

2020

Benefits Guide

Look inside to
learn all about your
Capital One benefits.



Be Well
Benefits

How to Use This Guide

Review your 2020 benefits, coverage costs and tips to help you think about your needs and choose benefits that work best for your family and finances. Visit mybewellbenefits.com to access a digital version of this guide.

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Health Insurance Requirements

Qualified individuals have the opportunity to purchase their 2020 health insurance through the public health insurance marketplace (often referred to as an “exchange”). As a Capital One associate, you're offered comprehensive, affordable insurance that likely provides better coverage at a lower cost, so selecting one of the company's health plans may be a better option for you.

Enrollment 101



Eligibility for Benefits

Your eligibility for Capital One's Health and Welfare plans described in this guide is based on your employment status.

If you're a full-time associate (regularly scheduled to work 33-40 standard hours per week as maintained in Capital One's system of record, Workday), you're eligible for Capital One benefits on your date of hire (except Short-Term Disability).

If you're a part-time associate (regularly scheduled to work at least 20 standard hours per week as maintained in Capital One's system of record, Workday), you're eligible for Capital One health benefits (except Short-Term Disability) after 90 days of employment.

If you're rehired any time by Capital One as a part-time associate, you must have completed 90 days of full-time or part-time service before your original departure to be eligible for health benefits on date of rehire.

The Patient Protection and Affordable Care Act (the Health Care Reform law) requires employers with 100 or more employees to offer affordable health care coverage to full-time employees who work an average of 30 or more hours per week. Capital One eligibility guidelines already meet—and exceed—this requirement. We're including additional measures to ensure all associates who could meet the eligibility criteria set forth by the law are eligible for our health benefits.

If you're a part-time associate regularly scheduled to work fewer than 20 standard hours per week as maintained in Capital One's system of record, (Workday), you are typically ineligible for benefits. However, if you meet the required average of 30 "hours of service" per week as defined by the Health Care Reform regulations, you may be eligible for health benefits (except Short-Term Disability and the Vacation/Paid Time Off (PTO) Buy-Up program) after 90 days of employment. We'll monitor service hours to ensure eligible associates receive benefits.

Note: Contractors (e.g., leased employees, independent contractors and other workers who are not classified as employees by Capital One), temporary associates, interns and similar categories of workers are not eligible for Capital One benefits, such as health and welfare, retirement and leave and time-off benefits.

Social Security Numbers

By law, we must ask for Social Security numbers (SSNs) during online enrollment. If either you or one of your dependents doesn't have a SSN, contact the Capital One Benefits Center at **1-888-376-8836** to enroll by phone.

Important

All eligible associates, **including part-time associates**, must enroll in benefits within 31 days of date of hire. Full-time associate elections are effective as of date of hire and part-time associate elections will take effect 90 days from date of hire.

A complete listing of eligibility for all benefit programs can be found on Pulse.

For Your Dependents

Eligible dependents include:

- Your spouse or domestic partner
- Dependent children who are married or unmarried—including adopted children, foster children in your care and stepchildren. Children are eligible from the day they are born, adopted or placed with you as a foster child until the end of the month of their 26th birthday.
- Your domestic partner's biological or adopted children who reside with you until the end of the month of their 26th birthday
- Other minor children if you are a legal guardian
- Older children with mental or physical impairments may be eligible—certifications must be provided (as applicable)

Ineligible dependents include, but are not limited to:

- Divorced spouses—**if you are legally required to provide medical coverage for your divorced spouse, you must purchase individual coverage outside of the Capital One plans**
- Parents, grandparents, siblings, aunts, uncles and cousins—are not eligible under any circumstance
- Spouses of dependent children

Domestic Partner

Eligible associates may enroll their domestic partner for medical, dental, vision and life insurance coverage.

A domestic partner is a person of the same or opposite gender as you, with whom you share your life. To be eligible for domestic partner coverage, you and your domestic partner must:

- Be at least 18 years of age
- Not be related by blood
- Be each other's sole domestic partner and intend to remain so indefinitely
- Reside in the same residence
- Be financially interdependent
- Not be legally married to anyone else

You also may cover your domestic partner's biological or adopted children if:

- You cover your domestic partner
- The children are under age 26 (older children with mental or physical impairments may be eligible—certifications must be provided (as applicable))
- They live in your household

How to Enroll

Enrolling in benefits is easy at capitalonebenefits.com (access via SSO through the Pulse home page then navigate to Resources > Benefits > Enroll In or Change Benefits > click on the link):

- Log in with your current username and password.
- If you're a new associate or don't already have access, just follow the prompts to register as a New User.
- Watch the Welcome Tour video and set up your personal profile.
- Click **Get Started** in the upper left on the Home page to enroll.
- Click the **Choose Benefits** tab at the top of the page.
- To enroll for 2020 or make a change to your benefits, click the links for Medical, Dental, Vision, Spending Accounts, Life and Disability plus Vacation/Paid Time Off (PTO) Buy-Up program (time off program updates are only possible during Open Enrollment) under the **Choose Benefits** tab or use the **Previous** and **Next** buttons to progress through each benefit.
- Your cart will begin with default coverage. As you make your benefit selections or changes, your choice will be added to your cart. You can click the **Your Cart** tab at any time to review your selections.
- After you made all your choices you will need to **Review Your Cart**.
- Scroll to the bottom of the page to see your **Cost of Benefits**. From there you can make changes, if you need to, or click **Check Out** to finish your enrollment. Keep in mind you need to accept the **Terms and Conditions Statement** in the **Check Out** process to submit your enrollment.
- Once you have checked out, you will see a confirmation screen; you can print this screen and save it for your records.

Questions?

Contact the Capital One Benefits Center at **1-888-376-8836 (options 2, 2, 0)**, 8 a.m. to 8 p.m. ET, Monday–Friday.

When to Enroll New associates must enroll within 31 days of hire. Elections generally take effect for full-time associates on their date of hire and 90 days from date of hire for part-time associates.

- Associates who become newly eligible for benefits must enroll within 31 days of becoming eligible for benefits. The elections will be effective for full-time associates on the date they go full-time or after 90 days for part-time associates.
- Current associates must enroll during the Open Enrollment period.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, please review the information provided on page 44.

If you're a new hire or experience a life event between October 10, 2019 and December 31, 2019, please review the New Hire/Life Event page on **MyBeWellBenefits.com** before enrolling. You'll need to enroll in or update your benefits coverage for 2019 and 2020 benefits.

The Capital One Benefits Center

Visit capitalonebenefits.com anytime, anywhere—you have the freedom to log in, review and manage your benefits from any mobile device, tablet or computer.

Benefits at a glance—After logging in, you can easily view your Dashboard and Benefits Summary, showing the key details most relevant to you.

Personalized for you—Customize your profile by selecting Menu on the top right and then clicking Profile under My Account. There are several items you can change, so you have a tailored online experience.

Knowledge Center resources—View articles and videos chosen just for you based on your profile's Personalization selections.

Life event changes—Link directly from the homepage to the easy-to-use Life Event reporting tool that walks you through considerations and action steps.

Tools and quick links—You'll have easy access to helpful estimating tools and frequently used resources, using intuitive options.

What's New for 2020

Medical Plan Changes

For 2020, we are enhancing and simplifying some of our benefits, making costs more predictable. Proactively managing your health will help you live your best life and can reduce your future health care costs.

- **Free in-network Primary Care Physician (PCP) visits,** for both preventive/wellness check ups and sick visits, to ensure you can get the care you need, when you need it!
- **You'll only pay a specialist co-pay for in-network physical therapy, speech therapy and occupational therapy visits.** You will no longer be required to meet your deductible (the amount you pay before your health plan benefits kick in) for these services, so it will be even easier to predict your costs.
- **Visits to a psychologist or psychiatrist will have a lower co-pay** than other specialist providers making mental health care more affordable in 2020.
- **We are making it easier to understand your total out-of-pocket costs.** Instead of showing a co-insurance maximum that does not include the deductible, we'll show the out-of-pocket maximum that includes your deductible. The total dollar amounts are staying the same.
- **If you choose to see an out-of-network provider, your co-insurance amount will be higher** than in past years. Always remember that in-network providers have agreed to negotiated rates and cost you significantly less than using an out-of-network provider.

As you review the plan changes, be sure to take into account how these changes impact your health care expenses. You'll want to consider that when you plan how much you may want to contribute to a Health Care Flexible Spending Account. Many of these changes will save you money!

Be sure to review the medical plan comparison table on page 14 to help you understand how the plans are changing.

Also, be on the lookout for a new medical plan ID card from Anthem in late December.

Prescription Drug Plan Changes

To keep pace with rising costs and changing prices in the prescription drug market, our pharmacy benefits are moving to a co-pay design. Switching to co-pays will cause the cost of some drugs to increase and some to decrease but it will make it easier to understand what you will pay when filling a prescription. We are also adding a new co-pay tier for Specialty drugs to differentiate the cost of these medications from less expensive non-specialty medications.

You can find complete details about these changes in the Prescription Drug Coverage section on page 18.

Health Care Flexible Spending Account Changes

- The Health Care FSA contribution limit for associates is increasing to \$2,700 for 2020. The maximum contribution, including Capital One's contribution, is \$3,700.
- If you enroll in a Health Care FSA for 2020, you must incur all eligible expenses by December 31, 2020, and submit for reimbursement by April 30, 2021.
 - If you have a remaining balance after April 30, you can roll over up to \$500 into 2021 to be added to your available balance for use throughout the calendar year.
- Be sure to factor in the health plan changes when deciding how much to contribute to your HC FSA!

Health Care Costs

For 2020, with the changes we are making, and depending on which plan you choose and who you cover, your paycheck contributions for 2020 may be increasing or decreasing. When you think about what health plan is right for you, it's important to look at the full picture – what you pay from your paycheck and what you'll pay when getting care. We know health care is expensive and Capital One continues to have your back by picking up the majority (80% on average) of associates' total health care costs. As you consider your choices for 2020 benefits, we encourage you to:

- Look at the whole picture, meaning it's not just about how you pay from your paycheck.
- Think about how much coverage you need for the upcoming year.
- Consider when and how you pay for care. Would you prefer to pay more out of your paycheck and less if and when you need care, or are you ok with paying less per paycheck and more if and when you go to the doctor?

Estimate Your Health Care Costs with the Medical Plan Selector Tool.

You shouldn't pay more for more coverage than necessary. That's why we offer the Medical Plan Selector Tool. With the Selector Tool, you can estimate and compare costs for medical plans based on your past claims and expected needs. Plus, you can calculate contributions for your Health Care Flexible Spending Account.

Cost of Coverage

2020 Associate Benefits Contributions—Medical Coverage

Plan	Coverage Tier	Bi-weekly Associate Contribution
Basic	Associate	\$21.11
	Associate + Spouse or Domestic Partner	\$91.36
	Associate + Child(ren)	\$72.90
	Associate + Spouse or Domestic Partner + Child(ren)	\$139.32
Enhanced	Associate	\$48.30
	Associate + Spouse or Domestic Partner	\$150.72
	Associate + Child(ren)	\$126.87
	Associate + Spouse or Domestic Partner + Child(ren)	\$227.46
Premium	Associate	\$79.77
	Associate + Spouse or Domestic Partner	\$219.94
	Associate + Child(ren)	\$191.26
	Associate + Spouse or Domestic Partner + Child(ren)	\$325.78

2020 Associate Benefits Contributions—Vision Coverage

Plan	Coverage Tier	Bi-weekly Associate Contribution
Basic	Associate	\$1.01
	Associate + Spouse or Domestic Partner	\$2.02
	Associate + Child(ren)	\$2.44
	Associate + Spouse or Domestic Partner + Child(ren)	\$3.62

2020 Associate Benefits Contributions—Dental Coverage

Plan	Coverage Tier	Bi-weekly Associate Contribution
Basic	Associate	\$6.09
	Associate + Spouse or Domestic Partner	\$12.19
	Associate + Child(ren)	\$10.98
	Associate + Spouse or Domestic Partner + Child(ren)	\$17.07
Enhanced	Associate	\$10.98
	Associate + Spouse or Domestic Partner	\$21.95
	Associate + Child(ren)	\$19.51
	Associate + Spouse or Domestic Partner + Child(ren)	\$30.48

Voluntary Supplemental Life Insurance and Accidental Death and Personal Loss (AD&PL)

You can buy, with post-tax dollars, additional life and AD&PL insurance for yourself of up to 8 times your Annual Benefits Salary*. Together with company-provided Basic Life and AD&PL Insurance, that means that you can have up to 9 times your Annual Benefits Salary up to \$2.5 million. The minimum coverage amount is \$5,000. The maximum coverage amount is calculated separately for life and AD&PL.

For VPs and above:

For those enrolled in the Executive Life Insurance Program (ELIP), you can purchase Supplemental Life Insurance for up to 8 times your pay. Combined with ELIP, your Life Insurance coverage can be up to \$5 million.

Associate Voluntary Supplemental Life Insurance Costs

Associate's Age as of Jan. 1, 2020	Bi-weekly Cost per \$1,000 of Coverage (post-tax)
<30	\$0.02
30–34	\$0.03
35–39	\$0.03
40–44	\$0.04
45–49	\$0.06
50–54	\$0.08
55–59	\$0.12
60–64	\$0.16
65–69	\$0.23
70–74	\$0.47
75–79	\$0.75
80+	\$0.75

Coverage Options Available for Dependent Life—Spouse/Domestic Partner and/or Children

Coverage Option	Bi-weekly Cost (post-tax)
\$25,000 spouse or domestic partner	\$1.08
\$50,000 spouse or domestic partner	\$2.15
\$75,000 spouse or domestic partner	\$3.22
\$100,000 spouse or domestic partner	\$4.29
\$125,000 spouse or domestic partner	\$5.37
\$150,000 spouse or domestic partner	\$6.44
\$175,000 spouse or domestic partner	\$7.51
\$200,000 spouse or domestic partner	\$8.58
\$225,000 spouse or domestic partner	\$9.66
\$250,000 spouse or domestic partner	\$10.73
\$10,000 child only	\$0.51
\$20,000 child only	\$1.02

* An associate's Annual Benefits Salary is effective January 1 of each calendar year and is equal to his/her base salary as of September 1 of the prior year. If an associate receives commissions or sales incentives, his/her Annual Benefits Salary includes those amounts received during the 12 months preceding September of the prior year. Annual Benefits Salary does not include annual performance bonuses, long-term incentives or operational non annual performance or achievement awards. If an associate is hired after September 1 of the prior year, his/her Annual Benefits Salary is equal to his/her base salary as of the hire date and does not include any commissions or sales incentives. If a Draw associate does not have a base salary, then his/her Annual Benefits Salary defaults to \$50,000.



Supplemental Long-Term Disability

Capital One automatically provides 50% of your Annual Benefits Salary for Long-Term Disability coverage. You have the opportunity to purchase additional coverage. The monthly cost for the additional 20% of coverage is \$0.277 per \$100 of your Annual Benefits Salary. The rate takes into account that you're buying just 20% of your Annual Benefits Salary in coverage.

Coverage Option	Monthly Cost (post-tax)
Additional 20% of Annual Benefits Salary to provide 70% of total income replacement	\$0.277 per \$100 of your monthly benefits salary

Sample Calculation for Supplemental Long-Term Disability

Let's use Keith as an example. He:

- Earns \$60,000 per year
- Is covered at no cost to him for 50% of his base pay, or \$30,000
- Purchases the extra 20% coverage and will pay \$5.23 per paycheck

$$\begin{aligned} \$60,000 / 12 &= \$5,000 \text{ monthly pay} \\ \$5,000 / \$100 &= \$50 \text{ (your monthly pay / \$100)} \\ \$50 \times 0.227 &= \$11.35 \text{ per month} \\ \$11.35 \times 12 \text{ months a year} &= \$136.20 \\ \$136.20 / 26 \text{ pay periods} &= \$5.23 \end{aligned}$$



Cost Considerations for Domestic Partner Coverage

In accordance with IRS regulations, there are unique cost considerations for those associates who cover a domestic partner. The key considerations are the following:

- The portion of the associate's premium that is attributable to covering the domestic partner is paid on a post-tax basis rather than on a pre-tax basis like for the associate's own coverage or that of other dependents.
- The company's contribution toward the cost of the domestic partner's coverage (called the fair market value) is added to your earnings for the year and is subject to the applicable taxes.

Capital One will provide associates with a domestic partner (under our medical, dental and visions plans) a gross-up amount to help cover the taxes owed on these benefits. If you have indicated on IRS Form W-4 that you are exempt from federal income tax withholding, no gross-up will be applied. Similarly, if you have indicated that you are exempt from state tax withholding, no state gross-up will be provided.

Glossary of Benefits Terms

Term	Definition
Co-payment or Co-pay	Set dollar amount you pay for network doctor office visits and prescriptions. No other fees or deductibles apply.
Deductible	Dollar amount an individual or family must pay for covered care each calendar year before the medical plan pays benefits for most services—the deductible does not apply to network doctor office visits, preventive or wellness care, prescriptions or routine lab work.
Co-insurance	Percentage of the cost for eligible medical expenses that you pay after you meet the deductible.
Out-of-Pocket Maximum	The maximum annual dollar amount an individual or family pays for covered health care expenses, which includes co-pays, deductible and co-insurance. Once you reach this maximum, the plan covers 100% of the cost of any additional eligible expenses incurred for the rest of the calendar year. This feature provides financial protection for you by limiting your out-of-pocket expenses in a given calendar year. Any out-of-network expenses incurred in excess of the allowed amount are not included in this maximum number.
Allowable Charge	The maximum amount that a health benefit plan will pay for a given covered service or supply. Also called maximum benefit allowance, maximum allowance or reasonable charge.
Urgent Care	Services that are non-preventive or non-routine, and needed in order to prevent the serious deterioration of a member's health following an unforeseen illness, injury or condition. Urgent care includes conditions that could not be adequately managed without immediate care or treatment but do not require the level of care provided in the emergency room.
Walk-In or Retail Clinics	Clinics that can be found in certain retail settings like in a CVS store, Walgreens, or one of many other retailers. Care for minor acute conditions can be sought in this setting. These clinics offer high-quality care at no cost to you (no co-pays).



Helpful Contact Resources

If you have questions that aren't answered in this guide, visit capitalonebenefitsite.com to send an email or chat live with a service representative. You can also use these telephone and online resources to get answers.

Have Questions About...	Company...	Phone/Web...	App...
Benefits			
Medical	Anthem Blue Cross Blue Shield Member Services Health Guide (Be Well Care Center)	1-844-390-4133 or anthem.com/capitalone	✓
Prescription Drug	CVS Caremark	1-877-210-3556 or caremark.com	✓
Dental	Delta Dental	1-844-344-8006 or deltadentalva.com	✓
Vision	Anthem Blue View Vision	1-866-723-0515 or anthem.com/capitalone	
Fertility and New Parent Benefits	WINFertility Milk Stork	1-844-323-7539 or winfertility.com/capital-one/ 1-888-207-6909 or milkstork.com/capitalone	✓
Medical Second Opinions	Consumer Medical	1-888-361-3944	
Flexible Spending Accounts	Anthem Blue Cross Blue Shield Member Services Health Guide (Be Well Care Center)	1-844-390-4133 or anthem.com/capitalone	✓
Be Well Rewards Program (Incentive Program)	Redbrick Health (Be Well Rewards Program)	1-844-894-WELL (844-894-9355) or BeWellBenefits.RedbrickHealth.com	✓
Shopping for Care	Castlight Health (Capital One Medical Plan Participants)	1-866-970-2314 or https://mycastlight.com/capitalone/ or support@castlighthealth.com	✓
Telemedicine	LiveHealth Online	888-LiveHealth (548-3432) or email help@livehealthonline.com	✓
Life and AD&PL Insurance	The Hartford	1-877-867-4790	
Short-Term Disability	Sedgwick	1-844-321-CAP1 or https://claimlookup.com/capitalone	
Long-Term Disability	Cigna	1-800-238-2125 or mycigna.com	
401(k) Associate Savings Plan	Capital One Retirement Savings Center (Fidelity Investments)	1-800-854-4015 or netbenefits.com	✓
Commuter Benefits	WageWorks	1-877-924-3967 or wageworks.com	
Associate Stock Purchase Plan	Equity Administrator	EquityAdministrator@capitalone.com	
Educational Assistance	EdAssist	1-855-789-3852 or https://capitalone.edassist.com	✓
Adoption/Surrogacy Reimbursement	Anthem EAP	1-855-383-7222 or anthemeap.com (login: Capital One)	
Employee Assistance Program	Anthem EAP	1-855-383-7222 or anthemeap.com (login: Capital One)	
Back-Up Child and Family Care	Bright Horizons	1-877-242-2737 or go to careadvantage.com/capitalone • User name: CapitalOne • Password: Bewell	✓
Time-Off	Capital One Benefits Center (Morneau Shepell Benefits Administration)	1-888-376-8836	
Vacation Buy-Up	HR Help Center	HRHelpCenter@capitalone.com	
College Coach	College Coach	1-877-527-3550 or https://passport.getintocollege.com	
Other			
Enrolling or Making Health and Welfare Benefits Changes	Capital One Benefits Center (Morneau Shepell Benefits Administration)	1-888-376-8836 (options 2, 2, 0) or capitalonebenefitsite.com	
Enrolling or Making Benefit Changes to Your 401(k) Participation (may be done at any time during the year)	Capital One Retirement Savings Center (Fidelity Investments)	1-800-854-4015 or netbenefits.com	
Open Enrollment (general questions and eligibility)	Capital One Benefits Center (Morneau Shepell Benefits Administration)	Call 1-888-376-8836 (options 2, 2, 0)	
Passwords (for help with Capital One Benefit Site passwords)	Capital One Benefits Center (Morneau Shepell Benefits Administration)	Call 1-888-376-8836 (options 2, 2, 0)	
COBRA Coverage and Enrollment	Anthem Blue Cross Blue Shield	1-877-775-9393 or benefitadminsolutions.com Select "Anthem Blue Cross Blue Shield (Anthem)" from drop-down	

Choosing the Best Medical Plan for You



Medical Coverage Overview

Administered by Anthem Blue Cross and Blue Shield



You Have Three Medical Plan Options

- Basic
- Enhanced
- Premium

All cover the same medical services and use the same provider network, but financial aspects—such as deductible amounts, co-insurance levels and out-of-pocket maximums—differ. Enrollment in the prescription plan is included as part of your enrollment in the medical plan, and pharmacy coverage is the same for all three medical plans. In general, as you increase the plan level (move from Basic to Enhanced or from Enhanced to Premium), the bi-weekly premiums increase, while the out-of-pocket costs for services rendered decrease.

Capital One's medical plan offers a large network of doctors, hospitals and other health care specialists who deliver quality care according to network standards and have agreed to preferred rates for covered services. With Anthem, you have access to one of the broadest networks in the country. That means better savings and more choices for you.

With your Anthem plan, you will have the choice to see a provider who is out-of-network. However, your coverage is lower and you will pay more for services. Because out-of-network providers don't have a contract with Anthem, they can charge any price they want and you may be responsible for paying the costs above the reasonable rate.

A Few Things to Think About

- How much you plan to contribute to an HCFA, which can help you save tax-free dollars to pay for eligible expenses
- Your bi-weekly premium contribution—the amount that comes out of your paycheck
- Your cost of care—for example, co-payments, co-insurance, deductible amounts

Help Choosing a Medical Option

Generally, the higher your premium cost, the lower your out-of-pocket costs for care—and vice versa.

As you consider your medical plan options, you'll also want to:

- Identify the kind of health care services you expect to use—based on the historical use of medical care by you and your covered dependents, and your anticipated needs for the year.
- Think about whether you and your covered dependents are likely to use medical services often or have high out-of-pocket costs.
- Consider other coverage options you may have—for example, through your spouse's employer—and compare the estimated total cost of using that plan versus the Capital One plan.

You should strongly consider using the Medical Plan Selector Tool to select the best plan for your health care needs.

Coordination of Benefits

If you, your spouse or your dependents are covered under the Anthem plan and another group health plan or local, state or government program other than Medicaid, benefits from the company's health plan will coordinate with any other benefits you receive.

Medical coverage provided by the Plan follows Medicare's primary versus secondary payer rules when determining when Capital One's Plan pays as primary. If Medicare rules say Medicare is the primary payer for a covered person, the Capital One Plan will be the secondary payer. If Medicare rules say the Capital One Plan is the primary payer, Medicare will be the secondary payer. For additional information please refer to the Summary Plan Description or visit [medicare.gov](https://www.medicare.gov) for primary vs. secondary rules.

Choose How to Reach Anthem

Anthem's Member Services Health Guides work closely with health care professionals like nurses, health coaches, social workers and others. This combined super-service team is here to help you make the most of your plan's benefits. Member Services Health Guides can help you:

- Connect with programs and support covered by your benefits
- Stay on top of checkups, tests and preventive screenings by reminding you to make an appointment
- Compare costs of health care services
- Find in-network doctors and much more

Reach Anthem Member Services Health Guides by:

- **Calling 1-844-390-4133** Monday through Friday from 8 a.m. to 8 p.m. ET. The number is also on your Anthem ID card.
- Sending us a **secure email** by logging in at anthem.com/capitalone and selecting **Customer Support > Message Center > Compose Message**
- **Chatting with us** by logging in at anthem.com/capitalone and choosing **Customer Support > Contact Us > Chat With Us**

Preventive Versus Diagnostic Care

What's the difference? Preventive care helps you stay healthy and can detect any illnesses before you experience symptoms. Diagnostic care is used to find the cause of existing illnesses. For example, say your doctor suggests you have a colonoscopy because of your age when you have no symptoms. That's preventive care. On the other hand, say you have symptoms and your doctor suggests a colonoscopy to see what's causing them. That's diagnostic care.

Preventive Care at No Cost to You

Regular preventive care can help you identify health risks before they lead to more serious medical issues. To encourage regular routine physical exams, screenings and immunizations, the Capital One plans pay the full cost of covered preventive care—with no out-of-pocket expense to you. This includes the cost of preventive care office visits and any related preventive care lab services.

- All preventive care is covered at 100%, regardless of age or restrictions, based on AMA guidelines.
- Associates and their dependents may get preventive care screenings at any age, and at their desired intervals, with no out-of-pocket cost.
- Routine physicals
- Well-child exams
- Routine annual OB-GYN exams and Pap tests and mammograms
- Routine PSA and DRE screenings
- Colonoscopies (in some cases a consultation with a specialist is required and a co-pay will apply)
- Immunizations
- Annual vision exams
- Routine hearing exams
- Certain female contraception
- Breastfeeding support
- Nutritional counseling (covered at 100% if overweight and have at least one risk factor)
- Coverage for aspirin and certain supplements
- Anthem ID cards include the \$0 co-pay provision for preventive care to help remind you and your doctor.
- **Remember:**
 - You should only use your visit for preventive care. If you ask your doctor to treat you for something that is not considered preventive, you may be subject to the applicable co-pay.
 - Make sure your doctor codes all eligible claims as preventive care in order to be eligible for the 100% coverage.
 - This includes both a Preventive Procedure Code (a five-digit code that identifies the type of procedure) and the Preventive Diagnosis Code (a three- to five-digit code that identifies the reason the service is being performed).

Also Covered by the Medical Plans

- Hearing aids up to \$2,000 per ear every 24 months
- WINFertility Program for fertility treatment services (includes same-sex couples that do not have a diagnosis of clinical infertility)
- Contraception and lactation counseling

Autism Coverage

Capital One offers additional coverage under its medical plans to support dependents on the autism spectrum:

- Applied Behavior Analysis (ABA) is covered whether you use an in-network or out-of-network therapist with no plan dollar limits or age limits. ABA therapy is covered at 100% billed charges under the plans. These services are subject to pre-certification through Anthem.
- Speech Therapy, Occupational Therapy and Physical Therapy are covered with no dollar maximums, visit limits or age limits. Subject to deductibles and co-insurance of the plan in which you are enrolled.

Gender Reassignment

Certain gender reassignment surgery is covered at the same level as other surgeries covered by the plans. Associated prescription drugs required for gender reassignment are also covered as other similarly situated drugs. Covered medical expenses include charges in connection with a medically necessary Transgender (Sex Change) Surgery as long as you or a covered dependent have obtained pre-certification from Anthem and meet the plan clinical criteria.

Designate a Primary Care Physician (PCP)!

Regularly seeing a PCP is proven to lead to lower health costs and keep you healthy. PCP visits for preventive or non-preventive care are covered at 100% by your medical plan when you see an in-network provider!

Using the Network

When you enroll in a medical plan option, you generally significantly reduce your out-of-pocket costs when you use doctors, hospitals and other providers in Anthem's network. As long as you use in-network providers, you will pay lower costs. While you can see out-of-network providers, you will pay more out of pocket and could be balance-billed.

If You Live Outside the Network's Covered Service Area

If there is not an Anthem participating (i.e., in-network) provider within 30 miles of your home address or if there is not a participating (i.e., in-network) provider within 30 miles who can perform medically necessary services related to a condition or illness, then you may be approved to have out-of-network services paid at the in-network benefits levels of your plan at the reasonable and customary allowance. Please contact Anthem at **1-844-390-4133** for more information.

Walk-In or Retail Clinics

Walk-in or retail clinics are those that are found within certain retail environments like CVS Minute Clinics or Walgreens Health Clinics. There is no co-pay for services rendered at an in-network walk-in clinic. Walk-in clinics generally:

- Have longer hours than most local doctors' offices and are open weekends and holidays
- Are staffed by knowledgeable nurse practitioners or physician assistants who treat common illnesses and injuries, as well as provide wellness screenings
- Have comparable quality to primary care offices, cost less and have higher patient satisfaction scores
- Are convenient to where the majority of our associates live or work

Blue Distinction Specialty Care Can Help You Find the Right Hospital

When you face a major health problem, you want expert care from doctors and hospitals. The fact is there are often differences in the quality of care you get from the hospital you choose. So finding the right hospital can be hard. That's why you have access to Blue Distinction Centers and Blue Distinction Centers+.

The hospitals that are named as Blue Distinction Centers are chosen for a few reasons. They're known for their expert health care team, the number of times they've done a procedure and their track record for results in specialized care. You deserve peace of mind when you make important health care choices with your doctor. Having access to the Blue Distinction Centers and Blue Distinction Centers+ makes these choices simpler. Both centers offer quality specialty care. But the Blue Distinction Centers+ are honored for how cost effectively they provide care.

Use Castlight and if a provider listed is a Blue Distinction Center, you will find a Blue Distinction recognition/award in the Quality Snapshot next to the provider's name.

With more than 2,200 Blue Distinction Centers across the country, the care you need is never far away.

Castlight

All eligible Capital One associates and dependents enrolled in a medical plan have free access to Castlight, a personalized online health care resource that helps you shop for doctors, prescriptions and medical services. Castlight shows you quality and price information, so you can make informed health care decisions.

Log into anthem.com/capitalone, visit mycastlight.com/capitalone or download the Castlight app.



How Your Plan Works

Routine Lab Services

Routine X-ray and lab services are covered at 100%. More complex tests and imaging, such as PET and CT scans, MRIs and MRAs, are subject to deductible and co-insurance.

Other Covered Care

For all the medical plan options, you must first meet the individual or family calendar-year deductible before the plan begins paying most benefits. After the deductible, you pay a percentage of the cost—or co-insurance—for most other care.

Eligible expenses count toward both your individual and family deductible:

- When an individual meets the deductible, the plan begins paying benefits for that person
- When combined eligible expenses for covered family members reach the family deductible, the plan pays benefits for all covered family members. No additional individual deductible amounts are required that year.

Here's an example of how the deductible works:

Meet Jane

Enrolled in:	Basic medical plan, family coverage
Covered family members:	Husband, Jim; son, Jonah

Jane had some recent medical issues that resulted in a minor outpatient surgical procedure. The allowable charges for surgeon and hospital claims totaled \$2,750. After paying the first \$1,250 out-of-pocket to meet her in-network individual deductible, the remaining \$1,500 was covered at 70%. Jane paid 30% of that amount, or \$450.

Unfortunately, Jonah fell at the park and had to go to the emergency room for a broken leg. The \$1,700 Jane already paid counts toward the family deductible of \$2,000. She pays the first \$300 of the ER bill. Then, the plan pays 70% of the remaining amount, with Jane responsible for 30%.

Jane and her family have satisfied the in-network family deductible for the year.

Out-of-Pocket Maximum

You are protected from catastrophic medical expenses by the annual out-of-pocket maximum. Here's how it works: When your out-of-pocket expenses (deductible, co-insurance and co-pays) reach the out-of-pocket maximum, the plan pays the full cost for any covered care you receive for the rest of the year. Penalties do not count toward reaching your annual out-of-pocket maximum.



Compare Your Medical Plan Options

The chart below provides a side-by-side comparison of the plans and how much each plan pays for various services.

Why free PCP care?

Studies show that people who establish a relationship with a PCP do more to proactively manage their health, and thereby keep their total healthcare costs lower.

	Basic		Enhanced	
	In-Network	Out-of-Network ¹	In-Network	Out-of-Network ¹
Deductible (individual/family)	\$1,250/\$2,000	\$3,000/\$6,000	\$600/\$1,200	\$2,000/\$4,000
Out-of-Pocket Max – Includes Deductible (individual/family)	\$4,750/\$9,000	\$10,000/\$20,000	\$3,100/\$6,200	\$7,000/\$14,000
Office Visits and Preventive Care				
Primary Care Provider	Covered at 100%	Covered at 50% after deductible	Covered at 100%	Covered at 60% after deductible
Preventive Care	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%
OB-GYN	\$30 co-pay	Covered at 50% after deductible	\$25 co-pay	Covered at 50% after deductible
Other Specialists	\$60 co-pay	Covered at 50% after deductible	\$50 co-pay	Covered at 50% after deductible
Routine Diagnostic Labs and X-rays	Included with office visit co-pay	Covered at 50% after deductible	Included with office visit co-pay	Covered at 50% after deductible
When You Need Care Right Away				
Onsite/Retail/Walk-in Clinics ²	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%
LiveHealth Online	Covered at 100%	N/A	Covered at 100%	N/A
Urgent Care Center	\$60 co-pay	Covered at 50% after deductible	\$50 co-pay	Covered at 60% after deductible
Emergency Room	Covered at 70% after deductible	Covered at 70% after deductible ^{3, 4}	Covered at 80% after deductible	Covered at 80% after deductible ^{3, 4}
Ambulance	Covered at 70% after deductible	Covered at 70% after deductible ⁴	Covered at 80% after deductible	Covered at 80% after deductible ⁴
Inpatient Services				
Hospital	Covered at 70% after deductible	Covered at 50% after deductible	Covered at 80% after deductible	Covered at 60% after deductible
Professional Services	Covered at 70% after deductible	Covered at 50% after deductible	Covered at 80% after deductible	Covered at 60% after deductible
Outpatient Services				
Surgeon and Facility Fees	Covered at 70% after deductible	Covered at 50% after deductible	Covered at 80% after deductible	Covered at 60% after deductible
Complex Diagnostic Imaging (MRIs, CT scans, etc.)	Covered at 70% after deductible	Covered at 50% after deductible	Covered at 80% after deductible	Covered at 60% after deductible
Mental Health and Substance Abuse Services				
Psychiatrist/Psychologist Office Visits	\$30 co-pay	Covered at 50% after deductible	\$25 co-pay	Covered at 60% after deductible
LiveHealth Online Psychiatry LiveHealth Online Psychology	Covered at 100%	N/A	Covered at 100%	N/A
Inpatient Services	Covered at 70% after deductible	Covered at 50% after deductible	Covered at 80% after deductible	Covered at 60% after deductible
Outpatient Services	Covered at 70% after deductible	Covered at 50% after deductible	Covered at 80% after deductible	Covered at 60% after deductible
Other Services				
Applied Behavioral Analysis	Covered at 100%	Covered at 100% ⁴	Covered at 100%	Covered at 100% ⁴
Allergy Shots and Serum	Covered at 70%	Covered at 50%	Covered at 80%	Covered at 60%
Chiropractic Visits	\$60 co-pay	Covered at 50% after deductible	\$50 co-pay	Covered at 60% after deductible
Occupational Therapy, Physical Therapy, Speech Therapy	\$60 co-pay	Covered at 50% after deductible	\$50 co-pay	Covered at 60% after deductible

¹ Of allowable charges

² Such as CVS Minute Clinics

³ Not covered for non-emergencies

⁴ Of billed charges

Compare Your Medical Plan Options

{continued}

	Premium	
	In-Network	Out-of-Network
Deductible (individual/family)	\$350/\$700	\$1,000/\$2,000
Out-of-Pocket Max – Includes Deductible (individual/family)	\$1,850/\$3,700	\$4,000/\$8,000
Office Visits and Preventive Care		
Primary Care Provider	Covered at 100%	Covered at 70% after deductible
Preventive Care	Covered at 100%	Covered at 100%
OB-GYN	\$20 co-pay	Covered at 50% after deductible
Other Specialists	\$40 co-pay	Covered at 50% after deductible
Routine Diagnostic Labs and X-rays	Included with office visit co-pay	Covered at 50% after deductible
When You Need Care Right Away		
Onsite/Retail/Walk-in Clinics ²	Covered at 100%	Covered at 100%
LiveHealth Online	Covered at 100%	N/A
Urgent Care Center	\$40 co-pay	Covered at 70% after deductible
Emergency Room	Covered at 90% after deductible	Covered at 90% after deductible ^{3, 4}
Ambulance	Covered at 90% after deductible	Covered at 90% after deductible ⁴
Inpatient Services		
Hospital	Covered at 90% after deductible	Covered at 70% after deductible
Professional Services	Covered at 90% after deductible	Covered at 70% after deductible
Outpatient Services		
Surgeon and Facility Fees	Covered at 90% after deductible	Covered at 70% after deductible
Complex Diagnostic Imaging (MRIs, CT scans, etc.)	Covered at 90% after deductible	Covered at 70% after deductible
Mental Health and Substance Abuse Services		
Psychiatrist/Psychologist Office Visits	\$20 co-pay	Covered at 70% after deductible
LiveHealth Online Psychiatry LiveHealth Online Psychology	Covered at 100%	N/A
Inpatient Services	Covered at 90% after deductible	Covered at 70% after deductible
Outpatient Services	Covered at 90% after deductible	Covered at 70% after deductible
Other Services		
Applied Behavioral Analysis	Covered at 100%	Covered at 100% ⁴
Allergy Shots and Serum	Covered at 90%	Covered at 70%
Chiropractic Visits	\$40 co-pay	Covered at 70% after deductible
Occupational Therapy, Physical Therapy, Speech Therapy	\$40 co-pay	Covered at 70% after deductible

¹ Of allowable charges

² Such as CVS Minute Clinics

³ Not covered for non-emergencies

⁴ Of billed charges

Where To Go For Care

It's after hours or the weekend, and you just can't wait until you can call your doctor. Where do you go?

LiveHealth Online or a Retail Clinic – Visit with an online doctor from the comfort of your home and get expert advice, a treatment plan and a prescription if needed. Allergies, pinkeye, bronchitis, sinus infection, stomach flu, strep throat, cold sore, UTI, hypertension and rashes are just some of the conditions that can be addressed.

Urgent Care – They can handle a variety of medical problems that need to be treated right away, such as flu-like symptoms, small cuts, sprains or strains. They can be a great option when you can't get in to see your regular doctor right away.

Emergency Room and/or Ambulance – When you are experiencing life-threatening situations, the ER or ambulance is your best bet. Significant loss of blood, slurred speech, head or eye injury, a sudden or severe headache, chest pain or seizures are all examples of when you should go to the ER or call an ambulance.

Additional Medical Programs

Anthem Health Programs

Through our health care benefits administrator Anthem, our associates have access to Anthem Nurse Programs.

- **Personal Health Consultant**—With the Personal Health Consultant, your family has a primary nurse and health professionals who are there to discuss your health needs and help you reach your health goals. When you need more specialized advice, your primary nurse can connect you to medical professionals like dietitians or pharmacists.
- **ConditionCare**—This program provides extra support to people of all ages who are managing the symptoms of asthma or diabetes. It's also for adults who are dealing with chronic obstructive pulmonary disease (COPD), heart failure or coronary artery disease and need a little extra attention and support.
- **Future Moms**—This program gives expecting moms support and guidance from registered nurses for a healthy pregnancy and a safe delivery.
- **24/7 NurseLine**—You have access to registered nurses wherever you are, anytime. The nurses can answer any questions you have about your health and help you decide where to go for care.

Anthem Discount Program

The Anthem Discount Program is part of your Capital One Medical Plan. The program offers discounted health and wellness products and services, including fitness, weight management and hearing services. You can use the discounts whenever you want, as often as you want. Log in to anthem.com/capitalone to view all available discounts (under **Learn About** on the homepage).



Fertility and New Parent Benefits

WINFertility

The WINFertility Program will help associates receive the highest quality care for fertility treatment services.

For associates of the medical plan, WIN will assist in maximizing your insured benefit by explaining the most effective treatment options based on your individual treatment needs; helping select a high quality, in-network provider; and managing your infertility prescriptions to ensure you get the most out of your infertility medication benefit.

For associates who have reached the maximum medical or prescription coverage and will need to pay out-of-pocket, the WIN Consumer Program can provide substantial medical and pharmacy discounts and access to high quality care delivered by a network of fellowship-trained reproductive endocrinologists.

Key features of the WINFertility Program include:

- Help with provider selection
- 24/7 access to education and emotional support provided by WIN's FertilityCoachSM nurses with decades of experience with infertility patients
- Guidance to help increase efficient use of hormonal medications to avoid wastage and the risks of over-stimulation
- Improved likelihood of successful outcomes through WIN's evidence-based protocols, expert clinical advice and treatment by qualified subspecialists
- For those who have exhausted their benefit, medical treatment and pharmacy savings of 10%–30% off retail prices and financing options to make paying for treatment even more manageable
- Complimentary supply of folic acid to help prevent neural tube defects. The WINFertility programs will also connect you with the existing maternity program once you become pregnant to ensure a healthy pregnancy and the healthy birth of your baby.

Prescription Drug Coverage

Administered by CVS Caremark



How the Program Works

When you enroll in a Capital One medical plan, you may fill prescriptions:

- **At a participating pharmacy for up to a 30-day supply.** When you do, you pay a set amount, based on the drug tier of the prescription.
- **Through CVS Caremark's Maintenance Choice program for a 90-day supply.** Under the Maintenance Choice program, you can order your maintenance medications from CVS Caremark's mail-order pharmacy and have them shipped to your home or address of your choosing. Or, you can elect to have your maintenance medications dispensed in a 90-day supply at a CVS pharmacy. CVS can work with you on payment options for your medications. Please contact CVS Caremark at **1-877-210-3556** or log in to [caremark.com](https://www.caremark.com) for more information regarding signing up for these programs.
- **At the Knolls, Plano and West Creek Health Centers and Pharmacies.** The Knolls, Plano and West Creek Health Centers offer a pharmacy for short-term medications (like antibiotics), 90-day supply for maintenance medications and a limited selection of over-the-counter medications. See Pulse for more information.

You do not need to enroll separately in the prescription plan. Enrollment in the prescription plan is included as part of your enrollment in the medical plan, and pharmacy coverage is the same for all three medical plans.

Your CVS Caremark information can be found on your Anthem ID card.

Your prescription cost reflects the type of medication used in your prescription:

- **Tier 1: Generic**—drugs that are chemically and therapeutically equivalent to their brand-name counterparts but cost less.
- **Tier 2: Preferred brand**—brand-name drugs selected by the plan based on cost and effectiveness.
- **Tier 3: Non-preferred brand**—brand-name drugs not included in the plan's formulary.
- **Specialty**—specific drugs selected by the plan based on their limited use and high cost.

Note: If either you or your doctor requests a brand-name medicine when a generic equivalent is available, you will pay the brand co-pay, plus the difference in cost between the brand-name and the generic medicine. When using most pharmacies, including CVS Caremark Mail Service Pharmacy, a generic medicine, if available, will be substituted for a brand-name medicine unless your doctor indicates "Dispense as Written" on the prescription, or you request that only the brand-name medicine be provided and is subject to approval by CVS/Caremark.

Your prescription drug payments do not count toward the medical plan's annual deductible, but they do count toward your in-network out-of-pocket maximum totals.

If you use a retail pharmacy that's not in the CVS Caremark network or do not use the Specialty Pharmacy for eligible prescriptions, you pay the full cost of your prescription; no part of the cost is covered by the plan. You may, however, request reimbursement, subject to approval by CVS Caremark.

Some prescriptions are required to meet defined criteria before they are covered by the plan. You may also have additional controls, such as prior authorization, for certain medications.

If you enroll in health coaching through Anthem, you will receive three prescription smoking-cessation aids at no co-pay.

Certain generic and single-source brand female contraceptives are also covered at no co-pay.

Certain infusion therapies (with some exceptions such as oncology) are part of your pharmacy coverage and such therapies may be required to be administered in specified outpatient infusion centers or at home rather than in a hospital setting.

Participating Pharmacies

CVS Caremark provides a variety of participating retail chains, including Giant, Walgreens, Wal-Mart and independent pharmacies, in addition to CVS pharmacies. These pharmacies can be utilized for all short-term medications—generally those taken less than 60 days or two fills at retail.

For maintenance medications (those taken ongoing—generally longer than 60 days or after two fills at retail), you must have those filled as a 90-day supply either at a local CVS or via CVS Caremark's mail-order program. Find a network pharmacy at [caremark.com](https://www.caremark.com) or call **1-877-210-3556**.

Pharmacy Advisor Counseling

Pharmacy Advisor Counseling will provide support for patients in CVS stores. The service offers confidential advice, medication information, tips to help manage or avoid medication side effects, and additional guidance.

Type of Drug	Cost You Pay	
	Retail—up to 30-day supply	Mail order or CVS—90-day supply
Generic	\$10 co-pay	\$20 co-pay
Preferred Brand	\$50 co-pay	\$100 co-pay
Non-Preferred Brand	\$100 co-pay	\$200 co-pay

Specialty

30-day supply

Generic:	\$40
Preferred Brand:	\$100
Non-Preferred Brand:	\$200

Specialty medication can be purchased only through the CVS Caremark Specialty Pharmacy—no part of the cost is covered by the plan if purchased from a retail pharmacy.

Be Well Pharmacy Discount Program

For patients who have one of the following conditions and who engage with Anthem nurses.

- Diabetes
- Hypertension
- High cholesterol
- COPD/Asthma
- Congestive heart failure

Available for mail order prescriptions only:

- Generic are \$0.
- Preferred Brand are \$20.
- Non-Preferred Brand are \$100.

Call an Anthem Nurse to qualify for the discount at **1-844-390-4133**; press option 4 to speak with a nurse Monday through Friday from 8 a.m. to 11 p.m. ET.

When You Need Prescriptions, Consider Several Things to Help Control Your Costs

Use non-specialty generic—Ask your doctor or pharmacist about generic medications and pay less—only \$20 for a 90-day supply. Generics generally cost between 20% and 70% less than their brand-name counterparts. When you buy generic, the active ingredient is exactly the same, but the cost to you is lower. Generics are approved by the Food and Drug Administration (FDA). They have to meet the same quality standards as brand-name drugs. Simply asking your doctor or pharmacist whether generics will work for you can make a big difference.

Ask for a preferred drug—When a generic drug isn't recommended by your doctor, ask your doctor to prescribe a brand-name medication on the plan's preferred drug list on [caremark.com](https://www.caremark.com). Your cost for brand-name drugs on the preferred drug list is lower than for those that aren't on the list.

Use the mail-order pharmacy for all maintenance prescriptions—By ordering your prescriptions for ongoing conditions such as diabetes or high blood pressure through the mail, you can receive up to a 90-day supply—and spend much less than you would at a retail pharmacy. Mail service delivers medications to your home, providing an added convenience. You can also have your 90-day maintenance prescriptions filled at your local participating CVS pharmacy. **Note:** You may only fill your maintenance medications via mail order or at your local CVS retail pharmacy.

What Is a Preferred Drug List?

A preferred drug list is a formulary list of drugs the plan has determined to be reasonable in cost and effective for treatment. A non-formulary drug also is effective for treatment, but isn't as cost-effective as a formulary or generic drug. A group of practicing physicians and pharmacists routinely reviews drugs to include in a formulary. If clinical data shows several drugs are equally effective, the most cost-effective drug is usually chosen. The formulary may change from time to time. You can view CVS Caremark's formulary at [caremark.com](https://www.caremark.com).

Specialty Medications

The Specialty Pharmacy is designed to provide associates who routinely take medications for the following conditions with access to the best discounts and highest quality of medication available:

- Anemia
- Cancer
- Crohn's disease
- Cystic fibrosis
- Growth hormone, related disorders and other hormonal therapies
- Hemophilia, von Willebrand disease and related bleeding disorders
- Hepatitis B
- Hepatitis C
- HIV
- Immune disorders
- Infertility
- Macular degeneration
- Multiple sclerosis
- Osteoporosis
- Pulmonary arterial hypertension
- Pulmonary disorders
- Rheumatoid arthritis/Psoriasis
- RSV prevention
- Transplants

Medication for these conditions can be purchased only through the CVS Caremark Specialty Pharmacy—no part of the cost is covered by the plan if purchased from a retail pharmacy.

All associates can use the programs listed below—you don't need to be enrolled in a Capital One medical plan to take advantage of them. How great is that!

Milk Stork

Milk Stork provides Capital One associates who are on U.S. business travel and are breastfeeding with everything they need to ship a day's supply of fresh milk home to their babies.

How Milk Stork works:

- **She Plans Her Trip:** A mom orders her kits at milkstork.com/capitalone. When she arrives at her hotel, there will be a package with all of the Milk Stork Kits she ordered for her trip. The kits are pharmaceutical-grade shipping coolers that provide her with everything she needs to ship or tote her milk home.
- **Pump & Pack: Available in two sizes:** 34 oz. and 72 oz., the coolers are easy-to-use with "push button" activation. There is no freezing required and no gel packs.
- **Ship or Tote:** Pump & Ship coolers arrive pre-addressed with FedEx Priority Overnight shipping labels. Pump & Totes arrive with a convenient tote.

Consumer Medical

Get information from expert physicians to address your questions or uncertainty around any condition or treatment from back pain to surgery to other serious medical conditions. It's available to all U.S. associates, including your family members (even if they aren't eligible dependents).

Here's How It Works:

- You'll be assigned a doctor as a direct contact to lead you through the process.
- Review is based on your medical information—collected with your consent—so recommendations are personalized for you.
- You'll get a comprehensive report summarizing expert insights, highlighting opportunities to optimize treatment and addressing your questions about future care.

Ready to Get a Second Opinion?

Call Consumer Medical's Virtual Second Opinion program and speak with a nurse at 1-888-361-3944 Monday–Friday, 8:30 a.m. – 11:00 p.m. ET to get started.



Picking Other Health Plans



Vision Coverage

Administered by Anthem Blue View VisionSM

Before You Choose, Consider

- Whether you need to participate in the vision program (e.g., if you have perfect vision and don't wear glasses, the annual eye checkup provided through your Anthem medical plan will likely meet your needs)
- Your eye care needs and what kind of vision services you expect to use. Add up your likely vision expenses and what each plan option would cover, so you can compare what your overall cost would be. Also, think about whether you can take advantage of the vision plan's provider network to lower your costs.
- Your anticipated expenses and whether it's better to make contributions each paycheck for vision coverage or to pay for vision services out of your pocket

Learn More

- Call **Anthem Blue View Vision** at **1-866-723-0515**.
- Go online to **anthem.com/capitalone**.
- The Blue View Vision plan coverage includes a routine eye exam, frames and either eyeglass lenses or contact lenses. Kids can get Transitions® lenses to protect their eyes from harmful UV rays and polycarbonate lenses to help protect them from damage at no additional cost.
- You have access to a network of over 30,000 doctors and more than 25,000 locations across the country, including convenient retail stores like LensCrafters®, Sears OpticalSM, Target Optical®, JCPenney® Optical and most Pearle Vision® stores. You have the flexibility to go to a non-participating provider, but you will maximize your benefits by using a participating provider.
- Blue View Vision Members can use their in-network benefit to order contact lenses from **1-800 CONTACTS**. **1-800 CONTACTS** offers a large in-stock inventory, discounted prices, outstanding customer service and free shipping. Call **1-800 CONTACTS** or go to **1800contacts.com**.

To Start Using Vision Coverage

- Once you are enrolled in the plan, log in at **anthem.com/capitalone** to find a provider and review your plan.
- Visit your provider and provide them with your Anthem ID card.



Vision Benefits

Benefit	In-Network	Out-of-Network
■ Routine eye exam once every calendar year	\$0 co-pay	Up to \$35
■ One pair of eyeglass frames every two calendar years for adults ■ One pair of eyeglass frames every calendar year for kids under 19	\$130 allowance, then 20% off* any remaining balance	Up to \$45
■ One pair of eyeglass lenses (standard plastic), once every calendar year you may receive any one of the following lens options: <ul style="list-style-type: none"> – Single vision lenses – Bi-focal lenses – Tri-focal lenses 	100% after \$20 co-pay	Up to \$45 Up to \$55 Up to \$65
■ Eyeglass lens enhancements* <ul style="list-style-type: none"> – Transitions® lenses for kids under 19 – Standard polycarbonate for kids under 19 – Factory scratch coating – Standard anti-reflective coating 	\$0 co-pay	No allowance on lens enhancements when obtained out-of-network
■ Eyeglass lens upgrades <ul style="list-style-type: none"> – Transitions® for adults – Standard polycarbonate for adults – Tint (solid and gradient) – UV coating 	Upgrades (after any applicable co-pay) \$75 \$40 \$15 \$15	
■ Progressive lenses <ul style="list-style-type: none"> – Standard – Premium Tier 1 – Premium Tier 2 – Premium Tier 3 	Progressive (after any applicable co-pay) \$65 \$85 \$95 \$110	
■ Anti-reflective coating <ul style="list-style-type: none"> – Premium Tier 1 – Premium Tier 2 	Anti-reflective (after any applicable co-pay) \$12 \$23	
■ Other add-ons (eyeglass materials purchased separately, non-prescription sunglasses, lens and/or contact lens cleaning/ solutions, etc.)	20% off retail (after any applicable co-pay)	
■ 2nd complete pair	40% off retail (after any applicable co-pay)	
■ Contact lenses once every calendar year (disposable or planned replacement are permitted) <ul style="list-style-type: none"> – Elective conventional lenses; or – Elective disposable lenses; or – Non-elective contact lenses 	\$130 allowance, then 15% off any remaining balance \$130 allowance (no additional discount) Covered in full	Up to \$75 Up to \$75 Up to \$90
■ A contact lens fitting and up to two follow-up visits are available to you once a comprehensive eye exam has been completed.** <ul style="list-style-type: none"> – Standard contact lens fitting – Premium contact lens fitting 	\$0 10% off retail price, then apply \$55 allowance	\$35 \$35

**Standard contact lens fitting includes spherical clear contacts for conventional wear and planned replacement.
 Premium contact lens fitting includes all lens design, materials and specialty fittings other than standard contact lenses.

Dental Coverage

Administered by Delta Dental



How the Dental Plan Works

Capital One provides two dental plan options to help you care for your teeth and gums:

- Basic Dental Plan
- Enhanced Dental Plan (includes orthodontia coverage)

Delta Dental administers both dental plan options. You have the flexibility to receive care from any licensed dental provider. The plan covers the same services whether or not you use a network dentist, but your out-of-pocket costs will generally be lower when you use a network or participating dentist.

When you enroll in either option, you will have access to two types of network dentists—**Delta Dental PPO** and **Delta Dental Premier**. If you choose to see an out-of-network dentist, the plan will pay the same amount, but your out-of-pocket expenses may be higher.

Dental Network

Both options pay the full cost of preventive care and provide coverage for basic service if seeing an in-network provider.

Balance billing may apply if you see a non-participating provider even for diagnostic and preventive services. The Enhanced Dental option also covers major care, as well as orthodontia for children and adults.

The chart (on the next page) highlights some commonly used covered services and shows how the dental plan options compare.

Before You Choose, Consider

- The kind of dental services you expect to use. For example, will your child need braces this year? Are you planning to get a crown replaced?
- Oral surgery (simple and surgical extractions, impactions, and other oral surgical procedures) will be covered under both dental plans.
- Implants will be covered under the medical plan in a few limited situations (i.e. accident/injury to the face/mouth). In all other cases, they will be covered under the dental plan.
- What your overall cost is likely to be under each option, by adding up your likely dental expenses and the coverage cost for the year.

You can contact Delta Dental at 1-844-344-8006 or deltadentalva.com. You may select the dentist of your choice. However, you will receive the highest level of benefits available in your group's program by choosing a Delta Dental PPO Dentist. Please review the chart below for more information on how Delta Dental bases its payment for both participating and non-participating dentists. In addition, your out-of-pocket costs will usually be lower if you use a participating dentist. If you choose a:

Delta Dental PPO Dentist	Delta Dental Premier Dentist who is not a Delta Dental PPO Dentist	Non-Participating Dentist
<ul style="list-style-type: none"> ■ Payment will be made directly to the dentist for covered benefits. ■ Delta Dental's payment will be based on the Delta Dental PPO Allowance for covered benefits. ■ The dentist will accept Delta Dental's payment, plus any required co-insurance and deductible (if applicable) as payment in full for covered benefits. 	<ul style="list-style-type: none"> ■ Payment will be made directly to the dentist for covered benefits. ■ Delta Dental's payment will be based on the Delta Dental Premier Allowance for covered benefits. ■ Delta Dental Premier Dentists have agreed to accept Delta Dental Premier Allowances plus any required co-insurance and deductible (if applicable) as payment in full for covered benefits. ■ The amount you would owe a Delta Dental Premier Dentist who is not a Delta Dental PPO Dentist may be higher than the amount you would owe a Delta Dental PPO Dentist for the same covered benefits. 	<ul style="list-style-type: none"> ■ Payment will be made directly to you. ■ Delta Dental's payment will be based on the Non-Participating Dentist Allowance for covered benefits. ■ You will be responsible for any required co-insurance and deductible (if applicable) as well as the difference between the non-participating dentist's charge and Delta Dental's payment for covered benefits. ■ The amount you would owe a non-participating dentist may be higher than the amount you would owe a Delta Dental PPO or Delta Dental Premier Dentist for the same covered benefits. ■ Keep in mind that for preventive and basic services, balance billing may apply if you see a non-participating provider.

Coverage	Basic Dental	Enhanced Dental
Annual Deductible	None	\$50/person, \$100/family
Annual Maximum	\$500/person	\$2,000/person
Preventive Care <ul style="list-style-type: none"> ■ Two routine exams and cleanings each year ■ One set of bitewing X-rays a year; one full set of X-rays every 36 months ■ Sealants for dependents under age 16 ■ Space maintainers for dependents under age 14 ■ Denture relines starting six months after installation 	100%	100%
Basic Care <ul style="list-style-type: none"> ■ Fillings, root canals, periodontal therapy ■ Oral surgery (simple and surgical extractions, impactations, and other oral surgical procedures) 	80% coinsurance, subject to the annual maximum	80% coinsurance, subject to the deductible and annual maximum
Major Care <ul style="list-style-type: none"> ■ Bridges, crowns and dentures ■ Dental implants 	Not covered	50% coinsurance, subject to the deductible and annual maximum
Orthodontia* (Covers Children and Adults) <ul style="list-style-type: none"> ■ Braces ■ Mouth guards ■ Temporomandibular Joint (TMJ) disorders 	Not covered	50% coinsurance, with no deductible. The lifetime orthodontia benefit maximum is \$2,500 per person.

*You must be enrolled in the Enhanced Plan for the entire course of orthodontia treatment to get full benefits. At-home orthodontia treatment is not covered.

Pre-Determination of Benefits

If you need dental care that is expected to cost \$250 or more, ask your dentist to request pre-determination of benefits. It is not required, but it can let you know in advance how much your dental plan will pay for the recommended care—and how much you will have to pay out of your pocket. This can help you avoid surprises.

Healthy Smile, Healthy You® Program

Healthy Smile, Healthy You® offers additional benefits for four important health conditions connected to oral health:

- Pregnancy • Diabetes • Certain high risk cardiac conditions • Cancer being treated via radiation and/or chemotherapy

If you have one of these conditions, you can enroll in the program to become eligible for one additional cleaning and exam. For pregnant members, the additional service is offered during the term of pregnancy. Cancer patients will also be eligible for an additional fluoride application beyond the age of 19.

Enrolling is Easy

Complete the Healthy Smile, Healthy You® enrollment form, which can be found at deltadentalva.com. Click on **Subscribers** and then go the Forms list at the bottom left section of the page. Be sure to include your physician's name and signature. Mail or fax the completed form to:

Delta Dental of Virginia, ATTN: Healthy Smile, Healthy You, 4818 Starkey Road, Roanoke, VA 24018

Fax: 540.725.3880

Note: If Anthem has your health condition on record, you may already be enrolled in the program. Please contact Delta Dental to confirm.

Building Your Wealth



Flexible Spending Accounts (FSAs)

Capital One Offers Two FSAs—a Health Care FSA and a Dependent Care FSA

The HCFSAs allows you to save money by using pre-tax dollars to pay for qualified health care expenses, including prescriptions, co-pays, deductibles and co-insurance for you, your spouse or eligible dependents.

The Dependent Care Flexible Spending Account (DCFSA) lets you contribute pre-tax dollars to pay for eligible dependent care expenses such as preschool, day camp, or child/adult daycare expenses, while you and your spouse/partner are working, looking for work, or attending school full time. Remember, Capital One will match the money you put into your FSAs, up to the annual maximum. That means free money for you to use!

	Health Care FSA	Dependent Care FSA
Total contribution maximum (this includes your contribution, plus the company matching contribution)	\$3,700 (minimum contribution of \$50)	\$5,000 (minimum contribution of \$50*) <i>*If you're single or married filing jointly. The contribution limit is \$2,500 if you're married and file a separate tax return. For spouses who both contribute to a DCFSA, the maximum amount that can be contributed between both accounts is \$5,000.</i>
Capital One matching contribution	\$0.50 for every \$1.00 you contribute, up to \$1,000	
How you select your contribution amount	Once-a-year election during Open Enrollment (unless you experience a qualifying life event)	
Eligible expenses	<ul style="list-style-type: none"> ■ Medical, vision and dental co-payments, deductibles and co-insurance you pay for covered services for you and your spouse/dependents (even if they are not covered under your Capital One health care plans) ■ Prescription drug co-pays/co-insurance ■ Expenses for glasses or contact lenses ■ Expenses you pay above the reasonable and customary rates or plan maximums <p>Note: Over-the-counter medications cannot be reimbursed through your HCFSAs, unless you have a doctor's letter of medical necessity.</p> <p>Domestic partner expenses are not eligible.</p> <p>See IRS Publications 502 and 969 at irs.gov for an explanation of the programs and a complete list of reimbursable HCFSAs expenses.</p>	<p>Dependent care that is necessary for you and your spouse to work, look for work, or attend school full-time, including care for</p> <ul style="list-style-type: none"> ■ Dependents under age 13 whom you can claim as dependents on your federal income tax return or have legal custody of ■ Spouse or other dependent, such as an elderly parent, if they are physically or mentally incapable of caring for themselves and spend at least eight hours a day in your home <p>Eligible dependent care expenses include:</p> <ul style="list-style-type: none"> ■ Child care centers ■ Family day care providers ■ Babysitters ■ Nursery schools ■ Day camps ■ Caregivers for a disabled dependent or spouse who lives with you ■ Some household services for a qualifying dependent <p>See IRS Publications 503 and 969 at irs.gov for an explanation of the programs and a complete list of reimbursable DCFSA expenses.</p>
Deadline for expenses to be incurred	December 31, 2020 (you may carry over \$500 to 2021)	March 15, 2021
Claim deadline	April 30, 2021	April 30, 2021

Be sure to keep all of your receipts (or statements) for expenses where you use your FSA debit card. Most transactions will approve automatically, but if a match isn't found, Anthem will ask you to provide back-up documentation for a charge up to three times. **If you don't respond, your debit card will be turned off until you provide documentation or repay the claim.**

Important Reminders on FSAs

- You should be prepared to provide documentation for any reimbursements.
- **DCFSA is only to be used for eligible dependent care expenses (see page 26), NOT for medical expenses for spouse and/or other dependents. You may use a HCFSAs for those expenses.**
- It is a violation of the Internal Revenue Code to use the DCFSA for child care expenses if you have a stay-at-home spouse or partner but still use outside day care or day camp programs for your child. The DCFSA is only to be used if both parents work or if your spouse is a full-time student.

Selecting Your Contribution Amounts

When deciding how much to contribute to your FSAs, keep the following in mind:

- Consider how much you are likely to spend out of your pocket for health care during the year.
- If you will have eligible dependent care costs (e.g., day care expenses), consider whether your children will start school or reach age 13 in 2020? Do you have a parent or elderly relative living with you who needs supervised care?
- The matching contribution Capital One will provide counts toward the maximum amount that can be contributed to each FSA.
- You'll get a tax break when you use pre-tax dollars from FSAs to pay for expenses you would have to pay out of your pocket anyway.
- Domestic partner expenses are not eligible for reimbursement.
- If you plan on using your HCFSAs for orthodontia or similar services, please contact Delta Dental to discuss reimbursement eligibility.

Capital One Contribution: Free Money!

Capital One will match \$0.50 of every \$1 you contribute to your FSAs, up to a combined maximum company contribution of \$1,000 each year between the HCFSAs and DCFSA. The company's contribution counts toward the maximum amount that can be contributed to each FSA.

FSA Calculator

You can use the FSA calculator on capitalonebenefitsite.com to help you determine how much to contribute for the year. Remember: When you elect your contribution amount, you're selecting the TOTAL amount you wish to contribute for the whole year—including the Capital One match. Then, this amount (minus the match) will be automatically divided into equal amounts to be deducted from each paycheck. You need to elect a target contribution amount of at least \$3,000 in one or both FSAs in order to earn the maximum company contribution of \$1,000.

Orthodontia Expenses

Anthem allows reimbursement for pre-paid scheduled payments under an orthodontia contract regardless of the date of service. The payment must have been made while you were covered under the HCFSAs. If there is coverage under any dental plan, payment from the FSA will be reduced by the amount paid by the dental coverage. Please note that orthodontia differs from other dental procedures that require the actual service to be performed within the coverage period, regardless of when payment is made.

How to Use Your FSA

You can use your FSA debit card to pay for qualified expenses, and money will be pulled directly from your HCFSAs, or you can pay for qualified expenses out of pocket and ask to be reimbursed.

If you have a DCFSA and your dependent care provider will accept it, you can use your FSA debit card to pay for those services. Hold onto your receipts because you'll need to submit them for debit card swipes for DCFSA expenses.

Manage your account online by logging in at anthem.com/capitalone. You can:

- Track your claims and FSA spending.
- Request reimbursement (see details below).
- Check your balance.

Plan carefully so you use all of the money in your FSA by the end of the plan year. If you don't use the money, you could lose it.

Receiving Reimbursement from the Health Care FSA

Expenses you or your eligible dependents have are eligible for reimbursement under the FSA, even if your dependent(s) is not covered under your medical, dental or vision plan.

Only expenses you have while employed and during the plan year in which you made the contribution may be reimbursed. Due to IRS regulations, a domestic partner's expenses are not eligible for reimbursement.

To receive reimbursements:

- You can use your HCFSAs debit card for all eligible health care expenses wherever it is accepted.
- Add a manual claim through anthem.com/capitalone by clicking on *Spending Accounts* then *Manage Your Account*.
- You can also submit a receipt with the Anthem Sydney app — just snap a picture and upload it!
- **Note:** In some cases, even with auto-substantiation, additional documentation may be required.

Receiving Reimbursement from the Dependent Care FSA

To receive reimbursements:

- Add a manual claim through anthem.com/capitalone by clicking on *Spending Accounts* then *Manage Your Account*.
- You can also submit a receipt with the Anthem Sydney app — just snap a picture and upload it!

Verifying Your FSA Purchases

Be sure to keep all of your receipts (or statements) for expenses where you use your FSA debit card. Most transactions will approve automatically but if a match isn't found Anthem will ask you to provide back-up documentation for a charge up to three times.

If you don't respond, your debit card will be turned off until you provide documentation or repay the claim.

If you submit a manual claim during this time, the money owed to that claim will be applied to the unsubstantiated debit card purchase first until the plan is fully repaid.

You can check the status of your debit card at [anthem.com/capitalone](https://www.anthem.com/capitalone) as well as any transactions that require documentation. If you have questions, call **Anthem Member Services** at **1-844-390-4133**.

Dependent Care Reminders

Before deciding to enroll in the DCFSA, compare its tax benefit to the Dependent Care Tax Credit. Generally, the DCFSA saves you more in taxes, but it depends on your income. For assistance deciding which provides more savings for you, consult an accountant or tax advisor.

Note: The DCFSA is only used for dependent care expenses that are necessary for you and your spouse to work, look for work or attend school full time. It is NOT for health care expenses for you and/or your dependents.

- **If you are married:** You may only submit for dependent care expenses that allow you and your spouse to work or so you can work full time while your spouse goes to school full time. **Note:** If your spouse is a stay-at-home mother/father, for example, and you send your child(ren) to pre-school, camp or day care, you are not eligible for this benefit per IRS regulations.
- **If you are divorced or separated:** Work-related expenses of the custodial parent are eligible for reimbursement, even if the custodial parent does not claim the child as a tax dependent. Work-related child care expenses of a non-custodial parent are not eligible for reimbursement, however, even if the child is claimed as a tax dependent.

What Happens if I Leave the Company?

- For the HCFSA, you may elect to continue your participation on a post-tax basis for the remainder of the calendar year under COBRA. If you do not continue your participation under COBRA, any amount left in your account will be forfeited if you do not have any eligible expenses incurred prior to your termination date.
- For the DCFSA, you may file for reimbursement of eligible claims incurred anytime in the calendar year (even after your termination date), as long as you file by April 30 of the following year.



Use It or Lose It

Based on IRS rules, FSAs are “use-it-or-lose-it” accounts. That means you’ll lose any money in your HCFSA other than the \$500 you can carry over after the deadline for submitting expenses (April 30), so it’s important to carefully estimate your contribution amount for the year.

Associate Stock Purchase Plan

All full-time and part-time associates in the U.S. are eligible to participate in the non-qualified Capital One Associate Stock Purchase Plan (ASPP).

Contributions/Company Match

You can elect to contribute between 1% and 15% of your base salary** to the ASPP and receive a partial match on your contributions from Capital One. Your contributions are deducted from your Salary each paycheck and along with the Capital One match, are used to buy Capital One stock at the end of each month. Purchased shares are deposited into your E*TRADE account shortly following the purchase date. There is no fee to purchase shares through the ASPP. However, when you sell shares, E*TRADE deducts a brokerage fee of \$0.05 per share (\$6.95 minimum per trade) from stock sale proceeds.

Note: The Capital One match is considered taxable income.

Learn More

Visit the Associate Stock Purchase Plan page on Pulse.

**Includes standard pay and any commissions you receive for your job.

A description of the Associate Stock Purchase Plan can be found in the plan document, prospectus and other materials available on Pulse. You are advised to exercise caution in relation to any award under the plan. If you have any doubt about the contents of the plan or any documentation in respect of the plan, you should obtain your own independent professional advice from an appropriately authorized independent advisor. As you know, no one can predict the future value of any stock, and investment in a single security is inherently subject to greater risk than diversified investments. You should carefully and periodically evaluate your investments in the Company's common stock to make sure that the amount of your investment is appropriate for your individual financial situation.



401(k) Associate Savings Plan

The Capital One 401(k) Associate Savings Plan is a convenient, tax-effective way to help save for retirement. Through automatic payroll deductions, you may contribute up to 50% of your Annual Benefits Salary (base salary, shift differential, bonuses, commission, incentives and overtime) to your account. You may contribute any combination of pre-tax and Roth 401(k) contributions up to the annual Internal Revenue Service (IRS) dollar limit of \$19,000 in 2019. This amount is often indexed on an annual basis for inflation and may be subject to change in 2020. For the most up-to-date limits visit the IRS web site.

Company Contributions

In addition to your contributions, Capital One helps grow your retirement savings by contributing to your 401(k) Plan account:

- **Basic Non-Elective Company Contributions**—Capital One will contribute 3% of your Annual Benefits Salary, whether or not you participate in the 401(k) Plan.
- **Matching Contributions**—Capital One will match 100% of the first 3% of Annual Benefits Salary that you contribute, plus 50% of the next 3% of Annual Benefits Salary that you contribute, for a total company matching contribution of 4.5% on 6% of Annual Benefits Salary.

Don't Leave Money on the Table!

To maximize the company matching contribution, simply contribute at least 6% of your Annual Benefits Salary (base salary, shift differential, bonuses, commission, incentives and overtime) to your 401(k) Plan account. Capital One will then contribute a total of 7.5% of your Annual Benefits Salary to your account. You will be contributing just 6%, but your account has the potential to grow as though you are contributing 13.5%!

See how an associate can maximize the company match just by deferring 6% (\$3,000) in the example below.

AN EXAMPLE: An associate earning \$50,000 (\$45,000 in base salary and \$5,000 in annual bonus) and currently contributing 6% of their Annual Benefits Salary to the 401(k) Plan.

Associate Elective Contribution (6% of eligible compensation)	\$3,000
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3% Basic Non-Elective Company Contribution (3% of eligible compensation, regardless of whether or not you participate)	\$1,500
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Company Matching Contribution (100% of the first 3% you contribute plus 50% of the next 3% you contribute)	\$2,250
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Total Annual Contributions to the 401(k) Plan	\$6,750
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Rollover Contributions

You may roll pre-tax, after-tax or Roth 401(k) assets from another qualified retirement plan into your account.

When Are Contributions Yours?

Your account balance within the 401(k) Plan is yours once you are vested. You are immediately vested in your contributions as well as your basic non-elective company contributions. Matching contributions vest upon two years of service with Capital One. This means that all of the amounts contributed to your 401(k) Plan account—as well as any investment earnings—are entirely yours after just two years of employment.

Enrolling in the 401(k) Plan

You will receive an enrollment kit approximately one week after you start with Capital One, but you are eligible to enroll in the 401(k) Plan immediately. (You may need to wait up to a week after your hire date in order to enroll.)

Your associate elective contributions (through payroll deduction) and matching company contributions will begin within two pay cycles following your enrollment, or as soon as administratively possible after you enroll. Please review the Fidelity Cut Off Schedule on the “Payroll Calendar (US)” Pulse page for more details.

The 3% Basic Non-Elective Contributions will automatically begin as soon as administratively possible after your date of hire, typically within three pay periods. If you do not elect to contribute to the 401(k) Plan, you are still eligible for the 3% basic non-elective contributions.

If you do not enroll within 60 days of your hire date, you will be automatically enrolled at an associate elective contribution rate of 3% of your eligible pre-tax compensation. Additionally, unless you make an alternative selection, your contributions will be automatically invested in the BlackRock LifePath® Fund that best matches your expected retirement date.

The LifePath Fund will then invest your money in such a way that takes your age and retirement date into account. The investment direction will be somewhat more aggressive if you are younger and will move to a more conservative path as your expected retirement date nears.

For More Information

For more information about the 401(k) Plan or to enroll, visit Fidelity NetBenefits® at netbenefits.com or call the Capital One Retirement Savings Center at Fidelity at **1-800-854-4015**. You can also learn more on Pulse.

Enriching Life for You and Your Family



Other Benefits

Vacation/Paid Time Off (PTO) Buy-Up

Your time-off benefits depend on your employment status:

- Non-exempt associates: Paid Time Off (PTO)
- Exempt associates: Vacation, Sick and Family Care Days

Additionally, all full- and part-time associates receive 11 fixed and 2 floating holidays, for a total of 13 paid holidays. Paid bereavement leave is also available.

Non-Exempt Associates

PTO provides a “bank” of time for associates to use at their discretion, such as for a vacation, illness or other time-off needs.

Full-time non-exempt associates working 40 standard hours a week are granted PTO based on calendar years of service.

- In your first calendar year of service (year 0), your PTO is based on a prorated portion of a 15 day PTO allotment using date of hire.
- After the year in which you were hired, you receive 20 PTO days annually (calendar years 1-4).
- Upon completing four full-calendar years, you receive 25 PTO days annually (calendar years 5-9).
- Upon completing nine full-calendar years, you receive 30 PTO days annually (calendar years 10+).

Exempt Associates

Full-time associates working 40 standard hours a week are granted vacation based on calendar years of service.

- In your first calendar year of service (year 0), your vacation is based on a prorated portion of a 10 day vacation allotment using date of hire.
- After the year in which you were hired, you receive 15 vacation days annually (calendar years 1-4).
- Upon completing four full-calendar years, you receive 20 vacation days annually (calendar years 5+).

Exempt associates are granted paid sick time on an as-needed basis. Additionally, three Family Care Days are granted annually for you to take care of family members.

All Associates

- If you work less than 40 standard hours, the PTO/vacation allotments shown above are prorated based on your standard hours as maintained in Workday.
- You may use PTO/vacation time after satisfying an initial 90-day probationary period.

Purchasing Additional PTO/Vacation

During Open Enrollment, full-time and eligible part-time associates may purchase up to one week of PTO/vacation time for the coming year, in one-hour increments. Your annual base salary as of January 1, 2020, will be used to calculate the value of the additional time off that you purchase.

Note: It’s important to note that unused purchased PTO/vacation may not be carried over into another calendar year—and you must use earned PTO/vacation before purchased time.

See Pulse for more details about Capital One’s time-off programs.

Parental Leave

Parental Leave options are available to eligible full-time associates who are new mothers, fathers and secondary care parents, including birth via a surrogate, adoption and foster care.

Here’s an at-a-glance look at the various types of parental leave (see Pulse for complete details and eligibility).

Maternity Leave

Birth mothers are eligible for up to 18 weeks of Maternity Leave.

- Use PTO (non-exempt) or Sick Time (exempt) for your first week of leave, if available.
- Weeks 2-10 are paid at 100% under Short-Term Disability. If you go out on STD prior to your delivery date due to a medical reason, the 2-10 weeks of 100% pay begins. Any time after 10 weeks will be paid at 85% of your pay. You will still receive 10 weeks of STD “recovery” from the date of the birth.
- Weeks 11-18 are paid at 100% under the Parental Leave Program. Leave must be taken in a minimum of two week blocks. You have 12 months from the date of birth to use their Parental Leave.
- 2 of the 8 weeks of the Parental Leave may be used prior to your expected due date.
- You should provide at least a 30-day advance notice to your manager and the Capital One Leave and Accommodation Service Center prior to taking your Parental Leave (for both consecutive leaves and incremental leaves).



Paternity/Secondary Parental Care

New dads and secondary care parents may be eligible for up to 12 weeks of time off to care for and bond with their child.

- Eight weeks of Parental Leave, paid at 100%, which can be broken up in two week increments. Two of the eight weeks of the Parental Leave may be used prior to expected date of birth. You have 12 months from the date of birth to use your Parental Leave. Documentation is not required for the two weeks prior to expected date of birth, but proof of birth will be required for anytime taken after the birth. You should provide at least a 30-day advance notice to your manager and the Capital One Leave and Accommodation Service Center prior to taking Parental Leave time (for both consecutive leaves and incremental leaves). Both Parental and Family and Medical (FML) Leaves are set up simultaneously and run concurrently.
- If you're eligible for FMLA at the time of your child's birth, you're eligible for 4 additional weeks of unpaid leave under FML time. You must use all but ONE week of earned vacation (exempt associates) or PTO (non-exempt associates) before taking unpaid leave. You are not required to use any vacation/PTO that you've purchased. **Note:** Any FML taken outside of the Parental Leave must be taken consecutively, but you don't have to take it immediately following your 8 weeks of Parental Leave.

Adoption/Foster Care Leave

Adoptive and Foster parents may be eligible for up to 12 weeks of time off to care for and bond with their child.

- Eight weeks of Parental Leave, paid at 100%, which can be broken up in two week increments. Two of the eight weeks of the Parental Leave may be used prior to the expected adoption or placement in the home. You have 12 months from the date of adoption or placement in the home to use their Parental Leave. Documentation is not required for the two weeks prior to expected adoption or placement in your home, but proof of adoption or placement in your home will be required for anytime taken after the adoption or placement in your home. You should provide at least a 30-day advance notice to your manager and the Capital One Leave and Accommodation Service center prior to taking your Parental Leave time (for both consecutive leaves and incremental leaves). Both Parental and Family and Medical (FML) Leaves are set up simultaneously and run concurrently.
- If you're eligible for FML at the time of your child's birth, you're eligible for 4 additional weeks of unpaid leave under FML time. You must use all but ONE week of earned vacation (exempt associates) or PTO (non-exempt associates) before taking unpaid leave. You are not required to use any vacation/PTO that you've purchased. **Note:** Any FML taken outside of the Parental Leave must be taken consecutively, but you don't have to take it immediately following your 8 weeks of Parental Leave.

Birth via Surrogate

Associates may be eligible for up to 12 weeks of time off for a child born via surrogacy.

- Eight weeks of Parental Leave, paid at 100%, which can be broken up in two week increments. Two of the eight weeks of the Parental Leave may be used prior to expected date of birth. You have 12 months from the date of birth to use your Parental Leave. Documentation is not required for the two weeks prior to expected date of birth, but proof of birth will be required for anytime taken after delivery. You should provide at least a 30-day advance notice to your manager and the Capital One Leave and Accommodation Service Center prior to taking your Parental Leave time (for both consecutive leaves and incremental leaves). Both Parental and Family and Medical (FML) Leaves are set up simultaneously and run concurrently.
- If you're eligible for FML at the time of your child's birth, you're eligible for 4 additional weeks of unpaid leave under FML time. You must use all but ONE week of earned vacation (exempt associates) or PTO (non-exempt associates) before taking unpaid leave. You are not required to use any vacation/PTO that you've purchased. **Note:** Any FML taken outside of the Parental Leave must be taken consecutively, but you don't have to take it immediately following your 8 weeks of Parental Leave.

If you need to take a parental leave, call the Capital One Leave and Accommodation Service Center at **844-324-CAP1 (2271)** 30 days prior to your expected delivery date or requested leave date—they'll let you know what paperwork is needed to approve your time off and initiate your Short-Term Disability and/or Parental Leave claims.

Back-Up Child and Family Care

The Bright Horizons Care Advantage Program provides alternative child and adult care options during a lapse or breakdown in normal care arrangements for your children or other family members for whom you have care responsibilities. In addition, the Priority Child Care Access Program puts you at the top of the waiting list for full-time and part-time child care at a Bright Horizon center.

The back-up care programs are provided free of charge to associates, but have a 15-day annual limit. It is also important to pre-register for this service (can be done at any time) so that you can request care as soon as you need it.

If you need help with ongoing care, Sittercity helps you find the right caretakers for any situation with their free, online caregiver database. Quickly get connected with nannies, baby sitters, elder care and pet sitters. The annual membership fee has been covered by Capital One if accessed through this site.

For more information, check out Pulse or contact Bright Horizons at **1-877-242-2737**, or go to: careadvantage.com/capitalone, enter "Capital One" as the username and "Bewell" as the password.

Adoption & Surrogacy Reimbursement

The Adoption Reimbursement program provides financial support up to \$35,000 per child for full-time associates who are building their families through adoption. Our Employee Assistance Program (EAP), administered by Anthem, can guide you through each step of the adoption process. In addition to assisting you with reimbursement claims, contact the EAP for assistance with information resources and referral services, evaluating adoption agencies, finding an adoption attorney and more.

The Surrogacy Reimbursement program provides financial support up to \$35,000 per surrogacy arrangement for full-time associates who are building their families through surrogacy. Expenses such as legal costs, attorney's fees, surrogacy agency fees, and some medical and travel expenses are eligible for reimbursement.

Associates are limited to three lifetime claims for Adoption and/or Surrogacy Reimbursement combined.

For more information about these benefits programs, review the Adoption Reimbursement Program and Surrogacy Reimbursement Program pages on Pulse, contact the Anthem Employee Assistance Program at **1-855-383-7222**, or visit Anthem EAP online at anthemeap.com, enter "Capital One" as the login.

College Coach

College Coach provides valuable information and insight from former admissions officers, college finance professionals, and teachers. College Coach can help answer questions like how to navigate the complex college admissions process and determine the best way to pay for college. For more information, check out Pulse or contact College Coach at **1-877-527-3550** or capitalone@getintocollege.com, or go to <https://passport.getintocollege.com/Account/Login>. Use the password "Bewell" for new registrations.

Educational Assistance

Capital One's Educational Assistance program offers you an annual budget to use for course-specific tuition, required books and eligible course-specific fees at regionally and nationally accredited institutions. Depending upon your field of study and meeting eligibility requirements, you may be reimbursed through the Educational Assistance Program. Full-time and part-time associates (who work at least 20 standard hours/week) are eligible on their date of hire for reimbursement for courses starting on or after their hire date.

- For eligible associates, the Educational Assistance Program provides up to a \$5,250 per year allowance (or budget) for course specific tuition, required books and eligible course specific fees.
- Through the program, associates are eligible for tuition discounts at over 200 selected schools and programs through the EdAssist Education Network. Even if you don't qualify for Educational Assistance, you can still receive discounts at participating schools.
- Associates must receive a grade of "C" or better (Undergraduate), a grade of "B" or better (Graduate), or "Pass" if a class only allows a "Pass/Fail" grading option.

Visit Pulse for full details and eligibility requirements of the various Educational Assistance programs.

Employee Assistance Program

Capital One's Employee Assistance Program (EAP) provides a robust set of services including telephonic support, or face-to-face /virtual counseling, legal and financial assistance, ID theft recovery and information on health and well-being.

Free up your day by using the EAP to research family needs such as daycare or eldercare referrals. Moving? Use the Relocation Center to find maps, school reports and houses of worship. If you like to save money, you can also find discounts on a variety of products and services.

Use of EAP services is completely confidential and free of charge to all Capital One associates and their household members. Assistance is available online or by phone 24 hours a day, every day.

Areas frequently addressed by the EAP include:

- Child care and parenting
- Financial issues
- Work and career
- Addiction and recovery
- Concierge and convenience services
- Helping aging parents
- Legal concerns
- Emotional well-being
- Wellness and prevention
- Life events

To access the Anthem EAP, call **1-855-383-7222**. Visit Anthem EAP online at anthemeap.com for more information. When you go to the site, enter "Capital One" as the login.

Commuter Benefits

The plan allows you to set aside a portion of your paycheck before taxes are deducted, which WageWorks—our benefit provider—uses to pay your commuting expenses, such as parking, mass transit and van pool. You see your savings in the form of reduced tax withholding. You may sign up for this program at any time and may cancel at any time before the monthly cutoff date (the 10th of each month). When you reach your pre-tax savings limit, you don't have to leave the plan. WageWorks provides convenience by then using post-tax dollars to continue paying eligible commuting costs for you. Capital One pays for program administration of the commuter benefits offering. You pay only the cost of your transit or parking.

How to Sign Up

Go to wageworks.com and click on **Register Now**. The site will guide you through a few simple steps. You will be assigned a username and password. You'll need to use the last four digits of your Capital One employee ID (that's the six digit number available under **More Details** in your Pulse profile—not to be confused with your eID, which is a series of three numbers and letters) and your home ZIP code in order to register a new account with WageWorks. Capital One doesn't send Social Security numbers on our files to WageWorks. We only provide your employee ID.

During sign-up, you'll be able to select your transit or parking provider directly at the site. If your provider is not listed, please contact WageWorks at **1-877-924-3967** for assistance.

In general, you need to sign up early in the month (by the 10th of the month in most cases) to begin receiving benefits the following month. If you want to cancel your benefits you must also do so by the 10th of the month prior to the next benefits month.

Visit Pulse for more details.

Be Well Rewards

Capital One's Be Well Rewards (Incentive Program) is designed to provide services, information and personalized coaching to encourage and support you to feel your best. RedBrick Health, our wellness partner, has the guidance and tools to help get you going—all while earning up to \$350 in rewards.

The program is available to all associates, plus any spouses/domestic partners enrolled in the Capital One Medical Plan.

2020 Be Well Rewards

You (and your Capital One Medical Plan enrolled spouse or domestic partner) can earn rewards for participating with RedBrick Health in the Be Well Rewards program. Associates and enrolled spouses/domestic partners can each earn \$350 this year, for a total family reward of \$700. You must be an active associate to redeem rewards.

Visit Pulse to see how your healthy activities with RedBrick Health can add up—and get rewarded for getting healthier.

*Participating in an Anthem Nurse coaching program qualifies you for the Be Well Pharmacy Discount Program.

Get Started

Log in to BeWellBenefits.RedBrickHealth.com or call **1-844-894-WELL (1-844-894-9355)** to get started.



Be Well Health & Fitness Centers

Depending on your location, you may have access to on-site Be Well Health & Fitness Centers.

Be Well Health Centers

Capital One offers care for associates and their family members free of charge at our Be Well Health Centers at many of our office locations. All associates are eligible for services, even if they aren't enrolled in Capital One's medical plan.

The following eligible family members can also use the Health Centers:

- A spouse or domestic partner
- Dependent child from age 2 up to the end of the month of their 26th birthday

Be Well Health Centers provide:

- Preventive care, including physical exams, health screenings and immunizations
- Urgent care and minor injury treatment
- Allergy shots, travel immunizations and other injections
- Chronic medical conditions and ongoing health conditions
- Disease management and healthy living programs

See Pulse for locations and details on the Be Well Health Centers.

Fitness Centers

Many of our major locations have fitness centers that include state-of-the-art equipment, personal training and group exercise classes. Visit Pulse to learn more.

Confidentiality

The Health Centers and staff are managed by Premise Health, an independent medical organization bound by the same confidentiality laws that apply to all health care providers. Capital One does not have access to medical information of associates or their families.



Preparing for the Unexpected



Life and Accidental Death & Personal Loss (AD&PL) Insurance

Eligibility

Full-time and eligible part-time associates receive Basic Life and Accidental Death and Personal Loss (AD&PL) Insurance at no cost to you, and the option to purchase additional Life and AD&PL Insurance for yourself and your dependents.

Generally, if you are out on any type of leave, including FMLA, on the day your Basic Life, Supplemental Life, Dependent Life or Associate and Dependent AD&PL coverage (or any change in coverage) is scheduled to take effect, the coverage (or change in coverage) does not take effect until you have been back at work for one full day.

Before You Choose, Consider

- How much do you spend on day-to-day living expenses for your household. This can provide a guideline for the amount of income you need replaced.
- Other coverage you have—including individual coverage, coverage through your spouse's employer and other insurance that provides a death benefit, such as mortgage insurance
- What savings and investments you have, and how many people depend on you for financial support

Basic Coverage

You automatically have Basic Life and AD&PL coverage equal to one times your Annual Benefits Salary, rounded to the next \$1,000, if not already a multiple of \$1,000. For VP+ executives, your Executive Life Insurance Program (ELIP) is calculated separately. **Note:** If you are covered under the Executive Bonus Insurance Plan (EBIP), your coverage follows that of all non-executives (one times your Annual Benefits Salary).

If you have a covered accident, you may be eligible for a one-time payout under the AD&PL line of coverage. AD&PL is a separate line of coverage and is equal to the Basic Life coverage amount. Both are provided to you at no charge.

If you die, your Basic Life coverage provides a payout equal to one times your Annual Benefits Salary, as described above. If you die or experience an injury as a result of a covered accident, you will receive an amount equal to the percentage shown in the chart in the right column in addition to any Basic Life amount paid out.

For Loss of:	You receive this percentage of your Annual Benefits Salary:
Life	100%
Both hands or both feet or sight of both eyes	100%
One hand and one foot	100%
Speech and hearing in both ears	100%
Either hand or foot and sight of one eye	100%
Movement of both upper and lower limbs	100%
Movement of both lower limbs	100%
Movement of three limbs	100%
Movement of the upper and lower limbs of one side of the body	100%
Either hand or foot	50%
Sight of one eye	50%
Speech or hearing in both ears	50%
Movement of one limb	25%
Thumb and index finger of either hand	25%
Third degree burn (75% or more of your body)	100%
Third degree burn (50%–74% of your body)	50%

Designating a Beneficiary

Your beneficiary is the person who will receive your insurance benefits upon your death. You are always the beneficiary for Dependent Life Insurance.

If you wish, you can name more than one beneficiary. To designate or update your beneficiary(ies), go to the Capital One online enrollment system. Look for the link labeled **Update your beneficiary** from the homepage.

Supplemental Coverage

Supplemental Life and AD&PL Insurance is a voluntary benefit offered in addition to the basic coverage that the company automatically provides. With Supplemental Insurance, you can buy, with post-tax dollars, additional Life Insurance for yourself up to 8 times your Annual Benefits Salary. Included in Supplemental Insurance is a separate line of coverage for AD&PL equal to the Supplemental Life coverage amount. Together with Basic Insurance, that means you can have coverage up to 9 times your Annual Benefits Salary or \$2.5 million, whichever is less. The minimum coverage amount is \$5,000. The maximum coverage amount is calculated separately for Life and AD&PL.

For those enrolled in the ELIP (VP+), you can purchase Supplemental Life Insurance for up to 8 times your Annual Benefits Salary. Combined with ELIP, your Life Insurance coverage can be up to \$5 million.

If you are on any type of leave (including FMLA) as of January 1, 2020, any change made to your Supplemental/Dependent Life and AD&PL insurance coverage during Open Enrollment, including increases to your Annual Benefits Salary, will not go into effect until you actively return to work in 2020.

Dependent Coverage

You may purchase Dependent Life and AD&PL Insurance for your spouse or domestic partner and your dependent children up to age 26. Dependents in active, full-time military service are not eligible for Dependent Life coverage.

Payments will be made to you in the event of a dependent's death. If you are not living at the time of payment, it will be made to the executors or administrators of your estate.

Your choices for Dependent Life and AD&PL coverage for your family are:

- \$25,000–\$250,000 spouse or domestic partner; coverage must be in multiples of \$25,000
- \$10,000 or \$20,000 child only

Evidence of Insurability

Some situations require Evidence of Insurability (EOI), or proof of good health, for Supplemental Life/AD&PL coverage and spousal/domestic partner life.

The chart below contains some examples of when EOI is and is not required.

	EOI Required	EOI Not Required
New Hire	<ul style="list-style-type: none"> ■ Basic and Supplemental Insurance over \$1 million ■ Spouse/domestic partner insurance over \$50,000 	<ul style="list-style-type: none"> ■ Basic and Supplemental Insurance less than or equal to \$1 million ■ Spouse/domestic partner insurance less than or equal to \$50,000
During Open Enrollment	<ul style="list-style-type: none"> ■ If no coverage is in place, electing Supplemental Insurance greater than 1 times Annual Benefits Salary ■ If coverage is already in place, increasing Supplemental Insurance greater than 2 times Annual Benefits Salary ■ Any new or increased spouse/domestic partner insurance coverage 	<ul style="list-style-type: none"> ■ If no coverage is in place, electing Supplemental Insurance equal to 1 times Annual Benefits Salary* ■ If coverage is already in place, increasing Supplemental Insurance by 2 times Annual Benefits Salary* <p>* EOI is required with when Basic/ELIP and Supplemental coverage exceeds \$1 million</p>

EOI is never required for Basic Life and AD&PL insurance, child insurance and coverage increases due to salary changes and promotions.

Until you provide EOI and it's approved by The Hartford, you will be covered at the highest level of coverage you are allowed without EOI rather than your actual election.

Disability Insurance

Capital One automatically provides full-time associates with Short-Term Disability and Basic Long-Term Disability coverage at no cost. You have the option to purchase Supplemental Long-Term Disability.

Short-Term Disability

Short-Term Disability benefits replace all or part of your income for up to six months if you're unable to perform your job due to a non-work-related injury, illness or condition, including pregnancy.

During your first week out, you'll use PTO (non-exempt) or Sick Time (exempt) equal to the same amount of hours you're scheduled to work in a week. If you don't have PTO available, you won't receive pay until the following week when your Short-Term Disability begins.

To be eligible for this plan, you must be full-time and have more than 90 days of service with the company, and the disability must be after the 90th day of service. See Pulse for more details.

Long-Term Disability

Long-Term Disability benefits replace 50% of your Annual Benefits Salary after six months. You may purchase Supplemental Long-Term Disability coverage, on an after-tax basis, which replaces an additional 20% of your Annual Benefits Salary, to receive 70% income replacement.

If you've been eligible, but not enrolled for additional Supplemental Long-Term Disability coverage up to now, you will have to provide Evidence of Insurability (EOI) in order to be approved for the 70% of Annual Benefits Salary. Long-Term Disability elections made as a new hire are not subject to EOI.

Generally, if you are not at work on the day your Supplemental LTD coverage (or any change in coverage) is scheduled to take effect, the coverage (or change in coverage) will not take effect until you have been back at work for five full consecutive days. Additionally, if you are disabled at the time of the election of supplemental coverage, the coverage does not take effect for the current disability.



Life Events

Changing Your Coverage During the Year

Based on IRS rules, you can generally make changes during the year only if you have a qualifying change in your family or employment status. This includes events such as:

- Marriage or divorce
- Gaining or losing a domestic partner
- Birth or adoption of a child
- Death of your spouse or dependent
- Your spouse ending or starting employment when that affects coverage eligibility
- You or your spouse changing from full-time to part-time employment status or vice versa, when the change affects coverage eligibility
- Change in health coverage by your spouse's employer
- Loss of eligibility for your dependent because of exceeding the age eligibility requirements
- Loss or gain of eligibility (for you or your eligible dependents) for another group health plan
- Loss or gain of eligibility for a state/federal insurance program such as Medicaid or the Children's Health Insurance Program (CHIP)
- Cost increase of 15% or more in another employer's plan affecting spouse/domestic partner/dependent

Benefit changes must be consistent with the eligible life event. You must make changes by logging in to capitalonebenefits.com or contacting the Capital One Benefits Center at **1-888-376-8836 (options 2, 2, 0)** within 31 days of the event (60 days after birth or adoption of a child or loss, gain of eligibility for a state/federal insurance program such as Medicaid or the Children's Health Insurance Program (CHIP), or for life insurance coverage changes.) If you do not, you must wait until the next Open Enrollment period to make updates.

If you're a new hire or experience a life event between October 10, 2019 and December 31, 2019, please review the New Hire/Life Event page on [MyBeWellBenefits.com](https://mybewellbenefits.com) before enrolling. You'll need to enroll in or update your benefits coverage for 2019 and 2020 benefits.



Appendix



Appendix

Privacy and Your Health Coverage

The privacy rules under the Health Insurance Portability and Accountability Act (HIPAA) require that the Capital One health plans periodically remind you about the availability of the privacy notice and how to obtain that notice. The privacy notice explains participants' rights and the plan's legal duties with respect to protected health information (PHI) and how the plan may use and disclose PHI.

To obtain a copy of the privacy notice or for any questions about the plans' privacy policies, please contact the Capital One HR Help Center at **1-888-376-8836 (options 2, 2, 0)**. You can also go online at **capitalonebenefitsite.com** to view a copy of the notice.

Reminder: HIPAA Description of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends or employer contributions to such other health insurance coverage terminate. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage or 60 days after the birth, adoption or placement for adoption. During a loss of coverage event, members can enroll in medical, dental and vision. Contact the Capital One HR Help Center at **1-888-376-8836 (options 2, 2, 0)**.

Post-Mastectomy Benefits

Under federal law, all group health plans are required to provide medical and surgical benefits following a mastectomy—and to communicate this coverage to plan participants. All medical options provide coverage for these services, including reconstructive breast surgery needed after mastectomy, prostheses and treatment of any physical complications after a mastectomy. These services are covered in the same way as other surgery or services under each medical option.

Length of Maternity Hospital Stay

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier. Additionally, no group health plan or issuer may require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods.

Reminder: Women's Health and Cancer Rights Act

As required by the Women's Health and Cancer Rights Act, a member receiving benefits for a medically necessary mastectomy who elects breast reconstruction after the mastectomy will also receive coverage for:

- All stages of reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of all stages of mastectomy, including lymphedemas

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and co-insurance provisions that apply for the mastectomy. Information about how to obtain a detailed description of the mastectomy-related benefits is available via Anthem Blue Cross and Blue Shield at **1-844-390-4133** or **anthem.com/capitalone**.

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

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

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

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

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

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

Medicaid and CHIP Contact Information

Alabama (Medicaid)	Website: myalhipp.com Phone: 1-855-692-5447	Iowa (Medicaid)	Website: dhs.iowa.gov/hawk-i Phone: 1-800-257-8563
Alaska (Medicaid)	The AK Health Insurance Premium Payment Program Website: myakhipp.com Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: dhss.alaska.gov/dpa/Pages/medicaid/default.asp	Kansas (Medicaid)	Website: kdheks.gov/hcf/ Phone: 1-785-296-3512
Arkansas (Medicaid)	Website: myarhipp.com Phone: 1-855-MyARHIPP (855-692-7447)	Kentucky (Medicaid)	Website: https://chfs.ky.gov Phone: 1-800-635-2570
Colorado (Medicaid and CHIP)	Health First Colorado Website: healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991 State Relay 711	Louisiana (Medicaid)	Website: dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447
Florida (Medicaid)	Website: flmedicaidprecovery.com/hipp/ Phone: 1-877-357-3268	Maine (Medicaid)	Website: maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY Maine relay 711
Georgia (Medicaid)	Website: medicaid.georgia.gov (Click on Health Insurance Premium Payment (HIPP)) Phone: 404-656-4507	Massachusetts (Medicaid and CHIP)	Website: mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840
Indiana (Medicaid)	Healthy Indiana Plan for low-income adults 19-64 Website: in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: indianamedicaid.com Phone: 1-800-403-0864	Minnesota (Medicaid)	Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739

Medicaid and CHIP Contact Information

Missouri (Medicaid)	Website: dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Rhode Island (Medicaid)	Website: www.eohhs.ri.gov Phone: 855-697-4347
Montana (Medicaid)	Website: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	South Carolina (Medicaid)	Website: www.scdhhs.gov Phone: 1-888-549-0820
Nebraska (Medicaid)	Website: ACCESSNebraska.ne.gov Phone: 855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	South Dakota (Medicaid)	Website: dss.sd.gov Phone: 1-888-828-0059
Nevada (Medicaid)	Website: dhcfp.nv.gov Phone: 1-800-992-0900	Texas (Medicaid)	Website: gethipptexas.com Phone: 1-800-440-0493
New Hampshire (Medicaid)	Website: dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll-Free: 800-852-3345, ext 5218	Utah (Medicaid and CHIP)	Medicaid Website: medicaid.utah.gov/ CHIP Website: health.utah.gov/chip Phone: 1-877-543-7669
New Jersey (Medicaid and CHIP)	Medicaid Website: www.state.nj.us/humanservices/dmahs/clients/medicaid Medicaid Phone: 609-631-2392 CHIP Website: njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Vermont (Medicaid)	Website: greenmountaincare.org Phone: 1-800-250-8427
New York (Medicaid)	Website: health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Virginia (Medicaid and CHIP)	Medicaid Website: coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
North Carolina (Medicaid)	Website: dma.ncdhhs.gov/ Phone: 919-855-4100	Washington (Medicaid)	Website: hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
North Dakota (Medicaid)	Website: nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	West Virginia (Medicaid)	Website: mywvhipp.com/ Phone: 1-855-MyWVHIPP (1-855-699-8447)
Oklahoma (Medicaid and CHIP)	Website: insureoklahoma.org Phone: 1-888-365-3742	Wisconsin (Medicaid)	Website: dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
Oregon (Medicaid)	Website: healthcare.oregon.gov/Pages/index.aspx oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Wyoming (Medicaid)	Website: health.wyo.gov/healthcarefin/medicaid/ Phone: 307-777-7531
Pennsylvania (Medicaid)	Website: dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462		

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

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately 7 minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebssa.opr@dol.gov and reference the OMB Control Number 1210-0137.

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

Medicare Part D Prescription Drug Plan—Notice of Creditable Coverage

Effective since 2006, every individual who is eligible for Medicare had the opportunity to enroll in the Medicare Part D prescription drug plan. We are required to annually provide every person who may be eligible for Medicare prescription drug coverage (and who may have coverage under the health plan offered by Capital One) with the enclosed Notice of Creditable Coverage. You and your family members should consider it carefully if this applies to you.

Important things to know about your rights

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. The prescription drug coverage provided under the CVS Caremark plan will provide you with better coverage than the standard Medicare Part D prescription drug plan. However, you may be able to obtain richer coverage than what is offered under a standard Medicare Part D prescription drug plan that may provide for better coverage than our CVS Caremark plan provides, but it is likely to be more expensive than the cost for the standard Medicare prescription drug coverage. Please be aware that Medicare Part D prescription drug plans vary from state to state.
2. Generally, you may be better off retaining your current coverage and NOT enrolling in any of the Medicare Part D prescription drug plans available to you; however, you should fully weigh your options. Here are some considerations:
 - Your present coverage is more generous to you than standard Medicare Part D prescription drug plans.
 - You won't have to pay the premium for the Medicare Part D prescription drug plan.
 - If you enroll in Medicare later, you won't have to pay any penalty for doing so, as long as you enroll within 63 days after your prescription drug coverage under this plan ends for any reason.

If you do enroll in a Medicare Part D prescription drug plan:

- Capital One will NOT pay for your Medicare coverage
- You WILL NOT LOSE your coverage under the CVS Caremark plan
- Your Capital One premiums will not be reduced

The enclosed notice provides details about how to get more information about your options. We encourage you to read it carefully to fully understand how this new program impacts you.

Should you have any questions regarding this notice, please contact the Capital One Benefits Center at **1-888-376-8836 (options 2, 2, 0)**.

Please read this notice carefully and keep it where you can find it. This notice has information about prescription drug coverage with Capital One and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare Part D prescription drug plans in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Part D prescription drug plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Capital One has determined that the prescription drug coverage offered by CVS Caremark is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare Part D prescription drug plan.

When can you join a Medicare Part D prescription drug plan?

You can join a Medicare Part D prescription drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare Part D prescription drug plan.

What happens to your current coverage if you decide to join a Medicare Part D prescription drug plan?

If you decide to join a Medicare Part D prescription drug plan, your current CVS Caremark coverage will not be affected. Generally, if you are a retiree, if you do decide to join a Medicare Part D prescription drug plan and drop your current CVS Caremark coverage, be aware that you and your dependents will not be able to get this coverage back. If you are an active member and you drop your current coverage either at Open Enrollment or due to a qualifying event, you can re-enroll in coverage during the next Open Enrollment period.

When will you pay a higher premium (penalty) to join a Medicare Part D prescription drug plan?

You should also know that if you drop or lose your current coverage with Capital One and don't join a Medicare Part D prescription drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare Part D prescription drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without Creditable Coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare Part D prescription drug plan coverage. In addition, you may have to wait until the following October to join. For more information about this notice or your current prescription drug coverage, contact Capital One's Human Resources Benefits Center at **1-888-376-8836 (options 2, 2, 0)**.

Note: You'll get this notice each year. You will also get it before the next period you can join a Medicare Part D prescription drug plan, and if this coverage through Capital One changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook.

You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit **medicare.gov**
- Call your state Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call **1-800-medicare (1-800-633-4227)**. TTY users should call **1-877-486-2048**.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **socialsecurity.gov**, or call them at **1-800-772-1213 (TTY 1-800-325-0778)**.

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained Creditable Coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	October 2019
Name of Entity/Sender:	Capital One Benefits
Address:	PO Box 9740
	Providence, RI 02940-9740
Phone Number:	1-888-376-8836 (options 2, 2, 0)

All Changes Go Into Effect on January 1, 2020*

This open enrollment guide is designed to help you learn about and understand the benefits available under the 2020 Plan, which include medical (including prescription drug coverage), wellness, dental and vision coverage (together, referred to as healthcare coverage), as well as flexible spending accounts, life, accident and disability coverage offered by Capital One to eligible associates. If applicable, this guide will serve as a Summary of Material Modification (SMM) outlining any changes which take effect on January 1, 2020.

This guide, the Welfare Plan document together with the SPD and any insurance contracts providing benefits under the plan constitute the official “plan documents” that govern Capital One’s health and welfare benefits. In the event that another document or communication (whether written, oral or electronic) conflicts in any way with the terms of the official plan documents, the official plan documents will take precedence.

As you read through this guide, keep in mind that as a matter of prudent business planning, Capital One continually reviews and evaluates proposals for changes in its benefits under the Plan. These proposals, if approved, could be more or less advantageous to you than the current benefits. Capital One reserves the right to end, suspend or amend the benefits under the Plan at any time, in whole or in part, for whatever reason. Until Capital One formally announces the changes in writing in the applicable plan documents, no one is authorized to give assurances that any changes will be or have been made. In addition, please note that nothing in this document states or implies that participation in this Plan is a guarantee of employment with the company. Employment with Capital One is “at will,” meaning that you or the company may end your employment at any time, for any reason, within the limitations of the law. Further, nothing in this document guarantees that benefit levels will remain unchanged in the future.

*Unless otherwise noted

