Be well.

We’re here to help you. Find your 2018 benefits information inside.

Health Care Coverage
Getting Answers
And More ...
Questions

If you have questions that aren’t answered in this guide, visit capitalonebenefitsite.com to send an email or chat live with a service representative. You can also use these telephone and online resources to get answers.

<table>
<thead>
<tr>
<th>Have Questions About...</th>
<th>Company...</th>
<th>Phone/Web...</th>
<th>App...</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benefits</strong></td>
<td></td>
<td></td>
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<tr>
<td>Medical</td>
<td>Be Well Care Center at Anthem Blue Cross Blue Shield (Member Services Health Guide)</td>
<td>1-844-390-4133 or anthem.com/capitalone</td>
<td>✔️</td>
</tr>
<tr>
<td>Prescription Drug</td>
<td>CVS Caremark</td>
<td>1-877-210-3556 or caremark.com</td>
<td>✔️</td>
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<tr>
<td>Dental</td>
<td>Delta Dental</td>
<td>1-844-344-8006 or deltadentalva.com</td>
<td>✔️</td>
</tr>
<tr>
<td>Vision</td>
<td>Anthem Blue View Vision</td>
<td>1-866-723-0515 or anthem.com/capitalone</td>
<td>✔️</td>
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<tr>
<td>Fertility and New Parent Benefits</td>
<td>WINFertility Milk Stork</td>
<td>1-844-323-7539 or winfertility.com/capital-one/1-888-207-6909 or milkstork.com/capitalone</td>
<td>✔️</td>
</tr>
<tr>
<td>Flexible Spending Accounts</td>
<td>HealthEquity</td>
<td>1-844-341-4939, email <a href="mailto:memberservices@healthequity.com">memberservices@healthequity.com</a> or myhealthequity.com</td>
<td>✔️</td>
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<tr>
<td>Be Well Rewards Program (Incentive Program)</td>
<td>Redbrick Health (Be Well Rewards Program)</td>
<td>1-844-894-WELL (844-894-9355) or MyRedBrick.com/BeWellBenefits</td>
<td>✔️</td>
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<tr>
<td>Shopping for Care</td>
<td>Castlight Health (Capital One Medical Plan Participants)</td>
<td>1-866-970-2314 or <a href="https://mycastlight.com/capitalone/or">https://mycastlight.com/capitalone/or</a> <a href="mailto:support@castlighthealth.com">support@castlighthealth.com</a></td>
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<td>Life and AD&amp;PL Insurance</td>
<td>The Hartford</td>
<td>1-877-867-4790</td>
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<td>Short-Term Disability</td>
<td>Sedgwick</td>
<td>1-844-321-CAPI or <a href="https://claimlookup.com/capitalone">https://claimlookup.com/capitalone</a></td>
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<tr>
<td>Long-Term Disability</td>
<td>Cigna</td>
<td>1-800-238-2125 or mycigna.com</td>
<td></td>
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<tr>
<td>401(k) Associate Savings Plan</td>
<td>Capital One Retirement Savings Center (Fidelity Investments)</td>
<td>1-800-854-4015 or netbenefits.com</td>
<td>✔️</td>
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<tr>
<td>Commuter Benefits</td>
<td>WageWorks</td>
<td>1-877-924-3967 or wageworks.com</td>
<td></td>
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<tr>
<td>Associate Stock Purchase Plan</td>
<td>Equity Administrator</td>
<td><a href="mailto:EquityAdministrator@capitalone.com">EquityAdministrator@capitalone.com</a></td>
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<tr>
<td>Educational Assistance</td>
<td>EdAssist</td>
<td>1-855-789-3852 or <a href="https://capitalone.edassist.com">https://capitalone.edassist.com</a></td>
<td></td>
</tr>
<tr>
<td>Adoption/Surrogacy Reimbursement</td>
<td>Anthem EAP</td>
<td>1-855-383-7222 or anthemeap.com (login: Capital One)</td>
<td></td>
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<tr>
<td>Employee Assistance Program</td>
<td>Anthem EAP</td>
<td>1-855-383-7222 or anthemeap.com (login: Capital One)</td>
<td></td>
</tr>
<tr>
<td>Back-Up Child and Family Care</td>
<td>Bright Horizons</td>
<td>1-877-242-2737 or go to careadvantage.com/capitalone • User name: CapitalOne • Password: Bewell</td>
<td>✔️</td>
</tr>
<tr>
<td>College Coach</td>
<td>College Coach</td>
<td>1-877-527-3550 or <a href="https://passport.getintocolege.com">https://passport.getintocolege.com</a></td>
<td></td>
</tr>
</tbody>
</table>

| **Other**               |            |              |        |
| Enrolling or Making Health and Welfare Benefits Changes | Capital One Benefits Center | 1-888-376-8836 or capitalonebenefitsite.com | |
| Enrolling or Making Benefit Changes to Your 401(k) Participation (may be done at any time during the year) | Capital One Retirement Savings Center (Fidelity Investments) | 1-800-854-4015 or netbenefits.com | |
| Annual Enrollment (general questions and eligibility) | Capital One Benefits Center | Call 1-888-376-8836 | |
| Passwords (for help with Capital One Benefit Site passwords) | Capital One Benefits Center | Call 1-888-376-8836 | |
| COBRA Coverage and Enrollment | Anthem Blue Cross Blue Shield | 1-877-775-9393 benefitadminsolutions.com Select “Anthem Blue Cross Blue Shield (Anthem)” from drop-down | |
Health Insurance Is Required

Keep in mind that all Americans (with a few exceptions) are required to be covered under basic health insurance coverage or pay a penalty when filing their federal income tax returns. Enrolling in a health plan offered through Capital One will meet this requirement.

Qualified individuals have the opportunity to purchase their 2018 health insurance through the public health insurance marketplace (often referred to as an “exchange”). As a Capital One associate, you’re offered comprehensive, affordable insurance that likely provides better coverage at a lower cost, so selecting one of the company’s health plans may be a better option for you.
Health and Welfare Plan Eligibility

Your eligibility for Capital One’s Health and Welfare plans is based on your employment status.

If you're a full-time associate, you're eligible for Capital One benefits on your date of hire.

If you're a part-time associate (regularly scheduled to work at least 20 standard hours per week as maintained in Capital One’s system of record, Workday), you're eligible for Capital One health benefits (except Short-Term Disability) after 90 days of employment.

If you're rehired any time by Capital One as a part-time associate, you must have completed 90 days of full-time or part-time service before your original departure to be eligible for health benefits on date of rehire.

The Patient Protection and Affordable Care Act (the Health Care Reform law) requires employers with 100 or more employees to offer affordable health care coverage to full-time employees who work an average of 30 or more hours per week. Capital One eligibility guidelines already meet—and exceed—this requirement. We’re including additional measures to ensure all associates who could meet the eligibility criteria set forth by the law are eligible for our health benefits.

If you’re a part-time associate regularly scheduled to work fewer than 20 standard hours per week as maintained in Capital One’s system of record, (Workday), you are typically ineligible for benefits. However, if you meet the required average of 30 “hours of service” per week as defined by the Health Care Reform regulations, you may be eligible for health benefits (except Short-Term Disability and the vacation/paid time-off program) after 90 days of employment. We’ll monitor service hours to ensure eligible associates receive benefits.

Note: 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.

For Your Dependents

Eligible dependents include:

- Your spouse or domestic partner
- Dependent children who are married or unmarried—including adopted children, foster children in your care and stepchildren. Children are eligible from the day they are born, adopted or placed with you as a foster child until the end of the month of their 26th birthday.
- Your domestic partner’s biological or adopted children who reside with you until the end of the month of their 26th birthday
- Other minor children if you are a legal guardian
- Older children with mental or physical impairments may be eligible—certifications must be provided (as applicable)

Ineligible dependents include, but are not limited to:

- Divorced spouses—if you are legally required to provide medical coverage for your divorced spouse, you must purchase individual coverage outside of the Capital One plans
- Parents, grandparents, siblings, aunts, uncles and cousins—are not eligible under any circumstance
- Spouses of dependent children

Domestic Partner

Eligible associates may enroll their domestic partner for medical, dental, vision and life insurance coverage.

A domestic partner is a person of the same or opposite gender as you, with whom you share your life. To be eligible for domestic partner coverage, you and your domestic partner must:

- Be at least 18 years of age
- Not be related by blood
- Be each other’s sole domestic partner and intend to remain so indefinitely
- Reside in the same residence
- Be financially interdependent
- Not be legally married to anyone else

You also may cover your domestic partner’s biological or adopted children if:

- You cover your domestic partner
- The children are under age 26 (older children with mental or physical impairments may be eligible—certifications must be provided (as applicable))
- They live in your household
How to Enroll

Enrolling is easy at capitalonebenefitsite.com:

- Log in with your current username and password.
- If you’re a new associate or don’t already have access, just follow the prompts to register as a New User.
- Watch the Welcome Tour video and set up your personal profile.
- Click Get Started in the upper left on the Home page to enroll.
- Click the Choose Benefits tab at the top of the page.
- To enroll for 2018 or make a change to your benefits, click the links for Medical, Dental, Vision, Spending Accounts, Life and Disability plus vacation/paid time-off program (time-off program updates are only possible during Annual Enrollment) under the Choose Benefits tab or use the Previous and Next buttons to progress through each benefit.
- Your cart will begin with default coverage. As you make your benefit selections or changes, your choice will be added to your cart. You can click the Your Cart tab at any time to review your selections.
- After you made all your choices you will need to Review Your Cart.
- Scroll to the bottom of the page to see your Cost of Benefits. From there you can make changes, if you need to, or click Check Out to finish your enrollment. Keep in mind you need to accept the Terms and Conditions Statement in the Check Out process to submit your enrollment.
- Once you have checked out, you will see a confirmation screen; you can print this screen and save it for your records.

Questions?
Contact the Capital One Benefits Center at 1-888-376-8836, 8 a.m. to 8 p.m. ET, Monday–Friday.

The Capital One Benefits Center

Visit capitalonebenefitsite.com anytime, anywhere—you have the freedom to log in, review and manage your benefits from any mobile device, tablet or computer.

Benefits at a glance—After logging in, you can easily view your Dashboard and Benefits Summary, showing the key details most relevant to you.

Personalized for you—Customize your profile by selecting Menu on the top right and then clicking Profile under My Account. There are several items you can change, so you have a tailored online experience.

Knowledge Center resources—View articles and videos chosen just for you based on your profile’s Personalization selections.

Life event changes—Link directly from the homepage to the easy-to-use Life Event reporting tool that walks you through considerations and action steps.

Tools and quick links—You’ll have easy access to helpful estimating tools and frequently used resources, using intuitive options.

When to Enroll

- New associates must enroll within 31 days of hire. Elections generally take effect for full-time associates on their date of hire and 90 days from date of hire for part-time associates.
- Associates who become newly eligible for benefits must enroll within 31 days of becoming eligible for benefits. The elections will be effective for full-time associates on the date they go full-time or after 90 days for part-time associates.
- Current associates must enroll during the Annual Enrollment period.

Changing Your Coverage During the Year

Based on IRS rules, you can generally make changes during the year only if you have a qualifying change in your family or employment status. This includes events such as:

- Marriage or divorce
- Gaining or losing a domestic partner
- Birth or adoption of a child
- Death of your spouse or dependent
- Your spouse ending or starting employment when that affects coverage eligibility
- You or your spouse changing from full-time to part-time employment status or vice versa, when the change affects coverage eligibility
- Change in health coverage by your spouse's employer
- Loss of eligibility for your dependent because of exceeding the age eligibility requirements
- Loss or gain of eligibility (for you or your eligible dependents) for another group health plan
- Loss or gain of eligibility for a state/federal insurance program such as Medicaid or the Children’s Health Insurance Program (CHIP)

Benefit changes must be consistent with the eligible life event. You must make changes by logging in to capitalonebenefitsite.com or contacting the Capital One Benefits Center at 1-888-376-8836 within 31 days of the event (60 days after birth or adoption of a child or loss or gain of eligibility for a state/federal insurance program such as Medicaid or the Children’s Health Insurance Program (CHIP).) If you do not, you must wait until the next Annual Enrollment period to make updates.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, please review the information provided on page 39.
What’s New

2018 Changes
- Bi-weekly contributions for the Basic medical plan will remain the same in 2018. Contributions for the Enhanced and Premium plans will increase.
- Learn about our top-notch benefits. We made just a few changes to support your well-being in 2018.

Medical Plan Enhancements
- In 2018, we will transition from Doctor on Demand to Anthem’s LiveHealth Online for 24/7 face-to-face access to a doctor from your computer or mobile device.

Dental Plan Changes
- In 2018, oral surgery will move from the medical plan to the dental plan. If you don’t enroll in dental coverage you will not have coverage for these services.
- The $50 co-pay for teeth extractions will be replaced with an 80% coinsurance, subject to deductible and annual maximum. Covered under both the Basic and Enhanced Dental Plans.
- Oral surgery (simple and surgical extractions, impactions, and other oral surgical procedures) will be covered at 80% coinsurance, subject to deductible and annual maximum. Covered under both the Basic and Enhanced Dental Plans.
- Implants will be covered under the medical plan in a few situations (i.e. accident/injury to the face/mouth). In all other cases, they will be covered under the dental plan.

Pharmacy Plan Changes
- The addition of Pharmacy Advisor Counseling will provide support for patients in CVS stores. The service offers confidential advice, medication information, tips to help manage or avoid medication side effects and additional guidance.
- In 2018, additional controls may apply for certain high-cost medications and specialty medications. These controls include prior authorizations and requirements to try certain lower cost medications first.

Health Care Flexible Spending Account Update
- The Health Care Flexible Spending Account (HCFSA) combined associate and employer contribution will increase to $3,600 in 2018. This limit includes the company contribution that will continue to be calculated as 50 cents for every $1.00 you contribute to your FSAs up to $1,000. In compliance with Health care Reform regulations, the maximum associate contribution is $2,600 per year.

Update on Health Care Costs
We want to ensure our associates have access to the best coverage at the lowest possible bi-weekly cost. To do this, we look for ways to balance the costs of services while helping you and your family make informed decisions on your care.
Capital One’s 2018 health care costs are projected to increase, driven by general inflation in health care costs and increased utilization of services by our associates. Our medical and dental benefit plans are self-insured—we pay for health care claims from our own budget. This allows us to offer cost-effective plans we feel are more tailored to the needs of our associates. We will continue our partnerships with Anthem and Delta Dental to administer these plans, which provide a broad choice of in-network providers and keep costs low for you and Capital One. We’ve already seen positive results from these partnerships in keeping our overall year-over-year costs lower than many other employers.
Capital One and enrolled associates and retirees share the total cost of coverage and the related administrative costs supporting our plans. You contribute funding to cover these costs. However, this covers only a fraction of the total cost. Most of the cost is paid by the company.
The reality is that as the cost of health care continues to rise, we have to make changes to help manage the costs. You can help—maintaining a healthy lifestyle, managing any chronic conditions and making thoughtful decisions on your care. These are some of the ways you can keep your out-of-pocket costs under control.

All Changes Go Into Effect on January 1, 2018*

This annual enrollment guide is designed to help you learn about and understand the benefits available under the 2018 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, accident and disability coverage offered by Capital One to eligible associates. If applicable, this guide will serve as a Summary of Material Modification (SMM) outlining any changes which take effect on January 1, 2018.
This guide, the Welfare Plan document together with the SPD and any insurance contacts providing benefits under the plan constitute the official “plan documents” that govern Capital One’s health and welfare benefits. In the event that another document or communication (whether written, oral or electronic) conflicts in any way with the terms of the official plan documents, the official plan documents will take precedence.
As you read through this guide, 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.

*Unless otherwise noted
## Cost of Coverage

### 2018 Associate Benefits Contributions—Medical Coverage

<table>
<thead>
<tr>
<th>Plan</th>
<th>Coverage Tier</th>
<th>Bi-weekly Associate Contribution</th>
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</thead>
<tbody>
<tr>
<td>Basic</td>
<td>Associate</td>
<td>$16.01</td>
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<td>Associate + Spouse or Domestic Partner</td>
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<tr>
<td>Enhanced</td>
<td>Associate</td>
<td>$45.57</td>
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<td>Associate + Spouse or Domestic Partner</td>
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<td>Larger Family, With Spouse or Domestic Partner (3+ Children)</td>
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<tr>
<td>Premium</td>
<td>Associate</td>
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<td>Larger Family, With Spouse or Domestic Partner (3+ Children)</td>
<td>$355.26</td>
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### 2018 Associate Benefits Contributions—Dental Coverage

<table>
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<tr>
<th>Plan</th>
<th>Coverage Tier</th>
<th>Bi-weekly Associate Contribution</th>
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</thead>
<tbody>
<tr>
<td>Basic</td>
<td>Associate</td>
<td>$5.98</td>
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<tr>
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<td>Associate + Spouse or Domestic Partner</td>
<td>$11.96</td>
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<td>Larger Family, No Spouse or Domestic Partner (3+ Children)</td>
<td>$13.15</td>
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<td>Small Family, With Spouse or Domestic Partner (1–2 Children)</td>
<td>$16.74</td>
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<td>Enhanced</td>
<td>Associate</td>
<td>$10.76</td>
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<td>Associate + Spouse or Domestic Partner</td>
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<td>Larger Family, With Spouse or Domestic Partner (3+ Children)</td>
<td>$33.48</td>
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### 2018 Associate Benefits Contributions—Vision Coverage

<table>
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<th>Bi-weekly Associate Contribution</th>
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</thead>
<tbody>
<tr>
<td>Basic</td>
<td>Associate</td>
<td>$1.01</td>
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<td></td>
<td>Associate + Spouse or Domestic Partner</td>
<td>$2.02</td>
</tr>
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<td>Small Family, With Spouse or Domestic Partner (1–2 Children)</td>
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<td></td>
<td>Larger Family, With Spouse or Domestic Partner (3+ Children)</td>
<td>$3.62</td>
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</table>
Voluntary Supplemental Life Insurance and Accidental Death and Personal Loss (AD&PL)

You can buy, with post-tax dollars, additional life and AD&PL insurance for yourself of up to 8 times your Annual Benefits Salary*. Together with company-provided Basic Life and AD&PL Insurance, that means that you can have up to 9 times your Annual Benefits Salary up to $2.5 million. The minimum coverage amount is $5,000. The maximum coverage amount is calculated separately for life and AD&PL.

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.

### Associate Voluntary Supplemental Life Insurance Costs

<table>
<thead>
<tr>
<th>Associate's Age as of Jan. 1, 2018</th>
<th>Bi-weekly Cost per $1,000 of Coverage (post-tax)</th>
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<tbody>
<tr>
<td>&lt;30</td>
<td>$0.02</td>
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<tr>
<td>30–34</td>
<td>$0.03</td>
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<tr>
<td>35–39</td>
<td>$0.03</td>
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<tr>
<td>40–44</td>
<td>$0.04</td>
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<tr>
<td>45–49</td>
<td>$0.06</td>
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<td>70–74</td>
<td>$0.47</td>
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<td>75–79</td>
<td>$0.75</td>
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<tr>
<td>80+</td>
<td>$0.75</td>
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</tbody>
</table>

### Coverage Options Available for Dependent Life—Spouse/Domestic Partner and/or Children

<table>
<thead>
<tr>
<th>Coverage Option</th>
<th>Bi-weekly Cost (post-tax)</th>
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</thead>
<tbody>
<tr>
<td>$25,000 spouse or domestic partner</td>
<td>$1.08</td>
</tr>
<tr>
<td>$50,000 spouse or domestic partner</td>
<td>$2.15</td>
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<td>$75,000 spouse or domestic partner</td>
<td>$3.22</td>
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<td>$100,000 spouse or domestic partner</td>
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<td>$200,000 spouse or domestic partner</td>
<td>$8.58</td>
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<tr>
<td>$225,000 spouse or domestic partner</td>
<td>$9.66</td>
</tr>
<tr>
<td>$250,000 spouse or domestic partner</td>
<td>$10.73</td>
</tr>
<tr>
<td>$10,000 child only</td>
<td>$0.51</td>
</tr>
<tr>
<td>$20,000 child only</td>
<td>$1.02</td>
</tr>
</tbody>
</table>

* 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. If a Draw associate does not have a base salary, then his/her Annual Benefits Salary defaults to $50,000.
Supplemental Long-Term Disability

Capital One automatically provides 50% of your Annual Benefits Salary for Long-Term Disability coverage. You have the opportunity to purchase additional coverage. The monthly cost for the additional 20% of coverage is $0.227 per $100 of your Annual Benefits Salary. The rate takes into account that you’re buying just 20% of your Annual Benefits Salary in coverage.

<table>
<thead>
<tr>
<th>Coverage Option</th>
<th>Monthly Cost (post-tax)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional 20% of Annual Benefits Salary to provide 70% of total income replacement</td>
<td>$0.227 per $100 of your monthly benefits salary</td>
</tr>
</tbody>
</table>

Sample Calculation for Supplemental Long-Term Disability

Let’s use Keith as an example. He:
- Earns $60,000 per year
- Is covered at no cost to him for 50% of his base pay, or $30,000
- Purchases the extra 20% coverage and will pay $5.23 per paycheck

\[
\begin{align*}
\text{Monthly Pay} & = \frac{\$60,000}{12} = \$5,000 \\
\text{Monthly Cost} & = \frac{\$5,000}{100} \times 0.227 = \$11.35 \\
\text{Annual Cost} & = \$11.35 \times 12 = \$136.20 \\
\text{Pay Periods} & = \frac{\$136.20}{26} = \$5.23
\end{align*}
\]

Cost Considerations for Domestic Partner Coverage

In accordance with IRS regulations, there are unique cost considerations for those associates who cover a domestic partner. The key considerations are the following:
- The portion of the associate’s premium that is attributable to covering the domestic partner is paid on a post-tax basis rather than on a pre-tax basis like for the associate’s own coverage or that of other dependents.
- The company’s contribution toward the cost of the domestic partner’s coverage (called the fair market value) is added to your earnings for the year and is subject to the applicable taxes.

Capital One will provide associates with a domestic partner (under our medical, dental and visions plans) a gross-up amount to help cover the taxes owed on these benefits. If you have indicated on IRS Form W-4 that you are exempt from federal income tax withholding, no gross-up will be applied. Similarly, if you have indicated that you are exempt from state tax withholding, no state gross-up will be provided.
Medical Plan Enhancements
In 2018, we will transition from Doctor on Demand to Anthem’s LiveHealth Online for 24/7 face-to-face access to a doctor from your computer or mobile device.

You Have Three Medical Plan Options
- Basic
- Enhanced
- Premium

All cover the same medical services and use the same provider network, but financial aspects—such as deductible amounts, co-insurance levels and out-of-pocket maximums—differ. Enrollment in the prescription plan is included as part of your enrollment in the medical plan, and pharmacy coverage is the same for all three medical plans. In general, as you increase the plan level (move from Basic to Enhanced or from Enhanced to Premium), the bi-weekly premiums increase, while the out-of-pocket costs for services rendered decrease.

Capital One’s medical plan offers a large network of doctors, hospitals and other health care specialists who deliver quality care according to network standards and have agreed to preferred rates for covered services. With Anthem, you have access to a large network of doctors and hospitals—one of the broadest networks in the country. That means better savings and more choices for you.

With your Anthem plan, you will have the choice to see a provider who is out-of-network. However, your coverage is lower and you will pay more for services. Because out-of-network providers don’t have a contract with Anthem, they can charge any price they want and you may be responsible for paying the costs above the reasonable rate.

A Few Things to Think About
- Leverage the Castlight tool to model your potential out-of-pocket costs before you schedule services
- Your cost of coverage—that’s your bi-weekly contribution
- Your cost of care—for example, co-payments, co-insurance, deductible amounts and out-of-pocket costs

Help Choosing a Medical Option
Generally, the higher your cost of coverage, the lower your out-of-pocket costs for care—and vice versa.

As you consider your medical plan options, you’ll also want to:
- Identify the kind of health care services you expect to use—based on the historical use of medical care by you and your covered dependents, and your anticipated needs for the year.
- Think about whether you and your covered dependents are likely to use medical services often or have high out-of-pocket costs.
- Consider other coverage options you may have—for example, through your spouse’s employer—and compare the estimated total cost of using that plan versus the Capital One plan.

You should strongly consider the Basic Plan for your health care needs by considering your annual average claim costs, not including preventive care services, lab services, X-rays and prescriptions.

Seventy to eighty percent of enrolled associates use little to no health care services over the course of the year, and this plan helps ensure that you will not overspend on your health coverage.

Choose How to Reach Anthem
Anthem’s Member Services Health Guides work closely with health care professionals like nurses, health coaches, social workers and others. This combined super-service team is here to help you make the most of your plan’s benefits. Member Services Health Guides can help you:
- Connect with programs and support covered by your benefits
- Stay on top of checkups, tests and preventive screenings by reminding you to make an appointment
- Compare costs of health care services
- Find in-network doctors and much more

Reach Anthem Member Services Health Guides by:
- Calling 1-844-390-4133 Monday through Friday from 8 a.m. to 8 p.m. ET. The number is also on your Anthem ID card.
- Sending us a secure email by logging in at anthem.com/capitalone and selecting Customer Support > Message Center > Compose Message
- Chatting with us by logging in at anthem.com/capitalone and choosing Customer Support > Contact Us > Chat With Us

Coordination of Benefits
If you, your spouse or your dependents are covered under the Anthem plan and another group health plan or local, state or government program other than Medicaid, benefits from the company’s health plan will coordinate with any other benefits you receive.

Medical coverage provided by the Plan follows Medicare’s primary versus secondary payer rules when determining when Capital One’s Plan pays as primary. If Medicare rules say Medicare is the primary payer for a covered person, the Capital One Plan will be the secondary payer. If Medicare rules say the Capital One Plan is the primary payer, Medicare will be the secondary payer. For additional information please refer to the Summary Plan Description or visit medicare.gov for primary vs. secondary rules.
## Key Health Care Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Co-payment or Co-pay</strong></td>
<td>Set dollar amount you pay for network doctor office visits and mail-order prescriptions. No other fees or deductibles apply.</td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td>Dollar amount an individual or family must pay for covered care each calendar year before the medical plan pays benefits for most services—the deductible does not apply to network doctor office visits, preventive or wellness care, prescriptions or routine lab work.</td>
</tr>
<tr>
<td><strong>Co-insurance</strong></td>
<td>Percentage of the cost for eligible medical expenses that you pay after you meet the deductible.</td>
</tr>
<tr>
<td><strong>Co-insurance Out-of-Pocket Maximum</strong></td>
<td>Annual dollar limit an individual or family pays in co-insurance in a calendar year—plan pays 100% of eligible expenses when the out-of-pocket maximum is reached. This feature provides financial protection for you by limiting your out-of-pocket expenses in a given calendar year. Co-payments, penalties and deductible amounts do not count toward reaching your annual co-insurance out-of-pocket maximum.</td>
</tr>
<tr>
<td><strong>Allowable Charge</strong></td>
<td>The maximum amount that a health benefit plan will pay for a given covered service or supply. Also called maximum benefit allowance, maximum allowance or reasonable charge.</td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td>Services that are non-preventive or non-routine, and needed in order to prevent the serious deterioration of a member’s health following an unforeseen illness, injury or condition. Urgent care includes conditions that could not be adequately managed without immediate care or treatment but do not require the level of care provided in the emergency room.</td>
</tr>
<tr>
<td><strong>Walk-In or Retail Clinics</strong></td>
<td>Clinics that can be found in certain retail settings like in a CVS store, Walgreens, Kroger or one of many other retailers. Care for minor acute conditions can be sought in this setting. These clinics offer high-quality care at no cost to you (no co-pays).</td>
</tr>
</tbody>
</table>

## Preventive Versus Diagnostic Care

What’s the difference? Preventive care helps protect you from getting sick. Diagnostic care is used to find the cause of existing illnesses. For example, say your doctor suggests you have a colonoscopy because of your age when you have no symptoms. That’s preventive care. On the other hand, say you have symptoms and your doctor suggests a colonoscopy to see what’s causing them. That’s diagnostic care.

## Preventive Care at No Cost to You

Regular preventive care can help you identify health risks before they lead to more serious medical issues. To encourage regular routine physical exams, screenings and immunizations, the Capital One plans pay the full cost of covered preventive care—with no expense to you. This includes the cost of preventive care office visits and any related preventive care lab services.

- All preventive care is covered at 100%, regardless of age or restrictions, based on AMA guidelines.
- Associates and their dependents may get preventive care screenings at any age, and at their desired intervals, with no out-of-pocket cost.
- Routine physicals
- Well-child exams
- Routine annual OB/GYN exams and Pap tests and mammograms
- Routine PSA and DRE screenings
- Colonoscopies (in some cases a consultation with a specialist is required and a co-pay will apply)
- Immunizations
- Annual vision exams
- Routine hearing exams
- Certain female contraception
- Breastfeeding support
- Nutritional counseling
- Coverage for aspirin, certain supplements and oral fluorides
- Anthem ID cards include the $0 co-pay provision for preventive care to help remind you and your doctor.

### Remember:
- You should only use your visit for preventive care. If you ask your doctor to treat you for something that is not considered preventive, you may be subject to the applicable co-pay.
- Make sure your doctor codes all eligible claims as preventive care in order to be eligible for the 100% coverage.
- This includes both a Preventive Procedure Code (a five-digit code that identifies the type of procedure) and the Preventive Diagnosis Code (a three- to five-digit code that identifies the reason the service is being performed).
Using the Network
When you enroll in a medical plan option, you generally significantly reduce your out-of-pocket costs when you use doctors, hospitals and other providers in Anthem’s network. The medical plan options offer:

- Flexibility to refer yourself to any health care provider or specialist in the network—you don’t need to select a primary care physician or request a referral. You also have the additional flexibility to receive care from a non-network provider, but you’ll pay more out-of-pocket and could be balance billed.
- Typically lower cost of care when you use network providers, because your share of the cost (co-insurance) is based on Anthem’s negotiated discounted cost of services rather than the billed charges
- Freedom from claim forms, since network providers file claims and bill the plan for payment—as a result, your money isn’t tied up waiting for reimbursement. If you see an out-of-network provider, you may have to file your own claims.
- Relief from balance billing—your doctor won’t charge you the difference between the negotiated service rate and the regular rate, as long as you stay in-network

If You Live Outside the Network’s Covered Service Area
If there is not an Anthem participating (i.e., in-network) provider within 30 miles of your home address or if there is not a participating (i.e., in-network) provider within 30 miles who can perform medically necessary services related to a condition or illness, then you may be approved to have out-of-network services paid at the in-network benefits levels of your plan at the reasonable and customary allowance. Please contact Anthem at 1-844-390-4133 for more information.

Walk-In or Retail Clinics
Walk-in or retail clinics are those that are found within certain retail environments like CVS Minute Clinics or Walgreens Health Clinics. There is no co-pay for services rendered at an in-network walk-in clinic. Walk-in clinics generally:

- Have longer hours than most local doctors’ offices and are open weekends and holidays
- Are staffed by knowledgeable nurse practitioners or physician assistants who treat common illnesses and injuries, as well as provide sports and camp physicals and wellness screenings
- Have comparable quality to primary care offices, cost less and have higher patient satisfaction scores
- Are convenient to where the majority of our associates live or work

Finding a Network Provider
With Castlight’s online tool, it’s simple to look for doctors who are part of the network.

Whether you’re checking to see if a family favorite is in-network or looking for someone new, it’s a snap. Go to anthem.com/capitalone and select Find a Doctor, Vision Provider, Hospital or Urgent Care Center to search your network.

A free mobile app allows you to view your health plan information via an iPhone or Android. You can find a doctor, view your benefits and coverage, view your ID card and search for a nearby urgent care provider.

Blue Distinction Specialty Care Can Help You Find the Right Hospital
When you face a major health problem, you want expert care from doctors and hospitals. The fact is there are often differences in the quality of care you get from the hospital you choose. So finding the right hospital can be hard. That’s why we’re giving you access to Blue Distinction Centers and Blue Distinction Centers+

The hospitals that are named as Blue Distinction Centers are chosen for a few reasons. They’re known for their expert health care team, the number of times they’ve done a procedure and their track record for results in specialized care. You deserve peace of mind when you make important health care choices with your doctor. Having access to the Blue Distinction Centers and Blue Distinction Centers+ makes these choices simpler. Both centers offer quality specialty care. But the Blue Distinction Centers+ are honored for how cost effectively they provide care.

Use Castlight and if a provider listed is a Blue Distinction Center, you will find a Blue Distinction recognition/award in the Quality Snapshot next to the provider’s name.

With more than 2,200 Blue Distinction Centers across the country, the care you need is never far away.

Castlight
All eligible Capital One associates and dependents enrolled in a medical plan have free access to Castlight, a personalized online health care resource that helps you shop for doctors, prescriptions and medical services. Castlight shows you quality and price information, so you can make informed health care decisions.

Visit mycastlight.com/capitalone or download the Castlight app.
Autism Coverage
To help families that cope with autism, Capital One offers additional support under its medical plans:

- Applied Behavior Analysis (ABA) is covered whether you use an in-network or out-of-network therapist with no plan dollar limits or age limits. ABA therapy is covered at 100% billed charges under the plans. These services are subject to pre-certification through Anthem.

- Speech Therapy, Occupational Therapy and Physical Therapy are covered with no dollar maximums, visit limits or age limits. Subject to deductibles and co-insurance of the plan in which you are enrolled. Out-of-network therapists are covered as in-network at the allowed charges with the deductible waived.

Paying for...

Network Office Visits and Routine Lab Services
You pay a set dollar amount (co-payment) for frequently used services like network doctor office visits. Routine X-ray and lab services are covered at 100%. More complex tests and imaging, such as PET and CT scans, MRIs and MRAs, are subject to deductible and co-insurance.

Co-payments don’t count toward the annual deductible or co-insurance out-of-pocket maximum, since they are generally for expenses you can predict.

Other Covered Care
For all the medical plan options, you must first meet the individual or family calendar-year deductible before the plan begins paying most benefits. After the deductible, you pay a percentage of the cost—or co-insurance—for most other care (Note: copays and prescription drug costs do not count toward the deductible or out-of-pocket maximum).

Eligible expenses count toward both your individual and family deductible:

- When an individual meets the deductible, the plan begins paying benefits for that person
- When combined eligible expenses for covered family members reach the family deductible, the plan pays benefits for all covered family members. No additional individual deductible amounts are required that year.

Here’s an example of how the deductible works:

Meet Jane

| Enrolled in: | Basic medical plan, family coverage |
| Covered family members: | Husband, Jim; son, Jonah |

Jane had some recent medical issues that resulted in a minor outpatient surgical procedure. The allowable charges for surgeon and hospital claims totaled $2,750. After paying the first $1,250 out-of-pocket to meet her in-network individual deductible, the remaining $1,500 was covered at 70%. Jane paid 30% of that amount, or $450.

Unfortunately, Jonah fell at the park and had to go to the emergency room for a broken leg. The $1,700 Jane already paid counts toward the family deductible of $2,000. She pays the first $300 of the ER bill plus the $125 co-pay. Then, the plan pays 70% of the remaining amount, with Jane responsible for 30%.

Jane and her family have satisfied the in-network family deductible for the year, and the plan pays benefits for all covered family members.

Out-of-Pocket Maximum
You are protected from catastrophic medical expenses by the annual co-insurance out-of-pocket maximum. Here’s how it works: When your co-insurance during a calendar year reaches the out-of-pocket maximum, the plan pays the full cost for any covered care you receive for the rest of the year. Co-payments, penalties and deductible amounts do not count toward reaching your annual co-insurance out-of-pocket maximum. In addition, pharmacy costs do not count towards your out-of-pocket maximum.

Gender Reassignment
Gender reassignment surgery is covered at the same level as other surgeries covered by the plans. Associated prescription drugs required for gender reassignment are also covered as other similarly situated drugs. Covered medical expenses include charges in connection with a medically necessary Transgender (Sex Change) Surgery as long as you or a covered dependent have obtained pre-certification from Anthem and meet the plan clinical criteria.

Also Covered by the Medical Plans

- Hearing aids up to $2,000 per ear every 24 months
- WINFertility Program for fertility treatment services (includes same-sex couples that don’t have a diagnosed clinical infertility)
- Contraception and lactation counseling
### Compare Your Medical Plan Options

The chart below provides a side-by-side comparison of the plans and how much each plan pays for various services.

<table>
<thead>
<tr>
<th>Services Subject to Deductible and Co-Insurance</th>
<th>Basic BlueCard PPO Network</th>
<th>Enhanced BlueCard PPO Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Office Visits and Preventive Care</strong> (Co-payments in-network; deductibles and co-insurance out-of-network)</td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Office Visits*</td>
<td>100% after co-pay of $30 PCP/$60 specialist</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Wellness/Preventive Care Visits, Including Related X-ray and Lab</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Annual Vision Exam</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Routine Diagnostic Laboratory and X-ray**</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Calendar-Year Deductible (Does NOT apply to services with co-pay)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$3,250</td>
<td>$3,000</td>
</tr>
<tr>
<td>Family</td>
<td>$2,000</td>
<td>$6,000</td>
</tr>
<tr>
<td><strong>Co-Insurance Out-of-Pocket Maximum (Deductibles, co-pays and penalties do not apply)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$3,500</td>
<td>$7,000</td>
</tr>
<tr>
<td>Family</td>
<td>$7,000</td>
<td>$14,000</td>
</tr>
<tr>
<td><strong>Services Subject to Deductible and Co-Insurance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>70% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Professional Services</td>
<td>70% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Surgical Fees: Select Minimally Invasive Procedures***</td>
<td>80% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td><strong>Outpatient Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complex Diagnostic, (MRI, MRA, PET and CT)</td>
<td>70% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>70% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Surgical Fees: Select Minimally Invasive Procedures***</td>
<td>80% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td><strong>Maternity Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Services Initial Office Visit to Confirm Pregnancy (Office Visit Co-Pay Waived for Visit to a Gynecologist)</td>
<td>You pay office visit co-pay ($30 PCP, $60 specialist), then plan pays 100%</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Routine Prenatal Office Visits</td>
<td>Plan pays 100%</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>Delivery and Postnatal Care</td>
<td>70% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Emergency Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent Care</td>
<td>100% after $60 co-pay</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Emergency Room (Non-Emergency Use of ER Not Covered)</td>
<td>70% after deductible and $125 co-pay (waived if admitted to hospital)</td>
<td>80% after deductible and $125 co-pay (waived if admitted to hospital)</td>
</tr>
<tr>
<td>Ambulance</td>
<td>70% after deductible</td>
<td>70% after deductible (Non-emergency use covered 60% after deductible)</td>
</tr>
<tr>
<td><strong>Mental Health and Substance Abuse Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>70% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Limit per Calendar Year</td>
<td>No specific day or dollar limits apply</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Outpatient</td>
<td>100% after $30 co-pay for counseling with psychologist; 100% after $60 co-pay for visit with psychiatrist</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Limit per Calendar Year</td>
<td>No specific day or dollar limits apply</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Other Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>100% after $60 co-pay/visit</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Physical, Occupational, Speech Therapy</td>
<td>70% after deductible</td>
<td>70% no deductible</td>
</tr>
<tr>
<td>Combined Physical, Occupational and Speech Therapy Limit per Calendar Year</td>
<td>No dollar maximums, visit or age limits</td>
<td>No dollar maximums, visit or age limits</td>
</tr>
<tr>
<td>ABA Therapy</td>
<td>100%</td>
<td>No limit</td>
</tr>
</tbody>
</table>

---

1. The benefits shown here are for routine maternity care and services provided by your OB-GYN, including routine prenatal care, delivery services and postnatal care. Additional services such as laboratory tests and care that is required due to complications of pregnancy are not considered routine maternity care. Note that the deductible doesn’t apply to the expenses of a newborn at the time of delivery, but will apply for the rest of the year. Contact an Anthem Member Services Health Guide at 1-844-390-4133 (also shown on the back of your ID card) if you have questions about coverage for care during your pregnancy.

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*Visit for acute/episodic care to a retail or walk-in clinic has zero co-pay and no co-insurance.

**Routine lab work includes simple blood tests and X-rays performed in the doctor’s office or at an outside lab.

***Minimally invasive procedures with higher benefit include colectomy (laparoscopic treatment of colon diseases), hysterectomy (laparoscopic or vaginal), esophagogastroduodenoplasty (surgical treatment of acid reflux), breast biopsy and hemorrhoidectomy (versus hemorrhoidectomy).
## Compare Your Medical Plan Options

### In-Network

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visits (Co-payments in-network, deductibles and co-insurance out-of-network)</td>
<td>100% after co-pay of $20 PCP/$40 specialist</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Wellness/Preventive Care Visits, Including Related X-ray and Lab</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Annual Vision Exam</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Routine Diagnostic Laboratory and X-ray**</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

### Out-of-Network

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visits (Co-payments in-network, deductibles and co-insurance out-of-network)</td>
<td>100% after co-pay of $20 PCP/$40 specialist</td>
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<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Routine Diagnostic Laboratory and X-ray**</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

### Calendar Year Deductible (Does NOT apply to services with co-pay)

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Individual</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>$350</td>
<td>$700</td>
<td>$2,000</td>
</tr>
<tr>
<td>$1,500</td>
<td>$3,000</td>
<td>$6,000</td>
</tr>
</tbody>
</table>

### Co-Insurance Out-of-Pocket Maximum (Deductibles, co-pays and penalties do not apply)

<table>
<thead>
<tr>
<th>Maximum</th>
<th>Individual</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,500</td>
<td>$3,000</td>
<td>$6,000</td>
</tr>
</tbody>
</table>

### Services Subject to Deductible and Co-Insurance

#### Inpatient Services

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>90% after deductible</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Professional Services</td>
<td>90% after deductible</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Surgical Fees: Select Minimally Invasive Procedures***</td>
<td>100% after deductible</td>
<td>90% after deductible</td>
</tr>
</tbody>
</table>

#### Outpatient Services

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex Diagnostic, (MRI, MRA, PET and CT)</td>
<td>90% after deductible</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>90% after deductible</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Surgical Fees: Select Minimally Invasive Procedures***</td>
<td>100% after deductible</td>
<td>90% after deductible</td>
</tr>
</tbody>
</table>

#### Maternity Care

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician’s Services</td>
<td>You pay office visit co-pay ($20 PCP, $40 specialist), then plan pays 100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Initial Office Visit to Confirm Pregnancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Office Visit Co-Pay Waived for</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visit to a Gynecologist)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Prenatal Office Visits</td>
<td>Plan pays 100%</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>Delivery and Postnatal Care</td>
<td>90% after deductible</td>
<td>80% after deductible</td>
</tr>
</tbody>
</table>

#### Emergency Services

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care</td>
<td>100% after $40 co-pay</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Emergency Room (Non-Emergency Use of ER Not Covered)</td>
<td>90% after deductible and $125 co-pay (waived if admitted to hospital)</td>
<td>90% after deductible and $125 co-pay (waived if admitted to hospital)</td>
</tr>
<tr>
<td>Ambulance</td>
<td>90% after deductible</td>
<td>(Non-emergency use covered 70% after deductible)</td>
</tr>
</tbody>
</table>

#### Mental Health and Substance Abuse Services

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>90% after deductible</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Limit per Calendar Year</td>
<td>No specific day or dollar limits will apply</td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td>100% after $20 co-pay for counseling visits with the psychologist; 100% after $40 co-pay for psychiatrist visits</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Limit per Calendar Year</td>
<td>No specific day or dollar limits will apply</td>
<td></td>
</tr>
</tbody>
</table>

#### Other Services

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic Services</td>
<td>100% after $40 co-pay/visit</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Physical, Occupational, Speech Therapy</td>
<td>90% after deductible</td>
<td>90% no deductible</td>
</tr>
<tr>
<td>Combined Physical, Occupational and Speech Therapy Limit per Calendar Year</td>
<td>No dollar maximums, visit or age limits</td>
<td></td>
</tr>
<tr>
<td>ABA Therapy</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

---

*The benefits shown here are for routine maternity care and services provided by your OB-GYN, including routine prenatal care, delivery services and postnatal care. Additional services such as laboratory tests and care that is required due to complications of pregnancy are not considered routine maternity care. Note that the deductible doesn’t apply to the expenses of a newborn at the time of delivery, but will apply for the rest of the year. Contact an Anthem Member Services Health Guide at 1-844-390-4133 (also shown on the back of your ID card) if you have questions about coverage for care during your pregnancy.

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### LiveHealth Online

Sometimes you just need a doctor—whether you’re at home in the middle of the night or in the middle of a road trip. Now you can talk to a doctor any time of day, wherever you are. LiveHealth Online lets you have face-to-face conversations with a doctor on your computer or mobile device—medical advice the moment you need it. No appointments. No waiting. So simple. And it costs the same or less than you’d pay for a regular doctor visit. If you’re enrolled in the Capital One Medical Plan, you and your eligible covered dependents can use LiveHealth Online at no cost to you.

See Pulse for more information.
Additional Medical Programs

Anthem Health Programs

Through our health care benefits administrator Anthem, our associates have access to Anthem Nurse Programs.

- **Personal Health Consultant**—With the Personal Health Consultant, your family has a primary nurse and health professionals who are there to discuss your health needs and help you reach your health goals. When you need more specialized advice, your primary nurse can connect you to medical professionals like dietitians or pharmacists.

- **ConditionCare**—This program provides extra support to people of all ages who are managing the symptoms of asthma or diabetes. It’s also for adults who are dealing with chronic obstructive pulmonary disease (COPD), heart failure or coronary artery disease and need a little extra attention and support.

- **Future Moms**—This program gives expecting moms support and guidance from registered nurses for a healthy pregnancy and a safe delivery.

- **24/7 NurseLine**—You have access to registered nurses wherever you are, anytime. The nurses can answer any questions you have about your health and help you decide where to go for care.

Anthem Discount Program

The Anthem Discount Program is part of your Capital One Medical Plan. The program offers discounted health and wellness products and services, including fitness, weight management and hearing services. You can use the discounts whenever you want, as often as you want. Log in to anthem.com/capitalone to view all available discounts (under Learn About on the homepage).

Fertility and New Parent Benefits

**WINFertility**

The WINFertility Program will help associates receive the highest quality care for fertility treatment services.

For associates of the medical plan, WIN will assist in maximizing your insured benefit 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.

For associates who have reached the maximum medical or prescription coverage and will need to pay out-of-pocket, the WIN Consumer Program can provide substantial medical and pharmacy discounts and access to high quality care delivered by a network of fellowship-trained reproductive endocrinologists.

Key features of the WINFertility Program include:

- Help with provider selection
- 24/7 access to education and emotional support provided by WIN’s FertilityCoach™ nurses with decades of experience with infertility patients
- Guidance to help increase efficient use of hormonal medications to avoid wastage and the risks of over-stimulation
- Improved likelihood of successful outcomes through WIN’s evidence-based protocols, expert clinical advice and treatment by qualified subspecialists
- For those who have exhausted their benefit, medical treatment and pharmacy savings of 10%–30% off retail prices and financing options to make paying for treatment even more manageable
- Complimentary supply of folic acid to help prevent neural tube defects. The WINFertility programs will also connect you with the existing maternity program once you become pregnant to ensure a healthy pregnancy and the healthy birth of your baby.
All associates can use the programs listed below—you don’t need to be enrolled in a Capital One medical plan to take advantage of them. How great is that!

*Milk Stork*

Milk Stork provides Capital One associates who are on U.S. business travel and are breastfeeding with everything they need to ship a day’s supply of fresh milk home to their babies.

*How Milk Stork works:*

- **She Plans Her Trip:** A mom orders her kits at milkstork.com/capitalone. When she arrives at her hotel, there will be a package with all of the Milk Stork Kits she ordered for her trip. The kits are pharmaceutical-grade shipping coolers that provide her with everything she needs to ship or tote her milk home.

- **Pump & Pack:** Available in two sizes: 34 oz. and 72 oz., the coolers are easy-to-use with “push button” activation. There is no freezing required and no gel packs.

- **Ship or Tote:** Pump & Ship coolers arrive pre-addressed with FedEx Priority Overnight shipping labels. Pump & Totes arrive with a convenient tote.

*Advance Medical*

Get information from expert physicians to address your questions or uncertainty around any condition or treatment from back pain to surgery to other serious medical conditions. It’s available to all U.S. associates, including your family members (even if they aren’t eligible dependents).

*Here’s How It Works:*

- You’ll be assigned a doctor as a direct contact to lead you through the process.

- Review is based on your medical information—collected with your consent—so recommendations are personalized for you.

- You’ll get a comprehensive report summarizing expert insights, highlighting opportunities to optimize treatment and addressing your questions about future care.

*Ready to Get a Second Opinion?*

Fill out the Expert Medical Opinion Contact Form (available on mybewellbenefits.com on the Advance Medical page in the Health drop down menu) and send it to Advance Medical using one of the options listed on the form.

You can contact Advance Medical by calling 1-888-797-6988.

*Wiser Health*

Take advantage of Wiser Health—an online tool to help you and your adult dependents make informed decisions about their care.

Through the personalized, interactive Wiser Health website, you and your family can review over 200 conditions and make treatment decisions based on medical research, most used treatments, your personal preferences and even how doctors would treat themselves if they had a condition.

*Here’s How to Register:*

2. Click Register in the upper right hand corner, enter your email address and select a password. Then accept the Terms and Privacy Policy by clicking the two checkboxes above the submit button and then click Submit.
3. You’ll see a screen asking you to verify your email address. Then you’ll be sent an email asking you to click a link verifying your email address. You may do that now or later. *(Note: The registration process is not complete unless you click the validation link in the welcome email.)*
4. Click Login in the upper right hand corner of the screen. Now you may log in with your email address and password.
Prescription Drug Coverage
Administered by CVS Caremark

Pharmacy Plan Changes
- The addition of Pharmacy Advisor Counseling will provide support for patients in CVS stores. The service offers confidential advice, medication information, tips to help manage or avoid medication side effects, and additional guidance.
- In 2018, additional controls may apply for certain high-cost medications and specialty medications. These controls include prior authorizations and requirements to try certain lower cost medications first.

How the Program Works
When you enroll in a Capital One medical plan, you may fill prescriptions:
- At a participating pharmacy for up to a 30-day supply. When you do, you pay a percentage of the cost of the prescription—or co-insurance—with a minimum and maximum co-insurance amount.
- Through CVS Caremark’s Maintenance Choice program for a 90-day supply. Under the Maintenance Choice program, you can order your maintenance medications from CVS Caremark’s mail-order pharmacy and have them shipped to your home or address of your choosing. Or, you can elect to have your maintenance medications dispensed in a 90-day supply at a CVS pharmacy. CVS can work with you on payment options for your medications. Please contact CVS Caremark at 1-877-210-3556 or log in to caremark.com for more information regarding signing up for these programs.
- At the West Creek and Knolls Health Centers and Pharmacies. The West Creek and Knolls Health Centers offer a pharmacy for short-term medications (like antibiotics), 90-day supply for maintenance medications and a limited selection of over-the-counter medications. See Pulse for more information.

Participating Pharmacies
CVS Caremark provides a variety of participating retail chains, including Giant, Walgreens, Wal-Mart and independent pharmacies, in addition to CVS pharmacies. These pharmacies can be utilized for all short-term medications—generally those taken less than 60 days or two fills at retail.

For maintenance medications (those taken ongoing—generally longer than 60 days or after two fills at retail), you must have those filled as a 90-day supply either at a local CVS or via CVS Caremark’s mail-order program. Find a network pharmacy at caremark.com or call 1-877-210-3556.

You do not need to enroll separately in the prescription plan. Enrollment in the prescription plan is included as part of your enrollment in the medical plan, and pharmacy coverage is the same for all three medical plans.

Your CVS Caremark information can be found on your Anthem ID card.

Your prescription cost reflects the type of medication used in your prescription:
- Tier 1: Generic—drugs that are chemically and therapeutically equivalent to their brand-name counterparts but cost less.
- Tier 2: Formulary brand—brand-name drugs selected by the plan based on cost and effectiveness.
- Tier 3: Non-formulary brand—brand-name drugs not included in the plan’s formulary.
- Specialty—specific drugs selected by the plan based on their limited use and high cost.

Note: If either you or your doctor requests a brand-name medicine when a generic equivalent is available, you will pay the brand co-pay, plus the difference in cost between the brand-name and the generic medicine. When using most pharmacies, including CVS Caremark Mail Service Pharmacy, a generic medicine, if available, will be substituted for a brand-name medicine unless your doctor indicates “Dispense as Written” on the prescription, or you request that only the brand-name medicine be provided.

Your prescription drug payments do not count toward the medical plan’s annual deductible or the co-insurance out-of-pocket maximum.

If you use a retail pharmacy that’s not in the CVS Caremark network or do not use the Specialty Pharmacy for eligible prescriptions, you pay the full cost of your prescription; no part of the cost is covered by the plan.

Some prescriptions are required to meet defined criteria before they are covered by the plan.

If you enroll in health coaching through Anthem, you will receive three prescription smoking-cessation aids at no co-pay.

Certain generic and single-source brand female contraceptives are also covered at no co-pay.

Certain infusion therapies (with some exceptions such as oncology) are part of your pharmacy coverage and such therapies may be required to be administered in specified outpatient infusion centers or at home rather than in a hospital setting.
When You Need Prescriptions, Consider Several Things to Help Control Your Costs

Use generic—Ask your doctor or pharmacist about generic medications and pay less—only $10 for a 90-day supply. Generics generally cost between 20% and 70% less than their brand-name counterparts. When you buy generic, the active ingredient is exactly the same, but the cost to you is lower.

Ask for a preferred drug—When a generic drug isn’t recommended by your doctor, ask your doctor to prescribe a brand-name medication on the plan’s preferred drug list on caremark.com. Your cost for brand-name drugs on the preferred drug list is lower than for those that aren’t on the list.

Use the mail-order pharmacy for all maintenance prescriptions—By ordering your prescriptions for ongoing conditions such as diabetes or high blood pressure through the mail, you can receive up to a 90-day supply—and spend much less than you would at a retail pharmacy. Mail service delivers medications to your home, providing an added convenience. You can also have your 90-day maintenance prescriptions filled at your local participating CVS pharmacy. Note: You may only fill your maintenance medications via mail order or at your local CVS retail pharmacy.

What Is a Preferred Drug List?

A preferred drug list is a formulary list of drugs the plan has determined to be reasonable in cost and effective for treatment. A non-formulary drug also is effective for treatment, but isn’t as cost-effective as a formulary or generic drug. A group of practicing physicians and pharmacists routinely reviews drugs to include in a formulary. If clinical data shows several drugs are equally effective, the most cost-effective drug is usually chosen. The formulary may change from time to time. You can view CVS Caremark’s formulary at caremark.com.

<table>
<thead>
<tr>
<th>Type of Drug</th>
<th>Cost You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Retail—up to 30-day supply</td>
</tr>
<tr>
<td></td>
<td>Mail order—up to 90-day supply</td>
</tr>
<tr>
<td>Generic</td>
<td>$5 co-pay</td>
</tr>
<tr>
<td></td>
<td>$10 co-pay</td>
</tr>
<tr>
<td>Formulary Brand</td>
<td>30% of retail cost ($35 min./$75 max.)</td>
</tr>
<tr>
<td></td>
<td>$75 co-pay</td>
</tr>
<tr>
<td>Non-Formulary Brand</td>
<td>50% of retail cost ($60 min./$125 max.)</td>
</tr>
<tr>
<td></td>
<td>$125 co-pay</td>
</tr>
<tr>
<td>Specialty</td>
<td></td>
</tr>
<tr>
<td>You pay for most* Specialty medications based on the retail co-insurance rates above, even though Specialty medications are delivered via mail order.</td>
<td></td>
</tr>
<tr>
<td>* Your cost for these non-medically necessary medications is 50% co-insurance with no minimum or maximum.</td>
<td></td>
</tr>
</tbody>
</table>

The Specialty Pharmacy is designed to provide associates who routinely take medications for the following conditions with access to the best discounts and highest quality of medication available:

- Anemia
- Crohn’s disease
- Cystic fibrosis
- Growth hormone, related disorders and other hormonal therapies
- Hemophilia, von Willebrand disease and related bleeding disorders
- Hepatitis B
- Hepatitis C
- HIV
- Immune disorders

Medication for these conditions can be purchased only through the CVS Caremark Specialty Pharmacy—no part of the cost is covered by the plan if purchased from a retail pharmacy.

Be Well Pharmacy Discount Program

For patients who have one of the following conditions and who engage with Anthem nurses:

- Diabetes
- Hypertension
- High cholesterol
- COPD/Asthma
- Congestive heart failure

Available for 90-day prescriptions filled at CVS or via mail order only:

- Generic are $0.
- Brand formulary are $10.
- Non-formulary brand are $75.

Call an Anthem Nurse to qualify for the discount at 1-844-390-4133; press option 4 to speak with a nurse Monday through Friday from 8 a.m. to 11 p.m. ET.
Dental Plan Changes
- In 2018, oral surgery will move from the medical plan to the dental plan. If you don’t enroll in dental coverage you will not have coverage for these services.
- The $50 co-pay for teeth extractions will be replaced with an 80% coinsurance, subject to deductible and annual maximum.
- Oral surgery (simple and surgical extractions, impactions, and other oral surgical procedures) will be covered at 80% coinsurance, subject to deductible and annual maximum.
- Implants will be covered under the medical plan in a few situations (i.e. accident/injury to the face/mouth). In all other cases, they will be covered under the dental plan.

How the Dental Plan Works
Capital One provides two dental plan options to help you care for your teeth and gums:
- Basic Dental Plan
- Enhanced Dental Plan (includes orthodontia coverage)

Delta Dental administers both dental plan options. You have the flexibility to receive care from any licensed dental provider. 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.

Dental Coverage
Administered by Delta Dental

When you enroll in either option, you will have access to two types of network dentists—Delta Dental PPO and Delta Dental Premier. If you choose to see an out-of-network dentist, the plan will pay the same amount, but your out-of-pocket expenses may be higher.

Dental Network
Both options pay the full cost of preventive care and provide coverage for basic service if seeing an in-network provider. Balance billing may apply if you see a non-participating provider even for diagnostic and preventive services. The Enhanced Dental option also covers major care, as well as orthodontia for children and adults.

The chart (on the next page) highlights some commonly used covered services and shows how the dental plan options compare.

Before You Choose, Consider
- The kind of dental services you expect to use (e.g., will your child need braces this year? Are you planning to get a crown replaced?)
- Oral surgery (simple and surgical extractions, impactions, and other oral surgical procedures) will be covered under both dental plans.
- Implants will be covered under the medical plan in a few limited situations (i.e. accident/injury to the face/mouth). In all other cases, they will be covered under the dental plan.
- What your overall cost is likely to be under each option, by adding up your likely dental expenses and the coverage cost for the year

You can contact Delta Dental at 1-844-344-8006 or 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:

<table>
<thead>
<tr>
<th>Delta Dental PPO Dentist</th>
<th>Delta Dental Premier Dentist who is not a Delta Dental PPO Dentist</th>
<th>Non-Participating Dentist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment will be made directly to the dentist for covered benefits.</td>
<td>Payment will be made directly to the dentist for covered benefits.</td>
<td>Payment will be made directly to you.</td>
</tr>
<tr>
<td>Delta Dental’s payment will be based on the Delta Dental PPO Allowance for covered benefits.</td>
<td>Delta Dental’s payment will be based on the Delta Dental Premier Allowance for covered benefits.</td>
<td>Delta Dental’s payment will be based on the Non-Participating Dentist Allowance for covered benefits.</td>
</tr>
<tr>
<td>The dentist will accept Delta Dental’s payment, plus any required co-insurance and deductible (if applicable) as payment in full for covered benefits.</td>
<td>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.</td>
<td>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.</td>
</tr>
<tr>
<td>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.</td>
<td>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.</td>
<td>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.</td>
</tr>
<tr>
<td>Keep in mind that for preventive and basic services, balance billing may apply if you see a non-participating provider.</td>
<td>Keep in mind that for preventive and basic services, balance billing may apply if you see a non-participating provider.</td>
<td>Keep in mind that for preventive and basic services, balance billing may apply if you see a non-participating provider.</td>
</tr>
</tbody>
</table>
**Coverage**

<table>
<thead>
<tr>
<th>Basic Dental</th>
<th>Enhanced Dental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible</td>
<td>None</td>
</tr>
<tr>
<td>Annual Maximum</td>
<td>$500/person</td>
</tr>
</tbody>
</table>

**Preventive Care**
- Two routine exams and cleanings each year
- One set of bitewing X-rays a year; one full set of X-rays every 36 months
- Sealants for dependents under age 16
- Space maintainers for dependents under age 14
- Denture relines starting six months after installation

**Basic Care**
- Fillings, root canals, periodontal therapy
- NEW! Oral surgery (simple and surgical extractions, impactions, and other oral surgical procedures)

**Major Care**
- Bridges, crowns and dentures
- Dental implants

**Orthodontia** (Covers Children and Adults)
- Braces
- Mouth guards
- Temporomandibular Joint (TMJ) disorders

**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.

**Enrolling is Easy**

Complete the Healthy Smile, Healthy You® enrollment form, which can be found at deltadentalva.com. Click on Subscribers and then go the Forms list at the bottom left section of the page. Be sure to include your physician’s name and signature.

Mail or fax the completed form to:

Delta Dental of Virginia, ATTN: Healthy Smile, Healthy You, 4818 Starkey Road, Roanoke, VA 24018

Fax: 540.725.3880

**Note:** If Anthem has your health condition on record, you may already be enrolled in the program. Please contact Delta Dental to confirm.
Before You Choose, Consider

- Whether you need to participate in the vision program (e.g., if you have perfect vision and don’t wear glasses, the annual eye checkup provided through your Anthem medical plan will likely meet your needs)
- Your eye care needs and what kind of vision services you expect to use. Add up your likely vision expenses and what each plan option would cover, so you can compare what your overall cost would be. Also, think about whether you can take advantage of the vision plan’s provider network to lower your costs.
- Your anticipated expenses and whether it’s better to make contributions each paycheck for vision coverage or to pay for vision services out of your pocket

Learn More

- Call Anthem Blue View Vision at 1-866-723-0515.
- Go online to anthem.com/capitalone.
- The Blue View Vision plan coverage includes a routine eye exam, frames and either eyeglass lenses or contact lenses. Kids can get Transitions® lenses to protect their eyes from harmful UV rays and polycarbonate lenses to help protect them from damage at no additional cost.
- You have access to a network of over 30,000 doctors and more than 25,000 locations across the country, including convenient retail stores like LensCrafters®, Sears Optical®, Target Optical®, JCPenney® Optical and most Pearle Vision® stores. You have the flexibility to go to a non-participating provider, but you will maximize your benefits by using a participating provider.
- Blue View Vision Members can use their in-network benefit to order contact lenses from 1-800 CONTACTS. 1-800 CONTACTS offers a huge in-stock inventory, unbeatable prices, outstanding customer service and free shipping. Call 1-800 CONTACTS or go to 1800contacts.com.

To Start Using Vision Coverage

- Once you are enrolled in the plan, log in at anthem.com/capitalone to find a provider and review your plan.
- Visit your provider and provide them with your Anthem ID card.

Contact Lens Fittings

Routine eye exams generally do not include contact lens fittings. Any applicable fees for the contact lens fittings are the responsibility of the member.
## Vision Benefits

<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine eye exam once every calendar year</td>
<td>$0 co-pay</td>
<td>Up to $35</td>
</tr>
<tr>
<td>One pair of eyeglass frames every two calendar years for adults</td>
<td>$130 allowance, then 20% off* any remaining balance</td>
<td>Up to $45</td>
</tr>
<tr>
<td>One pair of eyeglass frames every calendar year for kids under 19</td>
<td>$130 allowance, then 20% off* any remaining balance</td>
<td>Up to $45</td>
</tr>
<tr>
<td>One pair of eyeglass lenses (standard plastic), once every calendar year you may receive any one of the following lens options:</td>
<td>100% after $20 co-pay</td>
<td>$45</td>
</tr>
<tr>
<td>- Single vision lenses</td>
<td></td>
<td>$55</td>
</tr>
<tr>
<td>- Bi-focal lenses</td>
<td></td>
<td>$35</td>
</tr>
<tr>
<td>- Tri-focal lenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyeglass lens enhancements*</td>
<td>$0 co-pay</td>
<td>No allowance on lens enhancements when obtained out-of-network</td>
</tr>
<tr>
<td>- Transitions® lenses for kids under 19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Standard polycarbonate for kids under 19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Factory scratch coating</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Standard anti-reflective coating</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyeglass lens upgrades</td>
<td>Upgrades (after any applicable co-pay)</td>
<td></td>
</tr>
<tr>
<td>- Transitions® for adults</td>
<td>$75</td>
<td></td>
</tr>
<tr>
<td>- Standard polycarbonate for adults</td>
<td>$40</td>
<td></td>
</tr>
<tr>
<td>- Tint (solid and gradient)</td>
<td>$15</td>
<td></td>
</tr>
<tr>
<td>- UV coating</td>
<td>$15</td>
<td></td>
</tr>
<tr>
<td>Progressive lenses</td>
<td>Progressive (after any applicable co-pay)</td>
<td></td>
</tr>
<tr>
<td>- Standard</td>
<td>$65</td>
<td></td>
</tr>
<tr>
<td>- Premium Tier 1</td>
<td>$85</td>
<td></td>
</tr>
<tr>
<td>- Premium Tier 2</td>
<td>$95</td>
<td></td>
</tr>
<tr>
<td>- Premium Tier 3</td>
<td>$110</td>
<td></td>
</tr>
<tr>
<td>Anti-reflective coating</td>
<td>Anti-reflective (after any applicable co-pay)</td>
<td></td>
</tr>
<tr>
<td>- Premium Tier 1</td>
<td>$12</td>
<td></td>
</tr>
<tr>
<td>- Premium Tier 2</td>
<td>$23</td>
<td></td>
</tr>
<tr>
<td>Other add-ons (eyeglass materials purchased separately, non-prescription sunglasses, lens and/or contact lens cleaning/solutions, etc.)</td>
<td>20% off retail (after any applicable co-pay)</td>
<td></td>
</tr>
<tr>
<td>2nd complete pair</td>
<td>40% off retail (after any applicable co-pay)</td>
<td></td>
</tr>
<tr>
<td>Contact lenses once every calendar year (disposable or planned replacement are permitted)</td>
<td>$130 allowance, then 15% off any remaining balance</td>
<td>Up to $75</td>
</tr>
<tr>
<td>- Elective conventional lenses; or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Elective disposable lenses; or</td>
<td>$130 allowance (no additional discount) Covered in full</td>
<td>Up to $75</td>
</tr>
<tr>
<td>- Non-elective contact lenses</td>
<td></td>
<td>Up to $90</td>
</tr>
<tr>
<td>A contact lens fitting and up to two follow-up visits are available to you once a comprehensive eye exam has been completed.**</td>
<td>$0</td>
<td>$35</td>
</tr>
<tr>
<td>- Standard contact lens fitting</td>
<td>10% off retail price, then apply $55 allowance</td>
<td>$35</td>
</tr>
<tr>
<td>- Premium contact lens fitting</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Additional lens options available at fixed co-payments.
**Standard contact lens fitting includes spherical clear contacts for conventional wear and planned replacement. Premium contact lens fitting includes all lens design, materials and specialty fittings other than standard contact lenses.
## Flexible Spending Accounts (FSAs)

### Health Care Flexible Spending Account Update

The Health Care Flexible Spending Account (HCFSA) combined associate and employer contribution will increase to $3,600 in 2018. This limit includes the company contribution that will continue to be calculated as 50 cents for every $1.00 you contribute to your FSAs up to $1,000. In compliance with Health care Reform regulations, the maximum associate contribution is $2,600 per year.

### Capital One Offers Two FSAs—a Health Care FSA and a Dependent Care FSA

Flexible Spending Accounts (FSAs) allow you to save money by using pre-tax dollars to pay for qualified health or dependent care expenses, including prescriptions, co-pays, deductibles and co-insurance for you, your spouse or eligible dependents, day care services and much more. Even better, Capital One will match the money you put into your FSA, up to the annual maximum. That means free money for you to use to take care of yourself and your family.

<table>
<thead>
<tr>
<th></th>
<th>Health Care FSA</th>
<th>Dependent Care FSA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total contribution</strong>&lt;br&gt;maximum (this includes your contribution, plus the company matching contribution)</td>
<td>$3,600 (minimum contribution of $50)</td>
<td>$5,000 (minimum contribution of $50*)</td>
</tr>
<tr>
<td><strong>Capital One matching contribution</strong></td>
<td>Up to $1,000</td>
<td></td>
</tr>
<tr>
<td><strong>How you select your contribution amount</strong></td>
<td>Once-a-year election during Annual Enrollment (unless you experience a qualifying life event)</td>
<td></td>
</tr>
<tr>
<td><strong>Eligible expenses</strong></td>
<td>Medical, vision and dental co-payments, deductibles and co-insurance you pay for covered services for you and your spouse/dependents (even if they are not covered under your Capital One health care plans)&lt;br&gt;Prescription drug co-pays/co-insurance&lt;br&gt;Expenses for glasses or contact lenses&lt;br&gt;Expenses you pay above the reasonable and customary rates or plan maximums</td>
<td>Dependent care that is necessary for you and your spouse to work, look for work, or attend school full time, including care for&lt;br&gt;Dependents under age 13 whom you can claim as dependents on your federal income tax return or have legal custody of&lt;br&gt;Spouse or other dependent, such as an elderly parent, if they are physically or mentally incapable of caring for themselves and spend at least eight hours a day in your home</td>
</tr>
<tr>
<td><strong>Deadline for expenses to be incurred</strong></td>
<td>March 15, 2019</td>
<td>March 15, 2019</td>
</tr>
<tr>
<td><strong>Claim deadline</strong></td>
<td>April 30, 2019</td>
<td>April 30, 2019</td>
</tr>
</tbody>
</table>

*If you’re single or married filing jointly. The contribution limit is $2,500 if you’re married and file a separate tax return. For spouses who both contribute to a Dependent Care FSA (DCFSA), the maximum amount that can be contributed between both accounts is $5,000.

**Notes:**
- Dependent Care FSA is only to be used for eligible dependent care expenses (see above), NOT for medical expenses for spouse and/or other dependents. You may use a Health Care FSA for those expenses.
- It is a violation of the Internal Revenue Code to use the Dependent Care FSA for child care expenses if you have a stay-at-home spouse or partner but still use outside day care or summer camp programs for your child. The Dependent Care FSA is only to be used if both parents work or if your spouse is a full-time student.
Selecting Your FSA contribution
When deciding how much to contribute to your FSA, keep the following in mind:

- Consider how much you are likely to spend out of your pocket for health care during the year.
- If you will have eligible dependent care costs (e.g., day care expenses), consider whether your children will start school or reach age 13 in 2018? Do you have a parent or elderly relative living with you who needs supervised care?
- The matching contribution Capital One will provide counts toward the maximum amount that can be contributed to each FSA.
- You’ll get a tax break when you use pre-tax dollars from FSAs to pay for expenses you would have to pay out of your pocket anyway.
- Domestic partner expenses are not eligible for reimbursement.
- If you plan on using your Health Care FSA account for orthodontia or similar services, please contact Delta Dental to discuss reimbursement eligibility.

FSA Calculator
You can use the FSA calculator on [capitalonebenefitsite.com](http://capitalonebenefitsite.com) to help you determine how much to contribute for the year. Remember: When you elect your contribution amount, you’re selecting the TOTAL amount you wish to contribute for the whole year—including the Capital One match. Then, this amount (minus the match) will be automatically divided into equal amounts to be deducted from each paycheck. You need to elect a target contribution amount of at least $3,000 in one or both FSAs in order to earn the maximum company contribution of $1,000.

Capital One Contribution: Free Money!
Capital One will match $0.50 of every $1 you contribute to your FSAs, up to a combined maximum company contribution of $1,000 each year between the Health Care FSA and Dependent Care FSA. The company’s contribution counts toward the maximum amount that can be contributed to each FSA.

Orthodontia Expenses
HealthEquity allows reimbursement for pre-paid scheduled payments under an orthodontia contract regardless of the date of service. The payment must have been made while you were covered under the Health Care Flexible Spending Account (FSA). If there is coverage under any dental plan, payment from the FSA will be reduced by the amount paid by the dental coverage. Please note that orthodontia differs from other dental procedures that require the actual service to be performed within the coverage period, regardless of when payment is made.
HealthEquity
Managing your FSAs is easy and convenient with HealthEquity. You can:
- Access your account and history on-the-go—Access all account types wherever you go.
- Submit photo documentation—Take a photo with your device to initiate claims and payments.
- Send payments and reimbursements—Send payments to providers and reimburse yourself for out-of-pocket expenses from your FSA.
- Manage debit card transactions—Link your debit card transactions to claims and documentation.
- Initiate claims and view their status—View the status of claims as well as link payments and documentation to claims.

Visit the HealthEquity member resources site at http://learn.healthequity.com/capitalone/fsa/ to learn more.

Receiving Reimbursement From the Health Care FSA
Expenses you or your eligible dependents have are eligible for reimbursement under the FSA, even if your dependent(s) is not covered under your medical, dental or vision plan. Only expenses you have while employed and during the plan year, or grace period, in which you made the contribution may be reimbursed. Due to IRS regulations, a domestic partner’s expenses are not eligible for reimbursement.

To receive reimbursements:
- You can use your Health Care FSA debit card for all eligible health care expenses wherever it is accepted.
- Add a manual claim through the HealthEquity member portal at myhealthequity.com, go to the Claims & Payments menu, then select Add Claim.
- You can also submit a receipt with the HealthEquity Mobile app (just snap a picture and upload it!) or submit a form to HealthEquity.
- Note: In some cases, even with auto-substantiation, additional documentation may be required.

Receiving Reimbursement From the Dependent Care FSA
To receive reimbursements:
- Add a manual claim through the HealthEquity member portal at myhealthequity.com, go to the Claims & Payments menu, then select Add Claim.
- You can also submit a receipt with the HealthEquity Mobile app (just snap a picture and upload it!) or submit a form to HealthEquity.
Dependent Care Reminders

Before deciding to enroll in the Dependent Care FSA, compare its tax benefit to the Dependent Care Tax Credit. Generally, the Dependent Care FSA saves you more in taxes, but it depends on your income. For assistance deciding which provides more savings for you, consult an accountant or tax advisor.

Note: The Dependent Care FSA is only used for dependent care expenses that are necessary for you and your spouse to work, look for work or attend school full time. It is NOT for health care expenses for you and/or your dependents.

- If you are married: You may only submit for dependent care expenses that allow you and your spouse to work or so you can work full time while your spouse goes to school full time. Note: If your spouse is a stay-at-home mother/father, for example, and you send your child(ren) to preschool, camp or day care, you are not eligible for this benefit per IRS regulations.

- If you are divorced or separated: Work-related expenses of the custodial parent are eligible for reimbursement, even if the custodial parent does not claim the child as a tax dependent. Work-related child care expenses of a non-custodial parent are not eligible for reimbursement, however, even if the child is claimed as a tax dependent.

What Happens if I Leave the Company?

- For the Health Care FSA, you may elect to continue your participation on a post-tax basis for the remainder of the calendar year under COBRA. If you do not continue your participation under COBRA, any amount left in your account will be forfeited if you do not have any eligible expenses incurred prior to your termination date.

- For the Dependent Care FSA, you may file for reimbursement of eligible claims incurred anytime in the calendar year (even after your termination date), as long as you file by the April 30 deadline.

Use It or Lose It

Based on IRS rules, FSAs are “use-it-or-lose-it” accounts. That means you’ll lose any money left in the 2018 account after the claim deadline (April 30, 2019), so it’s important to carefully estimate your contribution amount for the year.

Do You Have Leftover 2017 Funds?

You can still use leftover 2017 funds for eligible expenses incurred up until March 15, 2018. You have until April 30, 2018, to submit eligible claims to HealthEquity.
Be Well Rewards

Capital One’s Be Well Rewards (Incentive Program) is designed to provide services, information and personalized coaching to encourage and support you to feel your best. RedBrick Health, our wellness partner, has the guidance and tools to help get you going—all while earning up to $350 in rewards.

The program is available to all associates, plus any spouses/domestic partners enrolled in the Capital One Medical Plan.

2018 Be Well Rewards

You (and your Capital One Medical Plan enrolled spouse or domestic partner) can earn rewards for participating with RedBrick Health in the Be Well Rewards program. Associates and enrolled spouses/domestic partners can each earn $350 this year, for a total family reward of $700.

Visit Pulse to see how your healthy activities with RedBrick Health can add up—and get rewarded for getting healthier.

*Enrolling in an Anthem Nurse coaching program qualifies you for the Be Well Pharmacy Discount Program.

Get Started

Log in to MyRedBrick.com/BeWellBenefits or call 1-844-894-WELL (1-844-894-9355) to get started.
Be Well Health & Fitness Centers

Depending on your location, you may have access to on-site Be Well Health & Fitness Centers.

Be Well Health Centers
Capital One offers care for associates and their family members free of charge at our Be Well Health Centers at many of our office locations. All associates are eligible for services, even if they aren’t enrolled in Capital One’s medical plan.

The following eligible family members can also 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

Be Well Health Centers provide:
- Preventive care, including physical exams, health screenings and immunizations
- Urgent care and minor injury treatment
- Allergy shots, travel immunizations and other injections
- Chronic medical conditions and ongoing health conditions
- Disease management and healthy living programs

See Pulse for locations and details on the Be Well Health Centers.

Fitness Centers
Many of our major locations have fitness centers that include state-of-the-art equipment, personal training and group exercise classes. Visit Pulse to learn more.

Confidentiality
The Health Centers and 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 of associates or their families.
Life Insurance and Accidental Death and Personal Loss (AD&PL) Insurance

Eligibility

Full-time and eligible part-time associates receive Basic Life and Accidental Death and Personal Loss (AD&PL) Insurance at no cost to you, and the option to purchase additional Life and AD&PL Insurance for yourself and your dependents.

Generally, if you are out on any type of leave, including FMLA, on the day your Basic Life, Supplemental Life, Dependent Life or Associate and Dependent AD&PL coverage (or any change in coverage) is scheduled to take effect, the coverage (or change in coverage) does not take effect until you have been back at work for one full day.

Before You Choose, Consider

- How much do you spend on day-to-day living expenses for your household. This can provide a guideline for the amount of income you need replaced.
- Other coverage you have—including individual coverage, coverage through your spouse’s employer and other insurance that provides a death benefit, such as mortgage insurance
- What savings and investments you have, and how many people depend on you for financial support

Basic Coverage

You automatically have Basic Life and AD&PL coverage equal to one times your Annual Benefits Salary, rounded to the next $1,000, if not already a multiple of $1,000. For VP+ executives, your Executive Life Insurance Program (ELIP) is calculated separately. **Note:** If you are covered under the Executive Bonus Insurance Plan (EBIP), your coverage follows that of all non-executives (one times your Annual Benefits Salary).

If you have a covered accident, you may be eligible for a one-time payout under the AD&PL line of coverage. AD&PL is a separate line of coverage and is equal to the Basic Life coverage amount. Both are provided to you at no charge.

If you die, your Basic Life coverage provides a payout equal to one times your Annual Benefits Salary, as described above. If you die or experience an injury as a result of a covered accident, you will receive an amount equal to the percentage shown in the chart in the right column in addition to any Basic Life amount paid out.

<table>
<thead>
<tr>
<th>For Loss of:</th>
<th>You receive this percentage of your Annual Benefits Salary:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>100%</td>
</tr>
<tr>
<td>Both hands or both feet or sight of both eyes</td>
<td>100%</td>
</tr>
<tr>
<td>One hand and one foot</td>
<td>100%</td>
</tr>
<tr>
<td>Speech and hearing in both ears</td>
<td>100%</td>
</tr>
<tr>
<td>Either hand or foot and sight of one eye</td>
<td>100%</td>
</tr>
<tr>
<td>Movement of both upper and lower limbs</td>
<td>100%</td>
</tr>
<tr>
<td>Movement of both lower limbs</td>
<td>100%</td>
</tr>
<tr>
<td>Movement of three limbs</td>
<td>100%</td>
</tr>
<tr>
<td>Movement of the upper and lower limbs of one side of the body</td>
<td>100%</td>
</tr>
<tr>
<td>Either hand or foot</td>
<td>50%</td>
</tr>
<tr>
<td>Sight of one eye</td>
<td>50%</td>
</tr>
<tr>
<td>Speech or hearing in both ears</td>
<td>50%</td>
</tr>
<tr>
<td>Movement of one limb</td>
<td>25%</td>
</tr>
<tr>
<td>Thumb and index finger of either hand</td>
<td>25%</td>
</tr>
<tr>
<td>Third degree burn (75% or more of your body)</td>
<td>100%</td>
</tr>
<tr>
<td>Third degree burn (50%–74% of your body)</td>
<td>50%</td>
</tr>
</tbody>
</table>

Designating a Beneficiary

Your beneficiary is the person who will receive your insurance benefits upon your death. You are always the beneficiary for Dependent Life Insurance.

If you wish, you can name more than one beneficiary. To designate or update your beneficiary(ies), go to the Capital One online enrollment system. Look for the link labeled **Update your beneficiary** from the homepage.
**Supplemental Coverage**

Supplemental Life and AD&PL Insurance is a voluntary benefit offered in addition to the basic coverage that the company automatically provides. With Supplemental Insurance, you can buy, with post-tax dollars, additional Life Insurance for yourself up to 8 times your Annual Benefits Salary. Included in Supplemental Insurance is a separate line of coverage for AD&PL equal to the Supplemental Life coverage amount. Together with Basic Insurance, that means you can have coverage up to 9 times your Annual Benefits Salary or $2.5 million, whichever is less. The minimum coverage amount is $5,000. The maximum coverage amount is calculated separately for Life and AD&PL.

For those enrolled in the ELIP (VP+), you can purchase Supplemental Life Insurance for up to 8 times your Annual Benefits Salary. Combined with ELIP, your Life Insurance coverage can be up to $5 million.

If you are on any type of leave (including FMLA) as of January 1, 2018, any change made to your Supplemental/Dependent Life and AD&PL insurance coverage during Annual Enrollment, including increases to your Annual Benefits Salary, will not go into effect until you actively return to work in 2018.

**Dependent Coverage**

You may purchase Dependent Life and AD&PL Insurance for your spouse or domestic partner and your dependent children up to age 26. Dependents in active, full-time military service are not eligible for Dependent Life coverage.

Payments will be made to you in the event of a dependent’s death. If you are not living at the time of payment, it will be made to the executors or administrators of your estate.

Your choices for Dependent Life and AD&PL coverage for your family are:
- $25,000–$250,000 spouse or domestic partner; coverage must be in multiples of $25,000
- $10,000 or $20,000 child only

**Evidence of Insurability**

Some situations require Evidence of Insurability (EOI), or proof of good health, for Supplemental Life/AD&PL coverage and spousal/domestic partner life.

The chart below contains some examples of when EOI is and is not required.

<table>
<thead>
<tr>
<th>EOI Required</th>
<th>EOI Not Required</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>New Hire</strong></td>
<td></td>
</tr>
<tr>
<td>Basic and Supplemental Insurance over $1 million</td>
<td>Basic and Supplemental Insurance less than or equal to $1 million</td>
</tr>
<tr>
<td>Spouse/domestic partner insurance over $50,000</td>
<td>Spouse/domestic partner insurance less than or equal to $50,000</td>
</tr>
<tr>
<td><strong>During Annual Enrollment</strong></td>
<td></td>
</tr>
<tr>
<td>If no coverage is in place, electing Supplemental Insurance greater than 1 times Annual Benefits Salary</td>
<td>If no coverage is in place, electing Supplemental Insurance equal to 1 times Annual Benefits Salary*</td>
</tr>
<tr>
<td>If coverage is already in place, increasing Supplemental Insurance greater than 2 times Annual Benefits Salary</td>
<td>If coverage is already in place, increasing Supplemental Insurance by 2 times Annual Benefits Salary*</td>
</tr>
<tr>
<td>Any new or increased spouse/domestic partner insurance coverage</td>
<td>* EOI is required with when Basic/ELIP and Supplemental coverage exceeds $1 million</td>
</tr>
</tbody>
</table>

EOI is never required for Basic Life and AD&PL insurance, child insurance and coverage increases due to salary changes and promotions.

Until you provide EOI and it’s approved by The Hartford, you will be covered at the highest level of coverage you are allowed without EOI rather than your actual election.
Disability Insurance

Capital One automatically provides full-time associates with Short-Term Disability and Basic Long-Term Disability coverage at no cost. You have the option to purchase Supplemental Long-Term Disability.

**Short-Term Disability**
Short-Term Disability benefits replace all or part of your income for up to six months if you’re unable to perform your job due to a non-work-related injury, illness or condition, including pregnancy.

During your first week out, you’ll use PTO (non-exempt) or Sick Time (exempt) equal to the same amount of hours you’re scheduled to work in a week. If you don’t have PTO available, you won’t receive pay until the following week when your Short-Term Disability begins.

To be eligible for this plan, you must be full-time and have more than 90 days of service with the company, and the disability must be after the 90th day of service. See Pulse for more details.

**Long-Term Disability**
Long-Term Disability benefits replace 50% of your Annual Benefits Salary after six months. You may purchase Supplemental Long-Term Disability coverage, on an after-tax basis, which replaces an additional 20% of your Annual Benefits Salary, to receive 70% income replacement.

If you’ve been eligible, but not enrolled for additional Supplemental Long-Term Disability coverage up to now, you will have to provide Evidence of Insurability (EOI) in order to be approved for the 70% of Annual Benefits Salary. Long-Term Disability elections made as a new hire are not subject to EOI.

Generally, if you are not at work on the day your Supplemental LTD coverage (or any change in coverage) is scheduled to take effect, the coverage (or change in coverage) will not take effect until you have been back at work for five full consecutive days. Additionally, if you are disabled at the time of the election of supplemental coverage, the coverage does not take effect for the current disability.
Associate Stock Purchase Plan

All full-time and part-time associates in the U.S. are eligible to participate in the non-qualified Capital One Associate Stock Purchase Plan (ASPP).

**Contributions/Company Match**

You can elect to contribute between 1% and 15% of your base salary** to the ASPP and receive a partial match on your contributions from Capital One. Your contributions are deducted from your Salary each paycheck and along with the Capital One match, are used to buy Capital One stock at the end of each month. Purchased shares are deposited into your E*TRADE account shortly following the purchase date. There is no fee to purchase shares through the ASPP. However, when you sell shares, E*TRADE deducts a brokerage fee of $0.05 per share ($14.99 minimum per trade) from stock sale proceeds.

Note: The Capital One match is considered taxable income.

**Learn More**

Visit the Associate Stock Purchase Plan page on Pulse.

**Includes standard pay and any commissions you receive for your job.

A description of the Associate Stock Purchase Plan can be found in the plan document, prospectus and other materials available on Pulse. You are advised to exercise caution in relation to any award under the plan. If you have any doubt about the contents of the plan or any documentation in respect of the plan, you should obtain your own independent professional advice from an appropriately authorized independent advisor. As you know, no one can predict the future value of any stock, and investment in a single security is inherently subject to greater risk than diversified investments. You should carefully and periodically evaluate your investments in the Company’s common stock to make sure that the amount of your investment is appropriate for your individual financial situation.
The Capital One 401(k) Associate Savings Plan is a convenient, tax-effective way to help save for retirement. Through automatic payroll deductions, you may contribute up to 50% of your Annual Benefits Salary (base salary, shift differential, bonuses, commission, incentives and overtime) to your account. You may contribute any combination of pre-tax and Roth 401(k) contributions up to the annual Internal Revenue Service (IRS) dollar limit of $18,500 in 2018. This amount is often indexed on an annual basis for inflation. For the most up-to-date limits visit the IRS web site.

Company Contributions
In addition to your contributions, Capital One helps grow your retirement savings by contributing to your 401(k) Plan account:

- **Basic Non-Elective Company Contributions**—Capital One will contribute 3% of your Annual Benefits Salary, whether or not you participate in the 401(k) Plan.

- **Matching Contributions**—Capital One will match 100% of the first 3% of Annual Benefits Salary that you contribute, plus 50% of the next 3% of Annual Benefits Salary that you contribute, for a total company matching contribution of 4.5% on 6% of Annual Benefits Salary.

Don’t Leave Money on the Table!
To maximize the company matching contribution, simply contribute at least 6% of your Annual Benefits Salary (base salary, shift differential, bonuses, commission, incentives and overtime) to your 401(k) Plan account. Capital One will then contribute a total of 7.5% of your Annual Benefits Salary to your account. You will be contributing just 6%, but your account has the potential to grow as though you are contributing 13.5%!
See how an associate can maximize the company match just by deferring 6% ($3,000) in the example below.

**AN EXAMPLE:** An associate earning $50,000 ($45,000 in base salary and $5,000 in annual bonus) and currently contributing 6% of their Annual Benefits Salary to the 401(k) Plan.

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associate Elective Contribution (6% of eligible compensation)</td>
<td>$3,000</td>
</tr>
<tr>
<td>3% Basic Non-Elective Company Contribution (3% of eligible compensation, regardless of whether or not you participate)</td>
<td>$1,500</td>
</tr>
<tr>
<td>Company Matching Contribution (100% of the first 3% you contribute plus 50% of the next 3% you contribute)</td>
<td>$2,250</td>
</tr>
<tr>
<td>Total Annual Contributions to the 401(k) Plan</td>
<td>$6,750</td>
</tr>
</tbody>
</table>

Rollover Contributions
You may roll pre-tax, after-tax or Roth 401(k) assets from another qualified retirement plan into your account.

When Are Contributions Yours?
Your account balance within the 401(k) Plan is yours once you are vested. You are immediately vested in your contributions as well as your basic non-elective company contributions. Matching contributions vest upon two years of service with Capital One. This means that all of the amounts contributed to your 401(k) Plan account—as well as any investment earnings—are entirely yours after just two years of employment.

Enrolling in the 401(k) Plan
You will receive an enrollment kit approximately one week after you start with Capital One, but you are eligible to enroll in the 401(k) Plan immediately. (You may need to wait up to a week after your hire date in order to enroll.) Your associate elective contributions (through payroll deduction) and matching company contributions will begin within two pay cycles following your enrollment, or as soon as administratively possible after you enroll. Please review the Fidelity Cut Off Schedule on the “Payroll Calendar (US)” Pulse page for more details.

The 3% Basic Non-Elective Contributions will automatically begin as soon as administratively possible after your date of hire, typically within three pay periods. If you do not elect to contribute to the 401(k) Plan, you are still eligible for the 3% basic non-elective contributions.

If you do not enroll within 60 days of your hire date, you will be automatically enrolled at an associate elective contribution rate of 3% of your eligible pre-tax compensation. Additionally, unless you make an alternative selection, your contributions will be automatically invested in the BlackRock LifePath® Fund that best matches your expected retirement date.
The LifePath Fund will then invest your money in such a way that takes your age and retirement date into account. The investment direction will be somewhat more aggressive if you are younger and will move to a more conservative path as your expected retirement date nears.

For More Information
For more information about the 401(k) Plan or to enroll, visit Fidelity NetBenefits® at netbenefits.com or call the Capital One Retirement Savings Center at Fidelity at 1-800-854-4015. You can also learn more on Pulse.
Other Benefits

Commuter Benefits
The plan allows you to set aside a portion of your paycheck before taxes are deducted, which WageWorks—our benefit provider—uses to pay your commuting expenses, such as parking, mass transit and van pool. You see your savings in the form of reduced tax withholding. You may sign up for this program at any time and may cancel at any time before the monthly cutoff date (the 10th of each month). When you reach your pre-tax savings limit, you don’t have to leave the plan. WageWorks provides convenience by then using post-tax dollars to continue paying eligible commuting costs for you. Capital One pays for program administration of the commuter benefits offering. You pay only the cost of your transit or parking.

How to Sign Up
Go to wageworks.com and click on Register Now. The site will guide you through a few simple steps. You will be assigned a username and password. You’ll need to use the last four digits of your Capital One employee ID (that’s the six digit number available under More Details in your Pulse profile—not to be confused with your eID, which is a series of three numbers and letters) and your home ZIP code in order to register a new account with WageWorks. Capital One doesn’t send Social Security numbers on our files to WageWorks. We only provide your employee ID.

During sign-up, you’ll be able to select your transit or parking provider directly at the site. If your provider is not listed, please contact WageWorks at 1-877-924-3967 for assistance.

In general, you need to sign up early in the month (by the 10th of the month in most cases) to begin receiving benefits the following month. If you want to cancel your benefits you must also do so by the 10th of the month prior to the next benefits month. Visit Pulse for more details.

Educational Assistance
Capital One’s Educational Assistance program offers you an annual budget to use for course-specific tuition, required books and eligible course-specific fees at regionally and nationally accredited institutions. Depending upon your field of study and meeting eligibility requirements, you may be reimbursed through the Educational Assistance Program. Full-time and part-time associates (who work at least 20 standard hours/week) are eligible on their date of hire for reimbursement for courses starting on or after their hire date.

- For eligible full-time associates, the Educational Assistance Program provides up to a $5,000 per year allowance (or budget) for course specific tuition, required books and eligible course specific fees. Part-time eligible associates are provided up to a $2,500 per year allowance (or budget) for course specific tuition, required books and eligible fees.
- Through the program, associates are eligible for tuition discounts at over 200 selected schools and programs through the EdAssist Education Network. Even if you don’t qualify for Educational Assistance, you can still receive discounts at participating schools.
- Associates must receive a grade of “C” or better (Undergraduate), a grade of “B” or better (Graduate), or “Pass” if a class only allows a “Pass/Fail” grading option.

Visit Pulse for full details and eligibility requirements of the various Educational Assistance programs.
Employee Assistance Program

Capital One’s Employee Assistance Program (EAP) provides a robust set of services including telephonic and/or face-to-face counseling, legal and financial assistance, ID theft recovery and information on health and well-being.

Free up your day by using the EAP to research family needs such as daycare or eldercare referrals. Moving? Use the Relocation Center to find maps, school reports and houses of worship. If you like to save money, you can also find discounts on a variety of products and services.

Use of EAP services is completely confidential and free of charge to all Capital One associates and their household members. Assistance is available online or by phone 24 hours a day, every day.

Areas frequently addressed by the EAP include:

- Child care and parenting
- Financial issues
- Work and career
- Addiction and recovery
- Concierge and convenience services
- Helping aging parents
- Legal concerns
- Emotional well-being
- Wellness and prevention
- Life events
- Concierge and convenience services

To access the Anthem EAP, call 1-855-383-7222. Visit Anthem EAP online at anthemeap.com for more information. When you go to the site, enter “Capital One” as the login.

Time-Off Programs

We offer two types of time-off programs:

- Non-exempt associates: Paid Time-Off (PTO)
- Exempt associates: Vacation

Additionally, all full-time associates receive 10 paid holidays a year. Full-time associates may also be eligible for paid leave for bereavement and family care.

Exempt Associates

Full-time associates working 40 standard hours a week are granted vacation based on calendar years of service.

- In your first calendar year of service (year 0), your vacation is based on a prorated portion of a 10 day vacation allotment using date of hire.
- After the year in which you were hired, you receive 15 vacation days annually (calendar years 1-4).
- Upon completing four full-calendar years, you receive 20 vacation days annually (calendar years 5+).

Exempt associates are granted paid sick time on an as needed basis.

All Associates

- If you work less than 40 standard hours, the PTO/vacation allotments shown above are prorated based on your standard hours as maintained in Workday.
- You may use PTO/vacation time after satisfying a 90-day probationary period.

Purchasing Additional PTO/Vacation

During Annual Enrollment, associates may purchase up to one week of PTO/vacation time for the coming year, in one-hour increments. Your annual base salary as of January 1, 2018, will be used to calculate the value of the additional time off that time you purchase.

Note: It’s important to note that unused purchased PTO/vacation may not be carried over into another calendar year—and you must use earned PTO/vacation before purchased time. See Pulse for more details about Capital One’s time-off programs.
Adoption & Surrogacy Reimbursement
The Adoption Reimbursement program provides financial support up to $35,000 per child for full-time associates who are building their families through adoption. Our Employee Assistance Program (EAP), administered by Anthem, can guide you through each step of the adoption process. In addition to assisting you with reimbursement claims, contact the EAP for assistance with information resources and referral services, evaluating adoption agencies, finding an adoption attorney and more.

The Surrogacy Reimbursement program provides financial support up to $35,000 per surrogacy arrangement for full-time associates who are building their families through surrogacy. Expenses such as legal costs, attorney’s fees, surrogacy agency fees, and some medical and travel expenses are eligible for reimbursement.

Associates are limited to three lifetime claims for Adoption and/or Surrogacy Reimbursement combined.

For more information about these benefits programs, review the Adoption Reimbursement Program and Surrogacy Reimbursement Program pages on Pulse, contact the Anthem Employee Assistance Program at 1-855-383-7222, or visit Anthem EAP online at anthemaleap.com, enter “Capital One” as the login.

Parental Leave
Parental Leave options are available to eligible full-time associates who are new mothers, fathers and secondary care parents, including birth via a surrogate, adoption and foster care.

Here’s an at-a-glance look at the various types of parental leave (see Pulse for complete details and eligibility).

Maternity Leave
Birth mothers are eligible for up to 18 weeks of Maternity Leave.

- Use PTO (non-exempt) or Sick Time (exempt) for your first week of leave, if available.
- Weeks 2-10 are paid at 100% under Short-Term Disability. If you go out on STD prior to your delivery date due to a medical reason, the 2-10 weeks of 100% pay begins. Any time after 10 weeks will be paid at 85% of your pay. You will still receive 10 weeks of STD “recovery” from the date of the birth.
- Weeks 11-18 are paid at 100% under the Parental Leave Program. Leave must be taken in a minimum of two week blocks. You have 12 months from the date of birth to use their Parental Leave.
- 2 of the 8 weeks of the Parental Leave may be used prior to your expected due date.
- You should provide at least a 30-day advance notice to your manager and the Capital One Leave and Accommodation Service Center prior to taking your Parental Leave (for both consecutive leaves and incremental leaves).

Paternity/Secondary Parental Care
New dads and secondary care parents may be eligible for up to 12 weeks of time off to care for and bond with their child.

- Eight weeks of Parental Leave, paid at 100%, which can be broken up in two week increments. Two of the eight weeks of the Parental Leave may be used prior to expected date of birth. You have 12 months from the date of birth to use your Parental Leave. Documentation is not required for the two weeks prior to expected date of birth, but proof of birth will be required for anytime taken after the birth. You should provide at least a 30-day advance notice to your manager and the Capital One Leave and Accommodation Service Center prior to taking Parental Leave time (for both consecutive leaves and incremental leaves). Both Parental and Family and Medical (FML) Leaves are set up simultaneously and run concurrently.
- If you're eligible for FMLA at the time of your child's birth, you're eligible for 4 additional weeks of unpaid leave under FML time. You must use all but ONE week of earned vacation (exempt associates) or PTO (non-exempt associates) before taking unpaid leave. You are not required to use any vacation/PTO that you've purchased. Note: Any FML taken outside of the Parental Leave must be taken consecutively, but you don't have to take it immediately following your 8 weeks of Parental Leave.

Adoption/Foster Care Leave
Adoptive and Foster parents may be eligible for up to 12 weeks of time off to care for and bond with their child.

- Eight weeks of Parental Leave, paid at 100%, which can be broken up in two week increments. Two of the eight weeks of the Parental Leave may be used prior to the expected adoption or placement in the home. You have 12 months from the date of adoption or placement in the home to use their Parental Leave. Documentation is not required for the two weeks prior to expected adoption or placement in your home, but proof of adoption or placement in your home will be required for anytime taken after the adoption or placement in your home. You should provide at least a 30-day advance notice to your manager and the Capital One Leave and Accommodation Service Center prior to taking your Parental Leave time (for both consecutive leaves and incremental leaves). Both Parental and Family and Medical (FML) Leaves are set up simultaneously and run concurrently.
- If you're eligible for FML at the time of your child's birth, you're eligible for 4 additional weeks of unpaid leave under FML time. You must use all but ONE week of earned vacation (exempt associates) or PTO (non-exempt associates) before taking unpaid leave. You are not required to use any vacation/PTO that you've purchased. Note: Any FML taken outside of the Parental Leave must be taken consecutively, but you don't have to take it immediately following your 8 weeks of Parental Leave.
Birth via Surrogate
Associates may be eligible for up to 12 weeks of time off for a child born via surrogacy.

- Eight weeks of Parental Leave, paid at 100%, which can be broken up in two week increments. Two of the eight weeks of the Parental Leave may be used prior to expected date of birth. You have 12 months from the date of birth to use your Parental Leave. Documentation is not required for the two weeks prior to expected date of birth, but proof of birth will be required for anytime taken after delivery. You should provide at least a 30-day advance notice to your manager and the Capital One Leave and Accommodation Service Center prior to taking your Parental Leave time (for both consecutive leaves and incremental leaves). Both Parental and Family and Medical (FML) Leaves are set up simultaneously and run concurrently.

- If you’re eligible for FML at the time of your child’s birth, you’re eligible for 4 additional weeks of unpaid leave under FML time. You must use all but ONE week of earned vacation (exempt associates) or PTO (non-exempt associates) before taking unpaid leave. You are not required to use any vacation/PTO that you’ve purchased. Note: Any FML taken outside of the Parental Leave must be taken consecutively, but you don’t have to take it immediately following your 8 weeks of Parental Leave.

If you need to take a parental leave, call the Capital One Leave and Accommodation Service Center at 844-324-CAP1 (2271) 30 days prior to your expected delivery date or requested leave date—they’ll let you know what paperwork is needed to approve your time off and initiate your Short-Term Disability and/or Parental Leave claims.

Back-Up Child and Family Care
The Bright Horizons Care Advantage Program provides alternative child and adult care options during a lapse or breakdown in normal care arrangements for your children or other family members for whom you have care responsibilities. In addition, the Priority Child Care Access Program puts you at the top of the waiting list for full-time and part-time child care at a Bright Horizon center.

The back-up care programs are provided free of charge to associates, but have a 15-day annual limit. It is also important to pre-register for this service (can be done at any time) so that you can request care as soon as you need it.

If you need help with ongoing care, Sittercity helps you find the right caretakers for any situation with their free, online caregiver database. Quickly get connected with nannies, baby sitters, elder care and pet sitters. The annual membership fee has been covered by Capital One if accessed through this site.

For more information, check out Pulse or contact Bright Horizons at 1-877-242-2737, or go to: careadvantage.com/capitalone, enter “Capital One” as the username and “Bewell” as the password.

College Coach
College Coach provides valuable information and insight from former admissions officers, college finance professionals, and teachers. College Coach can help answer questions like how to navigate the complex college admissions process and determine the best way to pay for college. For more information, check out Pulse or contact College Coach at 1-877-527-3550 or capitalone@getintocollege.com, or go to https://passport.getintocollege.com/Account/Login. Use the password “Bewell” for new registrations.
Appendix

Privacy and Your Health Coverage

The privacy rules under the Health Insurance Portability and Accountability Act (HIPAA) require that the Capital One health plans periodically remind you about the availability of the privacy notice and how to obtain that notice. The privacy notice explains participants’ rights and the plan’s legal duties with respect to protected health information (PHI) and how the plan may use and disclose PHI.

To obtain a copy of the privacy notice or for any questions about the plans’ privacy policies, please contact the Capital One HR Help Center at 1-888-376-8836. You can also go online at capitalonebenefitsite.com to view a copy of the notice.

Reminder: HIPAA Description of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends or employer contributions to such other health insurance coverage terminate. 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, provided that you request enrollment within 30 days after the marriage or 60 days after the birth, adoption or placement for adoption. During a loss of coverage event, members can enroll in medical, dental and vision. Contact the Capital One HR Help Center at 1-888-376-8836.

Post-Mastectomy Benefits

Under federal law, all group health plans are required to provide medical and surgical benefits following a mastectomy—and to communicate this coverage to plan participants. All medical options provide coverage for these services, including reconstructive breast surgery needed after mastectomy, prostheses and treatment of any physical complications after a mastectomy. These services are covered in the same way as other surgery or services under each medical option.

Length of Maternity Hospital Stay

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier. Additionally, no group health plan or issuer may require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods.

Reminder: Women’s Health and Cancer Rights Act

As required by the Women’s Health and Cancer Rights Act, a member receiving benefits for a medically necessary mastectomy who elects breast reconstruction after the mastectomy will also receive coverage for:

- All stages of reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- 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, and will be subject to the same annual deductibles and co-insurance provisions that apply for the mastectomy. Information about how to obtain a detailed description of the mastectomy-related benefits is available via Anthem Blue Cross and Blue Shield at 1-844-390-4133 or anthem.com/capitalone.

Important Notice From Capital One About Grandfathered Health Plans

The Capital One Employee Welfare Benefit Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain plan benefits or consumer protections afforded by the Affordable Care Act that apply to other plans. For example, the requirement for the provision of another layer of external claims review for claim denials and appeals and coverage for member cost for participating in clinical trials will not be provided under our plans. However, many of the Affordable Care Act provisions are already provided by our plans such as free preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other plan benefits or consumer protections mandated in the Affordable Care Act, for example, the elimination of lifetime limits on benefits and providing for the option to cover adult children up to age 26.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Anthem Blue Cross and Blue Shield at 1-844-390-4133 or anthem.com/capitalone. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor, at 1-866-444-3272 or dol.gov/ebisa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.
Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

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

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your state Medicaid or CHIP office, dial 1-877-KIDS NOW or visit insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at askesba.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of August 10, 2017. Contact your state for more information on eligibility.

### Medicaid and CHIP Contact Information

<table>
<thead>
<tr>
<th>State</th>
<th>Medicaid Contact Information</th>
</tr>
</thead>
</table>
| Alabama (Medicaid) | Website: myalhipp.com  
(Phone: 1-855-692-5447) |
| Alaska (Medicaid) | Website: myakhipp.com  
(Phone: 1-866-251-4861)  
(Email: CustomerService@MyAKHIPP.com)  
(Medicaid Eligibility: dhss.alaska.gov/dpa/Pages/medicaid/default.aspx) |
| Arkansas (Medicaid) | Website: myarhppo.com  
(Phone: 1-855-MyARHIPP (855-692-7447)) |
| Colorado (Medicaid and CHIP) | Website: healthfirstcolorado.com  
(High First Colorado Member Contact Center: 1-800-221-3943 State Relay 711  
(CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus  
(State Relay 711)) |
| Florida (Medicaid) | Website: flmedicaidtplrecovery.com/hipp/  
(Phone: 1-877-357-3268) |
| Georgia (Medicaid) | Website: dch.georgia.gov/medicaid (Click on Health Insurance Premium Payment (HIPP))  
(Phone: 404-656-4507) |
| Indiana (Medicaid) | Website: in.gov/fssa/hip/  
(Phone: 1-877-438-4479  
(All other Medicaid  
(Website: indianamedicaid.com  
(Phone: 1-800-403-0864) |
| Iowa (Medicaid) | Website: dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp  
(Phone: 1-888-346-9562) |
| Kansas (Medicaid) | Website: zkdhks.gov/hcf/  
(Phone: 1-785-296-3512) |
| Kentucky (Medicaid) | Website: chfs.ky.gov/dms/default.htm  
(Phone: 1-800-635-2570) |
| Louisiana (Medicaid) | Website: dhh.louisiana.gov/index.cfm/subhome/1/n/331  
(Phone: 1-888-695-2447) |
| Maine (Medicaid) | Website: maine.gov/dhhs/ofi/public-assistance/index.html  
(Phone: 1-800-442-6003  
(TTY Maine relay 711) |
| Massachusetts (Medicaid and CHIP) | Website: mass.gov/eohhs/departments/masshealth/  
(Phone: 1-800-862-4840) |
| Minnesota (Medicaid) | Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp  
(Phone: 1-800-657-3739) |
<table>
<thead>
<tr>
<th>State</th>
<th>Medicaid Website</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Missouri</td>
<td>Website: dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</td>
<td></td>
</tr>
<tr>
<td>Montana</td>
<td>Website: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084</td>
<td></td>
</tr>
<tr>
<td>Nebraska</td>
<td>Website: ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</td>
<td></td>
</tr>
<tr>
<td>Nevada</td>
<td>Website: dwss.nv.gov Phone: 1-800-992-0900</td>
<td></td>
</tr>
<tr>
<td>New Hampshire</td>
<td>Website: dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218</td>
<td></td>
</tr>
<tr>
<td>New Jersey</td>
<td>Medicaid Website: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid">www.state.nj.us/humanservices/dmahs/clients/medicaid</a> Medicaid Phone: 609-631-2392 CHIP Website: njfamilycare.org/index.html CHIP Phone: 1-800-701-0710</td>
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</tr>
<tr>
<td>New York</td>
<td>Website: health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</td>
<td></td>
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<tr>
<td>North Carolina</td>
<td>Website: dma.ncdhhs.gov/ Phone: 919-855-4100</td>
<td></td>
</tr>
<tr>
<td>North Dakota</td>
<td>Website: nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825</td>
<td></td>
</tr>
<tr>
<td>Oklahoma</td>
<td>Website: insureoklahoma.org Phone: 1-888-365-3742</td>
<td></td>
</tr>
<tr>
<td>Oregon</td>
<td>Website: healthcare.oregon.gov/Pages/index.aspx oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075</td>
<td></td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>Website: dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462</td>
<td></td>
</tr>
<tr>
<td>Rhode Island</td>
<td>Website: <a href="http://www.eohhs.ri.gov">www.eohhs.ri.gov</a> Phone: 855-697-4347</td>
<td></td>
</tr>
<tr>
<td>South Carolina</td>
<td>Website: <a href="http://www.scdhls.gov">www.scdhls.gov</a> Phone: 1-888-549-0820</td>
<td></td>
</tr>
<tr>
<td>South Dakota</td>
<td>Website: dss.sd.gov Phone: 1-888-828-0059</td>
<td></td>
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<tr>
<td>Texas</td>
<td>Website: gethipptexas.com Phone: 1-800-440-0493</td>
<td></td>
</tr>
<tr>
<td>Utah</td>
<td>Medicaid Website: medicaid.utah.gov/ CHIP Website: health.utah.gov/chip Phone: 1-877-543-7669</td>
<td></td>
</tr>
<tr>
<td>Vermont</td>
<td>Website: greenmountaincare.org Phone: 1-800-250-8427</td>
<td></td>
</tr>
<tr>
<td>Virginia</td>
<td>Medicaid Website: coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282</td>
<td></td>
</tr>
<tr>
<td>Washington</td>
<td>Website: hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473</td>
<td></td>
</tr>
<tr>
<td>West Virginia</td>
<td>Website: mywhipp.com/ Phone: 1-855-MyWHIPP (1-855-699-8447)</td>
<td></td>
</tr>
<tr>
<td>Wisconsin</td>
<td>Website: dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002</td>
<td></td>
</tr>
<tr>
<td>Wyoming</td>
<td>Website: wyequitycare.acs-inc.com/ Phone: 307-777-7531</td>
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</table>

To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

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

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

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

The public reporting burden for this collection of information is estimated to average approximately 7 minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019)

**Medicare Part D Prescription Drug Plan—Notice of Creditable Coverage**

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

**Important things to know about your rights**

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

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

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

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

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

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

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

Should you have any questions regarding this notice, please contact the Capital One Benefits Center at 1-888-376-8836.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Part D prescription drug plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Capital One has determined that the prescription drug coverage offered by CVS Caremark is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare Part D prescription drug plan.
When can you join a Medicare Part D prescription drug plan?
You can join a Medicare Part D prescription drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare Part D prescription drug plan.

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

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

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

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

For more information about your options under Medicare prescription drug coverage...
More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
- Visit medicare.gov
- Call your state Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
- Call 1-800-medicare (1-800-633-4227). TTY users should call 1-877-486-2048.

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

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained Creditable Coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).