Technology Consulting Inc.
Benefits Package

9300 Shelbyville Road, #300
P.O. Box 22529
Louisville, KY 40252-0529
502-394-9353
502-426-6233 fax
www.tcipro.com

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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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 – Anthem

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	
Email Address	
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 – Anthem

I choose the following medical insurance coverage:

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

☐ **Option 2:** Plan 2 — $3,500 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 $3,500
☐ **Employee Only**	**$186.95**	**$151.80**
☐ **Employee + Spouse**	**$597.11**	**$484.85**
☐ **Employee + Child(ren)**	**$444.19**	**$360.68**
☐ **Family**	**$967.26**	**$785.42**

Anthem Dental

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

Please choose one of the following coverage categories:

	Semi-Monthly Deduction
☐ **Employee Only**	**$14.30**
☐ **Employee + Spouse**	**$28.60**
☐ **Employee + Child(ren)**	**$34.38**
☐ **Family**	**$51.35**

Anthem 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**	**$3.90**
☐ **Employee + Spouse**	**$7.40**
☐ **Employee + Child(ren)**	**$8.68**
☐ **Family**	**$12.23**

_____ _____

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**

Your summary of benefits

Anthem

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Access PPO Option 21 with Rx Option E2

Your Network: Blue Access

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge medical deductible does not apply
Mental Health & Substance Use Disorder Services	No charge medical deductible does not apply
Specialist care	$50 copay per visit medical deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	$2,500 person / $5,000 family	$7,500 person / $15,000 family
Overall Out-of-Pocket Limit	$7,000 person / $14,000 family	$21,000 person / $42,000 family
The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit. All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit (excluding Out-of-Network Human Organ and Tissue Transplant (HOTT), Cellular and Gene Therapy services). In-Network and Out-of-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
Preferred PCP *virtual and office* *(Providers reflected in our FindCare tool as: EPHC.)*	$5 copay per visit medical deductible does not apply	Not covered
Primary Care (PCP) *virtual and office*	$20 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Mental Health and Substance Use Disorder Services *virtual and office*	$20 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Specialist Provider *virtual and office*	$50 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Other Practitioner Visits		
Maternity Doctor services (prenatal/postpartum care and delivery)	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$20 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Manipulation Therapy *Coverage is limited to 12 visits per benefit period.*	$20 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Other Services in an Office		
Allergy Testing *When Allergy injections are billed separately by network providers, the member is responsible for a $10 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.*	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Prescription Drugs *Dispensed in the office*	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Surgery	$50 copay per visit medical deductible does not apply‡	50% coinsurance after medical deductible is met
Preventive care / screenings / immunizations	No charge	50% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	Cost share is based on the setting services are received.
Diagnostic Services Lab		
Office	No charge	50% coinsurance after medical deductible is met
Freestanding Lab/Reference Lab	No charge	50% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Diagnostic Services X-Ray		
Office	No charge	50% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Diagnostic Services Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Freestanding Radiology Center	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Emergency and Urgent Care		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	$20 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Emergency Room Facility Services *Your copay will be waived if admitted.*	$300 copay per visit and 20% coinsurance medical deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance medical deductible does not apply	Covered as In-Network
Ambulance *Authorized Out-of-Network non-emergency ambulance services are limited to an Anthem maximum payment of $50,000 per trip. The $50,000 limit does not apply to air ambulance services.*	20% coinsurance after medical deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Doctor Services	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Ambulatory Surgical Center	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Physician and other services *including surgeon fees*		
Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Ambulatory Surgical Center	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)		
Facility Fees	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Human Organ and Tissue Transplants *Cornea transplants are treated as medical procedures, with benefits and cost sharing determined by the setting in which the services are received. You must get certain covered transplant procedures from an Approved In-Network Provider to receive the In-Network level of benefits.*	No charge	50% coinsurance after medical deductible is met
Physician and other services *including surgeon fees*	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Home Health Care *Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.*	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Therapy Services		
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *You are responsible for cost shares no greater than the PCP office visit when Covered Services are performed by a Physical Therapist or Occupational Therapist. Coverage for physical and occupational therapies is limited to 20 visits combined per benefit period. Coverage for speech therapy is limited to 20 visits per benefit period.*		
Office	$20 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Outpatient Hospital *Speech therapy by an In-Network Provider is subject to the following cost share instead of the one noted: 20% coinsurance after medical deductible is met*	$20 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Pulmonary rehabilitation		
Office	$50 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Cardiac rehabilitation *Coverage is limited to 36 visits per benefit period.*		
Office	$50 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Dialysis/Hemodialysis		
Office	$50 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Chemo/Radiation Therapy		
Office	$50 copay per visit medical deductible does not apply‡	50% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Skilled Nursing Care (facility) *Coverage for Skilled Nursing, Outpatient Rehabilitation and Inpatient Rehabilitation facility settings is limited to 150 days combined per benefit period.*	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Inpatient Hospice	No charge	No charge
Additional Services, Equipment and Devices		
Durable Medical Equipment	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Prosthetic Devices	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Wigs *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Hearing Aids *Coverage is limited to 1 item per ear every 36 months for members under 18 years of age.*	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Out-of-Network medical out-of-pocket limit
Prescription Drug Coverage **Network:** ***Base Network*** **Drug List:** ***Essential*** *Drugs not included on the Essential drug list will not be covered.*		
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below). Maintenance medications are available through our home delivery pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.* **Specialty Pharmacy** *30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.*		
Tier 1 - Typically Generic	$10 copay per prescription (retail) and $30 copay per prescription (home delivery)	50% coinsurance (retail) and Not covered (home delivery)
Tier 2 - Typically Preferred Brand	$35 copay per prescription (retail) and $105 copay per prescription (home delivery)	50% coinsurance (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	$75 copay per prescription (retail) and $225 copay per prescription (home delivery)	50% coinsurance (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	25% coinsurance up to $350 per prescription (retail and home delivery)	50% coinsurance (retail) and Not covered (home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
This is a brief outline of your vision coverage. To receive the In-Network benefit, you must use a Blue View Vision Provider. Only children's vision services count towards your out-of-pocket limit.		
Children's Vision exam (up to age 21) *Limited to 1 exam per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Adult Vision exam (age 21 and older) *Limited to 1 exam per benefit period.*	No charge	Reimbursed Up to $42

Notes:

- Dependent Age Limit: to the end of the month in which the child attains age 26.
- Members are encouraged to always obtain prior approval when using Out-of-Network Providers. Precertification will help the member know if the services are considered not medically necessary.
- No charge means no deductible / copayment / coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing an Out-of-Network Provider, the member is responsible for any balance due after the plan payment.
- If you have an office visit with your Primary Care Physician, Specialist or Urgent Care at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, 3D mammography, breast ultrasounds and MRIs are covered in full as required by state mandate.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.
- ‡ You will pay your PCP or Specialist office visit copay for certain services provided in their office.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

Questions: (833) 578-4443 or visit us at www.anthem.com

Your summary of benefits

Anthem

Your Plan: Anthem Blue Access PPO Option 21 with Rx Option E2

Your Network: Blue Access

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

Authorized group signature (if applicable)	Date
Underwriting signature (if applicable)	Date

We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document

Spanish
Usted tiene derecho a obtener asistencia en su idioma sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

Chinese
您有權免費獲得使用您的語言提供的協助。只需撥打印於您的 ID 卡上的會員服務部電話號碼即可。視力障礙？您也可以索取本文件的其他格式。

Vietnamese
Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thể yêu cầu các định dạng khác của tài liệu này.

Korean
귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가 있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 전화하십시오. 시각 장애인이신가요? 다른 형식으로 된 이 문서를 요청하실 수 있습니다.

Tagalog
May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga format ng dokumentong ito.

Russian
У вас есть право на бесплатное получение помощи на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы со зрением? Вы также можете запросить этот документ в других форматах.

French Creole
Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòma nan dokiman sa a.

Arabic
لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجانًا. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضًا طلب تنسيقات أخرى لهذه الوثيقة.

French
Vous avez le droit d'obtenir de l'aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d'identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d'autres formats.

Persian
شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضا مندرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال بینایی هستید؟ همچنین می‌توانید فرمت‌های دیگر این سند را درخواست کنید.

Armenian
Դուք իրավունք ունեք անվճար օգնություն ստանալու ձեր լեզվով: Պարզապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցո՞ղ եք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

Japanese
あなたにはあなたの言語で無料で支援を受ける権利があります。ID カードに記載されている会員サービス番号にお電話ください」視覚障害をお持ちですか？他の形式でこの文書を要求することもできます。

Italian
Hai il diritto di ricevere assistenza gratuita nella tua lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi di vista? È possibile richiedere anche altri formati di questo documento.

German
Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Rufen Sie einfach die Nummer des Mitgliederservices auf Ihrer ID-Karte an. Sehbehindert? Sie können dieses Dokument auch in anderen Formaten anfordern.

Polish
Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.

Pennsylvania Dutch
Du hoscht's Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrufe uff dei ID Card. Hoscht Druwwel fer sehne? Du kannscht des do Schreiwes in en differnter Weg griege so as du's besser sehne kannscht.

TTY/TTD:711

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate, on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Your summary of benefits

Anthem

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Access PPO HSA Option E10

Your Network: Blue Access

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge deductible does not apply
Mental Health & Substance Use Disorder Services	No charge deductible does not apply
Specialist care	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	$3,500 person / $7,000 family	$10,500 person / $21,000 family
Overall Out-of-Pocket Limit	$8,000 person / $16,000 family	$24,000 person / $48,000 family
The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit. All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit (excluding Out-of-Network Human Organ and Tissue Transplant (HOTT), Cellular and Gene Therapy services). In-Network and Out-of-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
Primary Care (PCP) and Mental Health and Substance Use Disorder Services *virtual and office*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Specialist Provider *virtual and office*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Other Practitioner Visits		
Maternity Doctor services (prenatal/postpartum care and delivery)	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 12 visits per benefit period.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Other Services in an Office		
Allergy Testing	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Surgery	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	50% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	Cost share is based on the setting services are received.
Diagnostic Services Lab		
Office	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Lab/Reference Lab	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Diagnostic Services X-Ray		
Office	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Diagnostic Services Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency Room Facility Services	30% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	30% coinsurance after deductible is met	Covered as In-Network
Ambulance	30% coinsurance after deductible is met	Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Authorized Out-of-Network non-emergency ambulance services are limited to an Anthem maximum payment of $50,000 per trip. The $50,000 limit does not apply to air ambulance services.		
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor Services	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Ambulatory Surgical Center	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Physician and other services *including surgeon fees*		
Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Ambulatory Surgical Center	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)		
Facility Fees	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Human Organ and Tissue Transplants *Cornea transplants are treated as medical procedures, with benefits and cost sharing determined by the setting in which the services are received. You must get certain covered transplant procedures from an Approved In-Network Provider to receive the In-Network level of benefits.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Physician and other services *including surgeon fees*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Home Health Care *Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Therapy Services		
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *You are responsible for cost shares no greater than the PCP office visit when Covered Services are performed by a Physical Therapist or Occupational Therapist. Coverage for physical and occupational therapies is limited to 20 visits combined per benefit period. Coverage for speech therapy is limited to 20 visits per benefit period.*		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Office	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Pulmonary rehabilitation *office and outpatient hospital*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Cardiac rehabilitation *office and outpatient hospital* *Coverage is limited to 36 visits per benefit period.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Dialysis/Hemodialysis *office and outpatient hospital*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Chemo/Radiation Therapy *office and outpatient hospital*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage for Skilled Nursing, Outpatient Rehabilitation and Inpatient Rehabilitation facility settings is limited to 150 days combined per benefit period.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Inpatient Hospice	No charge after deductible is met	No charge after deductible is met
Additional Services, Equipment and Devices **Durable Medical Equipment**	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Wigs *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Hearing Aids *Coverage is limited to 1 item per ear every 36 months for members under 18 years of age.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with Out-of-Network medical deductible
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Out-of-Network medical out-of-pocket limit
Prescription Drug Coverage **Network:** ***Base Network*** **Drug List:** ***Essential*** *Drugs not included on the Essential drug list will not be covered.*		

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below). Maintenance medications are available through our home delivery pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.* **Specialty Pharmacy** *30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.*		
Tier 1 - Typically Generic	30% coinsurance after deductible is met (retail and home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 2 - Typically Preferred Brand	30% coinsurance after deductible is met (retail and home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	30% coinsurance after deductible is met (retail and home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	30% coinsurance after deductible is met (retail and home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
This is a brief outline of your vision coverage. To receive the In-Network benefit, you must use a Blue View Vision Provider. Only children's vision services count towards your out-of-pocket limit.		
Children's Vision exam (up to age 21) *Limited to 1 exam per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Adult Vision exam (age 21 and older) *Limited to 1 exam per benefit period.*	No charge	Reimbursed Up to $42

Notes:

- Dependent Age Limit: to the end of the month in which the child attains age 26.
- Members are encouraged to always obtain prior approval when using Out-of-Network Providers. Precertification will help the member know if the services are considered not medically necessary.

- No charge means no deductible / copayment / coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing an Out-of-Network Provider, the member is responsible for any balance due after the plan payment.
- If you have an office visit with your Primary Care Physician, Specialist or Urgent Care at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, 3D mammography, breast ultrasounds and MRIs are covered in full after deductible as required by state mandate.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

Questions: (833) 578-4443 or visit us at www.anthem.com

Anthem

Your Plan: Anthem Blue Access PPO HSA Option E10

Your Network: Blue Access

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

Authorized group signature (if applicable)	Date
Underwriting signature (if applicable)	Date

We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document

Spanish
Usted tiene derecho a obtener asistencia en su idioma sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

Chinese
您有權免費獲得使用您的語言提供的協助。只需撥打印於您的 ID 卡上的會員服務部電話號碼即可。視力障礙？您也可以索取本文件的其他格式。

Vietnamese
Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thể yêu cầu các định dạng khác của tài liệu này.

Korean
귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가 있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 전화하십시오. 시각 장애인이신가요? 다른 형식으로 된 이 문서를 요청하실 수 있습니다.

Tagalog
May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga format ng dokumentong ito.

Russian
У вас есть право на бесплатное получение помощи на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы со зрением? Вы также можете запросить этот документ в других форматах.

French Creole
Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòma nan dokiman sa a.

Arabic
لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجانًا. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضًا طلب تنسيقات أخرى لهذه الوثيقة.

French
Vous avez le droit d'obtenir de l'aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d'identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d'autres formats.

Persian
شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضا مندرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال بینایی هستید؟ همچنین می‌توانید فرمت‌های دیگر این سند را درخواست کنید.

Armenian
Դուք իրավունք ունեք անվճար օգնություն ստանալու ձեր լեզվով: Պարզապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցո՞ղ եք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

Japanese
あなたにはあなたの言語で無料で支援を受ける権利があります。ID カードに記載されている会員サービス番号にお電話ください」視覚障害をお持ちですか？他の形式でこの文書を要求することもできます。

Italian
Hai il diritto di ricevere assistenza gratuita nella tua lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi di vista? È possibile richiedere anche altri formati di questo documento.

German
Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Rufen Sie einfach die Nummer des Mitgliederservices auf Ihrer ID-Karte an. Sehbehindert? Sie können dieses Dokument auch in anderen Formaten anfordern.

Polish
Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.

Pennsylvania Dutch
Du hoscht's Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrufe uff dei ID Card. Hoscht Druwwel fer sehne? Du kannscht des do Schreiwes in en differnter Weg griege so as du's besser sehne kannscht.

TTY/TTD:711

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate, on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Summary of Benefits
Anthem Dental Essential Choice

Technology Consulting Inc
Anthem Blue Cross and Blue Shield Dental Complete Network

Anthem

WELCOME TO YOUR DENTAL PLAN!

Regular dental checkups can help find early warning signs of certain health problems, which means you can get the care you need to get healthy. So, don't skimp on your dental care, good oral care can mean better overall health!

Powerful and easily accessible member tools.

- **Ask a Hygienist:** Dental members can simply email their dental questions to a team of licensed dental professionals who in turn will respond in about 24 hours.
- **Dental Health Risk Assessment:** We want our dental members to better understand their oral health and their risk factors for tooth decay, gum disease and oral cancer. This easy to use online tool can help them do this.
- **Dental Care Cost Estimator:** In order to help our dental member better understand the cost of their dental care, we offer access to a user-friendly, web-based tool that provides estimates on common dental procedures and treatments when using a network dentist.
- **More Capabilities:** With our latest mobile application, members can find a network dentist as well as view their claims. Our application is available for both Android and Apple phones.

Dentists in your plan network.

- You'll save money when you visit a dentist in your plan network because Anthem Blue Cross and Blue Shield (Anthem) and the dentist have agreed on pricing for covered services. Dentists who are not in your plan network have not agreed to pricing, and may bill you for the difference between what Anthem pays them and what the dentist usually charges.
- To find a dentist by name or location, go to anthem.com or call dental customer service at the number listed on the back of your ID card.

Ready to use your dental benefits?

- Choose a dentist from the network
- Make an appointment
- Show the office staff your member ID card
- Pay any deductible or copay that is part of your plan

Need to contact us?

See the back of your ID card for who to call, write or email us.

Your dental benefits at a glance

The following benefit summary outlines how your dental plan works and provides you with a quick reference of your dental plan benefits. For complete coverage details, please refer to your policy.

	In-Network	Out-of-Network
Coverage Year	**Calendar Year**	
Annual Benefit Maximum		
● Per insured person	**$1,000**	**$1,000**
● Diagnostic & Preventive Services are applied to the Annual Maximum		
Annual Maximum Carryover	**No**	**No**
Orthodontic Lifetime Benefit Maximum		
● Per eligible child	**$1,000**	**$1,000**
Annual Deductible		
● Per insured person	**$50**	**$50**
● Family maximum	**3x single member deductible**	**3x single member deductible**
Deductible Waived for Diagnostic/Preventive Services	**Yes**	**Yes**
Out-of-Network Reimbursement:	**Prime (MAC)**	

Dental Services	In-Network Anthem Pays:	Out-of-Network Anthem Pays:	Waiting Period
Diagnostic and Preventive Services ● Periodic oral exam ○ Limited to 2 per 12 months ● Teeth cleaning (prophylaxis) ○ Limited to two per 12 months combined with periodontal maintenance ● Bitewing X-rays ○ Limited to one set per 12 months ● Full-Mouth or Panoramic X-rays ○ Limited to one per 36 months ● Fluoride application ○ Limited to one per 12 months through age 18 ● Sealant application ○ Limited to one per 60 months through age 18 ● Space maintainer insertion ○ Limited to one per tooth space per lifetime through age 18	**100% Coinsurance**	**100% Coinsurance**	**No Waiting Period**
Basic (Restorative) Services ● Consultation (second opinion); only with X-rays and no other services ○ Limited to one per 12 months ● Amalgam (silver-colored) filling ○ Limited to one per tooth surface per 24 months ● Composite (tooth-colored) filling ○ Limited to one per tooth surface per 24 months posterior (back) fillings not paid as an amalgam (silver-colored filling) ● Brush Biopsy (cancer test) ○ Limited to one per 12 months; all ages	**80% Coinsurance**	**80% Coinsurance**	**No Waiting Period**
Endodontics (Non-Surgical) ● Root Canal (permanent teeth only) ○ Limited to one per tooth per lifetime; permanent teeth only	**80% Coinsurance**	**80% Coinsurance**	**No Waiting Period**
Endodontics (Surgical) ● Apicoectomy and apexification ○ Limited to one per tooth per lifetime; permanent teeth only	**80% Coinsurance**	**80% Coinsurance**	**No Waiting Period**
Periodontics (Non-Surgical) ● Periodontal maintenance ○ Limited to four per 12 months combined with teeth cleanings ● Scaling and root planning; when the tooth pocket has a depth of four millimeters or greater ○ Limited to one per quadrant per 24 months	**80% Coinsurance**	**80% Coinsurance**	**No Waiting Period**
Periodontics (Surgical) ● Periodontal surgery (osseous, gingivectomy, graft procedures) ○ Limited to one per quadrant per 36 months	**80% Coinsurance**	**80% Coinsurance**	**No Waiting Period**
Oral Surgery (Simple) ● Simple extraction ○ Limited to one per tooth per lifetime	**80% Coinsurance**	**80% Coinsurance**	**No Waiting Period**
Oral Surgery (Complex) ● Surgical extraction ○ Limited to one per tooth per lifetime	**80% Coinsurance**	**80% Coinsurance**	**No Waiting Period**
Major (Restorative) Services ● Crowns, onlays, veneers ○ Limited to one per tooth per 60 months	**50% Coinsurance**	**50% Coinsurance**	**No Waiting Period**
Prosthodontics ● Dentures and bridges ○ Limited to one per tooth per 60 months ● Implant placement ○ Limited to one per tooth/arch per 60 months ● Implant prosthodontics ○ Limited to one per tooth per 60 months as a non-implant crown, bridge, and/or denture	**50% Coinsurance**	**50% Coinsurance**	**No Waiting Period**
Repairs/Adjustments ● Crown, denture, bridge repairs ○ Limited to one per 12 months not within 6 months of placement ● Denture and bridge adjustments: ○ Limited to two per tooth per 12 months not within 6 months of placement	**50% Coinsurance**	**50% Coinsurance**	**No Waiting Period**

Dental Services (continued)	In-Network Anthem Pays:	Out-of-Network Anthem Pays:	Waiting Period
Child Orthodontic Services ○ Through age 18	**50% coinsurance**	**50% coinsurance**	**No waiting periods**
Temporomandibular Joint Disorder (TMJ) ● X-rays, splints, and surgical procedures including arthroscopy and orthotic devices ○ Not Covered	**Not Covered**	**Not Covered**	**N/A**
Cosmetic Teeth Whitening ○ Not covered	**Not Covered**	**Not Covered**	**N/A**

NOTE: Cosmetic benefits, such as teeth bleaching, in an insurance policy may have income tax implications for both employer groups and plan members. For example, the dollar value of the cosmetic benefit may be considered part of an individual's taxable income. For more information concerning the tax ramifications of cosmetic insurance benefits, please consult a legal or tax advisor.

Additional Services and Programs	In-Network Anthem Pays:	Out-of-Network Anthem Pays:	Waiting Period
Anthem Whole Health Connection® - Dental ● For members with certain health conditions, additional dental benefits are available without a deductible, office visit copay, nor waiting periods. Eligible services are paid at 100% and won't reduce your coverage year annual maximum (if applicable).	**Included**	**Included**	**No waiting period**
Accidental Dental Injury Benefit ● Provides members 100% coverage for accidental injuries to teeth up to the coverage year annual maximum (if applicable). No deductibles, office visit copay, member coinsurance, nor waiting periods apply.	**Included**	**Included**	**No waiting period**
Extension of Benefits ● Following termination of coverage, members are provided up to 60 days to complete treatment started prior to their termination of coverage under the plan and eligible services will be covered.	**Included**	**Included**	**No waiting period**
International Emergency Dental Program ● Provides emergency dental benefits while working or traveling abroad from licensed, English-speaking dentists. Eligible covered services will be paid 100% with no deductibles, office visit copay, member coinsurance, nor waiting periods and won't reduce the member coverage year annual maximum (if applicable).	**Included**	**Included**	**No waiting period**
Kids Plus ● For members through age 12 covered services excluding orthodontia services, receive the corresponding coinsurance up to the coverage year annual maximum (if applicable). No deductibles, office visit copay, nor waiting periods apply. All other benefit limitations and exclusions apply. For additional coverage details, please refer to your policy.	**Not Included**	**Not Included**	**Not applicable**

Additional Limitations & Exclusions

Below is a partial listing of non-covered services under your dental plan. Please see your policy for a full list.

Services provided before or after the term of this coverage - Services received before your effective date or after your coverage ends, unless otherwise specified in the dental plan certificate

Orthodontics (unless included as part of your dental plan benefits) including orthodontic braces, appliances and all related services

Cosmetic dentistry (unless included as part of you dental plan benefits) provided by dentists solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (cavities) exist

Drugs and medications including intravenous conscious sedation, IV sedation and general anesthesia when performed with nonsurgical dental care

Analgesia, analgesic agents, and anxiolysis nitrous oxide, therapeutic drug injections, medicines or drugs for nonsurgical or surgical dental care except that intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.

Waiting periods for endodontic, periodontic and oral surgery services may differ from other Basic Services or Major Services under the same dental plan. There

is a 24 month waiting period for replacement of congenitally missing teeth or teeth extracted prior to coverage under this plan.

This is not a contract; it is a partial listing of benefits and services. All covered services are subject to the conditions, limitations, exclusions, terms and provisions of your policy. **In the event of a discrepancy between the information in this summary and the policy, your policy will prevail.**

Blue View Vision℠
FS.B.10.10.130.130

Anthem

Welcome to your Blue View Vision plan!

You have many choices when it comes to using your benefits. As a Blue View Vision plan member, you have access to one of the nation's largest vision networks. You may choose from many private practice doctors, local optical stores, and national retail stores including LensCrafters®, Target Optical®, and most Pearle Vision® locations. You may also use your in-network benefits to order eyewear online at Glasses.com and ContactsDirect.com. To locate a participating network eye care doctor or location, log in at **anthem.com**, or the Sydney app. You may also call member services for assistance at **1-866-723-0515**.

Out-of-Network – If you choose to, you may instead receive covered benefits outside of the Blue View Vision. Just pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement up to your maximum out-of-network allowance.

Your vision plan includes coverage for routine eye exams and prescription eyewear from your choice of eye care providers.

YOUR BLUE VIEW VISION PLAN BENEFITS	IN-NETWORK	OUT-OF-NETWORK	FREQUENCY
Routine Eye Exam			
A comprehensive eye examination	$10 Copay	Reimbursed Up To $42	Once every calendar year
Eyeglass Frames			
One pair of eyeglass frames	$130 Allowance, then 20% off any remaining balance	Reimbursed Up To $45	Once every other calendar year
Eyeglass Lenses *(instead of contact lenses)*			
One pair of standard plastic prescription lenses o Single vision lenses o Bifocal lenses o Trifocal lenses	 $10 Copay $10 Copay $10 Copay	 Reimbursed Up To $40 Reimbursed Up To $60 Reimbursed Up To $80	Once every calendar year
Eyeglass Lens Enhancements *When obtaining covered eyewear from a Blue View Vision provider, you may choose to add any of the following lens enhancements at no extra cost*			
o Transitions Lenses (for a child under age 21) o Standard polycarbonate (for a child under age 21) o Factory Scratch Coating	$0 Copay $0 Copay $0 Copay	No allowance when obtained out-of-network	Same as covered eyeglass lenses
Contact Lenses *(instead of eyeglass lenses)* *Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.*			
o Elective conventional (non-disposable) OR	$130 Allowance, then 15% off any remaining balance	Reimbursed Up To $105	Once every calendar year
o Elective disposable OR	$130 Allowance *(no additional discount)*	Reimbursed Up To $105	
o Non-elective (medically necessary)	Covered in full	Reimbursed Up To $210	

This is a primary vision care benefit intended to cover only routine eye examinations and corrective eyewear. Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care doctor from your medical network. Benefits are payable only for expenses incurred while the group and insured person's coverage is in force. This information is intended to be a brief outline of coverage. All terms and conditions of coverage, including benefits and exclusions, are contained in the member's policy, which shall control in the event of a conflict with this overview. This benefit overview is only one piece of your entire enrollment package. .

EXCLUSIONS & LIMITATIONS (not a comprehensive list – please refer to the member Certificate of Coverage for a complete list)

Combined Offers. Not to be combined with any offer, coupon, or in-store advertisement.
Excess Amounts. Amounts in excess of covered vision expense.
Sunglasses. Plano sunglasses and accompanying frames.
Safety Glasses. Safety glasses and accompanying frames.
Not Specifically Listed. Services not specifically listed in this plan as covered services.
Lost or Broken Lenses or Frames. Any lost or broken lenses or frames are not eligible for replacement unless the insured person has reached his or her normal service interval as indicated in the plan design.
Non-Prescription Lenses. Any non-prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no refractive power.
Orthoptics. Orthoptics or vision training and any associated supplemental testing

Contract code: 4M3F

OPTIONAL SAVINGS AVAILABLE FROM BLUE VIEW VISION IN-NETWORK PROVIDERS ONLY (Discounts are not covered benefits under your vision plan and will not be listed in your certificate of coverage.)		**In-Network Member Cost** (after any applicable copay)
Retinal Imaging - at member's option, can be performed at time of eye exam		Not More Than $39

Eyeglass lens upgrades
When obtaining eyewear from a Blue View Vision provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass lens copayment applies.
	• Transitions lenses (Adults)
	• Standard Polycarbonate (Adults)
	• Tint (Solid and Gradient)
	• UV Coating
	• Progressive Lenses[1]
	  • Standard
	  • Premium Tier 1
	  • Premium Tier 2
	  • Premium Tier 3
	  • Premium Tier 4
	• Anti-Reflective Coating[2]
	  • Standard
	  • Premium Tier 1
	  • Premium Tier 2
	  • Premium Tier 3
	• Other Add-ons (i.e. high index lenses, anti-fog coating)
		$75
		$40
		$15
		$15
		
		$55
		$85
		$95
		$110
		$175
		
		$45
		$57
		$68
		$85
		20% off retail price

Additional Pairs of Eyeglasses **Anytime from any Blue View Vision network provider**	• Complete Pair • Eyeglass materials purchased separately	40% off retail price 20% off retail price
Eyewear Accessories	• Items such as non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc.	20% off retail
Conventional Contact Lenses **(non-disposable type)**	• Discount applies to materials only •	15% off retail price
Contact lens fit and follow-up **A contact lens fitting and up to two follow-up visits are available to you once a comprehensive eye exam has been completed.**	• Standard contact lens fitting3 • Premium contact lens fitting4	Up to $55 10% off retail price

[1] Please ask your provider for his/her recommendation as well as the available progressive brands by tier.

[2] Please ask your provider for his/her recommendation as well as the available anti-reflective brands by tier.

[3] Standard fitting includes spherical clear lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.

[4] Premium fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

Cannot be combined with any other offer. Discounts are subject to change without notice. Discounts are not covered benefits under your vision plan and will not be listed in your certificate of coverage. Discounts will be offered from in-network providers except where State law prevents discounting of products and services that are not covered benefits under this plan. Discounts on frames will not apply if the manufacturer has imposed a no discount on sales at retail and independent provider locations. Some of our in-network providers include:

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION OPTICAL

GLASSES.COM contactsdirect 1800contacts Ray-Ban befitting OAKLEY

Savings on items like additional eyewear after your benefits have been used, non-prescription sunglasses, hearing aids and even LASIK laser vision correction surgery are available through a variety of vendors. Just log in at **anthem.com**, select discounts, then Vision, Hearing & Dental. * Discounts cannot be used in conjunction with your covered benefits.

OUT-OF-NETWORK

If you choose to receive covered services or purchase covered eyewear from an out-of-network provider, network discounts will not apply and you will be responsible for payment of services and/or eyewear materials at the time of service. Please complete an out-of-network claim form and submit it along with your itemized receipt to the fax number, email address, or mailing address below. To download a claim form, log in at **anthem.com**, or from the home page menu under Support select Forms, click Change State to choose your state, and then scroll down to Claims and select the Blue View Vision Out-of-Network Claim Form. You may instead call member services at 1-866-723-0515 to request a claim form.

TO FAX: 866-293-7373
TO EMAIL: ooneclaims@eyewearspecialoffers.com
TO MAIL: Blue View Vision
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

Get Help in Your Language

Curious to know what all this says? We would be too. Here's the English version:
You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish
Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda**. (TTY/TDD: 711)**

Arabic
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة(TTY/TDD:711).

Chinese
您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。**(TTY/TDD: 711)**

French
Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. **(TTY/TDD: 711)**

German
Sie haben das Recht, diese Informationen und Unterstützung kostenlos in Ihrer Sprache zu erhalten. Rufen Sie die auf Ihrer ID-Karte angegebene Servicenummer für Mitglieder an, um Hilfe anzufordern. **(TTY/TDD: 711)**

Japanese
この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。**(TTY/TDD: 711)**

Kirundi
Ufise uburenganzira bwo gufashwa mu rurimi rwawe ku buntu. Akura umunywanyi abikora Ikaratakarangamuntu yawe kugira ufashwe. **(TTY/TDD: 711)**

Korean
귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. **(TTY/TDD: 711)**

Nepali
तपाईंले यो जानकारी तथा सहयोग आफ्नो भाषामा नःशुल्क प्राप्त गर्ने तपाईंको अधिकार हो। सहायताको लागि तपाईंको ID कार्डमा दिइएको सदस्य सेवा नम्बरमा कल गर्नुहोस्। **(TTY/TDD: 711)**

Oromo
Odeeffanoo kana fi gargaarsa afaan keetiin kaffaltii malee argachuuf mirga qabda. Gargaarsa argachuuf lakkoofsa bilbilaa tajaajila miseensaa (Member Services) waraqaa enyummaa kee irratti argamu irratti bilbili. **(TTY/TDD: 711)**

Pennsylvania Dutch
Du hoscht die Recht selle Information un Helfe in dei Schprooch mitaus Koscht griege. Ruf die Member Services Nummer uff dei ID Kaarte fer Helfe aa. **(TTY/TDD: 711)**

Russian
Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. **(TTY/TDD: 711)**

Serbian
Imate pravo da dobijete sve informacije i pomoć na vašem jeziku, i to potpuno besplatno. Pozovite broj Centra za podršku članovima koji se nalazi na vašoj identifikacionoj kartici. **(TTY/TDD: 711)**

Tagalog
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. **(TTY/TDD: 711)**

Vietnamese
Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. **(TTY/TDD: 711)**

It's important we treat you fairly
That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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.)
$_____ + $_____ + $_____ = 0
$BASE EARNINGS (if applicable) COMMISSIONS (if applicable) BONUS TOTAL EARNINGS

☐ HOURLY ☐ MONTHLY ☐ SALARIED ☐ EXEMPT
☐ WEEKLY ☐ SEMI-MONTHLY ☐ HOURLY ☐ NON-EXEMPT
☐ BI-WEEKLY ☐ ANNUALLY ☐ 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.

DO NOT USE THIS AREA

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:

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.

Information Systems Consulting Services
9300 Shelbyville Road, Suite 300
Louisville, KY 40222
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 see the TransAmerica Attachment in your Welcome email with instructions on how to register online @ transamerica.com/portal/home and click "Create An Account" in the top right corner. Follow the instructions to create a new account.

Payroll Manager

Diane Gibson