

**Employee benefits for the
U.S. employees of
HIGHBROW TECH LLC**

Employee Benefits

Version 1.1



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Welcome To HIGHBROW TECH LLC

HIGHBROW TECH LLC was founded by professionals with deep industry experience. The management team at HIGHBROW TECH LLC has extensive experience, having worked for many clients during the last 15+ years. During this period, they have worked on complex projects across multiple technology platforms. From an employer's perspective you need a partner to help maximize the value of your most important asset – your people. Look no further than the Highbrow team, as our strong experience across a variety of disciplines backed by an innovative use of technology enables us to deliver results that add value directly to your business

Founding Principles

One of our founding principles is the desire to understand our clients' needs. It is only then when we are able to offer a solution that matches a client's specific individual requirements. Delivering the desired results and ensuring that whatever your staffing needs is results in only one outcome: success. Highbrow brings a unique combination of experience and intuitive use of technology to deliver results. First, your needs are analyzed and evaluated. Based on your desired outcomes, we conduct a search of our extensive active database of "ready to work" candidates, providing you a quick and measured response. Not only are we able to leverage our collective marketing, sales, and recruitment experience into delivering your ultimate solution, but we are also able to enhance that solution through the additional skills and attributes of our excellent staffing database.

Paid Leave Benefit

- Typically, employee can avail 2 types of leaves
 1. Privilege leave
 2. Sick leave
- All leave calculations are done as per calendar year i.e. January 01 to December 31.
- Leaves will be credited to the employees account from date of joining on pro-rata basis.
- It is the employee's responsibility to regularize their attendance and maintain timely communication with their respective supervisors and the Human Resource department regarding their leaves.
- Employees in Probation / Trainees are not eligible for above categories of leaves, until they are confirmed as permanent employees. However, leaves may be sanctioned on an advance basis, depending upon the need /merit, by the management and the balance for the same will be adjusted when the employee is confirmed.

1. PTO:

- PTO leaves are accrued per month by all employees
- Every employee is entitled to take PTO leave as per mentioned on offer letter. (on pro-rata for new joinees)
- Employees are encouraged to plan their privilege leaves well in advance and inform manager appropriately.
- Un-availed PTO's cannot be carry forward. It will lapse, unless the same is availed by December 31 (i.e. at the end of the calendar year)

2. Sick Leave:

Specified limit as per mentioned on offer letter

- If an employee has to take or has taken Sick Leave for three or more days, he/she must submit the Medical Certificate along with the leave application form.
- In case of sickness, the employee is required to inform their immediate Manager on the same day.
- Sick Leave form must be submitted for sanction immediately on resuming the duties.
- Un-availed Sick Leave cannot be carry forward. It will lapse, unless the same is availed by December 31 (i.e. at the end of the calendar year)

Health Care Benefit Summary

Service Provider: United HealthCare Services, Inc

For Employee Employee Enrollment Form: Contact HR Team

What is a benefit summary?

This is a summary of what the plan does and does not cover. This summary can also help you understand your share of the costs. It's always best to review your Certificate of Coverage (COC) and check your coverage before getting any health care services, when possible.

What are the benefits of the Choice Plus Plan?

Get more protection with a national network and out-of-network coverage.

A network is a group of health care providers and facilities that have a contract with UnitedHealthcare. You can receive care and services from anyone in or out of our network, but you save money when you use the network.

- > **There's coverage if you need to go out of the network.** Out-of-network means that a provider does not have a contract with us. Choose what's best for you. Just remember out-of-network providers will likely charge you more.
- > **There's no need to choose a primary care provider (PCP) or get referrals to see a specialist.** Consider a PCP; they can be helpful in managing your care.
- > **Preventive care is covered 100% in our network.**

Are you a member?

Easily manage your benefits online at myuhc.com[®] and on the go with the **UnitedHealthcare Health4Me**[®] mobile app.

For questions, call the member phone number on your health plan ID card.

Not enrolled yet? Learn more about this plan and search for network doctors or hospitals at welcometouhc.com/choiceplus or call **1-866-873-3903**, TTY 711, 8 a.m. to 8 p.m. local time, Monday through Friday.

Benefits At-A-Glance

What you may pay for network care

This chart is a simple summary of the costs you may have to pay when you receive care in the network. It doesn't include all of the deductibles and co-payments you may have to pay. You can find more benefit details beginning on page 2.

Co-payment	Individual Deductible	Co-insurance
(Your cost for an office visit)	(Your cost before the plan starts to pay)	(Your cost share after the deductible)
\$30	\$500	20%

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage for certain conditions. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Schedule of Benefits, Riders, and/or Amendments, those documents are correct. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

UnitedHealthcare Insurance Company

Your Costs

In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Annual Deductible		
What is an annual deductible?		
The annual deductible is the amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. It does not include any amount that exceeds Allowed Amounts. The deductible may not apply to all Covered Health Care Services. You may have more than one type of deductible.		
<ul style="list-style-type: none"> > Your co-pays don't count towards meeting the deductible unless otherwise described within the specific covered health care service. > All individual deductible amounts will count towards meeting the family deductible, but an individual will not have to pay more than the individual deductible amount. 		
Medical Deductible - Individual	\$500 per year	\$1,000 per year
Medical Deductible - Family	\$1,000 per year	\$2,000 per year
Dental - Pediatric Services Deductible - Individual	Included in your medical deductible.	Included in your medical deductible.
Dental - Pediatric Services Deductible - Family	Included in your medical deductible.	Included in your medical deductible.

Out-of-Pocket Limit		
What is an out-of-pocket limit?		
The Out-of-Pocket Limit is the maximum you pay per year. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year.		
<ul style="list-style-type: none"> > All individual out-of-pocket limit amounts will count towards meeting the family out-of-pocket limit, but an individual will not have to pay more than the individual out-of-pocket limit amount. > Your co-pays, co-insurance and deductibles (including pharmacy) count towards meeting the out-of-pocket limit. 		
Out-of-Pocket Limit - Individual	\$7,000 per year	\$14,000 per year
Out-of-Pocket Limit - Family	\$14,000 per year	\$28,000 per year

Your Costs

What is co-insurance?

Co-insurance is the amount you pay each time you receive certain Covered Health Care Services calculated as a percentage of the Allowed Amount (for example, 20%). You pay co-insurance plus any deductibles you owe. Co-insurance is not the same as a co-payment (or co-pay).

What is a co-payment?

A Co-payment is the amount you pay each time you receive certain Covered Health Care Services calculated as a set dollar amount (for example, \$50). You are responsible for paying the lesser of the applicable Co-payment or the Allowed Amount. Please see the specific Covered Health Care Service to see if a co-payment applies and how much you have to pay.

What is Prior Authorization?

Prior Authorization is getting approval before you receive certain Covered Health Care Services. Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However there are some Benefits that you are responsible for obtaining authorization before you receive the services. Please see the specific Covered Health Care Service to find services that require you to obtain prior authorization.

Want more information?

Find additional definitions in the glossary at justplainclear.com.

Your Costs

Following is a list of services that your plan covers in alphabetical order. In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Acupuncture Services		
Limited to 12 treatments per year. Benefits for acupuncture for the treatment of Chemical Dependency as described under Mental health Care and Substance-Related and Addictive Disorders Services are not subject to the limit stated above.	\$30 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Ambulance Services		
Emergency Ambulance:	20% co-insurance, after the medical deductible has been met.	20% co-insurance, after the network medical deductible has been met.
Non-Emergency Ambulance:	20% co-insurance, after the medical deductible has been met. Prior Authorization is required for Non-Emergency Ambulance.	20% co-insurance, after the network medical deductible has been met. Prior Authorization is required for Non-Emergency Ambulance.
Cellular and Gene Therapy		
For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Facility.	The amount you pay is based on where the covered health care service is provided. Benefits will be the same as those stated under Hospital - Inpatient Stay; Lab, X-Ray and Diagnostics - Outpatient; Physician Fees for Surgical and Medical Services; and Physician Office Services - Sickness and Injury. Prior Authorization is required.	Out-of-Network Benefits are not available.
Clinical Trials		
	The amount you pay is based on where the covered health care service is provided. Benefits will be the same as those stated under Hospital - Inpatient Stay; Lab, X-Ray and Diagnostics - Outpatient; Physician Fees for Surgical and Medical Services; and Physician Office Services - Sickness and Injury. Prior Authorization is required.	Prior Authorization is required.
Congenital Heart Disease (CHD) Surgeries		
	Benefits will be the same as stated under Hospital - Inpatient Stay. Prior Authorization is required.	
Dental - Pediatric Services (Benefits covered up to age 19)		
Benefits provided by the National Options PPO 30 Network (PPO-UCR 50th).		

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Dental - Pediatric Preventive Services		
Dental Prophylaxis (Cleanings) Limited to two times every 12 months.	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Fluoride Treatments Limited to three times every 12 months.	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Space Maintainers (Spacers)	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Dental - Pediatric Diagnostic Services		
Evaluations (Check-up Exams) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Intraoral Radiographs (X-ray) Limited to 2 series of films per 12 months for Bitewings and 1 time per 36 months for Panoramic radiograph image.	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Dental - Pediatric Basic Dental Services		
Endodontics (Root Canal Therapy)	40% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Adjunctive Services <u>Palliative (Emergency) Treatment:</u> Covered as a separate Benefit only if no other services (other than the exam and radiographs) were done on the tooth during the visit. <u>General Anesthesia:</u> Covered only when clinically Necessary. <u>Occlusal Guard:</u> Limited to one guard every 12 months.	40% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Oral Surgery	40% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Periodontics <u>Periodontal Surgery:</u> Limited to one every 36 months per surgical area. <u>Scaling and Root Planing:</u> Limited to one time per quadrant every 24 months. <u>Periodontal Maintenance:</u> Limited to four times every 12 months in combination with prophylaxis.	40% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Minor Restorative Services (Amalgam or Anterior Composite)	40% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Simple Extractions (Simple tooth removal) Limited to one time per tooth per lifetime.	40% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Dental - Pediatric Major Restorative Services		
Crowns/Inlays/Onlays Limited to one time per tooth every 60 months.	50% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Removable Dentures (Full denture/partial denture) Limited to a frequency of one every 60 months.	50% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Bridges (Fixed partial dentures)	50% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Implant Procedures Limited to one time every 60 months.	50% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Dental - Pediatric Medically Necessary Orthodontics		
Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies.	50% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
	Prior Authorization is required for orthodontic treatment.	Prior Authorization is required for orthodontic treatment.
Dental Services - Accident Only		
	20% co-insurance, after the medical deductible has been met.	20% co-insurance, after the network medical deductible has been met.
Dental Services - Hospitalization and Anesthesia		
	The amount you pay is based on where the covered health care service is provided. Benefits will be the same as those stated under Hospital - Inpatient Stay; Physician Fees for Surgical and Medical Services; and Surgery - Outpatient.	
		Prior Authorization is required for Inpatient Stay.
Diabetes Services		
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care:	The amount you pay is based on where the covered health care service is provided. Benefits will be the same as those stated under Physician Office Services - Sickness and Injury.	
Diabetes Self-Management Items:	The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies in this Schedule of Benefits or as described under the Outpatient Prescription Drug Schedule of Benefits.	
		Prior Authorization is required for DME that costs more than \$1,000.
Durable Medical Equipment (DME), Orthotics and Supplies		
	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
		Prior Authorization is required for DME or orthotics that costs more than \$1,000.
Emergency Health Care Services - Outpatient		
	20% co-insurance, after the medical deductible has been met.	20% co-insurance, after the network medical deductible has been met.
		Notification is required if confined in an Out-of-Network Hospital.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Formulas for Phenylketonuria (PKU)		
	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
		Prior Authorization is required.
Gender Dysphoria		
	The amount you pay is based on where the covered health care service is provided and in the Outpatient Prescription Drug Rider. Benefits will be the same as those stated under Durable Medical Equipment (DME), Orthotics and Supplies, Hospital - Inpatient Stay; Lab, X-Ray and Diagnostic - Outpatient; Major Diagnostic and Imaging - Outpatient; Mental Health Care and Substance-Related and Addictive Disorders Services; Pharmaceutical Products - Outpatient; Physician Fees for Surgical and Medical Services; Physician's Office Services - Sickness and Injury; Surgery - Outpatient; Prosthetic Devices; and/or Reconstructive Procedures.	
	Prior Authorization is required for certain services.	Prior Authorization is required for certain services.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Habilitative Services		
<p>Inpatient: Habilitative services received during an Inpatient Stay in an Inpatient Rehabilitative Facility are limited to 30 days per year.</p>	<p>The amount you pay is based on where the covered health care service is provided. Benefits will be the same as those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services.</p>	
<p>Outpatient: Outpatient therapies are limited per year as follows: 25 visits for any combination of physical therapy, occupational therapy and speech therapy. 30 visits of post-cochlear implant aural therapy. 20 visits of cognitive rehabilitation therapy. 12 visits of Manipulative Treatments.</p>	<p>\$30 co-pay per visit. A deductible does not apply.</p>	<p>50% co-insurance, after the medical deductible has been met.</p>
<p>The limits stated above do not apply to Applied Behavioral Analysis or other therapy services for treatment of autism spectrum disorder diagnoses, subject to medical necessity and clinical appropriateness. The limits above do not apply to Neurodevelopmental therapy or other types of therapy which may be provided as treatment of autism spectrum disorder or other mental health diagnoses if the therapy is deemed medically necessary and appropriate.</p>	<p>Prior Authorization is required for certain Inpatient services.</p>	
Hearing Aids		
<p>Limited to \$5,000 every year. Benefits are further limited to a single purchase per hearing impaired ear every year. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.</p>	<p>20% co-insurance, after the medical deductible has been met.</p>	<p>50% co-insurance, after the medical deductible has been met.</p>

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Home Health Care		
<p>Limited to 130 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.</p> <p>To receive Network Benefits for the administration of intravenous infusion, you must receive services from a provider we identify.</p>	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
		Prior Authorization is required.
Hospice Care		
	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
		Prior Authorization is required for Inpatient Stay.
Hospital - Inpatient Stay		
	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
		Prior Authorization is required.
Lab, X-Ray and Diagnostic - Outpatient		
<p>Lab Testing - Outpatient: Limited to 18 Presumptive Drug Tests per year. Limited to 18 Definitive Drug Tests per year.</p> <p>X-Ray and Other Diagnostic Testing - Outpatient:</p>	<p>\$15 co-pay per service. A deductible does not apply.</p> <p>\$50 co-pay per service. A deductible does not apply.</p>	<p>50% co-insurance, after the medical deductible has been met.</p> <p>50% co-insurance, after the medical deductible has been met.</p> <p>Prior Authorization is required for sleep studies, stress echocardiography and transthoracic echocardiogram services.</p>
Major Diagnostic and Imaging - Outpatient		
	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
		Prior Authorization is required.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Mental Health Care and Substance - Related and Addictive Disorders Services		
Inpatient:	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Outpatient:	\$30 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain Inpatient, Outpatient and Partial Hospitalization/Intensive Outpatient Treatment services.
Neurodevelopment Therapy		
	\$30 co-pay per visit for a primary care physician office visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Ostomy Supplies		
	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Pharmaceutical Products - Outpatient		
This includes medications given at a doctor's office, or in a Covered Person's home.	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Physician Fees for Surgical and Medical Services		
	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Physician's Office Services - Sickness and Injury		
	\$30 co-pay per visit for a primary care physician office visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
	\$50 co-pay per visit for a specialist office visit. A deductible does not apply.	Prior Authorization is required for Genetic Testing.

Additional co-pays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Pregnancy - Maternity Services		
	<p>The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. Benefits will be the same as those stated under Hospital - Inpatient Stay; Lab, X-Ray and Diagnostics - Outpatient; Physician Fees for Surgical and Medical Services; and Physician Office Services - Sickness and Injury.</p>	<p>Prior Authorization is required if the stay in the hospital is longer than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.</p>
Prescription Drug Benefits		
Prescription drug benefits are shown in the Prescription Drug benefit summary.		
Preventive Care Services		
Physician Office Services, Lab, X-Ray or other preventive tests.	You pay nothing. A deductible does not apply.	Out-of-Network Benefits are not available.
<p>Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a co-pay, co-insurance or deductible.</p>		
Prosthetic Devices		
	20% co-insurance, after the medical deductible has been met.	<p>50% co-insurance, after the medical deductible has been met.</p> <p>Prior Authorization is required for Prosthetic Devices that costs more than \$1,000.</p>
Reconstructive Procedures		
	<p>The amount you pay is based on where the covered health care service is provided. Benefits will be the same as those stated under Hospital - Inpatient Stay; Lab, X-Ray and Diagnostics - Outpatient; Physician Fees for Surgical and Medical Services; Physician Office Services - Sickness and Injury and Prosthetic Devices.</p>	
	<p>Prior Authorization is required.</p>	

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Telemedicine Services		
	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Temporomandibular Joint Services		
	The amount you pay is based on where the covered health care service is provided. Benefits will be the same as those stated under Hospital - Inpatient Stay; Lab, X-Ray and Diagnostics - Outpatient; Physician Fees for Surgical and Medical Services; Physician Office Services - Sickness and Injury and Surgery - Outpatient.	Prior Authorization is required for Inpatient Stay.
Therapeutic Treatments - Outpatient		
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Transplantation Services		
Network Benefits must be received from a Designated Facility.	The amount you pay is based on where the covered health care service is provided. Benefits will be the same as those stated under Hospital - Inpatient Stay; Lab, X-Ray and Diagnostics - Outpatient; Physician Fees for Surgical and Medical Services; Physician Office Services - Sickness and Injury and Surgery - Outpatient. Prior Authorization is required.	Out-of-Network Benefits are not available.
Urgent Care Center Services		
Additional co-pays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery and lab work.	\$50 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Virtual Visits		
<p>Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.</p>	<p>\$10 co-pay per visit. A deductible does not apply.</p>	<p>Out-of-Network Benefits are not available.</p>
Vision - Pediatric Services (Benefits covered up to age 19)		
<p>Find a listing of Spectera Eyecare Network Vision Care Providers at myuhcvision.com.</p>		
<p>Routine Vision Exam Limited to once every 12 months.</p>	<p>You pay nothing. A deductible does not apply.</p>	<p>50% co-insurance, after the medical deductible has been met.</p>
<p>Eyeglass Lenses Limited to once every 12 months.</p>	<p>You pay nothing. A deductible does not apply.</p>	<p>50% co-insurance, after the medical deductible has been met.</p>
<p>Lens Extras Limited to once every 12 months. Coverage includes polycarbonate lenses and standard scratch-resistant coating.</p>	<p>You pay nothing. A deductible does not apply.</p>	<p>You pay nothing, after the medical deductible has been met.</p>
<p>Eyeglass Frames Limited to once every 12 months.</p>	<p>You pay nothing. A deductible does not apply.</p>	<p>50% co-insurance, after the medical deductible has been met.</p>
<p>Contact Lenses/Necessary Contact Lenses You are eligible to choose only one of either eyeglasses (Eyeglass Lenses and/or Eyeglass Frames) or Contact Lenses. If you choose more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service. Fitting and evaluation limited to once every 12 months. Limited to a 12 month supply. Find a complete list of covered contacts at myuhcvision.com.</p>	<p>You pay nothing. A deductible does not apply.</p>	<p>50% co-insurance, after the medical deductible has been met.</p>
<p>Low Vision Services Limited to once every 24 months.</p>	<p>You pay nothing for Low Vision Testing. A deductible does not apply. You pay nothing for Low Vision Therapy. A deductible does not apply.</p>	<p>You pay nothing for Low Vision Testing. A deductible does not apply. You pay nothing for Low Vision Therapy. A deductible does not apply.</p>

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

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

Dental Plan:

Consumer MaxMultiplier Options PPO 30/covered dental services

P3436 /U85

	NETWORK	NON-NETWORK
Individual Annual Deductible	\$50	\$50
Family Annual Deductible	\$150	\$150
Annual Maximum Benefit* <i>(The total benefit payable by the plan will not exceed the highest listed maximum amount for either Network or Non-Network services.)</i>	\$1500 per person per calendar year	\$1500 per person per calendar year
Annual Deductible Applies to Preventive and Diagnostic Services	No	
Waiting Period	No waiting period	

COVERED SERVICES**	NETWORK PLAN PAYS***	NON-NETWORK PLAN PAYS****	BENEFIT GUIDELINES
DIAGNOSTIC SERVICES			
Periodic Oral Evaluation	100%	100%	Limited to 2 times per consecutive 12 months.
Radiographs	100%	100%	Bitewing: Limited to 1 series of films per calendar year. Complete/Panorex: Limited to 1 time per consecutive 36 months.
Lab and Other Diagnostic Tests	100%	100%	
PREVENTIVE SERVICES			
Dental Prophylaxis (Cleanings)	100%	100%	Limited to 2 times per consecutive 12 months.
Fluoride Treatments	100%	100%	Limited to covered persons under the age of 16 years and limited to 2 times per consecutive 12 months.
Sealants	100%	100%	Limited to covered persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.
Space Maintainers	100%	100%	For covered persons under the age of 16 years, limit 1 per consecutive 60 months.
BASIC DENTAL SERVICES			
Restorations <i>(Amalgam or Anterior Composite)**</i>	80%	80%	Multiple restorations on one surface will be treated as a single filling.
General Services <i>(including Emergency Treatment)</i>	80%	80%	Palliative Treatment: Covered as a separate benefit only if no other service was done during the visit other than X-rays. General Anesthesia: when clinically necessary. Occlusal Guard: Limited to 1 guard every consecutive 36 months.
Simple Extractions	80%	80%	Limited to 1 time per tooth per lifetime.
Oral Surgery <i>(includes surgical extractions)</i>	80%	80%	
Periodontics	80%	80%	Perio Surgery: Limited to 1 quadrant or site per consecutive 36 months per surgical area. Scaling and Root Planing: Limited to 1 time per quadrant per consecutive 24 months. Periodontal Maintenance: Limited to 2 times per consecutive 12 months following active and adjunctive periodontal therapy, exclusive of gross debridement.
Endodontics	80%	80%	Root Canal Therapy: Limited to 1 time per tooth per lifetime.
MAJOR DENTAL SERVICES			
Inlays/Onlays/Crowns**	50%	50%	Limited to 1 time per tooth per consecutive 60 months.
Dentures and other Removable Prosthetics	50%	50%	Full Denture/Partial Denture: Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.
Fixed Partial Dentures (Bridges)**	50%	50%	Limited to 1 time per tooth per consecutive 60 months.

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

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

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

**** The non-network percentage of benefits is based on the schedule of usual and customary fees in the geographic area in which the expenses are incurred.

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

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

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

Dental exclusions and limitations:

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

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

GENERAL LIMITATIONS

PERIODIC ORAL EVALUATION Limited to 2 times per consecutive 12 months.

COMPLETE SERIES OR PANOREX RADIOGRAPHS Limited to 1 time per consecutive 36 months.

BITEWING RADIOGRAPHS Limited to 1 series of films per calendar year.

EXTRAORAL RADIOGRAPHS Limited to 2 films per calendar year.

DENTAL PROPHYLAXIS Limited to 2 times per consecutive 12 months.

FLUORIDE TREATMENTS Limited to covered persons under the age of 16 years, and limited to 2 times per consecutive 12 months.

SPACE MAINTAINERS Limited to covered persons under the age of 16 years, limited to 1 per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.

SEALANTS Limited to covered persons under the age of 16 years, and once per first or second permanent molar every consecutive 36 months.

RESTORATIONS Multiple restorations on one surface will be treated as a single filling.

PIN RETENTION Limited to 2 pins per tooth, not covered in addition to cast restoration.

INLAYS AND ONLAYS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.

CROWNS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.

POST AND CORES Covered only for teeth that have had root canal therapy.

SEDATIVE FILLINGS Covered as a separate benefit only if no other service, other than x-rays and exam, were performed on the same tooth during the visit.

SCALING AND ROOT PLANING Limited to 1 time per quadrant per consecutive 24 months.

ROOT CANAL THERAPY Limited to 1 time per tooth per lifetime.

PERIODONTAL MAINTENANCE Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.

FULL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.

PARTIAL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.

RELINING AND REBASING DENTURES Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.

REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES

Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.

PALLIATIVE TREATMENT Covered as a separate benefit only if no other service, other than the exam and radiographs, were performed on the same tooth during the visit.

OCCUSAL GUARDS Limited to 1 guard every consecutive 36 months and only covered if prescribed to control habitual grinding.

FULL MOUTH DEBRIDEMENT Limited to 1 time every consecutive 36 months.

GENERAL ANESTHESIA Covered only when clinically necessary.

OSSEOUS GRAFTS Limited to 1 per quadrant or site per consecutive 36 months.

PERIODONTAL SURGERY Hard tissue and soft tissue periodontal surgery are limited to 1 quadrant or site per consecutive 36 months per surgical area.

REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE

PARTIAL DENTURES, CROWNS, INLAYS OR ONLAYS Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.

GENERAL EXCLUSIONS

The following are not covered:

1. Dental Services that are not necessary.
2. Hospitalization or other facility charges.
3. Any dental procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. Reconstructive Surgery regardless of whether or not the surgery is incidental to a dental disease, injury, or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any dental procedure not directly associated with dental disease.
6. Any dental procedure not performed in a dental setting.
7. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
8. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the covered person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
9. Expenses for dental procedures begun prior to the covered person becoming enrolled under the Policy.
10. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.
11. Services rendered by a provider with the same legal residence as a covered person or who is a member of a covered person's family, including spouse, brother, sister, parent or child.
12. Foreign Services are not covered unless required as an Emergency.
13. Replacement of complete dentures, fixed and removable partial dentures, or crowns, if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is necessary because of patient non-compliance, the patient is liable for the cost of replacement.
14. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
15. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
16. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
17. Placement of dental implants, implant-supported abutments and prostheses
18. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
19. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
20. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
21. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
22. Acupuncture, acupressure and other forms of alternative treatment, whether or not used as anesthesia.
23. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
24. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
25. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
26. Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

Vision Benefit Summary

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

myuhcvision.com

Plan SF020

UnitedHealthcare vision has been trusted for more than 50 years to deliver affordable, innovative vision care solutions to the nation's leading employers through experienced, customer-focused people and the nation's most accessible, diversified vision care network. In-network, covered-in-full benefits (up to the plan allowance and after applicable copay) include a comprehensive exam, eyeglasses with standard single vision, lined bifocal, lined trifocal, or lenticular lenses, standard scratch-resistant coating and the frame, or contact lenses in lieu of eyeglasses. Members age 0-12 are eligible for a 2nd exam. Members age 0-12 are also eligible for a replacement frame and lenses if they have a prescription change of 0.5 diopter or more. The 2nd exam and replacement benefits are the same as the initial exam, frame and lens benefits.

Exam with Materials	
Benefit Frequency	
Comprehensive Exam(s)	Once every 12 months
Comprehensive Exam(s) for diabetics only	Twice every 12 months
Spectacle Lenses	Once every 12 months
Frames	Once every 24 months
Contact Lenses in Lieu of Eyeglasses	Once every 12 months
In-Network Services	
Copays	
Exam(s)	\$ 10.00
Materials	\$ 25.00
Retinal Screening for Diabetics	\$ 0.00
Frame Benefit (for frames that exceed the allowance, an additional 30% discount may be applied to the overage)¹	
Private Practice Provider	\$130.00 retail frame allowance
Retail Chain Provider	\$130.00 retail frame allowance
Lens Options	
Standard Scratch-resistant Coating, Polycarbonate Lenses for Dependent Children (up to age 19) - covered in full. Other optional lens upgrades may be offered at a discount. Based on state guidelines, lens materials and options may not be available at these discounted prices at all provider locations. Please ask your provider for details. The Lens Options list can be found at myuhcvision.com.	
Contact Lens Benefit² (Formulary contact lenses refer to contact lenses available on our formulary contact list. Contact lenses not on this list are referred to as Non-Formulary. A copy of the list can be found at myuhcvision.com).	
Formulary contact lenses The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full after copay (if applicable).	If you choose disposable contacts, up to 4 boxes are included when obtained from an in-network provider.
Non-Formulary contact lenses An allowance is applied toward the purchase of contact lenses outside the Formulary. Material copay (if applicable) is waived.	\$105.00
Necessary contact lenses³	Covered in full after copay (if applicable).
Out-of-Network Reimbursements (Copays do not apply)	
Exam(s)	Up to \$40.00
Frames	Up to \$45.00
Single Vision Lenses	Up to \$40.00
Lined Bifocal Lenses	Up to \$60.00
Lined Trifocal Lenses	Up to \$80.00
Lenticular Lenses	Up to \$80.00
Elective Contacts in Lieu of Eyeglasses ²	Up to \$105.00
Necessary Contacts in Lieu of Eyeglasses ³	Up to \$210.00

Discounts	
Laser vision	UnitedHealthcare has partnered with the Laser Vision Network of America (LVNA) to provide our members with access to discounted laser vision correction providers. Members receive 15% off standard or 5% off promotional pricing at more than 550 network provider locations and even greater discounts through set pricing at Lasik/Plus® locations. For more information, call 1-888-563-4497 or visit us at www.uhclasik.com .
Additional Material	At a participating in-network provider you will receive up to a 20% discount on an additional pair of eyeglasses or contact lenses. This program is available after your vision benefits have been exhausted. Please note that this discount shall not be considered insurance, and that UnitedHealthcare shall neither pay nor reimburse the provider or member for any funds owed or spent. Additional materials do not have to be purchased at the time of initial material purchase.
Hearing Aids	As a UnitedHealthcare vision plan member, you can save on high-quality hearing aids when you buy them from hi HealthInnovations™. To find out more go to hiHealthInnovations.com . When placing your order use promo code myVision to get the special price discount.

¹30% discount available at most participating in-network provider locations. May exclude certain frame manufacturers. Please verify all discounts with your provider.

²Contact lenses are in lieu of eyeglass lenses and/or eyeglass frames. Coverage for Formulary contact lenses does not apply at Costco, Walmart or Sam's Club locations. The allowance for Non-Formulary contact lenses applies to materials. No portion will be exclusively applied to the fitting and evaluation.

³Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with eyeglass lenses and/or frames; with certain conditions such as anisometropia, keratoconus, irregular corneal/astigmatism, aphakia, pathological myopia, aniseikonia, aniridia, facial deformity, or corneal deformity. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare vision confirming the reimbursement that UnitedHealthcare will make before you purchase such contacts.

Important to Remember:

In-Network

- Always identify yourself as a UnitedHealthcare vision member when making your appointment. This will assist the provider in obtaining your benefit information.
- Your participating provider will help you determine which contact lenses are available in the UnitedHealthcare Formulary.
- Your \$105.00 contact lens allowance applies to materials. No portion will be exclusively applied to the fitting and evaluation. Your material copay is waived when purchasing Non-Formulary contacts.
- Patient options such as UV coating, progressive lenses, etc., which are not covered-in-full, may be available at a discount at participating providers. Based on state guidelines, lens materials and options may not be available at these discounted prices at all provider locations. Please ask your provider for details. The Lens Options list can be found at myuhcvision.com.

Choice and Access of Vision Care Providers

UnitedHealthcare offers its vision program through a national network including both private practice and retail chain providers. To access the Provider Locator service or for a printed directory, visit our website myuhcvision.com or call (800) 638-3120, 24 hours a day, seven days a week. You may also view your benefits, search for a provider or print an ID card online at myuhcvision.com.

Retain this UnitedHealthcare vision benefit summary which includes detailed benefit information and instructions on how to use the program. Please refer to your Certificate of Coverage for a full explanation of benefits.

In-Network Provider - Copays and non-covered patient options are paid to provider by program participant at the time of service.

Out-of-Network Provider - Participant pays all billed charges to the provider, and UnitedHealthcare reimburses the participant for services rendered up to the maximum allowance. Copays do not apply to out-of-network benefits. Receipts for payments should be submitted within 90 days after the date of service to the following address: UnitedHealthcare Vision, Attn. Claims Department, P.O. Box 30978, Salt Lake City, UT 84130. If it was not reasonably possible to give written proof in the time required, the Company will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, but no later than 1 year after the date of service unless the Covered Person was legally incapacitated.

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

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

Benefit Summary:

Outpatient Prescription Drug Products

Washington Plan 729

Standard Drugs: 15/40/70/300

Your Co-payment and/or Co-insurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging into your account on myuhc.com[®] or calling the Customer Care number on your ID card.

Annual Deductible - Network and Out-of-Network

Individual Deductible	See Medical Benefit Summary
Family Deductible	See Medical Benefit Summary

Out-of-Pocket Limit - Network

Individual Out-of-Pocket Limit	See the Medical Benefit Summary for the total Individual Out-of-Pocket Limit that applies.
Family Out-of-Pocket Limit	See the Medical Benefit Summary for the total Family Out-of-Pocket Limit that applies.

Out-of-Pocket Limit does not apply to Out-of-Network Charges, Ancillary Charges and Coupons.

A deductible and out-of-pocket limit may apply. Please refer to the medical plan documents for the annual deductible and out-of-pocket limit amounts, which include both medical and pharmacy expenses. This means that you will pay the full amount we have contracted with the pharmacy to charge for your prescriptions (not just your co-payment), until you have satisfied the deductible. Once the deductible is satisfied, your prescriptions will be subject to the co-payments outlined below. If you reach the out-of-pocket limit, you will not be required to pay a co-payment.

This summary of Benefits is intended only to highlight your Benefits for Outpatient Prescription Drug Products and should not be relied upon to determine coverage. Your plan may not cover all of your Outpatient Prescription Drug expenses. Please refer to your Outpatient Prescription Drug Schedule of Benefits and Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Outpatient Prescription Drug Rider or the Certificate of Coverage, the Outpatient Prescription Drug Schedule of Benefits and Certificate of Coverage shall prevail.

UnitedHealthcare of Washington, Inc.

Tier Level	Up to 31-day supply			Up to 90-day supply
	Retail Network Pharmacy or Preferred Specialty Network Pharmacy	Retail Non-Preferred Specialty Network Pharmacy	Retail Out-of-Network Pharmacy	*Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy
Tier 1 Prescription Drug Products	\$15	\$30	\$15	\$37.50
Tier 2 Prescription Drug Products	\$40	\$80	\$40	\$100
Tier 3 Prescription Drug Products	\$70	\$140	\$70	\$175
Tier 4 Prescription Drug Products	\$300	\$600	\$300	\$750

Benefit Plan Co-payment/Co-insurance - The amount you pay for Prescription Drug Products.

* Only certain Prescription Drug Products are available through mail order; please visit myuhc.com[®] or call Customer Care at the telephone number on the back of your ID card for more information. If you choose to opt out of Mail Order Network Pharmacy but do not inform us, you will be subject to the Out-of-Network Benefit for that Prescription Drug Product after the allowed number of fills at the Retail Network Pharmacy.

For Specialty Drugs from a Non-Preferred Pharmacy, you will be required to pay 2 times the Preferred Specialty Network Pharmacy Co-payment and/or 2 times the Preferred Specialty Network Pharmacy Co-insurance (up to 50% of the Prescription Drug Charge) based on the applicable Tier.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is Chemically Equivalent. When you choose the higher cost drug of the two, you will pay the difference between the higher cost drug and the lower cost drug in addition to your Co-payment and/or Co-insurance that applies to the lower cost drug. The Ancillary Charge may not apply to any Annual Deductible or Out of Pocket Limit.

Other Important Information about your Outpatient Prescription Drug Benefits

The amounts you are required to pay is based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge. We will not reimburse you for any non-covered drug product.

For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the applicable Co-payment and/or Co-insurance, the Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product or the Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the applicable Co-payment and/or Co-insurance or the Prescription Drug Charge for that Prescription Drug Product. See the Co-payments and/or Co-insurance stated in the Benefit Information table for amounts.

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

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

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

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee to determine whether the Prescription Drug Product is in accordance with our approved guidelines and it meets the definition of a Covered Health Care Service and is not an Experimental or Investigational or Unproven Service. You may determine whether a particular Prescription Drug Product requires prior authorization and the duration of the authorization by contacting us at www.myuhc.com or the telephone number on your ID card.

If you require certain Prescription Drug Products including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you may opt-out of the Designated Pharmacy program by contacting us at myuhc.com[®] or the telephone number on your ID card. If you want to opt-out of the program and fill your Prescription Drug Product at a non-Designated Pharmacy but do not inform us, you will be responsible for the entire cost of the Prescription Drug Product and no Benefits will be paid. If you are directed to a Designated Pharmacy and you have informed us of your decision not to obtain your Prescription Drug Product from a Designated Pharmacy, you may be subject to the Out-of-Network Benefit for that Prescription Drug Product. For a Specialty Prescription Drug Product, if you choose to obtain your Specialty Prescription Drug Product at a Non-Preferred Specialty Network Pharmacy, you may be subject to the Non-Preferred Specialty Network Co-payment and/or Co-insurance. You may determine if a pharmacy is a Designated Pharmacy by contacting us at myuhc.com[®] or at the telephone number on your ID card.

You may be required to fill the first Prescription Drug Product order and obtain 2 refills through a retail pharmacy before using a mail order Network Pharmacy.

If you require certain Maintenance Medications, we may direct you to the Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy, you may opt-out of the Maintenance Medication Program by contacting us at myuhc.com[®] or the telephone number on your ID card. If you choose to opt out when directed to a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy but do not inform us, you will be subject to the out-of-Network Benefit for that Prescription Drug Product after the allowed number of fills at Retail Network Pharmacy.

Certain PPACA Zero Cost Share Preventive Care Medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician are payable at 100% of the Prescription Drug Charge (without application of any Co-payment, Co-insurance, Annual Deductible, or Annual Drug Deductible) as required by applicable law. You may find out if a drug is a PPACA Zero Cost Share Preventive Care Medication by contacting us at myuhc.com[®] or the telephone number on your ID card.

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

PHARMACY EXCLUSIONS

The following exclusions apply. In addition see your Certificate of Coverage and SBN for additional exclusions and limitations that may apply.

Exclusions

- A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to two times per year but not more than quarterly. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to two times per year but not more than quarterly. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to two times per year but not more than quarterly. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Experimental or Investigational or Unproven Services and medications; medications used for experimental treatments for specific diseases and/or dosage regimens determined to be experimental, investigational or unproven. This exclusion does not apply to Prescription Drug Products which have not yet been approved by the Food and Drug Administration for a particular indication, if the prescribed drug has been recognized as safe and effective for treatment of a particular indication in or by one or more of the following: in one of the following standard reference compendia: The American Hospital Formulary Service Drug Information, The American Medical Association Drug Evaluation, The United States Pharmacopoeia Drug Information, or other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services or the insurance commissioner; in the majority of relevant peer reviewed medical literature if not recognized in one of the standard reference compendia; or by the Federal Secretary of Health and Human Services.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- Medications used for cosmetic purposes.
- Prescription Drug Products when prescribed to treat infertility.
- Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that have been determined to be Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to two times per year but not more than quarterly. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. You may determine whether a drug is designated as an eligible over-the-counter medication by contacting us at www.myuhc.com or at the telephone number on your ID card. This exclusion does not apply to over-the-counter drugs used for tobacco cessation.
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury, except as required by state mandate as described under Formulas for Phenylketonuria (PKU) in Section 1 of the COC, or except as required by state mandate as described under Eosinophilic Gastrointestinal Disorder and Prescription Drug Products under Defined Terms.

Life and Accidental Death & Dismemberment Insurance

Employee Benefits from The Hartford for the U.S. Employees of
HIGHBROW TECH LLC

Service Provider: Connexion Insurance Solutions

Basic Employee Life and AD&D

Class Description(s):

All Full-time Active Employees

Full Time Eligibility: 30 hours per week

Feature	Description
Benefit Schedule	Flat \$100,000
Guaranteed Issue	Equal to Benefit Amount
Benefit Reduction Schedule	35% @ 65 and 50% of Original Amount @ 70
Continuity Of Coverage	Standard
Life Disability Provision	Premium Waiver to Normal Retirement Age if Disabled Prior to 60
Premium Waiver Elimination Period	9 Months
Living Benefit Option (Accelerated Benefit)	24 Months Life Expectancy, 80% of Benefit (Total Basic and/or Supplemental Acceleration may never exceed \$250,000)
Life Portability Option	Portability Plus
Conversion	Included
Military Leave Of Absence Continuation	12 Weeks
ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)	Matches Basic Life Benefit
Employee Contribution	Non-Contributory
Participation Requirement	100% of Eligible Employees
Initial Rate Guarantee Period	2 Years

*Reminder - Compliance with ADEA is the responsibility of the Employer. Please consult your legal counsel to determine if this schedule complies with ADEA guidelines.

Supplemental Employee Life and AD&D

Class Description(s):

All Full-time Active Employees

Full Time Eligibility: 30 hours per week

Feature	Description
Benefit Schedule	\$10,000 increments not to exceed 3 times Earnings or \$250,000
Minimum Benefit Amount	\$10,000
Combined Basic & Supplemental Life Maximum Benefit	No
Guaranteed Issue	Flat \$100,000
Benefit Reduction Schedule	35% @ 65 and 50% of Original Amount @ 70
Continuity Of Coverage	None
Life Disability Provision	Premium Waiver to Normal Retirement Age if Disabled Prior to 60
Premium Waiver Elimination Period	9 Months
Living Benefit Option (Accelerated Benefit)	24 Months Life Expectancy, 80% of Benefit (Total Basic and/or Supplemental Acceleration may never exceed \$250,000)
Life Portability Option	Portability Plus
Conversion	Included
Military Leave Of Absence Continuation	12 Weeks
Suicide Exclusion	Not Included
ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)	Matches Supplemental Life Benefit
Employee Contribution	Contributory, 100 % Employee Paid
Enrollment Type	Traditional EOI (Annual Enrollment) ²
Actual Participation	Minimum 40% of Eligible lives (6 Lives)
Initial Rate Guarantee Period	2 Years

*Reminder - Compliance with ADEA is the responsibility of the Employer. Please consult your legal counsel to determine if this schedule complies with ADEA guidelines.

² Assumes a scheduled enrollment period and standard evidence of insurability requirements apply for late entrants (employees who were previously eligible for coverage who did not enroll within 31 days of the date they were initially eligible) and for increases in coverage.

Supplemental Dependent Life and AD&D

Class Description(s):

All Full-time Active Employees

Full Time Eligibility: 30 hours per week

Feature	Description
Spouse Benefit Schedule	\$5,000 increments to \$25,000 not to exceed 50% of the Employee Elected and Approved Supplemental Life Insurance.
Spouse Guaranteed Issue	Flat \$25,000
Living Benefit Option (Accelerated Benefit)	24 Months Life Expectancy, 80% of Benefit (Total Basic and/or Supplemental Acceleration may never exceed \$500,000)
Child Benefit Schedule	15 days to 6 months - \$500 ; 6 months to 22 - \$10,000
Student Extension To Age	25 Years
Waiver Of Dependent Premium	Included. Applies if Employee Qualifies for Premium Waiver
Life Portability Option	Portability Plus
Conversion	Included
Suicide Exclusion	Not Included
SPOUSE ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)	Matches Spouse Supplemental Dependent Life Benefit
CHILD ACCIDENTAL DEATH & DISMEMBERMENT	Matches Child Supplemental Dependent Life Benefit

*Spouse premium is based on employee's age

Qualifications and Assumptions

With this rate structure the employer may be electing to partially support employer paid coverages with the rate for the employee paid coverages. This means that premiums paid for one coverage may cover the cost of another coverage under the Plan. When we quote rates with such partial support between the employee paid and employer paid coverages we do so with the understanding that the employer and employee coverages are part of a single ERISA plan sponsored by the employer and that the employer has determined that the rate structure is consistent with information provided to employees and with its ERISA obligations. If this understanding is not accurate, please contact us.

The following are assumptions upon which this proposal is based:

1. The effective date of this case will be October 1, 2018.
2. Proposal and rates are valid until October 1, 2018.
3. Rates assume a SIC code of 7361.
4. Quote assumes a Situs State of WA. Hartford standard filed contract language applies. State filings or specially drafted contract language is not assumed in the quoted rates.
5. Assumes employees must be actively-at-work on the effective date and the deferred effective date provision applies.
6. The enrolled census information must include coverage election amounts, and be within 10% of the census data used to develop this quote.
7. The Hartford requires a minimum of 10 enrolled lives per coverage.
8. The Hartford reserves the right to re-price:
 - if the sold plan design differs from the proposed/quoted plan design
 - for changes in State or Federal Insurance regulations
 - if a material misstatement of the information provided in the RFP, bid specifications, claim experience, or plan of benefits is discovered post-sale
 - if the quoted minimum enrollment threshold is not met
9. The Hartford reserves the right to change the plan to comply with state mandated benefits, including charging additional premium for such changes, if applicable.
10. If any contributory lines of coverage are sold, a 45-day Grace Period will apply to all lines of coverage. If only non-contributory lines of coverage are sold, a 31-day Grace Period will apply.
11. The Minimum Life Benefit stated represents the minimum benefit before the application of Age Reduction Provisions.
12. Assume case is not a Sovereign Nation or Union Group.
13. Assumes Military Leave of Absence is 12 weeks.
14. The Hartford assumes no liability to extend coverage under severance agreements unless reviewed and approved by underwriting in advance.
15. Contract language and standard benefits approved by The Hartford will be used for all insured contract and employee booklet communication material.
16. The Disability definition of earnings includes Base Annual Earnings and Definition of Earnings. Overtime pay and target income is not included.

17. The Hartford's standard policyholder reporting package and frequency applies.
18. We assume all eligible employees are U.S. citizens or U.S. residents, working in U.S. locations.
19. We assume the company has been in business for at least 2 years.
20. Assumes claims incurred prior to the effective date of the contract will be the liability of the prior carrier.
21. Late entrants are required to provide Evidence of Insurability to enter into the plan at any coverage level/amount, unless otherwise noted.
22. Assumes the plan of benefits is subject to ERISA regulations.
23. Employees are required to complete Hartford Enrollment forms.
24. Employees are required to complete Hartford Beneficiary designation forms.
25. The Hartford assumes no liability to extend coverage under severance agreements.
26. We assume no liability or coverage for any existing disabled persons.
27. Initial and Annual enrollment must be completed no later than 30 days before the Effective Date of Coverage.
28. Coverage for Retirees is not included.

Deviations

Our proposal reflects our standard product and, consequently, may deviate from the features and/or plan designs that you requested. Accordingly, please review our proposal carefully, as we have not identified specific areas where our proposal deviates from your request. Please note that this proposal does not constitute a final offer or agreement, and it is only a summary of the benefits offered to your company.

The rates and costs shown in this proposal are based on the information provided. Rates may be affected by the actual enrollment (and transferred business information) provided. Please consult with the Producer regarding all terms and conditions in this proposal.

Please note the following descriptions that further explain some of our benefits and features. The descriptions are based on our Standard Language. The benefits shown below are available in most states, however, please be aware that state variations may apply.

General:

Support: As Simple as 1, 2, 3

The Hartford offers three service options to help you administer your group benefits. We also offer online tools for your employees.

Employer View[®]

Employer View is a secure, password-protected Web site where employers can quickly obtain plan information and transact business to help reduce administrative burden. We continually work to enhance the site's capabilities to make it more responsive to your needs. On Employer View, you are able to access such features as:

- Electronic billing
- Reports (available in either PDF or Excel)
- Medical underwriting status for evidence of insurability
- Claim status inquiry
- Booklets
- Administration kits with forms specific to your coverage(s)

Additional Support from our Customer Solutions Center

Questions or services that cannot be handled on the Web can be addressed by our Customer Solutions Center. Our skilled representatives, who are familiar with your case, are available Monday through Friday from 8 a.m. to 8 p.m. EST at 1-800-523-2233 and provide support to new and existing customers.

Local Service Representatives

If our Customer Solutions Center representatives can't assist you with your request, they'll be glad to put you in touch with a local service representative.

The Hartford At Work for Your Employees

TheHartfordAtWork.com, a secure, password-protected Web site, is a valuable resource that makes your job easier. This site is an informational resource for your employees that they can access at any time. The site offers employees the ability to:

- ✓ View claim and payment status.
- ✓ Check their medical underwriting status for evidence of insurability.
- ✓ File an STD claim in place of telephonic submission (if your plan offers this coverage).
- ✓ Start an LTD claim.
- ✓ Registered users can access forms specific to your plan's coverage(s).
- ✓ Obtain information on coverage overviews and frequently asked benefit questions
- ✓ Enroll in direct deposit for their claim payments.
- ✓ Assess appropriate coverage levels and costs using an online calculator (based on industry averages).

Voluntary Enrollment Services:

A Hassle Free Enrollment Process to Maximize Employee Participation

As benefit costs continue to rise and consume a larger portion of a company's budget, voluntary coverage enhances an employer's group plan at no additional cost to the employer.

The Hartford is committed to making it as easy as possible to communicate information on your plan and the associated cost to your employees. Our goal is to engage employees so they fully understand the benefits offering and make it easy for them to enroll. To accomplish this, The Hartford will prepare enrollment packages for employees that include:

- Benefits information (brochures and tools) to help employees understand their potential needs and how these offerings can help them make an educated decision.
- Benefit Highlight Sheets that describe plan provisions in more detail to help explain product offerings.
- Personalized Enrollment Forms for each employee. These simple forms show the price (payroll deduction amount) of coverage based on the employee's salary and age.

We support voluntary plans with a complete package of enrollment communication materials. To simplify the employee's purchase decision, we can provide each employee with a personalized enrollment form that outlines his or her coverage choices and costs. This service is offered at no charge to employers.

To help ensure a hassle-free enrollment process and to maximize participation, The Hartford will work with you to:

- Develop an enrollment strategy to maximize employee participation levels that best fits this case.
- Identify the appropriate tools that will support the enrollment strategy. (e.g. WebEx meetings; conference call meetings employee-focused marketing materials)
- Create an eligible census that allows us to produce a detailed and personalized enrollment package for each employee.
- Identify the enrollment period that is convenient for you and provides us time to sufficiently manage the post-enrollment process.
- Identify post enrollment communication needs (e.g. tabulating enrollment results and transferring results back to Employer electronically showing the coverage elections and related payroll deduction amounts)

Enrollment Type Options Available:

“Options to meet your needs.”

We have the ability to support voluntary plans with a variety of enrollment type options. If you would like to hear more about a particular option and how it may work with your program, please contact your Hartford Representative.

No Enrollment - This enrollment type has no scheduled enrollment period. Employees enrolled in the previous carrier's plan transition to The Hartford's plan on a no loss no gain basis. "Enrollment" into the plan is typically offered to new hires only as defined in the plan document. Standard evidence of insurability (EOI) requirements apply for late entrants (employees who were previously eligible for coverage who did not enroll within 31 days of the date they were initially eligible) and for increases in coverage.

Traditional (EOI) - This enrollment type has a scheduled enrollment period and standard evidence of insurability (EOI) requirements apply for late entrants (employees who were previously eligible for coverage who did not enroll within 31 days of the date they were initially eligible) and for increases in coverage.

Modified Open Enrollment - **Note: This option is only offered on Supplemental Life.** This enrollment type allows all eligible employees to enroll for a "limited" benefit amount (typically "one" additional increment of coverage). Employees not currently enrolled may elect the first available (most conservative) increment of coverage. Employees currently enrolled may elect one additional increment of coverage. Plan Guarantee Issue limits and maximums apply.

Life:

Common Notice:

When employees are Disabled, our Waiver of Premium benefit allows them to continue their life insurance coverage without premium payment. In addition, we provide a value-added service called Common Notice. This service initiates a Life Waiver of Premium claim at the appropriate time when an insured employee is receiving benefits under a disability plan provided by The Hartford. Common Notice eliminates the need to file a separate life Waiver of Premium claim, which helps ensure an employee's group life protection is maintained during a Disability.

Living Benefit Option (Accelerated Benefit):

The Living Benefits Option (LBO) allows the employee to elect to receive an accelerated payment of a portion of the life insurance benefit when a covered person (may include employee or employee and dependent) is diagnosed as terminally ill with a 24 Month life expectancy. The employer determines applicable life expectancy and whether the benefit applies to dependent coverage.

We will pay up to 80% of the terminally ill individual's Group Term Life benefit as long as he or she has a minimum life coverage amount of \$10,000 and has not exceeded the maximum age, if any, described in the contract. LBO pays a minimum of \$3,000 and a maximum of \$250,000. Accelerated funds are paid to the employee with no restrictions on how they may be used; the remaining death benefit is then payable to the beneficiary.

Portability Plus:

Portability allows employees to continue voluntary and/or basic life insurance protection for themselves and their families when the employee changes jobs. Portability Plus is included at no additional cost to the Employer. Terminated employees who elect Portability pay for the cost of this benefit.

Offered at group rates, this is an affordable way for many terminating employees to continue to be protected with life insurance. No medical exam is required and the employee may elect coverage continuation equal to 100 percent, 75 percent, or 50 percent of their current life insurance, subject to an overall maximum of \$250,000. Continued coverage of spouse and dependent children is also available, subject to maximum amounts of \$50,000 and \$10,000 respectively. This Portability option is available to terminating employees who have not reached Normal Retirement Age as defined by the 1983 Federal Social Security Act (generally age 65 or later, based on a graded scale). Coverage may continue to age 75 with a reduction at age 65 to 25 percent of the original amount.

Safe Haven:

The Hartford's Safe Haven program is available for group life or accidental death claims(s) of \$10,000 or more, which are payable to a single beneficiary. The beneficiary elects that the proceeds be distributed through the program in lieu of a lump sum check for the full death benefit amount.

Safe Haven is intended to provide customers with a convenient means for paying immediate needs. This allows the beneficiary time to decide how to use the remaining balance of their insurance proceeds during a time when making financial decisions may be difficult. Proceeds are available to use right away to pay bills, make purchases, receive cash, reinvest or make other financial transactions. Here's how it works:

- The beneficiaries can write as many drafts each month as they wish, at anytime and for any reason - just as they might write a check.
- The draft book can be used immediately for any expenses the beneficiaries incur and in any dollar amount - up to and including the full balance, plus interest.
- Interest on the proceeds are compounded daily and credited to the account the last day of each month. The interest rate is determined by The Hartford. For interest earned equal to \$10 per year or greater, a form 1099-INT will be provided annually.
- For accurate reporting, statements summarizing activity are mailed quarterly, or monthly if a new transaction other than earned interest posts to the account.
- The Safe Haven Program does not charge any fees against the account.

Instead of contacting a traditional call center, each beneficiary is assigned his/her own personal representative. The representative will contact the beneficiary immediately upon claim payment to disclose the amount and expected delivery date. Alleviating a major stress point. And giving the beneficiary a key point of contact. The same representative will assist with all of the services Safe Haven offers.

With Safe Haven, insurance proceeds are held in our general account and payments are based on the claims-paying ability of Hartford Life and Accident Insurance Company. The Hartford will earn investment income on Safe Haven assets. The difference between the investment income earned on the Safe Haven assets and the interest credited to customers participating in the Safe Haven program will provide Hartford with a profit and cover expenses we incur. The Hartford in its sole discretion determines the credited interest rate.

Safe Haven is not intended to be a long-term investment vehicle. Safe Haven is not a bank account and as such, Safe Haven assets are not insured by the Federal Deposit Insurance Corporation. Nor are they backed or guaranteed by any federal or state government agency.

Suicide Exclusion:

A Suicide Exclusion is included on Supplemental Life insurance for employees and dependents to help protect the employer's experience from unanticipated losses. It applies only to elected coverage amounts which became effective within two years of the date of death, and the two year period includes the time coverage was in force under the prior group life policy.

Life Disability Provision:

Premium Waiver to Normal Retirement Age, if Disabled Prior to Age 60

Any covered employee who becomes Disabled before age 60 is eligible for continued employee life insurance, without payment of premium, while the employee remains continuously Disabled. Premium is required until the employee is approved for coverage. Once approved, premium will be waived and coverage will be continued until Normal Retirement Age while the employee remains Disabled.

Employees are considered Disabled if they are prevented by injury or sickness from doing any work for which they are, or could become, qualified by education, training or experience. If Living Benefit Option is included, employees will also be considered Disabled if they meet the definition of Terminally Ill in the certificate.

Standard Employee Continuity of Coverage:

This language addresses continuation of employee coverage in takeover situations. Standard Continuity of Coverage extends coverage to employees insured under the prior policy, who were actively at work or on an authorized family and medical leave, on the day before our Policy Effective Date.

Coverage under this provision continues until the first of the following,

- the date the employee returns to work as an Active Full-Time Employee;
- the last day of a 12-month period following our Policy Effective Date;
- the last day the employee would have been covered under the prior policy had the prior policy not terminated; or
- the date insurance terminates for one of the reasons stated in the Termination Provisions.

The Amount of Coverage provided is equal to,

- The lesser of the amount under the prior policy or the amount under our policy
Reduced by any amount in force, paid or payable under the prior policy; or which would have been payable if timely election had been made.

AD & D

AD&D Standard Package: Under our Standard Accidental Death and Dismemberment Benefit package, we provide payment of benefits if the following Losses occur within 365 days of the Accident. Subject to state availability, the following benefits are included:

Loss of Life	100% of Principal Sum
Loss of Both Hands or Both Feet or Sight of Both Eyes	100% of Principal Sum
Loss of One Hand and One Foot	100% of Principal Sum
Loss of Speech & Hearing in Both Ears	100% of Principal Sum
Loss of Either Hand or Foot and Sight of One Eye	100% of Principal Sum
Loss of Either Hand or Foot	50% of Principal Sum
Loss of Sight of One Eye	50% of Principal Sum
Loss of Speech or Hearing in Both Ears	50% of Principal Sum
Loss of Thumb & Index Finger of Either Hand	25% of Principal Sum
Seat Belt and Air Bag Benefit	<p>Seat Belt - 10% of Principal Sum to a maximum of \$10,000 Air Bag - additional 5% of Principal Sum to a maximum of \$5,000, if seat belt also used.</p> <p>Minimum Benefit - If it cannot be determined that the injured person was wearing a Seat Belt at the time of the Accident, a Minimum Benefit of \$1,000 will be payable.</p> <p>If a covered individual sustains an Injury payable under the Accidental Death and Dismemberment Benefit, we will pay an additional Seat Belt Benefit if the injury occurs while riding in or driving a Motor Vehicle and wearing a Seat Belt.</p> <p>If a Seat Belt Benefit is payable, we will pay an additional Air Bag Benefit, if the individual was positioned in a seat with a factory installed Air Bag, and was properly strapped in the Seat Belt when the Air Bag inflated.</p>
Repatriation Benefit	<p>The lesser of:</p> <ul style="list-style-type: none"> • 5% of Principal Sum • \$5000; or • the actual expense incurred for preparation and transportation of the body for burial or cremation. <p>If a covered individual dies and a benefit is payable under the Accidental Death and Dismemberment Benefit, we will pay an additional benefit if death occurs outside of the state or country of permanent residence.</p>

<p>Loss of Movement</p>	<p>Quadriplegia*-100% of Principal Sum</p> <p>Triplegia*-75% of Principal Sum</p> <p>Paraplegia*-75% of Principal Sum</p> <p>Hemiplegia*-50% of Principal Sum</p> <p>Uniplegia*-25% of Principal Sum</p> <p>If any of these Losses occur as the result of an Injury, the described benefit is payable. Loss of movement of Limbs means that movement is completely lost and is irreversible</p> <p>*Quadriplegia- Loss of movement of both upper and lower Limbs</p> <p>*Triplegia- Loss of movement of three Limbs</p> <p>* Paraplegia- Loss of movement of both lower Limbs</p> <p>* Hemiplegia-Loss of movement of both upper and lower Limbs on one side of the body</p> <p>* Uniplegia- Loss of movement of one Limb on one side of the body</p>
<p>More than one of the above Losses resulting from the same Accident</p>	<p>The lesser of:</p> <ul style="list-style-type: none"> • Principal Sum; or • Sum of each Benefit payable

<p>Child Education Benefit</p>	<p>Lesser of:</p> <ul style="list-style-type: none"> • 2.5% of Principal Sum or • \$2,500; <p>payable for each dependent who qualifies.</p> <p>Minimum Benefit - If no dependent qualifies, will pay \$1,250 in accordance with the beneficiary designation.</p> <p>Maximum of 1 Child Education Benefit per Student during a school year and a maximum of 4 Education Benefits per Student.</p> <p>If a covered Employee dies and a benefit is payable under the Accidental Death and Dismemberment Benefit, we will pay an additional benefit for each dependent child who qualifies as a Student. The child must be a full-time post-high school student on the date of death or become such, within 1 year of the death.</p>
<p>Day Care Benefit</p>	<p>Lesser of:</p> <ul style="list-style-type: none"> • 2.5% of Principal Sum or • \$2,500; <p>payable annually for each qualifying dependent.</p> <p>Minimum Benefit - If no dependent qualifies, will pay \$1,250 in accordance with beneficiary designation.</p> <p>Maximum of 4 benefits for each dependent who qualifies.</p> <p>If a covered Employee dies and a benefit is payable under the Accidental Death and Dismemberment Benefit, we will pay an additional benefit for each dependent child who is less than age 7 on the date of death and is enrolled in or will be enrolled in a Day Care Program within 365 days.</p>
<p>Rehabilitation Benefit</p>	<p>Lesser of:</p> <ul style="list-style-type: none"> • 2.5% of Principal Sum or • \$2,500; or • the actual expense incurred for a Rehabilitative Program. <p>If a covered Employee sustains an Injury, other than Loss of life, which is payable under the Accidental Death and Dismemberment Benefit, we will pay an additional benefit to help prepare the injured person for an occupation for which he or she was not previously trained.</p> <p>Training expenses must be incurred within one year of the accident.</p>

Spouse Education Benefit	<p>Lesser of:</p> <ul style="list-style-type: none"> • 2.5% of Principal Sum or • \$2,500; or • the expense incurred for Occupational Training. <p>Minimum Benefit - If there is no surviving spouse, we will pay \$1,250 in accordance with beneficiary designation.</p> <p>If a covered Employee dies and a benefit is payable under the Accidental Death and Dismemberment Benefit, we will pay an additional benefit to the surviving spouse for Occupational Training.</p> <p>Training expenses must be incurred within one year of the Employee's death.</p>
Adaptive Home & Vehicle Benefit	<p>Lesser of:</p> <ul style="list-style-type: none"> • 2.5% of Principal Sum or • \$2,500; or • the actual one-time cost of alterations. <p>If a covered Employee sustains an Injury, other than Loss of life, which is payable under the Accidental Death and Dismemberment Benefit, we will pay an additional benefit to help make the residence and/or automobile more accessible.</p> <p>Expenses must be incurred within two years of the accident.</p>

Additional Services:

Additional Services for Employees- Family Coverage

Funeral Planning and Concierge Services¹ A service that helps guide employees through key decisions before a loss, including help comparing funeral-related costs. After a loss, this service includes family advocacy and professional negotiation of funeral prices with local providers-often resulting in significant financial savings. In addition, Express Pay is offered for expedited claims payments.

Estate Guidance² (online will preparation) A service that helps employees protect their family's future by creating a customized and legally binding online will. Online support is also available from licensed attorneys, if needed.

Beneficiary Assist³ Services that provide compassionate expertise to help employees or their loved ones cope with emotional, financial and legal issues that arise after a loss. Includes unlimited phone contact with professionals, as well as five face-to-face sessions.

Travel Assistance & ID Theft Protection Services⁴ A service that includes pre-trip information that helps employees feel safe and secure while traveling. It also gives them access to medical professionals across the globe for medical assistance when traveling 100+ miles away from home for 90 days or less when unexpected detours arise. Another important service is ID theft protection, available 24/7 whether home or away. Protection is provided two ways: Educational materials to help prevent identity theft. And access to caseworkers who can help victims resolve problems that result from identity theft.

¹ Funeral Concierge Services are offered through Everest Funeral Package, LLC (Everest). Everest is not affiliated with The Hartford and is not a provider of insurance services. Everest and its affiliates have no affiliation with Everest Re Group, Ltd., Everest Reinsurance Company or any of their affiliates.

² EstateGuidance[®] services are provided through The Hartford by ComPsych[®]. ComPsych is not affiliated with The Hartford and is not a provider of insurance services. A simple will does not cover credit shelter trust, printing or certain other features. These features are available at an additional cost to you.

³ Beneficiary Assist[®] is offered through The Hartford by ComPsych[®]. ComPsych is not affiliated with The Hartford and is not a provider of insurance services.

⁴ Travel Assistance and ID Theft Protection Services are provided by Europ Assistance USA. Europ Assistance is not affiliated with The Hartford and is not a provider of insurance services.

Travel Assistance and ID Theft Protection & Assistance Services

Travel Assistance & ID Theft Protection Services: Services include pre-trip information that helps employees feel safe and secure while traveling. It also gives them access to medical professionals across the globe for medical assistance when traveling 100+ miles away from home for 90 days or less when unexpected detours arise. Another important service is ID theft protection, available 24/7 whether home or away. Protection is provided two ways: Educational materials to help prevent identity theft. And access to caseworkers who can help victims resolve problems that result from identity theft.

¹Travel Assistance and ID Theft Protection Services are provided by Europ Assistance USA. Europ Assistance is not affiliated with The Hartford and is not a provider of insurance services.

Cost Structure

Employer Cost (70%)	Employee Cost (30%)
\$140/Month	\$60/Month
\$70 Bi-weekly	\$30 Bi-weekly

For any queries please contact: Healthbenefits@highbrow-tech.com

Retirement Savings and Planning Benefit

Service Provider: ADP

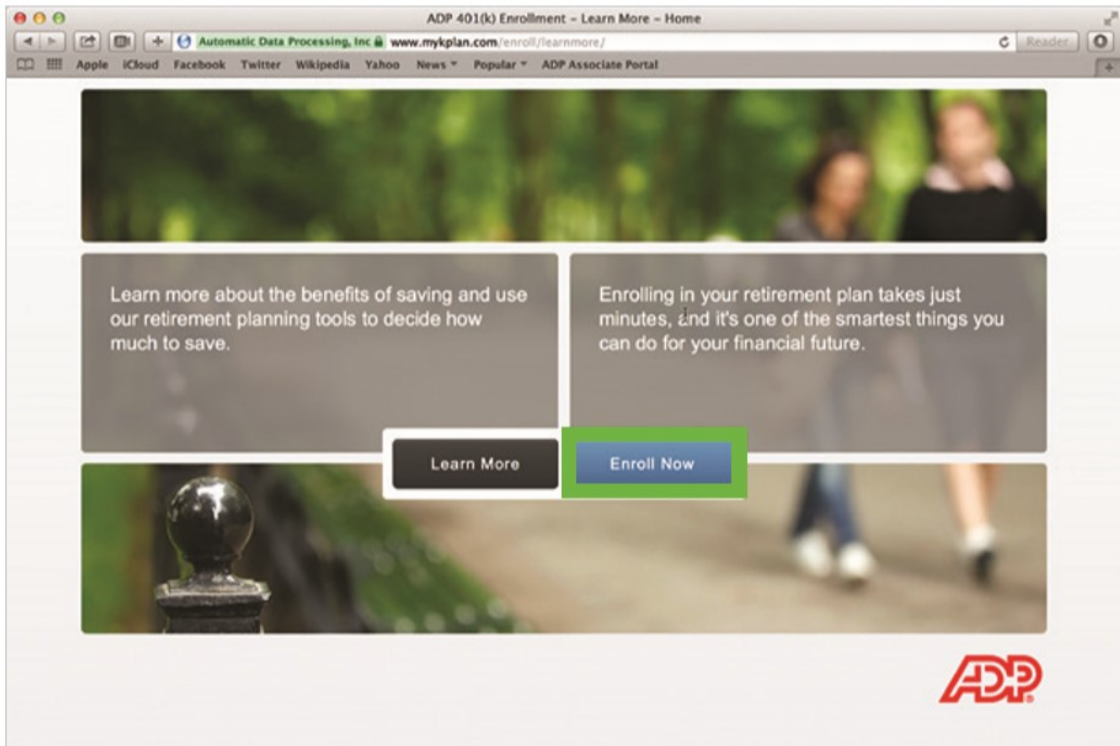
Enrollment Process:

This is the easiest and quickest way to get your 401(k) account set up. If you are enrolling prior to your organization’s start date with ADP, simply go to: www.mykplan.com/enroll/learnmore

Step 1: Begin the Enrollment Process

When you navigate to the Enrollment website, you may select one of two options:

- The “Learn More” option allows you to find out more information about 401(k) Plans and how they may be beneficial for your retirement savings. You are welcome to review this material and may begin the Enrollment process at any time.
- If you’re ready to enroll, select the “Enroll Now” link (highlighted in the illustration by the green box).

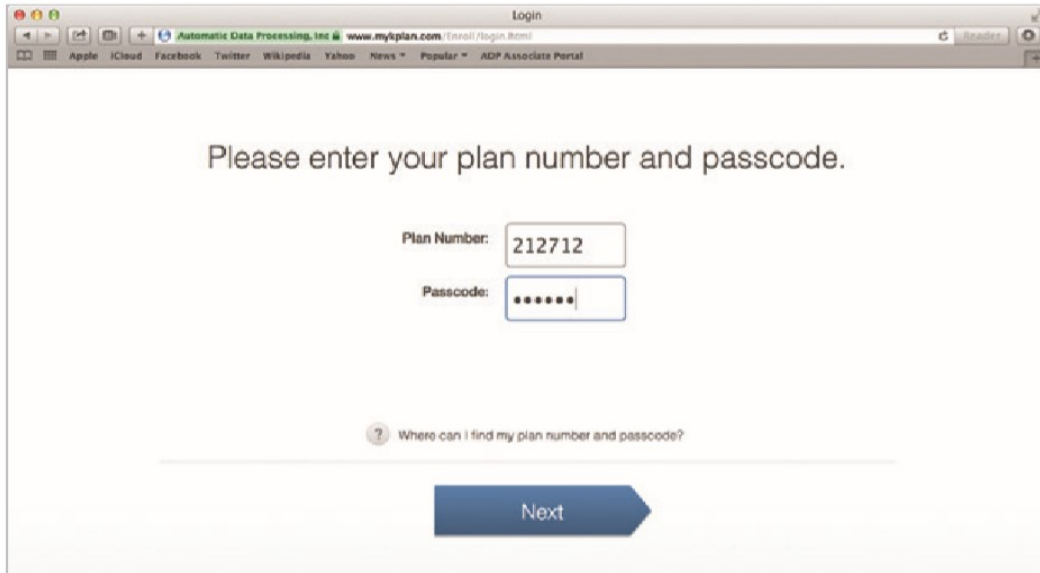


Step 2: Log onto the Online Application Tool

On the next screen, you will need to type in your organization’s 401(k) Plan Number and the Passcode which have been provided to you at the Enrollment meeting.

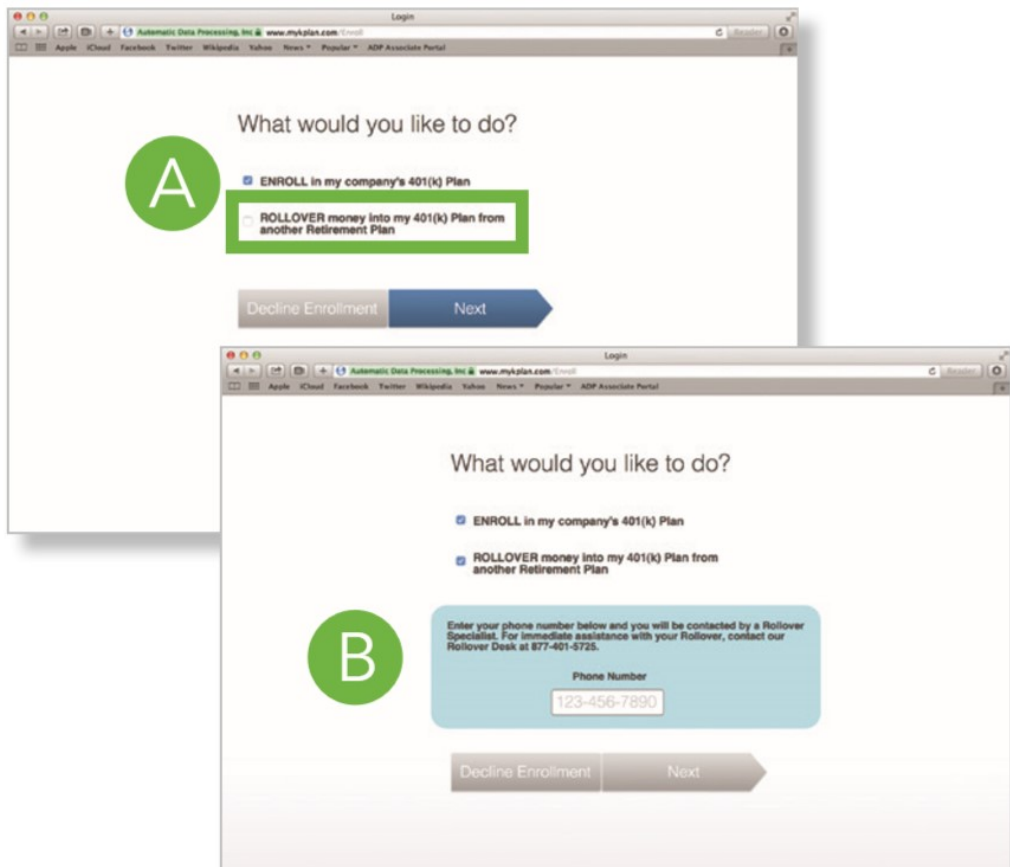
If you have misplaced or not received this information, please contact your Plan Administrator or call 1.888.822.9238 and our Client Service team can assist you with establishing your credentials.

Select the “Next” button to continue.



Step 3: Consider Rolling Over Investments from another Retirement Plan

- A. If you have a retirement savings account from a previous employer that you would like to roll over into this 401(k) account, select the “ROLLOVER money into my 401(k) Plan from another Retirement Plan” check box (highlighted in the illustration by the green box).
- B. Provide your telephone number in the alert box and an ADP Retirement Counselor¹ will contact you. Otherwise, select the “Next” button to continue.



Step 4: Enter Your Date of Birth

On this screen, enter your birth date through the drop down menus. Select the “Next” button to continue.

Enroll - Date of Birth

Automatic Data Processing, Inc. www.mykplan.com (enroll/step1.html)

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When were you born?

Quick Guide
Tap each box and select the month, day and year.
Tap to cancel.

May 10 1971

? Why do I need to provide this information?

Decline Enrollment Next

Step 5: Choose a Savings Level

- The percentage you indicate here is the percentage of your salary which will be deducted each pay period, before taxes are deducted.
- If your organization offers a Roth feature with its 401(k) Plan, you may elect that option by selecting the text (highlighted in the illustration by the green box).
- If you decide to elect the Roth option, on the next screen, designate a portion of your post-tax salary to fund that feature. Otherwise you may skip step 5C. When you are satisfied with the savings level, select the “Next” button.

Enroll - Contribution Rate/Savings Level

Automatic Data Processing, Inc. www.mykplan.com (enroll/step2.html)

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Choose a savings level

Decide how much to save.
The percentage you select will be deducted each pay period, subject to maximum contribution limits.

401(k) before-tax contribution election:

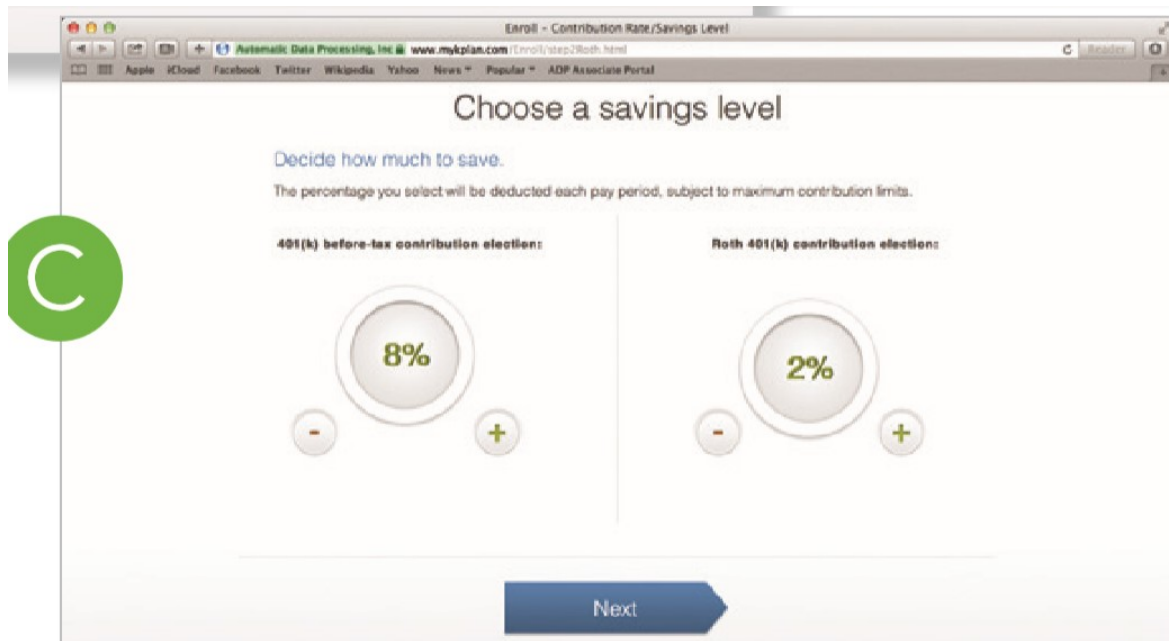
8%

Click here to make a Roth contribution

Next

A

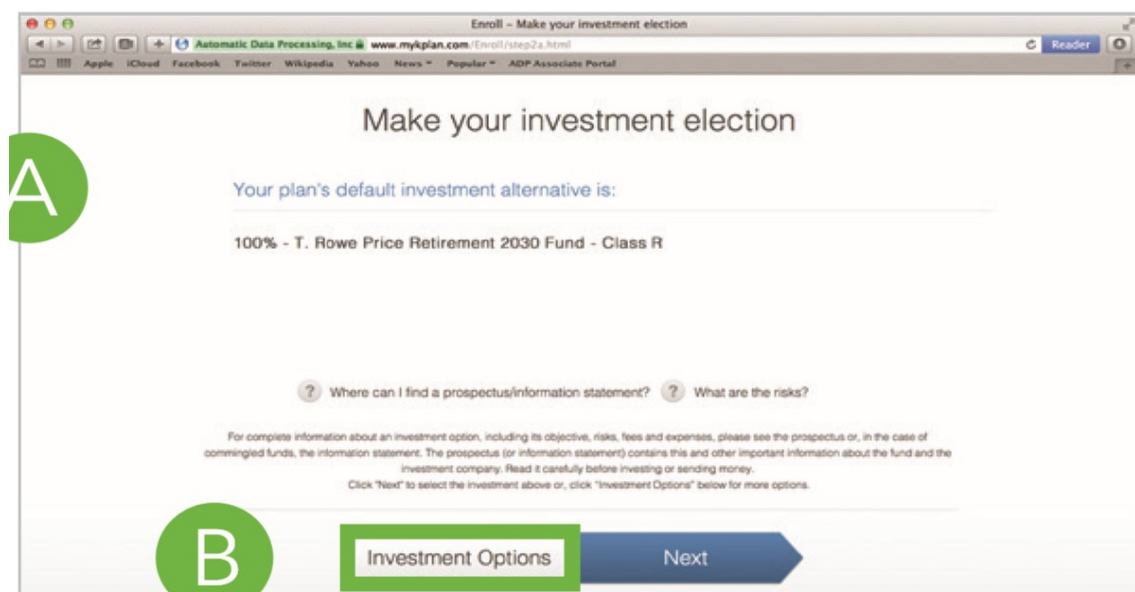
B



Step 6: Choose Your Investment Election(s)

- A. This screen allows you to select the asset allocation that will make up your 401(k) Plan. The default allocation is set to a predetermined Target Date Fund based on your birth date. However, you do not need to choose this fund. If you would like to choose another fund, proceed to step 6B. Otherwise, proceed to step 6C. If you would like to find out more about this fund, please ask for a fund prospectus.
- B. If you wish to customize asset allocations for your 401(k) Plan, please select the “Investment Options” button. To find out information about any fund, please look at the fund prospectus (or information statement, if applicable).
- C. On the next screen, select the asset allocations so that elections total 100%. Don’t worry, you can always adjust these percentages and assign different asset allocation elections once your account has been established.

Select the “Next” button to continue.





Sort by: Alphabetical	Sort by: Fund Category	
20% <input type="checkbox"/>	Invesco Stable Asset Fund	Income
0% <input checked="" type="checkbox"/>	PIMCO Total Return Fund - Class A	Income
1% <input type="checkbox"/>		
2% <input type="checkbox"/>		
3% <input type="checkbox"/>	Invesco Comstock Fund - Class A	Growth
4% <input type="checkbox"/>		
5% <input type="checkbox"/>		
6% <input type="checkbox"/>		
7% <input type="checkbox"/>	SSgA S&P 500 Index Securities Lending Series Fund - Class IX	Growth
8% <input type="checkbox"/>		
9% <input type="checkbox"/>		
10% <input type="checkbox"/>	T. Rowe Price Blue Chip Growth Fund - Class R	Growth
11% <input type="checkbox"/>		
12% <input type="checkbox"/>		
13% <input type="checkbox"/>		
14% <input type="checkbox"/>		
15% <input type="checkbox"/>		
16% <input type="checkbox"/>		
17% <input type="checkbox"/>		
18% <input type="checkbox"/>		
19% <input type="checkbox"/>		
20% <input type="checkbox"/>		
21% <input type="checkbox"/>		
22% <input type="checkbox"/>		
23% <input type="checkbox"/>		
24% <input type="checkbox"/>		
25% <input type="checkbox"/>		

What are fund categories?

Back Next

Step 7: Confirm Your Investment Elections

Here you will confirm your elections selected on the previous screen. If you would like to change these elections, select the "Investment Options" button.

Otherwise, select the "Next" button.

Choose how to invest

Your contributions will be invested as you designated in the investment option(s) below.

20% - Invesco Stable Asset Fund
20% - PIMCO Total Return Fund - Class A
20% - Invesco Comstock Fund - Class A
20% - SSgA S&P 500 Index Securities Lending Series Fund - Class IX
20% - T. Rowe Price Blue Chip Growth Fund - Class R

Where can I find a prospectus/information statement? What are the risks?

Investment Options Next

Step 8: You're Almost Finished

To wrap up this application, you will need to provide your personal information:

- Your First and Last Name
- A Valid Email Address; and
- Your Social Security Number

Confirm that this information is correct, review the required acknowledgment, click on the box to indicate you've done so, and then select the "Enroll" button to complete the online enrollment process.

Enroll - Personal Information

Automatic Data Processing, Inc. www.mykplan.com/Enroll/step3.html

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You're almost finished!

Please enter the information below and click 'Enroll'.

First Name Middle Initial

Last Name

Email Address

Social Security Number

Confirm SSN

I have read the acknowledgement

By clicking Enroll you are authorizing the deductions from your pay that you chose, which will be invested in the options you selected.

[Privacy Policy](#)

Enroll - Personal Information

Automatic Data Processing, Inc. www.mykplan.com/Enroll/step3.html

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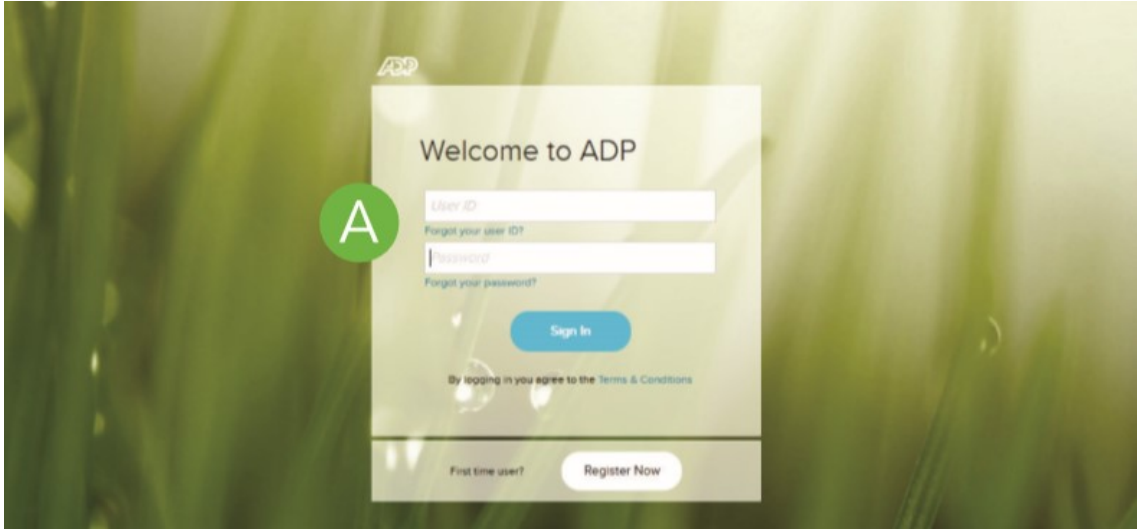
Congratulations!

You will receive an email confirming your enrollment in the plan.

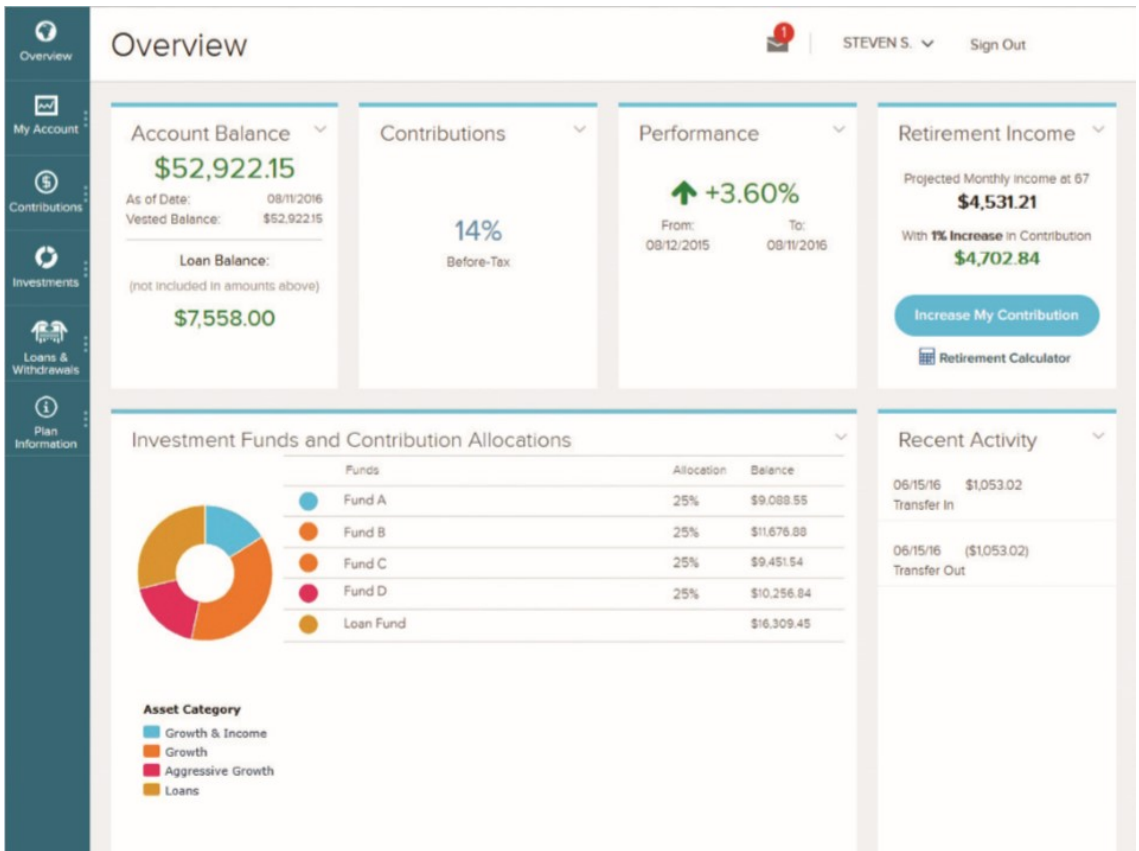
To protect your privacy, the information you entered will be deleted from this device.

Accessing Your 401(k) Account Online:

- A.** Once your account is established, you will receive a notification by mail which includes information to access your account online. To log into your account, simply go to: www.mykplan.com



Accessing your online account will allow you to monitor performance; make adjustments to your asset allocations; increase or decrease deferral percentages; and make updates to your personal information.



In the event you would like to setup your account over the telephone or require additional assistance:

Setting up Your Account over the Telephone: 888-822-9238

You have secure access to your account through the automated Voice-Response System, and personal assistance through a Customer Service Representative.

-
- | | |
|------------------------------|--|
| Voice-Response System | <ul style="list-style-type: none">▶ 24 hours a day, 7 days a week²▶ Get account information▶ Conduct transactions▶ Request investment information and prospectuses |
|------------------------------|--|

- | | |
|--|---|
| Customer Service Representative | <ul style="list-style-type: none">▶ Available Monday – Friday 8am – 9pm EST▶ Get answers to your questions▶ Review account information▶ Request transactions |
|--|---|

² Generally available 24 hours a day, 7 days a week except for periods of scheduled maintenance. Customer Service Representatives are employed by ADP Broker-Dealer, Inc., an affiliate of ADP, LLC, One ADP Boulevard, Roseland, NJ 07068. Member FINRA.

Please note:

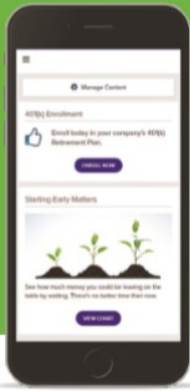
If you misplaced or did not receive your letter, you can simply call 1-800-MYKPLAN and our Client Service team can help you establish your login credentials.

Stay connected to your account and get there one step at a time.

www.mykplan.com | 888-822-9238

Enrollment Process through the ADP Mobile App.:

1. Not enrolled in your company's 401(k) plan? You can do it now — it's fast and easy through the ADP Mobile App.



Enrolling in your company's 401(k) plan — and contributing even a small amount regularly — can really add towards your savings for retirement. Participating in the plan allows you to take advantage of these great benefits:

- ▶ Tax-advantaged savings;
- ▶ Convenient, automatic payroll deductions;
- ▶ Variety of ways to become retirement ready;
- ▶ Features that simplify planning; and
- ▶ An account you can take with you.

Scan the QR Code to Download the ADP Mobile App.¹



The app is also available through the Apple App Store and Google Play.

2. Once you're enrolled, managing your savings is a snap.

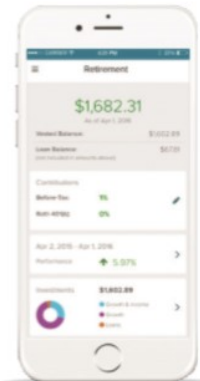
Getting the latest information about your Retirement Plan Savings Account has never been easier. Log in through your Desktop or within the ADP Mobile App.

Convenient Dashboard

- ▶ Designed for easy navigation to your Retirement Plan Savings Account.²

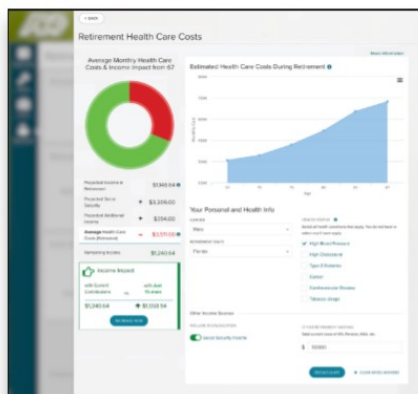
Fast Access to Your Retirement Plan Savings Account, Online or On the Road

- ▶ Check account balances, vested balance, outstanding loan balance, and rate of return;
- ▶ Change your contribution rate; and
- ▶ Change how future contributions are invested; and options to receive personalized mobile notifications.



3. Become a Financial Wellness Know-it-All.

This online library of financial wellness tools, located on the ADP Retirement Services Participant website, includes timely articles and information; calculators; tutorials; and videos to help plan your finances for every stage of life — no matter what stage of life you're in.³



4. Plan for your future medical expenses in retirement.

The Retirement Healthcare Costs Projector is an interactive tool that allows you to estimate your future medical expenses — all geared to help you plan and save for your health care needs during retirement.⁴

All these tools are accessible through the ADP Retirement Services Participant Website, www.mykplan.com. All to help you get started saving today.

ADP Retirement Services 71 Hanover Road, Florham Park, NJ 07932

- 1 ADP Mobile App Minimum system requirements: The ADP Mobile App is available on the following devices: iPhone®, iPad®, iPod touch® iOS v7.0 or higher, Android™ v4.4 or higher.
- 2 If Mobile is enabled for other ADP products, additional features will be displayed on the dashboard.

New 401(k) Plan Feature Update:

Updating the Beneficiaries for Your ADP 401(k) Plan's Retirement Account Can Now be Completed Online. To begin, log onto your ADP 401(k) Retirement Savings Account at www.mykplan.com or follow below process.

You can make updates to your 401(k) Plan's beneficiaries online. To begin, log onto your ADP 401(k) Retirement Savings Account at www.mykplan.com, and select the **Manage My Beneficiaries** option from under the **My Account** tab.

- A. On the **Manage My Beneficiaries** screen, select one of the two options.
1. When the first option is selected, you will need to follow the direction listed under Step B.
 2. If the second option is selected, you will be prompted to complete and return a hardcopy of the Beneficiary Form requiring spousal consent.

- B. When you select the first option, you will be redirected to a second screen.

To continue the online process, select the **Add New Beneficiary** button located at the bottom of the screen.

- C. On the last screen, you will be able to complete your online beneficiary designations for your 401(k) Plan account.

BENEFICIARY INFORMATION

Primary Beneficiary
 Secondary Beneficiary

Relationship: **-Select Relationship-**

Percent:

Social Security Number:

Name:

Address 1:

Address 2:

City:

State: **-Select State-**

Zip Code:

Date of Birth:

My Account Manage My Beneficiaries

PLEASE READ THIS IMPORTANT INFORMATION REGARDING YOUR BENEFICIARY SELECTION BEFORE YOU CONTINUE.

By making a beneficiary designation, you are selecting who will receive any balance in your plan account when you die. You may designate one or more beneficiaries, including individuals or trusts, as provided under the terms of your plan. If you do not designate a beneficiary, the terms of your plan will determine who will receive any account balance you have at the time of your death, or if the plan is silent on this subject, your beneficiary will be determined under applicable law.

- If you are single, you can make your beneficiary election online.
- If you are married and wish to name your spouse as the sole primary beneficiary, you can make your beneficiary election online. If you are married and wish to name someone other than or in addition to your spouse as the beneficiary, you must complete and return a signed Beneficiary Designation Form. Complete this form and submit it to the address listed on the form. Be sure that your spouse has signed the form to approve the beneficiary designation.
- If you have any questions as to whether your plan permits the designation of a beneficiary who is not an individual (i.e., a trust) and the effect of whether or not such a designation will be valid, you should contact your Plan Administrator.
- If you have any questions as to whether or not you are considered "married" for purposes of your plan (i.e., married, if you are separated from your spouse, have been abandoned by your spouse, etc.), please contact your Plan Administrator.

SELECT AN OPTION

I am either married and want all of my death benefits paid to my spouse, or I'm married.

I am married and want my death benefits paid to someone other than my spouse or in addition to my spouse. Please note: If you choose this option, you will be prompted to complete and return a Beneficiary Designation Form (requiring spousal consent).

Area Detail

SELECT AN OPTION

I am either married and want all of my death benefits paid to my spouse, or I'm married.

I am married and want my death benefits paid to someone other than my spouse or in addition to my spouse. Please note: If you choose this option, you will be prompted to complete and return a Beneficiary Designation Form (requiring spousal consent).

My Account Manage My Beneficiaries

By completing the information on this page you will have designated one or more beneficiaries to receive any balance in your plan account when you die. You may modify your election by returning to this page at any time. You may modify or modify your beneficiary designation by returning to this page and designating a new beneficiary and your new designation will become effective immediately.

IMPORTANT: After you have designated your beneficiaries, click "Print" at the top of this page to print a copy for your records. If you have difficulties printing, please contact your Plan Administrator to obtain a copy.

To add a new beneficiary, click **Add New Beneficiary**, enter the information required, and then click **Save**. To update or delete an existing beneficiary, click the appropriate button in the last column, enter the new information, and then click **Save**. The total amount designated to your primary and/or secondary beneficiaries must each total 100%.

Be sure to click **SAVE** to complete your transaction.

Participant: **STEVEN STANHOPE**

PRIMARY BENEFICIARY		SECONDARY BENEFICIARY			
SSN	Name	Address	DOB	Relationship	Percent
xxxx	xxxx	xxxx	xxxx	xxxx	0%
xxxx	xxxx	xxxx	xxxx	xxxx	0%

Add New Beneficiary

If you do not want to designate your beneficiary information online and would prefer to use the Beneficiary Designation Form, click here.

The information contained herein is intended as general information only, and nothing in these materials is intended to be, nor should be construed as, advice or a recommendation for a particular situation, individual or plan. ADP, LLC and its affiliates (ADP) do not endorse or recommend specific investment companies or products, financial advisors or service providers; offer financial, investment, tax or legal advice or management services; or serve in a fiduciary capacity with respect to retirement plans. Please consult with your own advisors for such advice.

Rollovers:

If you're not sure what to do with a retirement plan from a previous employer, you may want to consider rolling it into your current plan.

You have several options for what to do with assets in a prior employer's 401(k) plan¹. Rolling this money over into your current employer's plan may help you:

- Simplify your planning by consolidating your money into one account to manage.
- Protect your money from taxes, penalties and withholding²
- Access this money should you need to take a loan or in-service distribution (if available)

ADP make it easy for you:

ADP can provide you with information about all of your options and, if you choose to roll your previous retirement account into your current plan, we can help you complete the rollover process. Our Retirement Counselors³ can give you one-on-one assistance and help you every step of the way to:

- Guide you through the process
- Assist you with the paperwork
- Oversee the transfer of the money into your current plan

For more about rollover and how they can help contact ADP Retirement Counselor:

ADP Rollover Desk: 1-877-401-5725, option 2

¹ In addition to rolling assets into your new employer's plan, you can also take a cash distribution, roll the assets into an IRA or leave the money in your prior plan.

² You may be subject to taxes and penalties if you take a cash distribution.

³ Licensed representatives of ADP Broker-Dealer, Inc., an affiliate of ADP, LLC, One ADP Blvd., Roseland, NJ; Member FINRA

Referral Benefit

It is our endeavor to attract the right talent at HIGHBROW TECH LLC and using referrals as a source for hiring has helped us to improve our quality of hires & offer acceptance ratio.

- **Scope and Eligibility:**
 - The referral scheme is applicable to all permanent employees.
 - Management team and HR team shall not be eligible for employee referral incentive.
- **Details:**
 - HR Team will post resource requirements on Highbrow website or communicate through email.
 - Employees may refer suitable candidates through email only to respected HR team members.
 - The referred candidate will undergo HR pre-screening as per the recruitment process map and if found suitable, will be short listed for further interviews to be conducted by the concerned clients.
 - If HR already has the referred resume in the database, it will not be considered as reference resume. HR will revert about the same to the employee.
 - Referred resume will be active for a period of 6 months from the date of referral.
 - Contact the HR Team to know the status of your referral.
 - The incentive amount is \$1000 and it is taxable and will paid along with the salary of the employee upon successful completion of 1 month of the referred candidate in the organization.
 - The decision of Director-HR on hiring referral candidate will be final and binding.