2020

Benefits Enrollment Guide

GlobalPundits

Globalpundits

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The following descriptions of available benefit elections options, are purely informational and have been provided to you for illustrative purposes only. Payment of benefits will vary from claim to claim within a particular benefit option and will be paid at the sole discretion of the applicable insurance provider for each benefit option. The terms and conditions of each applicable policy or certificate of coverage will provide specific details and will govern in all matters relating to each particular benefit option described in this summary. In no case will any information in this summary amend, modify, expand, enhance, improve or otherwise change any term, condition or element of the policies or certificates of coverage that govern the benefit options described in this summary.

Presented by:

ONEDIGITAL HEALTH AND BENEFITS

ENROLLMENT AND ELIGIBILITY

Offering a comprehensive and competitive benefits package is one way we recognize your contribution to the success of the organization and our role in helping you and your family to be healthy, feel secure and maintain work/life balance. This enrollment guide has been designed to provide you with information about the benefit choices available to you. Remember, open enrollment is your only opportunity each year to make changes to your elections, unless you or your family members experience an eligible "change in status."

How to Enroll in the Plans

Read your materials and make sure you understand all of the options available.

- Please go to Paychex www.myapps.paychex.com and proceed to the Benefits Administration tab on the left side of the page.
- Fill out any necessary personal information.
- Make your benefit choices.
- If you have questions or concerns, please contact your HR department.

Whom Can You Add to Your Plan?

Eligible:

- Legally married spouse
- Natural or adopted children up to age 26, regardless of student and marital status
- Children under your legal guardianship
- Stepchildren
- Children under a qualified medical child support order
- Disabled children 19 years or older
- Children placed in your physical custody for adoption

Ineligible:

- Divorced or legally separated spouse
- Common law spouse, even if recognized by your state
- Domestic partners, unless your employer states otherwise
- Foster children
- Sisters, brothers, parents or in-laws, grandchildren, etc.

Change in Status

Generally, you may enroll in the plan, or make changes to your benefits, when you are first eligible. However, you can make changes/enroll during the plan year if you experience a change in status. As with a new enrollee, you must submit your paperwork within 30 days of the change or you will be considered a late enrollee.

Examples of changes in status:

- You get married, divorced or legally separated
- You have a baby or adopt a child
- You or your spouse takes an unpaid leave of absence
- You or your spouse has a change in employment status
- Your spouse dies
- You become eligible for or lose Medicaid coverage
- Significant increase or decrease in plan benefits or cost

Did you know?

Open Enrollment is the only chance to make changes, unless you experience a “change in status.”

PACKAGE OVERVIEW & CONTACT INFORMATION

GlobalPundits offers eligible employees a comprehensive benefit package that provides both financial stability and protection. Our offering provides flexibility for employees to design a package to meet their unique needs.

Effective January 1, 2020:

- Medical benefit plans with **BlueChoice**
  800-868-2528 | www.bluechoicesc.com
- Dental, Life/AD&D, Voluntary Life, and Long Term Disability benefit plans with **Mutual of Omaha**
  800-228-7104 | www.mutualofomaha.com
- Vision benefit plan with **EyeMed**
  866-939-3633 | www.eyemed.com

After you have enrolled in insurance coverage, you will receive additional information in the mail from the insurance carriers. This information will contain your personal identification cards. In the meantime, you can look up providers for your plans on the internet.

Broker Contacts:
Carol Iverson
CIverson@OneDigital.com
803-227-8639 ext. 2

HR at GlobalPundits:
Tammie J. King. RHU, REBC
TJKing@OneDigital.com
803-227-8639 ext 1

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MEDICAL PLANS

For this plan year, you can choose from the following medical options. Refer to the carrier benefits summaries for the exact benefit levels associated with your plan choice.

Carrier Name	BlueChoice	
Name of Plan	BlueChoice Advantage Plus	BlueChoice Advantage Plus HDHP
Type of Plan	PPO	PPO/HDHP
Office Visits	**In Network**	**In Network**
Primary	$35 Copay	Deductible then 0%
Specialist	$50 Copay	Deductible then 0%
Pharmacy		
Deductible	Not Applicable	Integrated with Medical Deductible
Retail Standard	$8/$25/$45/$70	Deductible then 0%
Retail Specialty	$125/$175	
Mail Order (90 days - Standard)	$20/$62.50/$112.50/$175/$312.50/$437.50	
Common Services		
In-Patient Facility	Deductible then 30%	Deductible then 0%
Out-Patient Facility	Deductible then 30%	Deductible then 0%
Urgent Care	$35 Copay	Deductible then 0%
Emergency Room	$200 Copay then 30%	Deductible then 0%
Annual Deductible		
Individual	$1,000	$5,000
Family	$3,000	$10,000
Coinsurance	30%	0%
Annual Out of Pocket	Includes Deductible	Includes Deductible
Individual	$4,000	$5,000
Family	$9,000	$10,000
Maximum Benefits	Unlimited – Life Time Maximum	Unlimited – Life Time Maximum

The benefit plan information shown in this guide is illustrative only. To the extent the benefit plan information summarized herein differs from the underlying plan details specified in the insurance documents that govern the terms and conditions of the plans of insurance described in this guide, the underlying insurance documents will govern in all cases.

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DENTAL PLAN

For this plan year, you can choose from the following dental option. Refer to the carrier benefits summary for the exact benefit level associated with your plan.

Carrier Name	Mutual of Omaha	
Name of Plan	Group Dental Plan w/ Ortho	
Type of Plan	PPO	
Class	**In Network**	**Out of Network**
Preventive	0%	0%
Basic Restorative	Deductible then 20%	Deductible then 20%
Major Services	Deductible then 50%	Deductible then 50%
Orthodontia	50%	50%
Plan Details		
Deductible applies to Preventive	No	No
Endodontics/Periodontics: Basic or Major	Major	Major
Orthodontics (Adult/Children)	Children	Children
Waiting Periods Applied	Yes	Yes
Deductible		
Person - Calendar Year	$50	
Family - Calendar Year	$150	
Plan Maximums		
Calendar Year Max	$1,000	
Ortho Lifetime Max	$1,000	

Did you know?

Allowing your child to sip juice throughout the day puts them at a higher risk for tooth decay. - American Dental Association

**Source:* American Dental Association (ADA)

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VISION PLAN

For this plan year, you can choose from the following vision option. Refer to the carrier benefit summary for the exact benefit level associated with your plan.

Carrier Name	EyeMed	
Name of Plan	Insight Option 1	
Exam	**In Network**	**Out of Network**
Copay	$10 Copay	Reimbursed to $40
Frequency	12 Months	
Lenses		
Frequency	12 Months	
Single	$25 Copay	Reimbursed to $30
Bifocal	$25 Copay	Reimbursed to $50
Trifocal	$25 Copay	Reimbursed to $70
Contacts Elective	$130 Allowance plus 15% off Balance	Reimbursed to $130
Contacts Medically Necessary	$0 Copay	Reimbursed to $210
Frames		
Frequency	24 Months	
Frames	$130 Allowance plus 20% off Balance	Reimbursed to $91

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LIFE AND AD&D INSURANCE PLAN

Basic Life

Carrier Name	Mutual of Omaha
Life Benefit	$10,000
AD&D Benefit	$10,000
Guaranteed Issue Amount	$10,000
Conversion Privilege	Yes
Waiver of Premium	Yes

Voluntary Life

Carrier Name	Mutual of Omaha
Employee Life and AD&D Benefit	Increments of $10,000 up to Lesser of 5x Salary or $500,000 Maximum
Dependent Life and AD&D Benefit	**Spouse:** Increments of $5,000 to $250,000; not to exceed 100% of Employee's benefit **Child:** Increments of $1,000 to $10,000 Maximum
Guaranteed Issue Amounts	**Employee:** $100,000 **Spouse:** $25,000 **Child(ren):** $10,000 (evidence of insurability is required for amounts above these guaranteed amounts)
Conversion Privilege	Yes
Waiver of Premium	Yes

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DISABILITY INSURANCE

Long Term Disability

Carrier Name	Mutual of Omaha	
	Core	**Buy-Up**
Benefit	40%	60%
Maximum Monthly Benefit	$10,000	$10,000
Elimination Period	180 Days	180 Days
Duration of Benefits	RBD to SSNRA	RBD to SSNRA
Buy-Up cost from Core(40%) plan to Buy-Up(60%) plan is $0.20 per $100 of covered monthly payroll.		

Did you know?

Over a billion people worldwide live with some form of disability- about 15% of world population.*

**Source: World Health Organization "www.who.int/features/factfiles/disability/en/*

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EMPLOYEE ASSISTANCE PROGRAM (EAP) with Sun First

GlobalPundits provides these services at no cost to employees or their families. No referrals are needed to see an EAP counselor, and you never have to worry about finding a provider who is in your network. And unlike insurance-covered care, you never have a co-pay. In addition, all household family members are covered regardless if they are covered by other benefits.

The call center is open 24 hours a day, 7 days a week. All operators have clinical backgrounds and at minimum a bachelor's degree in the field. You can also talk to a licensed counselor at any time. Instead of waiting weeks to be seen by a counselor, you can contact one anytime.

We offer short-term counseling to help people work through any problems they may be having. Some counseling sessions are done over the phone, while in other instances the employee visits the counselor.

Sun First - www.sunfirst.com
(Specific benefit information in the "Additional Benefit Information" section at the end of this guide. Click "here" to access.

- Stress Management
- Divorce/Marital Problems
- Grief
- Feeling Unmotivated
- Feeling Depressed
- Family Issues
- Feeling Stuck
- Drug and Alcohol Issues

The benefit plan information shown in this guide is illustrative only. This information is not intended to be exhaustive nor should any discussion or opinions be construed as professional advice.

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401(K)

Globalpundits – 401k - 2020 Update

Globalpundits provides access to a 401k plan through Paychex and pays the administrative expenses for employees. Begin planning for your retirement with a 401(k) savings plan. Participating in the plan can also help you save taxes today. Qualifying contributions are tax-deferred until you withdraw them from your account. In addition, tax-deferral allows the full amount of your investment to work for you.

Benefit Eligibility

All employees of Globalpundits are immediately eligible as long as they are over the age of 21.

Contribution Limits

Your deferral amount can be anywhere between 0% to 96% of your compensation. There is however an annual limit of $19,500 for 2020. If you are 50 or above there is a "catch-up" provision that allows you to increase your contribution with $6,500. There is no matching. Your Investment Options for 2020 are 26 mutual funds choices.

Enrollment instructions

Once eligible, you can enroll at any time. Use the self-service portal to all your Paychex services and begin by registering at: www.online.paychex.com

Options

Once you enroll at the self-service portal.

1. Decide a contribution amount (%).
2. Decide whether you want it to be pre-taxed, Roth or a combination of both.
3. Fund selection. You have 26 Mutual Funds to choose from, in several investment divisions and you can pick any combination that you want.

The default is American Funds the Cash Management Trust of America. You have access to prospectus and past performance online.
If you have questions on what investment option would be most suitable, contact Roger Johansson.

Contact Information
Roger Johansson, LUTCF
803-376-2000 or 803-429-0448
Paychex 877-283-9520

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EMPLOYEE DEDUCTIONS

GlobalPundits contributes to the cost of the medical and dental plans for you.

Coverage Tier	Employee Bi-Weekly Contribution	
Medical Plans	**High Deductible Health Plan**	**Traditional Copay Plan**
Employee Only	$119.65	$205.85
Employee/Spouse	$369.81	$546.00
Employee/Child(ren)	$293.08	$441.58
Employee/Family	$543.35	$781.96
Dental Plan		
Employee Only	$6.51	
Employee + 1	$22.69	
Family	$41.70	
Vision Plan		
Employee Only	$3.19	
Employee/Spouse	$6.07	
Employee/Child(ren)	$6.39	
Employee/Family	$9.40	

The rates shown in this guide are illustrative only. To the extent the rates contained herein differ from those in the insurance documents that govern the terms and conditions of the plans of insurance described in this guide, the rates in the underlying insurance documents will govern in all cases.

REQUIRED NOTICES

Newborn and Mothers' Health Protection Act

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

Women's Health and Cancer Rights Act

- In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully. As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a covered mastectomy is also entitled to the following benefits: 1. All stages of reconstruction of the breast on which the mastectomy has been performed: 2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3. Prostheses and treatment of physical complications of the mastectomy , including lymphedemas. Health plans must provide coverage of mastectomy related benefits in a manner to determine in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and insurance amounts that are consistent with those that apply to other benefits under the plan.

REQUIRED CHIP NOTICE

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your State for more information on eligibility –

ALABAMA - Medicaid	**FLORIDA- Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA - Medicaid	**GEORGIA- Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
ARKANSAS - Medicaid	INDIANA- Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA - Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563

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REQUIRED CHIP NOTICE (CONT)

KANSAS - Medicaid	NEW HAMPSHIRE - Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll-Free: 1-800-852-3345, ext 5218
KENTUCKY - Medicaid	**NEW JERSEY - Medicaid and CHIP**
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA - Medicaid	**NEW YORK - Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE - Medicaid	**NORTH CAROLINA - Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS - Medicaid and CHIP	NORTH DAKOTA - Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid Phone: 1-844-854-4825
MINNESOTA - Medicaid	**OKLAHOMA - Medicaid and CHIP**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI - Medicaid	**OREGON - Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA - Medicaid	**PENNSYLVANIA - Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA - Medicaid	**RHODE ISLAND - Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct Rite Share Line)

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REQUIRED CHIP NOTICE (CONT)

NEVADA - Medicaid	SOUTH CAROLINA - Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
TEXAS - Medicaid	**WEST VIRGINIA - Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH - Medicaid and CHIP	WISCONSIN - Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
SOUTH DAKOTA - Medicaid	WASHINGTON - Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
VERMONT - Medicaid	**WYOMING - Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://health.wyo.gov/healthcarefin/medicaid/ Phone: 307-777-7531
VIRGINIA - Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.
The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

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

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HIPAA Notice

HIPAA Privacy Notices

HIPAA requires group health plans to provide a notice of current privacy practices regarding protected personal health information (PHI) to enrolled participants. All employers must distribute HIPAA Privacy Notices if the plan is self-funded or if the plan is fully- insured and the employer has access to PHI. If the employer maintains a benefits website, the HIPAA Privacy Notice must be included on the website.

The HIPAA Privacy Notice must be written in plain language and must describe three things: (1) the use and disclosures of PHI that may be made by the group health plan; (2) plan participants' privacy rights; and (3) the group health plan's legal responsibilities with respect to the PHI.

The Department of Health and Human Services (HHS) has developed three different model Privacy Notices for health plans to choose from: booklet version, layered version, and full-page version.

More information can be found at: https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/privacy-practices-for-protected-health-information/index.html

Link to OneDigital's privacy policy: https://www.onedigital.com/privacy-policy/

Model Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within the appropriate time period that applies under the plan after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within the appropriate time period that applies under the plan after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the appropriate plan representative.

More information can be found at: https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/hipaa-compliance

For additional information on your employer's privacy policy, please contact your HR department.

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CONFIDENTIALITY NOTICE

Digital Insurance LLC dba OneDigital Health and Benefits does not sell or share any information we learn about our clients and understands you may have to answer sensitive questions about your medical history, physical condition and personal health habits as required by our insurance carrier partners.

We collect nonpublic personal information from the following sources:

- Information from you, including data provided on applications or other forms, such as name, address, telephone number, date of birth and Social Security number
- Information from your transactions with us and/or our partners such as policy coverage, premium, claim, and payment history.

OneDigital Health and Benefits recognizes the importance of safeguarding the privacy of our clients and prospective clients, and we pledge to protect the confidential nature of your personal information. We understand our ability to provide access to affordable health insurance to businesses and individuals can only succeed with an environment of complete trust.

In the course of business, we may disclose all or part of your customer information without your permission to the following persons or entities for the following reasons:

- To an insurance carrier, agent or credit reporting agency to detect, prevent or prosecute actual or potential criminal activity, fraud, misrepresentation, unauthorized transactions, claims or other liabilities in connection with an insurance transaction.
- To a medical care institution or medical professional to verify coverage or benefits, to inform you of a medical problem of which you may or may not be aware or to conduct an audit that would enable us to verify treatment.
- To an insurance regulatory authority, law enforcement or other governmental authority to protect our interests in detecting, preventing or prosecuting actual or potential criminal activity, fraud, misrepresentation, unauthorized transactions, claims or other liabilities in connection with an insurance transaction.
- To a third party, for any other disclosures required or permitted by law. We may disclose all of the information that we collect about you, as described above.

Our practices regarding information confidentiality and security: We restrict access to your customer information only to those individuals who need it to provide you with products or services, or to otherwise service your account. In addition, we have security measures in place to protect against the loss, misuse and/or unauthorized alternation of the customer information under our control, including physical, electronic and procedural safeguards that meet or exceed applicable federal and state standards.

Additional Benefit Information

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BlueChoice HealthPlan South Carolina

Global Pundits Technology

Coverage Period: 01/01/2020 - 12/31/2020

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage for: Individual/Family | **Plan Type:** HDHP

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-868-2528 or visit us at www.BlueChoiceSC.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-800-868-2528 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$5,000/Individual $10,000/Family for in-network; $7,000/Individual/$14,000/Family for out-of-network.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out–of–pocket limit for this plan?	Yes. $5,000/Individual/$10,000/family for in-network. $10,000/Individual/$20,000/family for out-of-network.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.BlueChoiceSC.com or call 1-800-868-2528 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146
Released on April 6, 2016

⚠ All copayment and coinsurance costs shown in this chart are after your overall deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-Of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	40% coinsurance	None
	Specialist visit	0% coinsurance	40% coinsurance	None
	Preventive care/screening/immunization	No charge for covered services	Not covered	None
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	40% coinsurance	Preauthorization is required.
	Imaging (CT/PET scans, MRIs)	0% coinsurance	40% coinsurance	Preauthorization is required.
If you need drugs to treat your illness or condition	Tier 1 Tier 2	0% coinsurance/retail prescription 0% coinsurance/mail order prescription 0% coinsurance/retail prescription 0% coinsurance/mail order prescription	Not covered	You will have to pay more if you select a non-generic drug instead of its less expensive Covered generic drug (or Covered over-the-counter alternative).
	Tier 3	0% coinsurance/retail prescription 0% coinsurance/mail order prescription	Not covered	You will have to pay more if you select a non-generic drug instead of its less expensive Covered generic drug (or Covered over-the-counter alternative).
	Tier 4	0% coinsurance/retail prescription 0% coinsurance/mail order prescription	Not covered	You will have to pay more if you select a non-generic drug instead of its less expensive Covered generic drug (or Covered over-the-counter alternative).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-Of-Network Provider (You will pay the most)	
More information about **prescription drug coverage** is available at **www.BlueChoiceSC.com/CDL**	Tier 5 Tier 6	0% coinsurance/retail prescription 0% coinsurance/mail order prescription 0% coinsurance/retail prescription; 0% coinsurance/mail order prescription	Not covered	Specialty medications are not available through the mail order program for a 90-day supply. This only applies to generic or brand drugs in these tiers. Not Covered: Drugs designated as excluded on the Prescription Drug List.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	40% coinsurance	Preauthorization is required. Ambulatory Surgery Center covered at 0% coinsurance/visit
	Physician/surgeon fees	0% coinsurance	40% coinsurance	Preauthorization is required. Ambulatory Surgery Center covered at 0% coinsurance/visit
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	None
	Emergency medical transportation	0% coinsurance	40% coinsurance	None
	Urgent care	0% coinsurance	40% coinsurance	Must be at a participating Urgent Care provider.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	40% coinsurance	Preauthorization is required.
	Physician/surgeon fees	0% coinsurance	40% coinsurance	None
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	0% coinsurance	40% coinsurance	Preauthorization is required for certain services.
	Inpatient services	0% coinsurance	40% coinsurance	Preauthorization is required for certain services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-Of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	0% coinsurance	40% coinsurance	Prior authorization required No additional co-pay for ongoing routine care Home births are not covered
	Childbirth/delivery professional services	0% coinsurance	40% coinsurance	Prior authorization required No additional co-pay for ongoing routine care Home births are not covered
	Childbirth/delivery facility services	0% coinsurance	40% coinsurance	Prior authorization required No additional co-pay for ongoing routine care Home births are not covered
If you need help recovering or have other special health needs	Home health care	0% coinsurance	40% coinsurance	None
	Rehabilitation services	0% coinsurance	40% coinsurance	Preauthorization is required; 20 visits each/year. Includes physical therapy, speech therapy and occupational therapy.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	0% coinsurance	40% coinsurance	Preauthorization is required; 120 days/year
	Durable medical equipment	0% coinsurance	40% coinsurance	Preauthorization is required; initial device only
	Hospice service	0% coinsurance	40% coinsurance	Preauthorization is required
If your child needs dental or eye care	Children's eye exam	$0 / exam for eyeglasses every Benefit Period $45 / exam for contact lens fitting every Benefit Period	Not covered	For Members outside of the South Carolina service area, $71 will be allowed toward the routine eye exam and a $120 credit will apply to the purchase of eyewear. Claims must be filed by the Member.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-Of-Network Provider (You will pay the most)	
	Children's glasses	No charge (every other benefit period)	Not covered	Coverage limited to one pair of glasses/year.
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Hearing aids
- Long-term care
- Routine foot care (Adult)
- Weight loss programs
- Chiropractic care
- Dental Care (Adult)
- Infertility treatment

Other Covered Services. (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care (Adult)

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: BlueChoice HealthPlan at 1-800-868-2528 or visit www.BlueChoiceSC.com, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the South Carolina Department of Insurance, Consumer Services Division, Post Office Box 100105, Columbia, SC 29202-3105, telephone: 803-737-6180, Email: consumers@doi.sc.gov.

Does this Coverage Provide Minimum Essential Coverage? Yes.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this Coverage Meet the Minimum Value Standard? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-868-2528

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-868-2528

Chinese: (中文): 如果需要中文的帮助，请拨打这个号码 1-800-868-2528

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-868-2528

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$5,000**
- **Specialist Coinsurance** **0%**
- **Hospital (facility) Coinsurance** **0%**
- **Other Coinsurance** **0%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,060**

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$5,000**
- **Specialist Coinsurance** **0%**
- **Hospital (facility) Coinsurance** **0%**
- **Other Coinsurance** **0%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$5,060**

Mia's Simple Fracture (in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$5,000**
- **Specialist Coinsurance** **0%**
- **Hospital (facility) Coinsurance** **0%**
- **Other Coinsurance** **0%**

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,400
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,400**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.BlueChoiceSC.com or by calling 1-800-868-2528.

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The **plan** would be responsible for the other costs on these EXAMPLE coverage services.

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice.

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance online at contact@hrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697(TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 1-844-396-0188。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187 로 연락주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. PC 명조 (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839 . (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات
الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de ce plan médical, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-396-0190 . (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید.
(Persian-Farsi)

BlueChoice HealthPlan South Carolina

Global Pundits Technology

Coverage Period: 01/01/2020 - 12/31/2020

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage for: Individual/Family | **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-868-2528 or visit us at www.BlueChoiceSC.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-800-868-2528 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$1,000/Individual/$3,000/family for in-network; $2,000/Individual/$6,000/family for out-of-network	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out–of–pocket limit for this plan?	$4,000/Individual/$9,000/family for in-network providers. $8,000/Individual/$18,000/family for out-of-network.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.BlueChoiceSC.com or call 1-800-868-2528 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

⚠ All copayment and coinsurance costs shown in this chart are after your overall deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-Of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay/visit; deductible does not apply	50% coinsurance	None
	Specialist visit	$50 copay/visit; deductible does not apply	50% coinsurance	None
	Preventive care/screening/immunization	No charge for covered services	Not covered	None
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	Preauthorization is required.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	Preauthorization is required.
If you need drugs to treat your illness or condition	Tier 1 Tier 2	$8.00 copay/retail prescription; $16.00 copay/mail order prescription; $25.00 copay/retail prescription; $50.00 copay/mail order prescription	Not covered	You will have to pay more if you select a non-generic drug instead of its less expensive Covered generic drug (or Covered over-the-counter alternative). Deductible does not apply
	Tier 3	$45.00 copay/retail prescription; $90.00 copay/mail order prescription	Not covered	You will have to pay more if you select a non-generic drug instead of its less expensive Covered generic drug (or Covered over-the-counter alternative). Deductible does not apply
	Tier 4	$70.00 copay/retail prescription; $140.00 copay/mail order prescription	Not covered	You will have to pay more if you select a non-generic drug instead of its less expensive Covered generic drug (or Covered over-the-counter alternative). Deductible does not apply

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-Of-Network Provider (You will pay the most)	
More information about **prescription drug coverage** is available at **www.BlueChoiceSC.com/CDL**	Tier 5 Tier 6	$125.00 copay/retail prescription; $250.00 copay/mail order prescription; $175.00 copay/retail prescription; $350.00 copay/mail order prescription	Not covered	Specialty medications are not available through the mail order program for a 90-day supply. This only applies to generic or brand drugs in these tiers. Not Covered: Drugs designated as excluded on the Prescription Drug List. Deductible does not apply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	Preauthorization is required. Ambulatory Surgery Center covered at $50 copay/visit; deductible does not apply
	Physician/surgeon fees	30% coinsurance	50% coinsurance	Preauthorization is required. Ambulatory Surgery Center covered at $50 copay/visit; deductible does not apply
If you need immediate medical attention	Emergency room care	$200 copay/visit then 30% coinsurance; deductible does not apply	$200 copay/visit, 30% coinsurance; deductible does not apply	None
	Emergency medical transportation	30% coinsurance	50% coinsurance	None
	Urgent care	$35 copay/visit; deductible does not apply	50% coinsurance	Must be at a participating Urgent Care provider.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Preauthorization is required.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	$35 copay/office visit and 30% coinsurance for other outpatient services	50% coinsurance	Preauthorization is required for certain services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-Of-Network Provider (You will pay the most)	
	Inpatient services	30% coinsurance	50% coinsurance	Preauthorization is required for certain services.
If you are pregnant	Office visits	30% coinsurance	50% coinsurance	Prior authorization required No additional co-pay for ongoing routine care Home births are not covered
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	Prior authorization required No additional co-pay for ongoing routine care Home births are not covered
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	Prior authorization required No additional co-pay for ongoing routine care Home births are not covered
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	None
	Rehabilitation services	30% coinsurance	Not covered	Preauthorization is required; 20 visits each/year. Includes physical therapy, speech therapy and occupational therapy.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	30% coinsurance	50% coinsurance	Preauthorization is required; 120 days/year
	Durable medical equipment	30% coinsurance	Not covered	Preauthorization is required; initial device only
	Hospice service	30% coinsurance	50% coinsurance	Preauthorization is required

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-Of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	$0 / exam for eyeglasses every Benefit Period $45 / exam for contact lens fitting every Benefit Period	Not covered	For Members outside of the South Carolina service area, $71 will be allowed toward the routine eye exam and a $120 credit will apply to the purchase of eyewear. Claims must be filed by the Member.
	Children's glasses	No charge (every other benefit period)	Not covered	Coverage limited to one pair of glasses/year.
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Hearing aids
- Long-term care
- Routine foot care (Adult)
- Weight loss programs
- Dental Care (Adult)
- Infertility treatment

Other Covered Services. (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Chiropractic care
- Routine eye care (Adult)

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: BlueChoice HealthPlan at 1-800-868-2528 or visit www.BlueChoiceSC.com, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the South Carolina Department of Insurance, Consumer Services Division, Post Office Box 100105, Columbia, SC 29202-3105, telephone: 803-737-6180, Email: consumers@doi.sc.gov.

Does this Coverage Provide Minimum Essential Coverage? Yes.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this Coverage Meet the Minimum Value Standard? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-868-2528

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-868-2528

Chinese: (中文): 如果需要中文的帮助，请拨打这个号码 1-800-868-2528

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-868-2528

———————————*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*———————————

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$1,000**
- **Specialist Copayment** **$50**
- **Hospital (facility) Coinsurance** **30%**
- **Other Coinsurance** **30%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$700
Copayments	$700
Coinsurance	$2,600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,060**

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$1,000**
- **Specialist Copayment** **$50**
- **Hospital (facility) Coinsurance** **30%**
- **Other Coinsurance** **30%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$1,700
Coinsurance	$600
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$3,360**

Mia's Simple Fracture (in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$1,000**
- **Specialist Copayment** **$50**
- **Hospital (facility) Coinsurance** **30%**
- **Other Coinsurance** **30%**

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$800
Copayments	$200
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,500**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.BlueChoiceSC.com or by calling 1-800-868-2528.

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The **plan** would be responsible for the other costs on these EXAMPLE coverage services.

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice.

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance online at contact@hrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697(TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 1-844-396-0188。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187 로 연락주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. PC 명조 (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839 . (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات
الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de ce plan médical, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-396-0190 . (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید.
(Persian-Farsi)

Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan or health insurance policy. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Underlined text indicates a term defined in this Glossary.
- See page 6 for an example showing how deductibles, coinsurance and out-of-pocket limits work together in a real life situation.

- **Allowed Amount**

This is the maximum payment the plan will pay for a covered health care service. May also be called "eligible expense", "payment allowance", or "negotiated rate".

- **Appeal**

A request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).

- **Balance Billing**

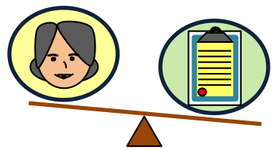
When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $90. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not bill you for covered services.

- **Claim**

A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.

- **Coinsurance**

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance plus any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is$100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)



Jane pays 20%

Her plan pays 80%

(See page 6 for a detailed example.)

- **Complications of Pregnancy**

Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non- emergency caesarean section generally aren't complications of pregnancy.

- **Copayment**

A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

- **Cost Sharing**

Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out- of-pocket costs you and your spouse and/or child(ren)must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay, or the cost of care a plan doesn't cover usually aren't considered cost sharing.

- **Cost-sharing Reductions**

Discounts that reduce the amount you pay for certain services covered by an individual plan you buy through the Marketplace. You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally- recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

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OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

- **Deductible**

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible.)

- **Diagnostic Test**

Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

- **Durable Medical Equipment (DME)**

Equipment and supplies ordered by a health care provider for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

- **Emergency Medical Condition**

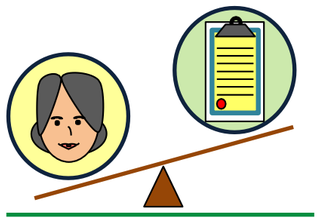
An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

- **Emergency Medical Transportation**

Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land, or sea. Your plan may not cover all types of emergency medical transportation, or may pay less for certain types.

- **Emergency Room Care / Emergency Services**

Services to check for an emergency medical condition and treat you to keep an emergency medical condition from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for emergency medical conditions.



Jane pays 100%

Her plan pays 0%

(See page 6 for a detailed example.)

- **Excluded Services**

Health care services that your plan doesn't pay for or cover.

- **Formulary**

A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost sharing amounts will apply to each tier.

- **Grievance**

A complaint that you communicate to your health insure or plan.

- **Habilitation Services**

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/ or outpatient settings.

- **Health Insurance**

A contract that requires a health insurer to pay some or all of your health care costs in exchange for a premium. A health insurance contract may also be called a "policy" or "plan".

- **Home Health Care**

Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care providers. Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

- **Hospice Services**

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

- **Hospitalization**

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.

- **Hospital Outpatient Care**

Care in a hospital that usually doesn't require an overnight stay.

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- **Individual Responsibility Requirement**

Sometimes called the "individual mandate", the duty you may have to be enrolled in health coverage that provides minimum essential coverage. If you don't have minimum essential coverage, you may have to pay a penalty when you file your federal income tax return unless you qualify for a health coverage exemption.

- **In-network Coinsurance**

Your share (for example, 20%) of the allowed amount for covered healthcare services. Your share is usually lower for in-network covered services.

- **In-network Copayment**

A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

- **Marketplace**

A marketplace for health insurance where individuals, families and small businesses can learn about their plan options; compare plans based on costs, benefits and other important features; apply for and receive financial help with premiums and cost sharing based on income; and choose a plan and enroll in coverage. Also known as an "Exchange". The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children's Health Insurance Program (CHIP). Available online, by phone, and in-person.

- **Maximum Out-of-pocket Limit**

Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of- pocket limits stated for your plan.

- **Medically Necessary**

Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

- **Minimum Essential Coverage**

Health coverage that will meet the individual responsibility requirement. Minimum essential coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage.

- **Minimum Value Standard**

A basic standard to measure the percent of permitted costs the plan covers. If you're offered an employer plan that pays for at least 60% of the total allowed costs of benefits, the plan offers minimum value and you may not qualify for premium tax credits and cost sharing reductions to buy a plan from the Marketplace.

- **Network**

The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

- **Network Provider (Preferred Provider)**

A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider network. Also called "preferred provider" or in the "participating provider."

- **Orthotics and Prosthetics**

Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.

- **Out-of-network Coinsurance**

Your share (for example, 40%) of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of- network coinsurance usually costs you more than in-network coinsurance.

- **Out-of-network Copayment**

A fixed amount (for example, $30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

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- **Out-of-network Provider (Non-Preferred Provider)**

A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-particiapting" instead of "out- of-network provider".

- **Out-of-pocket Limit**

The most you could pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

- **Physician Services**

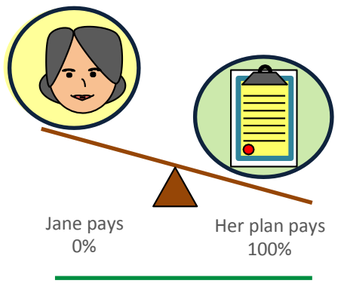
Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

- **Plan**

Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called "health insurance plan", "policy", "health insurance policy" or "health insurance".

- **Preauthorization**

A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.



(See page 6 for a detailed example.)

- **Premium**

The amount that must be paid for your health insurance or plan. You and/ or your employer usually pay it monthly, quarterly, or yearly.

- **Premium Tax Credits**

Financial help that lowers your taxes to help you and your family pay for private health insurance. You can get this help if you get health insurance through the Marketplace and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly premium costs.

- **Prescription Drug Coverage**

Coverage under a plan that helps pay for prescription drugs. If the plan's formulary uses "tiers" (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in cost sharing will be different for each "tier" of covered prescription drugs.

- **Prescription Drugs**

Drugs and medications that by law require a prescription.

- **Preventive Care (Preventive Service)**

Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

- **Primary Care Physician**

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

- **Primary Care Provider**

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the plan, who provides, coordinates, or helps you access a range of health care services.

- **Provider**

Some examples of a provider include a doctor, An individual or facility that provides health care services. chiropractor, physician assistant, hospital, surgical center, nurse, skilled nursing facility, and rehabilitation center. plan may require the provider to be licensed, certified, or the accredited as required by state law.

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- **Reconstructive Surgery**

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

- **Referral**

A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your primary care provider. If you don't get a referral first, the plan may not pay for the services.

- **Rehabilitation Services**

Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

- **Screening**

A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

- **Skilled Nursing Care**

Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is not the same as "skilled care services", which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

- **Specialist**

A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

- **Specialty Drug**

A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

- **UCR (Usual, Customary and Reasonable)**

The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

- **Urgent Care**

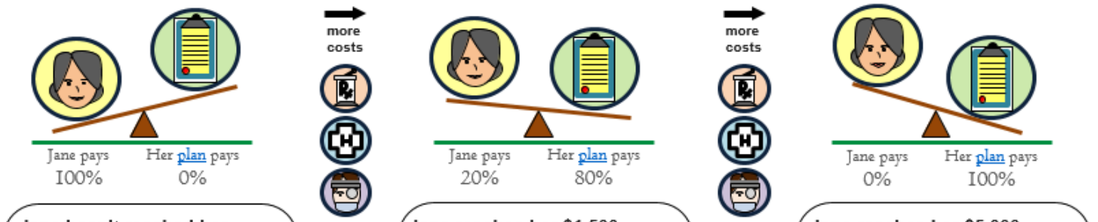
Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: $1,500 **Coinsurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st — *Beginning of Coverage Period*

December 31st — *End of Coverage Period*



Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.
Office visit costs: $125
Jane pays: $125
Her plan pays: $0

Jane reaches her $1,500 deductible, coinsurance begins

Jane has seen a doctor several times and paid $1,500 in total, reaching her deductible. So her plan pays some of the costs for her next visit.
Office visit costs: $125
Jane pays: 20% of $125 = $25
Her plan pays: 80% of $125 = $100

Jane reaches her $5,000 out-of-pocket limit

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.
Office visit costs: $125
Jane pays: $0
Her plan pays: $125

Back to Start

Enhanced Employee Assistance Program

Be at Your Best

Your employer wants to support you in being your best at work and in your personal life by providing the Enhanced Employee Assistance Program (EAP). This program is run by First Sun EAP. Because it is a separate company from BlueChoice HealthPlan, First Sun will be responsible for all services related to the employee assistance program. First Sun services are free to you and your household members. They include:

Enhanced Counseling Sessions

Six free face-to-face sessions for you and your family members per person per contract year for individual, couples and family counseling.

Counseling Services

- Personal Concerns
- Grief and Loss
- Trauma Issues
- Anger Management
- Marital/Relationship Issues
- Family Conflict
- Stress Management
- Spiritual Concerns
- Alcohol/Substance Abuse
- Workplace Concerns
- Depression
- Anxiety

Focus on life. Focus on health. ***Stay focused.***

BlueChoice® HealthPlan South Carolina

All counseling services are confidential in compliance with the law.

Enhanced Life Management Services

Six free life management services are available for you and your family members per person per contract year.

Financial Counseling

- Budgeting
- Debt Counseling
- Refinancing
- Purchasing a Home/Car
- College Funds
- Retirement Planning/401(k)

Legal Services

- Domestic/Family
- Civil/Consumer
- Criminal
- Estate Planning
- Real Estate
- Legal Documents

Adult Care Resources

- Caregiver Support
- Community Resources
- Financial/Legal Education

Child Care Resources

- Child Development
- Special Needs Concerns
- School Selection
- Tutoring Information
- Parent/Child Concerns
- Day Care Information
- Summer Camp Information

College Consultation Resources

"College Coaches" help with:

- Selecting the Appropriate School
- Understanding the Application and Admissions Process
- Admissions Testing Questions
- Financial Aid Websites

Parenting/Adoption Resources

- Parenting Skills/Support
- Adoption Information
- List of Fertility Resources

Dedicated professionals are available to serve you 24 hours a day, seven days a week. Call 800-968-8143.

BlueChoice® HealthPlan South Carolina

An independent licensee of the Blue Cross and Blue Shield Association

FIRST SUN EAP

161052-6-2018

› Dental Insurance

More Than a Pretty Smile

Taking good care of your teeth and mouth is an important part of a healthy lifestyle. Practicing proper dental hygiene, like brushing, flossing, and avoiding sugary foods and drinks, is only part of the oral health equation. Visiting a dentist on a regular basis is also very important.

As an active employee of Globalpundits Technology Consultancy, Inc., you have access to a dental insurance policy from United of Omaha Life Insurance Company.

You have so many reasons to keep your teeth and gums healthy. Ongoing dental care will help you maintain the best possible oral – and overall – health and well-being.

Coverage guidelines and benefits are outlined in the chart below.

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES DENTAL	
Eligibility Requirement	You must be actively working a minimum of 30 hours per week to be eligible for coverage.
Dependent Eligibility Requirement	A child must meet the eligibility requirements of the Policy and be under age 26 if eligible as defined by Policy. In order for your spouse and/or children to be eligible for coverage, you must elect coverage for yourself.
Premium Payment	The premiums for this insurance are shared by you and the policyholder. The premium amounts below reflect your contribution to the cost of this insurance.

LATE ENTRANT WAITING PERIODS	
Type A	None
Type B	12 Months
Type C	12 Months
Orthodontia	12 Months

PLAN YEAR DEDUCTIBLES AND MAXIMUMS	IN-NETWORK	OUT-NETWORK
Type A	Waived	Waived
Type B & C Deductible		
Individual	$50	$50
Family	3 times Individual	3 times Individual
Annual Maximum	$1,000	$1,000
Orthodontia Lifetime Maximum	$1,000	$1,000
The same expenses may be used to satisfy both the In-Network and Out-Network deductible.		

COVERED SERVICES	IN-NETWORK	OUT-NETWORK
Type A Services • Examinations/Evaluations • Bitewing X-rays • Fluoride Treatments • Cleaning/Prophylaxis • Sealants • Space Maintainers • Brush Biopsy/Cancer Screening	100%	100%
Type B Services • Full Mouth X-rays, Panoramic Film • Palliative Treatment • Periodontal Maintenance • Fillings • Stainless Steel Crowns • Simple Extractions • Oral Surgery • Surgical Extractions • General Anesthesia or I.V. Sedation	80%	80%
Type C Services • Endodontics • Periodontics • Full or Partial Removable Dentures • Repair of Full or Partial Removable Dentures • Adjustments, Tissue Conditioning, Rebasing or Relining of Full or Partial Removable Dentures • Bridges • Repair/Recementation of Bridges • Cast Crowns, Inlays, Onlays, Labial Veneers • Repair/Recementation of Cast Crowns/Inlays/Onlays/Labial Veneers • Implants • Surgical Periodontics • Non-Surgical Periodontics	50%	50%
Child Orthodontia • Harmful Habit Appliances	50%	50%

1) The plan pays the percentage shown after the deductible is satisfied up to the maximum. Additional information about the benefits and covered services of this plan will be included in the certificate booklet, which you will receive after enrolling for this coverage. Please contact your employer or benefits administrator if you have questions prior to enrolling.

2) The plan pays the same coverage levels for both In-Network and Out-Network services. However, because In-Network providers offer their services at predetermined fees, out-of-pocket expenses may be lower for plan members when receiving covered services from an In-Network provider.

3) The Maximum Allowance for Out-Network Services is based on the 90th Percentile as determined by Mutual of Omaha. Charges that exceed the Maximum Allowance (as defined in the certificate booklet) for any covered dental service are not considered.

LIMITATIONS

Information about the limitations and exclusions for this plan will be included in the certificate booklet, which you will receive after enrolling for this coverage. Please contact your employer or Benefits Administrator if you have any questions prior to enrolling.

- Exams – Two services in a 12-month period.
- Bitewing X-rays – Four films in a 12-month period.
- Full Mouth X-rays or Panoramic Film – 1 in any 36-month period.
- Fluoride – For dependent children up to age 14. Two services in a 12-month period.
- Harmful Habit Appliance – For dependent children up to age 14.
- Cleaning/Prophylaxis – Two services in a 12-month period.
- Sealants – For dependent children up to age 14; one per permanent bicuspid or molar tooth in any 36-month period.
- Brush Biopsy/Cancer Screen – Two services in a 12-month period.
- Space Maintainers – For dependent children up to age 14, includes recementations and removal.
- Fillings – Composite fillings on molars are limited to the amount otherwise payable for an amalgam filling. Replacement once in a 12 month period.
- Stainless Steel Crowns – For dependent children up to age 16; one per tooth per lifetime. Not for temporary restoration.
- Periodontal Maintenance – Two services in a 12-month period in addition to routine cleaning. Following active periodontal treatment only.
- Bridges – Replacement allowed once in 10 years.
- Dentures – Replacement allowed once in 10 years.
- Implants – One per tooth per lifetime.
- Orthodontia – Includes case workup, all appliances and one set of retainers. Braces/Appliances must be placed prior to the dependent child turning age 19 for orthodontic benefits to be payable.

SERVICES

Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.

Frequently Asked Questions

Who is eligible for this insurance?

You must be actively working (performing all normal duties of your job) at least 30 hours per week.

When does my coverage begin?

Complete enrollment information must be submitted to us through your Benefits Administrator *prior* to the requested effective date. Enrollment will be accepted within 31 days following the day you become eligible; however your effective date will then be the first of the following month.

When does my coverage begin for my dependents?

A Dependent child is considered eligible for insurance at birth and may be added to your policy at any time up to the child's third birthday. If we do not receive notification of the child's enrollment by age 3, you will be required to wait until the next Subsequent Enrollment Period to enroll the child.

Are there any waiting periods on this plan?

There is never a waiting period for Type A services. All insured persons will have these services available to them on the day they become effective.

Any employee who did not elect coverage when they were first eligible are considered 'late' to the plan at any other time they enroll. For these employees and family members, there is a 12 months waiting period for Type B, Type C and Orthodontic services.

If I enroll now, can I change or drop my coverage at any time?

Your enrollment in this coverage is for a 12 month Policy Year. During the Policy Year, you may drop coverage, or add or remove dependents, or terminate coverage within 31 days of a qualifying Life Change Event (as defined in the Certificate). These events include the birth of a child, pending adoption, marriage, divorce or loss of other coverage.

Globalpundits

Additional discounts

40% OFF
Complete pair of prescription eyeglasses

20% OFF
Non-prescription sunglasses

20% OFF
Remaining balance beyond plan coverage

These discounts are not insured benefits and are for in-network providers only.

Take a sneak peek before enrolling

- You're on the **Insight** Network
- For a complete list of in-network providers near you, use our Enhanced Provider Locator on eyemed.com or call 1-866-804-0982
- For LASIK providers, call 1-877-5LASER6

SUMMARY OF BENEFITS

Vision Care Services	In-Network Member Cost	Out of Network Reimbursement
Exam With Dilation as Necessary	$10 Copay	Up to $40
Retinal Imaging	Up to $39	N/A
Frames	$0 Copay; $130 allowance, 20% off balance over $130	Up to $91
Standard Plastic Lenses		
Single Vision	$25 Copay	Up to $30
Bifocal	$25 Copay	Up to $50
Trifocal	$25 Copay	Up to $70
Lenticular	$25 Copay	Up to $70
Standard Progressive Lens	$80 Copay	Up to $50
Premium Progressive Lens[Δ]	$110 Copay - $200 Copay	Up to $50
Tier 1	$110 Copay	Up to $50
Tier 2	$120 Copay	Up to $50
Tier 3	$135 Copay	Up to $50
Tier 4	$200 Copay	Up to $50
Lens Options *(paid by the member and added to the base price of the lens)*		
UV Treatment	$15	N/A
Tint (Solid and Gradiant)	$15	N/A
Standard Plastic Scratch Coating	$15	N/A
Standard Polycarbonate - age 19 and over	$40	N/A
Standard Polycarbonate - under age 19	$40	N/A
Standard Anti-Reflective Coating	$45	Up to $5
Premium Anti-Reflective Coating[Δ]	$57 - $85	Up to $5
Tier 1	$57	Up to $5
Tier 2	$68	Up to $5
Tier 3	$85	Up to $5
Photochromic/Transitions	$75	N/A
Polarized	20% off Retail Price	N/A
Other Add-Ons and Services	20% off Retail Price	N/A
Contact Lens Fit and Follow-up *(Contact lens fit and two follow-up visits are available once a comprehensive eye exam has been completed.)*		
Standard Contact Lens Fit & Follow-Up:	$40	N/A
Premium Contact Lens Fit & Follow-Up:	10% off Retail Price	N/A
Contact Lenses *(Contact Lens allowance includes materials only)*		
Conventional	$0 copay, $130 allowance, 15% off balance over $130	Up to $130
Disposable	$0 copay, $130 allowance, plus balance over $130	Up to $130
Medically Necessary	$0 copay, Paid-In-Full	Up to $210
Laser Vision Correction		
LASIK or PRK from U.S. Laser Network	15% off the retail price or 5% off the promotional price	N/A
Hearing Care		
Hearing Health Care from Amplifon Hearing Network	40% off hearing exams and low price guarantee on discounted hearing aids	
Frequency		
Examination	Once every 12 months	
Lenses (in lieu of contact lenses)	Once every 12 months	
Contacts (in lieu of lenses)	Once every 12 months	
Frame	Once every 24 months	

QL-0000067618

[Δ] Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level . All providers are not required to carry all brands at all levels. Benefits are not provided from services or materials arising from: 1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures; 3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear; 4) Services provided as a result of anyWorkers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; 5) Plano (non-prescription) lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals; 8) Services or materials provided by any other group benefit plan providing vision care 9) Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order. 10) Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/Premium Progressive lens not covered-fund as a Bifocal lens. Standard Progressive lens covered-fund Premium Progressive as a Standard. Benefit allowance provides no remaining balance for future use within the same benefit year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered.

Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York. Fidelity Security Life Policy number VC-19/VC-20, form number M-9083. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.

Get more and see more with EyeMed

72% AVERAGE SAVINGS

on eye exams and glasses for EyeMed members*

CHOOSE A DOC

EyeMed members choose from the right mix of thousands of providers—independent eye doctors, your favorite retail stores and everything in between. Find your ideal fit at eyemed.com or the EyeMed Members App.

CREATE AN ACCOUNT

Get special offers with an account on eyemed.com. Enter your email, choose a password and sign up for emailed savings. Log in 24/7 to view your benefit details or health and wellness information.

MOBILIZE YOUR BENEFITS

The EyeMed Members App makes your benefits easy to understand—and even easier to use. Find an eye doctor near you, schedule an appointment and manage your vision benefits.

Learn more about enrolling in EyeMed vision benefits at **enroll.eyemed.com** and see more of the good stuff

*Based on a sample transaction on the Insight network with a covered exam and eyewear benefits

EyeMed | INDEPENDENT PROVIDER NETWORK + LensCrafters | Pearle Vision | Target Optical | Sears Optical | JCPenney optical

PDF-1609-M-557

FREEDOM PASS

Supersize their savings

Any frame, any brand at any price point for no out-of-pocket expense – a special offer for your employees from Target® Optical and Sears® Optical.* Plus, members also get $20 off their contacts purchase (and free shipping) from ContactsDirect.com.

HOW IT WORKS – SAVINGS ON FRAMES

Your employees will simply go to their local Target Optical or Sears Optical store, find their frame (ANY available frame!) and they'll incur no cost.* And that means they have the freedom to find a great frame that matches their style and personality, while keeping money in their pocket.

HOW IT WORKS – SAVINGS ON CONTACT LENSES

When members visit ContactsDirect.com to purchase contact lenses, they simply create an account and register their vision benefits. The $20 savings will then automatically apply in their cart during checkout.

WHAT IT INCLUDES

With this special offer from Target Optical, Sears Optical and ContactsDirect, your employees can choose from a wide selection of frame and contact lens brands, including:

Ray-Ban · OAKLEY · COACH NEW YORK · ACUVUE OASYS · VOGUE eyewear · DKNY DONNA KARAN NEW YORK · A|X ARMANI EXCHANGE · AIR OPTIX

*A special offer from Target Optical and Sears Optical. Valid for each year of the initial contract term and in-store only at Target Optical and Sears Optical. Offer not valid at Sears Optical stores affiliated with US Vision. Member is still responsible for lenses, which are covered based on benefits outlined in the vision benefits and may include an additional copay. **EyeMed analysis of business results, before and after offering Freedom Pass from Target Optical and Sears Optical, 2017.

WITH THE FREEDOM PASS OFFER:**

Utilization goes up

Member out-of-pocket costs go down

SEE THE VALUE

COACH NEW YORK

Coach HC6091B

Retail cost of Coach frame	$230
Member frame cost without Freedom Pass *($130 frame allowance + 20% standard additional discount)*	$80
Member cost with Freedom Pass	**$0**

12 pack (6 month supply)

Retail cost of Acuvue Oasys	$144
Member contact lens cost without Freedom Pass *($130 contact lens allowance)*	$14
Member cost with Freedom Pass	**$0**

WHERE MEMBERS SAVE

Target Optical, Sears Optical and ContactDirect offer plenty of chances to use the Freedom Pass:

	Locations	Selection
Target Optical	More than 350 nationwide	About 700 frames, per location
Sears Optical	Nearly 600 nationwide	About 900 frames, per location
contactsdirect	Always available online	Many top-selling contact lens brands

HELPING MEMBERS FEEL FREE

Freedom Pass makes it even better. *The combination of great style, with a guarantee of no additional out-of-pocket cost on preferred, quality brands – it's a game changer.*

– Internet services company, Scottsdale AZ

** on average

Give your employees more freedom than ever –
Contact your EyeMed rep or visit **starthere.eyemed.com**

EyeMed

S-1801-CB-79

› Term Life Insurance

Help Protect What Matters – You, Your Family & Your Future

We understand you've worked hard to get where you are today. Ensuring your loved ones can maintain financial stability if an unexpected death should occur is something to consider when planning for the future.

We've Got You Covered

As an active employee of Globalpundits Technology Consultancy, Inc., you have access to a life insurance policy from United of Omaha Life Insurance Company.

It replaces the income you would have provided, and helps pay funeral costs, manage debt and cover ongoing expenses.

How much insurance is enough?

When determining how much life insurance you need, think about the expenses you may encounter now and through every stage of your life.

Coverage guidelines and benefits are outlined in the chart below.

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES LIFE	
Eligibility Requirement	You must be actively working a minimum of 30 hours per week to be eligible for coverage.
Premium Payment	The premiums for this insurance are paid in full by the policyholder. There is no cost to you for this insurance.
Life Insurance Benefit Amount	For You: $10,000 In the event of death, the benefit paid will be equal to the benefit amount after any age reductions less any living care/accelerated death benefits previously paid under this plan.
Accidental Death & Dismemberment (AD&D) Benefit Amount	For You: The Principal Sum amount is equal to the amount of your life insurance benefit.
FEATURES	
Living Care/ Accelerated Death Benefit	50% of the amount of the life insurance benefit is available to you if terminally ill, not to exceed $5,000.
Waiver of Premium	If it is determined that you are totally disabled, your life insurance benefit will continue without payment of premium, subject to certain conditions.

Conversion	If your employment ends, you may apply for an individual life insurance policy from Mutual of Omaha without having to provide evidence of insurability (information about your health). You will be responsible for the premium for the coverage.
SERVICES	
Travel Assistance	The Travel Assistance program is an added benefit that provides assistance for your travels over 100 miles away from home or outside the country.
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.
Will Prep	We work with Willing® to offer employees discounted online will preparation tools. In just a few clicks you can complete a customized plan to protect your family and property (valid in all 50 states). To get started visit www.willing.com/mutualofomaha
AGE REDUCTIONS AND EXCLUSIONS	

Insurance benefits and guarantee issue amounts are subject to age reductions:

- At age 65, amounts reduce to 65%
- At age 70, amounts reduce to 50%

Information about the AD&D exclusions for this plan will be included in the summary of coverage, which you will receive after enrolling.

Please contact your employer if you have questions prior to enrolling.

Frequently Asked Questions

Who is eligible for this insurance?

You must be actively working (performing all normal duties of your job) at least 30 hours per week.

What is Guarantee Issue?

The amount of insurance applied for without answering any health questions (or which does not require evidence of insurability). Coverage amounts over the Guarantee Issue Amount will require evidence of insurability.

What is Evidence of Insurability?

Evidence of Insurability or proof of good health – may be required if you are a late entrant and/or you request any additional coverage above your guarantee issue amount.

Can I take this insurance with me if I change jobs/am no longer a member of this group?

In the event this insurance ends due to a change in your employment/membership status with the group, or for certain other reasons, you may have the right to continue this insurance under the Conversion provision, subject to certain conditions.

Are there any limitations, reductions or exclusions?

The benefits payable are based on the following:

- Insurance benefits and guarantee issue amounts are subject to age reductions:
  - At age 65, amounts reduce to 65%
  - At age 70, amounts reduce to 50%
- Information about the AD&D exclusions for this plan will be included in the summary of coverage, which you will receive after enrolling.

All exclusions may not be applicable, or may be adjusted, as required by state regulations.

› Voluntary Term Life Insurance

Help Protect What Matters – You, Your Family & Your Future

We understand you've worked hard to get where you are today. Ensuring your loved ones can maintain financial stability if an unexpected death should occur is something to consider when planning for the future.

We've Got You Covered

As an active employee of Globalpundits Technology Consultancy, Inc., you have access to a life insurance policy from United of Omaha Life Insurance Company.

It replaces the income you would have provided, and helps pay funeral costs, manage debt and cover ongoing expenses.

How much insurance is enough?

When determining how much life insurance you need, think about the expenses you may encounter now and through every stage of your life.

Coverage guidelines and benefits are outlined in the chart below.

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES VTL	
Eligibility Requirement	You must be actively working a minimum of 30 hours per week to be eligible for coverage.
Dependent Eligibility Requirement	To be eligible for coverage, your dependents must be able to perform normal activities, and not be confined (at home, in a hospital, or in any other care facility), and any child(ren) must be under age 26. In order for your spouse and/or children to be eligible for coverage, you must elect coverage for yourself.
Premium Payment	The premiums for this insurance are paid in full by you.

COVERAGE GUIDELINES	Minimum	Guarantee Issue	Maximum
For You	$10,000	5 times annual salary, up to $100,000	$500,000, in increments of $10,000, but no more than 5 times annual salary
Spouse	$5,000	100% of employee's benefit, up to $25,000	100% of employee's benefit, up to $250,000
Children	$2,000	100% of employee's benefit	100% of employee's benefit, up to $10,000

Subject to any reductions shown below. Guarantee Issue is available to new hires. Amounts over the Guarantee Issue will require a health application/evidence of insurability. For late entrants, all amounts will require a health application/evidence of insurability.

BENEFITS	
Life Insurance Benefit Amount	Within the coverage guidelines defined above, you select the amount of life insurance coverage you want. This plan includes the option to select coverage for your spouse and dependent children. Children include those, up to age 26. In the event of death, the benefit paid will be equal to the benefit amount after any age reductions less any living care/accelerated death benefits previously paid under this plan.
Accidental Death & Dismemberment (AD&D) Benefit Amount	For you, your spouse and your dependent child(ren): The Principal Sum amount is equal to the amount of the life insurance benefit. AD&D coverage is available if you or your dependents are injured or die as a result of an accident, and the injury or death is independent of sickness and all other causes. The benefit amount depends on the type of loss incurred, and is either all or a portion of the Principal Sum.
FEATURES	
Living Care/ Accelerated Death Benefit	50% of the amount of the life insurance benefit is available to you if terminally ill, not to exceed $100,000.
Waiver of Premium	If it is determined that you are totally disabled, your life insurance benefit will continue without payment of premium, subject to certain conditions.
Annual Benefit Amount Increase	If you enroll for even the minimum amount of coverage during your initial enrollment, you have the ability to enroll for additional coverage at your next enrollment by up to $10,000, provided the total amount of insurance does not exceed your maximum benefit amount. This feature allows you to secure additional life insurance protection in the event your needs change (ex. you get married or have a child). Amounts over the Guarantee Issue will require evidence of insurability (proof of good health).
Portability	Allows you to continue this insurance program for yourself and your dependents should you leave your employer for any reason, without having to provide evidence of insurability (information about your health). You will be responsible for the premium for the coverage.
Conversion	If your employment ends, you may apply for an individual life insurance policy from Mutual of Omaha without having to provide evidence of insurability (information about your health). You will be responsible for the premium for the coverage.
SERVICES	
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.
Will Prep	We work with Willing® to offer employees discounted online will preparation tools. In just a few clicks you can complete a customized plan to protect your family and property (valid in all 50 states). To get started visit www.willing.com/mutualofomaha

AGE REDUCTIONS AND EXCLUSIONS

Insurance benefits and guarantee issue amounts are subject to age reductions:

- At age 70, amounts reduce to 65%
- At age 75, amounts reduce to 45%
- At age 80, amounts reduce to 30%
- At age 85, amounts reduce to 20%
- At age 90, amounts reduce to 15%

Spouse coverage terminates when you reach age 70.

Life insurance benefits will not be paid if the insured's death is the result of suicide within two years from the date coverage begins. If this occurs, the sum of the premiums paid will be returned to the beneficiary. The same applies for any future increases in coverage under this plan.

Information about the AD&D exclusions for this plan will be included in the summary of coverage, which you will receive after enrolling.

Please contact your employer if you have questions prior to enrolling.

Frequently Asked Questions

Who is eligible for this insurance?

- You must be actively working (performing all normal duties of your job) at least 30 hours per week.
- Your dependent(s) must be performing normal activities and not be confined (at home or in a hospital/care facility) and any child(ren) must be under age 26.

What is Guarantee Issue?

The amount of insurance applied for without answering any health questions (or which does not require evidence of insurability). Coverage amounts over the Guarantee Issue Amount will require evidence of insurability.

What is Evidence of Insurability?

Evidence of Insurability or proof of good health – may be required if you are a late entrant and/or you request any additional coverage above your guarantee issue amount.

Can I take this insurance with me if I change jobs/am no longer a member of this group?

In the event this insurance ends due to a change in your employment/membership status with the group, or for certain other reasons, you or your insured spouse may have the right to continue this insurance under the Portability or Conversion provision, subject to certain conditions.

Are there any limitations, reductions or exclusions?

The benefits payable are based on the following:

- Insurance benefits and guarantee issue amounts are subject to age reductions:
  - At age 70, amounts reduce to 65%
  - At age 75, amounts reduce to 45%
  - At age 80, amounts reduce to 30%
  - At age 85, amounts reduce to 20%
  - At age 90, amounts reduce to 15%
- Spouse coverage terminates when you reach age 70.
- Life insurance benefits will not be paid if the insured's death is the result of suicide within two years from the date coverage begins. If this occurs, the sum of the premiums paid will be returned to the beneficiary. The same applies for any future increases in coverage under this plan.
- Information about the AD&D exclusions for this plan will be included in the summary of coverage, which you will receive after enrolling.

All exclusions may not be applicable, or may be adjusted, as required by state regulations.

› Long-Term Disability Insurance

Your Ability to Earn an Income May Be Your Most Important Asset

Most people don't think twice about insuring their home, automobile or health. However, many people don't recognize just how important it is to insure their income.

We've Got You Covered

As an active employee of Globalpundits Technology Consultancy, Inc., you have access to a disability income insurance policy from United of Omaha Life Insurance Company.

A lengthy disability can be devastating, and is more common than you might think. It may lead to a loss of income, independence and financial security.

A disability income insurance policy can help provide security when you need it most. It pays you cash benefits when you're sick or hurt and can't work.

Coverage guidelines and benefits are outlined in the chart below.

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES LTD	
Eligibility Requirement	You must be actively working a minimum of 30 hours per week to be eligible for coverage.
Premium Payment	Your employer pays 100% of the premium for core coverage, and you pay 100% of the premium for buy-up coverage through easy payroll deduction. The premium amounts below reflect your contributions to the cost of the buy-up insurance.
BENEFITS	
Elimination Period	Your benefits begin on the later of 180 calendar days after the onset of your disabling injury or illness or the date your short term disability ends.
Monthly Benefit	This long-term disability plan is a "core/buy-up" plan. "Core" benefits offer a basic level of income protection, and are paid for by your employer. You also have the option to enroll for "buy-up" benefits, which allow you to increase your level of income protection, through the convenience of affordable group rates and payroll deduction of premium. Under the core plan, your benefit is equivalent to 40% of your before-tax monthly earnings, not to exceed the plan's maximum monthly benefit amount less other income sources. If you enroll for the buy-up plan, your total monthly benefit is equivalent to 60% of your before-tax monthly earnings, not to exceed the plan's maximum monthly benefit amount less other income sources. The premium for your long-term disability coverage is waived while you are receiving benefits.

Maximum Monthly Benefit	$10,000
Minimum Monthly Benefit	$100
Maximum Benefit Period	If you become disabled prior to age 62, benefits are payable to age 65, your Social Security Normal Retirement Age or 3.5 years, whichever is longest. At age 62 (and older), the benefit period will be based on a reduced duration schedule.
Partial Disability Benefits	If you become disabled and can work part-time (but not full-time), you may be eligible for partial disability benefits.
DEFINITIONS	
Own Occupation	2 Years
Own Occupation Earnings Test	99%
Definition of Monthly Earnings	Monthly earnings is the average gross monthly income received during the calendar year immediately prior to the year in which disability begins, as shown in the income box of the W-2 form. If employed for part of the previous calendar year monthly earnings is the average gross monthly income received for the months worked.
FEATURES	
Vocational Rehabilitation Benefit	If you become disabled and participate in the vocational rehabilitation program, you will be eligible for a monthly benefit increase of 5%.
Survivor Benefit	If you pass away while receiving disability benefits, a lump sum equal to 3 times your monthly benefit will be paid to your eligible survivor.
SERVICES	
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.

Frequently Asked Questions

Who is eligible for this insurance?

You must be actively working (performing all normal duties of your job) at least 30 hours per week.

How long will my benefits be paid?

Benefits begin after the end of the elimination period and can be payable up to the maximum benefit period as long as you remain disabled.

Will my benefits be reduced by other sources of income?

Yes, depending on the type of income you receive. Your benefit amount may be reduced by other sources of income such as retirement/government plans, other group disability plans, salary continuance/sick leave, settlements on payments received and no-fault benefits.

Does this plan cover me if I become disabled due to an injury at work?

Yes, your LTD insurance provides benefits for both on-the-job and off-the-job coverage for disabilities due to injury or sickness.

Are there any limitations or exclusions?

The benefits payable are subject to the following:

- Disabilities related to alcohol and drug abuse are only payable for up to 24 months while insured under the policy.
- Disabilities related to mental disorders are only payable for up to 24 months while insured under the policy.
- Your plan is subject to a pre-existing condition limitation. A pre-existing condition is one for which you have received medical treatment, consultation, care or services including diagnostic measures, or if you were prescribed or took prescription medications in the predetermined time frame prior to your effective date of coverage. The pre-existing condition under this plan is 3/12 which means any condition that you receive medical attention for in the 3 months prior to your effective date of coverage that results in a disability during the first 12 months of coverage, would not be covered.
- Benefits are not payable for any disability or loss that:
  - Results from an act of declared or undeclared war or armed aggression
  - Results from participation in a riot or commission of or attempt to commit a felony
  - Results, whether the insured person is sane or insane, from an intentionally self-inflicted injury or illness, suicide, or attempted suicide
  - Results from alcohol and drug abuse and/or substance abuse, except as noted above
  - Results from a mental disorder, except as noted above
  - Is caused by alcohol and drug abuse and/or substance abuse, while not being actively supervised by and receiving continuing treatment from a rehabilitation center or designated institution approved for such treatment by an appropriate body in the governing jurisdiction
  - Occurs while incarcerated or imprisoned for any period exceeding 31 days
  - Is solely a result of a loss of a professional license, occupation license or certification

All exclusions may not be applicable, or may be adjusted, as required by state regulations.

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