Technology Consulting Inc.
Benefits Package

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TECHNOLOGY CONSULTING INC

WELCOME TO T.C.I.

Since its inception in 1988, TCI has been the one constant in the IT industry. As the world expands and new opportunities become available, we will be at the forefront providing quality people to keep client information systems up to date and competitive.

In today's economy, we are always striving to provide more for our employees and their families. We, at TCI, employ independent firms, such as Reisert and Associates, Inc., and Pentegra Retirement Services to maintain the highest level of benefits available. To that end, we offer the enclosed benefit package to all TCI employees. Please take time to look over this booklet carefully. All of the plans have been carefully selected to provide the best value possible.

If you have any questions after looking over the benefits offered by TCI, Please call:

Diane Gibson
502-326-4719
dgibson@tcipro.com

or

Karen Walsh
502-326-4799
kwalsh@tcipro.com

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- United Healthcare Benefits Summary Option 1 - PPO
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- Long Term Disability Worksheet/Pricing
- Long Term Disability – Enrollment Form

- Transamerica Retirement Services (401k)

INSTRUCTIONS
BENEFITS ENROLLMENT/WAIVER FORMS

*****PLEASE MAKE SURE ALL FORMS ARE FILLED OUT COMPLETELY WHETHER ELECTION OF COVERAGE OR WAIVE OF COVERAGE*****

TCI – Employee Benefit Election Form – Please fill out each section out this form indicating whether you are enrolling or waiving benefits offered.

Medical - Choose which health plan and type of coverage you are interested in (Option 1 PPO or Option 2 HDHP) or Waive coverage. The policy will become effective the 1st of the month after completing a 30-day probationary period.

Dental – Elect type of coverage or waive

Vision – Elect type of coverage or waive

Life – TCI provides at no cost $20,000 life coverage to each employee. Please fill in beneficiary information

Additional Term Life & Dependent Life - With the Anthem Life policy, it is now possible to purchase additional term life insurance on yourself up to $100,000.00 without any questions and up to 3 times your annual salary with the completion of a Personal Health Statement ($150,000 max, call Administration for form if interested). If more insurance is purchased on employee, you will also have the ability to purchase insurance on a spouse ($25,000 max) and children ($10,000.00 per child). Please fill out the "Additional Term Life – Spousal/Dependent Application" for all covered dependents.

Unumprovident long term Disability – Mark "Request" if you choose to participate, sign form and return.

Transamerica 401k Plan – Follow instructions on page 6 of attachment to enroll online through Transamerica. Please send email to tciadmin@tcipro.com to let us know you have enrolled.

TCI Employee Benefit Election Form – United HealthCare

Payroll Deduction Authorization

If you do not wish to participate in a plan, fill out name and please check the box(es) marked "waive", and sign and return the form.

Employee First Name	
Employee Last Name	
Address	
Address 2	
City, State, Zip	
Date of Birth	
Gender	
Social Security Number	
Phone Number	
Date of Hire	
Occupation	
Annual Salary	

	Dependent 1	**Dependent 2**	**Dependent 3**	**Dependent 4**
First Name				
Last Name				
Gender				
Relationship				
Date of Birth				
Social Security Number				

*Use separate sheet if adding more than 4 dependents

Medical Insurance – United

I choose the following medical insurance coverage:

☐ **Option 1:** Plan 1 — $2,500 deductible PPO

☐ **Option 2:** Plan 2 — $3,000 HSA

☐ **Waive:** I choose not to participate in any of the medical plans.

(Please check the reason why you are waiving coverage below):

Spousal/Domestic Partner Coverage	Covered on Parents Plan	Medicaid/Medicare Coverage	Coverage does not meet my needs
State Exchange	VA/Tri-Care Coverage	Plan is too expensive	Don't want Medical Coverage

Please choose one of the following coverage categories:

	Semi-Monthly Deduction	
	PPO $2,500	**HSA $3,000**
☐ **Employee Only**	**$156.17**	**$148.18**
☐ **Employee + Spouse**	**$498.78**	**$473.28**
☐ **Employee + Child(ren)**	**$371.04**	**$352.07**
☐ **Family**	**$807.98**	**$766.67**

United Dental

☐ **Waive:** I choose not to participate in the dental plan.

Please choose one of the following coverage categories:

	Semi-Monthly Deduction
☐ **Employee Only**	**$11.65**
☐ **Employee + Spouse**	**$23.29**
☐ **Employee + Child(ren)**	**$28.00**
☐ **Family**	**$41.83**

United Vision Insurance

☐ **Waive:** I choose not to participate in the vision plan.

Please choose one of the following coverage categories:

	Semi-Monthly Deduction
☐ **Employee Only**	**$3.80**
☐ **Employee + Spouse**	**$7.21**
☐ **Employee + Child(ren)**	**$8.46**
☐ **Family**	**$11.90**

_____ _____

Signature **Date**

Life Insurance $20,000 Term Life

TCI provides to each employee $20,000 of group term life insurance. Please fill out the beneficiary information below.

ASSIGN BENEFICIARY

Name: _____
Relationship to you: _____
Age: _____

CONTINGENT BENEFICIARY

Name: _____
Relationship to you: _____
Age: _____

*Please fill out both beneficiaries

Additional Term Life Spousal/Dependent Life Enrollment Application

☐ Waive all additional coverage

Please fill out information below if you choose to buy-up extra life insurance, at your own cost. (See attached sheet for rates) *

☐ Up to $100,000.00 Increments of $10,000 _____
(No Personal Health Statement Needed.)

☐ 1x's salary
☐ 2x's salary
☐ 3x's salary

Personal Health Statement required if additional exceeds $100,001 up to a max of $150,000.

*** Anthem life insurance, you must choose optional life on yourself if you want to buy-up on spouse or child.**

3**. Please indicate if you would like to buy-up additional on your spouse.**
These can be purchased in $5000 increments up to ½ of employee. $25,000 maximum

A. _____
(name of spouse and amount)

4**. Please indicate if you would like to buy-up additional life on your child(ren),** The *rate is .21 per $1000 per unit (per unit is regardless of the number of children) the policyholder is the beneficiary*. (**AGES 15 days to 19 years old)**

_____
(name of dependent and amount)

_____
(name of dependent and amount)

_____
(name of dependent and amount)

_____
(name of dependent and amount)

These can be purchased in $5000 increments up to $10,000**.**

_____ _____
Signature **Date**

Here's a more in-depth look at how Choice Plus works.

Medical Benefits - OPTION 1 PPO Plan

	In Network	Out-of-Network
Annual Medical Deductible		
Individual	$2,500	$7,500
Family	$5,000	$15,000

All individual deductible amounts will count toward the family deductible, but an individual will not have to pay more than the individual deductible amount.

**After the Annual Medical Deductible has been met.*

You're responsible for paying 100% of your medical expenses until you reach your deductible. For certain covered services, you may be required to pay a fixed dollar amount - your copay.

Annual Out-of-Pocket Limit		
Individual	$7,350	$15,000
Family	$14,700	$30,000

All individual out-of-pocket maximum amounts will count toward the family out-of-pocket maximum, but an individual will not have to pay more than the individual out-of-pocket maximum amount.

Once you've met your deductible, you start sharing costs with your plan - coinsurance. You continue paying a portion of the expense until you reach your out-of-pocket limit. From there, your plan pays 100% of allowed amounts for the rest of the plan year.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network	Out-of-Network
Preventive Care Services		
Preventive Care Services *Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a copay, co-insurance or deductible.* *Includes services such as Routine Wellness Checkups, Immunizations, Breast Pumps, Mammography and Colorectal Cancer Screenings.*	No copay	Not covered
Office Services - Sickness & Injury		
Primary Care Physician *Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.* *Telehealth is covered at the same cost share as in the office.*	$30 copay	50%*
Specialist *Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.* *Telehealth is covered at the same cost share as in the office.*	$60 copay	50%*
Urgent Care Center Services	$100 copay	50%*

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network	Out-of-Network
Virtual Care Services *Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.*	No copay	Not covered
Emergency Care		
Ambulance Services - Emergency Ambulance		
Air Ambulance	30%*	30%*
Ground Ambulance	30%*	30%*
Ambulance Services - Non-Emergency Ambulance[1]		
Air Ambulance	30%*	30%*
Ground Ambulance	30%*	50%*
Dental Services - Accident Only	30%*	30%*
Emergency Medical Services - Outpatient[1]	$300 copay then 30%	$300 copay then 30%
Inpatient Care		
Congenital Heart Disease (CHD) Surgeries[1]	30%*	50%*
Habilitative Services - Inpatient[1] *Limit will be the same as, and combined with, those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services.*	The amount you pay is based on where the covered health care service is provided.	
Hospital - Inpatient Stay[1]	30%*	50%*
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services[1] *Limited to 60 days per year.*	30%*	50%*
Outpatient Care		
Habilitative Services - Outpatient *Limits will be the same as, and combined with those stated under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment.* *Visit limits for physical therapy, occupational therapy or speech therapy do not apply to Autism Spectrum Disorder.*	$30 copay	50%*
Home Health Care[1] *Limited to 60 visits per year.* *One visit equals at least four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.*	30%*	50%*

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network	Out-of-Network
Lab, X-Ray and Diagnostic - Outpatient - Lab Testing *Limited to 18 Definitive Drug Tests per year.* *Limited to 18 Presumptive Drug Tests per year.*	30%*	Not covered
Lab, X-Ray and Diagnostic - Outpatient - X-Ray and other Diagnostic Testing[1]	30%*	50%*
Major Diagnostic and Imaging - Outpatient[1] *You may have to pay an extra copay, deductible or coinsurance for physician fees or pharmaceutical products.*	30%*	50%*
Physician Fees for Surgical and Medical Services	30%*	50%*
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment *Limited to 20 visits of cognitive rehabilitation therapy per year.* *Limited to 20 visits of manipulative treatments per year.* *Limited to 25 visits of occupational therapy per year. Limited to 25 visits of physical therapy per year.* *Limited to 25 visits of pulmonary rehabilitation therapy per year.* *Limited to 25 visits of speech therapy per year.* *Limited to 30 visits of post-cochlear implant aural therapy per year.* *Limited to 36 visits of cardiac rehabilitation therapy per year.*	$30 copay	50%*
Scopic Procedures - Outpatient Diagnostic and Therapeutic *Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.*	30%*	50%*
Surgery - Outpatient[1]	30%*	50%*
Therapeutic Treatments - Outpatient[1] *Dialysis services not covered out-of-network.* *Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.*	30%*	50%*
Supplies and Services		
Diabetes Self-Management Items and Medications[1]	The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies or in the Prescription Drug Benefits Section.	
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care[1]	The amount you pay is based on where the covered health care service is provided.	

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network	Out-of-Network
Durable Medical Equipment (DME), Orthotics and Supplies *Limited to a single purchase of a type of DME or orthotic every 3 years.* *Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums.*	30%*	Not covered
Enteral Nutrition	30%*	50%*
Hearing Aids *Limited to a single purchase per hearing impaired ear every 3 years.*	30%*	50%*
Ostomy Supplies	30%*	Not covered
Pharmaceutical Products - Outpatient *This includes medications given at a doctor's office, or in a covered person's home.*	30%*	50%*
Prosthetic Devices[1] *Limited to a single purchase of each type of prosthetic device every three years.* *Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase.*	30%*	50%*
Urinary Catheters	30%*	Not covered
Pregnancy		
Pregnancy - Maternity Services[1] *The Annual Deductible will not apply for a newborn child within 31 days of the birth.*	The amount you pay is based on where the covered health care service is provided.	
Mental Health Care & Substance Related and Addictive Disorder Services		
Inpatient[1]	30%*	50%*
Outpatient	No copay	50%*
Partial Hospitalization[1]	30%*	50%*
Other Services		
Cellular or Gene Therapy *For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.*	The amount you pay is based on where the covered health care service is provided.	Not covered
Clinical Trials[1]	The amount you pay is based on where the covered health care service is provided.	
Dental Anesthesia[1]	The amount you pay is based on where the covered health care service is provided.	
Endometrioses and Endometritis[1]	The amount you pay is based on where the covered health care service is provided.	

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network	Out-of-Network
Fertility Preservation for Iatrogenic Infertility[1] *Limited to $20,000 per Covered Person per lifetime.* *Limited to $5,000 for Prescription Drug Products per Covered Person.* *This Benefit limit will be the same as, and combined with, those stated under Preimplantation Genetic Testing (PGT) and Related Services. Benefits are further limited to one cycle of fertility preservation for Iatrogenic Infertility per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy.*	30%*	50%*
Gender Dysphoria[1]	The amount you pay is based on where the covered health care service is provided or in the Prescription Drug Benefits Section.	
Hospice Care[1] *Benefits for hospice care will not be less than the hospice care benefits provided by Medicare.* *You pay nothing after $5 copayment per prescription or refill for prescription drugs or biologicals.*	No copay	No copay
Preimplantation Genetic Testing (PGT) and Related Services[1] *Benefit limits for related services will be the same as, and combined with, those stated under Fertility Preservation for Iatrogenic Infertility. This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder. This limit includes Benefits for ovarian stimulation medications provided under the Outpatient Prescription Drug Rider.*	30%*	50%*
Reconstructive Procedures[1]	The amount you pay is based on where the covered health care service is provided.	
Telehealth or Digital Health	The amount you pay is based on where the covered health care service is provided.	
Temporomandibular (TMJ) and Craniomandibular (CMJ) Joint Services[1]	The amount you pay is based on where the covered health care service is provided.	
Tobacco Cessation Services	No copay	50%*
Transplantation Services *Network Benefits must be received from a Designated Provider.*	The amount you pay is based on where the covered health care service is provided.	Not covered

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Pharmacy Benefits

Pharmacy Plan Details	
Pharmacy Network	National
Prescription Drug List	Advantage

Annual Pharmacy Deductible	In Network
Individual	You do not have to pay a pharmacy deductible
Family	You do not have to pay a pharmacy deductible

Prescription Drug Product Tier Level	Up to a 31-day supply		Up to a 90-day supply
	Retail and Specialty Pharmacy Network	Out-of-Network Pharmacy	Mail Order Network Pharmacy**
Tier 1 $	$15	$15	$37.50
Tier 2 $$	$40	$40	$100
Tier 3 $$$	$75	$75	$187.50

** Only certain Prescription Drug Products are available through mail order; please visit myuhc.com® or call Customer Care at the telephone number on the back of your ID card for more information. You will be charged a retail Copayment and/or Coinsurance for 31 days or 2 times for 60 days based on the number of days supply dispensed for any Prescription Order or Refills sent to the mail order pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate, rather than a 30-day supply with three refills.

Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3.

If you are a member, you can find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging into your account on myuhc.com® or calling the Customer Care number on your ID card. If you are not a member, you can view prescription information at welcometouhc.com > Benefits > Pharmacy Benefits.

Here's an example of how the plan's costs come into play.

1 At the start of your plan year...

You're responsible for paying 100% of your covered health services until you reach your **deductible**, which is the amount you pay before your health plan pays a portion.

YOU PAY 100%

2 Once you reach your deductible...

Your health plan starts to share a percentage of costs (the allowed amounts, excluding copays) for covered health care services with you—this is your **coinsurance**.*

YOU PAY 20%*

YOUR PLAN PAYS 80%

3 When you reach your out-of-pocket limit...

Your plan covers your costs (the allowed amount) at 100%. Your **out-of-pocket limit** is the most you'll pay for covered health services in a plan year—copays and coinsurance count toward this.

YOUR PLAN PAYS 100%

Along the way, you may also be required to pay a fixed amount (for example, $15)—or **copay**—for covered health care services, such as seeing a provider or purchasing a prescription. You pay 100% of the copay, usually when you receive the service.

* Your coinsurance may vary by service. This example is for illustrative purposes only.

More ways to help manage your health plan and stay in the loop.

Search the network to find doctors.

You can go to providers in and out of our network — but when you stay in network, you'll likely pay less for care. To get started:

- Go to **welcometouhc.com** > **Benefits** > **Find a Doctor or Facility.**
- Choose **Search for a health plan.**
- Choose **Choice Plus** to view providers in the health plan's network.

Manage your meds.

Look up your prescriptions using the Prescription Drug List (PDL). It places medications in tiers that represent what you'll pay, which may make it easier for you and your doctor to find options to help you save money.

- Go to **welcometouhc.com** > **Benefits** > **Pharmacy Benefits.**
- Select **Advantage** to view the medications that are covered under your plan.

Access your plan online.

With **myuhc.com®**, you've got a personalized health hub to help you find a doctor, manage your claims, estimate costs and more.

Get on-the-go access.

When you're out and about, the UnitedHealthcare® app puts your health plan at your fingertips. Download to find nearby care, video chat with a doctor 24/7, access your health plan ID card and more.

Other important information about your benefits.

Medical Exclusions

Services your plan generally does NOT cover. It is recommended that you review your COC, Amendments and Riders for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult/Child)
- Glasses
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Private-Duty Nursing
- Routine Eye Care (Adult/Child)
- Routine Foot Care
- Weight Loss Programs

Outpatient Prescription Drug Benefits

For Prescription Drug Products dispensed at a retail Network Pharmacy, you are responsible for paying the lowest of the following: 1) The applicable Copayment and/or Coinsurance; 2) The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product; and 3) The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: 1) The applicable Copayment and/or Coinsurance; and 2) The Prescription Drug Charge for that Prescription Drug Product. For an out-of-Network Pharmacy, your reimbursement is based on the Out-of-Network Reimbursement Rate, and you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

See the Copayment and/or Coinsurance stated in the Benefit Information table for amounts. We will not reimburse you for any non-covered drug product.

For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change.

Specialty Prescription Drug Products supply limits are as written by the provider, up to a consecutive 31-day supply of the Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits, or as allowed under the Smart Fill Program. Supply limits apply to Specialty Prescription Drug Products obtained at a Preferred Specialty Network Pharmacy, a Non-Preferred Specialty Network Pharmacy, an out-of-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.

Certain Prescription Drug Products for which Benefits are described under the Prescription Drug Rider are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first. You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at myuhc.com or the telephone number on your ID card.

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee to determine whether the Prescription Drug Product is in accordance with our approved guidelines and it meets the definition of a Covered Health Care Service and is not an Experimental or Investigational or Unproven Service. We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist.

If you require certain Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you will be subject to the Out-of-Network Benefit for that Prescription Drug Product.

Certain Preventative Care Medications may be covered at zero costshare. You can get more information by contacting us at myuhc.com or the telephone number on your ID card.

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy. The Outpatient Prescription Drug Schedule of Benefits will tell you how mail order Network Pharmacy and Preferred 90 Day Retail Network Pharmacy supply limits apply. Please contact us at myuhc.com or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

Other important information about your benefits.

Pharmacy Exclusions

The following exclusions apply. In addition see your Pharmacy Rider and SBN for additional exclusions and limitations that may apply.

- A Pharmaceutical Product for which Benefits are provided in your Certificate. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
- A Prescription Drug Product with either: an approved biosimilar, a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.
- Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare).
- Any product dispensed for the purpose of appetite suppression or weight loss.
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury, except as required by state mandate.
- Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by our PDL Management Committee.
- Certain Prescription Drug Products for tobacco cessation not approved by the FDA.
- Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available.
- Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors.
- Certain compounded drugs.
- Diagnostic kits and products, including associated services.
- Drugs available over-the-counter. This exclusion does not apply to over-the-counter drugs used for tobacco cessation.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- Durable Medical Equipment, including certain insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your Certificate. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
- Experimental or Investigational or Unproven Services and medications.
- General vitamins, except Prenatal vitamins, vitamins with fluoride, and single entity vitamins when accompanied by a Prescription Order or Refill.
- Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
- Medications used for cosmetic or convenience purposes.
- Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
- Prescription Drug Products when prescribed to treat infertility. This exclusion does not apply to Prescription Drug Products prescribed to treat Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) as described in the Certificate.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Care Service.
- Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

Here's a more in-depth look at how Choice Plus works.

Medical Benefits - OPTION 2 - HDHP

	In Network	Out-of-Network
Annual Medical Deductible		
Individual	$3,000	$7,500
Family	$6,000	$15,000

All individual deductible amounts will count toward the family deductible, but an individual will not have to pay more than the individual deductible amount.

**After the Annual Medical Deductible has been met.*

You're responsible for paying 100% of your medical expenses until you reach your deductible. For certain covered services, you may be required to pay a fixed dollar amount - your copay.

Annual Out-of-Pocket Limit		
Individual	$6,250	$12,500
Family	$12,500	$25,000

All individual out-of-pocket maximum amounts will count toward the family out-of-pocket maximum, but an individual will not have to pay more than the individual out-of-pocket maximum amount.

Once you've met your deductible, you start sharing costs with your plan - coinsurance. You continue paying a portion of the expense until you reach your out-of-pocket limit. From there, your plan pays 100% of allowed amounts for the rest of the plan year.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network	Out-of-Network
Preventive Care Services		
Preventive Care Services *Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a copay, co-insurance or deductible.* *Includes services such as Routine Wellness Checkups, Immunizations, Breast Pumps, Mammography and Colorectal Cancer Screenings.*	No copay	Not covered
Office Services - Sickness & Injury		
Primary Care Physician *Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.* *Telehealth is covered at the same cost share as in the office.*	20%*	50%*
Specialist *Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.* *Telehealth is covered at the same cost share as in the office.*	20%*	50%*
Urgent Care Center Services	20%*	50%*

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network	Out-of-Network
Virtual Care Services *Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.*	No copay	Not covered
Emergency Care		
Ambulance Services - Emergency Ambulance		
Air Ambulance	20%*	20%*
Ground Ambulance	20%*	20%*
Ambulance Services - Non-Emergency Ambulance[1]		
Air Ambulance	20%*	20%*
Ground Ambulance	20%*	50%*
Dental Services - Accident Only	20%*	20%*
Emergency Medical Services - Outpatient[1]	20%*	20%*
Inpatient Care		
Congenital Heart Disease (CHD) Surgeries[1]	20%*	50%*
Habilitative Services - Inpatient[1] *Limit will be the same as, and combined with, those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services.*	The amount you pay is based on where the covered health care service is provided.	
Hospital - Inpatient Stay[1]	20%*	50%*
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services[1] *Limited to 60 days per year.*	20%*	50%*
Outpatient Care		
Habilitative Services - Outpatient *Limits will be the same as, and combined with those stated under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment.* *Visit limits for physical therapy, occupational therapy or speech therapy do not apply to Autism Spectrum Disorder.*	20%*	50%*
Home Health Care[1] *Limited to 60 visits per year.* *One visit equals at least four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.*	20%*	50%*

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services	
	Network	Out-of-Network
Lab, X-Ray and Diagnostic - Outpatient - Lab Testing *Limited to 18 Definitive Drug Tests per year.* *Limited to 18 Presumptive Drug Tests per year.*	20%*	Not covered
Lab, X-Ray and Diagnostic - Outpatient - X-Ray and other Diagnostic Testing[1]	20%*	50%*
Major Diagnostic and Imaging - Outpatient[1] *You may have to pay an extra copay, deductible or coinsurance for physician fees or pharmaceutical products.*	20%*	50%*
Physician Fees for Surgical and Medical Services	20%*	50%*
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment *Limited to 20 visits of cognitive rehabilitation therapy per year.* *Limited to 20 visits of manipulative treatments per year.* *Limited to 25 visits of occupational therapy per year. Limited to 25 visits of physical therapy per year.* *Limited to 25 visits of pulmonary rehabilitation therapy per year.* *Limited to 25 visits of speech therapy per year.* *Limited to 30 visits of post-cochlear implant aural therapy per year.* *Limited to 36 visits of cardiac rehabilitation therapy per year.*	20%*	50%*
Scopic Procedures - Outpatient Diagnostic and Therapeutic *Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.*	20%*	50%*
Surgery - Outpatient[1]	20%*	50%*
Therapeutic Treatments - Outpatient[1] *Dialysis services not covered out-of-network.* *Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.*	20%*	50%*
Supplies and Services		
Diabetes Self-Management Items and Medications[1]	The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies or in the Prescription Drug Benefits Section.	
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care[1]	The amount you pay is based on where the covered health care service is provided.	

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network	Out-of-Network
Durable Medical Equipment (DME), Orthotics and Supplies *Limited to a single purchase of a type of DME or orthotic every 3 years.* *Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums.*	20%*	Not covered
Enteral Nutrition	20%*	50%*
Hearing Aids *Limited to a single purchase per hearing impaired ear every 3 years.*	20%*	50%*
Ostomy Supplies	20%*	Not covered
Pharmaceutical Products - Outpatient *This includes medications given at a doctor's office, or in a covered person's home.*	20%*	50%*
Prosthetic Devices[1] *Limited to a single purchase of each type of prosthetic device every three years.* *Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase.*	20%*	50%*
Urinary Catheters	20%*	Not covered
Pregnancy		
Pregnancy - Maternity Services[1] *The Annual Deductible will not apply for a newborn child within 31 days of the birth.*	The amount you pay is based on where the covered health care service is provided.	
Mental Health Care & Substance Related and Addictive Disorder Services		
Inpatient[1]	20%*	50%*
Outpatient	No copay*	50%*
Partial Hospitalization[1]	20%*	50%*
Other Services		
Cellular or Gene Therapy *For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.*	The amount you pay is based on where the covered health care service is provided.	Not covered
Clinical Trials[1]	The amount you pay is based on where the covered health care service is provided.	
Dental Anesthesia[1]	The amount you pay is based on where the covered health care service is provided.	
Endometrioses and Endometritis[1]	The amount you pay is based on where the covered health care service is provided.	

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network	Out-of-Network
Fertility Preservation for Iatrogenic Infertility[1] *Limited to $20,000 per Covered Person per lifetime.* *Limited to $5,000 for Prescription Drug Products per Covered Person.* *This Benefit limit will be the same as, and combined with, those stated under Preimplantation Genetic Testing (PGT) and Related Services. Benefits are further limited to one cycle of fertility preservation for Iatrogenic Infertility per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy.*	20%*	50%*
Gender Dysphoria[1]	The amount you pay is based on where the covered health care service is provided or in the Prescription Drug Benefits Section.	
Hospice Care[1] *Benefits for hospice care will not be less than the hospice care benefits provided by Medicare.* *You pay nothing after $5 copayment per prescription or refill for prescription drugs or biologicals.*	No copay	No copay
Preimplantation Genetic Testing (PGT) and Related Services[1] *Benefit limits for related services will be the same as, and combined with, those stated under Fertility Preservation for Iatrogenic Infertility. This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder. This limit includes Benefits for ovarian stimulation medications provided under the Outpatient Prescription Drug Rider.*	20%*	50%*
Reconstructive Procedures[1]	The amount you pay is based on where the covered health care service is provided.	
Telehealth or Digital Health	The amount you pay is based on where the covered health care service is provided.	
Temporomandibular (TMJ) and Craniomandibular (CMJ) Joint Services[1]	The amount you pay is based on where the covered health care service is provided.	
Tobacco Cessation Services	No copay	50%*
Transplantation Services *Network Benefits must be received from a Designated Provider.*	The amount you pay is based on where the covered health care service is provided.	Not covered

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Pharmacy Benefits

Pharmacy Plan Details	
Pharmacy Network	National
Prescription Drug List	Advantage

Annual Pharmacy Deductible	In Network
Individual	You do not have to pay a pharmacy deductible
Family	You do not have to pay a pharmacy deductible

Prescription Drug Product Tier Level	Up to a 31-day supply		Up to a 90-day supply
	Retail and Specialty Pharmacy Network	Out-of-Network Pharmacy	Mail Order Network Pharmacy**
Tier 1 $	$15	$15	$37.50
Tier 2 $$	$40	$40	$100
Tier 3 $$$	$75	$75	$187.50

** Only certain Prescription Drug Products are available through mail order; please visit myuhc.com® or call Customer Care at the telephone number on the back of your ID card for more information. You will be charged a retail Copayment and/or Coinsurance for 31 days or 2 times for 60 days based on the number of days supply dispensed for any Prescription Order or Refills sent to the mail order pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate, rather than a 30-day supply with three refills.

Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3.

If you are a member, you can find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging into your account on myuhc.com® or calling the Customer Care number on your ID card. If you are not a member, you can view prescription information at welcometouhc.com > Benefits > Pharmacy Benefits.

Here's an example of how the plan's costs come into play.

1 At the start of your plan year...

You're responsible for paying 100% of your covered health services until you reach your **deductible**, which is the amount you pay before your health plan pays a portion.

YOU PAY 100%

2 Once you reach your deductible...

Your health plan starts to share a percentage of costs (the allowed amounts, excluding copays) for covered health care services with you—this is your **coinsurance**.*

YOU PAY 20%*

YOUR PLAN PAYS 80%

3 When you reach your out-of-pocket limit...

Your plan covers your costs (the allowed amount) at 100%. Your **out-of-pocket limit** is the most you'll pay for covered health services in a plan year—copays and coinsurance count toward this.

YOUR PLAN PAYS 100%

Along the way, you may also be required to pay a fixed amount (for example, $15)—or **copay**—for covered health care services, such as seeing a provider or purchasing a prescription. You pay 100% of the copay, usually when you receive the service.

* Your coinsurance may vary by service. This example is for illustrative purposes only.

More ways to help manage your health plan and stay in the loop.

Search the network to find doctors.

You can go to providers in and out of our network — but when you stay in network, you'll likely pay less for care. To get started:

- Go to **welcometouhc.com** > **Benefits** > **Find a Doctor or Facility.**
- Choose **Search for a health plan.**
- Choose **Choice Plus** to view providers in the health plan's network.

Manage your meds.

Look up your prescriptions using the Prescription Drug List (PDL). It places medications in tiers that represent what you'll pay, which may make it easier for you and your doctor to find options to help you save money.

- Go to **welcometouhc.com** > **Benefits** > **Pharmacy Benefits.**
- Select **Advantage** to view the medications that are covered under your plan.

Access your plan online.

With **myuhc.com®**, you've got a personalized health hub to help you find a doctor, manage your claims, estimate costs and more.

Get on-the-go access.

When you're out and about, the UnitedHealthcare® app puts your health plan at your fingertips. Download to find nearby care, video chat with a doctor 24/7, access your health plan ID card and more.

Other important information about your benefits.

Medical Exclusions

Services your plan generally does NOT cover. It is recommended that you review your COC, Amendments and Riders for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult/Child)
- Glasses
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Private-Duty Nursing
- Routine Eye Care (Adult/Child)
- Routine Foot Care
- Weight Loss Programs

Outpatient Prescription Drug Benefits

For Prescription Drug Products dispensed at a retail Network Pharmacy, you are responsible for paying the lowest of the following: 1) The applicable Copayment and/or Coinsurance; 2) The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product; and 3) The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: 1) The applicable Copayment and/or Coinsurance; and 2) The Prescription Drug Charge for that Prescription Drug Product. For an out-of-Network Pharmacy, your reimbursement is based on the Out-of-Network Reimbursement Rate, and you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

See the Copayment and/or Coinsurance stated in the Benefit Information table for amounts. We will not reimburse you for any non-covered drug product.

For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change.

Specialty Prescription Drug Products supply limits are as written by the provider, up to a consecutive 31-day supply of the Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits, or as allowed under the Smart Fill Program. Supply limits apply to Specialty Prescription Drug Products obtained at a Preferred Specialty Network Pharmacy, a Non-Preferred Specialty Network Pharmacy, an out-of-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.

Certain Prescription Drug Products for which Benefits are described under the Prescription Drug Rider are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first. You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at myuhc.com or the telephone number on your ID card.

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee to determine whether the Prescription Drug Product is in accordance with our approved guidelines and it meets the definition of a Covered Health Care Service and is not an Experimental or Investigational or Unproven Service. We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist.

If you require certain Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you will be subject to the Out-of-Network Benefit for that Prescription Drug Product.

Certain Preventative Care Medications may be covered at zero costshare. You can get more information by contacting us at myuhc.com or the telephone number on your ID card.

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy. The Outpatient Prescription Drug Schedule of Benefits will tell you how mail order Network Pharmacy and Preferred 90 Day Retail Network Pharmacy supply limits apply. Please contact us at myuhc.com or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

Other important information about your benefits.

Pharmacy Exclusions

The following exclusions apply. In addition see your Pharmacy Rider and SBN for additional exclusions and limitations that may apply.

- A Pharmaceutical Product for which Benefits are provided in your Certificate. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
- A Prescription Drug Product with either: an approved biosimilar, a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.
- Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare).
- Any product dispensed for the purpose of appetite suppression or weight loss.
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury, except as required by state mandate.
- Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by our PDL Management Committee.
- Certain Prescription Drug Products for tobacco cessation not approved by the FDA.
- Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available.
- Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors.
- Certain compounded drugs.
- Diagnostic kits and products, including associated services.
- Drugs available over-the-counter. This exclusion does not apply to over-the-counter drugs used for tobacco cessation.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- Durable Medical Equipment, including certain insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your Certificate. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
- Experimental or Investigational or Unproven Services and medications.
- General vitamins, except Prenatal vitamins, vitamins with fluoride, and single entity vitamins when accompanied by a Prescription Order or Refill.
- Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
- Medications used for cosmetic or convenience purposes.
- Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
- Prescription Drug Products when prescribed to treat infertility. This exclusion does not apply to Prescription Drug Products prescribed to treat Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) as described in the Certificate.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Care Service.
- Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

UnitedHealthcare®

Kentucky FlexAppeal Enhanced dental plan

Consumer MaxMultiplier Voluntary National Options PPO 20 Network/covered dental services

7X077 /MAC

	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Individual Annual Deductible	$50	$50	$0	$0
Family Annual Deductible	$150	$150	$0	$0
Annual Maximum Benefit* *(The total benefit payable by the plan will not exceed the highest listed maximum amount for either Network or Non-Network services.)*	$1000 per person per Calendar Year	$1000 per person per Calendar Year	$1000 per person per Lifetime	$1000 per person per Lifetime
Annual Deductible Applies to Preventive and Diagnostic Services	No			
Annual Deductible Applies to Orthodontic Services	No			
Waiting Period	No waiting period			
Orthodontic Eligibility Requirement	Child Only Up to Age 19			

COVERED SERVICES**	NETWORK PLAN PAYS***	NON-NETWORK PLAN PAYS****	BENEFIT GUIDELINES
PREVENTIVE & DIAGNOSTIC SERVICES			
Periodic Oral Evaluation	100%	100%	Limited to 2 times per consecutive 12 months.
Radiographs - Bitewing	100%	100%	Bitewing: Limited to 1 series of films per calendar year. Complete/Panorex: Limited to 1 time per consecutive 36 months.
Radiographs - Intraoral/Extraoral	100%	100%	Limited to 2 films per calendar year.
Lab and Other Diagnostic Tests	100%	100%	
Dental Prophylaxis (Cleanings)	100%	100%	Benefit is not to exceed in combination with periodontal maintenance 4 per consecutive 12 months.
Fluoride Treatments	100%	100%	Limited to covered persons under the age of 16 years and limited to 2 times per consecutive 12 months.
Sealants	100%	100%	Limited to covered persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.
Space Maintainers	100%	100%	For covered persons under the age of 16 years, limit 1 per consecutive 60 months.
BASIC DENTAL SERVICES			
Restorations; Amalgam or Composite (Anterior & Posterior)	80%	80%	Multiple restorations on one surface will be treated as a single filling.
General Services - Emergency Treatment	80%	80%	Covered as a separate benefit only if no other service was done during the visit other than X-rays.
General Services - Occlusal Guards	80%	80%	Limited to 1 guard every consecutive 36 months.
General Services - Anesthesia	80%	80%	When clinically necessary.
Simple Extractions	80%	80%	Limited to 1 time per tooth per lifetime.
Oral Surgery - Brush Biopsy	80%	80%	
Oral Surgery - Surgical Extractions	80%	80%	
Oral Surgery - Partial/Bony	80%	80%	
Oral Surgery - Other	80%	80%	
Endodontics - Pulpotomy	80%	80%	
Endodontics - Other	80%	80%	Root Canal Therapy: Limited to 1 time per tooth per lifetime.
Periodontal Maintenance	80%	80%	Benefit is not to exceed in combination with dental prophylaxis 4 per consecutive 12 months.
Periodontics - Non Surgical	80%	80%	Scaling and Root Planing: Limited to 1 time per quadrant per consecutive 24 months.
Periodontics - Surgical	80%	80%	Limited to 1 quadrant or site per consecutive 36 months per surgical area.
Periodontics - Osseous Surgery	80%	80%	Limited to 1 quadrant or site per consecutive 36 months per surgical area.
MAJOR DENTAL SERVICES			
Inlays/Onlays/Crowns**	50%	50%	Limited to 1 time per tooth per consecutive 60 months.
Dentures and other Removable Prosthetics	50%	50%	Full Denture/Partial Denture: Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.
Fixed Partial Dentures (Bridges)**	50%	50%	Limited to 1 time per tooth per consecutive 60 months.
Implant Services	50%	50%	Limited to 1 time per tooth per consecutive 60 months.
ORTHODONTIC SERVICES			
Diagnose or correct misalignment of the teeth or bite	50%	50%	

* This plan includes a maximum benefit award program. Some of the unused portion of your annual maximum benefit may be available in future benefit periods.

** Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist have agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over $500; please consult your dentist.

*** The network percentage of benefits is based on the discounted fee negotiated with the provider.

**** The non-network percentage of benefits is based on the allowable amount applicable for the same service that would have been rendered by a network provider.

For additional coverage details and to locate a dentist please visit myuhc.com® or contact Customer Service.

In accordance with the Illinois state requirement, a partner in a Civil Union is included in the definition of Dependent. For a complete description of Dependent Coverage, please refer to your Certificate of Coverage.

The Prenatal Dental Care (not available in WA) and Oral Cancer Screening programs are covered under this plan. The material contained in the above table is for informational purposes only and is not an offer of coverage. Please note that the above provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary Benefits and your Certificate of Coverage/benefits administrator, the Certificate/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

UnitedHealthcare Dental® Voluntary Options PPO Plan is either underwritten or provided by: UnitedHealthcare Insurance Company, Hartford, Connecticut; UnitedHealthcare Insurance Company of New York, Hauppage, New York; Unimerica Insurance Company, Milwaukee, Wisconsin; Unimerica Life Insurance Company of New York, New York, New York; United Healthcare Services, Inc.; or UnitedHealthcare of Kentucky, LTD.

UnitedHealthcare/dental exclusions and limitations

Dental Services described in this section are covered when such services are:

A. Necessary;
B. Provided by or under the direction of a Dentist or other appropriate provider as specifically described;
C. The least costly, clinically accepted treatment; and
D. Not excluded as described in the Section entitled, General Exclusions.

GENERAL LIMITATIONS

1. **PERIODIC ORAL EVALUATION** Limited to 2 times per consecutive 12 months.
2. **COMPLETE SERIES OR PANOREX RADIOGRAPHS** Limited to 1 time per consecutive 36 months.
3. **BITEWING RADIOGRAPHS** Limited to 1 series of films per calendar year.
4. **EXTRAORAL RADIOGRAPHS** Limited to 2 films per calendar year.
5. **DENTAL PROPHYLAXIS** Is Covered in combination with periodontal maintenance but not on the same date of service, benefit is not to exceed in combination with periodontal maintenance 4 per consecutive 12 months.
6. **FLUORIDE TREATMENTS** Limited to covered persons under the age of 16 years, and limited to 2 times per consecutive 12 months.
7. **SPACE MAINTAINERS** Limited to covered persons under the age of 16 years, limited to 1 per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.
8. **SEALANTS** Limited to covered persons under the age of 16 years, and once per first or second permanent molar every consecutive 36 months.
9. **RESTORATIONS (Amalgam or Composite)** Multiple restorations on one surface will be treated as a single filling.
10. **PIN RETENTION** Limited to 2 pins per tooth; not covered in addition to cast restoration.
11. **INLAYS, ONLAYS, AND VENEERS** Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.
12. **CROWNS** Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.
13. **POST AND CORES** Covered only for teeth that have had root canal therapy.
14. **SEDATIVE FILLINGS** Covered as a separate benefit only if no other service, other than x-rays and exam, were performed on the same tooth during the visit.
15. **SCALING AND ROOT PLANING** Limited to 1 time per quadrant per consecutive 24 months.
16. **ROOT CANAL THERAPY** Limited to 1 time per tooth per lifetime.
17. **PERIODONTAL MAINTENANCE** Is covered in combination with dental prophylaxis but not on the same date of service, benefit is not to exceed in combination with dental prophylaxis 4 per consecutive 12 months.
18. **FULL DENTURES** Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.
19. **PARTIAL DENTURES** Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.
20. **RELINING AND REBASING DENTURES** Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.
21. **REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES** Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.
22. **PALLIATIVE TREATMENT** Covered as a separate benefit only if no other service, other than the exam and radiographs, were performed on the same tooth during the visit.
23. **OCCLUSAL GUARDS** Limited to 1 guard every consecutive 36 months and only covered if prescribed to control habitual grinding.
24. **FULL MOUTH DEBRIDEMENT** Limited to 1 time every consecutive 36 months.
25. **GENERAL ANESTHESIA** Covered only when clinically necessary.
26. **OSSEOUS GRAFTS** Limited to 1 per quadrant or site per consecutive 36 months.
27. **PERIODONTAL SURGERY** Hard tissue and soft tissue periodontal surgery are limited to 1 quadrant or site per consecutive 36 months per surgical area.
28. **REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS OR ONLAYS AND IMPLANTS, IMPLANT CROWNS, IMPLANT PROTHESIS** Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.
29. **CONE BEAM** Limited to 1 time per consecutive 60 months.

GENERAL EXCLUSIONS

1. Dental Services that are not Necessary.
2. Hospitalization or other facility charges.
3. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any Dental Procedure not directly associated with dental disease.
6. Any Dental Procedure not performed in a dental setting.
7. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
8. Any implant procedures performed which are not listed as Covered implant procedures in the Schedule of Covered Dental Services.
9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
11. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
12. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
13. Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
14. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
15. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
16. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled under the Policy.
17. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
18. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis o this nature.

GENERAL EXCLUSIONS

19. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
20. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
21. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
22. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child. This exclusion does not apply for groups situsedin the state of Arizona, in order to comply with state regulations.
23. Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to th date individual Coverage under the Policy terminates.
24. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
25. Orthodontic service Coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, or a surgical procedure to correct a malocclusion, replacement of retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.
26. Foreign Services are not Covered unless required as an Emergency.
27. Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
28. Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.

Vision Benefit Summary

Powered by UnitedHealthcare Vision Network

Customer Service and Provider Locator: (800) 638-3120

myuhcvision.com

Plan S108V

UnitedHealthcare vision has been trusted for more than 50 years to deliver affordable, innovative vision care solutions to the nation's leading employers through experienced, customer-focused people and the nation's most accessible, diversified vision care network.

	Exam with Materials
Benefit Frequency	
Comprehensive Exam(s)	Once every 12 months
Comprehensive Exam(s) for diabetics only	Twice every 12 months
Eyeglass Lenses	Once every 12 months
Frames	Once every 24 months
Contact Lenses instead of Eyeglasses	Once every 12 months
In-Network Services	
Copays	
Exam(s)	$ 10.00
Eyeglasses (lenses and frame)	$ 10.00
Contact lenses instead of Eyeglasses	$ 10.00
Retinal Screening for Diabetics	$ 0.00
Frame Benefit (for frames that exceed the allowance, an additional 30% discount may be applied to the overage)[1]	
Private Practice Provider	$130.00 retail frame allowance
Retail Chain Provider	$130.00 retail frame allowance
Lens Options	
Standard Scratch-resistant Coating, Polycarbonate Lenses for Dependent Children (up to age 19) - covered in full.	
Contact Lens Benefit[2]	
Elective contact lenses Allowance is applied toward the purchase of contact lenses. Contact lens copay is waived.	$125.00
Elective contact lens fitting and evaluation Allowance is applied toward the contact lens fitting/evaluation fees.	$30.00
Necessary contact lenses[3]	Covered in full after copay (if applicable).
Children's and Maternity Eye Care Benefit	
Members age 0-12 and members pregnant or breastfeeding are eligible for a 2nd exam. Members age 0-12 and members pregnant or breastfeeding are also eligible for a replacement frame and lenses if they have a prescription change of 0.5 diopter or more. The 2nd exam and replacement benefits are the same as the initial exam, frame and lens benefits.	
Out-of-Network Reimbursements (Copays do not apply)	
Exam(s)	Up to $40.00
Frames	Up to $45.00
Single Vision Lenses	Up to $40.00
Lined Bifocal and Progressive Lenses	Up to $60.00
Lined Trifocal Lenses	Up to $80.00
Lenticular Lenses	Up to $80.00
Elective Contacts instead of Eyeglasses[2]	Up to $100.00
Contact Lens Fitting and Evaluation	Up to $0.00
Necessary Contacts instead of Eyeglasses[3]	Up to $210.00

UnitedHealthcare®

Discounts	
	Laser vision UnitedHealthcare has partnered with QualSight LASIK, the largest LASIK manager in the United States, to provide our members with access to discounted laser vision correction providers. Member savings represent up to 35% off the national average price of Traditional LASIK. Contracted prices start at $945 per eye for Traditional LASIK and $1,395 per eye for Custom LASIK. Discounts are also provided on newer technologies such as Custom Bladeless (all laser) LASIK. For more information, visit myuhcvision.com.
	Additional Material At a participating in-network provider you will receive up to a 20% discount on an additional pair of eyeglasses or contact lenses. This program is available after your vision benefits have been exhausted. Please note that this discount shall not be considered insurance, and that UnitedHealthcare shall neither pay nor reimburse the provider or member for any funds owed or spent. Additional materials do not have to be purchased at the time of initial material purchase.
	Hearing Aids As a UnitedHealthcare vision plan member, you can save on custom-programmed hearing aids when you buy them from UnitedHealthcare Hearing. To find out more go to UHCHearing.com. When placing your order use promo code MYVISION to get the special price discount.

[1]30% discount available at most participating in-network provider locations. May exclude certain frame manufacturers. Please verify all discounts with your provider.
[2]Contact lenses are instead of eyeglass lenses and/or eyeglass frames.
[3]Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following cataract surgery without intraocular lens impla to correct extreme vision problems that cannot be corrected with eyeglass lenses and/or frames; with certain conditions such as anisometropia, keratoconus, irregular corneal/astigmatism, aphakia, pathological myopia, aniseikonia, aniridia, facial deformity, or corneal deformity. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare vision confirming the reimbursement that UnitedHealthcare will make before you purchase such contacts.

Important to Remember:

In-Network

- Always identify yourself as a UnitedHealthcare vision member when making your appointment. This will assist the provider in obtaining your benefit information.
- Patient lens options which are not covered-in-full may be available at a discount at participating providers. Based on state guidelines, lens materials and options may not be available at these discounted prices at all provider locations. Please ask your provider for details. The Lens Options list can be found at myuhcvision.com.

Choice and Access of Vision Care Providers

UnitedHealthcare offers its vision program through a national network including both private practice and retail chain providers. To access the Provider Locator service or for a printed directory, visit our website myuhcvision.com or call (800) 638-3120, 24 hours a day, seven days a week. You may also view your benefits, search for a provider or print an ID card online at myuhcvision.com.
Retain this UnitedHealthcare vision benefit summary which includes detailed benefit information and instructions on how to use the program. Please refer to your Certificate of Coverage for a full explanation of benefits.
In-Network Provider - Copays and non-covered patient options are paid to provider by program participant at the time of service.
Out-of-Network Provider - Participant pays all billed charges to the provider, and UnitedHealthcare reimburses the participant for services rendered up to the maximum allowance. Copays do not apply to out-of-network benefits. Receipts for payments should be submitted within 90 days after the date of service to the following address: UnitedHealthcare Vision, Attn. Claims Department, P.O. Box 30978, Salt Lake City, UT 84130. If it was not reasonably possible to give written proof in the time required, the Company will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, but no later than 1 year after the date of service unless the Covered Person was legally incapacitated.

Customer Service is available toll-free at (800) 638-3120 from 8:00 a.m. to 11:00 p.m. Eastern Time Monday through Friday, and 9:00 a.m. to 6:30 p.m. Eastern Time on Saturday.

This Benefit Summary is intended only to highlight your benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your healthcare expenses. More complete descriptions of benefits and the terms under which they are provided are contained in the certificate of coverage that you will receive upon enrolling in the plan. If this Benefit Summary conflicts in any way with the Policy issued to your employer, the Policy shall prevail.

UnitedHealthcare vision coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, UnitedHealthcare Insurance Company of New York, located in Islandia, New York, or its affiliates. Administrative services provided by Spectera, Inc., United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number VPOL.06.TX, VPOL.13.TX or VPOL.18.TX and associated COC form number VCOC.INT.06.TX, VCOC.CER.13.TX or VCOC.18.TX. Plans sold in Virginia use policy form number VPOL.06.VA, VPOL.13.VA or VPOL.18.VA and associated COC form number VCOC.INT.06.VA, VCOC.CER.13.VA or VCOC.18.VA. If you opt to receive vision care services or vision care materials that are not covered benefits under this plan, a participating vision care provider may charge you their normal fee for such services or materials. Prior to providing you with vision care services or vision care materials that are not covered benefits, the vision care provider will provide you with an estimated cost for each service or material upon your request. This cost may be higher than if you had received only covered vision services and you may incur additional out-of-pocket expenses. Eyewear materials may be ordered through our national lab network.

UnitedHealthcare®

Technology Consulting Inc.

Term Life Rate Sheet

- Employees must elect Optional Life to be eligible for Optional Dependent Life coverage.

- Optional Dependent Life benefit amount cannot exceed 50% of the employee combined Term Life and Optional Life benefit.
- Spouse benefits will reduce based on the Optional Life reduction schedule and the age of the Employee.
- Optional Dependent Life spouse rates are dependent upon the employee age.
- Optional Dependent Life insurance for a spouse will end at the employee's retirement.
- Optional Dependent Life Guarantee Issue Limit is $25,000.
- If this Optional Life program is replacing an existing plan, the Optional Life guarantee issue will only apply to new hires who were not eligible for Optional Life benefits prior to our effective date. Anyone who was eligible prior to our Effective date will be subject to evidence of insurability on their full Optional benefit amount.
- Travel Assistance is included in this proposal.

Proposed Optional Life Rates

Employee and Spouse Monthly rate per $1,000

Age	*Monthly rate per $1,000*
under 25	$ 0.07
25-29	$ 0.06
30-34	$ 0.07
35-39	$ 0.08
40-44	$ 0.14
45-49	$ 0.21
50-54	$ 0.33
55-59	$ 0.54
60-64	$ 0.78
65-69	$ 1.37
70-74	$ 3.03
over 74	$ 4.91

Dep Life Child Monthly Rate $.21 per $1,000 per unit***

*** Per unit is regardless of the number of children

Coverage Monthly Rate

Optional AD&D 0.020 (Per $1,000) **Dependent eligibility: children are eligible if they are age 15 days to 19 years (24 years if they qualify as a tax exemption). Eligibility is extended beyond the maximum age limit if the child is not capable of self-support.**

TECHNOLOGY CONSULTING INC.

DISABILITY INSURANCE
GROUP LONG TERM DISABILITY
Provident Life & Accident

Provident Life & Accident Company, a 130 yr. old stock insurance company specializing in disability insurance. As an innovator in group long term disability, (LTD), Paul Revere has incorporated many of the features of its individual products into its group plan.

Our plan pays for Total and Residual Disability. Here are some of the features of our plan:

- Total Disability means you are sick or injured, under a doctor's care and unable to perform the material or substantial duties of your regular occupation.
- Residual Disability means you are sick or injured, under a doctor's care and unable to perform one or more of the material and substantial duties of your regular occupation, but while working you sustain a loss of at least 2% of your pre-loss income.
- Our plan has a 90-day elimination period.
- Our plan will pay up to 60% of your pre-loss current income, a maximum of $5,000 per month in benefits.
- Under our current plan, premiums are paid with "after tax dollars", BENEFITS ARE PAID TO YOU TAX FREE!!!
- Our plan will pay benefits to age 65.
- ZERO DAY RESIDUAL BENEFIT means that our plan requires 0 days of TOTAL DISABILITY to pay residual benefits.
- Upon termination, you have the ability to continue the current policy, IF you have been covered for 12 months or more.

Rate Calculation: Class 1 All Employees
Monthly Premium per $100.00 of Covered Monthly Earnings
Monthly Rates Based On Age

Under 30	0.25
30------39	0.42
40------44	0.67
45------49	1.00
50------54	1.40
55------59	1.68
Over 60	1.68

TECHNOLOGY CONSULTING INC.

DISABILITY INSURANCE
GROUP LONG TERM DISABILITY
UNUM PROVIDENT WORKSHEET

How to calculate an employee's Voluntary LTD monthly premium

A. Enter employees monthly earnings amount, rounding up to the nearest dollar (i.e. $2500.33 - $2501). If the monthly earnings are greater than $10,000 enter $10,000. $_____(A)

B. Divide employee's monthly earnings by 100 (i.e.) 2501/100 = 25.01) _____(B)

C. Enter the rate for employee's age from table above. _____(C)

D. Multiply (B) X (C) to get employee's monthly premium, Rounding up to (2) places after decimal point. $_____(D)

Final premium may vary based on the actual age and earnings of the employee insured on the approved effective date.

ENROLLMENT/REFUSAL REQUEST FORM

THE PAUL REVERE LIFE INSURANCE COMPANY
2211 Congress Street, Portland, ME 04122

FOR PAUL REVERE USE ONLY DATE RECEIVED:	
MEMBER NUMBER	OCC CODE:
EFFECTIVE/RECORDED DATE:	

☑ NEW EMPLOYEE	☐ PREVIOUSLY INELIGIBLE EFF DATE _____ REASON:	☐ REINSTATED EMPLOYEE DATE REHIRED _____	☐ PART-TIME TO FULL TIME DATE REHIRED _____	☐ CHANGE OF STATUS

GROUP NO.	ACCT.	CLASS	EMPLOYER NAME AND ADDRESS
97985	00	01	Technology Consulting, Inc.

EMPLOYEE NAME: (LEAVE SPACE BETWEEN LAST MI FIRST)

NO. OF HOURS WORKED PER WEEK	☐ MALE ☐ FEMALE	☐ MARRIED ☐ SINGLE # CHILDREN ____	SOCIAL SECURITY NO.	DATE HIRED FULL TIME	DATE OF BIRTH	☐ UNION ☑ NON-UNION

BASIC EARNINGS (Refer to your Plan Administrator for proper Earnings definition.)
$_____ + $_____ = $_____ = $_____
BASE EARNINGS | COMMISSIONS (if applicable) | BONUS (if applicable) | TOTAL EARNINGS

☐ HOURLY ☐ MONTHLY
☐ WEEKLY ☐ SEMI-MONTHLY
☐ BI-WEEKLY ☐ ANNUALLY

☐ SALARIED ☐ EXEMPT
☐ HOURLY ☐ NON-EXEMPT
☐ COMMISSIONED

OCCUPATION: (List Job Title & Major Responsibilities)	STATE YOU LIVE IN	ZIP CODE

EMPLOYEE COVERAGE REQUESTED Select or refuse only the coverage(s) included in your Employer's policy or certificate

	Request	Refuse
Long Term Disability (LTD)	☐	☑
Core LTD + Buy-Up LTD	☐	☑
Voluntary LTD	☐	☐
Short Term Disability (STD)	☐	☑
Core STD + Buy-Up STD	☐	☑
Employee Basic Life and Accidental Death & Dismemberment (AD&D)	☐	☑
Employee Basic Life	☐	☑
Basic Dependent Life	☐	☑
Employee Supplemental Life	☐ $_____	☑

	Request	Refuse
Employee Supplemental AD&D	☐ $_____	☑
Supplemental Dependent Life or Life/AD&D Spouse	☐ $_____	☑
Spouse Date of Birth: _____ (No AD&D) Child	☐ $_____	☑
Voluntary Life	☐ $_____	☑
Voluntary Dependent Life	☐	☑
Voluntary AD&D	☐ $_____	☑
Voluntary AD&D Family Plan	☐	☑

BENEFICIARY DESIGNATIONS

PRIMARY – FIRST MI LAST (Equally or survivor(s), if any) | RELATIONSHIP | DATE OF BIRTH
BENEFICIARY ADDRESS (NO., STREET, CITY, STATE, ZIP CODE) REQUIRED FOR FLORIDA AND VIRGINIA RESIDENTS | SOC. SEC. NO.

SECONDARY – FIRST MI LAST (Equally or survivor(s), if any) | RELATIONSHIP | DATE OF BIRTH
BENEFICIARY ADDRESS (NO., STREET, CITY, STATE, ZIP CODE) REQUIRED FOR FLORIDA AND VIRGINIA RESIDENTS | SOC. SEC. NO.

REQUEST FOR CHANGE

☐ 1. PLEASE ADD DEPENDENT BENEFITS TO MY GROUP INSURANCE COVERAGE DATE I ACQUIRED ELIGIBLE DEPENDENTS _____
REASON: ☐ MARRIAGE ☐ BIRTH OF SON/DAUGHTER ☐ OTHER (EXPLAIN):

☐ 2. PLEASE CHANGE MY BENEFICIARY TO: FIRST MI LAST (Equally or survivor(s), if any) | RELATIONSHIP | DATE OF BIRTH
BENEFICIARY ADDRESS (NO., STREET, CITY, STATE, ZIP CODE) REQUIRED FOR FLORIDA AND VIRGINIA RESIDENTS | SOC. SEC. NO. | WITNESSED:

☐ 3. PLEASE CHANGE MY NAME
FROM: TO:

Do Not Use This Section

TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL INFORMATION SHOWN ABOVE, INCLUDING THE REFUSAL SECTION, IS CORRECT AND MY SIGNING BELOW INDICATES THAT I UNDERSTAND ALL INFORMATION GIVEN IS SUBJECT TO VERIFICATION. **I UNDERSTAND THAT COVERAGE UNDER THE GROUP POLICY WILL NOT GO INTO EFFECT UNLESS I AM ACTIVELY AT WORK ON OR AFTER THE PROPOSED EFFECTIVE DATE OF COVERAGE.**
ANY PERSON WHO, WITH THE INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

SIGNATURE OF EMPLOYEE	DATE

TECHNOLOGY CONSULTING INC.
140 Whittington Parkway
P.O. Box 22529
Louisville, KY 40252-0529
502-326-4719
dgibson@tcipro.com

TRANSAMERICA RETIREMENT SERVICES

TCI – 401k plan

TECHNOLOGY CONSULTING INC. administers an employee 401K plan. If you have any interest in contributing to our group plan, please call or email me for a booklet and instructions on how to set up through www.ta-retirement.com

Payroll Manager

Diane Gibson