provide certain information about each of its plans, including the official plan name and number, sources of funding, type of administration, and the Claims Administrator.

Health and Welfare Plan

The Plan includes your medical, dental, prescription drug, vision coverage, wellness program, health centers, Health Care Flexible Spending Accounts, life, accident, disability, and Business Travel Accident coverage.

Plan Name	Capital One Financial Corp. Employee Welfare Benefits Plan
Plan Type	Health and welfare benefit plan
Plan Year	January 1 to December 31
Plan Number	501
Plan Sponsor	The plan sponsor for the Capital One benefit plans is: Capital One Financial Corp. 1680 Capital One Drive McLean, VA 22102-3491 703-720-1000

Employer Identification Number	54-1719854
Agent for Service of Legal Process	The agent for service of legal process is: Chief Legal Officer Capital One Financial Corp. 1680 Capital One Drive McLean, VA 22102-3491 Service of legal process also may be made upon the Plan Administrator.
Plan Administrator	This plan is administered by the Benefits Committee of Capital One Financial Corp. Capital One Financial Corp. 1680 Capital One Drive McLean, VA 22102-3491 703-720-1000 Certain administrative duties are performed by either administrative service companies who have entered into contracts with Capital One or individual insurance companies. (See Claim Administrators, below.)
Plan Funding	Medical, dental, prescription drug and wellness benefits, health centers, flexible spending accounts, health savings accounts and short-term disability are self funded by Capital One Financial Corp (not including Hawaii-associate coverage which is fully insured). This means that no separate trust fund or insurance contract has been established to provide benefits under those plans. All benefits are paid from Capital One's general assets. The claim administrators are responsible for administrative duties; they do not provide benefits payable under the plans. Vision benefits, associate life/AD&PL, dependent life, long-term disability,the Business Travel Accident plan and HMSA's medical, drug, dental and vision coverage are fully insured. This means that Capital One has entered into an insurance contract with third-party insurance companies to provide plan benefits. The insurance company is the fiduciary with respect to these claims. Under that contract, Capital One submits regular premiums to the insurance companies, and the insurance companies pay all benefits due under the plan. The claim administrator is also the insurer in these cases. In addition, in lieu of the claims and appeal procedures described in the Appeals section of this SPD, the insurer's own claims and appeals procedures will apply to benefits provided under that contract. The Plan Administrator will notify employees annually as to what the employee contribution rates will be. Capital One, in its sole and absolute discretion, shall determine the amount of any required contributions under

	the Plan and may increase or decrease the amount of the required contribution at any time. Any refund, rebate, dividend, experience adjustment, or other similar payment under a group insurance contract shall be applied first to reimburse Capital One for their contributions, unless otherwise provided in that group insurance contract or required by applicable law.
Claims Administrator	Capital One has engaged the services of the following third-party administrators. The Claims Administrator for all other benefits is the Capital One Benefits Committee or its delegate.
Medical/FSA/HSA	Anthem Blue Cross and Blue Shield P.O. Box 60007 Los Angeles, CA 90060-0007
Prescription Drugs	CVS Caremark P.O. Box 52196 Phoenix, AZ 85072-2196 877-210-3556 Reference: Capital One
Dental	Delta Dental of Virginia 4818 Starkey Road Roanoke, VA 24018-8542 844-344-8066
Vision	Anthem Blue View Vision℠ P.O. Box 8504 Mason, OH 45040-7111 866-723-0515
Life and Accident	The Hartford Reference: Capital One P.O. Box 14299 Lexington, KY 40512-4299
Business Travel Accident	The Hartford Group Benefits Division — Southern Division Reference: Capital One P.O. Box 2250 Alpharetta, GA 30023 888-560-9632
Short-Term Disability	Capital One Leave and Accommodation Service Center

	National Appeals Unit (NAU) P.O. Box 14446 Lexington, KY 40512-4446
Long-Term Disability	Life Insurance Company of North America a New York Life Insurance company 1601 Chestnut Street Philadelphia, PA 19192-2235
Retiree Medical/HRA	Mercer Marketplace 365+ Retiree P.O. Box 1440 Des Moines, IA 50306
Retiree Life Insurance	The Hartford Reference: Capital One P.O. Box 14299 Lexington, KY 40512-4299
COBRA	Anthem Blue Cross Blue Shield (Health Equity) P.O. Box 66350, Dallas, TX 75266-0350
Hawaii Health Plan	HMSA PO Box 860 Honolulu, HI 96808-0860

Plan Administrator

The Benefits Committee of Capital One Financial Corp. is the Plan Administrator for the Plan. The Plan Administrator's discretionary powers include, but are not limited to, the power to:

- Administer the plans and/or designate others to administer the plans;
- Make and enforce such rules and regulations as deemed necessary or proper for the efficient plan administration;
- Interpret the plans;
- Decide all questions concerning plans, including the right to remedy possible ambiguities, inconsistencies or omissions by general rule or particular decision;
- Determine the eligibility of any person to participate in plans and the entitlement of any person to any plan benefits; and
- Appoint other persons to render it advice and assist it in administering the plans, and designate other persons to carry out any of its responsibilities under the plans.

Any interpretation, decision or determination made by the Plan Administrator in good faith shall be final and binding on all persons claiming benefits under the plans. Benefits will be paid under the Plan only if the Plan Administrator decides in its discretion that the applicant is entitled to them. Where a third party is designated as Claims Administrator and as permitted by law, the Claims Administrator is hereby delegated discretionary authority to determine whether benefits are payable under the Plan and to interpret the terms of the Plan.

You may reach the Plan Administrator at:

Benefits Committee
Attention: Head of Benefits
Plan Administrator, Employee Welfare and Retirement Plans
Capital One Financial Corp.
15000 Capital One Drive
Richmond, VA 23238

Phone: 804-284-1000

Amendment and Termination

The Plan may be amended at any time by the Benefits Committee, or its delegate, company officers and their delegates may take all actions necessary or appropriate to implement any plan amendment.

While the Plan has been established with the intention and expectation that it will be continued indefinitely, Capital One has no obligation to maintain it for any particular length of time. Capital One reserves the right to discontinue or to terminate the Plan, partially or in its entirety, as of any date specified by the Board of Directors, the Plan Administrator or other authorized representative. The Benefits Committee may, for example, reduce or eliminate benefits provided to active and former associates, retirees, their dependents and beneficiaries, as applicable (with appropriate approval from the Board of Directors, where necessary), or may change eligibility requirements at any time. In addition, oral or written statements shall not change the terms of any plan or program. Absent an express delegation of authority from the Benefits Committee or its authorized delegate, no person has the authority to add or modify any benefit or benefit provision not provided under the Plan or to change eligibility criteria or other provisions of the Plan.

Any covered claims or expenses incurred before an amendment or termination of the Plan are covered only to the extent provided in the Plan immediately before the amendment or termination.

If a benefit under the Plan is terminated and surplus assets remain after all liabilities have been paid, such surplus shall revert to Capital One to the extent permitted under applicable law, unless otherwise stated in the applicable Plan document. If the entire Plan terminates, plan assets will be used for the benefit of participants and beneficiaries or to defray reasonable administrative expenses.

Legal Action

Before pursuing legal action for benefits under the Plan, you must first exhaust the Plan's claim, review and appeal procedures. Additionally, any lawsuit you bring for Plan benefits must be filed within 36 months of the date on which your claim is incurred under the Plan (unless the documents governing the particular plan benefit specify a shorter time frame).

LEGAL NOTICES

You have certain rights as a participant in the Capital One benefit plans, as described in this section.

In this section

Your HIPAA Privacy and Enrollment Rights

If you are declining health plan enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in health coverage if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in health coverage. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or get more information, contact the HR Benefits Center at 888-376-8836.

Your Rights under FMLA

Under the Family and Medical Leave Act of 1993 (FMLA), you have certain rights to take leave time and retain certain coverage and rights under various benefit plans.

See *Participation* for additional information on FMLA leaves.

Your Rights under USERRA

If you take a military leave, whether for active duty or for training, you are entitled to extend your medical, dental, vision, Health Care Flexible Spending Accounts, Health Savings Account, EAP, *Be Well* Health Centers, and Supplemental LTD coverage for the duration of your leave as long as you give Capital One advance notice of the leave (unless military necessity prevents this, or if providing notice would be otherwise impossible or unreasonable). You may continue Basic Life, Supplemental Life and Dependent Life for up to 24 months from your last day worked. This continuation coverage is pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Your total leave, when added to any prior periods of military leave from Capital One, cannot exceed five years. There are a number of exceptions, however, such as types of service that are not counted toward the five-year limit — including situations where service members are involuntarily retained beyond their obligated service date; additional required training; federal service as a member of the National Guard; and service under orders during war or national emergencies declared by the President or Congress. Additionally, the maximum time may be extended due to your hospitalization or convalescence following service-related injuries after your uniformed service ends.

If the entire length of the leave is:

- 30 days or less, you will not be required to pay any more than the contributions required for active employees.
- Longer than 31 days, you may be required to pay up to 102% of the full amount necessary to cover an employee (including any amount for dependent coverage) who is not on military leave.

If your leave is 180 days or longer, you will be able to take your unused Health Care FSA balance as a taxable cash distribution by the last day of the FSA plan year (extended for any grace period).

If you take a military leave, but your coverage under the Plan is terminated — for instance, because you do not elect the extended coverage — when you return to work, you will be treated as if you had been actively employed during your leave when determining whether an exclusion or waiting period applies to health plan coverages. USERRA permits a health plan to impose an exclusion or waiting period to an illness or injury determined by the Secretary of Veterans Affairs to have been incurred or aggravated during performance of service in the uniformed services.

If you do not return to work at the end of your military leave, you may be entitled to purchase COBRA continuation coverage if you extended benefits for less than 18 months. However, your military leave benefits continuation period runs concurrently with your COBRA coverage period, subject to the limitation of COBRA. This means that COBRA coverage and USERRA coverage begin at the same time. If you do not return to work at the end of your military leave, you may be entitled to continue COBRA continuation coverage for the remainder of the COBRA continuation period, if any. In other words, any continuation of coverage under USERRA will reduce the maximum COBRA continuation period for which you and/or your dependents may be eligible. (See "Group Health Continuation under COBRA — Coverage Rights".) Your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to continuation coverage elected. If COBRA and USERRA give you (or your covered spouse or dependent children) different rights or protections, the law that provides the greater benefit will apply.

Newborns' and Mothers' Health Protection Act

Maternity hospital stays under the plan will be covered for a minimum of 48 hours following a vaginal delivery or 96 hours for a cesarean section delivery. These minimums are set by a federal law called The Newborns' and Mothers' Protection Act. However, the plan may pay for a shorter stay if the attending provider (physician, nurse midwife or physician assistant) discharges the mother or newborn earlier, after consulting with the mother. See the Anthem booklets in the *Appendix* for details. The plan cannot require precertification for a stay of up to 48 or 96 hours, as described above — although stays beyond those times must be precertified. See the Anthem booklet for Precertification details.

Women's Health and Cancer Rights Act of 1998 — Rights after a Mastectomy

When a covered woman decides to have reconstructive surgery after a medically necessary mastectomy, the Women's Health and Cancer Rights Act requires the plan to cover these procedures:

- Reconstruction of the breast on which a mastectomy has been performed;
- Surgery and reconstruction of the other breast to create a symmetrical (balanced) appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient. Benefits for breast reconstruction are subject to annual deductibles and coinsurance provisions that apply to other covered medical and surgical benefits.

For answers to questions about the plan's coverage of mastectomies and reconstructive surgery, call Member Services at the number on your ID card.

Qualified Medical Child Support Orders (QMCSOs)

The Plan may be required to cover your child due to a Qualified Medical Child Support Order (QMCSO) even if you have not enrolled the child. You or your beneficiaries are entitled to a copy of the procedures governing Qualified Medical Child Support Orders (QMCSO) or court orders or decrees that apply to medical child support. To request a copy of the QMCSO procedures for Capital One's medical benefit plans, call the HR Benefits Center at 888-376-8836.

A QMCSO is any judgment, decree or order, including a court approved settlement agreement, issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law which has the force and effect of law in that state, and which assigns to a child the right to receive health benefits for which a participant or beneficiary is eligible under the Plan, and that the plan administrator determines is qualified under the terms of ERISA and applicable state law. Children who may be covered under a QMCSO include children born out of wedlock, those not claimed as dependents on your Federal income tax return, and children who don't reside with you. However, children who are not eligible for coverage under the Plan, due to their age for example, cannot be added under a QMCSO.

You may not cover grandchildren, unless you are their legal guardian. Similarly, you may not cover children who are not related to you (other than stepchildren or the children of your covered domestic partner) unless you have legal guardianship to provide them coverage.

You or your beneficiaries are entitled to a copy of the procedures governing Qualified Medical Child Support Orders (QMCSO) or court orders or decrees that apply to medical child support. To request a free copy of the QMCSO procedures for Capital One's medical benefit plans, call the HR Benefits Center at 888-376-8836.

Mental Health Parity and Addiction Equity Act of 2008

Under the Mental Health Parity and Addiction Equity Act of 2008, financial requirements and treatment limitations on mental health and substance use disorder benefits under the medical plan must be the same as medical and surgical benefits. The criteria for medical necessity determinations with respect to mental health or substance use disorder benefits will be made available upon request.

Genetic Information Nondiscrimination Act of 2008 (GINA)

Under GINA, effective May 1, 2009, Capital One will not:

- Use your genetic information to adjust a group or individual plan's premiums, deny coverage, or impose a preexisting condition exclusion;
- Require or request genetic testing; and
- Request, require, or purchase genetic information for underwriting purposes before your enrollment or in connection with enrollment.

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, 2023. 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	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid- a-to-z/hipp 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://kidshealth.ky.gov/Pages/index.aspx 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/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	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. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
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	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**
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.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx 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	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
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 July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/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

Medicare Part D Prescription Drug Plan - Notice of Creditable Coverage

Effective since 2006, every individual who is eligible for Medicare had the opportunity to enroll in the Medicare Part D prescription drug plan. We are required to annually provide every person who may be eligible for Medicare prescription drug coverage (and who may have coverage under the health plan offered by Capital One) with the enclosed Notice of Creditable Coverage. You and your family members should consider it carefully if this applies to you.

Important things to know about your rights

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. The prescription drug coverage provided under the CVS Caremark plan will provide you with better coverage than the standard Medicare Part D prescription drug plan. However, you may be able to obtain richer coverage than what is offered under a standard Medicare Part D prescription drug plan that may provide for better coverage than our CVS Caremark plan provides, but it is likely to be more expensive than the cost for the standard Medicare prescription drug coverage. Please be aware that Medicare Part D prescription drug plans vary from state to state.

2. Generally, you may be better off retaining your current coverage and NOT enrolling in any of the Medicare Part D prescription drug plans available to you; however, you should fully weigh your options. Here are some considerations:

- Your present coverage is more generous to you than standard Medicare Part D prescription drug plans.
- You won't have to pay the premium for the Medicare Part D prescription drug plan.
- If you enroll in Medicare later, you won't have to pay any penalty for doing so, as long as you enroll within 63 days after your prescription drug coverage under this plan ends for any reason.

If you do enroll in a Medicare Part D prescription drug plan:

- Capital One will NOT pay for your Medicare coverage
- You WILL NOT LOSE your coverage under the CVS Caremark plan
- Your Capital One premiums will not be reduced

The enclosed notice provides details about how to get more information about your options. We encourage you to read it carefully to fully understand how this new program impacts you.

Please read this notice carefully and keep it where you can find it. This notice has information about prescription drug coverage with Capital One and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare Part D prescription drug plans in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Part D prescription drug plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Capital One has determined that the prescription drug coverage offered by CVS Caremark is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare Part D prescription drug plan.

When can you join a Medicare Part D prescription drug plan? You can join a Medicare Part D prescription drug plan when you first become eligible for Medicare and each year from October 15 to December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare Part D prescription drug plan.

What happens to your current coverage if you decide to join a Medicare Part D prescription drug plan? If you decide to join a Medicare Part D prescription drug plan, your current CVS Caremark coverage will not be affected. Generally, if you are a retiree, if you do decide to join a Medicare Part D prescription drug plan and drop your current CVS Caremark coverage, be aware that you and your dependents will not be able to get this coverage back. If you are an active member and you drop your current coverage either at Open Enrollment or due to a qualifying event, you can re-enroll in coverage during the next Open Enrollment period.

When will you pay a higher premium (penalty) to join a Medicare Part D prescription drug plan? You should also know that if you drop or lose your current coverage with Capital One and don't join a Medicare Part D prescription drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare Part D prescription drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without Creditable Coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare Part D prescription drug plan coverage. In addition, you may have to wait until the following October to join. For more information about this notice or your current prescription drug coverage, contact the HR Benefits Center at 1-888-376-8836.

Note: You'll get this notice each year. You will also get it before the next period you can join a Medicare Part D prescription drug plan, and if this coverage through Capital One changes. You also may request a copy of this notice at any time.

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook.

You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit medicare.gov
- Call your state Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-medicare (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at socialsecurity.gov, or call them at 1-800- 772-1213 (TTY 1-800-325-0778).

Paperwork Reduction Act statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Your Rights under ERISA

As a participant in the Employee Welfare Benefits Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants are entitled to the rights described below.

Receive Information about Your Plans and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the plans, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the plans 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 plans, including insurance contracts, and copies of the latest annual reports (Form 5500 Series) and updated Summary Plan Descriptions. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plans' annual financial reports, if applicable. The Plan Administrator may be required by law to furnish each participant with a copy of these summary annual reports.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Employee Welfare Benefits Plan because of a qualifying event. You or your dependents may have to pay for this coverage. Review this Summary Plan Description and documents governing the Employee Welfare 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 fiduciaries, or the people responsible for the operation of employee benefits plans. Fiduciaries have a duty to function 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 getting a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to get copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. See above for a description of the plan's claims and appeal procedures. If your claim is denied, you cannot pursue the claim in court until you have timely requested a review of the denial in accordance with the plan's claims procedures. If you fail to follow claims procedures, you lose your right to sue the plan concerning your denied claim.

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 plans and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials,

unless the materials were not sent because of reasons beyond the control of the administrator. If, after following the plan's claims procedures, you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plans' 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 decides 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 plans, contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in getting documents from the Plan Administrator, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Office of Outreach, Education and Assistance, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave. NW, Washington, D. C. 20210. You may also get certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HIPAA Notice of Privacy Practices

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

Introduction

You are receiving this Notice of Privacy Practices (Notice) as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) because you are a participant or may become a participant in a group health plan component of the Capital One Financial Corporation Welfare Plan (the Plan) sponsored by Capital One Financial Corporation (Capital One). The group health plan components of the Plan include health, dental, vision, and health flexible spending accounts. This Notice applies to those benefits but does not apply to non-health plan components under the Plan such as disability and life insurance benefits.

Effective Date

This Notice was originally effective April 14, 2003 and has been modified as required by law or as otherwise appropriate. This version is effective November 10, 2021.

Protected Health Information (PHI)

The HIPAA privacy rules regulate the use and disclosure by the Plan of "protected health information" (PHI). PHI includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic). Individually identifiable health information is health information that identifies you or creates a reasonable basis to believe that it could be used to identify you, including information relating to your health condition or receipt of health care. Health information that is merely in summary form and that does not identify you as its subject is not PHI and may be used or disclosed by the Plan without restriction under HIPAA.

The vast majority of health information the Plan receives is not PHI. In most cases, the Plan only receives summary health information without identifying information. This type of information is typically provided by the Plan's healthcare provider and other vendors (Business Associates) and is not PHI. The majority of PHI received by the Plan is limited to information shared directly by associates for purposes of asking benefit-related questions, making claims inquiries and similar escalations. It is that information that is the subject of this Notice. Unlike the Plan, Capital One's Business Associates receive substantial PHI and are required to comply with the HIPAA rules applicable to them. This Notice is focused on use and disclosures of PHI received by the Plan, rather than by its Business Associates. Nevertheless, some sections below address PHI received by Business Associates to ensure you understand the rules regarding appropriate use of PHI, particularly, when authorization is required and when it is not.

Because the Plan receives some limited PHI, it is required by HIPAA to take reasonable steps to ensure the privacy of your PHI and to inform you about:

- The Plan's uses and disclosures of PHI;
- Your privacy rights with respect to your PHI;
- The Plan's duties with respect to your PHI;
- Your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
- The person or office to contact for further information about the Plan's privacy practices.
- HIPAA rules permit the Plan to use or disclose your PHI for certain purposes without your permission. The following categories describe the different ways the Plan (and in some cases its Business Associates) may use and disclose your PHI with or without your permission. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Uses and Disclosures of PHI

Required PHI Uses and Disclosures

Disclosures to You

Upon your request, the Plan is required to give you access to PHI maintained by the Plan in order to inspect and copy it.

Disclosures to the Department of Health and Human Services

Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

Uses and Disclosures Not Requiring Your Permission

Uses and disclosures to carry out treatment, payment and health care operations.

The Plan and its Business Associates are permitted by law to use PHI to carry out certain functions under HIPAA, including treatment, payment and health care operations, without your consent, authorization or opportunity to agree or object. The Plan and its Business Associates are also permitted to disclose PHI to Capital One for purposes related to treatment, payment and health care operations. Capital One has amended its plan documents to protect your PHI as required by federal law.

- Treatment —The Plan or its Business Associates may use or disclose your PHI to facilitate medical treatment or service by health care providers.
    - For example, Capital One's Business Associates may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental X-rays from the treating dentist.
- Payment — The Plan or its Business Associates may use or disclose your PHI to determine your eligibility for Plan benefits, to facilitate payment for treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. Such uses (typically performed by our Business Associates) may include, but are not limited to billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and pre-authorizations.
    - For example, Capital One's Business Associates may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.
- Health care operations — The Plan or its Business Associates may use or disclose your PHI for other activities related to the administration of the Plan, including but not limited to quality assessment and improvement, and reviewing competence or qualifications of health care professionals. Capital One's Business Associates may also use or disclose your PHI for

purposes of underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. Such activities may also include disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

- For example, Capital One's Business Associates may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions. Or, the Plan may use or disclose your PHI for purposes of annual renewals with benefits carriers and annual rate setting.

Uses and Disclosures to Business Associates

As noted above, the Plan contracts with Business Associates to perform various functions on the Plan's behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your PHI, but only after they agree in writing with us to implement appropriate safeguards regarding your PHI.

For example, the Plan may disclose your PHI to a Business Associate to help facilitate resolution of a question or administration of a claim which you raise with the Plan, but only if the Business Associate has entered into a Business Associate contract with us.

Uses and Disclosures to Certain Capital One Associates for Plan Administration Functions

The Plan may disclose your PHI to certain designated associates who are involved in the administration of the Plan. These disclosures will be made in connection with Capital One's role as the sponsor of the Plan, and will be made to enable the appropriate associates to carry out their duties in administering the Plan.

Capital One has instituted policies and procedures to help ensure that your PHI is made available only to those individuals who need it to perform important Plan functions. Such associates will only use or disclose information as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your PHI will not be used for employment actions or decisions or without your specific authorization.

Other Uses and Disclosures Not Requiring Your Permission

In addition, federal law allows the Plan to use or disclose your PHI without your consent, authorization or opportunity to object in under the following circumstances:

- Required or authorized by law. The Plan may disclose your PHI when required by federal, state or local law, or when authorized for intelligence, counterintelligence and other national securities activities.

- Public health risks. The Plan may disclose your PHI when public health risks exist. These actions generally include the following:
    - to prevent or control disease, injury, or disability;
    - to report births and deaths;
    - to report child abuse or neglect;
    - to report reactions to medications or problems with products;
    - to notify people of recalls of products they may be using;
    - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

- Health oversight activities. The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in:
    - Civil, administrative or criminal investigations;
    - Inspections;
    - Licensure or disciplinary actions (for example, to investigate complaints against providers); and
    - Other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

- Lawsuits or disputes. The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request, provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.

- Law enforcement purposes. The Plan may disclose your PHI when required for law enforcement purposes such as:
    - In response to a court order, subpoena, warrant, summons or similar process;
    - To identify or locate a suspect, fugitive, material witness, or missing person.
    - To provide information about the victim of a crime if, under certain limited circumstances, we are unable to get the victim's agreement;

    - To provide information about a death that we believe may be the result of criminal conduct; and
    - To provide information about criminal conduct.

- Coroners, medical examiners and funeral directors. The Plan may disclose your PHI when required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. The Plan may also disclose your PHI to funeral directors, as necessary to carry out their duties with respect to the decedent.

- Organ and tissue donation. The Plan may disclose your PHI to organizations that handle organ procurement or organ, eye, or tissue transplantation to an organ donation bank, as necessary to facilitate organ or tissue donation and transplant.

- Research. The Plan may disclose PHI for research when the individual identifiers have been removed, or when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

- Public safety. The Plan may disclose your PHI when consistent with applicable law and standards of ethical conduct, the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

- Workers compensation. The Plan may disclose your PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

Uses and Disclosures Requiring an Opportunity to Agree or Disagree

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if the information is directly relevant to the family or friend's involvement with your care or payment for that care; and

- You are incapacitated and/or there is an emergency situation; or
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Uses and Disclosures Requiring Written Authorization

Other uses or disclosures of your PHI not described above will only be made with your written authorization. You may revoke written authorization at any time, so long as the 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.

Rights of Individuals

Right to Request Restrictions on PHI Uses and Disclosures

You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. The Plan is not required to agree to your request. However, the Plan must agree to restrictions as to the disclosure of PHI for payment or health care operations if the information pertains only to a service that you have paid for out of pocket in full, unless the disclosure is otherwise required by law or for treatment purposes.

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

Such requests may be made to the applicable Claims Administrator or to the Plan's Privacy Committee. See "Whom to Contact at the Plan for More Information" for contact information.

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI.

"Designated Record Set" is defined to include the enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the group health plan components of the Plan; or other information used in whole or in part by or for the Plan to make decisions about individuals. Since the Plan receives very limited PHI (typically disclosed by associates for purposes of answering questions or facilitating claims), only the limited PHI received by the Plan will be included in an associate's designated record set from the Plan. All other relevant information is maintained by Capital One's Business Associates.

The requested information will be provided by the Plan within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

Requests for access to PHI should be made to the Plan's Privacy Committee. See "Whom to Contact at the Plan for More Information" for contact information.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

Right to Amend PHI

You have the right to request the Plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set. The Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, it may deny your request if you ask to amend information that:

- Is not part of the medical information kept by or for the Plan;
- Was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the information that you would be permitted to inspect and copy; or
- Is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with the Plan and any future disclosures of the disputed information will include your statement.

The Plan has 60 days after the request is made to act on the request. A 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Requests for amendment of PHI in a designated record set should be in writing, should provide a reason to support your requested amendment and should be made to the Plan's Privacy Committee. See "Whom to Contact at the Plan for More Information" for contact information.

Right to Receive an Accounting of PHI Disclosure

At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years before the date of your request. Such accounting generally need not include PHI disclosures made:

- To carry out treatment, payment or health care operations;
- To individuals about their own PHI; or
- Before the compliance date.

However, you may receive information on disclosures of your health information going back for three years for treatment, payment and health care operations disclosures, if the Plan maintains electronic health records of such data.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Such requests can be made to the Plan's Privacy Committee. See "Whom to Contact at the Plan for More Information" for contact information.

Right to Be Notified of a Breach

You have the right to be notified in the event the Plan discovers a breach of unsecured PHI. A reportable breach occurs when the unauthorized acquisition, access, use, or disclosure of unsecured PHI compromises the security or privacy of the protected health information (poses a significant risk of financial, reputational, or other harm to the individual).

Right to Receive a Paper Copy of This Notice upon Request

You have a right to receive a paper copy of this Notice even if you have already received a copy electronically. To get a paper copy of this Notice, contact the HR Benefits Center at 888-376-8836. You may also get a copy of this notice on mybewellbenefits.com by searching for "HIPAA."

A Note about Personal Representatives

You may exercise your rights through a personal representative by completing a Designated Recipient form. Your personal representative will be required to produce evidence of their authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual; or
- An individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

The Plan's Duties

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of their legal duties and privacy practices.

The Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan before that date. If a privacy practice is changed, a revised version of this notice will be provided to all past and present participants and beneficiaries for whom the Plan still maintains PHI. You will receive a copy of any revised notice from the Plan by mail or by email if you agree to delivery by email.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply to the following situations:

- Disclosures to or requests by a health care provider for treatment;
- Uses or disclosures made to the individual;
- Disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- Uses or disclosures that are required by law; and
- Uses or disclosures that are required for the Plan's compliance with legal regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

In addition, the Plan may use or disclose "summary health information" to Capital One for getting premium bids or modifying, amending or terminating the Plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom Capital One has provided health benefits under the Plan; and from which identifying information has been deleted in accordance with HIPAA.

Your Right to File a Complaint with the Plan or the HHS Secretary

If you believe that your privacy rights have been violated or if you have a complaint about the Plan's notification process for breaches of unsecured PHI, you may complain to the Plan's Privacy Committee. See "Whom to Contact at the Plan for More Information" for contact information. You

may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S. W., Washington, and D. C. 20201 or calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. You will not be penalized, or in any way retaliated against for filing a complaint with the Office for Civil Rights or with the Plan.

Whom to contact at the Plan for more information

If you have any questions regarding this notice or the subjects addressed in it or wish to enforce your rights under this notice you may contact the Plan's Privacy Committee:

Capital One Financial
Attn: Pam Ventura
Vice President, Benefits
15000 Capital One Drive
Richmond, VA 23238
Phone: 804-690-1348
Email: pamela.ventura@capitalone.com

To get a copy of this notice, please visit mybewellbenefits.com or contact the HR Benefits Center at 888-376-8836 to request a paper copy.

Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This notice merely summarizes the regulations. The regulations will supersede any discrepancy between the information in this notice and the regulations.

APPENDIX

This appendix is a complete list of all the additional documents available to provide details about each benefit plan described in this summary document. These supplemental documents along with the information contained in this summary document serve as the Summary Plan Description (SPD) for the Capital One Financial Corporation Employee Welfare Benefits Plan.

Topic	Links to Supporting Documents
Change in Status	COF-QLE-Matrix-for-SPD.pdf
Medical	
Anthem BCBS Basic Plan booklet	Capital-One-Medical-Basic-PPO-2024.pdf
Anthem BCBS Enhanced Plan booklet	Capital-One-Medical-Enhanced-PPO-2024.pdf
Anthem BCBS CDHP Plan booklet	Capital-One-Medical-CDHP-2024.pdf
Hawaii Health Plan (HMSA)	Hawaii-Health-Plan.pdf
Prescription Drug	
Benefits summary	Prescription-Drug-Benefits.pdf
Dental	
Delta Dental Basic Plan	Capital-One-Delta-Dental-Basic-Plan-2024.pdf
Delta Dental Enhanced Plan	Capital-One-Delta-Dental-Enhanced-Plan-2024.pdf
Vision	
Anthem Blue View Vision℠ Plan certificate	Capital-One-Certificate.pdf
Anthem Blue View Vision℠ Summary of Benefits	Capital-One-SOB.pdf
Flexible Spending Accounts	
Flexible Spending Accounts summary	Flexible-Spending-Accounts.pdf
Life and Accident Insurance	
Life and Accident Insurance Booklet — Associates	Basic-Supplemental-and-Dep-Life.pdf Associate-SCF-12_14_20.pdf Associate-SCF-11_1_22.pdf
Executive Life Insurance (ELIP) Booklet	ELIP-Supplemental-and-Dep-Life.pdf Executives-SCF-12_14_20.pdf Executives-SCF-11_1_22.pdf
Business Travel Accident (BTA) Insurance	
Business Travel Accident (BTA) Insurance summary	How-the-Plan-Pays-BTA-Benefits.pdf
Disability Coverage	
Short-Term Disability summary	Short-Term-Disability.pdf STD-90-Day-National-Emergency-Amendment.pdf
LTD certificate of coverage	FLK980219c01.pdf
LTD amendment (eligibility waiting period)	FLK980219a01.pdf

Retiree Medical and Life Insurance Benefits	
HRA Booklet	Capital-One-HRA-Reimbursement-Instructional-Guide.pdf
Life and Accident Insurance Booklet — Retirees	Retiree-Associates-Booklet.pdf
Life and Accident Insurance Booklet — Retiree Hibernia	Retiree-Hibernia-Booklet.pdf
Life and Accident Insurance— Retiree Executive ELIP	Retired-ELIP-Booklet.pdf