SUMMARY PLAN DESCRIPTION

Employee Welfare Benefits Plan

Effective January 1, 2021

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," on page 5) to participate in the various benefits offered by the program.

This summary document, along with the supporting documents included in the *Appendix*, on page 101, 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 SPD 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* on page 101.

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* on page 101. 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 Help Center 888-376-8836 www.capitalonebenefitsite.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 Centers**	For contact information on Health Center locations, visit the Health Center Pulse page
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
Health Care and Dependent Care Flexible Spending Accounts	Anthem Blue Cross Blue Shield 844-390-4133 anthem.com/capitalone
Employee Assistance Program	Anthem 855-383-7222 www.anthemeap.com (login: Capital One, no password required)
Life and AD&PL Insurance **Associate** **Dependent** **Business Travel Accident**	The Hartford 877-867-4790

For Questions About	Contact
Short-Term Disability	Capital One Leave and Accommodation Service Center, managed by Sedgwick 844-324-CAP1 (2271) viaOneexpress (https://claimlookup.com/capitalone.com)
Long-Term Disability	Cigna 800-238-2125 www.mycigna.com
COBRA	Anthem Blue Cross Blue Shield (WageWorks) 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* on page 101, 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" on page 5 in the *Participation* section), 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, 2021, unless otherwise noted.

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
- 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

PARTICIPATION

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 managers 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 more than 32 hours 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,
- Life/AD&PL insurance,
- Business travel accident insurance,

- Health center access,
- Disability (short and long-term) benefits*, and
- Purchased Time Off.

* You are automatically covered under Short-Term Disability coverage after completing 90 days of service, provided you continue to be a full-time associate.

Part-Time Eligible Associates

If you are a part-time eligible associate who has Standard Hours in Capital One's system of record of between 20 and 32 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 after 90 days of service (except as noted below):

- Medical and pharmacy benefits,
- Dental benefits,
- Vision benefits,
- Employee Assistance Program (EAP) benefits,
- Health Center Access,
- Flexible spending accounts,
- Life/AD&PL insurance,
- Business Travel Accident insurance,
- Long Term Disability coverage*, and
- 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, including the 90-day waiting period for health benefits for part-time associates, 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 Care program 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* on page 101.

Definitions of Eligible Dependents

- **Spouse —** Your spouse means 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; and
  - You are not legally married to anyone else.

The tax implications of covering a domestic partner are detailed under "Paying for Benefits" on page 11 in the *Participation* section.

- **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 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), or are older children with intellectual and/or physical disabilities, as defined below; and
    - 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 him or her 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 [Anthem], Delta Dental, The Hartford, etc.) of your child's condition within 31 days of the child's 26th birthday and periodically thereafter as may be requested. Your child is fully disabled if he or she is unable to earn his or her own living because of an intellectual or physical disability that started before the date he or she reaches the maximum age for dependent children, and he or she depends solely on you for support and maintenance.
- **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.

Note about Non-Eligible Dependent Children

- 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.

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 your 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" on page 58.

If You and Your Spouse/Domestic Partner Both Work for Capital One

Capital One's benefits program does not allow associates and their dependents to be doubly covered except for life and AD&PL insurance.

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 have children, you and your spouse or domestic partner may not both cover the children for medical, dental or vision coverage.

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" on page 16 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.

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 parents, divorced spouses or grandparents — even if they are your legal dependents.

Enrollment

How to Enroll

As a new hire or newly eligible associate, you will complete the online enrollment process through www.capitalonebenefitsite.com 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 Open Enrollment only if you have a qualifying mid-year election change event. (See "Changing Coverage " on page 13.)

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.

What Happens If You Don't Enroll

If you do not enroll in benefits:

- In your first 31 days of your employment (including part-time associates whose coverage is not effective for 90 days),
- 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, or
- During Open Enrollment for the following year

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	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. *Life and Accident Insurance* on page 50
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 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 after you have been employed for 90 calendar days. Part-time associates are not eligible for this coverage.
Long-Term Disability (LTD)	You are automatically covered at 50% of your Annual Benefits Salary. You must enroll in order to participate in Supplemental LTD that equals 70% of your Annual Benefits Salary. *Disability Coverage* on page 52
Employee Assistance Program (EAP)/Health Centers	Automatically covered — enrollment not required
Purchased Time Off	No coverage. Only available to elect during 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, Health Center access, 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 vacation/paid 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*; and
- 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.

By paying for these benefits with pre-tax contributions, you save money! That is because 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 his or her 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 laws.

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 his or her 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. Please speak to your tax advisor regarding whether your domestic partner and his or her children, if any, qualify for the special state income tax treatment. If they do qualify, you must notify the HR Help Center at 888-376-8836 immediately in writing of this special state income tax status.

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 and Purchased Time Off do not carry over to the following year and must be made annually during the Open Enrollment period.

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.

Mid-Year Changes

You may make changes to your benefit elections during the year (outside the Open Enrollment process) 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, such as moving outside of the 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.

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, as long as they are initiated within 31 days of the event date (or 60 days in the event of birth/adoption or loss/gain of government sponsored medical coverage).

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.
- Change coverage tiers
- Change medical plan options

- 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" on page 86 in the *Legal Notices* section for more about your rights under HIPAA.

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 through www.capitalonebenefitsite.com 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 period. 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 through www.capitalonebenefitsite.com 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 process through www.capitalonebenefitsite.com. 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 process through www.capitalonebenefitsite.com within 60 days of the date of birth.

Visit www.capitalonebenefitsite.com to process your status change online. You must initiate your status change through www.capitalonebenefitsite.com 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).

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 "Plan Administrator" on page 84) 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. Cost change mid-year elections do not apply to the Health Care FSA.
- **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. If the restriction is equivalent to a complete loss of coverage, and no other similar coverage is available, you may revoke your existing election.
  - **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.

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 un-enroll your dependent from a dependent care provider.

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.

Unpaid Leave of Absence

If you are on an approved unpaid leave of absence, you may stop your participation under the Plan. You also are not eligible for Short-Term or Long-Term Disability while on an approved unpaid leave, unless your leave qualifies as FMLA leave or Capital One places you on administrative leave.

If you choose, your medical, dental and vision coverage, life and AD&PL insurance, Flexible Spending Accounts and purchased time off may continue until you return. However, you must send a check to the respective vendor once a month to cover your portion of the benefits premiums. Or, if you choose, you may stop your participation in any or all benefits for the period of your unpaid leave, as allowed by the change in status rules. You may elect to stop benefits coverage through www.capitalonebenefitsite.com within 31 days of the day your leave begins.

If you lose any group health coverage during an unpaid FMLA leave, either because it ended due to the leave or because you did not make the required contributions, you may re-enroll when you return from your leave.

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, Supplemental and Dependent Life and AD&PL and Health Care Flexible Spending Accounts. The benefits can be extended for up to 24 months 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 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 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.

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," on page 58.) 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. 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. However, you may choose to continue your medical, health center, 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," on page 58). 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* on page 101 for details about converting your Life/AD&PL coverage.

A dependent that is dropped from coverage due to divorce, dissolution of a domestic partnership or 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 that your plans provide duplicate benefits. For this reason, many plans — including Capital One's — have a "coordination of benefits" provision.

For more information, refer to the medical and dental booklets in the *Appendix* on page 101. You may also contact an Anthem Health Guide at 844-390-4133 or Delta Dental at 844-344-8006.

Right of Recovery by the Plan (Subrogation)

When the Plan pays benefits to you for expenses incurred due to third party injuries, then the Plan retains the right to repayment of the full cost of all benefits provided by the Plan on your behalf that are associated with the third party injuries.

By accepting benefits under this Plan, you specifically acknowledge the Plan's right of subrogation.

For more information about Recovery of Benefits and Subrogation, refer to the medical and dental booklets in the *Appendix* on page 101. You may also contact an Anthem Health Guide at 844-390-4133 or Delta Dental at 844-344-8006.

Acts of Third Parties

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; and
- 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.

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. Medical benefits include prescription drug coverage.

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

- Basic Level;
- Enhanced Level; or
- Premium Level.

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* on page 101, 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* on page 101 serve as the Summary Plan Description (SPD).

Medical Benefits at a Glance

All three medical benefit options cover the same basic medical services and use the same provider network, but the cost sharing features — such as deductible amounts, coinsurance levels and out-of-pocket maximums — differ. In general, as you increase the benefit level (move from Basic to Enhanced or from Enhanced to Premium), your per-paycheck premiums increase, while the cost for using benefits decrease.

You have the freedom to use the doctors and hospitals of your choice. If you are covered by the one of the three medical benefit options, you receive higher benefits when you use doctors and hospitals in the Anthem network. You can use out-of-network doctors or hospitals, but you will pay more for your care.

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* on page 101, or view the Summary of Benefits and Coverage (SBC) for each plan, available at www.anthem.com/capitalone.

	Basic		Enhanced		Premium	
	In-Network	*Out-of-Network*	*In-Network*	*Out-of-Network*	*In-Network*	*Out-of-Network*
Annual Deductible (individual/ family)	$1,000/ $2,000	$3,000/ $6,000	$600/ $1,200	$2,000/ $4,000	$500/ $1,000	$1,500/ $3,000
Annual Out-of-Pocket Maximum (individual/ family)	$4,000/ $8,000	$10,000/ $20,000	$3,100/ $6,200	$7,000/ $14,000	$2,500/ $5,000	$5,000/ $10,000
Coinsurance*	30%	50%	20%	40%	10%	30%
Preventive Care	No charge	No charge	No charge	No charge	No charge	No charge
Office Visits						
Primary Care	No charge	50% coinsurance after deductible	No charge	40% coinsurance after deductible	No charge	30% coinsurance after deductible
OB/GYN/Psychiatrist/ Psychologist	$30 co-pay	50% coinsurance after deductible	$25 co-pay	40% coinsurance after deductible	$20 co-pay	30% coinsurance after deductible
Specialist	$60 co-pay	50% coinsurance after deductible	$50 co-pay	40% coinsurance after deductible	$40 co-pay	30% coinsurance after deductible

* Some treatments have a different coinsurance. See the specific benefit level option charts in the Anthem booklets available in the *Appendix* on page 101 for specific details.

You can search for in-network providers by calling an Anthem Health Guide at 844-390-4133, or by going to www.anthem.com/capitalone and selecting “Find a Doctor, Hospital or Urgent Care.”

If you enroll in one of Capital One’s medical benefit options, you also benefit from:

- ***Preventive vision and hearing coverage:*** The medical benefit options cover 100% of the cost of annual routine vision and hearing exams.
- ***Prescription drug coverage:*** When enrolled in one of Capital One’s medical benefit options, you also receive prescription drug benefits administered by CVS Caremark. See the “Prescription Drug Benefits" document noted in the *Appendix* for more information.

How the Medical Benefits Work

General Overview

In general, the Basic, Enhanced and Premium Level options are preferred provider organization (PPO) options that 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:

- 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 Basic, Enhanced and Premium Level options 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). 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 pay a fixed copay for office visits, and a percentage of the negotiated charge for other covered services (this is your coinsurance) after the annual in-network deductible is met. 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.

The prescription drug copays for medications covered under our plan you pay will apply towards your annual out-of-pocket maximum.

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.

LiveHealth Online

LiveHealth Online can provide a private and secure video visit with a board-certified doctor, lactation consultant, or licensed therapist on your smartphone, tablet or computer with a webcam. It's an easy way to get the care you need at home or on the go. When your own doctor isn't available, use LiveHealth online 24/7 if you have pinkeye, a cold, the flu, a fever, allergies, a sinus infection or other common health conditions. A doctor can assess your condition, provide a treatment plan and even send a prescription to your pharmacy, if it's needed. If you're enrolled in the Capital One Medical Plan (U.S.), you and your eligible covered dependents can use LiveHealth Online.

For Behavioral Health visits:

If you're feeling anxious or having trouble coping on your own and need some support, you can have a video visit with a therapist or psychologist using LiveHealth Online Psychology. Make an appointment in four days or less at www.livehealthonline.com or on the phone at 888-548-3432 from 7:00 a. m. to 7:00 p. m., seven days a week. Evening and weekend appointments are available. You can get help for anxiety, depression, grief, panic attacks and more.

The steps to set up an appointment with a therapist or psychologist using **LiveHealth Online Psychology** are very similar to seeing a doctor. You need to select **LiveHealth Online Psychology** to see available therapists or psychologists and schedule an appointment.

For EAP counselor visits:

You can use your Employee Assistance Program (EAP) to see a therapist at no extra cost. With the EAP, you can talk privately with a licensed therapist face-to-face or using **LiveHealth Online Psychology**. Just call 855-383-7222 to get your free online therapy visit coupon code and details to make your first appointment.

The BlueCard Program

Like all Blue Cross and Blue Shield plans throughout the country, Anthem participates in a program called "BlueCard." This program allows you to receive covered services at the in-network level when you are traveling out of state and need health care, as long as you use a Blue Cross and Blue Shield provider. When you present your ID card to a participating provider, the provider will submit a claim on your behalf.

If you are out of state and need emergency or urgent care, get care immediately.

Please visit the Blue Cross and Blue Shield website (www.BCBS.com) for more information on BlueCard.

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 medical 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 a Doctor, Hospital or Urgent 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 Basic, Enhanced and Premium Level options, 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^{SM} 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.

Services are available if you are infertile and have failed to achieve a pregnancy using other generally acceptable methods of treating infertility. Same-sex couples and single females are not required to meet the clinical definition of infertility before receiving services.

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 up to the age of 45 with storage for up to one year; and
  - Cryo-preservation of oocytes only as directed by medical policy up to the age of 45 with storage for up to one year.
- 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 is exhausted after the third retrieval attempt.

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

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* on page 101.

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

For more information about these tools and resources, see the Anthem booklets available in the medical section of the *Appendix* on page 101.

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 medical benefits option, 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* on page 101 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* on page 101, 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 68,000 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). All specialty medications must be filled through the CVS Specialty Pharmacy.

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 the annual deductible does not apply to prescription drugs. In addition, the amount you pay for prescriptions does not count toward meeting the annual deductible but will apply toward the medical out-of-pocket maximum.

Type of Drug	Cost You Pay	
	Retail — up to 30-day supply	*Mail order or CVS — 90-day supply*
Generic	$10 co-pay	$20 co-pay
Preferred Brand	$50 co-pay	$100 co-pay
Non-Preferred Brand	$100 co-pay	$200 co-pay
Specialty*	30-day supply purchased through CVS Caremark Specialty Pharmacy	
▪ Generic	$40 co-pay	
▪ Preferred Brand	$100 co-pay	
▪ Non-Preferred Brand	$200 co-pay	

* Specialty medications must be purchased through the CVS Caremark Specialty Pharmacy and will not be covered if filled at a regular retail pharmacy. .Additionally, pre-packaged specialty medications in quantities more or less than 30 days will still be covered by the copay.

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 must have those filled as a 90-day supply at a local CVS or via CVS Caremark's mail-order program. 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. 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-copay 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* on page 101, 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* on page 101.

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 per year (a 700 combined household value) for completing health and well-being related activities and team challenges. One point equals $1.

Be Well Rewards

You can earn rewards by completing activities as described below:

Program Name	Related Vendor / Evive Native	Benefit Enrolled Only	Benefit Enrolled Max Point Value	Non Benefit Enrolled Max Point Value
Download the MyEvive App & Login	Evive	No	25	25
Health Assessment (Evive Activity)	Evive	No	50	50
Complete a Health Quest (options available — list below). Each Health Quest can only be completed once. Max point value of 125 points.	Evive	No	125	125
Non-Acute Doctors Visit — Annual visit/physical (general practice)	Anthem — form from Aduro	Yes	50	0
Flu Vaccination	Anthem, CVS Caremark, Premise Health	No	20	20
Evive Team Challenge — Works of Art	HES/Evive	No	40	40
Evive Team Challenge — Sustain	HES/Evive	No	40	40

Program Name	Related Vendor / Evive Native	Benefit Enrolled Only	Benefit Enrolled Max Point Value	Non Benefit Enrolled Max Point Value
Get me off the Stress Bus (Evive Toolkit Activity)	Evive	No	10	10
Look 'n' Cook (Evive Toolkit Activity)	Evive	No	10	10
Quittin' Kate (Evive Toolkit Activity)	Evive	Yes	10	0
Complete an Anthem Nurse Coaching Call (can be redeemed up to 4X)	Anthem	Yes	60	0
Complete an Anthem or Premise Dietician Call (Can be redeemed up to 3x)	Anthem / Premise	Yes	45	0
***Be Well* Eat Well Program (Weight Management Program)**	Premise Health	No	50	50
Diabetes Management Program	Premise Health	No	70	70
Fidelity Student Debit tool	Fidelity	Yes	20	20
Fidelity Planning and Guidance Center	Fidelity	Yes	20	20
Fidelity Money Check	Fidelity	Yes	20	20

Be Well Health Center Activities

Be Well Nutritional Counseling

You can earn rewards by meeting with a Registered Dietician or Licensed Nutritionist as described below.

Associates and Spouses/DPs Participating in a Capital One Medical Plan

Receive nutritional counseling with an Anthem in-network or out-of-network provider (Licensed Nutritionist or Registered Dietician) or with a Registered Dietician at one of our onsite ***Be Well*** Health Centers to earn rewards.

Note: Anthem considers nutritional counseling medically necessary for chronic disease in which dietary adjustment has a therapeutic role, when it is prescribed by a physician and furnished by a provider (e.g., Licensed Nutritionist, Registered Dietician, or other qualified licensed health professionals such as nurses who are trained in nutrition) recognized under the plan. For more information about Anthem providers, go to www.anthem.com/capitalone.

Associates Not Participating in a Capital One Medical Plan

Receive nutritional counseling with a Registered Dietician at one of our onsite ***Be Well*** Health Centers to earn rewards.

Be Well **Health Center** *Be Well* Eat Well (Nutrition and Mindful Eating) Program

Take advantage of an eight-week nutrition counseling group class led by a ***Be Well*** Health Center Registered Dietitian. Topics include Mindful Eating, Nutrition, Activity, Building a Healthy Plate, Integrating Healthy Eating into Our Lives, Recipes and more. You can earn rewards when you attend six out of eight classes.

Be Well Health Centers

Who May Use 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. **All services performed at the *Be Well* Onsite Health Centers are available at no cost to the patient. 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 office** 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)
- Behavioral 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* on page 101, 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* on page 101, serves as the Summary Plan Description (SPD).

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 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* on page 101.

Benefits and Covered Services	Basic Plan	Enhanced Plan
Deductible	None	$50/person, $100/family
Annual Maximum	$500/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% after the deductible, subject to the annual maximum

Benefits and Covered Services	Basic Plan	Enhanced Plan
Major Care (bridges, crown, dentures, dental implants)	Not covered	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. The Enhanced Level option also covers major restorative services (such as inlays, bridges, crowns, dentures) and 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" on page 40 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. ▪ Delta Dental's payment will be based on the Delta Dental PPO Allowance or covered benefits. ▪ The dentist will accept Delta Dental's payment, plus any required co-insurance and deductible (if applicable) as payment in full for covered benefits.	▪ Payment will be made directly to the dentist for covered benefits. ▪ Delta Dental's payment will be based on the Delta Dental Premier Allowance for covered benefits. ▪ Delta Dental Premier Dentists have agreed to accept Delta Dental Premier Allowances, plus any required co-insurance and deductible (if applicable) as payment in full 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.	▪ Payment will be made directly to you. ▪ Delta Dental's payment will be based on the Non-Participating Dentist Allowance for covered benefits. ▪ You will be responsible for any required co-insurance 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 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.

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.

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/uploadedFiles/Subscribers/HSHYEmployeeBrochure.pdf to learn more.

Advance 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 non-participating 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 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* on page 101 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* on page 101, serves as the Summary Plan Description (SPD).

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 co-pay	$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 any remaining balance	$45 allowance
Eyeglass Lenses ▪ Single vision lenses ▪ Bi-focal lenses ▪ Tri-focal lenses	100% after $20 co-pay	▪ $45 allowance ▪ $55 allowance ▪ $65 allowance
Contact Lenses ▪ Elective conventional lenses ▪ Elective disposable lenses ▪ Non-elective contact lenses	▪ $130 allowance, then 25% off any remaining balance ▪ $130 allowance (no additional discount) ▪ Covered in full	▪ $75 allowance ▪ $75 allowance ▪ $90 allowance
Additional benefits are available for lens enhancements, lens upgrades and progressive lenses. See the Anthem Blue View Vision℠ certificate in the *Appendix* on page 101 for details.		

*For out-of-network services, member pays 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 not 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.

If you purchase lenses, frames, or contact lenses, separate copays apply, as shown in *Benefits at a Glance*. Some ophthalmologists may also charge an additional copay for a contact lens fitting. 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 include 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* on page 101, 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 paid by Capital One; 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.

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 via LiveHealth Online sessions with a qualified profession 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 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 behavioral 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.

Through the EAP, you and your eligible dependents can get help from qualified professionals for the following:

Category	Personal concern
Parenting and child care	▪ Adoption ▪ Becoming a parent ▪ Child care services ▪ Children's health ▪ Children's mental health ▪ Infertility ▪ Parenting skills ▪ Stress management ▪ Alcohol and substance abuse
Career	▪ Leadership skills ▪ Conflict resolution
Education	▪ Career planning ▪ Choosing a school ▪ Preparing for college ▪ Talking with teachers
Disability	▪ Autism ▪ Independent living ▪ Living with a disability ▪ Specific disabilities
Financial	▪ Budgeting ▪ Credit and collections ▪ Financial emergencies ▪ Home buying or renting ▪ Saving and investing ▪ Taxes

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 behavioral health benefits if you are enrolled in one of the options. See the medical plan booklets available in the *Appendix* on page 101 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* on page 101. Information is also available online at qme.anthem.com. The information in this summary document, along with the supporting documents in the *Appendix* on page 101, serves as the Summary Plan Description (SPD).

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 50 cents for every dollar you put into your FSAs, up to $500 for the Health Care FSA and $500 for the Dependent Care FSA.

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 *(includes your contribution + Capital One's matching contribution)*	Minimum: $50 Maximum: $3,250	Minimum: $50 Maximum: $5,000*
Capital One Matching Contribution	$0.50 for every $1.00 you contribute, up to $500	$0.50 for every $1.00 you contribute, 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 $550 (may be indexed in future years) to 2022	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.

How the FSAs Work

Associate Contributions

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

The Company Match

Capital One matches 50 cents for every dollar you put into the account (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 may 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," on page 58 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 earlier.

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 provide 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 $550 (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 $550 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 " on page 13 in the *Participation* section. You can also visit www.capitalonebenefitsite.com or contact the HR Help 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.

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.

All life and AD&PL 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* on page 101 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* on page 101, 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 — 1× Annual Benefits Salary, rounded to next $1,000*	▪ Supplemental Employee Life — 1–8× Annual Benefits Salary – Combined with Basic Life, you can have coverage up to 9× your Annual Benefits Salary or up to $2. 5 million, whichever is less ▪ 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	▪ Supplemental Employee AD&PL — 1–8× Annual Benefits Salary, up to $2. 5 million – You automatically receive the same amount of Supplemental Employee AD&PL when you elect Supplemental Employee Life Insurance

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

For VPs and above: For those enrolled in the Executive Life Insurance Program (ELIP), you can purchase Supplemental Life Insurance for up to 8 times your pay (combined with ELIP), your Life Insurance coverage can be up to $5 million.

Eligible Compensation

All associate lines of coverage are based on Annual Benefits Salary except for the ELIP and EBIP benefits.

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), even though the premium may be paid by Capital One.

An associate's Annual Benefits Salary is effective January 1 of each calendar year and is equal to his/her base salary as of September 1 of the prior year. If an associate receives commissions or sales incentives, his/her 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, his/her Annual Benefits Salary is equal to his/her 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 his/her Annual Benefits Salary defaults to $50,000.

Paying for Coverage

Basic Life, Basic AD&PL, ELIP Life, ELIP 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 Basic Life or ELIP Life insurance worth more than $50,000, the part of the premium paid for this coverage is considered taxable income (imputed income) to you, even though the premium is paid by Capital One.

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), go to the Capital One enrollment site at www.capitalonebenefitsite.com.

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* on page 101 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* on page 101, serves as the Summary Plan Description (SPD).

Disability Benefits at a Glance

Capital One offers two types of coverage:

- Short-Term Disability — managed by Sedgwick
- Long-Term Disability — managed by Cigna

	Short-Term Disability	Long-Term Disability
Who is eligible	Full-time associates	Full-time and part-time associates (see "Who Is Eligible for Plan Benefits" on page 5 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 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: $12,000 monthly Supplemental: ▪ 70% of your Annual Benefits Salary ▪ Minimum: $100 monthly ▪ Maximum: $17,500 monthly
When benefits begin ▪ Non-exempt associate ▪ Exempt associate	▪ After seven calendar days, due to a non-work illness or injury. You must use paid time off (PTO) in order to be paid during the time missed due to illness or disability. If you do not have PTO available, your time will be unpaid. ▪ After seven calendar days, due to a non-work illness or injury.	After your Short-Term Disability benefits end

	Short-Term Disability	Long-Term Disability
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 Cigna

Your Annual Benefits Salary

An associate's Annual Benefits Salary is effective January 1 of each calendar year and is equal to his/her base salary as of September 1 of the prior year. If an associate receives commissions or sales incentives, his/her 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 non-annual performance or achievement awards. If an associate is hired after September 1 of the prior year, his/her Annual Benefits Salary is equal to his/her 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. 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 Cigna, 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 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 his or her 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 not at work on the day your supplemental LTD coverage (or any change) is scheduled to take effect, the coverage (or change in coverage) will not take effect until you have been back at work for one full working day. Additionally, if you are disabled at the time of the 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 Short-Term Disability Insurance summary and Long-Term Disability Insurance summary in the *Appendix* on page 101 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.

Workers' Compensation and Other Offsets

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.

LTD 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, Cigna 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.

RETIREE MEDICAL AND LIFE INSURANCE BENEFITS

Capital One provides retiree medical and prescription drug benefits, as well as retiree life insurance coverage to associates who have met the age and service requirements. For information about these retiree benefits, see the “Retiree Medical and Life Insurance Benefits" document noted in the *Appendix*.

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. 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, and vision coverage and to the *Be Well* Health Centers and Health Care FSA. 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 his or her 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 his or her 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 his or her 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 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 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 from, you must notify Capital One if any qualified beneficiary has become entitled to Medicare (Part A, Part B or both) and, if so, the date of Medicare entitlement.

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 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 his employment terminates, COBRA continuation coverage for his 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 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)" on page 62.

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 Help 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 THIS 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" on page 82) 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.

Claims Advocacy Services

Our Claims Advocacy service gives you external, unbiased assistance to help you work with Anthem BlueCross BlueShield (Anthem), CVS Caremark, Delta Dental, Anthem Blue View Vision℠, Sedgwick and Cigna to appeal any denied claims, help facilitate the claims process and help you understand our plans.

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 insurance plans subject to ERISA was incorrectly denied, 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 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 and Retiree Medical

For information about Claims and Appeals under the medical and retiree medical plans, please see the Anthem booklets available in the *Appendix* on page 101.

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 his or her 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 his or her 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
E-Mail	mchip@vdh.virginia.gov	bureauofinsurance@scc.virginia.gov
Web-Page	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
E-Mail	ombudsman@scc.virginia.gov
Web-Page	www.scc.virginia.gov

Vision Claims

For information about vision plan Claims and Appeals, please see the vision plan booklet available in the *Appendix* on page 101.

Flexible Spending Account Claims

For information about Claims and Appeals, please see the Flexible Spending Accounts summary available in the *Appendix* on page 101.

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" on page 89 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* on page 101.

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.

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 and short-term disability are self-funded by Capital One Financial Corp. 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 and the Business Travel Accident plan 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.
Claim Administrators	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 (including Retiree Medical)/FSA	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 VisionSM 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 2000 Park Lane Pittsburgh, PA 15275
COBRA	Anthem Blue Cross Blue Shield (WageWorks) P.O. Box 66350, Dallas, TX 75266-0350

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.

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

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 timeframe)

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 Security 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 Help 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* on page 5 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, EAP, *Be Well* Health Centers, Supplemental Life, Dependent Life and Supplemental LTD coverage for up to 24 months 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 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” on page 58.) 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* on page 101 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 Help 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 Help 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.

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 to up $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 January 1, 2021. It reflects applicable changes since the previous version published December 15, 2016.

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" on page 100 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" on page 100 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" on page 100 for contact information.

Right to Receive an Accounting of PHI Disclosures

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" on page 100 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 Help Center at 888-376-8836. You may also get a copy of this notice on www.capitalonebenefitsite.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 his/her 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" on page 100 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. 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
Senior Director, Benefits
15000 Capital One Drive
Richmond, VA 23236

804-690-1348

pamela.ventura@capitalone.com

To get a copy of this notice, please visit www.capitalonebenefitsite.com or contact the HR Help 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	status-change-matrix.pdf
Medical	
Anthem BCBS Basic Plan booklet	2021-final-capital-one-benefit-booklet-basic-plan.pdf
Anthem BCBS Enhanced Plan booklet	2021-final-capital-one-benefit-booklet-enhanced.pdf
Anthem BCBS Premium Plan booklet	2021-final-capital-one-benefit-booklet-premium.pdf
Prescription Drug	
	prescription-drug-benefits.pdf
Dental	
	2021-capital-one-services-llc-basic-plan.pdf
	2021-capital-one-services-llc-enhanced-plan.pdf
Vision	
Anthem Blue View Vision℠ Plan certificate	2021-capital-one-certificate.pdf
Anthem Blue View Vision℠ Summary of Benefits	2021-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	capital-one-associates-8_1_2019.pdf
Life and Accident Insurance Booklet — Associates 60-day QSC	associate-booklet-60-day-qsc.pdf
Associate Booklet Insurance Rider	associate-booklet-rider.pdf
Life and Accident Insurance Booklet — CEO	capital-one-ceo-8_1_2019.pdf
Life and Accident Insurance Booklet — CEO 60-day QSC	ceo-booklet-60-day-qsc.pdf
CEO Booklet Insurance Rider	ceo-booklet-scf-rider.pdf
Life and Accident Insurance Booklet — VP-Executive Committee	capital-one-vp-executive-committee-8_1_2019.pdf
Life and Accident Insurance Booklet and Rider — VP and Executive Committee	vp-exec-committee-booklet-scf-rider.pdf
VP and Executive Committee Insurance Rider	scf-vp-exec-rider.pdf
Business Travel Accident (BTA) Insurance	
Business Travel Accident (BTA) Insurance summary	how-the-plan-pays-bta-benefits.pdf

Topic	Links to Supporting Documents
Disability Coverage	
Short-Term Disability summary	short-term-disability.pdf
LTD certificate of coverage	FLK980219c01.pdf
LTD amendment (eligibility waiting period)	FLK980219a01.pdf
Retiree Medical and Life Insurance Benefits	Please see documents listed under “Medical” above
Retiree Medical and Prescription Drug and Life Insurance Benefits summary	retiree-medical-and-life-insurance-benefits.pdf
Life and Accident Insurance Booklet — Retirees	retiree-associates.pdf
Life and Accident Insurance Booklet — Retiree Hibernia	retiree-hibernia.pdf