2019 New Hire Enrollment Guide
For Conduent employees
This version (as of 11/9/18) supersedes prior versions.
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Welcome

This guide is designed to provide the key information you need to choose the benefits that best meet your needs for 2019. Go to BenefitsWeb, your personalized benefits site, to see the benefits available to you and their associated costs.

As you prepare to enroll, there are some important things to keep in mind:

- Do not miss the enrollment deadline. If you miss your enrollment deadline, coverage will be assigned to you automatically, as described below. Other than the coverage listed below, your coverage cannot begin until you actively enroll during your election period, which is generally the first 30 days of your employment.

You will automatically be enrolled in the following coverage as of your benefits eligibility date, even if you do not submit elections by the deadline:

- Company-provided basic employee life insurance coverage in the amount of 1 times annual salary, up to $500,000, and
- Long-term disability for Conduent employees.

These benefits are described in more detail on page 31 and page 33.

- Make your decisions carefully. After the enrollment deadline, you will not be able to change your elections until the next Annual Enrollment, unless you have a qualifying status change, as described on page 38.


Or if you have questions about your benefits, call the Workplace Solutions Center at 1.888.471.2271, and select “2” for benefit information. Representatives are available between 8 a.m. and 8 p.m. ET, Monday through Friday, except holidays.

Your benefits — all in one place with BenefitsWeb

BenefitsWeb is your convenient, one-stop-shop for benefits news, information and support.

- Review your benefit options and enroll in your benefits in a few simple steps. On BenefitsWeb, you’ll find summaries of benefits and coverage (SBCs), which are standardized at-a-glance charts of medical and prescription drug coverage.
- Learn tips on how to use benefits wisely. Find a medical provider in your plan's network, or check your prescription drug costs.


If you are unable to submit your elections on BenefitsWeb, or if you have any questions regarding your benefit options, election deadline or email address on record, you must contact the Workplace Solutions Center. Note: The Workplace Solutions Center closes at 8 p.m. ET, Monday through Friday, so you will need to call during business hours for assistance. Your enrollment deadline will not be extended.

This message is intended for U.S. benefits-eligible employees of Conduent Business Services, LLC (Conduent) and it provides information about benefits and wellness programs offered by or through Conduent. Each year, there are legally required notices and disclosures that Conduent is required to provide related to certain benefit plans. Those legally required notices are all contained in the Enrollment Guide, along with a description of benefits and programs offered each year. The provisions set forth in this document or communication are intended to constitute a Summary of Material Modifications (SMM) to the Summary Plan Descriptions (SPDs) of the applicable plans, but is not intended as a substitute for the official plan documents. Please keep this message with the SPDs for future reference. In some cases, more complete information about certain benefits may be found in the applicable plan documents, collective bargaining agreements, HR policies, HMO agreements, insurance certificates, and Summary Plan Descriptions (SPD). There also may be differences in benefits based on your business group or location. Every effort has been made to ensure that the information in this communication accurately describes the terms outlined in the applicable plan documents, collective bargaining agreements, HR policies, HMO agreements, insurance certificates, or SPDs. The plan documents, collective bargaining agreements, HR policies, HMO agreements or insurance certificates control the administration and operation of the plans. In the event of an inconsistency between this booklet and the applicable plan documents, collective bargaining agreements, HR policies, HMO agreements, insurance certificates, or SPDs, the latter document(s) will control. Conduent and its vendors comply with HIPAA's privacy and security requirements. For copies of the applicable plan documents, visit www.ConduentConnect.com > BenefitsWeb for more information about your benefits, or call the Workplace Solutions Center at 1.888.471.2271. Subject only to any applicable regulations or contracts, Conduent reserves the right to amend or terminate the plans or programs at any time for any reason without prior notice to or consent from any employee or participant to the extent permitted by law, including, without limitation, the right to increase costs and/or reduce or eliminate any Conduent contribution.
Enrollment checklist

☐ **Review the medical plan options for 2019.** Conduent employees have several medical plan options to choose from (not applicable to employees who live in Hawaii, Puerto Rico or employees who are enrolling in the UHC International Plan — see page 10 for more details).

☐ **Review your applicable Summaries of Benefits and Coverage (SBC) and your specific 2019 options and associated costs, which are shown on BenefitsWeb.** If you have questions, please call your medical carrier at the phone number shown in the “Contacts” section of this guide on page 46.

☐ **Review the Health Plan Evaluator by visiting the homepage of BenefitsWeb** to evaluate your medical plan options and decide which one is best for you and your family.

☐ **Working spouse/domestic partner exclusion.** If your spouse/domestic partner has access to medical coverage through another employer, he/she will not be eligible for medical coverage under the Conduent plans. Eligible spouses/domestic partners who do not have access to medical coverage through another employer will be eligible for coverage through Conduent medical plans.

☐ **Decide whether you want to cover dependents.** It’s important that you enroll only eligible dependents for health care coverage. Review the dependent eligibility rules on page 6 and decide which of your eligible dependents you want to cover. Documentation of each dependent’s eligibility must be submitted within 30 days.

☐ **Have your dependents’ Social Security numbers ready.** When you’re ready to enroll dependents, make sure you have your dependents’ Social Security numbers and dates of birth handy. You must enter them during the enrollment process. See page 42 for instructions on how to enroll via BenefitsWeb. If you have difficulty, or if your dependent does not have a Social Security number, you can also call the Workplace Solutions Center.

☐ **Check your medical or dental provider network.** Medical and dental plan administrators will be assigned to you based on where you live. Review your assigned provider network to determine if your current doctors and facilities are in the network of your new plan.

☐ **Self-attest to your nicotine status** for you and your spouse/domestic partner. If you enroll in medical coverage, supplemental life insurance for yourself or your spouse/domestic partner, or critical illness supplemental insurance, you will need to self-attest to your nicotine status separately for each benefit.

☐ **Enroll by the deadline.** You must make elections within your first 30 days of employment. The election deadline will not be extended. If you don’t enroll by the deadline reflected on BenefitsWeb, you will receive default coverage, described on page 3.
Eligibility

This 2019 New Hire Enrollment Guide is intended for U.S. benefits-eligible employees of Conduent.

Generally, you are eligible for Conduent benefits if you are classified as a regular full-time employee and are regularly scheduled to work at least 30 hours per week for Conduent or one of its subsidiaries that participates in Conduent benefits.

In general, all such regular full-time employees are eligible for all of the benefits described in this guide; however, certain variations exist for temporary (project-based) employees, for employees working in Hawaii and Puerto Rico, for inpatriates and expatriates.

Certain part-time employees and contractors, including (without limitation) leased employees, supplemental contract workers, consultants, or any other third-party personnel, or anyone classified by the company as such, who perform services for the company, are neither eligible for nor covered by the plans and programs summarized herein (unless they qualify as eligible dependents). Project-based employees are eligible for Conduent medical coverage, as described on page 7.

Eligibility waiting period

You are eligible for benefits as follows:

• If you are an exempt employee, your eligibility date is your date of hire.
• If you are a non-exempt employee, whose annual pay is more than $30,000, your eligibility date is your date of hire.
• If you are a non-exempt employee, whose annual pay is $30,000 or less, your eligibility date is the first of the month following 60 days of employment, or on the 60th day if it falls on the first of the month.
• If you are a rehire, eligibility waiting periods are as follows:
  – If you leave with at least one year of service and you return within one year of leaving the company, you will be eligible for benefits on first day of your reemployment. You will need to make new elections by the deadline listed on BenefitsWeb.
  – In all other rehire situations, you will need to satisfy the waiting period for benefits as if you are a new hire (see above).
• If you live in Hawaii and work at least 20 hours per week, you are eligible for benefits on your first day of employment.

<table>
<thead>
<tr>
<th>Enrollment &amp; coverage timing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Once you complete your enrollment on BenefitsWeb, your election information will be transmitted to the appropriate insurance carriers.</strong></td>
</tr>
</tbody>
</table>

**Elections are sent to insurance carriers on a weekly basis, and your coverage will generally become effective in the insurance carrier’s system within 10 business days.** If you make your enrollment elections after your eligibility date, your coverage will be retroactively effective back to your eligibility date. If you incur health care expenses after your eligibility date, but before your information has been updated with the insurance carrier, you can submit a claim for reimbursement for those eligible covered expenses.

If you submit your enrollment elections prior to the processing deadline for your first paycheck following your benefits effective date, deductions from your first paycheck may be prorated and therefore lower than the amount reflected on BenefitsWeb. Subsequent deductions will match the amounts reflected on BenefitsWeb.

However, if you submit your enrollment elections after the processing deadline for the paycheck(s) after your benefits effective date, the contributions that you missed will be deducted from your subsequent paycheck(s) — double deductions until the past due amount is paid in full — except for HSA contributions, which cannot be made retroactively.

If you have questions about covered expenses during this time, call the Workplace Solutions Center.
Eligibility (continued)

Eligible dependents

You may enroll your eligible dependents in medical, dental, vision, supplemental insurance and life insurance benefits. Generally, eligible dependents include your legal opposite sex or same-sex spouse (subject to restrictions), your same-sex or opposite-sex domestic partner (including but not limited to couples who have registered with any state or local government domestic partnership registry, subject to restrictions) and your and your spouse’s/domestic partner’s dependent children, up to certain age limits. **There is a working spouse/domestic partner exclusion. If you have a working spouse or domestic partner, see information at the right.**

To enroll a dependent in a Conduent medical, dental, vision, or supplemental insurance plan, you must provide documentation of the dependent’s eligibility. Review the documentation requirements and gather the appropriate materials. Following enrollment, you will receive information by mail and email with instructions for uploading documentation via BenefitsWeb. **You will have 30 days following your enrollment deadline to upload the required documentation. If you miss this deadline, your dependent’s coverage will not become effective.**


Conduent couples

If you and your spouse/domestic partner both work for Conduent, you may enroll for medical, dental and vision as either an employee or a dependent of your Conduent-employed spouse, not both. If you are covering yourself, you are the employee for benefit purposes and you may log in to BenefitsWeb as the employee. If your spouse/domestic partner is covering you and you are the dependent for benefit purposes, you may log in to www.conduent.com/BenefitsWeb as the dependent of your spouse/domestic partner.

Working spouse/domestic partner exclusion

If your spouse/domestic partner was offered medical coverage through another employer, regardless of whether he/she enrolled in coverage, he/she is not eligible for coverage under the Conduent medical plans. This exclusion will be strictly enforced. Not adhering to it may result in disciplinary action, up to and including termination, recovery of ineligible claims and reasonable attorney fees.

Your spouse is eligible for coverage if your spouse or domestic partner:

- Does not work,
- Was laid off from his or her job and did not elect COBRA,
- Works for a company that does not offer medical coverage, works part-time, or was not offered medical coverage through his or her employer for any other reason, or
- Is also a Conduent employee.

**Note:** Eligible spouses/domestic partners who do not have access to medical coverage through another employer will be eligible for coverage through Conduent medical plans.

Covering a same-sex spouse or domestic partner?

You’re able to add your spouse during enrollment on BenefitsWeb in order to avoid imputed income. If you and your domestic partner (same- or opposite-sex partner) are not lawfully married, you may cover him or her as a domestic partner.

Neither a civil union, nor a domestic partnership is considered a marriage for federal income tax purposes. (See page 8 for details.)

If you have questions, call the Workplace Solutions Center.
Eligibility (continued)

**Expatriates**
If you are an expatriate employee, your medical, prescription drug, dental and vision benefits are different than those described in this guide, as are the wellness resources available to you. For more information, review the Summary of Benefits and Coverage (SBC) for the UnitedHealthcare International Plan, which is available in the Library on BenefitsWeb, or contact UHC at **1.877.844.0280**.

Expatriates are eligible to participate in the following benefits described in this guide: Life Insurance, Accidental Death & Dismemberment (AD&D) Insurance, Disability Insurance, Hospital Indemnity Insurance, Flexible Spending Account, and the Legal Services Plan.

**Temporary (project-based) employees**
Temporary (project-based) employees are defined as employees hired for specific periods of time, to cover peak workloads or for the completion of a specific project.

Full-time temporary (project-based) employees working at least 30 hours per week are eligible for the medical benefits and the associated wellness programs listed in this guide.

Your eligible dependent children, up to age 26, may also be covered under your medical plan. Note that spouses, domestic partners, and children of domestic partners are not eligible for coverage.

**Health Savings Account:** When you enroll in one of the Consumer Choice plans, you may be eligible to open a Health Savings Account (HSA) so you can save money to help cover your out-of-pocket expenses, including your deductible and coinsurance. Note that temporary (project-based) employees are not eligible for company contributions.
Paying for coverage

Imputed income
The contributions the company pays for coverage for your domestic partner and/or your domestic partner’s dependent children are considered taxable (imputed) income, and you will pay income tax on the employer’s contributions toward the cost of coverage for these dependents. Your costs for coverage of a domestic partner (or a domestic partner’s children) will be deducted on an after-tax basis.
You are also required to pay tax on the value of any basic life insurance in excess of $50,000.

Contributions
Your annual base pay as of your hire date will be used to determine your 2019 medical plan contributions, life insurance and short-term disability contributions. Any pay change during the year will not affect your 2019 contributions.

Payroll deductions
If you submit your enrollment elections after the processing deadline for the first paycheck after the benefits effective date, the contributions that you missed will be deducted from your subsequent paycheck(s), except for HSA contributions as these cannot be made retroactively. Failure to pay for coverage in a timely manner may result in termination of coverage.
Payroll deductions will take place each pay period throughout the year, for a total of 26 pay deductions.

Coverage end date
Benefits coverage ends on the last day of employment. Depending on payroll processing deadlines, you may pay for coverage even after your employment ends.

By enrolling, you authorize Conduent to make regular payroll deductions from your pay checks in the amounts described on BenefitsWeb to cover your health plan contributions (including any applicable surcharges, such as the tobacco surcharge) and to fund your participation in the Conduent benefit plan(s) in which you enroll. You authorize payroll deductions to cover the surcharge(s) as part of your health plan contributions. These authorizations shall continue and remain in effect until you revoke such authorization, meaning the authorizations will apply to any automatic re-enrollment in the same Conduent benefit plans which may occur through passive or default benefit plan enrollment in future years. You also agree and understand that if you submit enrollment elections after the processing deadline for the benefits effective date reflected herein, or if you fail to make required health plan contributions for any other reason, the contributions that you fail to make will be deducted from your subsequent paycheck(s) — which may result in double deductions until the past due amount is paid in full — except for any missed HSA contributions, which cannot be made retroactively.
How medical and dental coverage is assigned

When you enroll in one of the eligible medical plans or the Basic Dental or Enhanced Dental, we work with plan administrators to provide the greatest access and most competitive network discounts in each geographic area. This means that your medical and dental carriers and networks will be determined by your (employee) home ZIP code, regardless of your assigned work location or where your dependents live. However, these are national plan administrators. You and your covered dependents can use providers and services wherever they are located, throughout the U.S. **Note:** If you live in Hawaii or Puerto Rico, or your medical carrier is Kaiser Permanente, coverage is not available nationwide and there are no out-of-network benefits.

### After you enroll

**ID cards**

Your medical and dental carriers and provider networks are assigned based on your home ZIP code and may change from year to year. You may receive separate ID cards for medical coverage, prescription drug coverage and dental coverage from your carriers. BenefitsWeb will show you what carriers are assigned to you.

**Note:** You do not need an ID card for Aetna dental coverage or for vision coverage. Also, if you live in District of Columbia, Florida, Georgia, Maryland, Missouri, Virginia or Wisconsin, please call Anthem at 1.855.804.2076 to find a provider.

**If you move during the plan year**

Generally, you’ll stay with your current medical carrier the entire plan year. However, if you live in Hawaii or Puerto Rico, or you are enrolled in medical coverage through Kaiser Permanente and you move to an area where coverage through your current carrier is not available, you’ll be reassigned to the medical carrier and/or plan option designated for that location.

Likewise, if you move during the year, you will generally keep the same dental carrier until the next Annual Enrollment period, unless you are in the Aetna DMO and you move to an area where the Aetna DMO is not available. If that happens, you will be enrolled automatically in the Basic Dental option with the dental carrier assigned to your new location (Aetna or Cigna). If you prefer, you may enroll in the Enhanced Dental option instead. Watch your email for your deadline to elect this change.
Medical

Conduent offers a variety of medical plan choices for eligible employees. Our comprehensive medical coverage options — including extensive coverage for preventive care — help you and your family stay healthy.

You can choose among the following medical plan options:
• Classic PPO Plan
• Consumer Choice 1400/2800 Deductible Plan
• Consumer Choice 2000/4000 Deductible Plan
• Limited Coverage Plan for employees earning $75,000 or less per year

Conduent offers these plans with an assigned medical carrier (Aetna, Anthem or Cigna), based on where you live. In some locations, you may also have a choice of Kaiser Permanente. If you enroll in the Limited Coverage Plan, coverage will be available through Allegiance, a Cigna company.

Overview of the Plans

Classic PPO Plan

The Classic PPO Plan provides comprehensive medical coverage and access to both in-network and out-of-network providers, although in-network providers are preferred and will cost you less. For certain services, like a primary care office visit, you will pay a copay. For other services you will pay coinsurance once you’ve met the annual deductible. This type of coverage has a higher premium rate.

Under this option, medical benefits are provided by a medical plan administrator assigned to your location — Aetna, Anthem or Cigna. Kaiser Permanente may be an available option based on your location, but will not be assigned to you. Each medical plan administrator has its own network of providers. Visit BenefitsWeb to check whether your medical plan administrator has changed for 2019. Then visit the medical plan administrator’s website to see if your doctor is in your new network. If not, see “Need help finding a doctor?”

Coverage is summarized in the at-a-glance table, starting on page 13. Here are the plan’s main features:
• Certain in-network preventive care is covered at 100%.
• For certain non-preventive services, including primary care visits, you pay a copayment for each service. For some non-preventive services, you must satisfy a deductible before the plan pays a percentage of eligible expenses.
• Prescription coverage is available with a variable coinsurance and no deductible.

Detailed information on prescription drug coverage can be found on page 15.

• There are minimum and maximum limits on the amount you pay for prescription drugs depending on whether you purchase generic, preferred brand or non-preferred brand prescription drugs.
• An annual out-of-pocket maximum limits the amount of medical and prescription drug expenses you have to pay in a calendar year. If your share of expenses reaches this maximum, the plan will pay 100% of eligible in-network expenses for the rest of the year.
• You may choose in-network or out-of-network providers, but you will pay more for out-of-network care. Note: If your medical carrier is Kaiser Permanente, there are no out-of-network benefits.

Need help finding a doctor?

To find a new network doctor, visit your medical plan administrator’s website and search the appropriate provider network. For confirmation that your current doctor participates in the network offered in your area, you’ll need to go to the medical plan administrator’s website or call member services, as shown in the “Contacts” section of this guide on page 46.

Once your enrollment becomes effective in 2019, you can access your plan administrator’s website through BenefitsWeb, or call Health Advocate for assistance at 1.877.776.6211.
Medical (continued)

Consumer Choice plans

The Consumer Choice plans are high deductible health plans that give you greater control over how you spend your benefit dollars. You have the option of selecting either the 1400/2800 Deductible Plan or the 2000/4000 Deductible Plan.

The differences between the two Consumer Choice high deductible plans are the deductible, out-of-pocket maximums, prescription coinsurance as well as minimums and maximums, and the per paycheck contributions. Coverage is summarized in the at-a-glance table, starting on page 13.

Here are the plan’s main features:

• Certain routine in-network preventive care is covered at 100%.

• Medications on the CVS Caremark™ preventive drug list are covered at 75% with no deductible in the Consumer Choice 2000/4000 Deductible Plan and at 80% with no deductible in the Consumer Choice 1400/2800 Deductible Plan, with maximum limits on the amount you pay for generic and brand-name medications. Go to CVS Caremark Preventive Drug List for the full preventive drug list.

• For non-preventive services, including medical and prescription drugs, you pay the full cost of services until you meet an annual deductible. Then you and the plan each pay a percentage of eligible expenses. Detailed information on prescription drug coverage can be found on page 15.

• An annual out-of-pocket maximum limits the amount of medical and prescription drug expenses you have to pay in a year. If your share of expenses reaches this maximum, the plan will pay 100% of eligible in-network expenses for the rest of the year.

• You may choose in-network or out-of-network providers, but you will pay more for out-of-network care. Note: If your medical carrier is Kaiser Permanente, generally, there are no out-of-network benefits.

• If eligible, you can open a Health Savings Account (HSA) and use it to help pay for qualified health care expenses with pre-tax dollars, as shown on page 19. Once you’ve opened your HSA, Conduent will also make contributions on your behalf as long as you’re eligible.

Limited Coverage Plan

The Limited Coverage Plan is available only to employees whose base salary is $75,000 or less per year. This plan does not cover hospitalization, surgeries, emergency room visits, specialty medications and other health care services that you and your family may need. Coverage is summarized in the at-a-glance table, starting on page 13. This plan provides you with minimal essential coverage only. Here are the plan’s main features:

• Certain routine in-network preventive care is covered at 100%.

• Coverage for up to five primary care, including mental health services, specialty doctor and convenience care visits for minor illnesses per year; $25 copay for a primary care physician visit, $35 copay for a specialty doctor visit and $10 copay for a convenience care clinic visit.

• Unlimited online or telephonic doctor visits through MD Live telemedicine for $20 copay.

• Prescription drug coverage has a $10 retail generic copay and a 50% coinsurance for retail preferred brands.

This plan meets the Affordable Care Act requirement for having health coverage. Please review your options carefully before making your decision.

What’s not covered by the Limited Coverage Plan

• Any services by a physician not in the provider network (Visit www.askallegiance.com/conduent to find an in-network doctor or facility)

• Emergency room visits

• Urgent care visits

• Hospital stays, surgeries

• Imaging (X-ray, MRI, CT Scan)

• Non-preferred brand prescriptions

• Specialty medications

• Prescriptions not listed on the plan formulary and prescriptions filled at a non-participating pharmacy (the plan formulary and a list of participating pharmacies are available on the website)

• Maternity care/delivery

• Most other common health care expenses

You will be responsible for the cost of non-covered services.
Plan administrators

Classic PPO Plan and Consumer Choice plans

If you enroll in the Classic PPO Plan or one of the Consumer Choice plans, your assigned medical carrier will be Aetna, Anthem or Cigna, depending on your home ZIP code. Under Aetna, Anthem and Cigna, the plan offers the same level of benefits. In some locations, you will have a choice between your assigned medical carrier and Kaiser Permanente. Each medical carrier has its own network of providers and certain regions are assigned to a local provider network. Be sure to check whether your providers participate in the network.

Kaiser Permanente

Kaiser Permanente benefits differ from benefits under Aetna, Anthem and Cigna.

With Kaiser Permanente:

- Generally, there are no out-of-network benefits (you must use providers and facilities in the Kaiser Permanente network). However, emergency services are covered by any provider.
- According to California state law, an individual member of a family who meets a deductible of $2,600 will pay coinsurance for subsequent services he or she receives, even if the family deductible has not been met. Services received by other members of the family will not be eligible for coinsurance rates until the family deductible is satisfied. For information on the deductibles for each plan, refer to the Medical Plans Summary of Benefits table, starting on page 13.
- The plan will pay 100% of the cost of services for any individual enrolled in family coverage who reaches the individual out-of-pocket maximum, even if the family out-of-pocket maximum has not been reached. Services received by other members of the family will be covered according to applicable coinsurance rates until the family out-of-pocket maximum is satisfied.
- Certain services — such as private duty nursing, physical therapy, massage therapy or acupuncture — may be covered differently or not at all.
- There also are variations from state to state.

Please visit BenefitsWeb to see which medical carrier is assigned to you and whether coverage with a Kaiser Permanente plan is available to you.

For more information about the Kaiser Permanente coverage available to you, please refer to the Summary of Benefits and Coverage (SBC), available on the Kaiser Permanente website shown under “Contacts” on page 46.

Limited Coverage Plan administrator

If you enroll in the Limited Coverage Plan, your medical carrier and network will be Allegiance — a Cigna Company.
Medical plans summary of benefits

This is a summary of available benefits. For a complete list of covered services, please contact your medical carrier directly. Coverage varies for Kaiser Permanente so please contact Kaiser Permanente for detailed information on covered services.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Classic PPO</th>
<th>Consumer Choice 1400/2800 Deductible</th>
<th>Consumer Choice 2000/4000 Deductible</th>
<th>Limited Coverage Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-network</td>
<td>Out-of-network*</td>
<td>In-network</td>
<td>Out-of-network*</td>
</tr>
<tr>
<td>Single</td>
<td>$1,000</td>
<td>$2,000</td>
<td>$1,400</td>
<td>$4,200</td>
</tr>
<tr>
<td>Family</td>
<td>$3,000</td>
<td>$6,000</td>
<td>$2,800</td>
<td>$8,400</td>
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</tbody>
</table>

Out-of-pocket maximum (includes deductible, copays, coinsurance)

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<tr>
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</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$6,850</td>
<td>$13,700</td>
<td>$6,000</td>
<td>$12,000</td>
<td>$6,250</td>
<td>$12,500</td>
<td>$6,600</td>
<td>$13,200</td>
</tr>
</tbody>
</table>

What you will pay

<table>
<thead>
<tr>
<th>Physician services</th>
<th>Classic PPO</th>
<th>Consumer Choice 1400/2800 Deductible</th>
<th>Consumer Choice 2000/4000 Deductible</th>
<th>Limited Coverage Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$30 copay</td>
<td>40% after deductible</td>
<td>40% after deductible</td>
<td>$25 copay</td>
</tr>
<tr>
<td>Primary care; mental health</td>
<td>$50 copay</td>
<td>40% after deductible</td>
<td>40% after deductible</td>
<td>$35 copay</td>
</tr>
<tr>
<td>Specialist</td>
<td>0%</td>
<td>40% after deductible</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Preventive care; immunizations</td>
<td>$50 copay</td>
<td>40% after deductible</td>
<td>40% after deductible</td>
<td>n/a</td>
</tr>
<tr>
<td>Urgent care</td>
<td>$20 copay</td>
<td>20% after deductible</td>
<td>20% after deductible</td>
<td>$10 copay</td>
</tr>
<tr>
<td>Convenience care</td>
<td>Not Covered</td>
<td>20% after deductible</td>
<td>n/a</td>
<td>$20 copay</td>
</tr>
</tbody>
</table>

* For out-of-network coverage the plan will only consider the expense up to the allowed amount as defined by the medical plan administrator (Aetna, Cigna or Anthem). You will be responsible for the out-of-network deductible and your share of eligible expenses up to the allowed amount, plus any amounts over the allowed amount.

** Percentage after deductible shown, indicates the percentage you will be responsible for paying. For example, 20% after deductible means that you will pay 20% and the plan will pay 80%.
## Medical Plans Summary of Benefits (continued)

<table>
<thead>
<tr>
<th></th>
<th>Classic PPO</th>
<th>Consumer Choice 1400/2800 Deductible</th>
<th>Consumer Choice 2000/4000 Deductible</th>
<th>Limited Coverage Plan Allegiance, a Cigna Company</th>
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<tr>
<td></td>
<td>Aetna, Anthem, Cigna</td>
<td>Aetna, Anthem, Cigna</td>
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<td>Allegiance, a Cigna Company</td>
</tr>
<tr>
<td><strong>What you will pay</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital services or skilled nursing facility; maternity/delivery; mental health or substance abuse</td>
<td>$350 copay; then 20% after deductible**</td>
<td>$700 copay; then 40% after deductible</td>
<td>20% after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Outpatient facility</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Imaging (X-ray, MRI, CT scan); laboratory</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Emergency room (copay waived if admitted)</td>
<td>$150 copay; then 20% after deductible</td>
<td>$150 copay; then 20% after deductible</td>
<td>20% after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity care</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Ambulance</td>
<td>20% after deductible</td>
<td>20% after deductible</td>
<td>20% after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Hospice; durable medical equipment</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Chiropractic services (subject to maximums)</td>
<td>$50 copay</td>
<td>40% after deductible</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Physical, occupational, speech therapy (subject to maximums)</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>ABA Therapy for autism spectrum disorder diagnosis</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

* For out-of-network coverage the plan will only consider the expense up to the allowed amount as defined by the medical plan administrator (Aetna, Cigna or Anthem). You will be responsible for the out-of-network deductible and your share of eligible expenses up to the allowed amount, plus any amounts over the allowed amount.

** Percentage after deductible shown, indicates the percentage you will be responsible for paying. For example, 20% after deductible means that you will pay 20% and the plan will pay 80%.
Prescription drug coverage

Prescription drug coverage for the Classic PPO Plan and the Consumer Choice plans

When you enroll in the Classic PPO Plan or one of the Consumer Choice plans with Aetna, Anthem or Cigna, you automatically receive prescription drug coverage through CVS Caremark, with a separate prescription benefit ID card. The CVS Caremark pharmacy network has more than 50,000 pharmacies nationwide, including 7,600 CVS pharmacies plus Walmart, Target and many other national and independent retail pharmacies. Coverage is available for pharmacies outside the CVS Caremark network, but you will save money if you use participating network pharmacies.

Visit [https://info.caremark.com/conduent](https://info.caremark.com/conduent) for information about drug costs and other important information, even before you are enrolled.

Note: Walgreens is excluded from the pharmacy network.

Get the most from your prescription drug plan

- **For the Classic PPO Plan only:** For most medicines you pay a percentage of the cost, known as “coinsurance,” and the plan pays the remainder of the expense. There are minimums and maximums on the amount you pay. Your coinsurance percentage — as well as the minimums and maximums — depend on whether your prescription is for generic, preferred brand or non-preferred brand medicine. Prescription drug expenses count toward the in-network out-of-pocket maximum.

- **For the Consumer Choice plans only:** Be familiar with the Preventive Drug List. Medications on this list are covered at 75% with no deductible in the Consumer Choice 2000/4000 Deductible Plan and at 80% with no deductible in the Consumer Choice 1400/2800 Deductible Plan. Check the list to verify coverage for your prescriptions, and note that the formulary is subject to changes throughout the year as CVS Caremark conducts reviews. Go to [CVS Caremark Preventative Drug List](https://info.caremark.com/conduent) to access the preventive drug list.

- **Choose generics:** If you or your doctor requests a brand-name medicine when a less-costly generic equivalent is available, you will be responsible for the brand copay, plus the difference in cost between the brand-name and generic medicine, even if your doctor writes Dispense as Written (DAW) on the prescription. This additional amount does not count toward the out-of-pocket maximum.

- **Specialty medication.** If you need special medication for conditions such as cancer, hepatitis C or rheumatoid arthritis, your medicine will be provided through the CVS Caremark Specialty Pharmacy rather than your local retail pharmacy.

- **Kaiser Permanente:** Prescription drug coverage is provided by Kaiser Permanente instead of CVS Caremark and the minimum and maximum coinsurance amounts for prescription drugs are different.

Mail order prescriptions

**Mail order is required for maintenance medications** (medicines taken regularly for chronic conditions such as high blood pressure, asthma, diabetes or high cholesterol). You can take advantage of mail order rates for 90-day prescriptions through the CVS Caremark Mail Service Pharmacy or with CVS Caremark Maintenance Choice, which allows you to fill your 90-day prescription at a local CVS Pharmacy. For coverage to be provided for maintenance medications after an initial fill and two refills (for a total of three fills), you must use the CVS Caremark Mail Service Pharmacy or a CVS Pharmacy. **You will pay 100% of the cost of maintenance medications if you purchase a 30-day supply at a retail pharmacy after the three fills.**

There are three ways to obtain refills by mail order. Have your prescription ID ready, then:

1. Log on to [Caremark.com](http://Caremark.com) (and register if necessary). Under the “Prescriptions” tab, click “Start Mail Service”. CVS Caremark will contact your doctor for you.

2. Call FastStart® at 1.800.875.0867. A representative will fill out the order form and contact your doctor for you.

3. Have your doctor call FastStart at 1.800.378.5697, with a 90-day supply of your prescription. Your doctor will need your prescription ID number.

Please allow 10 days for delivery.

Note: Penalties for not complying with the mandatory generic rule, step therapy rules or the prescription drug authorization rules do not count toward your out-of-pocket maximum.

Prescription drug coverage for the Limited Coverage Plan

Prescription drug coverage will be available through Navitus. You’ll receive annual cost-saving coverage on generic and preferred brand name medications. Non-preferred and specialty brand medications are not covered. Visit [www.askallegiance.com/conduent](http://www.askallegiance.com/conduent) to view a list of participating pharmacies and for a list of covered prescriptions and whether they are generic or preferred brand.
### Classic PPO prescription drug benefits (through CVS Caremark)

<table>
<thead>
<tr>
<th>What you will pay</th>
<th>Retail pharmacy and specialty pharmacy (30-day supply)</th>
<th>Mail order or CVS Caremark Maintenance Choice (90-day supply)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Generic</strong></td>
<td>25% of the discounted cost ($20 max)</td>
<td>25% of the discounted cost ($50 max)</td>
</tr>
<tr>
<td>(Participant minimum/maximum)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Brand</strong></td>
<td>30% of the discounted cost ($40 min/$90 max)</td>
<td>30% of the discounted cost ($80 min/$200 max)</td>
</tr>
<tr>
<td>(Participant minimum/maximum)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Non-preferred brand</strong></td>
<td>45% of the discounted cost ($60 min/$125 max)</td>
<td>45% of the discounted cost ($120 min/$250 max)</td>
</tr>
<tr>
<td>(Participant minimum/maximum)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Consumer Choice Plans prescription drug benefits (through CVS Caremark)

<table>
<thead>
<tr>
<th>What you will pay</th>
<th>Consumer Choice 1400/2800 Deductible Plan</th>
<th>Consumer Choice 2000/4000 Deductible Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Retail pharmacy and specialty pharmacy (30-day supply)</td>
<td>Mail order or CVS Caremark Maintenance Choice (90-day supply)</td>
</tr>
<tr>
<td><strong>Generic</strong></td>
<td>20% after deductible ($4 min/$15 max, after deductible)</td>
<td>20% after deductible ($10 min/$35 max, after deductible)</td>
</tr>
<tr>
<td>(Participant minimum/maximum)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Brand</strong></td>
<td>20% after deductible ($20 min/$50 max, after deductible)</td>
<td>20% after deductible ($50 min/$125 max, after deductible)</td>
</tr>
<tr>
<td>(Participant minimum/maximum)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Non-preferred brand</strong></td>
<td>20% after deductible ($40 min/$80 max, after deductible)</td>
<td>20% after deductible ($100 min/$200 max, after deductible)</td>
</tr>
<tr>
<td>(Participant minimum/maximum)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** For medications on the [preventive drug list](#), your coinsurance will remain the same as listed above, but there is no minimum payment amount and no deductible.

Under Kaiser Permanente, prescription drug coverage is provided through Kaiser Permanente, not CVS Caremark and the minimums and maximums are different.
Prescription drug coverage (continued)

### Limited Coverage Plan

<table>
<thead>
<tr>
<th>What you will pay</th>
<th>Retail pharmacy (30-day supply)</th>
<th>Mail order</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic (Participant minimum/maximum)</td>
<td>$10 copay</td>
<td>Not covered</td>
</tr>
<tr>
<td>Brand (Participant minimum/maximum)</td>
<td>50% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>Non-preferred brand (Participant minimum/maximum)</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

### Terms you should know

**Annual deductible**
The amount you pay out of pocket for health care expenses.

**Annual out-of-pocket maximum**
The most you’ll have to pay during a calendar year for health care services. Once you’ve reached your out-of-pocket maximum, typically your plan begins to pay 100 percent of the allowed amount for covered services on an eligible plan.

**Coinsurance**
You and the plan share the cost of most eligible expenses.

**Convenience care**
See page 23.

**Copay**
A fixed amount you pay for a covered service before you receive services from a physician.

**In-network**
A healthcare professional, hospital, or pharmacy that is part of your health plan’s network of preferred providers. Services from in-network providers will cost you less.

**Out-of-network**
A health care professional, hospital, or pharmacy that is not part of your health plan’s network of preferred providers. Services from out-of-network providers will cost you more.

**Routine preventive care/wellness**
Includes an annual physical and certain recommended screenings.

**Telemedicine**
See page 23.
If you live in Hawaii or Puerto Rico

In Hawaii and Puerto Rico, you have different medical plan options. With these options, your medical plan provides both medical and prescription drug coverage.

If you live in Hawaii

In Hawaii, you have access to the HMSA PPO. With this option, you have the flexibility to see any health care provider. However, you save money when you use providers who are part of the plan’s network. Prescription drug coverage is provided by the PPO Plan through CVS Caremark. For office visits and prescription drugs, you pay a copayment. For other services, you share a percentage of the cost, called coinsurance.

Note that there are changes to HMSA coverage for 2019, including changes to the annual deductible. See the SBC or contact HMSA for more information.

If you live in Puerto Rico

If you live in Puerto Rico, you will have an HMO option, Human Puerto Rico HMO. An HMO is a network of independent health care providers offering a comprehensive package of medical services within a set geographic area. When you enroll in an HMO, you may be required to select a primary care physician (PCP). If your HMO requires PCPs, you will receive benefits only if your medical care is coordinated by your selected PCP. In this case, your PCP would provide all your routine care and refer you to specialists when needed. The exception is that you do not need a referral to obtain care from a professional in the network who specializes in obstetrical or gynecological care. The provider, however, may be required to comply with certain rules, including obtaining pre-authorization for certain procedures, following a pre-approved treatment plan or rules, and making referrals.

For each doctor’s visit or for other routine care, you typically pay a small flat fee called a copayment and your provider submits your claims to the HMO for you. Special rules apply to routine preventive services and immunizations. For other services, you may need to meet an annual deductible before the plan will pay benefits. Copayments and deductibles vary by HMO. Your HMO will also provide prescription drug coverage.

Benefits in these options may change from year to year. To see the coverage available for 2019, be sure to review the summaries of benefits and coverage (SBCs) on BenefitsWeb > Library > 2019 Summaries of Benefits and Coverage. If you have questions, please call your medical carrier at the phone number shown in the “Contacts” section of this guide.
Health Savings Accounts (HSAs)

When you enroll in the Consumer Choice 1400/2800 Deductible Plan or the Consumer Choice 2000/4000 Deductible Plan, you may be eligible to establish an HSA — an exclusive tax-advantaged savings account. You can use an HSA to pay for qualified medical, prescription, dental and vision expenses now — or save to pay for health care expenses in the future. The money in your account can be used to pay deductibles, coinsurance and other out-of-pocket health care expenses. Funds in the HSA are in an interest-bearing, FDIC-insured checking account. You pay for these expenses with an HSA debit card, checkbook or online.

Open your HSA online at any time by visiting www.mybenefitwallet.com/hsaadvantage.

YOU MUST open your HSA online or mail in a signed Master Signature Card provided by BenefitWallet to make or receive contributions. Conduent cannot make contributions until you open your HSA with BenefitWallet, and contributions are not retroactive. You must open your account by November 30, 2018 to receive the full Conduent contribution for 2019. Contributions will begin as soon as administratively feasible after your election becomes effective and you have opened your account, usually within one to two pay periods.

**Conduent HSA at-a-glance**

| Eligibility | You are eligible to establish an HSA only if you enroll in one of the Consumer Choice plans.  
**Note**: You cannot contribute to an HSA if you are covered by another health care plan, such as Medicare, TRICARE, a health plan sponsored by your spouse’s employer (unless that plan is also a qualified high deductible health plan), or a general purpose Health Care FSA. You also are not eligible to contribute if you can be claimed as a dependent on another individual’s tax return. |

| Advantages of an HSA | • **Tax advantages.** As long as you use the account for qualified health care expenses, your contributions are exempt from federal and, in most cases, state income taxes, as well as Social Security taxes. See below for more information.  
• **Can be used in the future.** Unlike a Health Care Flexible Spending Account (FSA), unused funds in your HSA at the end of the year remain in your account to pay for future health care expenses.  
• **Portability.** You can take all the money in your account with you if you change employers or retire. You can use any of your HSA funds to pay for qualified health care expenses tax free.  
• **Investments.** Once your balance reaches $1,000, you can invest any excess funds among a selection of investment options. And investment earnings are tax-free.  
• **Company contribution.** Once you’ve opened your HSA, Conduent will make contributions on your behalf even if you do not contribute to your account, if eligible. See the next page for contribution amounts. These contributions will begin automatically if you are eligible and have opened an account. Company contributions are not retroactive and are also exempt from federal tax. |

| Taxes | Contributions, earnings (if any) and distributions are tax-free on a federal level, but state-tax varies, as long as you use them for qualified health care expenses incurred after you have established your HSA. If you withdraw funds for non-qualified expenses, the withdrawal will be subject to federal taxes and penalties.  
Generally, qualified health care expenses are expenses incurred by you, your spouse, or your dependent children who you can claim on your tax return, with some exceptions. Note that the definition of dependent child is different for HSA purposes than it is for health care FSA purposes — generally, you can only be reimbursed for your child’s expenses until he or she is age 18 (or age 24 if he or she is a full-time student). Expenses for your domestic partner (or his or her children) cannot be reimbursed without incurring a tax penalty unless they are considered your tax dependent(s). If you have questions, please contact your tax advisor. |

Conduent HSA at-a-glance
Health Savings Accounts (HSAs) (continued)

**Maximum HSA contributions**

The maximum annual amount you may contribute to an HSA, based on IRS limits, is shown in the table below. Contributions will be deducted from your pay over 26 pay periods throughout the year. The annual company contribution is prorated and deposited into your account on a per paycheck basis. Contributions are only available when deposited into your HSA.

<table>
<thead>
<tr>
<th>Coverage level</th>
<th>Maximum annual company contribution</th>
<th>Per paycheck company contribution</th>
<th>Your maximum annual contribution</th>
<th>Maximum total annual contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee only</td>
<td>$500</td>
<td>$19.25</td>
<td>$3,000</td>
<td>$3,500</td>
</tr>
<tr>
<td>Employee + 1 or more dependents</td>
<td>$1,000</td>
<td>$38.50</td>
<td>$6,000</td>
<td>$7,000</td>
</tr>
</tbody>
</table>

If you're age 55 or older, you may contribute an additional $1,000 per year to your HSA as a catch-up contribution.

**Note:** No employee or company contributions will be made while you are on a leave of absence and contributions can’t be made retroactively. Temporary (project-based) employees are not eligible for company contributions.
Flexible Spending Accounts

Flexible Spending Accounts (FSAs) offer a great way for you to save on taxes and budget for the health care and dependent care expenses you expect to pay during the year. When you enroll in the Health Care or Dependent (Day) Care FSA through BenefitWallet, the money you put in is not taxed, which saves you money.

### Flexible Spending Accounts at-a-glance

<table>
<thead>
<tr>
<th></th>
<th>Health Care FSA</th>
<th>Dependent (Day) Care FSA (DCFSA)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Who is eligible</strong></td>
<td>Benefit-eligible employees who are not enrolled in the Consumer Choice 1400/2800 Deductible plan or the Consumer Choice 2000/4000 Deductible plan.</td>
<td>All benefit-eligible employees</td>
</tr>
<tr>
<td><strong>Amount you can contribute per year</strong></td>
<td>$100 to $2,650</td>
<td>$100 generally up to $5,000, with a few exceptions as noted in “Dependent (Day) Care FSA Limits” box at the right.</td>
</tr>
<tr>
<td><strong>Use it or lose it rule</strong></td>
<td>Plan your contribution amount carefully because you’ll lose unused funds at the end of the year. You have through December 31, 2019 (or your last day of employment, if earlier) to incur expenses.</td>
<td>Use your debit card to pay expenses on the spot or pay the provider directly and submit a claim for reimbursement.</td>
</tr>
<tr>
<td><strong>How you get reimbursed</strong></td>
<td>Pay your day care provider directly and submit a claim for reimbursement.</td>
<td>Reimbursement Deadline: April 15, 2020</td>
</tr>
<tr>
<td><strong>When receipts must be received by BenefitWallet</strong></td>
<td>Reimbursement Deadline: April 15, 2020</td>
<td>No substantiation is required for DCFSA.</td>
</tr>
<tr>
<td><strong>Which expenses are eligible</strong></td>
<td>Health care expenses that are not covered by your medical, prescription drug, dental or vision plans, such as deductibles, coinsurance, copays, insulin and certain over-the-counter prescribed drugs. You can use IRS Publication 502 as a reference to determine what can or cannot be reimbursed from an FSA. However, it is not intended to be the definitive source. Publication 502 is available from your local IRS office, or on the IRS website at <a href="http://www.irs.gov/pub/irs-pdf/p502.pdf">www.irs.gov/pub/irs-pdf/p502.pdf</a>. If you have a question about whether an expense is eligible, please call the BenefitWallet Service Center at 1.877.472.4200.</td>
<td>Eligible childcare (for children under age 13) and elder care expenses, including in-home babysitters, day care, after-school care and summer day camp, so you or your spouse/domestic partner can work or attend school full-time (see IRS Publication 503, on the IRS website at: <a href="https://www.irs.gov/pub/irs-pdf/p503.pdf">https://www.irs.gov/pub/irs-pdf/p503.pdf</a>, for more information).</td>
</tr>
<tr>
<td><strong>When you can access the money in your account</strong></td>
<td>You can access the full amount of your annual contribution as soon as you are eligible.</td>
<td>You can access only the amount you have contributed to your account at the time you submit your claim.</td>
</tr>
<tr>
<td><strong>If you leave Conduent</strong></td>
<td>You may continue to submit claims for expenses incurred while you were a participant in the account. If you still have money left in your current year’s account after filing all claims incurred before your last day of work, you can continue to submit claims for eligible expenses incurred after your last day of work until the end of the plan year by continuing your participation in the Health Care FSA at your current contribution rate through the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). You can submit requests for reimbursement of dependent care expenses incurred through your last day of work. Any remaining balance after all claims have been submitted will be forfeited.</td>
<td>You can submit requests for reimbursement of dependent care expenses incurred through your last day of work. Any remaining balance after all claims have been submitted will be forfeited.</td>
</tr>
</tbody>
</table>

### Dependent (Day) Care FSA limits

The IRS sets a maximum amount you can contribute to this account each year. Generally, the maximum is $5,000 with a few exceptions noted below.

**Note:** The Dependent Care FSA is for day care expenses only. This account may not be used for health care expenses for your dependents. Use the Health Care FSA for your dependents’ health care expenses.

<table>
<thead>
<tr>
<th><strong>Dependent (Day) Care FSA contribution limits</strong></th>
<th><strong>If you are:</strong></th>
<th><strong>Your annual contribution maximum is:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Married and your spouse earns less than $5,000 per year</strong></td>
<td>Any amount up to your spouse’s annual earnings</td>
<td></td>
</tr>
<tr>
<td><strong>Married and you and your spouse file separate tax returns</strong></td>
<td>$2,500 (if your spouse has access to a separate Dependent Care FSA, he or she may also contribute the $2,500 balance up to the $5,000 annual limit)</td>
<td></td>
</tr>
<tr>
<td><strong>Married and file a joint tax return, and your spouse is a student or disabled</strong></td>
<td>$5,000</td>
<td></td>
</tr>
</tbody>
</table>

Contact a financial advisor or tax accountant if you have questions about tax rules.
Medical plan resources

Additional resources for Classic PPO, Consumer Choice plans and Limited Coverage Plan participants

When you enroll in the Classic PPO, a Consumer Choice plan or the Limited Coverage Plan, you and your covered family members have access to some or all of the wellness benefits on this page.

If you are not enrolled in one of the eligible medical plans, contact your medical carrier directly for information about medical plan resources available to you.

Health Advocate

Health Advocate is your specialized one-stop source for help with billing questions, coordinating care, accessing community resources and more.

Health Advocate will be available to you, your covered spouse/domestic partner, your covered dependent children, your parents and your parents-in-law.

You can access Health Advocate 24 hours a day, seven days a week by calling 1.877.776.6211. Normal business hours are Monday through Friday, from 8 a.m. to 9 p.m. ET. After hours and during weekends, staff is available for limited assistance.

ConsumerMedical™

ConsumerMedical* is a tool that can help you and your covered dependents make more informed decisions about your medical treatment. ConsumerMedical provides personalized research and support for any health condition. A team of doctors, nurses and medical researchers will evaluate your situation, then provide information from trusted sources to help you learn about your diagnosis and treatment options — including providers, procedures and their costs. Contact ConsumerMedical at 1.888.361.3944, Monday through Friday, from 8:30 a.m. to 11 p.m. ET.

*Limited Coverage Plan participants do not have access to ConsumerMedical

Medical plan resources

When you participate in the Classic PPO or Consumer Choice Plan, your medical plan administrator (Aetna, Anthem, Cigna or Kaiser Permanente) offers you and your covered family members a number of wellness programs and resources designed to encourage good health. These confidential programs are available at no additional cost to you.

- **Maternity Management** gives you the resources of an experienced maternity nurse who can offer advice and answer your questions so you can have a healthy pregnancy. You will receive support through every stage of pregnancy and delivery.

- **Nurseline services** allow you to contact experienced, registered nurses toll free, 24 hours a day, seven days a week. During a confidential conversation, you may receive information on self-care, be referred to your physician, or be advised to go to an urgent care center or emergency room.

- **Disease Management programs** like case management and condition support supplement your doctor’s care for health conditions such as asthma, cancer, depression, diabetes, heart disease, high blood pressure and stroke, which require special care and attention. Experienced registered nurses can help you prepare for physician visits, answer questions and reduce the obstacles that may interfere with your health.

To learn more about these programs, call your medical plan administrator at the phone number listed in the “Contacts” section of this guide on page 46.
Medical plan resources (continued)

**Telemedicine (available for Classic PPO plans, both Consumer Choice plans and the Limited Coverage Plan)**

Telemedicine involves speaking to a qualified physician about your health issue virtually, one-on-one instead of in-person. You can access telemedicine 24 hours a day, seven days a week online, by phone or by webcam*. You’ll always talk with an experienced, board-certified physician who can diagnose you and, if appropriate, prescribe medication. There are certain times when telemedicine is particularly helpful and other times when it may not be the best option.

Consider using telemedicine when you need quick access to a doctor for a minor, non-emergency and non-life threatening health issue. Use telemedicine if your doctor is not immediately available to see you, you get sick while you’re traveling, or you’re considering going to the emergency room for a non-emergency. Do not use telemedicine for true medical emergencies, conditions that may require more advanced testing or a physical exam, complex and chronic conditions like diabetes or heart disease, and serious injuries, sprains and bone breaks. Contact your medical carrier for instructions to access telemedicine.

*Restrictions apply in certain states.

**Convenience care also known as Retail Health Clinic (available for Classic PPO Plan, both Consumer Choice plans and the Limited Coverage Plan)**

Convenience care is another way to receive more affordable access to medical care. Convenience care clinics, such as Target Clinic or Minute Clinic, provide convenient access to care for non-life threatening injuries and illnesses. No appointment is necessary for treatment. Most convenience care clinics are staffed by nurses and physician assistants, without on-site access to a physician. Convenience care is best for minor infections, cold and flu symptoms, minor cuts and bites and other non-emergency situations.

A convenience care clinician can treat you for a range of routine medical conditions. You can find convenience care clinics in grocery stores, pharmacies and other retail stores. Contact your medical care provider to see which convenience care facilities are in-network.
Supplemental insurance benefits

If you or your family members should ever become seriously ill or injured, you may face expenses that are not typically covered by medical insurance. Conduent offers you a choice of supplemental plan options, to supplement the valuable health, life and accident and disability benefits available to you, even if you are not enrolled in the company’s medical coverage. In the event of a covered illness or injury, these benefits pay cash directly to you so that you may spend these funds as needed.

Coverage is available for you only or you and your dependents. If you elect to purchase any of these supplemental benefits, you will pay the full cost of coverage through automatic payroll deductions. You pay the cost of this coverage on a before-tax basis.

Specific details about these benefits are available on BenefitsWeb. Go to My Health > Access My Forms and Documents > Summary Plan Descriptions, or, if you don’t have a My Health link, click the Library link on the upper right side of the BenefitsWeb home page.

For more information about these supplemental benefits, contact the supplemental insurance plan administrators through the phone number or website shown under “Contacts” on page 46.

**Note:** Pre-existing condition limitations apply to all three supplemental insurance plans. See page 27 for more information. Supplemental insurance benefits are meant to serve as an extra layer of financial protection. They are not meant to be a substitute for medical insurance.

<table>
<thead>
<tr>
<th>Supplemental insurance benefit</th>
<th>Your options</th>
<th>Coverage levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accidental injury</td>
<td>• Basic</td>
<td>• Employee only</td>
</tr>
<tr>
<td></td>
<td>• Enhanced</td>
<td>• Employee + spouse/domestic partner</td>
</tr>
<tr>
<td></td>
<td>• No coverage</td>
<td>• Employee + children</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Family</td>
</tr>
<tr>
<td>Critical illness*</td>
<td>• $15,000 Non-tobacco user</td>
<td>• Employee only</td>
</tr>
<tr>
<td></td>
<td>• $15,000 Tobacco user</td>
<td>• Employee + spouse/domestic partner</td>
</tr>
</tbody>
</table>
|                               | • $30,000 Non-tobacco user | These coverage levels include your children, as long as they are listed when you enroll.
|                               | • $30,000 Tobacco user  | • Employee + children* |
|                               | • No coverage      | • Family* |

* Your coverage costs, which are shown on BenefitsWeb, are also affected by your age.
Supplemental insurance benefits (continued)

**Allstate Benefits Supplemental Accidental Injury Insurance**

This plan, administered by Allstate Benefits, pays benefits in addition to any other health coverage you may have. Accidental injury insurance pays a specific dollar amount for inpatient and outpatient services related to an injury (including a benefit per hospital admission), injury-related physician or physical therapy visits, emergency room costs and ambulance charges resulting from an accident and more.

In addition, the plan provides a benefit when you or a covered dependent visit a doctor for any reason (even when it’s unrelated to an accident), which may help to offset the cost of the policy:

- **Basic Plan** — $25 per visit (up to an annual maximum of $50 per person/$100 per family)
- **Enhanced Plan** — $50 per visit (up to an annual maximum of $100 per person/$200 per family)

Accidental injuries include, but are not limited to:

- Dislocations
- Lacerations
- Fractures
- Loss of limbs
- Burns
- Disabilities or deaths due to accidents
- Hospital admission and additional benefits for confinement
- Broken bones
- Ambulance
- Emergency room treatment
- Accident follow up
- Diagnostics (X-rays, CT, MRI)
- Physical therapy
- Family lodging
- Transportation

For additional plan information including full details of the benefits, costs, exclusions and limitations, refer to the product brochure (ABJ33765X) or see the Allstate Benefits Group Accident Insurance Policy.

**Allstate Benefits Supplemental Critical Illness Insurance**

This plan, administered by Allstate Benefits, pays a lump-sum cash benefit in addition to any other health coverage you may have. Payments are made when a diagnosis of a specific illness is made or a health event occurs (such as cancer, heart attack or stroke), provided the initial diagnosis is after the effective date of the policy. It is designed to help offset catastrophic expenses that can arise as a result of such illnesses.

**Note:** Your coverage costs, which are shown on BenefitsWeb, are affected by the cash benefit you elect and your age. **You must make a nicotine attestation when you elect or review your critical coverage during the enrollment process.** If you attest as nicotine-free when you elect or re-elect coverage, you will receive a lower rate for 2019.

**Coverage amounts**

<table>
<thead>
<tr>
<th>Your options</th>
<th>Basic plan</th>
<th>Enhanced plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$15,000</td>
<td>$30,000</td>
</tr>
<tr>
<td>Spouse</td>
<td>$7,500</td>
<td>$15,000</td>
</tr>
<tr>
<td>Children</td>
<td>$7,500</td>
<td>$15,000</td>
</tr>
</tbody>
</table>
Supplemental insurance benefits (continued)

Benefits are payable according to the percentages listed in the table below for each critical illness:

- **Initial diagnosis** — If covered, you can receive benefits for each critical illness listed in the table below. Benefits will be paid for a different diagnosis if the subsequent diagnosis is separated by 90 days or more from the prior diagnosis. Each critical illness will be paid only once unless Recurrent Diagnosis is available.

<table>
<thead>
<tr>
<th>Covered critical illness</th>
<th>Initial diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Invasive cancer</td>
<td>100%</td>
</tr>
<tr>
<td>Carcinoma in situ</td>
<td>25%</td>
</tr>
<tr>
<td>Advanced Alzheimer’s disease</td>
<td>25%</td>
</tr>
<tr>
<td>Advanced Parkinson’s disease</td>
<td>25%</td>
</tr>
<tr>
<td>Benign brain tumor</td>
<td>100%</td>
</tr>
<tr>
<td>Coma</td>
<td>100%</td>
</tr>
<tr>
<td>Complete blindness</td>
<td>100%</td>
</tr>
<tr>
<td>Complete loss of hearing</td>
<td>100%</td>
</tr>
<tr>
<td>Paralysis</td>
<td>100%</td>
</tr>
<tr>
<td>Heart attack</td>
<td>100%</td>
</tr>
<tr>
<td>Stroke</td>
<td>100%</td>
</tr>
<tr>
<td>Coronary artery bypass surgery</td>
<td>25%</td>
</tr>
<tr>
<td>Major organ transplant</td>
<td>100%</td>
</tr>
<tr>
<td>End stage renal failure</td>
<td>100%</td>
</tr>
</tbody>
</table>

- **Recurrent diagnosis** — If covered, you will receive benefits for the same diagnosis if the subsequent diagnosis is separated by 12 months or more. Benefits for Recurrent Diagnosis are paid only once for each applicable critical illness. The program covers the recurrent diagnosis of heart attack, stroke, major organ transplant and end stage renal failure at 100%, and coronary artery bypass surgery at 25%.

In addition, to encourage you to seek preventive care, the plan also provides a $50 benefit per covered person per year for certain diagnostic wellness procedures and tests, which applies even if the preventive care is already covered 100% by the Conduent medical plan.

For additional plan information including full details of the benefits, costs, exclusions and limitations, refer to the product brochure (ABJ33765X) or see the Allstate Benefit Group Critical Illness Insurance Policy.

Allstate Benefits Coverage is provided by limited benefit Supplemental Critical Illness and Accident insurance policies. Benefits provided by forms: GVCIP2 and GVAP1, or state variations thereof. The policies have exclusions, limitations and may not be available for sale in all states. Allstate Benefits is the marketing name used by American Heritage Life Insurance Company (Home Office, Jacksonville, FL), a subsidiary of the Allstate Corporation. [www.allstatebenefits.com](http://www.allstatebenefits.com)
Supplemental insurance benefits (continued)

**Aetna Supplemental Hospital Indemnity Insurance**

This plan, underwritten and administered by Aetna, pays benefits in addition to any other health coverage you may have. If you are hospitalized for a covered service, the plan provides cash benefits for you to spend as you see fit. Most primary health insurance plans do not cover all hospital costs. A hospital indemnity plan covers some of the costs associated with a hospital stay and may provide extra coverage that major health plans do not.

The amount to be paid is determined in advance and you can elect either the Basic Plan or the Enhanced Plan, see the coverage amounts in the table below. This plan covers the following:

- Hospital admission
- Daily hospital stay
- ICU stay

<table>
<thead>
<tr>
<th>Coverage amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of benefit</strong></td>
</tr>
<tr>
<td>Admission benefit</td>
</tr>
<tr>
<td>Lump-sum benefit for one stay in the hospital as an inpatient per coverage year (in a calendar year)</td>
</tr>
<tr>
<td>Daily hospital benefit</td>
</tr>
<tr>
<td>Daily benefit amount while a member is an inpatient in a hospital</td>
</tr>
<tr>
<td>Maximum number of days per coverage year (in a calendar year)</td>
</tr>
</tbody>
</table>

This plan does not cover all health care expenses and has exclusions and limitations. If you have a question about which health care services are covered and to what extent, please contact Aetna by calling **1.800.571.4015**.

**Pre-existing condition limitations**

All three plans have limitations on when benefits are payable:

- **Supplemental Accidental Injury** pays the benefits described for an accidental injury when services are rendered after the effective date of coverage, even if the accident or injury occurred before the effective date.
- **Supplemental Critical Illness** pays benefits only if the initial diagnosis (or coronary artery bypass) occurs after the effective date of coverage, and following that there are 90 days between diagnoses of covered conditions.
- **Supplemental Hospital Indemnity** pays a benefit for hospitalization, when you or a covered dependent are admitted to the hospital as an inpatient. **Note**: In some states, this exclusion may not apply to all conditions.

THIS PLAN DOES NOT COUNT AS MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT. THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

THIS IS NOT A MEDICARE SUPPLEMENT (MEDIGAP) PLAN. If you are or will become eligible for Medicare, review the free Guide to Health Insurance for People with Medicare available at [www.medicare.gov](http://www.medicare.gov).
**Dental**

Conduent dental options generally cover the same types of eligible expenses, but differ in how much you pay for care.

- **You can choose from two plans: Basic Dental or Enhanced Dental.** With these options, you will be assigned to either Aetna’s or Cigna’s network of providers, depending on your home ZIP code. You have the freedom to see any provider, but you save money if you use a dentist in your network and the dentist will file claims for you.

- **In some locations, you will also have a third option: The Aetna Dental Maintenance Organization (DMO).** This plan pays benefits only if you use a participating Aetna DMO/DNO network provider. If you are covering dependents, you must each select a primary dentist from the network (but you don’t have to select the same one). There is no annual deductible or annual maximum benefit. Instead, you pay a copayment for each covered service you receive.

**Note:** The Aetna DMO provider network is different from the network for the Basic and Enhanced Dental options. **If you’re considering this option, be sure to check that your dentist participates within this more restricted network before you make your election.**

Please visit BenefitsWeb to see which dental carrier is assigned to you and whether the Aetna DMO is available to you.

### Dental plans at-a-glance

<table>
<thead>
<tr>
<th>Covered services</th>
<th>Enhanced Dental</th>
<th>Basic Dental</th>
<th>Aetna DMO</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-network*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual deductible</td>
<td>$50/person (3 per family)</td>
<td>$75/person (3 per family)</td>
<td>None</td>
</tr>
<tr>
<td>Diagnostic/preventive care</td>
<td>100% (no deductible)</td>
<td>100% (no deductible)</td>
<td>100%</td>
</tr>
<tr>
<td>Basic care</td>
<td>80% after the deductible</td>
<td>60% after the deductible</td>
<td>100% of negotiated fees after $5 copay</td>
</tr>
<tr>
<td>Major care</td>
<td>50% after the deductible</td>
<td>50% after the deductible</td>
<td>60% of negotiated fees after $5 copay</td>
</tr>
<tr>
<td>Maximum annual benefit</td>
<td>$1,500/person</td>
<td>$1,000/person</td>
<td>None</td>
</tr>
<tr>
<td>Orthodontia</td>
<td>50% (no deductible) for adults and children</td>
<td>50% (no deductible) for children only (must be “banded” before age 20)</td>
<td>100% after $2,400 copay for adults and children</td>
</tr>
<tr>
<td>Maximum lifetime benefit</td>
<td>$1,500/person</td>
<td>$1,000/person</td>
<td>24 months of treatment plus 24 months of retention</td>
</tr>
</tbody>
</table>

*This chart displays only in-network benefits. In the Basic and Enhanced Dental options, benefits for out-of-network services are based on R&C charges.*

---

**Need help finding a dentist?**

To find a dentist, visit your dental carrier’s website and search the appropriate provider network, or call member services as shown in the “Contacts” section of this guide on page 46.

You can also access your carrier’s website through BenefitsWeb, one of the medical plans, or you can call Health Advocate for assistance at **1.877.776.6211**.
Vision

Vision coverage, provided by VSP, includes coverage for eye exams, eyeglasses or contact lenses, and discounts for laser surgery. If you visit a VSP network provider, you pay a fee at the time you receive care, and the plan pays the rest of the expense. (Note that an ID card is not required to receive services; the provider may ask for your Social Security number to identify you as a covered employee.) If you see an out-of-network provider, you pay in full at the time that you receive care and submit a claim for reimbursement.

<table>
<thead>
<tr>
<th>Vision Plan at-a-glance</th>
<th>Description</th>
<th>Copay</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>WellVision exam</td>
<td>Focuses on your eyes and overall wellness</td>
<td>$10</td>
<td>Every calendar year</td>
</tr>
<tr>
<td>Frame</td>
<td>$130 allowance</td>
<td>$25 copay (combined for frames and lenses) plus 80% of the amount over allowance</td>
<td>Every calendar year</td>
</tr>
<tr>
<td>Lenses</td>
<td>Single vision, lined bifocal and lined trifocal</td>
<td>$25 copay (combined for frames and lenses)</td>
<td>Every calendar year</td>
</tr>
<tr>
<td>Lens enhancements</td>
<td>Standard progressive lenses, Premium progressive lenses, Custom progressive lenses, Average savings of 20-25% on other lens enhancements</td>
<td>$25 copay plus: $55, $95 - $105, $150 - $175</td>
<td>Every calendar year</td>
</tr>
<tr>
<td>Contacts (instead of glasses)</td>
<td>$130 allowance for contacts; copay does not apply, Contact lens exam (fitting and evaluation)</td>
<td>Up to $15</td>
<td>Every calendar year</td>
</tr>
<tr>
<td>Extra savings</td>
<td>Glasses and Sunglasses</td>
<td>20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Retinal Screening</td>
<td>No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Laser Vision Correction</td>
<td>Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.</td>
<td></td>
</tr>
</tbody>
</table>

Your coverage with out-of-network providers

Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network plan details.

| Exam: up to $45 | Lined bifocal lenses: up to $50 | Progressive lenses: up to $50 |
|                | Lined trifocal lenses: up to $65 | Contacts: up to $105 |

Looking for a VSP provider?

To find a VSP doctor or retail chain affiliate within the VSP Choice network, such as Costco Optical, Visionworks or Cohen’s Fashion Optical, visit www.vsp.com or call 1.800.877.7195.
Survivor benefits

The Conduent benefit program features several survivor benefit plans, including life insurance, accidental death and dismemberment (AD&D) insurance and company-provided business travel accident insurance, which provide you and your family with important financial protection. The company provides a basic level of coverage and options which you can purchase to supplement your coverage.

Don’t forget to designate a beneficiary.

You must designate a beneficiary to receive payment of your employee life and AD&D insurance benefits in the event of your death.

You can designate and update your beneficiaries at any time on the Personal Information section of BenefitsWeb. From the home page, go to My Health > View My Personal Information > Beneficiaries. If you do not designate a beneficiary, your employee life and accident benefits will be distributed in the following order to your: spouse/domestic partner, child(ren), parent(s), siblings or estate.
Life insurance

Conduent offers a variety of life insurance options to protect your family’s financial future. The company provides basic life insurance at no cost to you. You may purchase additional coverage for yourself and your eligible dependents. You may see all your coverage options in the at-a-glance chart below.

The cost you pay for additional life insurance coverage varies depending on whether you use tobacco. **You must make a nicotine use attestation during the enrollment process to get nicotine-free rates.**

Your annual base salary as of your date of hire will be used to determine life insurance contributions and coverage amount.

**Note:** Coverage that does not require evidence of insurability will become effective upon enrollment. The additional coverage (and the associated premiums) will not be effective until your evidence of insurability is approved. You should provide this additional information or evidence during the online enrollment process.

The IRS requires you to pay income taxes on the value of basic life insurance over $50,000, known as imputed income.

<table>
<thead>
<tr>
<th>Type of service</th>
<th>Your coverage options</th>
<th>When evidence of insurability is required</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Basic employee life insurance</strong></td>
<td>Conduent pays the full cost of coverage in the amount of one times your annual salary, up to $500,000.</td>
<td>Evidence of insurability is not required.</td>
</tr>
</tbody>
</table>
| **Employee supplemental life insurance** | • No coverage  
• 1 to 10 times annual salary, up to $3 million                                                                                                                                                    | You may be required to provide evidence of insurability if:  
• You do not enroll for coverage when you are first eligible and wish to at a future date.  
• When you are first eligible, you elect coverage that exceeds the lower of $500,000 or three times your annual salary.  
• You make any changes to your coverage that are not associated with a qualifying change in status. **Note:** If you are on leave of absence, any approved increase will not become effective until you return to work. |
| **Spouse/domestic partner life insurance** | • No coverage  
• $10,000 to $250,000, in $10,000 increments, up to 100% of your combined basic and supplemental employee coverage amounts.                                                                 | You may be required to provide evidence of insurability if:  
• You do not enroll for coverage when you are first eligible and wish to at a future date.  
• When you are first eligible, you elect coverage that exceeds $50,000.  
• You make any changes to this coverage.                                                                                                   |
| **Child(ren) life insurance**            | • No coverage  
• $2,000 per child  
• $4,000 per child  
• $6,000 per child  
• $8,000 per child  
• $10,000 per child  
**Note:** All eligible children are automatically covered for the same amount.                                                                   | Evidence of insurability is not required.                                                                 |

* You are the beneficiary of spouse/domestic partner and/or child(ren) coverage.
Accidental Death & Dismemberment (AD&D) insurance

Conduent offers a number of AD&D insurance options to meet your needs. This coverage pays benefits in the event you and/or your eligible dependents die or suffer certain serious impairments due to an accidental injury. You pay the full cost of any AD&D coverage you elect.

<table>
<thead>
<tr>
<th>Voluntary AD&amp;D insurance</th>
<th>Your 2019 options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee AD&amp;D insurance</td>
<td>• No coverage</td>
</tr>
<tr>
<td></td>
<td>• $50,000 to $1 million, in $50,000 increments</td>
</tr>
<tr>
<td>Spouse/domestic partner AD&amp;D insurance</td>
<td>• No coverage</td>
</tr>
<tr>
<td></td>
<td>• $50,000 to $500,000, in $50,000 increments</td>
</tr>
<tr>
<td>Child AD&amp;D insurance</td>
<td>• No coverage</td>
</tr>
<tr>
<td></td>
<td>• $50,000</td>
</tr>
<tr>
<td></td>
<td>• $100,000</td>
</tr>
</tbody>
</table>
Disability insurance

If you’re unable to work due to a sickness or injury, disability insurance can help you maintain your standard of living — helping you pay your health insurance premiums and other expenses. Conduent offers both short-term disability (STD) coverage and long-term disability (LTD) coverage, which are designed to work together to provide continuous income replacement.

- STD coverage provides continuing income for up to 150 days when you are unable to work due to a short-term illness or injury. You choose whether to be covered by this plan. No STD benefits are paid for pre-existing conditions, including pregnancy, until you have been covered by the STD plan for 12 consecutive months. A pre-existing condition is any sickness or injury for which, during the six months immediately before coverage begins, you:
  - Received medical advice or treatment,
  - Consulted a physician or nurse practitioner, or
  - Had medications prescribed.

- LTD coverage provides continuing income after you have been unable to work due to illness or injury for more than 150 days. Conduent employees do not need to elect LTD coverage. The company pays the full cost of the LTD plan. For more information about your LTD benefits, please see your Summary Plan Description.

### STD at-a-glance

<table>
<thead>
<tr>
<th>Type of service</th>
<th>Your coverage options</th>
</tr>
</thead>
</table>
| STD coverage    | If you are unable to work due to illness or injury, STD coverage replaces 60% of your basic earnings, up to a maximum of $8,000 per month, for up to 150 days of disability. There is a waiting period before benefit payments begin. When you enroll, you may choose the length of this waiting period, as follows:  
  - **Option 1** — Benefit payments begin after you have been disabled for 7 consecutive days.  
  - **Option 2** — Benefit payments begin after you have been disabled for 14 consecutive days.  
  - **Option 3** — Benefit payments begin after you have been disabled for 30 consecutive days.  
  **Note:** You pay for STD coverage on an after-tax basis. Benefits continue as long as you remain disabled, up to 150 days from your date of disability, including the waiting period. For example, if you choose option 3, you will not receive more than 120 days of benefit payments.  
  This benefit is reduced by other sources of income, such as state disability income. If you work in a state with a mandatory state disability plan, including CA, HI, NJ, NY, RI and PR, you should review the state disability plan before making a decision to enroll in the company’s STD plan. Your combined benefits from the state and the company plan will not exceed 60% of your base annual earnings. |
Additional benefits

**Legal Services Plan**
Conduent offers the Legal Services Plan, through Hyatt Legal Plans. The Plan offers an unlimited number of advice and office consultations on personal legal matters with an attorney of your choice.

You, your spouse/domestic partner and your eligible children are able to use the program for a fee of $14.72 per month (automatic payroll deductions are made on an after-tax basis). Enrollment is your only opportunity to enroll in or drop this coverage.

A wide range of legal matters are covered, including:

**Estate planning documents**
- Simple and complex wills
- Trusts (revocable and irrevocable)
- Powers of Attorney (healthcare, financial, childcare)
- Living wills
- Codicils

**Consumer protection**
- Consumer matters
- Small claims assistance
- Personal property protection

**Defense of civil lawsuits**
- Administrative hearings
- Civil litigation defense
- Incompetency defense

**Document preparation**
- Affidavits
- Deeds
- Demand letters
- Mortgages
- Notes
- Elder law matters

**Document review**
- Any personal legal document

**Financial matters**
- Negotiation with creditors
- Debt collection defense
- Personal bankruptcy
- Identity theft defense
- Tax audit representation (municipal, state or federal)

**Family law**
- Uncontested adoption or guardianship
- Name change
- Prenuptial agreement

**Immigration assistance**
- Advice and consultation
- Review of immigration documents
- Preparation of affidavits and powers of attorney

**Family Matters™**
- Separate plan for parents of participants for estate planning documents
- Easy enrollment online or by phone
- Available for an additional fee

**Real estate matters**
- Sale or purchase of house or condominium
- Refinancing of house or condominium
- Tenant negotiations
- Eviction defense
- Home Equity loans
- Security deposit assistance (tenant only)

**Traffic offenses**
- Defense of traffic tickets (excludes DUI)
- Driving privileges restoration (includes license suspension due to DUI)

**Juvenile matters**
- Juvenile court defense, including criminal matters

For more information, visit www.legalplans.com and enter the access code 0101431, or call the Hyatt Legal Plans Client Service Center at 1.800.821.6400.
Additional benefits (continued)

Commuter benefits program
Provided through WageWorks, this is a tax savings program for employees who have parking expenses at their work location or use mass transit to commute to and from work. The program allows you to pay for your transit and parking costs on a before-tax basis, saving you up to 40% on your commuting costs. The amount of your savings depends on your state and federal tax rates.

Timing of election: You may enroll in this program any time during the year, and you have the option to change your commute options each month, as your transportation needs change. If you enroll by the fourth day of the month, your transit pass/voucher will be effective the first of the month following one month for processing (a total elapsed time of approximately two months).

Contribution limits: The amount you can get tax-free in any given month is determined by the IRS and can change annually. For 2019, the projected limits are:
• Transit and vanpool: $260 a month for transit and vanpool
• Parking: $260 a month for parking

The specified limits apply individually to each calendar month.

Refunds: In accordance with IRS Regulations, neither Conduent nor WageWorks can issue refunds for deductions taken from your earned wages based on your elections, even once your employment with Conduent ends.

Leaves of absence: If you go on a leave of absence, it is your responsibility to cancel your commuter benefits. Failure to do so will result in payroll deductions upon your return. You may re-enroll in commuter benefits once you return to active employment status.

Virtual employees: In general, commuter benefits are available for the employee's transit to and from work and/or for parking at or near work. Virtual or remote employees should consult a tax advisor before choosing to enroll in this benefit.

Employees in New York City: Employees in New York City are required to attest that they were offered commuter benefits. Visit Learning@Conduent on ConduentConnect and search for course ECF101 to submit your attestation, if you have not already done so.

For more information, or to enroll if eligible, visit www.wageworks.com > Sign Up Now and follow the steps; or call WageWorks at 1.877.924.3967.
Wellness

Understanding your benefits options and making informed decisions to ensure you have the coverage that best meets the needs of you and your family is critical to your role as a smart health care consumer. Equally important is managing your health and the health of your family. Maintaining a healthy lifestyle and practicing preventive health are effective ways to keep health care expenses in check. Conduent provides a number of resources to assist you in your journey towards better health. More information on wellness incentives will be available in 2019.

The following is an overview of programs currently available to you at no extra cost.

Employee Assistance Program — GuidanceResources

The Employee Assistance Program (EAP) provided through GuidanceResources® by ComPsych offers strictly confidential support, resources and information for personal and work-life issues.

You can get help with:

- Relationships
- Education
- Parenting
- Finances
- Work/life balance
- Legal

The EAP is available to all employees and their dependents. You do not need to be enrolled in a Conduent medical plan to contact the EAP.

When you call the EAP, a personalized initial assessment and consultation will be conducted. You will then be directed to confidential counseling, financial or legal representatives or work-life specialists, depending on the nature of your issue.

**1.833.806.8718**, 24 hours a day, 365 days a year or

www.GuidanceResources.com, web ID: CONDUENT

Tobacco cessation program — Quit For Life

The Quit For Life® tobacco cessation program, through Optum, is available to:

- All benefits-eligible employees, whether covered by a Conduent medical plan or not, and
- All spouses/domestic partners and dependent children (18 or older) who are covered under a Conduent medical plan.

Your Quit Coach will work with you to develop a personalized quit plan. If nicotine patches, gum or prescription medication are determined helpful for you during the quit process, these will be mailed directly to your home along with a Quit Guide.

Participants will receive ongoing coaching calls and text messages around their quit date followed by support calls for maintenance and relapse prevention.

**1.866.QUIT.4.LIFE (1.866.784.8454)**
Enrolling online

Log on to BenefitsWeb to begin enrollment.

For assistance with logging in, call the Workplace Solutions Center at 1.888.471.2271, and select “2” for benefit information. Your enrollment is not complete until you receive a Confirmation Statement.

You must make elections within your first 30 days of employment. The election deadline will not be extended. If you don't enroll by the deadline, you will receive default coverage, described on page 3.

If you have questions or need help submitting your elections, contact the Workplace Solutions Center by phone.

Enrolling by phone

If you have questions about your benefits, call the Workplace Solutions Center at 1.888.471.2271, and select “2” for benefit information. Representatives are available between 8 a.m. and 8 p.m. ET, Monday through Friday, except holidays.

The Workplace Solutions Center closes at 8 p.m. ET, Monday through Friday, so you will need to call during business hours for assistance. Your enrollment deadline will not be extended.

Confirmation statement

After submitting your elections, review your confirmation statement carefully. Print a copy of your confirmation statement and keep it for your records. If you made your elections online, you will not receive a confirmation statement in the mail.
Qualifying changes in status

In most cases, the enrollment decisions you make will remain effective through December 31, 2019. However, you may change some of your elections during the year if you have a qualifying change in status, provided the coverage change is consistent with your status change. Documentation may be required. Submitting false or misleading information can result in disciplinary actions. Changes in status include:

- Birth or adoption of a child
- Marriage or domestic partnership
- Divorce, legal separation or termination of a domestic partnership
- Death of a covered dependent
- Change in employment status for you or your spouse/domestic partner that results in a gain or loss of benefits
- Change in your dependent’s eligibility for benefits
- Issuance of a qualified medical child support order

You must make any coverage changes within 31 days of the change in status (60 days for birth or divorce). Any missed deductions will be taken from your upcoming paychecks, up to double your regular deduction amount, until the past due balance is paid in full. If you add a dependent, you will be required to submit documentation. See the Life Events Guide in the SPD for more information.

To make a change, go to BenefitsWeb, or call the Workplace Solutions Center at 1.888.471.2271.

If you don't make the change within 31 days of the change in status (or within 60 days for birth or divorce), you may not make the change until the next Annual Enrollment period.

Special enrollment rights

If you decline enrollment for yourself or your dependents (including your spouse/domestic partner) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in a Conduent medical plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents’ other coverage). You must request enrollment within 30 days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

The plan will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have 60 days — instead of 30 days — from the date of the Medicaid/CHIP eligibility change to request enrollment in the plan. (Documentation will be required after 30 days.) Note that this 60-day extension doesn't apply to enrollment opportunities other than the Medicaid/CHIP eligibility change.

Also, 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 in a Conduent plan. You must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.
Legal notices

Health plan participation

By electing to enroll in a Conduent sponsored health plan, you acknowledge that you understand, consent to and authorize the following:

1. Certain of our health plan options share claims data with health management vendors (or their subcontractors) who are business associates of the plan and have entered into business associate agreements with the plans that require them to maintain the privacy of such data to and use it only to identify individuals eligible for wellness management programs. An example of such companies is Optum. In accordance with HIPAA, eligible individuals may be contacted, but participation in these programs is entirely voluntary.

2. Conduent recognizes that your health information is private. Accordingly, personally identifiable health information is not shared with Conduent for non-plan-related purposes. Conduent may receive aggregate data not containing personally identifiable health information.

3. You are responsible for ensuring that only eligible dependents are enrolled in the Conduent plans. If you enroll someone as a dependent who is not an eligible dependent under the terms of the plan, such as a child over the age limit, a grandchild or a former spouse — or anyone else not eligible under the plan — and the plan learns that the individual is not eligible, the ineligible individual may not be covered by the plan for any expenses. Failure to notify the plan in a timely manner that an individual is or has become ineligible could cause the individual to lose his or her ability to continue coverage under COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended).

Confidentiality of your health information

Federal law, according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended, includes rules that require that health plans protect the confidentiality of your private health information. HIPAA applies to all Conduent medical, dental and vision care plans and plan options (collectively referred to as “the plan”). A complete description of your rights under HIPAA can be found in the plan’s privacy notice, which is available on BenefitsWeb or by calling the Workplace Solutions Center. The Conduent HIPAA Privacy Notice spells out what the plan is required by law to do, including notifying you of a breach of your unsecured protected health information (PHI), and how the plan will comply, as well as provides an explanation of your rights regarding your own PHI. For example, under the regulations you may request access to electronic copies of your PHI, or you may request in writing or electronically that another person receive an electronic copy of these records.

Neither the plan nor Conduent will use or further disclose information that is protected by HIPAA (PHI) except as necessary for treatment, payment, health plan operations and plan administration or as permitted or required by law. In no event will your PHI, that is genetic information, be used for underwriting purposes. In particular, the plan will not, without authorization, use or disclose protected health information for employment-related or union-related actions and decisions or in connection with any other benefit or employee benefit plan sponsored by Conduent. By contract, the plan has required all of its business associates to observe HIPAA’s privacy rules.

Under HIPAA, you have certain rights with respect to your PHI, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This plan maintains a privacy notice, which provides a complete description of your rights under HIPAA’s privacy rules. A copy of this notice is available in the Library section on Conduent BenefitsWeb, under Regulatory Notices, or call the Conduent Business Services, LLC, VP of Corporate Governance, at 1.214.841.6111 to request a copy.

If you have questions about the privacy of your health information, please contact the claims administrator associated with those benefits. Contact information is included in the “Contacts” section of this guide on page 46.

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

This Notice of Privacy Practices applies to the following plans, each of which is a member of an organized health care arrangement referred to throughout this Notice as a “Plan”:

• Classic PPO Plan
• Consumer Choice Plans
• Limited Coverage Plan
• All fully insured plans, including HMOs and fully insured PPO plans
• Health Care Flexible Spending Account
Legal notices (continued)

The purpose of this Notice is to describe how the Plan may use and disclose your protected health information in accordance with the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). This Notice also describes the obligations of the Plan with respect to your protected health information, and describes your rights to control and access your protected health information. Each Plan has agreed to the provisions set forth in this Notice.

1. Responsibilities of the plan

The Plan is required under HIPAA to maintain the privacy of your protected health information. Protected health information includes all individually identifiable health information transmitted or maintained by the Plan that relate to your past, present or future health, treatment or payment for health care services. The Plan must abide by the terms of this Notice, must provide you with a copy of this Notice upon request, and must provide notice to affected individuals following a breach of unsecured protected health information.

2. How the plan may use and disclose your protected health information

The following categories describe the different situations in which the Plan is permitted or required to use or disclose your protected health information:

• For management of treatment or payment purposes. The Plan has the right to use and disclose your protected health information to satisfy its responsibilities with respect to providing you with coverage and benefits under the Plan.

Such disclosures will include those necessary to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibilities under the Plan, or to coordinate Plan coverage. For example, the Plan may disclose your protected health information to determine if a treatment that you received was covered under the Plan.

• Health care operations. The Plan has the right to use and disclose your protected health information to perform functions necessary for the operation of the Plan. Such disclosures will include those made to conduct quality assessment and improvement activities, for underwriting, premium rating and other activities relating to insurance coverage, for legal services and auditing functions, and for other business management and general administrative activities. For example, the Plan may disclose your protected health information to respond to your customer service request, in connection with its fraud compliance programs, or to provide you with information regarding a new disease management program. The Plan may not use any protected health information that is “genetic information” (as defined by the Genetic Information Nondiscrimination Act of 2008) for underwriting purposes.

• Plan administration functions. The Plan (or its business associates, as applicable) may disclose your protected health information to the Plan Sponsor to permit it to perform administrative functions on behalf of the Plan and to service your benefits.

• Business associates. The Plan Sponsor of the Plan may contract with certain service providers (“Business Associates”) to perform various functions on behalf of the Plan. To provide these services, Business Associates may receive, create, maintain, use or disclose protected health information. The Plan Sponsor (on behalf of the Plan) and each Business Associate will enter into, or have already entered into, an agreement requiring the Business Associate to safeguard your protected health information as required by law and in accordance with the terms of this Notice.

• Organized health care arrangement. The Plan may share your protected health information with each other for payment purposes and to carry out health care operations.

• Required by law. The Plan may use or disclose your protected health information to the extent required by Federal, state or local law.

• Lawsuits and disputes. The Plan may disclose your protected health information in response to a court or administrative order. Your protected health information may also be disclosed in response to a subpoena, discovery request or other lawful process if efforts have been made to tell you about the request or to obtain an order protecting your protected health information.
Legal notices (continued)

- **Certain government agencies and officials.** The Plan may disclose your protected health information to (i) government agencies involved in oversight of the health care system, (ii) government authorities authorized to receive reports of abuse, neglect or domestic violence, (iii) law enforcement officials for law enforcement purposes, (iv) military command authorities, if you are or were a member of the armed forces, (v) correctional institutions, if you are an inmate or in under the custody of a law enforcement official, and (vi) Federal officials for intelligence, counterintelligence, and other national security activities.

- **Public health and research activities; medical examiners.** The Plan may also disclose your protected health information (i) for public health activities or to prevent a serious threat to health and safety, (ii) to organizations that handle organ donations, if you are an organ donor, (iii) to coroners, medical examiners and funeral directors as necessary, and (iv) to researchers, if certain conditions regarding the privacy of your protected health information have been met.

- **Workers’ compensation.** The Plan may disclose your protected health information to comply with workers’ compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

- **Disclosures to the Secretary of the U.S. Department of Health and Human Services.** The Plan may be required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services to investigate or determine the Plan’s compliance with the HIPAA Privacy Rules.

- **Other uses and disclosures with written authorization.** Disclosures and uses of your protected health information that are not described above may be made by a Plan with your written authorization. If a Plan is authorized to use or disclose your protected health information, you may revoke that authorization, in writing, at any time, except to the extent that the Plan has taken action relying on the authorization. The Plan will not be able to take back any disclosures of your protected health information that have already been made with your authorization. In most cases, the use or disclosure of psychotherapy notes, the use or disclosure of protected health information for marketing purposes, or the sale of protected health information will require your written authorization.

3. **Your rights with respect to your protected health information**

The following summarizes your rights with respect to your protected health information:

- **Right to request a restriction on uses and disclosures of protected health information.** You have the right to request a restriction or limitation on the protected health information used or disclosed about you by the Plan for treatment, payment or health care operations. You also have the right to request a limit on the disclosure of your protected health information to someone who is involved in your care or the payment for your care, such as a family member, friend or other person you have identified as responsible for your care.

In general, the Plan is not required to agree to a restriction that you request, although in certain circumstances, the Plan may be obligated to honor your request for a restriction on disclosures to another health plan relating to a health care item or service for which you paid in full.

The Plan will comply with any restriction request if: (i) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out-of-pocket in full.

- **Right to request confidential communications.** You have the right to request that the Plan communicate with you about your protected health information in a certain way or at a certain location. For example, you can request that the Plan only contact you at work or by mail.

The Plan will accommodate all reasonable requests.

- **Right to inspect and copy your protected health information.** You have the right to inspect and copy your protected health information which may be used to make decisions about your Plan benefits. Under certain circumstances, the Plan may deny you access to a portion of your records. For example, you do not have a right to inspect and copy psychotherapy notes or information that the Plan has collected in connection with, or in reasonable anticipation of, any legal claim or proceeding. If you request copies, the Plan may charge you copying and mailing costs.
Legal notices (continued)

- **Right to amend your protected health information.** You have the right to request an amendment of your protected health information that is maintained by a Plan if you believe that the information is inaccurate or incomplete. The Plan may deny your request if your protected health information is accurate and complete or if the law does not permit the Plan to amend the requested information. The Plans cannot amend information created by your doctor or any person other than the Plan.

- **Right to receive an accounting of disclosures of your protected health information.** You have the right to request an accounting of disclosures the Plan has made of your protected health information during the six years prior to the date of your request. However, you will not receive an accounting of (i) disclosures made prior to April 14, 2003 (ii) disclosures made to you, and (iii) disclosures made to carry out treatment, payment or health care operations (except to the extent required by law, if the Plan maintains your Protected Health Information as an electronic health record). Certain other disclosures are also excepted from the HIPAA accounting requirements. If you request more than one accounting in any 12 month period, the Plan will charge you a reasonable fee for each accounting after the first accounting statement.

- **Right to receive a paper copy of this notice.** You have the right to receive a paper copy of this Notice upon request. To obtain a paper copy of this Notice, contact the Workplace Solutions Center.

- **To exercise your individual rights.** To exercise any of your rights listed above, you must complete the appropriate form. To obtain the required form, please contact the HIPAA Privacy Officer for the Plan as set forth in Section 7 below.

- **To appoint someone to act on your behalf.** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. The Plan will make sure the person has this authority and can act for you before taking any action.

- **To provide us with instructions in certain situations.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:
  - Share information with your family, close friends, or others involved in payment for your care
  - Share information in a disaster relief situation

  If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

  In these cases we never share your information unless you give us written permission:
  - Marketing purposes
  - Sale of your information

- **Right to be notified of a breach affecting your protected health information.** You have the right to receive notice in the event that the Plan (or a business associate) discovers a breach (as defined by applicable law) involving your protected health information.

4. **Filing a complaint with the plan or the U.S. Dept. of Health and Human Services**

If you believe that a Plan has violated your HIPAA privacy rights, you may complain to the Plan or to the Secretary of the U.S. Department of Health and Human Services. Complaints to the Plan should be sent to the Workplace Solutions Center. Complaints to the Secretary should be sent to the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Ave. S.W., Washington, D.C. 20201.

The Plan will not penalize you or retaliate against you for filing a complaint.

5. **Changes to this notice**

The Plan reserves the right to change the provisions of this Notice and to apply the changes to all protected health information received and maintained by the Plan. If the Plan makes a material change to this Notice, a revised version of this Notice will be provided to you within sixty (60) days of the effective date of the change at your address of record.

6. **Effective date**

This Notice is effective January 1, 2019.
7. Contact information
If you have any questions regarding this Notice or would like to exercise any of your rights described in this Notice, please contact:
Workplace Solutions Center
P.O. Box 5202
Cherry Hill, NJ 08034-5202
1.888.471.2271
Fax: 855.818.3246
www.ConduentConnect.com

Notice of Creditable Coverage
You can find the most recent copy of the Medicare Part D Notice of Creditable Coverage on BenefitsWeb at My Health > Access My Forms & Documents or in the Library under Regulatory Notices.

Women’s Health and Cancer Rights Act of 1998
Your plan, as required by the Women’s Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy. Call your medical plan administrator for more information included in the Contacts section on page 46.

Newborn’s and Mothers’ Health Protection Act
Group health plans and health insurance issuers 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 vaginal 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 than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Notice of important rights under Medicaid and the Children’s Health Insurance Program (CHIP)
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 Conduent, 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 www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed on page 46, 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 or dial 1.877.KIDS.NOW or www.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.
This publication is intended for U.S. active employees of Conduent Business Services, LLC.
If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under a Conduent plan, Conduent must allow you to enroll in the Conduent 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 a Conduent plan, contact the Department of Labor at www.askebsa.dol.gov or call 1.866.444.EBSA (3272).
If you live in one of the states listed on page 46, you may be eligible for assistance paying your Conduent health plan premiums. The following list of states is current as of July 31, 2018. Contact your state for more information on eligibility.
ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1.855.692.5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1.866.251.4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1.855.MyARHIPP (855.692.7447)

COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: www.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

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1.877.357.3268

GEORGIA – Medicaid
Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP)
Phone: 1.404.656.4507

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: www.in.gov/fssa/hip/
Phone: 1.877.438.4479
All other Medicaid
Website: www.indianamedicaid.com
Phone: 1.800.403.0864

IOWA – Medicaid
Website: http://dhs.iowa.gov/hawk-i
Phone: 1.800.257.8563

KANSAS – Medicaid
Website: www.kdheks.gov/hcf/
Phone: 1.785.296.3512

KENTUCKY – Medicaid
Medicaid Website: https://chfs.ky.gov
Medicaid Phone: 1.800.635.2570

LOUISIANA – Medicaid
Website: http://ldh.la.gov/index.cfm/subhome/s/n/331
Phone: 1.888.695.2447

MAINE – Medicaid
Website: www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1.800.442.6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid
Website: www.mass.gov/eohhs/gov/departments/masshealth
Phone: 1.800.862.4840

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1.800.657.3739

MISSOURI – Medicaid
Website: www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 1.573.751.2005

MONTANA – Medicaid
Website: http://dpdhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1.800.694.3084

NEBRASKA – Medicaid
Website: www.ACCESSNebraska.ne.gov
Phone: 1.855.632.7633
Lincoln: 1.402.473.7000
Omaha: 1.402.595.1178

NEW HAMPSHIRE – Medicaid
Website: www.dhhs.nh.gov/ombp/nhhpp/
Phone: 603.281.5218
Hotline: NH Medicaid Service Center at 1.888.901.4999

NEW JERSEY – Medicaid and CHIP
Medicare Website: www.state.nj.us/humanservices/dmahs/clients/medicaid
Medicare Phone: 1.609.631.2392
CHIP: www.njfamilycare.org/index.html
CHIP Phone: 1.800.701.0710

NEW YORK – Medicaid
Website: www.health.ny.gov/health_care/medicaid/
Phone: 1.800.541.2831

NORTH CAROLINA – Medicaid
Website: https://dma.ncdhhs.gov
Phone: 919.855.4100

NORTH DAKOTA – Medicaid
Website: www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1.844.854.4825

OKLAHOMA – Medicaid
Website: www.insureoklahoma.org
Phone: 1.888.365.3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1.800.699.9075

Pennsylvania – Medicaid
Website: www.dhs.pa.gov/provider/medicalassistance/healthinsurancenewhireenrollmentguide.htm
Phone: 1.855.697.4347

Rhode Island – Medicaid
Website: www.eohhs.ri.gov
Phone: 1.855.697.4347

South Carolina – Medicaid
Website: www.scdhhs.gov
Phone: 1.888.549.0820

South Dakota – Medicaid
Website: http://dss.sd.gov
Phone: 1.888.828.0059

Texas – Medicaid
Website: http://gethipptexas.com/
Phone: 1.800.440.0493

Utah – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1.877.543.7669

Vermont – Medicaid
Website: www.greenmountaincare.org/
Phone: 1.800.250.8427

Virginia – Medicaid and CHIP
Medicaid Website: www.coverva.org/programs/premium_assistance.cfm
Medicaid Phone: 1.800.432.5924
CHIP Website: www.coverva.org/programs/premium_assistance.cfm
CHIP Phone: 1.855.242.8282

Washington – Medicaid
Website: www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
Phone: 1.800.562.3022 ext. 15473

West Virginia – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 1.877.MyWVHIPP (1.855.699.8447)

Wisconsin – Medicaid and CHIP
Website: www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1.800.362.3002

Wisconsin – Medicaid
Website: www.greenmountaincare.org/
Phone: 1.800.250.8427

Wyoming – Medicaid
Website: https://wyequalitycare.acs-inc.com/
Phone: 1.307.777.7531

To see if any other states have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1.866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1.877.267.2323, option 4, Ext. 61565
Contacts

Save time by accessing most of your benefits from the My Health tab on BenefitsWeb. Just choose the coverage you want to review, then click on the link to directly access the carrier’s website and skip the login process. (A one-time registration process is required.)

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<th>Website and provider network information</th>
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<td>Classic PPO Plan and Consumer Choice 1400/2800 Plan and 2000/4000 Plan</td>
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<tr>
<td>Aetna</td>
<td>1.855.695.3416</td>
<td><a href="http://www.aetna.com">www.aetna.com</a></td>
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<td></td>
<td></td>
<td>To find a network provider online, search the Aetna Choice POS II (Open Access) network plan. For Telemedicine, go to <a href="http://www.teladoc.com/aetna">www.teladoc.com/aetna</a> to establish an account or you can download the corresponding mobile app for free from the App Store or Google Play.</td>
</tr>
<tr>
<td>Anthem</td>
<td>1.855.804.2076</td>
<td><a href="http://www.anthem.com">www.anthem.com</a></td>
</tr>
<tr>
<td></td>
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<td>To find a network provider, go to <a href="http://www.anthem.com">www.anthem.com</a>, click on “Find a Doctor,” and enter the three alpha characters from your ID card. Search by provider type, name, and or distance from your home ZIP code. Or, call the customer service number for assistance. For telemedicine, go to <a href="http://www.livehealthonline.com">www.livehealthonline.com</a> to establish an account or you can download the corresponding mobile app for free from the App Store or Google Play.</td>
</tr>
<tr>
<td>Cigna</td>
<td>1.855.820.6604</td>
<td><a href="http://www.cigna.com">www.cigna.com</a></td>
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<tr>
<td></td>
<td></td>
<td>To find a network provider, search Open Access Plus (OAP), OA Plus, Choice Fund OA Plus with Carelink online. Or, call and ask for the Open Access Plus with Carelink (OAPC) network plan. For telemedicine, visit either <a href="http://www.AmWellforCigna.com">www.AmWellforCigna.com</a> or <a href="http://www.MDLIVEforCigna.com">www.MDLIVEforCigna.com</a> to establish an account or you can download the corresponding mobile app for free from the App Store or Google Play.</td>
</tr>
</tbody>
</table>
## Benefit plan administrator contact information

<table>
<thead>
<tr>
<th>Benefit plan administrator</th>
<th>Member services phone</th>
<th>Website and provider network information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Kaiser Permanente</strong></td>
<td>California: 1.800.464.4000</td>
<td><a href="http://my.kp.org/conduent">http://my.kp.org/conduent</a></td>
</tr>
<tr>
<td></td>
<td>Colorado: 1.303.338.3800</td>
<td>To find a network provider online, select “Find a Doctor,” select your location and click “Go.” For telemedicine, contact the number on the back of your ID card for your specific plan resources.</td>
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<tr>
<td></td>
<td>Other North CO areas: 1.800.632.9700</td>
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<td></td>
<td>Colorado Springs: 1.888.681.7878</td>
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<td></td>
<td>Georgia: Atlanta Metro area: 1.404.261.2590</td>
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<td></td>
<td>Other areas: 1.888.865.5813</td>
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<td></td>
<td>Mid-Atlantic: D.C. Metro area: 1.301.468.6000</td>
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<td></td>
<td>Other areas: 1.800.777.7902</td>
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<td></td>
<td>Other areas: 1.800.813.2000</td>
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<tr>
<td></td>
<td>To find a network provider online, select the PHCS network. For telemedicine, go to <a href="http://www.mdlive.com/allegiance">www.mdlive.com/allegiance</a> to establish an account or you can download the corresponding mobile app for free from the App Store or Google Play.</td>
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<tr>
<td><strong>Prescription drug coverage</strong></td>
<td>CVS Caremark: 1.855.559.1385</td>
<td><a href="https://info.caremark.com">https://info.caremark.com</a></td>
</tr>
<tr>
<td></td>
<td>Specialty Customer Care: 1.800.237.2767</td>
<td>Returning users: <a href="http://www.caremark.com">www.caremark.com</a></td>
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<tr>
<td></td>
<td></td>
<td>Specialty Customer Care: <a href="http://www.CVSCaremarkSpecialtyRx.com">www.CVSCaremarkSpecialtyRx.com</a></td>
</tr>
<tr>
<td><strong>Health Savings Account (HSA)</strong></td>
<td>BenefitWallet: 1.877.472.4200</td>
<td><a href="http://www.mybenefitwallet.com">www.mybenefitwallet.com</a></td>
</tr>
<tr>
<td><strong>Medical plans for employees in Hawaii and Puerto Rico</strong></td>
<td>HMSA PPO: Oahu: 1.808.948.6111</td>
<td><a href="http://www.hmsa.com">www.hmsa.com</a></td>
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<td></td>
<td>Neighbor Islands: 1.800.776.4672</td>
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### Benefit plan administrator contact information

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<tr>
<td>Humana of Puerto Rico HMO</td>
<td>1.800.314.3121</td>
<td><a href="http://www.humana.com">www.humana.com</a></td>
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<tr>
<td><strong>Medical plan for expatriates</strong></td>
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<tr>
<td>UnitedHealthcare</td>
<td>1.877.844.0280</td>
<td><a href="http://www.myuhc.com">www.myuhc.com</a></td>
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<tr>
<td><strong>Dental</strong></td>
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<tr>
<td>Aetna (Basic and Enhanced)</td>
<td>1.855.695.3416</td>
<td><a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
<tr>
<td>Aetna (DMO)</td>
<td>1.855.695.3416</td>
<td><a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
<tr>
<td>Cigna (Basic and Enhanced)</td>
<td>1.855.820.6604</td>
<td><a href="http://www.cigna.com">www.cigna.com</a></td>
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<td><strong>Vision</strong></td>
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<td>VSP</td>
<td>1.800.877.7195</td>
<td><a href="http://www.vsp.com">www.vsp.com</a></td>
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<tr>
<td><strong>Supplemental insurance benefits</strong></td>
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<tr>
<td>Hospital Indemnity</td>
<td>1.800.571.4015</td>
<td><a href="http://www.aetna.com/voluntary/employees">www.aetna.com/voluntary/employees</a></td>
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<tr>
<td><strong>Wellness programs</strong></td>
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<tr>
<td>Health Advocate</td>
<td>1.877.776.6211</td>
<td><a href="http://www.healthadvocate.com/members">www.healthadvocate.com/members</a></td>
</tr>
<tr>
<td>Employee Assistance Program (GuidanceResources)</td>
<td>1.833.806.8718</td>
<td><a href="http://www.guidanceresources.com">www.guidanceresources.com</a></td>
</tr>
<tr>
<td>Quit For Life, tobacco cessation program (Optum)</td>
<td>1.866.QUIT.4.LIFE (1.866.784.8454)</td>
<td><a href="http://www.quitnow.net">www.quitnow.net</a></td>
</tr>
<tr>
<td>ConsumerMedical</td>
<td>1.888.361.3944</td>
<td><a href="http://www.myconsumermedical.com">www.myconsumermedical.com</a></td>
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To find a network dentist online, search the **DMO/DNO network**.

To find a network dentist online, search the **Dental Maintenance Organization (DMO) network**.

To find a network dentist online, search the **Cigna DPPO Advantage/Cigna DPPO networks**.

To find a provider online, search the **Choice network**.

Enter Conduent as your employer and your home ZIP code (you do not need to enter your Health Plan).
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<td><strong>Flexible Spending Accounts (FSAs)</strong></td>
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<tr>
<td>BenefitWallet</td>
<td>1.877.472.4200</td>
<td><a href="http://www.mybenefitwallet.com">www.mybenefitwallet.com</a></td>
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<tr>
<td><strong>Life and Accidental Death &amp; Dismemberment insurance</strong></td>
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<tr>
<td>MetLife</td>
<td>1.800.638.6420</td>
<td>N/A</td>
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<tr>
<td><strong>Disability insurance</strong></td>
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<tr>
<td>MetLife</td>
<td>1.800.823.1703</td>
<td>N/A</td>
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<tr>
<td><strong>Legal services plan</strong></td>
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<tr>
<td>Hyatt Legal Services</td>
<td>1.800.821.6400</td>
<td><a href="http://www.legalplans.com">www.legalplans.com</a></td>
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<tr>
<td><strong>Commuter benefits program</strong></td>
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<td>WageWorks</td>
<td>1.877.924.3967</td>
<td><a href="http://www.wageworks.com">www.wageworks.com</a></td>
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<td><strong>Workplace Solutions Center</strong></td>
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<tr>
<td>Workplace Solutions Center</td>
<td>1.888.471.2271</td>
<td>BenefitsWeb</td>
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<td>Employees log in via ConduentConnect at <a href="http://www.ConduentConnect.com">www.ConduentConnect.com</a> &gt; BenefitsWeb</td>
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<td>Spouses/domestic partners go to <a href="http://www.Conduent.com/BenefitsWeb">www.Conduent.com/BenefitsWeb</a></td>
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Employees log in via ConduentConnect at www.ConduentConnect.com > BenefitsWeb
Spouses/domestic partners go to www.Conduent.com/BenefitsWeb
Summary of Material Modifications

This 2019 New Hire Enrollment Guide for Conduent employees constitutes a Summary of Material Modifications (SMM) to the Summary Plan Descriptions (SPDs) of the applicable plans and provides a general description of plan options available to eligible employees and their eligible dependents. It is each employee's (and his/her eligible dependents') responsibility to review the relevant SPD and/or other plan documents for specific information about the terms of your benefit plans. This document is intended only as a summary of your benefit options, and it does not create a contract between the company and any employee.*

More complete details of these plans and programs can be found in the applicable SPD and plan documents, collective bargaining agreements, insurance contracts, HMO agreements and/or HR policies that govern all aspects of the plan or program. In the event of a discrepancy between the information contained in this guide and the applicable SPD or other plan documents, the collective bargaining agreements, relevant HR policies, HMO agreements, or insurance contracts, the latter documents shall control. Subject only to any applicable regulations or contracts, the company reserves the right to amend or terminate the plans or programs at any time for any reason without prior notice to or consent from any employee or participant to the extent permitted by law.

The terms “you” and “your” as used in this document refer to an employee of Conduent, who meets all of the eligibility and participation requirements under the applicable plans and/or applicable collective bargaining agreement. Receipt of this document does not guarantee that the recipient is a participant under the plans or otherwise eligible for benefits under the plans.

* Certain-part-time employees, temporary employees, and contractors, including (without limitation) leased employees, supplemental contract workers, consultants, or any other third-party personnel, or anyone classified by the company as such, who perform services for the company, are neither eligible for nor covered by the plans and programs summarized herein (unless they qualify as eligible dependents). Temporary employees are eligible for medical coverage. If you are a temporary employee, see the applicable section of this guide for information regarding benefits available to you.
This document is intended only as a summary of your benefit options, and it does not create a contract between the company and any employee. The plans are governed by the terms of more detailed plan documents and insurance contracts. In the event of any difference between the information contained in this guide and the plan documents and insurance contracts, the documents and insurance contracts will control. Subject only to any applicable regulations or contracts, the company reserves the right to amend or terminate the plans or programs at any time for any reason.