Technology Consulting Inc. Benefits Package

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WELCOME TO T.C.I.

Since it's inception in 1988, TCI has been one of the fastest growing consulting firms 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., Advanced Pension Solutions to maintain the highest level of benefits available. To that end, we offer the enclosed benefit package to all **T.C.I.** 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	or	Karen Walsh
502-326-4719		502-326-4799
dgibson@tcipro.com		kwalsh@tcipro.com

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INSTRUCTIONS FOR WAIVER FORMS

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

TCI - Health Plan Election Form – Please fill out this form indicating whether you are enrolling or waiving coverage for the major medical health plan. If waiving ALL coverages, this will be the only form needed.

Anthem Health/Dental/Life/Vision Enrollment Form – If you are enrolling in the Anthem PPO plan please fill out form in its entirety. If you are enrolling in dental/vision and/or life only, note coverage in section 4 and fill out section 5. TCI will provide to each employee $20,000.00 of group term life insurance through Anthem. You must fill out section 7 (Life Insurance) with your primary and contingent beneficiaries for this policy to be effective. Also make sure you sign Box 10 on Page four and Box 11, if you are waiving any coverage we offer through Anthem. Coverage will be effective the first of the month after AFTER 30 days of fulltime continuous service.

Anthem Additional Term Life & Dependent Life - With the Anthem Life policy, it is now possible to purchase additional term life insurance on yourself up to $50,000.00 without a Personal Health Statement 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 (up to 50% of additional amount purchased for self) 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 – Please call if interested and we will send you out a packet immediately.

TCI – 2016 Benefit Election Form
Health, Dental and Vision – semi-monthly
Effective: October 1, 2016

	Anthem Health PPO 14	Anthem Health HDHP	Anthem Vision 12/12/24/12	Anthem Dental 5-1-2015
Employee	**$138.44**	**$92.36**	**$3.63**	**$11.65**
Employee/Spouse	**$442.09**	**$294.95**	**$6.31**	**$23.77**
Employee/Child **Employee/Children**	**$328.87**	**$219.42**	**$6.31** **$9.39**	**$28.23**
Family	**$716.15**	**$477.80**	**$9.39**	**$41.82**

Benefit Type	Benefit Plan (Check One)	Coverage Type / Cost
Medical Plan	☐ **Anthem PPO** ☐ **Anthem HDHP** ☐ **Waive (mark one below)** ☐ **I have insurance with** ________________ ☐ **No I do not have other insurance**	**Coverage Type** - Anthem Enrollment Form ☐ Employee ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family
Dental Plan	☐ **Dental** ☐ **Waive**	**Coverage Type** - Anthem Enrollment Form ☐ Employee ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family
Vision Plan	☐ **Vision** ☐ **Waive**	**Coverage Type** - Anthem Enrollment Form ☐ Employee ☐ Employee + 1 ☐ Family (more than 1)

ADDITIONAL COVERAGES

If you plan on waiving all coverages except TCI purchased Life, fill out "only" this form, if you plan on taking any one or more please fill out Anthem Enrollment form.

Benefit Type	Benefit Plan (Check One)	
Unum/Paul Revere LTD	☐ Elect	Fill out UNUM/Paul Revere Application at back of packet
	☐ Waive	
Anthem/ Additional Life	☐ Elect	Mark Box on Anthem Enrollment Form in Section 8, and complete additional life form.
	☐ Waive	
Life – 20K	☐ TCI PAID	ASSIGN BENEFICIARY: Name: Relationship to you: Age: Contingent Beneficiary: Name: Relationship to You: Age: **Please fill out both places.

If you plan on waiving all coverages (except the life that TCI will purchase for you), fill out "only" this form, if you plan on taking one or more please fill out Anthem Enrollment form.

I authorize TCI to deduct from my earnings until further notice my contributions for the group benefit plan.

Employee Name:
Please Print____SS#__________________________

Employee Signature____Date___________________

Your Summary *of* Benefits

Technology Consulting Inc
Blue Access® Option 19 with Rx Option R (Essential)
Effective 10/01/2016

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Covered Benefits	Network	Non-Network
Deductible (Single/Family)	$2,000/$6,000	$4,000/$12,000
Out-of-Pocket Limit (Single/Family)	$5,500/$11,000	$11,000/$22,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician(PCP)/Specialty Care Physician (SCP) Including Office Surgeries and allergy serum:	$25 / $50	50%
· Allergy injections (PCP and SCP)	$5	50%
· Allergy testing	30%	50%
· MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds and Pharmaceuticals	30%	50%
Preventive Care Services Services included but not limited to: Routine medical exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Hearing screenings and Vision screenings which are limited to Screening tests (i.e. Snellen eye chart) and Ocular Photo screening.	No Cost Share	50%
Emergency and Urgent Care		
· Emergency Room Services @Hospital (facility/other covered services) *(copayment waived if admitted)*	$250/30%	$250/30%
· Urgent Care Center Services	$75	50%
· MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, Non-Maternity related Ultrasounds and Pharmaceuticals	30%	50%
· Allergy injections	$5	50%
· Allergy testing	30%	50%
Inpatient and Outpatient Professional Services Include but are not limited to: · Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams	30%	50%
Inpatient Facility Services Unlimited days except for: · 60 days Network/Non-Network combined for physical medicine / rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) · 90 days Network/Non-Network combined for skilled nursing facility	30%	50%
Outpatient Surgery Hospital / Alternative Care Facility · Surgery and administration of general anesthesia	30%	50%
Other Outpatient Services (including but not limited to): · Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services. · Home Care Services (Network/Non-network combined) 100 visits (excludes IV Therapy) · Durable Medical Equipment, Orthotics, and Prosthetics · Physical Medicine Therapy Day Rehabilitation programs	30%	50%
· Ambulance Services	30%	30%

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Covered Benefits	Network	Non-Network
Outpatient Therapy Services **(Combined Network & Non-Network limits apply)**		
· Physician Home and Office Visits (PCP/SCP)	$25 / $50	50%
· Other Outpatient Services @ Hospital/Alternative Care Facility	30%	50%
Limits apply to: · Physical therapy: 20 visits · Occupational therapy: 20 visits · Manipulation therapy: 12 visits · Speech therapy: 20 visits · Cardiac Rehabilitation: 36 visits · Pulmonary Rehabilitation: 20 visits · Accidental Dental Coverage subject to cost share based on setting, see certificate for limitations		
Behavioral Health Services: **Mental Health and Substance Abuse**		
· Inpatient Facility Services	Benefits provided in accordance with	50%
· Physician Home and Office Visits	Federal Mental Health Parity	50%
· Other Outpatient Facility Services		50%
Human Organ and Tissue Transplants(3) · Acquisition and transplant procedures, harvest and storage.	No Cost Share	50%
Prescription Drugs :(4) Essential Formulary **Network Tier structure equals 1/2/3 (and 4 and 5 if applicable)**		
· Network Retail Pharmacies: (30 day supply) Includes diabetic test strip	$15 / $40 / $80	50% , min $80(5)
· Home Delivery (90 day supply) Includes diabetic test strip	$15 / $80 / $240	Not Covered
Specialty medications are limited to a 30 day supply regardless of whether they are retail or home delivery. - Member may be responsible for additional cost when not selecting the available generic drug. - Specialty Medications must be obtained via our Specialty Pharmacy network in order to receive network level benefits.		

Notes:

All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services).
· Deductible(s) apply to covered medical services listed with a percentage (%) coinsurance. However, the deductible does not apply to Emergency Room Services @ Hospital where a copayment and percentage (%) coinsurance applies and may not apply to some Behavioral Health services where coinsurance applies.
· Network and Non-network deductibles, copayments, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other. Network and non-network deductibles are combined for 500 series plans.
· Dependent age: to the end of the month in which the child attains age 26.
· Specialist copayment is applicable to all Specialists excluding General Physicians, Internist, Pediatricians, OB/GYN's and Geriatrics or any other Network Provider as allowed by the plan.
· When allergy injections are rendered with a Physicians Home and office visit, only the office visit cost share applies.
· No Cost Share means no deductible/copayment/coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
· PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/ gynecology, geriatrics or any other Network provider as allowed by the plan.

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Your Summary *of* Benefits

Anthem®

Technology Consulting Inc
Blue Access® Option 19 with Rx Option R (Essential)
Effective 10/01/2016

· SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.
· Certain diabetic and asthmatic supplies have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies except diabetic test strips .
· Benefit period = Calendar Year
· Autism Spectrum Disorder is covered based on state law for members age 1 through 21.
· Mammograms (diagnostic) have no copayment/coinsurance up to the maximum allowable amount in Network office and outpatient facility settings.
· Behavioral Health: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health Parity.
· Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits are covered.
· Private Duty Nursing - limited to 82 visits/Calendar Year and 164 visits/lifetime.
· Additional vision services covered as part of Preventive Services on series 500 plans.
· Home Care Services (Network and Non-network combined) are limited to 90 visits for 500 series plans.
· Hospice: No copayment/coinsurance up to the maximum allowable amount.
(1)These covered services are not subject to the deductible/copayment if you have a flat dollar copayment and if rendered without an office visit.
(2) We encourage you to refer to the Schedule of Benefits for limitations.
(3)Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.
(4)If applicable, all prescription drug expenses except tier 1, (Network/Non-network, Retail/Home-delivery combined) apply to the per individual RX deductible. Once the RX deductible is met, the appropriate copayment/coinsurance applies. Also, if applicable, the Prescription Drug out of pocket maximum applies to Network Retail and Home-delivery combined.
(5)Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.
**The Rx option includes the Essential formulary which is a closed drug list with a focus on therapeutic efficacy and cost effectiveness.*
·Physical and Occupational Therapy in the office setting and outpatient facility will be subject to the PCP cost share.
Precertification:
· Members are encouraged to always obtain prior approval when using Non-network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.

Pre-Existing Exclusion Period:*None.*

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.

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

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Your Summary *of* Benefits

Technology Consulting Inc
Lumenos Health Savings Accounts (with Copay) Option E3 with Rx Option AO
Effective 10/01/2016

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Covered Benefits	Network	Non-Network
Deductible The single deductible applies to the Family deductible. Once the single deductible has been satisfied, benefits for that member are payable subject to coinsurance. Once the family deductible has been satisfied, benefits for the family are payable subject to coinsurance.	Single: $5,000 Family: $10,000	Single: $10,000 Family: $20,000
Out-of-Pocket Limit	Single: $6,450 Family: $12,900	Single: $20,000 Family: $40,000
Physician Home and Office Services (PCP/SCP) (3) Primary Care Physician(PCP)/Specialty Care Physician (SCP) Including Office Surgeries and allergy serum:	$30 /$60	30%
· Allergy injections (PCP and SCP)	$5	30%
· Allergy testing	0%	30%
· MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds and Pharmaceuticals	0%	30%
Preventive Care Services Services included but not limited to: Routine medical exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Hearing screenings and Vision screenings which are limited to Screening tests (i.e. Snellen eye chart) and Ocular Photo screening.	No Cost Share	30%
Emergency and Urgent Care		
· Emergency Room Services @Hospital (facility/other covered services) *(copayment waived if admitted)*	$250	$250
· Urgent Care Center Services	$75	30%
· MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, Non-Maternity related Ultrasounds and Pharmaceuticals	0%	30%
· Allergy injections	$5	30%
· Allergy testing	0%	30%
Inpatient and Outpatient Professional Services Include but are not limited to: · Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams	0%	30%
Inpatient Facility Services Unlimited days except for: · 60 days Network/Non-Network combined for physical medicine / rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) · 100 days Network/Non-Network combined for skilled nursing facility	0%	30%

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Effective 10/01/2016

Covered Benefits	Network	Non-Network
Outpatient Surgery Hospital / Alternative Care Facility · Surgery and administration of general anesthesia	0%	30%
Other Outpatient Services (including but not limited to): · Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services. · Home Care Services (Network/Non-network combined) 100 visits (excludes IV Therapy) · Durable Medical Equipment, Orthotics, and Prosthetics · Physical Medicine Therapy Day Rehabilitation programs	0%	30%
· Ambulance Services	0%	0%
Outpatient Therapy Services **(Combined Network & Non-Network limits apply)**		
· Physician Home and Office Visits (PCP/SCP)	$30/$60	30%
· Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: · Physical therapy: 20 visits · Occupational therapy: 20 visits · Manipulation therapy: 12 visits · Speech therapy: 20 visits · Cardiac Rehabilitation: 36 visits · Pulmonary Rehabilitation: 20 visits · Accidental Dental Coverage subject to cost share based on setting, see certificate for limitations	0%	30%
Behavioral Health Services: **Mental Health and Substance Abuse**		
· Inpatient Facility Services	0%	30%
· Physician Home and Office Visits	$30	30%
· Other Outpatient Services @ Hospital/Alternative Care Facility	0%	30%
Human Organ and Tissue Transplants · Acquisition and transplant procedures, harvest and storage.	0%	30%
Prescription Drugs(National):		
· Network Retail Pharmacies: (30 day supply) Includes diabetic test strip	$10 / $30 / $50 / 25% $200 max*	50% , min $75(2)
· Home Delivery (90 day supply) Includes diabetic test strip *4th Tier per script max- 30 day supply. Specialty medications are limited to a 30 day supply regardless of whether they are retail or home delivery. -Specialty Medications must be obtained via our Specialty Pharmacy network in order to receive network level benefits. - Member may be responsible for additional cost when not selecting the available generic drug.	$10 / $75 / $150 / 25% $200 max*	Not Covered

Notes:
All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services).
· Deductible(s) apply to all covered medical services listed with a percentage (%) coinsurance and copayment, including prescription drug cost shares.
· Network and Non-network deductibles, coinsurance, and out of pocket maximums are separate and do not accumulate towards each other.
· Dependent age: to the end of the month in which the child attains age 26.

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Lumenos Health Savings Accounts (with Copay) Option E3 with Rx Option AO
Effective 10/01/2016

· 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment. No cost share means no deductible/copayment/coinsurance up to the maximum allowable amount.
· Benefit period = Calendar Year
· Autism Spectrum Disorder is covered based on state law for members age 1 through 21.
· Behavioral Health: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health Parity.
· Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits are covered.
· Private Duty Nursing - limited to 82 visits/Calendar Year and 164 visits/lifetime.
· Additional vision services covered as part of Preventive Services on series 500 plans.
· Hospice: Network copayment/coinsurance up to the maximum allowable amount.
(1) We encourage you to refer to the Schedule of Benefits for limitations.
(2)Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.
(3) For PCP/SCP copayment amounts and limitations see certificate of coverage for specific details.
Precertification:
· Members are encouraged to always obtain prior approval when using Non-network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.

Pre-Existing Exclusion Period:*None.*

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.

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

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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.**

Anthem. Health. Join In.℠

WELCOME TO BLUE VIEW VISION!

Good news—your vision plan is flexible and easy to use. This benefit summary outlines the basic components of your plan, including quick answers about what's covered, your discounts, and much more!

Technology Consulting Inc.

Blue View Vision℠ Option 25 Effective: 4/1/13

Your Blue View Vision network

Blue View Vision offers you one of the largest vision care networks in the industry, with a wide selection of experienced ophthalmologists, optometrists, and opticians. Blue View Vision's network also includes convenient retail locations, many with evening and weekend hours, including LensCrafters®, Pearle Vision®, Sears Optical℠, Target Optical® and JCPenney® Optical locations. Best of all – when you receive care from a Blue View Vision participating provider, you can maximize your benefits and money-saving discounts. Members may call Blue View Vision toll-free at (866) 723-0515 with questions about vision benefits or provider locations.

Out-of-network services

Did we mention we're flexible? You can choose to receive care outside of the Blue View Vision network. You simply get an allowance toward services and you pay the rest. (In-network benefits and discounts will not apply.) Just pay in full at the time of service and then file a claim for reimbursement.

YOUR BLUE VIEW VISION PLAN AT-A-GLANCE

VISION CARE SERVICES		IN-NETWORK	OUT-OF-NETWORK
Routine eye exam once every 12 months		$10 copay, then covered in full	$42 allowance
Eyeglass frames Once every 24 months you may select an eyeglass frame and receive the following allowance toward the purchase price:		$130 allowance then 20% off any remaining balance	$45 allowance
Eyeglass lenses *(Standard)* ***Factory scratch coating included*** ***Polycarbonate lenses included for children under 19 years old.*** ***Transitions® lenses included for children under 19 years old.*** Once every 12 months you may receive any one of the following lens options:			
	Standard plastic single vision lenses *(1 pair)*	$10 copay, then covered in full	$40 allowance
	Standard plastic bifocal lenses *(1 pair)*	$10 copay, then covered in full	$60 allowance
	Standard plastic trifocal lenses *(1 pair)*	$10 copay, then covered in full	$80 allowance
Eyeglass lens upgrades When receiving services from a Blue View Vision provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass lens copayment applies.	**Lens Options**	**Member cost for upgrades**	Discounts on lens upgrades are not available out-of-network
	UV Coating	$15	
	Tint (Solid and Gradient)	$15	
	Standard Polycarbonate	$40	
	Transitions® lenses	$75	
	Progressive Lenses[1]		
	Standard	$65	
	Premium Tier 1	$91	
	Premium Tier 2	$97	
	Premium Tier 3	$103	
	Standard Anti-Reflective Coating[2]	$45	
	Premium Tier 1 Anti-Reflective Coating[2]	$57	
	Premium Tier 2 Anti-Reflective Coating[2]	$68	
	Other Add-ons and Services	20% off retail price	
Contact lenses – once every 12 months Prefer contact lenses over glasses? You may choose contact lenses instead of eyeglass lenses and receive an allowance toward the cost of a supply of contact lenses.	Elective Conventional Lenses	$130 allowance then 15% off any remaining balance	$105 allowance
	Elective Disposable Lenses	$130 allowance *(no additional discount)*	$105 allowance
	Non-Elective Contact Lenses	Covered in full	$210 allowance

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

[2] Please ask your provider for his/her recommendation as well as the coating brands by tier.

Your contact lens allowance can only be applied toward the first purchase of contacts you make during a benefit period.

Any unused amount remaining cannot be used for subsequent purchases made during the same benefit period, nor can any unused amount be carried over to the following benefit period.

Transitions and the *swirl* are registered trademarks of Transitions Optical, Inc. Photochromic performance is influenced by temperature, UV exposure and lens material.

VISION CARE SERVICES

Contact lens fitting and follow-up A contact lens fitting and two follow-up visits are available to you once a comprehensive eye exam has been completed.	**IN-NETWORK Member Cost**	**OUT-OF NETWORK**
Standard contact fitting*	Fitting and follow up visits up to $55	Discounts not available out-of-network
Premium contact lens fitting**	10% off retail price	

*A standard contact lens fitting includes spherical clear contact lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.

**A premium contact lens fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

Discounts – Savings on additional eyewear and accessories – After you use your initial frame or contact lens allowance, you can take advantage of discounts on additional prescription eyeglasses, conventional contact lenses, and eyewear accessories courtesy of Blue View Vision network providers.

BLUE VIEW VISION ADDITIONAL SAVINGS	**MEMBER SAVINGS**
Additional Pair of Complete Eyeglasses	40% discount off retail*
Contact Lenses - Conventional *(Discount applied to materials only)*	15% off retail price
Eyewear Accessories Includes some non-prescription sunglasses, lens cleaning supplies, contact lens solutions and eyeglass cases, etc.	20% off retail price

*Items purchased separately are discounted 20% off the retail price. Blue View Vision's Additional Savings Program is subject to change without notice.

LASER VISION CORRECTION SURGERY
Glasses or contacts may not be the answer for everyone. That's why we offer further savings with discounts on refractive surgery. Pay a discounted amount per eye for LASIK Vision correction. For more information, go to SpecialOffers at anthem.com and select vision care.

USING YOUR BLUE VIEW VISION PLAN
The Blue View Vision network is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care physician from your medical network.

OUT-OF-NETWORK
If you choose an out-of-network provider, please complete the out-of-network claim form and submit it along with your itemized receipt to the below fax number, email address, or mailing address. When visiting an out-of-network provider, you are responsible for payment of services and/or eyewear materials at the time of service.

To Fax: **866-293-7373**
To Email: **oonclaims@eyewearspecialoffers.com**
To Mail: **Blue View Vision**
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

EXCLUSIONS

The following section indicates items that are excluded from benefit consideration, and are not considered Covered Services. This is in no way a complete listing, and we are the final authority for determining if services or supplies are Covered Services. This is a primary vision care benefit intended to cover only eye examinations and corrective eyewear. Materials not covered below may be purchased at preferred pricing from Blue View Vision providers.

We do not provide vision benefits for services, supplies or charges:

1. Received from an individual or entity that is not a Provider, as defined in the Certificate.
2. For any condition, disease, defect, aliment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.
3. To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
4. For illness or injury that occurs as a result of any act of war, declared or undeclared.
5. For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
6. For which you have no legal obligation to pay in the absence of this or like coverage.
7. Received from an optical or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
8. Prescribed, ordered, referred by, or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
9. For completion of claim forms or charges for medical records or reports unless otherwise required by law.
10. For missed or canceled appointments.
11. In excess of Maximum Allowable Amount.
12. Incurred prior to your Effective Date.
13. Incurred after the termination date of this coverage except as specified elsewhere in the Certificate.
14. For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified in the Certificate.
15. For sunglasses and accompanying frames.
16. For safety glasses and accompanying frames.
17. For inpatient or outpatient hospital vision care.
18. For Orthoptics or vision training and any associated supplemental testing.
19. For non-prescription lenses.
20. For two pairs of glasses in lieu of bifocals.
21. For Plano lenses (lenses that have no refractive power).
22. For medical or surgical treatment of the eyes.
23. Lost or broken lenses or frames, unless the Member has reached his or her normal interval for service when seeking replacements.
24. For services or supplies not specifically listed in the Certificate.
25. Certain brands on which the manufacturer imposes a no discount policy.
26. For services or supplies combined with any other offer, coupon or in-store advertisement.

This benefit overview insert is only one piece of your entire enrollment package. Exclusions and limitations are listed in the enrollment brochure.

Anthem Blue Cross and Blue Shield is the trade name of: In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Ohio: Community Insurance Company. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWi), which underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation (Compcare), which underwrites or administers the HMO policies; and Compcare and BCBSWi collectively, which underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are the registered marks of the Blue Cross and Blue Shield Association. 5/11

Your Summary of Benefits
Technology Consulting Inc
Anthem Dental Complete

WELCOME TO YOUR DENTAL PLAN!

This 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 certificate of coverage.

Dental coverage you can count on

Your Anthem dental plan lets you visit any licensed dentist or specialist you want - with costs that are normally lower when you choose one within our large network.

Savings beyond your dental plan benefits - you get more for your money.
You pay our negotiated rate for covered services from in-network dentists even if you exceed your annual benefit maximum.

YOUR DENTAL PLAN AT A GLANCE		In-Network	Out-of-Network
Annual Benefit Maximum • Per insured person	Calendar Year	$1,000	$1,000
Annual Maximum Carryover		No	No
Orthodontic Lifetime Benefit Maximum • Per eligible insured person		$1,000	$1,000
Annual Deductible (The Deductible does not apply to Orthodontic Services) • Per insured person	Calendar Year	$50	$50
• Family maximum		3X Individual	3X Individual
Deductible Waived for Diagnostic/Preventive Services		Yes	Yes
Out-of-Network Reimbursement Options:		Prime (MAC)	

Dental Services	In-Network Anthem Pays:	Out-of-Network Anthem Pays:	Waiting Period
Diagnostic and Preventive Services • Periodic oral exam • Teeth cleaning (prophylaxis) • Bitewing X-rays: 1X per 12 months • Intraoral X-rays	100% Coinsurance	100% Coinsurance	No Waiting Period
Basic Services • Amalgam (silver-colored) Filling • Front composite (tooth-colored) Filling • Back composite Filling, Alternated to Amalgam Benefit • Simple Extractions	80% Coinsurance	80% Coinsurance	No Waiting Period
Endodontics • Root Canal	80% Coinsurance	80% Coinsurance	No Waiting Period
Periodontics • Scaling and root planing	50% Coinsurance	50% Coinsurance	No Waiting Period
Oral Surgery • Surgical Extractions	50% Coinsurance	50% Coinsurance	No Waiting Period
Major Services • Crowns	50% Coinsurance	50% Coinsurance	No Waiting Period
Prosthodontics • Dentures • Bridges • Dental implants Standard - Covered	50% Coinsurance	50% Coinsurance	No Waiting Period
Prosthetic Repairs/Adjustments	50% Coinsurance	50% Coinsurance	No Waiting Period
Orthodontic Services ·Dependent Children Only*	50% Coinsurance	50% Coinsurance	No Waiting Periods

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 certificate of coverage. In the event of a discrepancy between the information in this summary and the certificate of coverage, the certificate will prevail.

*Child orthodontic coverage begins at age eight and runs through age 18. This means that the child must have been banded between the ages of eight and 19 in order to receive coverage. If children are dependents until age 19, they can continue to receive coverage, but they must have been banded before age 19.

Emergency dental treatment for the international traveler
As an Anthem dental member, you and your eligible, covered dependents automatically have access to the International Emergency Dental Program.**
With this program, you may receive emergency dental care from our listing of credentialed dentists while traveling or working nearly anywhere in the world.

** The International Emergency Dental Program is managed by DeCare Dental, which is an independent company offering dental-management services to Anthem Blue Cross Life and Health Insurance Company.

Finding a dentist is easy.
To select a dentist by name or location, do one of the following:
• Go to anthem.com/mydentalvision
• Call Customer Service at the toll-free number listed on the back of your ID card.

TO CONTACT US:

Call	Write
Refer to the toll-free number indicated on the back of your plan ID card to speak with a U.S.-based customer service representative during normal business hours. Calling after hours? We may still be able to assist you with our interactive voice-response system.	Refer to the back of your plan ID card for the address.

Limitations & Exclusions

Limitations – Below is a partial listing of dental plan limitations when these services are covered under your plan. Please see your certificate of coverage for a full list.

Diagnostic and Preventive Services
Oral evaluations (exam) Limited to two per Calendar Year
Teeth cleaning (prophylaxis) Limited to two per Calendar Year
Intraoral X-rays, single film Limited to four films per 12-month period
Complete series X-rays (panoramic or full-mouth) Coverage Every 3 Years
Topical fluoride application Limited to once every 12 months for members through age 18

Sealants Limited to first and second molars once every 24 months per tooth for members through age 15; sealants may be covered under Diagnostic and Preventive or Basic Services.

Basic and/or Major Services***
Fillings Limited to once per surface per tooth in any 24 months
Space Maintainers Limited to extracted primary posterior teeth once per lifetime per tooth for members through age 16; Space Maintainers may be covered under Diagnostic and Preventive or Basic Services.

Crowns Limited to once per tooth in a seven-year period

Fixed or removable prosthodontics – dentures, partials, bridges, tooth implants

Covered once in any seven-year period; benefits are provided for the replacement of an existing bridge, denture or partial for members age 16 or older if the appliance is seven years old or older and cannot be made serviceable.

Root canal therapy Limited to once per lifetime per tooth; coverage is for permanent teeth only.

Periodontal surgery Limited to one complex service per single tooth or quadrant in any 36 months, and only if the pocket depth of the tooth is five millimeters or greater

Periodontal scaling and root planing Limited to once per quadrant in 36 months when the tooth pocket has a depth of four millimeters or greater
Brush Biopsy Not Covered

*****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 waiting period of up to 24 months for replacement of congenitally missing teeth or teeth extracted prior to coverage under this plan.

ADDITIONAL LIMITATION FOR ORTHODONTIC SERVICES
Orthodontia Limited to one course of treatment per member per lifetime

Exclusions – Below is a partial listing of noncovered services under your dental plan. Please see your certificate of coverage 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) Orthodontic braces, appliances and all related services

Cosmetic dentistry Services 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 Intravenous conscious sedation, IV sedation and general anesthesia when performed with nonsurgical dental care

Analgesia, analgesic agents, 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.

Extractions - Surgical removal of third molars (wisdom teeth) that do not exhibit symptoms or impact the oral health of the member

The in-network dental providers mentioned in this communication are independently contracted providers who exercise independent professional judgment. They are not agents or employees of Anthem Blue Cross Life and Health Insurance Company.

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Kentucky, Inc. Independent licensee of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Choice of dentists
While your dental plan lets you choose any dentist, you may end up paying more for a service if you visit an out-of-network dentist.

Here's why:

In-network dentists have agreed to payment rates for various services and cannot charge you more. On the other hand, out-of-network dentists don't have a contract with us and are able to bill you for the difference between the total amount we allow to be paid for a service – called the "maximum allowed amount" – and the amount they usually charge for a service. When they bill you for this difference, it's called "balance billing."

How Anthem dental decides on maximum allowed amounts
For services from an out-of-network dentist, the maximum allowed amount is determined in one of the following ways:

- Out-of-network dental fee schedule/rate developed by Anthem, which may be updated based on such things as reimbursement amounts accepted by dentists contracted with our dental plans, or other industry cost and usage data
- Information provided by a third-party vendor that shows comparable costs for dental services
- In-network dentist fee schedule

Here's an example of higher costs for out-of-network dental services

This is an example only. Your experience may be different, depending on your insurance plan, the services you receive and the dentist who provides the services.

Ted gets a crown from an out-of-network dentist, who charges $1,200 for the service and bills Anthem for that amount.
Anthem's maximum allowed amount for this dental service is $800. That means there will be a $400 difference, which the dentist can "balance bill" Ted.

Since Ted will also need to pay $400 coinsurance, the total he'll pay the out-of-network dentist is $800.
Here's the math:

- Dentist's charge: $1,200
- Anthem's maximum allowed amount: $800
- Anthem pays 50%: $400
- Ted pays 50% (coinsurance): $400
- Balance Ted owes the provider: $1,200 - $800 = $400
- Ted's total cost: $400 coinsurance + $400 provider balance = $800

In the example, if Ted had gone to an in-network dentist, his cost would be only $400 for the coinsurance because he would not have been "balance billed" the $400 difference.

Enrollment Application

Group size 51-99 eligible employees

Anthem Health Plans of Kentucky, Inc.

Anthem Life Insurance Co.

Please complete in ink and return to your employer. Use extra sheets of paper if necessary. *All information given should apply to this employer.*
Anthem's Primary Care Physician (PCP) listings, for HMO/POS products can be obtained through www.anthem.com

1. Employer/Group Use:
Employer Name and Address:

Group #	Sub-group #/Life Division #	Request Effective Date	Life Classification	Applicant #/Dept. name
		/ /		

Anthem use: Plan	Health Effective Date	Life Effective Date	Dental Effective Date	Vision Effective Date	PCP	COB	Pre-ex (date)
	/ /	/ /	/ /	/ /	☐Yes ☐No	☐Yes ☐No	/ /

2. Reason for Application

☐ New enrollment
☐ Annual open enrollment (N/A to Life)
☐ COBRA
Qualifying event ______________ Event date ___/___/___
☐ Waiver
☐ New hire
☐ Rehire (date) ___/___/___
☐ Add dependent (see section 3)

3. Status Change/Event

Event date ___/___/___
☐ Marriage
☐ Birth
☐ Adoption*
☐ Legal Guardianship*
☐ Other __________
Include legal documentation.

4. Type of Coverage/Plan

Health Coverage

☐ HMO* ☐ POS* ☐ PPO
☐ Anthem Essential℠ PPO ☐ Blue Traditional®
☐ Blue Access℠ Hospital Surgical PPO
☐ Lumenos® Health Savings Account
☐ Lumenos® Health Reimbursement Account
☐ Lumenos® Health Incentive Account
☐ Lumenos® Health Incentive Account Plus
☐ Employee only
☐ Employee + spouse
☐ Employee + child(ren)
☐ Family coverage
☐ No coverage
Anthem will facilitate the opening of a Health Savings Account in your name, if directed by your Employer.

Dental Coverage

☐ PPO
☐ Dental Blue®
☐ Dental Blue® 100
☐ Dental Blue® 100/200/300
☐ Employee only
☐ Employee + spouse
☐ Employee + child(ren)
☐ Family coverage
☐ No coverage

Vision Coverage

☐ Vision
☐ Employee only
☐ Employee + spouse
☐ Employee + child(ren)
☐ Family coverage
☐ No coverage

Life Coverage

☐ Life (see section 8)

5. Employee Information **Only complete Primary Care Physician (PCP) information if enrolling in HMO or POS products.*

Last name	First name, M.I.	Date of birth	Age	Sex	Social Security # (required)		Height	Weight
		/ /		☐ M ☐ F	- -	☐ Single ☐ Divorced ☐ Married		

Home address	City	State	Zip code	County (KY residents include Municipality)

Home telephone	Business telephone	eMail Address
( )	( )	

Are you: Retired?	Disabled?	Hospitalized?	Occupation	Full time hire date	Hours working per week	Income reported by:
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		/ /		☐ W2 ☐ 1099 ☐ Other: ________

Anthem PCP name and address*	Anthem PCP ID number*	New patient?*
		☐ Yes ☐ No

6. Family Information **Spouse and dependents to be covered (Attach a separate sheet if necessary)* Only complete Primary Care Physician (PCP) information if enrolling in HMO or POS products.*

*** Please read the Genetic Information Non-discrimination Act (GINA) information on page 3, under Significant Terms, Conditions and Authorizations section , prior to answering the below questions.**

1 Last name	First name, M.I.	Relationship to applicant	Fulltime student?
		☐ Spouse ☐ Son ☐ Daughter ☐ Other ________	☐ Yes ☐ No

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

Date of birth	Sex	Social Security # (required for spouse/domestic partner)	Height	Weight	
/ /	☐ M ☐ F	- -			Eligible for federal income tax exemption? ☐ Yes ☐ No Court ordered health care coverage? ☐ Yes ☐ No (If yes, include legal documentation) Currently hospitalized or disabled? ☐ Yes ☐ No (If yes, give reason)

Anthem PCP name and address*	Anthem PCP ID number*	New patient?*
		☐ Yes ☐ No

2 Last name	First name, M.I.	Relationship to applicant	Fulltime student?
		☐ Spouse ☐ Son ☐ Daughter ☐ Other ________	☐ Yes ☐ No

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

Date of birth	Sex	Social Security #	Height	Weight	
/ /	☐ M ☐ F	- -			Eligible for federal income tax exemption? ☐ Yes ☐ No Court ordered health care coverage? ☐ Yes ☐ No (If yes, include legal documentation) Currently hospitalized or disabled? ☐ Yes ☐ No (If yes, give reason)

Anthem PCP name and address*	Anthem PCP ID number*	New patient?*
		☐ Yes ☐ No

NAME ______________________ SSN ______________

3 Last name	First name, M.I.	Relationship to applicant ☐ Spouse ☐ Son ☐ Daughter ☐ Other ______	Fulltime student? ☐ Yes ☐ No
Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)			

Date of birth	Sex	Social Security #	Height	Weight	
/ /	☐ M ☐ F	- -			Eligible for federal income tax exemption? ☐ Yes ☐ No Court ordered health care coverage? ☐ Yes ☐ No (If yes, include legal documentation) Currently hospitalized or disabled? ☐ Yes ☐ No (If yes, give reason)

Anthem PCP name and address*	Anthem PCP ID number*	New patient?* ☐ Yes ☐ No

4 Last name	First name, M.I.	Relationship to applicant ☐ Spouse ☐ Son ☐ Daughter ☐ Other ______	Fulltime student? ☐ Yes ☐ No
Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)			

Date of birth	Sex	Social Security #	Height	Weight	
/ /	☐ M ☐ F	- -			Eligible for federal income tax exemption? ☐ Yes ☐ No Court ordered health care coverage? ☐ Yes ☐ No (If yes, include legal documentation) Currently hospitalized or disabled? ☐ Yes ☐ No (If yes, give reason)

Anthem PCP name and address*	Anthem PCP ID number*	New patient?* ☐ Yes ☐ No

5 Last name	First name, M.I.	Relationship to applicant ☐ Spouse ☐ Son ☐ Daughter ☐ Other ______	Fulltime student? ☐ Yes ☐ No
Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)			

Date of birth	Sex	Social Security #	Height	Weight	
/ /	☐ M ☐ F	- -			Eligible for federal income tax exemption? ☐ Yes ☐ No Court ordered health care coverage? ☐ Yes ☐ No (If yes, include legal documentation) Currently hospitalized or disabled? ☐ Yes ☐ No (If yes, give reason)

Anthem PCP name and address*	Anthem PCP ID number*	New patient?* ☐ Yes ☐ No

6 Last name	First name, M.I.	Relationship to applicant ☐ Spouse ☐ Son ☐ Daughter ☐ Other ______	Fulltime student? ☐ Yes ☐ No
Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)			

Date of birth	Sex	Social Security #	Height	Weight	
/ /	☐ M ☐ F	- -			Eligible for federal income tax exemption? ☐ Yes ☐ No Court ordered health care coverage? ☐ Yes ☐ No (If yes, include legal documentation) Currently hospitalized or disabled? ☐ Yes ☐ No (If yes, give reason)

Anthem PCP name and address*	Anthem PCP ID number*	New patient?* ☐ Yes ☐ No

NAME ______________________ SSN ______________

7. Life and Disability Insurance

☐ Basic Life ☐ Basic AD&D ☐ Short Term Disability____% ☐ Dependent Life ☐ Supplemental AD&D ☐ Long Term Disability____% ☐ Supplemental Life: ________ x annual earnings OR $ ________ ☐ Current Income: $ ________ ☐ *Hour* ☐ *Week* ☐ *Month* ☐ *Year*	☐ Anthem By Design® Short Term Disability-BUY UP ☐ Anthem By Design® Long Term Disability-BUY UP ☐ Anthem By Design® Basic Life-BUY UP (Complete separate election form)	Life Class Are you currently active at work? ☐ Yes ☐ No If no, reason: ________

	Last name	First name, M.I.	Social Security #	Relationship to applicant	Age
Primary Beneficiary			- -		
Contingent Beneficiary			- -		

8. Other Health Coverage ***Please check one:*** ☐ *YES (completed below.)* ☐ *NO*

On the day your coverage begins, list family members, including yourself, who will be covered by any other health coverage.

Provide name, phone number and address of the HMO or insurance company	Policy/certificate number	Effective date
		/ /

Policy/certificate holder's name	Social Security number	Date of birth	Relationship to applicant
	– –	/ /	

If you and/or your dependents are enrolled in Medicare or Medicaid, complete the following.

Enrollee's name(s)	Medicare / Medicaid ID#	Medicare Part A effective date	Medicare Part B effective date	ESRD onset date
		/ /	/ /	/ /
		/ /	/ /	/ /
Medicare Part D ID#	**Medicare Part D Carrier**	**Medicare Part D effective date**	**Medicare Part D term date**	
		/ /	/ /	

Reason for Medicare entitlement: ☐ Age ☐ Disability ☐ ESRD & Disability ☐ End Stage Renal Disease (ESRD)

9. Prior Health Coverage ***Please check one:*** ☐ *YES (completed below.)* ☐ *NO*

	Group name/ID#	Dates Policy in effect:
Have you been covered by Anthem within the past two (2) years? ☐ Yes ☐ No Policy/Certificate #:		/ / — / /
Have you and / or your dependents had prior coverage with another carrier(s) within the past two (2) years? ☐ Yes ☐ No	List prior carrier(s)	Dates Policy in effect: / / — / /

Please check the type of prior coverage ☐ Employee ☐ Employee / Spouse ☐ Employee / Child(ren) ☐ Employee / Spouse / Child(ren)

Termination reason: ☐ Divorce/legal separation ☐ Death of spouse ☐ COBRA coverage exhausted ☐ Employment terminated ☐ Group plan terminated ☐ Employer/group contribution ceased ☐ Other:

Significant Terms, Conditions and Authorizations (TERMS) *Please read this section carefully before signing the application.*

Genetic Information Non-discrimination Act (GINA): When answering questions on this enrollment application the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will only be considered and applied to the individual in question.

Health Savings Account Notice: Except as otherwise provided in any agreement between me and *the financial custodian,* the custodian of my Health Savings Account (HSA), I understand that my authorization is required before *the financial custodian* may provide Anthem Blue Cross Blue Shield with information regarding my HSA. I hereby authorize *the financial custodian* to provide Anthem Blue Cross Blue Shield with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide Anthem Blue Cross Blue Shield with a written request to revoke my authorization at any time.

1. I may not assign any payment under my Anthem Blue Cross and Blue Shield program unless allowable by law.
2. I authorize deduction from my wages/pension, if necessary for the required premium for the coverage for which I, or any dependents have applied.
3. I am applying for the coverage selected on this application. If I select a coverage, or combination of coverages, not available to me and / or a class for which I am not eligible, I agree that my selection(s) is hereby automatically amended to be consistent with the employer's application.
4. I understand that, to the extent permitted by law, Anthem reserves the right to accept or decline this application (and that Anthem Life Insurance Company may accept only certain persons or conditions for coverage) and that no right whatsoever is created by this application. I also understand that this coverage, if approved, may exclude coverage for pre-existing conditions.
5. I am responsible to timely notify my employer of any change that would make me or any dependent ineligible for coverage.

NAME ______________________________ SSN ____________________

6. By signing this application, I agree and consent to the recording and / or monitoring of any telephone conversation between Anthem and myself.

   I acknowledge that I have read the Significant Terms, Conditions and Authorizations, and I accept such provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and I understand they are being relied on by Anthem in accepting this application. I understand that any misstatements or failure to report new medical information prior to my effective date may result in a material change to coverage or premium rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits or rescission or cancellation of my coverage(s).

Kentucky: Any person who knowingly and with intent to defraud any insurance company, health maintenance organization, self-insured plan, or other person, files an application for insurance or other form of health care coverage containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

I give this authorization for and on behalf of any eligible dependents and myself if covered by the Plan. I am acting as their agent and representative.

Your health coverage will be provided by one of the following companies based upon the state in which your employer, trust or association is located:

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Kentucky, Inc.

Thank you for choosing Anthem Blue Cross and Blue Shield

10. Read the TERMS section above carefully before signing. Please review your application for errors or omissions.

By signing this, I am indicating that I have read and understand the language in the TERMS section of this application and agree to all of its terms.

Applicant Signature	Date / /

11. Waiver of coverage for employee and / or any eligible dependent not enrolling

Check all that apply. Waiving: ☐ Health ☐ Dental ☐ Vision ☐ Life ☐ All	
Name of person waiving	Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None
Employer name	Carrier: ☐ Anthem (give certificate/policy #) ☐ Other carrier (give name, ID #)
Check all that apply. Waiving: ☐ Health ☐ Dental ☐ Vision ☐ Life ☐ All	
Name of person waiving	Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None
Employer name	Carrier: ☐ Anthem (give certificate/policy #) ☐ Other carrier (give name, ID #)
Check all that apply. Waiving: ☐ Health ☐ Dental ☐ Vision ☐ Life ☐ All	
Name of person waiving	Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None
Employer name	Carrier: ☐ Anthem (give certificate/policy #) ☐ Other carrier (give name, ID #)
Check all that apply. Waiving: ☐ Health ☐ Dental ☐ Vision ☐ Life ☐ All	
Name of person waiving	Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None
Employer name	Carrier: ☐ Anthem (give certificate/policy #) ☐ Other carrier (give name, ID #)

Check all that apply

☐ I certify that I have been given an opportunity to apply for Anthem Blue Cross and Blue Shield coverage and after careful consideration, have decided not to take advantage of this offer. In the event I wish to apply for such coverage hereafter, I may do so, subject to established procedures.
If I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that enrollment is requested within 31 days after other coverage ends. My dependent(s) or I may be subject to pre-existing condition restrictions or waiting periods specified in the group certificate, if a dependent or I are late enrollees. In addition, if I have a dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 31 days after the marriage, birth, adoption or placement of adoption.
I also understand that my dependents and I may enroll under two additional circumstances:

- Either my or my dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- My dependent or I become eligible for a subsidy (state premium assistance program)

In these cases, I may be able to enroll myself and my dependents provided that I request enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

☐ I certify that I have been given an opportunity to apply for the available group life benefits offered by my employer/group, the benefits have been explained to me, and I and / or my dependent(s) decline to participate. Neither my dependent(s) nor I were induced or pressured by my employer/group, agent or life carrier, into declining this coverage, but elected of my (our) own accord to decline coverage. I understand that if I wish to apply for such coverage in the future, I may be required to provide evidence of insurability at my expense.

Applicant Signature	Date / /

Life and Disability products underwritten by Anthem Life Insurance Company. Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Kentucky, Inc. Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Anthem Health Plans of Kentucky, Inc: 13550 Triton Park Blvd, Louisville, KY 40223
Anthem Life Insurance Company: 6740 N. High Street, Suite 200, Worthington, OH 43085

Anthem Additional Term Life
Spousal/Dependent Life Enrollment Application

Employee Name ____

.

Please indicate the buy-up extra life insurance, at your own cost. (See attached sheet for rates)

$50,000.00 _______ No Personal Health Statement Needed.

1x's salary _______ Personal Health Statement required
2x's salary _______
3x's salary _______

*No additional coverage _______

*** 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.

No coverage______

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)*see page 2**

____
(Name of dependent and amount)

____
(Name of dependent and amount)

These can be purchased in $5000 increments up to $10,000**.** **No coverage______**

Signature ____ **Date** __________________

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

18 Chestnut Street, Worcester, MA 01608-1528

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

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

Coverage	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	☐	☒

Coverage	Request	Refuse
Employee Supplemental AD&D	☐ $______	X☐
Supplemental Dependent Life or Life/AD&D Spouse	☐ $______	X☐
Spouse Date of Birth: ______ (No AD&D) Child	☐ $______	X☐
Voluntary Life	☐ $______	X☐
Voluntary Dependent Life	☐	X☐
Voluntary AD&D	☐ $______	X☐
Voluntary AD&D Family Plan	☐	X☐
Dental	☐	X☐
Dependent Dental Spouse	☐	X☐
Dependent Dental Children	☐	X☐

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:

Do Not Use this Area

☐ 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

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