Benefits FAQ

IMPORTANT NOTE: If any of the following information is inconsistent with plan documents or agreements, the respective plan document or agreement shall take precedence.

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401K Retirement Savings Plan

Q. Where can I learn about the 401K Retirement Savings Plan?
A. You can learn more by visiting https://mosaic.teletech.com/docs/DOC-416780 or

https://asknow.teletech.com/kb_view_customer.do?sysparm_article=KB0010245

ALEX

Q. Who is ALEX?
A. ALEX is your virtual benefit counselor. By asking you a few questions about your lifestyle and health care preferences, ALEX provides recommendations to help you choose the best plan. If you want to estimate what your out-of-pocket costs may be under each plan, ALEX can help you with that too.
Q. What if I don't know which plan would work best for me and my family?
A. ALEX walks you through all of your options to help you figure out the right coverage.

Q. Can ALEX help me understand why it's important to choose in-network providers?
A. Don't worry, ALEX helps you understand how to save money and make the most of your benefits.

Q. How do I access ALEX?
A. From any internet visit https://www.myalex.com/teletech/2017

Health Advocate

Q. How does the Health Advocate Program Work?
A. Health Advocate assists employers or plan sponsors and their employees or members (and eligible family members) through our staff of Personal Health Advocates (PHAs). Members needing assistance call a special, toll-free Health Advocate telephone number (866.695.8622). The member speaks with a PHA, who then becomes "their" Personal Health Advocate, personally helping them with their issue, problem or other need for assistance. After obtaining the necessary background information, the PHA, assisted by medical directors and benefits and claims specialists, researches and resolves the inquiry and establishes a time frame and method for responding back to the member.

Q. What are the typical issues that Health Advocate usually handles?
A. Our company serves as a liaison for members with healthcare providers, insurance plans and other health-related community resources. We offer a broad menu of services and can address nearly any medical question and issue; including providing assistance finding primary care and specialist physicians and medical institutions, and resolving claims, billing and related administrative problems. Health Advocate also helps members' access community resources, including senior care services that fall outside traditional healthcare coverage.

Q. Can you summarize Health Advocate's features?
A. Yes, see summary of benefits below:
- Saves members considerable time and money
- Helps members eliminate the hassles and frustrations typically encountered when dealing with the healthcare system
- Assists members in finding the right doctors, hospitals and other healthcare providers
- Handles problems and addresses issues quickly and professionally
- Protects member's privacy and confidentiality
- Facilitates access to Centers of Medical Excellence
- Cuts through administrative red tape

Q. What are the advantages of Health Advocate for the member?

A. Health Advocate offers a number of important benefits including providing expert assistance resolving healthcare and health insurance-related problems and saving members both time and money. Most importantly, Health Advocate gives members a special advantage by having someone "at their side" in order to enhance their healthcare experience.

Q. Does Health Advocate help to save members money?

A. Yes. Health Advocate can help members save money in several ways. First, we can save members a good deal of time, which translates into financial savings. Health Advocate's staff of experts knows the "ins and outs" of the healthcare and health insurance worlds. We get to the bottom of the problem quickly and provide solutions that can save a good deal of money. Second, Health Advocate can identify billing and claims processing errors, providing additional savings. We may also help negotiate provider charges, which can be another source of savings. Finally, Health Advocate can help get members in need of medical care to the right provider quickly, avoiding unnecessary shuffling between multiple providers, duplicate tests and services. This is not only an area of considerable cost savings, but also helps to enhance the quality of our members' healthcare experience.

Q. What is the background of the Personal Health Advocates?

A. Our Personal Health Advocates are trained professionals, typically registered nurses supported by medical directors and benefits and claims specialists, who have a number of years of experience working in healthcare-related jobs. Health Advocate's staff is carefully screened to make certain that they have both the necessary professional credentials and excellent personal communications skills to deal with the problems members present to them.

Q. Will I be able to speak with the same Personal Health Advocate each time I call with an issue?

A. Yes. When you call Health Advocate for the first time, you will speak with a Personal Health Advocate (PHA). Each time you call for follow-up help, you will be able to speak with the same person. Generally, the only time you will speak with someone other than your assigned PHA, is if you call after-hours or on weekends. In these circumstances, you may receive a return call from another Personal Health Advocate who is on duty to handle after-hours calls.

Q. What criteria does Health Advocate use when making suggestions to a member?

A. Health Advocate's staff carefully reviews available options. Depending on the circumstances of your case, we may contact leading medical authorities in local communities and acknowledged Centers of Medical Excellence throughout the nation. We also review the medical literature and have access to other databases to assist our medical team as they attempt to assist our members.

Q. How do I access my Health Advocate benefit?

A. You can reach Health Advocate using a convenient, toll-free number: 866.695.8622. You can also email Health Advocate at answers@HealthAdvocate.com or fax information to us at 610.941.4200.

Q. Does Health Advocate provide 24-hour telephone coverage?

A. Health Advocate can be accessed 24/7. Our normal business hours are Monday - Friday between 8am and 9pm Eastern Time. After hours and during weekends, staff is available for assistance.

Q. Can any member of my family call Health Advocate for assistance?

A. Yes. All eligible family members are allowed to call Health Advocate directly for service. In addition to the employee or member, family members who are covered and can use the service include a spouse, dependent children, parents and parents-in-law.

Q. Will Health Advocate provide assistance for my mother if she needs to use your services?

A. Yes. Your parents and parents-in-law are eligible to use our services if you are covered with a TeleTech medical plan.

Q. Can I call my PHA to locate senior services for one of my parents?
A. Yes. Health Advocate will work with you to assist your parents in locating necessary services.

Q. How do I find out if my mother is eligible for any free services provided in the community or through any other source?
A. Simply call Health Advocate. Our service can provide assistance to help you find the information you need. We can also help to find and arrange community-based services for your parents. Often, many of these services are provided at little or no cost through government and/or community organizations, which we can help you to identify.

Q. I don't carry my medical coverage through my employer or plan sponsor. Will Health Advocate still help me and my family?
A. You must be covered by the TeleTech medical plan to have access to the Health Advocate Services.

Q. Are Health Advocate services available nationwide?
A. Yes. Health Advocate serves clients throughout the United States.

Q. I travel within our country and abroad. Are there any geographic restrictions to my Health Advocate coverage?
A. There are no geographic boundaries to Health Advocate's program. All you need to do to access services is call the toll-free number: 866.695.8622. A member of the Health Advocate team is always available to assist you.

Q. My child has a chronic medical problem, and we have shuffled from doctor to doctor without getting a satisfactory solution. How can Health Advocate help me?
A. All you need to do is call Health Advocate for assistance. One of the Personal Health Advocates, assisted by our team of medical directors and benefits and claims specialists, will review the details of your child's medical condition in order to fully understand the nature of the problem. After they have reviewed this background information, they will work with you to find the right doctors and other medical providers to help your child.

Q. Who should sign the Health Advocate Authorization Form on behalf of a minor child?
A. Depending on the child's age and state laws, a minor child may be permitted to sign the Health Advocate release. In other circumstances, the child's parents or legal guardian are permitted to sign the authorization form. This authorization gives Health Advocate permission to work on behalf of the child and gain access to medical information.

Q. I have been following a course of treatment for a medical condition that my doctor recently recommended. Since I am a little anxious about this new approach, can I call Health Advocate to speak with another doctor to get a second opinion?
A. Yes. All you need to do is to call your Personal Health Advocate and explain the nature of your concern. Health Advocate's staff will review your need and help you find another qualified physician, who specializes in this condition, for a second opinion.

Q. What should I do if I get a bill from a doctor that I think my insurance should have paid?
A. First, it is best to contact your health plan and try to resolve the issue. If that doesn't work, simply call Health Advocate if you receive a bill that you believe has not been processed correctly. We will review the bill for you and work to resolve any discrepancies. If necessary, we will contact the healthcare provider and/or your insurance company to attempt to correct any errors.

Q. I recently tried to obtain an appointment with a specialist physician and was told that I would have to wait more than a month to see the doctor. Can Health Advocate help me get an expedited appointment?

A. Often, the answer is yes. If it is clear that your condition requires an earlier appointment, Health Advocate will call the specialist physician and attempt to arrange a more timely appointment.

Q. When I visit my doctor, I often get confused by all of the technical medical explanations. Can you help me to better understand what my doctor was trying to tell me?

A. Yes. Health Advocate may be able to help you better understand your condition. Many times we will take the time to call your doctor's office to get a complete update about what you were told, but did not fully understand. We may arrange another time for you to speak with your doctor or, after we speak with your doctor's office and get the details of your medical condition, we will call you back and explain in simple terms the status of your medical situation.

Q. Does Health Advocate provide assistance with dental issues?

A. Yes. We provide assistance with dental issues.

Q. My situation is very private. How do I know that my issues will be kept confidential?

A. We fully recognize the importance of protecting and respecting our members' privacy. Health Advocate's staff is specially trained to handle each case with the utmost confidentiality. Additionally, we follow careful protocols that comply with all government privacy standards to ensure that members' medical and personal information is fully protected and held confidential. Just like with all other health and assistance programs, your employer or plan sponsor does not receive or have access to any of your confidential information.

Q. What is the difference between traditional health insurance coverage and the services provided by Health Advocate?

A. Health Advocate's program is NOT health insurance and is not a replacement for healthcare coverage. Rather, the service is designed to help members more easily navigate the healthcare and health insurance systems. Health Advocate does this by providing each member with access to their own Personal Health Advocate. Health Advocate's goal is to maximize each person's healthcare experience without the hassles and frustrations they so often typically experience today.

Q. How long has Health Advocate been in business?

A. Health Advocate has been in business since 2001.

Q. Where is Health Advocate located?

A. Health Advocate's headquarters is located in Plymouth Meeting, Pennsylvania, which is a suburb of Philadelphia. We also have offices in West Chester, PA and Jacksonville, FL, as well as in Lodi, San Francisco and Westlake Village, CA.

Need More Help? Contact Health Advocate directly. All benefit vendor contact information can be located on http://mybenefits.teletech.com within the contact page.

LiveHealth Online

Q. What is LiveHealth?

A. LiveHealth Online is an online physician’s visit for those enrolled in a TeleTech medical plan. This program allows you to see a doctor face to face 24X7 on your computer or mobile device.

Q. How much does it cost to use the LiveHealth service?

A. The cost is $10 per visit or $49 if you are enrolled in the Choice HSA Plan (or less if you have met your deductible)

Q. Can the doctor prescribe a medication if it’s needed?

A. Yes however prescription availability is defined by physician judgment and state regulations.

Q. What are some commonly treated conditions?
A. Commonly treated conditions include:

- Cough
- Cold
- Minor Rashes
- Allergies
- Diarrhea
- Ear Pain
- Fever
- Flu
- Headache
- Pink Eye

Q. Where can I learn more about the LiveHealth program?
A. Visit www.livehealthonline.com to learn more about the LiveHealth program.

MDLive Telemedicine Program

Q. What is the Telemedicine Program?
A. The telemedicine program is a pay per use physician's consultation that is available 24X7 via the phone or Skype. This is a more convenient and affordable option for non-emergency care needs.

Q. Can I use Telemedicine even if I don't elect medical coverage with TeleTech?
A. Yes, all Full-time and Part-time Regular employees and their dependents are able to use Telemedicine at an affordable rate of just $10 per consult. If you are on the Choice HSA plan the cost would be $38.

Q. When will I become eligible to use the MDLive service?
A. You are eligible to use MDLive upon day one of employment.

Q. Can the Telemedicine providers prescribe medication if necessary?
A. Yes, the providers can call in a prescription to your nearest pharmacy however there are limitations. Please review the MDLive prescription policy.

Q. Will MDLive share my records with my primary care physician?
A. Yes, at your request MDLive will share your record with your primary care physician.

Q. Can I use my Flexible Spending Card to pay for the MDLive consultation?
A. Yes, because the physician consultation is considered an eligible health care expense, you can use your FSA card at the time of service or file to be reimbursed from your Health Reimbursement Account.

Q. Who are the doctors?
A. MDLive has the nation's largest network of doctors for telehealth services. On average the doctors have 15 years of experience practicing medicine and are licensed in the state where patients are located.

Q. Do the MDLive doctors have any specialties?
A. Their specialties include primary care, pediatrics, emergency medicine and family medicine.

Q. Are my children eligible to use the MDLive service?

A. Yes, MDLive has pediatricians on call 24/7/365 however a parent or guardian must be present during any interactions involving minors.

Q. When should I use MDLive?
A. Consider MDLive instead of going to the ER or an Urgent Care center for non-emergency issues. You can also use MDLive when your primary care physician is not available, during or after normal business hours, nights, weekends, and even holidays, and to request prescription refills when appropriate *See prescription policy.

Q. What can be treated by MDLive?
A. Many non-emergency issues like ear infections, cold and flu, asthma, allergies, headaches, sore throats etc. Click here to review the MDLive information.

Need More Help? Contact MDLive directly. All benefit vendor contact information can be located on http://mybenefits.teletech.com within the contact page.

Benefit Resources

Q. Where can I locate the online Benefit Enrollment Information?
A. You can locate the Benefit Enrollment Information at http://mybenefits.teletech.com

Q. Where can I find all of our benefit vendor's contact information and web addresses?
A. Visit http://mybenefits.teletech.com and click on the get started link to access the 'Help and Contacts' tab where you can find the customer service numbers, group numbers and website information for each of our benefit vendors.

Paying for Missed Insurance Premiums

Q. How do I pay for my insurance premiums while on a leave of absence?
A. You have two options for paying for your premiums while you are on leave.

1. The first is with a personal check addressed to Corporate Finance at 9197 S. Peoria St. Englewood CO 80112. Be sure to include your name, oracle number and the pay periods for which your payment is being made. Before sending your check in the mail, either scan a copy of that check or take a clear picture so that you can attach it to an AskNOW ticket and request that insurance premium arrears be cleared so that the entire amount of missed premiums are not deducted from your first paycheck with earnings.
2. The second option is to open an AskNOW ticket to request a premium repayment plan upon your return from leave of absence**.** We would calculate how much you owe in missed premiums and then set up the repayment plan so that you could pay back the amount you owe in equal installments over the next 4 or 6 pay periods directly from your pay check depending on the amount owed. The maximum number of pay periods allowed to repay missed premiums is 10 pay periods (only applies to balances over $1000 and must be requested). This would be in addition to the current deductions. All missed premiums must be collected in full no later than March of the following plan year.

Q. What happens if I forget to send in payment or request a repayment plan for missed premiums?
A. If you return from a leave of absence and owe for missed premiums, Oracle recognizes that premiums were missed and there is an amount owed. Oracle will automatically deduct additional funds from your

paycheck all at once until the arrears are paid in full. This could cause your entire check to be taken for missed premiums. It is the responsibility of the employee to either pay for premiums while on leave via a personal check or request a repayment plan via an AskNOW ticket.

Q. How can I calculate what I owe in missed premiums?
A. You can calculate how much you owe in premiums every pay period by viewing a previous check stub where all of your deductions were normal. Simply add all of the pre-tax and post-tax insurance premiums together excluding the 401K contributions. If you need assistance calculating how much you owe in missed premiums, simply submit a request in AskNOW>Benefits. Keep in mind that if you have any PTO (Paid Time Off) then premiums will be deducted from those earnings so it's hard to calculate how much you may owe in advance.

Dependent Verification

Q. How do I get my dependents covered?
A. You will need to add them as a dependent in Oracle when you are making your benefit elections. Please be sure to provide the date of birth and a social security number for each dependent. You would then be required to provide supporting documentation within the first 31 days of coverage. You can scan the documents or take a clear picture and attach the documents within an AskNOW ticket in the Benefits>Eligibility category.

Q. Which dependents are eligible for coverage?
A. If the dependent is your lawful spouse, common-law spouse (in the states that recognize common-law), same-sex domestic partner, natural born child, step-child, foster child, adopted child or one that you have a legal obligation to cover through your benefits, they are considered eligible dependents.

Q. Which documents must I provide to verify that my dependents are eligible for coverage?
A. **Employee's Spouse** (if he or she is married to the employee under state law): Copy of the first page of one of the last two years' tax returns (black out financial information); OR copy of valid marriage certificate or license.

Employee's Common-Law Spouse (if he or she is in a common-law marriage to the employee as defined by state law) - Common-law affidavit (available in the document library on mybenefits.teletech.com); AND current proof of joint mortgage or joint tenancy on a residential lease, OR joint bank account or joint liabilities (e.g., credit cards)

Employee's Same-Sex Domestic Partner (if he or she is in an ongoing relationship with the employee as defined by the same-sex domestic partner affidavit) - Same-sex domestic partner affidavit (available in the Document Library on mybenefits.teletech.com); AND current proof of joint mortgage or joint tenancy on a residential lease; OR joint bank account or joint liabilities (credit cards); OR designation of same-sex partner as beneficiary for life insurance, or a legal will or trust.

Children - A dependent up to age 26 who is not eligible for another group plan. This includes:

- Employee's natural-born child
- Employee's adopted or foster child for whom the employee has legal guardianship
- Employee's step-child (the child of the employee's spouse, common-law spouse, or covered domestic partner) FOR CHILDREN UP TO AGE 26

Provide one of the following:

- Natural-born child: Birth certificate

- Adopted/foster child: Legal documentation or birth certificate
- Step children: Marriage license or affidavit and birth certificate

Disabled children (Disabled by age 26) - Any one of the documents listed in each category above, AND

- Physician statement certifying that the dependent child is incapable of self-sustaining employment due to a mental or physical disability that began prior to age 26.

Q. What form do I need to complete for a Common-law spouse?
A. You will need to complete an affidavit for a Common Law Spouse, located in the Document Library on mybenefits.teletech.com. States that currently acknowledge common law are as follows:

- **Alabama** The requirements for a common-law marriage are: (1) capacity; (2) an agreement to be husband and wife; and (3) consummation of the marital relationship
- **Colorado** A common-law marriage may be established by proving cohabitation and a reputation of being married
- **Georgia** Recognized only if performed by January 1, 1997
- **Idaho** Recognized only if performed by January 1, 1996
- **Iowa** The requirements for a common-law marriage are: (1) intent and agreement to be married; (2) continuous cohabitation; and (3) public declarations that the parties are husband and wife.
- **Kansas** For a man and woman to form a common-law marriage, they must: (1) have the mental capacity to marry; (2) agree to be married at the present time; and (3) represent to the public that they are married.
- **Montana** The requirements for a common-law marriage are: (1) capacity to consent to the marriage; (2) an agreement to be married; (3) cohabitation; and (4) a reputation of being married.
- **New Hampshire** Common law marriages are recognized only at death and only for probate purposes. (N.H. RSA. 457:39)
- **Ohio** Recognized only if performed by October 10, 1991
- **Oklahoma** To establish a common-law marriage, a man and woman must (1) be competent; (2) agree to enter into a marriage relationship; and (3) cohabit
- **Pennsylvania** A common-law marriage may be established if a man and woman exchange words that indicate that they intend to be married at the present time
- **Rhode Island** The requirements for a common-law marriage are: (1) serious intent to be married and (2) conduct that leads to a reasonable belief in the community that the man and woman are married
- **South Carolina** A common-law marriage is established if a man and woman intend for others to believe they are married
- **Texas** A man and woman who want to establish a common-law marriage must sign a form provided by the county clerk. In addition, they must (1) agree to be married, (2) cohabit, and (3) represent to others that they are married
- **Utah** For a common-law marriage, a man and woman must (1) be capable of giving consent and getting married; (2) cohabit; and (3) have a reputation of being husband and wife
- **Washington, D.C.** The requirements for a common-law marriage are: (1) an express, present intent to be married and (2) cohabitation. (Added AD01-16)

Q. What form do I need to complete for a Same Sex Domestic partner?
A. You will need to complete an affidavit for a Same Sex Domestic Partner. The form is located in the Document Library on mybenefits.teletech.com.

Q. How do I provide my birth certificates, marriage certificates etc. to prove my dependents are eligible for the coverage I have elected?

A. Simply scan or take clear pictures of the documents and attach them to an AskNOW ticket in the Benefits>Eligibility category within the first 31 days of your coverage effective date.

Q. What if I don't get my documents turned in within the first 31 days of my coverage effective date?
A. We conduct a monthly audit to determine if there are required documents that have not been provided. If your documents are not provided by the deadline, your dependents will be removed from coverage as of the first day of the following month and no refund will be issued for premiums paid. Your next opportunity to enroll in benefits would be within 31 days of a Qualifying Life Event or during the next open enrollment period.

Q. Can I give my documents to my team lead and ask them to submit them for me?
A. Each employee is responsible to provide their own documents. Please do not rely on anyone else to provide your documents for you. If you need assistance, please submit an AskNOW ticket.

Health & Wellness Programs/Activities

Q. What is a health & wellness program?
A. A wellness program is designed to encourage you to become more aware of your health and ways to maintain or improve it. To that end, TeleTech is committed to creating a culture of wellness that promotes and encourages healthier lifestyle choices by providing mind, body, and finance-related programs, activities, tools, and resources designed to help you achieve your health goals. In addition, there are incentives that you can earn if you choose to participate in specific wellness activities.

Q. What health & wellness programs are available?
A. We offer a variety of programs and services designed to meet the health and wellness needs and interests of our diverse population. They include a Health Survey, fitness, nutrition, weight management, stress management and financial programs, EAP (Employee Assistance Program), a tobacco cessation program as well as a Healthy Moms program. We continue to grow our program so be on the lookout for new wellness activities and incentives.

Q. Why should I participate in wellness activities?
A. Participating in the wellness program is a win/win for you, as you have the opportunity to not only become more aware of and improve your health, but you can earn a wellness credit in your paycheck twice a year. Although you will receive the same amount as prior years when the wellness incentive was provided as a medical premium discount, it will now come as a separate line item in your paycheck. Wellness credits are prorated based on benefit activation dates. To learn about the wellness credits, please visit www.mybenefits.teletech.com. Note that TeleTech only receives high-level, aggregate information related to program participation – none of your personal data is shared with the company, so your privacy is always protected.

Need More Help?

Visit http://mybenefits.teletech.com/us/health-and-well-being-benefits/special-programs/ open an AskNOW ticket, Contact Health Advocate directly or contact your Health & Wellness Navigator for more information.

Part-Time Benefits

Q. What benefits are part time employees eligible for?
A. Regular Part Time employees are eligible for the following benefits:

- Basic Dental
- Vision

- Accident
- Critical Illness
- Long Term Disability
- Pre-Paid Legal

Q. Do Part Time Regular employees have the same enrollment opportunities as Full Time Regular employees?
A. Yes, all benefit eligible employees may enroll in benefits during their first 31 days of employment, within 31 days of a Qualifying Life Event or during the annual open enrollment period.

Medical

Q. If I am happy with my 2016 Medical, Dental and Vision benefits do I need to do anything?
A. No, the elections you currently have in place will rollover without any action required with the exception of the Flexible Spending Accounts and the Health Savings Account contributions. These plans require an active election each year.

Q. What happens if I do not make elections during Open Enrollment?
A. If you do not make an election during open enrollment, your current elections will roll over with the exception of the Flexible Spending Account which will be defaulted to waived, and the Health Savings Account contributions which will default to zero.

Defaults if you don't enroll for 2017 benefits		
Medical plan election	➡	Elections will roll over
Health Reimbursement Account (HRA) Balance	➡	If you have an HRA Balance and select the Primary Care Plan or the Balanced HRA Plan, your current HRA balance will roll over If you have an HRA and select the Choice HSA plan, your HRA balance will NOT roll over
Flexible Spending Account (FSA) Balance	➡	FSA elections will NOT roll over
Dental and Vision elections	➡	Elections will roll over
Disability, Supplemental Life and AD&D elections	➡	Elections will roll over
Critical Illness and Legal Plan elections	➡	Elections will roll over

Q. Are we changing medical carriers?
A. No, Anthem will continue to be our medical carrier for 2017.

Q. Will I get a new Anthem Member ID Card?
A. All employees who had medical coverage in 2016 will use their original card for 2017. Only those in MO, GA, FL and CA will receive new member ID cards as these locations will have new provider networks. You will be notified by Anthem if you are affected by this change. Keep in mind that provider networks can change frequently, visit Anthem.com to make sure your preferred provider or facility is still in network. Once you receive your new member ID card, please destroy your old card.

Q. How would I print a temporary medical ID card if mine is misplaced or lost?
A. Follow the steps below to print a temporary medical ID card from the Anthem website.

1. Log into your online account at www.Anthem.com
2. Click on the Customer Support tab

3. Click the ‘Print a Temporary ID card’ link
4. Use the drop down box to select a specific member and then print the image
5. You can also contact Anthem directly to request a new card be sent. All contact information can be found on http://mybenefits.teletech.com

Q. How can I check to see if my current providers are in the Anthem network?
A. You can check to see if your doctor, specialist and facilities are in the Anthem network or find new providers by visiting www.anthem.com (provider network code is Alpha Prefix – TQN)

Q. Are there new medical plans to choose from in 2017?
A. No, the same medical options that were available in 2016 will be available in 2017. There are three medical plans to choose from. To find the right fit, you should look at more than just the monthly contributions that come out of your paycheck. You should also consider you and your family’s health care needs, the plan deductible and the savings/spending account options available.

Q. How can I check to be sure I enrolled correctly?
A. From Oracle Employee Self Service, please use the link "enroll in benefits" Accept the fraud disclaimer, and click "Next", then Click "Next" from the overview/contacts page, make sure "TeleTech US Employee Benefits" is selected, click "Next" You will arrive at the confirmation page. Please note there are two tabs at the top: Benefits Enrollment and Current Benefits. You can view your enrollment results from the Benefits Enrollment tab, and view your current benefits from the Current Benefits tab.

If, after reviewing this information, you still have questions, please contact us via ASK NOW Request

Q. What are the highlights of each medical plan?

1. **Primary Care Plan**
    - Least expensive plan in terms of premiums from your paycheck – but has the highest potential for out-of-pocket costs
    - Highest deductible and out-of-pocket maximum
    - Includes copays for services like primary care, specialist, urgent care and emergency room visits as well as for some prescription drugs
    - Eligible for an incentive of $100 (Employees only) for completing a preventive care visit
    - Includes a Health Reimbursement Account (HRA) which does not include any up-front TeleTech contribution
2. **Choice HSA Plan**
    - Mid-range plan more costly premiums from your paycheck than the Primary Care Plan, but less than the Balanced HRA Plan
    - Mid-range out-of-pocket costs
    - Deductible is aggregate – and must be met before plan pays any benefits including prescription drugs
    - Includes a Health Savings Account (HSA) with a TeleTech contribution of $750 for individual coverage and $1,250 for employee + 1 or more coverage (employees can also contribute their own tax-free money to the HSA, up to the IRS contribution limits)
3. **Balanced HRA Plan**
    - Most expensive plan premiums out of your paycheck than the Primary Care Plan, but less than the Balanced HRA Plan
    - Deductible and out-of-pocket maximum are lower than the other two plans; each person enrolled in the plan is not required to incur more than the individual deductible
    - Includes a Health Reimbursement Account with a TeleTech contribution up front of $400 for employee only coverage and $600 for employee + 1 or more coverage
    - Eligible for an incentive of $100 for individual coverage and an additional $100 for spouse (if covered on the plan) completing a preventive exam

Q. What are the deductibles, co-pays and Out of Pocket Maximums for each medical plan?

A.

	Primary Care Plan	Choice HSA Plan	Balanced HRA Plan
Deductible* (Employee only/Employee+1 or more)	$3,000 / $7,000	$1,500 / $3,000	$1,300 / $2,600
Out-of-Pocket Maximum* (Employee only/Employee+1 or more)	$6,850 / $13,700	$4,500 / $9,000	$3,100 / $6,200
Co-Insurance (your responsibility)	30% after deductible	10% after deductible	20% after deductible
Co-Pays	$30 PCP $50 Specialist $10 Telemedicine or Convenience Care $50 Urgent Care $300 ER	You pay 10% after deductible MDLive Telemedicine $38 LiveHealth $49	You pay 20% after deductible MDLive, LiveHealth or convenience care $10
Spending or Savings Account	Health Reimbursement Account (HRA)	Health Savings Account (HSA)	Health Reimbursement Account (HRA)
Employer account Contribution	N/A	$750 for employee only $1,250 for employee + 1 or more	$400 for employee only $600 for employee + 1 or more
Wellness Incentive	$100	$100 for employee only / $200 for employee + Spouse	

****In-network only***

Q. Where can I learn more about the savings and spending plans that are available?
A. Click here to learn more about the savings and spending plans options available for 2017.

Q. Where can I find more information about the 2017 plans that are available?
A. Benefit information is located on our new website which has all the details and information you need. Get medical, dental, vision information and rates, watch educational videos, read FAQs, find details on the wellness incentive program and more. Visit http://MyBenefits.TeleTech.com

Q. What if I don't know which plan would work best for me and my family?
A. ALEX your online benefit counselor walks you through all of your options to help you figure out the right coverage.

Q. How do I access ALEX?
A. From any internet visit https://www.myalex.com/teletech/2017

Q. What is Continuation of Care also known as the Transition Assistance Program?
A. Transition Assistance is a process that allows continued care for members when:

- Their primary medical group, IPA, PPO provider, hospital, or other provider is terminated from the participating provider network.
- They are a new enrollee in an Anthem plan (except members with an Individual contract) and their treating provider is not part of the participating provider network.
- Continuity of care is at risk for reasons over which the member has no control.
- Please Note: If you require ongoing care for any chronic condition and you are not in an acute phase of your illness, one requiring a special course of treatment, you should select an in network provider to meet your ongoing health care needs and you do not need to complete a Continuation

of Care form. If you need assistance selecting a new provider you should contact your Anthem Customer Service.

Completing the Continuation of Care Form
You may request Continuation of Care if:
If you are in an active course of treatment for an acute medical condition or a serious chronic condition.

- An acute medical condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration.

- A serious chronic condition is a medical condition due to a disease, illness, or other medical problem that is serious in nature and that persists without full cure or worsens over time or one that requires ongoing treatment to maintain remission or prevent deterioration.

Completion of covered services may be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider;

- If you are in an active course of treatment for any behavioral health condition;
- Pregnant, regardless of trimester;
- You have a terminal illness;
- You have a surgery or other procedure that has been authorized by the previous plan or its delegated provider and is scheduled to occur within 180 days of the effective date of coverage for a newly covered enrollee.

Print a Continuation of Care form from anthem.com or the Managers Corner of http://mybenefits.teletech.com send completed forms to the following address: Anthem BCBS National Accounts
11 Corporate Woods
Mail Drop R5L
Albany, NY 12211
Attn: National Accounts Medical Management

Customer Service Phone Number: 1.844.301.5620
Fax: 1-888-438-7061

Q. What is an annual deductible?
A. The annual deductible is a specified dollar amount that the member must pay each year before the health plan will help you pay for eligible expenses; the deductible is waived for covered preventive care services.

Q. What is coinsurance?
A. Coinsurance is the percentage of your medical costs that the plan will pay. After you meet the deductible the plan will enter the cost sharing portion of the plan where you are responsible for a certain percentage of your eligible medical expenses until you have met the out of pocket maximum.

Q. What is a copay?
A. A copay is a fixed cost that you pay up front for a service, like doctors' visits, Tier 1 drugs, Urgent Care etc. If your plan has copays, they are due at the time of service. In most cases your copay will cover your responsibility for the cost of the service and the plan will pay the rest, unless the benefit is subject to a plan maximum or coinsurance. If your plan has a copay for the Emergency Room, it will be waived if you are admitted into the hospital.

Q. What is a lifetime maximum?

A. A lifetime maximum is a limit on the amount that a plan will pay for your health care costs for the duration that you are with your employer and enrolled in the medical plan. TeleTech has removed the lifetime maximum on their plans. Note that some plan limitations and exclusions may still apply.

Q. What is an annual out-of-pocket maximum?
A. The annual out-of-pocket maximum is the most a member is required to pay in a year, under a plan, for eligible expenses. The out-of-pocket maximum helps protect you from catastrophic medical costs. Once you reach your annual out-of-pocket maximum, your health plan will cover 100% of the costs of eligible expenses for that plan year. Services subject to a copay are the exception, as copays do not apply to your out-of-pocket maximum. For those services subject to a copay (for example office visits under the Primary Care plan), your copay will continue to apply even after the out-of-pocket maximum is reached.

Q. How does the Individual Out-of-Pocket Maximum for In-Network family coverage work if I elected the Choice HSA medical plan?

A. For participants with family coverage, your plan will include an individual out-of-pocket maximum of $6,850. This means that if one family member's out-of-pocket expenses reach $6,850, the plan will pay 100 percent of any future eligible expenses for the rest of the plan year for that individual, even if the family out-of-pocket maximum of $9,000 has not been reached.

Q. What are preventive services and will I have to pay for them?
A. Preventive care is covered at 100% only when you visit in-network providers and applies to the office visit, tests and procedures that are used to establish your health status or prevent a health problem. Some common examples of preventive care include well child visits, childhood immunizations (as outlined by the Centers for Disease Control and Prevention), mammograms and colorectal cancer screenings. Preventive care visits are covered at one hundred percent and are not subject to the deductible or coinsurance. Click here to learn more about Preventive Health Guidelines.

Q. What if I need to make changes to my plan mid-year?
A. If you have a qualifying event, such as having a baby, your spouse is laid off from his/her job, etc., you may be able to make mid-year changes. Qualifying Life Events allow you to change your level of coverage (i.e. change from employee only coverage to employee+spouse) however you cannot change your plans. Please open an AskNOW ticket within 31 days of a qualifying event for an opportunity to make benefit changes. Click here to learn more about qualifying life events.

Q. What is health care reform?
A. What you hear called "Health care reform" is a result of the Patient Protection and Affordable Coverage Act passed in 2010. This law requires employers like TeleTech to comply with certain rules and regulations regarding the medical plan coverage that they offer.

Q. How will health care reform affect TeleTech's plans?
A. To comply with health care reform regulations, the TeleTech plans will no longer include lifetime maximums for medical benefits. In addition, employees' dependent children will be allowed to continue coverage until they reach age 26.

Q. How will expanding the age of dependent coverage affect me?
A. If you have dependents (children, step children, adopted children, etc.) who were unable to stay on your plan because they were no longer a student or had reached the age of 19 and were not a student, you may now be able to add them back on to your plan. Your plan will now cover your dependent children up to age 26 regardless of student or marital status.

Q. What is a PPO?
A. PPO (Preferred Provider Organization) is a traditional medical plan that pays for services such as office visits, pharmacy costs and urgent care subject to a copay, then all other services are subject to a plan deductible and coinsurance. The Primary Care Plan covers certain service mentioned above with copays, such as a $30 office visit copay.

Q. How does a PPO work?
A. A preferred provider organization is a managed care organization of medical doctors, hospitals, and other health care providers who have agreed with an insurer or a third-party administrator to provide health care at reduced rates to the insurer's or administrator's clients. TeleTech pays for 100% of all preventive care visits and services in-network. For all other in-network services, after meeting your annual deductible, you pay only a percentage of the cost depending on your medical plan. This would include services such as other office services (i.e.- x-rays, labs) surgery or a hospital visit. If your medical expenses are very high, you may reach the out-of-pocket maximum, which means that the plan would then pay 100% of your eligible medical expenses that were previously subject to the deductible and coinsurance for the rest of that year. A copay would continue to apply to those services (e.g., prescriptions) for which you pay a copay rather than the deductible and coinsurance, even after the annual out-of-pocket maximum is met.

Q. What expenses does a PPO cover?
A. The PPO plans are comprehensive medical plans that covers all medically eligible expenses, including doctors' visits, hospital visits, outpatient treatments, surgery, diagnostic x-ray and lab test, etc. Please visit http://mybenefits.teletech.com for more benefit details.

Q. Who is eligible to enroll in our medical plans?
A. All regular full-time employees and certain regular part-time employees that have met the specific requirements are eligible to enroll in TeleTech's medical plans.

Q. How much do the medical plans cost?
A. The cost per pay period is available on mybenefits.com. The cost will depend on the plan you choose, who you choose to cover (you only or you plus your spouse/children). We're proud to announce that plan premiums are not increasing for employees in 2017, with the exception of supplemental life insurance. Refer to mybenefits.teletech.com to see the 2017 plan premiums. Instead of offering a wellness or discounted medical premium rate, we are now offering a wellness credit twice a year to those who qualify. This means the non-discounted rates that were in place for 2016 are the only rates for 2017.

Q. How does the single (individual) versus the family deductible work?
A. If only you, the employee, enroll in medical coverage, you will only have to pay the single (individual) deductible before plan coinsurance begins. But if you also enroll any of your eligible dependents on the Primary Care Plan or the Balanced HRA medical plan, then the family deductible will also apply. The first person in the family to reach the individual deductible amount will enter coinsurance while the rest of the family work to meet the remaining family deductible at which point all family members would enter coinsurance. However, if you enroll in the Choice HSA medical plan, it requires that the family deductible be met before anyone enters coinsurance.

Q. What does In-Network versus Out-of-Network mean?
A. In-network means that the medical provider you are visiting is a part Anthem's preferred network. In other words s/he has a contract with Anthem and is "participating" in the Anthem network. Out-of-network means that the medical provider does not have an agreement or contract with Anthem and is not part of Anthem's preferred network. Because out-of-network providers do not have a contract with Anthem, you cannot take advantage of the discounts Anthem has negotiated with in-network providers and your out-of-pocket cost could be higher. If you visit an out-of-network provider you have a separate deductible. In-Network and Out-of-Network deductibles are not combined.

Q. What is a Premium provider?
A. A Premium provider is a provider that has been identified by Anthem as doctor with high quality and efficiency. Premium providers can be found on www.anthem.com.

Need More Help? Review the full SPD (Summary Plan Description) on

http://mybenefits.teletech.com/us/health-and-well-being-benefits/medical/ contact Health Advocates or call Anthem directly. All benefit vendor contact information can be located on http://mybenefits.teletech.com within the contact page.

Tobacco Surcharge

Q. Will we continue to have a tobacco surcharge in 2017?
A. Yes there will still be a tobacco surcharge for those that use tobacco. You can change your tobacco status in Oracle by clicking on 'Update Personal Information" link in Employee Self Service. It is your responsibility to ensure your personal information is accurate in Oracle. No refunds will be issued for tobacco surcharges.

Q. What if I use e-cigarettes, am I still subject to the tobacco surcharge?
A. The use of any nicotine or tobacco products would make you subject to the tobacco surcharge.

Q. Is the tobacco surcharge changing?
A. Yes the tobacco surcharge will be $50 per month throughout 2017, which is separate from the medical premium.

Q. What if I don't update my tobacco status?
A. It is your responsibility to update your tobacco status and all other personal information in Oracle Self Service. If you fail to select a tobacco status, it will default to "tobacco user" and you will pay a tobacco surcharge. No refunds are issued for tobacco surcharges if you fail to update your status.

Q. Are all employees subject to the tobacco surcharge?
A. Only those enrolled in an active medical plan are subject to the tobacco surcharge.

Q. How do I update my tobacco status?
A. Access Oracle Self Service, click 'Update Personal Information' click 'Update Basic Details' and change your tobacco status.

Q. What if I want help to stop using tobacco products?
A. **C**oaching and resources are available to all TeleTech employees who are enrolled in a medical plan which will help you quit tobacco and nicotine. For information go to the Anthem web site at anthem.com or call 1.844.301.5620.

Q. If I do quit using tobacco products, when can I change my tobacco status?
A. Upon successful completion of the Healthy Lifestyles tobacco free program or maintenance of a tobacco-free lifestyle for 3 consecutive months, it is your responsibility to update your tobacco status to "None" in Oracle. Please note that misrepresentation constitutes fraud and you could be subject to dismissal from TeleTech if false statements are made in an attempt to defraud TeleTech.

Express Scripts Prescription Coverage

Q. Where can I find a list of covered prescriptions?
A. A list of covered prescriptions can be found on www.express-scripts.com/teletech. Click here to learn more about our new prescription provider Express-Scripts.

Q. What is the Express Scripts Customer Service phone number and what are the hours of operation?
A. Express Scripts Customer Service is available 24 hours per day, 7 days per week and can be reached at 855-687-3854.

Q. How can I find in-network pharmacies?
A. You will have access to a large network of participating retail pharmacies. Express Scripts has a network of nearly 60,000 independent and chain pharmacies nationwide, visit www.Express-Scripts.com.

Q. How do I find out if my prescriptions are covered and how much they might cost?
A. Visit www.express-scripts.com/teletech to learn about prescriptions coverage, tier and cost.

Q. Is Mail Order prescription an option with Express-Scripts?
A. Yes, you will have access to Convenient Home Delivery services through the Express Scripts PharmacySM. You'll be able to have up to a 90 day supply of most maintenance medications delivered directly to you. Maintenance medications are those taken to treat an ongoing condition, such as high blood pressure, high cholesterol or diabetes.

Q. What is the Express Scripts PharmacySM Home Delivery service?
A. The Express Scripts Pharmacy Home Delivery is a home delivery service available as part of your TeleTech prescription drug plan. With Express Scripts Home Delivery you'll save when you fill your long-term prescriptions for up to a 90 day supply.

Q. How can I start using the Express Scripts Pharmacy Home Delivery service?
A. To get started using the Express Scripts Pharmacy for medications you take on an ongoing basis, ask your doctor to write a prescription for up to a 90 day supply, plus refills for up to 1 year (as appropriate). To fill the prescription, you may:

1. Mail your prescription(s) along with the required copayment in the envelope provided with your Welcome Package.
2. Call Express Scripts toll-free at 855-687-3854. You will need to have your prescription number handy when you call.
3. After 1-1-2016, order through the Express Scripts website after registering at www.Express-Scripts.com.

Q. Is there an additional charge for shipping and handling with Home Delivery?
A. Medications are shipped via standard service at no cost to you. Express shipping is also available for an additional fee.

Q. How soon will I receive my Home Delivery prescription, and how can I check the status of my order?
A. Orders are usually processed and mailed within 48 hours of receipt. Please allow 8 days from the day you mail in your prescription. Newly hired employees can check to see if your prescriptions are available for mail order by visiting http://express-scripts.com/TeleTech. If your TeleTech medical plan is already active, you can check on the status of your order by logging on to www.Express-Scripts.com. Or you can call Customer Service and use the automated system. If you're a first-time visitor to the website, take a moment to register. Have your member ID number handy.

Q. How do I pay for my Home Delivery prescriptions?
A. You can pay by check, e-check (see below for additional information), money order or credit card. If you prefer to use a credit card, you have the option of joining Express Scripts' automatic payment program by calling 1-800-948-8779 or by enrolling online. If you currently use a credit card for your Home Delivery prescriptions, you'll need to contact Express Scripts with your credit card information, as this information can't be transferred.

*E-check is another term for electronic fund transfer. When you pay for Home Delivery prescriptions with e-check, your copayments are conveniently deducted from your checking account. There's a 10-day grace period between the time your order is sent and when the amount is deducted from the assigned checking account. (The amount that is being deducted will be included in the prescription information that accompanies your order.)

Q. What is a Specialty Medication?
A. Some prescription drugs are called "specialty medications." Specialty medications are used to treat complex, chronic health conditions like Multiple Sclerosis or Rheumatoid Arthritis. These medications usually have to be stored or handled in special ways.

Q. Is there an extra cost to use Accredo's services?
A. No. Accredo is part of your prescription drug benefit.

Q. Can I order all my medications from Accredo?
A. No. Accredo dispenses only specialty medications.

Q. What is a coverage review or prior authorization?
A. TeleTech Services Corporation uses coverage management programs to help ensure you receive the prescription drugs you need at a reasonable cost. Coverage management programs include prior authorization, step therapy and quantity duration. Each program is administered by Express Scripts to determine whether your use of certain medications meets your plan's conditions of coverage. In some cases, a coverage review may be necessary to determine whether a prescription can be covered under your plan. On or after 1-1-2016, if your prescription requires prior authorization, you or your doctor can initiate the prior authorization review by calling Express Scripts at 1-800-753-2851. Express Scripts will inform you and your doctor in writing of the coverage decision.

Q. Will my Prior Authorization (PA) information transfer to Express Scripts?
A. Your Prior Authorization (PA) records will be entered into the Express Scripts system, unless they have expired. If the PA is no longer valid, your doctor can submit a request for a new PA to Express Scripts.

Q. Can I find out ahead of time if a medication may need a coverage review?
A. Yes, you can log on to www.Express-Scripts.com/TeleTech (After 1/1/16 log into www.Express-Scripts.com) and use the "Price a medication" feature. After you look up a medication's name, click "View coverage notes." Or you can call customer service at 855-687-3854.

Q. What Is Step Therapy?
A. Step Therapy is a program especially for people who take prescription drugs regularly to treat an ongoing medical condition, such as arthritis, asthma or high blood pressure. The program helps you get the prescription drugs you need, with safety, cost and – most importantly – your health in mind.

In Step Therapy, prescription drugs are grouped in categories, based on cost:
Front-line drugs – the first step – are lower cost drugs that are proven safe, effective and affordable. These medications should be tried first because they can provide the same health benefit as more expensive medications, at a lower cost.

Back-up drugs – Step 2 and Step 3 drugs – are brand-name drugs such as those you see advertised on TV. There are lower-cost brand drugs (Step 2) and higher-cost brand drugs (Step 3). Back-up drugs almost always cost more than lower cost alternatives.

Q. What if I have been through the step therapy process for a medication I am taking? Will I need to go through the process again?
A. Your medication history will be entered into Express Scripts System and you may not be required to go through the process if you have already done so, as long as you continue to fill your medication regularly.

Q. What Is Drug Quantity Management?

A. Drug Quantity Management (DQM) is a program in your pharmacy benefit that's designed to make the use of prescription drugs safer and more affordable. It provides you with medications you need for your good health while making sure you receive them in the quantity considered safe.
Certain medications are included in this program. For these medications, you can receive an amount to last you a certain number of days: for instance, the program could provide a maximum of 30 pills for a medication you take once a day. This gives you the right amount to take the daily dose considered safe and effective, according to guidelines from the FDA.

Q. How do I register with the Express Scripts website?
A. Beginning 1-1-2016 visit www.Express-Scripts.com to register. You will be asked to provide your Express Scripts ID number and email address. Your Express Scripts ID number can be found on the ID card you will receive from Anthem.

Q. What can I do on the Express Scripts website?
A. Beginning 1-1-2016, you can visit www.Express-Scripts.com to get information about your plan, find participating retail pharmacies near you and see how much certain medications will cost. Beginning 1-1-2016, you'll be able to visit www.Express-Scripts.com to quickly refill Home Delivery prescriptions online, receive timely medication alerts, find potential lower-cost options available under your plan and ask questions of a pharmacist online.

Q. How do I download the Express Scripts Mobile App?
A. Visit your Smartphone's or tablet's market or store and search for "Express Scripts". It's free to download and use.

Q. What can I do on the Express Scripts Mobile App?
A. Beginning 1-1-2016, you can use the app to view your medications and set reminders for when to take them or to notify you when you are running low. You can also get personalized alerts, check for lower-cost prescription options available under your plan and display a virtual member ID card that you can present at the pharmacy.

Q. Who has access to my prescription information?
A. Express Scripts has a strong commitment to your privacy. Express Scripts has established effective administrative and technical safeguards to protect the confidentiality of your prescriptions and other information and to secure this information from unauthorized or improper access, disclosure or use. In addition, Express Scripts does not sell individually identifiable information nor lists of members and their covered dependents to outside companies for solicitation or marketing purposes.

Q. What can I do on the Express-Scripts website?
A. After January 1, 2016 Express-Scripts online resources will allow you to:

- Order prescription refills, renewals and check your order status
- Transfer retail prescriptions to Home Delivery for convenience and potential savings
- Enroll in Worry-Free Fills to conveniently receive Home Delivery medication automatically
- Discover possible ways to save money on medications, such as using generics and Home Delivery
- Receive time-sensitive medication-related alerts on your personalized pharmacy care profile
- Look up information about your medications and your prescription drug benefit
- Ask a pharmacist questions anytime, day or night
- View a financial summary of your prescription expenses, especially valuable at tax time
- Review your prescription history to share with your doctor

Q. What if I have questions about my medications?
A. Express-Scripts has specialist pharmacists, who each have expertise in the medications that treat a specific condition, such as high blood pressure, asthma, diabetes or cancer. Specialist pharmacists at Express Scripts can answer your questions about how your medications work with each other and how to make them work best for you. Since they know how your plan works, specialist pharmacists can also advise you on potentially reducing your medication costs.

Q. Will I get a separate pharmacy card?
A. You will receive a new ID card from Anthem. Beginning 1-1-2016, please show your new member ID card to your pharmacist when filling a prescription for yourself or a covered family member. In December, you will receive a Welcome Package from Express Scripts that offers you simple instructions on how to take full advantage of all the prescription services available to you

Q. How do I maximize my prescription drug coverage benefits?
A. The following will help to maximize your prescription drug coverage benefits:

- Use generic drugs whenever possible.
- If you are taking a brand-name drug that is not on your formulary, ask your doctor if a formulary drug or a generic would be right for you.
- Use your Home Delivery program for maintenance medications. Maintenance medications are prescription drugs that you take regularly to treat ongoing conditions like diabetes, high blood pressure and asthma. You can usually save time and money by using the Express Scripts Pharmacy to fill your maintenance medications.
- Use participating local pharmacies to fill your short-term prescriptions. For example, your doctor might prescribe a 15-day medication for an infection. You should always get these types of medications from a participating local pharmacy.

Q. How can I calculate my out-of-pocket cost for a preferred or a non-preferred drug?
A. There is a tool on www.Express-Scripts.com called "Price A Medication" that will help you calculate the estimated cost of a prescription drug. Register at www.Express-Scripts.com/TeleTech, and click on "Price a Medication".

Note: The Price a Medication calculator does not imply a guarantee of coverage as covered products or categories are subject to individual plan restrictions and/or limitations. The “Price A Medication” tool displays cost and coverage information for the current calendar year.

Q. Are generics safe?
A. Yes. Generic drugs, like brand-name drugs, must meet established FDA standards of quality and purity to help ensure their safety and effectiveness, and they usually cost less. Generic versions have the same active ingredients as their brand-name counterparts, and they are equal in strength and dosage. Sometimes drug manufacturers use different inactive ingredients, such as fillers and dyes, which affect a drug’s shape, color, size or taste.

Q. Why should I consider generics or preferred brand-name drugs?
A. You may save money by taking generics or preferred brand-name drugs because they usually cost less under your plan than non-preferred brand-name drugs. Many new generics have become available over the past year. If you’re taking a non-preferred drug, ask your doctor whether a lower-cost option would be right for you.

Q. How do I know whether my medication is covered or whether there is a generic equivalent?
A. To find coverage and pricing details online, and to find out if your medication has a generic equivalent, prior to January 1, 2016 visit www.Express-Scripts.com/TeleTech. After January 1, 2016 you can register and log in to www.Express-Scripts.com and choose “Price a medication” from the left-hand menu or contact customer service at 855-687-3854.

Q. Will there be changes to my plan’s list of preferred drugs?
A. Yes, effective 1-1-2016 your plan’s formulary (a list of preferred medications) will change. As a result, some preferred medications will become non-preferred, and vice versa. Prior to 1-1-2016 use the following link www.express-scripts.com/teletech to determine if a medication is on the Express Scripts formulary. Beginning 1-1-2016, you may also register to www.Express-Scripts.com to find out which medications are preferred. If you are taking a brand-name drug that is about to become non-preferred, you may want to talk to your doctor about a lower-cost option.

- **Preferred** (or formulary) medications are on the formulary and cost less than non-preferred medications. This list of drugs is determined based on the advice of pharmacists and a group of independent doctors.
- **Non-preferred** (or non-formulary) medications are not on your list of recommended drugs and may cost you more.

Q. Are there drugs that will not be covered by my plan?
A. Yes, beginning 1-1-2016, Express Scripts will help make safe and effective medications available for you. A national panel of physicians and pharmacists continually reviews and compares prescription drugs to ensure your drug list includes proven medications to treat every condition. Some drugs may no longer be included when other safe and effective alternatives are available. You can review the TeleTech Formulary and Exclusions list to identify any drugs that you are currently taking that will no longer be covered and the covered alternatives. Your doctor can prescribe another effective medication that's included on your drug list. If you elect to continue taking the current medication that is no longer covered on your drug list, you will pay the full retail price if you refill after 1-1-2016. You can also call Express Scripts toll-free at 855-687-3854 with questions about which drugs will be covered.

Need More Help? Contact Health Advocates or Express-Scripts directly. All benefit vendor contact information can be located on http://mybenefits.teletech.com within the contact page.

Connect Your Care (CYC)

Q. What benefit does CYC manage?
A. Connect Your Care is the plan administrator for all of the TeleTech savings and spending accounts including the Health Savings Account, Health Reimbursement Account and the Flexible Spending Accounts. You will receive a debit card from Connect Your Care shortly after enrollment that will allow you to access your account(s) to pay for eligible expenses (with the exception of the Dependent Care Account, all claims must be filed manually). You will also have an online account after you register as a new user at connectyourcare.com where you can view account balances, claims history, card transactions and more. If you have more than one account (e.g FSA and HRA) Connect Your Care will automatically coordinate your accounts for you.
You can only change your FSA contributions during the year if you have a qualifying family status change event.

Need More Help? Contact Health Advocates or Connect Your Care directly. All benefit vendor contact information can be located on http://mybenefits.teletech.com within the contact page.

Health Reimbursement Account

Q. What happens to my current Health Reimbursement Account (HRA) balance?
A. If you have an HRA and elect the Choice HSA plan, any funds left in your HRA at the end of 2016 will be forfeited. Your HRA balance **will not be transferred** to your Health Savings Account in 2017.

- If you elect the Primary Care or the Balanced HRA plans, your HRA **will roll over** to 2017 and will be available through the new plan administrator Connect Your Care.

- If you have a balance in your Health Care Flexible Spending Account at the end of the year, **it will roll over** to 2017 – but only up to $500. Any amount over $500 in your account at the end of the

year will be forfeited. If you elect an LPFSA (Limited Purpose Flexible Spending Account) your FSA balance cannot be rolled over.

Q. How do I view my HRA balance?
A. You can check your balance and manager your accounts by visiting www.Connectyourcare.com

Health Savings Account

Q. Who is the plan administrator for our spending and savings accounts in 2017?
A. Connect Your Care is the plan administrator for all of the TeleTech savings and spending accounts including the Health Savings Account, Health Reimbursement Account and the Flexible Spending Accounts. You will receive a debit card from Connect Your Care shortly after enrollment that will allow you to access your account(s) to pay for eligible expenses. You will also have an online account after you register as a new user at connectyourcare.com where you can view account balances, claims history, card transactions and more. If you have more than one account (e.g FSA and HRA) Connect Your Care will automatically coordinate your accounts for you.
*You can only change your FSA contributions during the year if you have a qualifying family status change event.

Q. What is a Health Savings Account?
A. A Health Savings Account, or HSA, is available to you if you are enrolled in the Choice HSA Plan. An HSA is like a 401(k) for health care. It's a tax-advantaged account that you can use to pay for eligible health care expenses today or save for future expenses. It is 100% owned by you. Your balance rolls over year-to-year, and the money in your HSA is yours to keep forever – even if you no longer work for TeleTech. For 2017, TeleTech will contribute $750 for employee-only coverage and $1,250 if you cover dependents to your HSA in quarterly payments based on your date of hire. You can also contribute to your HSA on a pre-tax basis with convenient paycheck deductions. One of the benefits of having an HSA is that it is triple-tax advantaged. There are no taxes on contributions, no taxes on withdrawals for eligible medical expenses, and no taxes on earnings from interest or investments. Because of the tax advantages, the IRS limits total annual contributions into your HSA (including those from TeleTech) to $3,400 for employee only coverage, and $6,750 if you cover dependents. If you are over the age of 55 then you can make catch up contributions up to an additional $1000 per year. Connect Your Care is the plan administrator if you enroll in the Choice HSA Plan, and your HSA will automatically be established. Access and manage your account at connectyourcare.com. You can view account balances, claims history, card transactions, and more.

Q. If I elect the Choice HSA medical plan am I required to also elect the Health Savings Account?
A. Yes, if you elect the Choice HSA medical plan, you must also elect the Health Savings Account however you are not required to contribute additional funds from your account. You can elect a zero-dollar contribution for your Health Savings Account.

Q. What if I need help deciding whether to contribute to a savings or spending account?
A. You can get guidance through ALEX our online benefit counselor 24X7 from any internet visit https://www.myalex.com/teletech/2017

Q. What savings and spending plans are available for 2017?
A.

	Health Savings Account (HSA)	**Health Reimbursement Account (HRA)**	**Flexible Spending Account (FSA)**	**Dependent Care Flexible Spending Account**

What am I eligible for?	Must enroll in the Choice HSA medical plan to be eligible. You must also elect the Health Savings Account to indicate any additional amount you would like to contribute tax free from your paycheck. *Your additional contribution amount can be $0	Must enroll in the Balanced HRA medical plan or the Primary Care Plan. These plans allow you to keep your HRA balance.	If you enroll in the Primary Care Plan or the Balanced HRA plan you can enroll in an FSA If you select the Choice HSA plan you can enroll only in the Limited Purpose FSA	All Full Time Regular employees are eligible to elect the Dependent Care FSA regardless of a medical election
What expenses can I use it for?	Can be used for eligible medical, prescription drugs, dental and vision expenses including deductibles and coinsurance	Can be used for eligible medical, prescription drugs, dental and vision expenses including deductibles and coinsurance	The FSA can be used for eligible medical, prescription drugs, dental and vision expenses The limited purpose FSA can be used for eligible dental and vision expenses and medical expenses after you have met your deductible.	These funds can be used to pay for eligible dependent care expenses like daycare, before and after care for your children under the age of 13 etc.
How much will TeleTech contribute?	$750 for employee only coverage and $1,250 for employee + 1 or more Contributions will be made in quarterly payments	$400 for employee only coverage and $600 for employee + 1 or more Those enrolled in the Primary Care Plan will not receive annual contributions from TeleTech – just the rollover balance from 2016. Contributions will be made Jan. 1	No contributions. Only you can contribute to your FSA or LPFSA	No contributions. Only you can contribute to your Dependent Care FSA
Employee contributions	If desired, you may contribute to your HSA on a pretax basis with paycheck deductions	You may not contribute to your HRA. You can only earn money for this account by completing a preventive medical exam. See the Health	You contribute to your FSA or LPFSA on a pretax basis with paycheck deductions	You contribute to your Dependent Care FSA on a pretax basis with paycheck deductions

	The IRS limits total contributions (including those from TeleTech) for $3,400 for employee only coverage and $6,750 for employee +1 or more coverage	and Wellness section for more information	The IRS limits total contributions to $2,550 per year	The IRS limits total contributions to $5,000 per year

Need More Help?

Contact Health Advocate or Connect Your Care. All benefit vendor contact information can be located on http://mybenefits.teletech.com within the contact page.

Flexible Spending Accounts

Q. Who is the plan administrator for our spending and savings accounts in 2017?
A. Connect Your Care is the plan administrator for all of the TeleTech savings and spending accounts including the Health Savings Account, Health Reimbursement Account and the Flexible Spending Accounts. You will receive a debit card from Connect Your Care shortly after enrollment that will allow you to access your account(s) to pay for eligible expenses. You will also have an online account after you register as a new user at connectyourcare.com where you can view account balances, claims history, card transactions and more. If you have more than one account (e.g FSA and HRA) Connect Your Care will automatically coordinate your accounts for you.
**You can only change your FSA contributions during the year if you have a qualifying family status change event.*

Q. What is a Flexible Spending Account?
A. Flexible Spending Accounts (FSAs) let you set aside tax-free money from your paycheck to pay for out-of-pocket health care and/or dependent day care expenses. You save money because you do not pay federal income or Social Security taxes on your FSA contributions.

Q. Can I spend my FSA money on anyone in my family?
A. You can use your FSA money on any IRS eligible dependents. If you can claim a dependent on your taxes, you can use your FSA money to pay for their eligible expenses.

Q. What types of Flexible Spending Accounts does TeleTech offer?
A. TeleTech offers three FSA options:

1. **Health Care FSA -** You can use the Health Care FSA
   for health expenses that your plan does not cover including medical, prescription drugs, dental and vision expenses for your IRS eligible dependents. You can elect this benefit if you choose to waive medical, select the Primary Care Plan or the Balanced HRA plan.
2. **Limited Purpose FSA (LPFSA) -** The LPFSA can be used for eligible dental and vision expenses that your plan doesn't cover – and medical expenses after you have met your deductible.
   The LPFSA is specifically designed for participants in the Choice HSA Plan as the IRS does not permit you to enroll in a Health Care FSA.
3. **Dependent Care FSA (For daycare expenses) -** The Dependent Care FSA helps you save on day care costs for children under age 13 and other eligible family members.

Q. Who can contribute to a Flexible Spending Account?
A. All regular, full-time employees are eligible to contribute to a Flexible Spending Account.

Q. Where can I learn more about the savings and spending plans available?
A. Click here to learn more about the savings and spending plans options available for 2017.

Q. What happens to my current Health Flexible Spending Account balance?
A. If you have a balance in your Health Care Flexible Spending Account at the end of the year, it will roll over to 2017 – but only up to $500. The rollover funds will be available for use after April 1, 2017 as the rollover does not take place until after the runout period expires. The runout period lasts until March 31, 2017 and allows you to submit receipts with a service date prior to December 31, 2016 for reimbursement so that you can claim the remaining funds in the 2016 FSA account. Any amount over $500 that is left in your 2016 FSA account at the end of the year will be forfeited. If you have a regular FSA and elect a LPFSA (Limited Purpose Flexible Spending Account) up to $500 will roll over into the following plan year.

Q. Why should I use a Medical Care Flexible Spending Account?
A. A Medical Care Flexible Spending Account allows you to set aside money before taxes, which means that you can pay for eligible medical expenses on a pre-tax basis. Using pre-tax dollars ultimately will save you money. You can set aside any amount from $120 - $2,550 each year. You will want to decide how much money to contribute based on your expected out-of-pocket medical expenses, keeping in mind that any unused funds at the end of the year over $500 will be forfeited, per IRS rules. Up to $500 will roll over for use in the following year.

Q. How do Flexible Spending Accounts work?
A. During enrollment, you will estimate your expenses for the year. Think about how much you might pay for health care and/or dependent care expenses during the year — for yourself or for your eligible dependents. Decide how much to contribute. Based on step 1, think about how much you want to contribute to your account(s) for the year. Your contribution amount (for each account) will be divided equally over the year's remaining pay periods. If you enroll in the Health Care FSA, keep in mind that you can carry over up to $500 of unused funds into the next year. The annual contribution limit will not be affected by any carryover funds. The money is taken out of your paycheck (in equal amounts) before taxes. That means you do not pay federal income or Social Security taxes on the money in your account. You pay your expenses as normal. You can pay for eligible health care expenses with your Health Care FSA debit card — no claim forms are needed. Be sure to keep your receipts.

Q. Do I have to submit receipts for every purchase I make using my Flexible Spending Card?
A. Generally no as long as you are enrolled in a TeleTech medical plan, however it's a good idea to keep all of your receipts for FSA purchases in case a charge is ever in question and you receive a request to submit verification of your eligible purchase.

Q. What are the eligible expenses that you can spend your Medical Care Flexible Spending Account money on?
A. Any out-of-pocket medical related expenses such as your deductible, copays, coinsurance, immunizations, prescription drugs, dental and vision expenses, etc. would be considered eligible expenses. Effective January 1, 2011, to comply with federal regulations, over the counter medications are no longer eligible expenses. Keep this change in mind as you decide how much to contribute to your Medical Care Flexible Spending Account. For a complete list of eligible health care expenses, please view Publication 502 at www.irs.gov.

Q. Can I spend my Medical Care Flexible Spending Account funds on my dependents even if they are not covered by TeleTech's medical plan?
A. Yes, you can spend your Medical Care Flexible Spending Account funds on any of your IRS eligible dependent's eligible expenses.

Q. How long do I have to use the money in my Medical Care Flexible Spending Account?
A. You have until December 31st to spend the money in your medical care reimbursement account on eligible health care expenses. Up to $500 will roll over into the following year and you would forfeit the remaining funds. If you did not use your card for purchases, you must submit your claims for reimbursement along with your receipts by March 31st of the following year.

Q. Do I have to wait until there is enough money in my Medical Care Flexible Spending Account to submit my claim for reimbursement?

A. No, you decide how much you will contribute during the year to your medical care flexible spending account when you enroll, and although the contributions to your account are deducted on a per paycheck basis, the entire amount you elect is available immediately (even if it has not been deducted from your pay check yet). You will then receive a debit card from Connect Your Care to use your Flexible Spending Account funds throughout the year.

Q. Will my funds be available for me when I need them?
A. Your Medical Care Flexible Spending Account is managed by Connect Your Care. If you have a Health Reimbursement Account and a Flexible Spending Account, when you use your debit card the FSA funds are spent first and then the HRA funds will be used to pay claims. If you do not use your debit card to pay for expenses, you can visit www.connectyourcare.com to use your HRA funds before your FSA funds. If you have a LPFSA (Limited Purpose Flexible Spending Account and a Health Savings Account, the LPFSA will be used before the HSA funds. Funds will be available for you when you need them throughout the year until your funds have been exhausted. Keep in mind that the Limited Purpose FSA can only be used on dental and vision expenses until your medical plan deductible has been met, at which point you can use the funds on Medical expenses as well.

Q. Can I move funds from my Health Reimbursement Account into the Flexible spending account?
A. No, these are two separate accounts. Only the amount you elected during your enrollment period would be available on your FSA card for use.

Q. Can I change the amount of my Flexible Spending Account during the year?
A. The only time changes can be made to benefits outside of Open Enrollment is during a Qualifying Life Event.

Q. Can I manage my claims online?
A. Yes, Online and Mobile Claims Submission is fast, convenient, and a secure management for FSA expenses (reimbursement and recordkeeping) from any web browser or mobile device. Connect Your Care processes reimbursement within a few days—with no minimum transaction amounts.

Q. Can I call Connect Your Care at any time if I have questions or need assistance?
A. Yes, not only will you experience superior customer service but their 24/7, U.S.-based customer service operation has earned outstanding satisfaction rates from employers and participants alike.

Q. Where can I learn more about the FSA card?
A. A Payment Card, sometimes called an “FSA Payment Card,” allows you to quickly and easily access FSA funds. It functions like a credit card, with funds deducted directly from the Flexible Spending Account.

Need More Help? You can call the Health Advocate team or contact Connect Your Care. All benefit vendor contact information can be located on http://mybenefits.teletech.com within the contact page.

Dependent Care Flexible Spending Account

Q. Who is the plan administrator for our spending and savings accounts in 2017?
A. Connect Your Care is the plan administrator for all of the TeleTech savings and spending accounts including the Health Savings Account, Health Reimbursement Account and the Flexible Spending Accounts. You will not receive a debit card from Connect Your Care for the Dependent Care FSA. You must pay out of pocket for eligible daycare expenses and submit receipts to be reimbursed up to the amount you have in your Dependent Care FSA at the time of your claim. You will also have an online account after you register as a new user at connectyourcare.com where you can view account balances, claims history, recent transactions and more. If you have more than one account (e.g FSA and HRA) Connect Your Care will automatically coordinate your accounts for you.

**You can only change your FSA contributions during the year if you have a qualifying family status change event.*

Q. What is a Dependent Care Flexible Spending Account?
A. A dependent care flexible spending account allows you to set aside pre-tax money from each pay check to pay for your day care expenses for your children under age 13 and/or for your mentally or physically disabled dependents of any age.

Q. Why should I use a Dependent Care Flexible Spending Account?
A. A Dependent Care FSA allows you to set aside money before taxes, which means you pay for eligible dependent care expenses on a pre-tax basis. Using pre-tax dollars ultimately will save you money. You can set aside any amount up to $5,000 each year. (If your spouse is also working and contributing to a dependent care flexible spending account and you file separate tax returns, the IRS limits your eligible contribution to $2,500.) You will want to decide how much money to contribute based on your expected child care expenses, keeping in mind that any unused funds at the end of the year will be forfeited, per IRS rules.

Q. How does the Dependent Care Flexible Spending Account work?
A. During enrollment, you decide how much you want to contribute to your Dependent Care FSA based on what you think you will pay in day care expenses during the year. You will need to estimate carefully, because any money that is left in your account after you submit your eligible expenses for the year will be forfeited, which means that you will lose any money that is left over. You will not receive a debit card from Connect Your Care to use the funds that you have already contributed. The daycare expenses must be necessary so you can work, and, if you are married, the expenses must also allow your spouse to work or go to school full time.

Q. How long do I have to use the money in my Dependent Care Flexible Spending Account?
A. You have until December 31st to incur the expenses. You must submit your claims for reimbursement along with your receipts by March 31st of the following year.

Q. What are the eligible expenses that you can spend your Dependent Care FSA money on?
A. Any expenses for nursery school, day care center, in-home day care, etc. The expenses that you submit must be necessary so that you can work, and, if you are married, the expenses must also allow your spouse to work or go to school full time. For a complete list of eligible, please contact Connect Your Care.

Q. Do I have to wait until there is money in my Dependent Care Flexible Spending Account to use the funds?
A. Yes, you can only use up to the amount in your account at any given time. This is different from the Medical Care Reimbursement Plan.

Need More Help? Call Health Advocate or Connect Your Care directly. All benefit vendor contact information can be located on http://mybenefits.teletech.com within the contact page.

Dental Insurance

Q. What does dental insurance cover?
A. Dental insurance helps to pay for eligible services (e.g., your cleanings, X-rays, basic and major care, and orthodontia) related to the care and treatment of your teeth and gums. You can choose any dentist or other dental provider but you can maximize your benefits and minimize your out-of-pocket costs if you choose a Delta Dental provider.

Q. Where can I find a list of Delta Dental's providers?

A. You can find a list of Delta Dental's providers near you by calling 1.800.610.0201 or by going to www.deltadentalco.com. You can reference TeleTech's group number: 0109.

Q. What if I don't want dental insurance?
A. Your dental election is completely separate from all other benefits, so if you do not want dental insurance because you already have coverage through another plan, you can decline coverage during the enrollment process.

Q. How much does Dental Insurance cost?
A. The cost per pay period is shown at http://mybenefits.teletech.com. The cost will depend on who you choose to cover (e.g., just yourself, or yourself and one or more of your eligible dependents).

Q. What is an annual deductible?
A. The annual deductible is a specified dollar amount that the member must pay each year before the dental plan will help you pay for eligible expenses; the deductible is waived for covered preventive care services.

Q. How does the single (individual) versus the family deductible work?
A. If only you, the employee, enroll in dental coverage, you will only have to pay the single (individual) deductible before plan coinsurance begins. But if you also enroll any of your eligible dependents on the dental plan, then the family deductible will also apply. While each covered person in the family will need to meet the single deductible and then plan coinsurance will begin for each person, the single deductibles will apply only until the total family deductible amount is paid for everyone in the family. Once the family deductible is met, then the plan coinsurance begins for all covered members of the family.

Q. What does In-Network versus Out-of-Network mean?
A. In-network means that the dental provider you are visiting is a part of Delta Dental's preferred network. In other words she has an agreement with Delta Dental and is "participating" in the Delta Dental network. Non-participating providers do not have a contract with Delta Dental and you cannot take advantage of the discounts Delta Dental has negotiated with their providers and your out-of-pocket cost could be higher. You can find Delta providers on www.deltadentalco.com.

Q. What do the percentages listed under In-Network and Out-of-Network mean?
A. The percentages indicate the percentage of your dental costs that the plan will pay after you meet the deductible. For example, if you or someone in your family needs a filling, which is listed as a basic treatment, the plan will pay 80% of the cost to get a filling and you will pay the remaining 20% of the cost, after your deductible.

Q. What is a plan maximum?
A. The plan maximum is the total amount that the plan will pay per person per year (or per lifetime in the case of orthodontia coverage). Once you meet your plan maximum you are responsible for all additional dental costs for the remainder of the year. Note that additional plan limitations and exclusions may apply.

Q. Will I receive a dental ID card?
A. No dental ID cards will be sent. Your dental provider can file a claim electronically using your personal information. You can print an ID card by visiting www.deltadentalco.com.

Q. Will I lose my dental benefits if I move from Full Time to Part Time?
A. Yes, all benefits end on the last day of your Full Time status and you would be responsible for re-electing dental if you want to have the coverage as a part time employee. The dental plan would start over as a new plan. You would be responsible for a new deductible and would have a new annual maximum available.

Q. Is Orthodontia covered for adults?
A. Yes, Adult orthodontia is covered on the Enhanced Dental plan for a lifetime maximum benefit of $1500.

Q. How do I view my dental claims?

A. To view dental claims and find in-network providers please visit http://www.deltadentalco.com/subscribers.aspx.

Need More Help? Contact Health Advocate or Delta Dental of CO. All benefit vendor contact information can be located on http://mybenefits.teletech.com within the contact page.

Vision Insurance

Q. What does vision insurance cover?
A. Vision insurance provides eye care and eyewear to keep your eyes healthy. The eye care insurance includes examinations, lenses, frames and contacts. You can choose any vision provider to receive services, but you can maximize your benefits and minimize your out-of-pocket costs if you choose a Vision Service Plan (VSP) preferred provider.

Q. Where can I find a list of VSP's preferred providers?
A. You can find a list of VSP's preferred providers near you by calling 1.800.877.7195 or by visiting and registering at www.vsp.com.

Q. What if I don't want vision insurance?
A. Your vision election is completely separate from all other benefits. So if you do not want vision insurance, you can decline coverage during the enrollment process.

Q. How much does Vision Insurance cost?
A. The cost per pay period is shown at http://mybenefits.teletech.com. The cost will depend on who you choose to cover (e.g., just yourself, or yourself and one or more of your eligible dependents).

Q. What is a copay?
A. A copay is a fixed cost that you pay up front for a service. Your copay will cover your responsibility for the cost of the service at a VSP preferred provider and the plan pays the rest, unless the benefit is subject to a plan allowance maximum.

Q. What is an allowance?
A. The allowance is the total dollar amount that the plan will pay for that service. You are responsible for additional vision care costs related to that service. If you purchase frames over the $160 allowance you will receive a 20% discount off the overages and it is your responsibility to pay the balance. The plan pays up to $160 for your contacts and you receive a 15% discount off the evaluation and fitting fees.

Q. If I get new eyeglass lenses and frames, do I need to pay two copays?
A. No, you would only pay one material copay per benefit period for lenses, frames or a complete pair of glasses. Cosmetic extras such as coatings, tints and progressive lenses are provided at 35-40% discount at VSP preferred providers.

Q. How often can I get contact lenses, eyeglass lenses and eyeglass frames?
A. You can get contact lenses or eyeglass lenses every 12 months. You can get frames every 24 months. You can get a 30% discount on non-covered glasses and sunglasses if you purchase them from the examining doctor on the day of the service or a 20% discount if purchased from any VSP provider within 12 months of the examination.

Q. Will my Vision Insurance cover both eyeglasses and contact lenses?
A. No, if you choose to get contact lenses, you will not be eligible to receive eyeglass lenses during the same calendar year or frames within 24 months

Q. Does my Vision Insurance cover Lasik/PRK Eye Surgery?
A. Your coverage will not pay for Lasik/PRK eye surgery; however, contracted Laser Centers do offer discounts for Lasik and PRK eye surgery if you use a VSP member.

Q. Will I receive a vision ID card?
A. No. Your vision provider can file a claim electronically using your personal information.

Need More Help?

Contact Health Advocate or VSP directly. All benefit vendor contact information can be located on http://mybenefits.teletech.com within the contact page.

Critical Illness

Q. What is Critical Illness Insurance?
A. This is coverage that can help cover the extra expenses associated with a serious illness. When a serious illness happens to you or a loved one, this coverage provides you with a lump-sum payment of your choice of either $15,000 or $30,000 in Initial Benefits upon diagnosis. Payments may be used to help pay for expenses generally not covered by medical and disability income coverage. The Total Benefit Amount available to you is 3 times (3x) the Initial Benefit Amount you select — either $45,000 or $90,000 in the event that you suffer more than one covered condition. Payment(s) you receive will be made in addition to any other insurance you may have and may be spent as you see fit.

Q. What types of illnesses are covered under this plan?
A. If you meet the group policy and certificate requirements, critical illness insurance provides you with a lump-sum payment upon diagnosis of the following conditions:

- Cancer
- Heart Attack
- Kidney Failure
- Stroke
- Coronary Artery Bypass Graft
- Alzheimer's Disease
- Major Organ Transplant
- 22 Listed Conditions (see the outline of coverage for details)

Q. Who is eligible to enroll for this coverage?
A. You and your eligible family members can enroll in the coverage during Open Enrollment.

Q. I have a good medical plan at work, why do I need critical illness insurance?
A. Medical and disability plans don't always cover all of your expenses. For example, your medical coverage may have deductibles and copays and may not cover out of-network treatments. And if you're out on disability, only a portion of your income may be covered. With the average person spending thousands of dollars during a time of critical illness and recovery, most people will need the means to cover extra medical and daily living expenses for items like groceries, housing expenses, car payments, and more.

Q. Can I enroll for this coverage without having to take a medical exam?
A. YES! Provided you are actively at work; your enrollment is guaranteed.

Q. Are there any other benefits payable under this critical illness insurance plan?
A. YES! This plan provides an annual benefit per calendar year for eligible health screenings/preventive exams.

Q. How do I pay for my coverage?

A. Premiums will be conveniently paid through payroll deductions so you never have to worry about writing a check or missing a payment.

Q. Are payments made directly to me or my health care providers?
A. Payments will be made directly to you, not to the doctors, hospitals or other health care providers. You will receive a check, mailed directly to your home.

Q. What happens if my employment status changes? Can I take my coverage with me?
A. YES. This coverage is "portable," meaning you can take it with you if your employment status changes.

Need More Help?
Contact MetLife directly or Health Advocate. All benefit vendor contact information can be located on http://mybenefits.teletech.com within the contact page.

Voluntary Accident Insurance

Q. What is Voluntary Accident Insurance?
A. Voluntary Accident Insurance is an optional insurance plan that will pay benefits if you are seriously injured or die as a result of a covered accident. This insurance is in addition to any basic or supplemental life or accidental death and dismemberment insurance benefits that you may receive.

Q. Who can be covered by Voluntary Accident Insurance?
A. You may choose to cover yourself, your spouse or domestic partner and/or your children. If you would like to cover your spouse or children, you must also purchase accident insurance coverage for yourself. You need to enroll during your Enrollment Period and be actively at work for your coverage to be effective.

Q. How much does Accident Insurance cost?
A. The cost per pay period is shown at http://mybenefits.teletech.com. The cost will depend on who you choose to cover (e.g., just yourself, or yourself and one or more of your eligible dependents).

Q. How do I pay for my accident coverage?
A. Premiums will be conveniently paid through payroll deduction, so you don't have to worry about writing a check or missing a payment.

Q. What happens if my employment status changes? Can I take my coverage with me?
A. Yes, you can take your coverage with you. You will need to continue to pay your premiums to keep your coverage in force. Your coverage will only end if you stop paying your premium or if your employer offers you similar coverage with a different insurance carrier.

Q. How do I file a claim?
A. Contact MetLife directly 800.638.6420

Need More Help?
Click here to review the Plan Summary. Call Health Advocate or MetLife directly. All benefit vendor contact information can be located on http://mybenefits.teletech.com within the contact page.

Pre-Paid Legal Plan

Q. What does the MetLaw pre-paid legal plan cover?

A. The prepaid legal plan will allow you to seek guidance with purchasing a home, estate planning and will preparation, financial matters, family law or adoption issues. You get the attorney you need at an affordable cost, with access by telephone or in-person for advice. Hyatt Legal access code is **6090815**

Q. Where can I find more information about the Pre-Paid Legal Plan?
A. Please visit mybenefits.teletech.com>Voluntary Plans.

Q. Can I cancel this plan at any time?
A. No, once you enroll you in the Pre-Paid Legal plan you must keep it for the entire calendar year even if you have a Qualifying Life Event. You can opt out during the annual Open Enrollment period.

Q. What is MetLaw?
A. MetLaw provides you with easy access to legal services at an affordable group rate.

Q. How would you benefit from MetLaw?
A. First and foremost, you save money. If you've ever hired a lawyer, you know how quickly the attorney fees can add up. With MetLaw — the group legal plan available through Hyatt Legal Plans, a MetLife Company — you can get legal advice and representation at an affordable price.

Q. How important is it for me to have a legal plan?
A. It's more important than you think. There are many times in life when you may need the services of a qualified attorney: purchasing a home, estate planning documents and will preparation, financial matters, family law or adoption issues. Yet according to a study conducted by the American Bar Association, many people who need legal help do not seek it — in part because they fear the cost and don't know how to find the right attorney.

Q. How does the plan work?
A. MetLaw gives you access to a nationwide network of over 13,000 attorneys. You can also choose a non-Plan Attorney and may be reimbursed through the MetLaw plan. You get the attorney you need at a cost that's very affordable, with access by telephone or in-person for advice on an unlimited number of personal legal matters, and representation for a wide variety of legal services.

Q. There are many different types of attorneys. Will I find the one I need?
A. Yes! MetLaw attorneys have an average of 25 years of experience and are well qualified to assist you in a wide range of legal matters, including:
• Estate Planning Documents, including Wills and Trusts
• Real Estate Matters
• Identity Theft Defense
• Financial Matters, such as Debt Collection Defense
• Traffic Offenses
• Document Review
• Family Law, including Adoption and Name Change
• Advice and Consultation on Personal Legal Matters
• And More

Need More Help?
Please call MetLife directly. All benefit vendor contact information can be located on http://mybenefits.teletech.com within the contact page.

Short Term Disability (STD) – For non-Corporate employees

Q. What is Short Term Disability coverage?
A. Short Term disability coverage is a voluntary coverage that will pay you a weekly benefit if you are unable to work for at least seven consecutive days because of a pregnancy, illness or non-work-related injury. Short

term disability coverage will pay up to 60% of your monthly pay (70% if you work in New York) to help replace part of your lost income when you are unable to work. The maximum weekly short term disability benefit per week is $1,050.

Q. Who can be covered by Short Term Disability?
A. All regular, full-time employees are eligible to enroll. This benefit only covers you, as the employee; dependents are not eligible for coverage.

Q. How much does Short Term Disability coverage cost?
A. The cost of short term disability coverage varies and will depend on your specific age, weekly pay and location. Please refer to at http://mybenefits.teletech.com for your rate.

Q. How do I calculate my per pay period cost?
A. Your cost will depend on your age, weekly pay and location. To calculate your specific rate, take your weekly income, multiply by 0.6 (unless you work in New York, then multiply by 0.7), divide that number by 10 and then multiply that number by the applicable rate found at http://mybenefits.teletech.com to get your monthly cost. If you want to calculate your per pay period cost, take your monthly cost (the number you just calculated) and multiply it by 12 (months) and then divide by 26 (pay periods).

Q. When do I need to provide evidence of insurability (EOI)?
A. If you are a new hire (within the first 31 days of employment), you will not have to provide evidence of insurability if you wish to elect Short Term Disability Insurance.

You will only need to provide evidence of insurability if you decline short term disability coverage when you are first eligible and later wish to apply, or if you enrolled in short term disability coverage, subsequently dropped the coverage and are now reapplying for coverage. During the benefit elections process, Oracle will show the election as “suspended” if you are required to provide MetLife with Evidence of Insurability, which must be printed from mybenefits.teletech.com, completed and mailed directly to MetLife for consideration.

Q. Do I have to use my paid time off (PTO) time to be eligible for STD benefits?
A. Yes, you have to use up your PTO days first, before STD benefits can be paid.

Q. How long will my Short Term Disability benefits last?
A. The maximum benefit covers13 weeks; however, each disability leave is evaluated separately with input from your physician. Please visit http://mybenefits.teletech.com for more information.

Q. Do I need to enroll to receive Short Term Disability coverage?
A. Yes, this coverage is totally voluntary, so you will need to enroll during open enrollment if you wish to have this coverage.

Q. How do I file a claim?
A. Contact MetLife directly 800.638.6420

Q. Is there a pre-existing conditions clause within Short Term Disability coverage?
A. Yes, please review the TeleTech Short Term Disability Certificate on http://mybenefits.teletech.com

Q. Who can I call if I would like more information about Short Term Disability coverage?
A. You can call MetLife at 1.866.492.6983 or Health Advocate 866-695-8622

Short Term Disability (STD) – Employer Paid

Corporate employees and select segments receive company paid Short Term Disability coverage automatically. This valuable benefit replaces part of your pay if you're unable to work for more than seven consecutive days due to a pregnancy, illness or non-work-related injury.

- First two years of employment: 60% of your base wages (up to $3,000 per week)
- After two years of employment: 80% of your base wages (up to $3,000 per week)

Long Term Disability (LTD)

Q. What is Long Term Disability coverage?
A. Long term disability coverage helps to replace part of your pay if you are disabled and unable to work for more than 3 months. This coverage will pay up to 50% of the income (subject to $5,000 per month maximum) that you were earning before you became disabled.

Q. Who can be covered by Long Term Disability?
A. Only you, as the employee, are eligible for the long term disability coverage.

Q. How much does Long Term Disability coverage cost?
A. If you are a full-time general or administrative employee, this coverage would provide 60% of the income that you were earning before you became disabled and is provided and paid for by TeleTech, there is no cost to you for this benefit. Taxes will apply to the benefit. If you are an associate you can see the cost for the LTD coverage within Oracle Self Service and there is a worksheet to help calculate your cost at http://mybenefits.teletech.com.

Q. Do I need to enroll to receive Long Term Disability coverage?
A. If you are a general and administrative employee, you will be automatically enrolled in the LTD coverage. If you are an associate you must enroll during your first 30 days of employment or during the Open Enrollment period.

Q. When do I need to provide evidence of insurability (EOI)?
A. You will only need to provide evidence of insurability if you decline long term disability coverage when you are first eligible and later wish to apply, or if you enrolled in long term disability coverage, subsequently dropped the coverage and are now reapplying for coverage. During the benefit elections process, Oracle will show the election as "suspended" if you are required to provide MetLife with Evidence of Insurability, which must be printed from mybenefits.teletech.com, completed and mailed directly to MetLife for consideration.

Q. How do I file a claim?
A. Contact MetLife directly 800.638.6420

Q. Is there a pre-existing conditions clause within Long Term Disability coverage?
A. Yes, please review the TeleTech Long Term Disability Certificate on http://mybenefits.teletech.com

Q. Who can I call if I would like more information about Long Term Disability coverage?
A. You can call MetLife at 800.638.6420 or Health Advocate 866-695-8622

Basic Life Insurance

Q. What is Basic Life Insurance?
A. Basic Life insurance pays a lump sum benefit to your designated beneficiaries (e.g., spouse, dependents, parents, siblings, or anyone you designate) upon your death. You may change your beneficiaries at any time at www.metlife.com/mybenefits . Please visit http://mybenefits.teletech.com for more details.

Q. How much does Basic Life Insurance cost?
A. This coverage is provided and paid for by TeleTech; there is no cost to you for this benefit.

Q. Who can be covered by the Basic Life policy?
A. Only you, as the employee, are covered by the Basic Life Insurance policy.

Q. How much Basic Life Insurance can I have?
A. The Basic Life Insurance coverage is based on your annual base salary. Taxes and benefit limits may apply. Please visit http://mybenefits.teletech.com for more details.

Q. Do I need to enroll to receive Basic Life Insurance coverage?
A. No, you will be automatically enrolled.

Q. Who can I call if I would like more information about Basic Life coverage?
A. Please open an AskNOW ticket for more information

Q. How do I designate a beneficiary?
A. To complete the life insurance beneficiary designation visit www.metlife.com/mybenefits.

Q. How do I file a claim?
A. Contact the TeleTech Benefit team who will provide guidance and help you get the proper forms submitted to MetLife. After the claim has been submitted you can check the status by contacting MetLife directly 800.638.6420

Basic Accidental Death and Dismemberment (AD&D) Insurance

Q. What is Basic AD&D Insurance?
A. Accidental Death and Dismemberment (AD&D) insurance is insurance which will pay a lump sum benefit to you, if you are seriously injured (e.g., paralyzed, lose an arm or leg) or to your designated beneficiaries (e.g., spouse, dependents, parents, siblings, or anyone you designate) if you die as a result of a covered accident.

Q. How much does Basic AD&D Insurance cost?
A. This coverage is provided and paid for by TeleTech; there is no cost to you for this benefit.

Q. Who can be covered by the Basic AD&D policy?
A. Only you, as the employee, are covered by the Basic AD&D insurance policy.

Q. How much Basic AD&D Insurance can I have?
A. The Basic AD&D Insurance coverage is based on your annual base salary and is equal to your Basic Life insurance coverage amount. Taxes and benefit limits may apply. Please visit http://mybenefits.teletech.com for more details.

Q. Do I need to enroll to receive Basic AD&D Insurance coverage?
A. No, you will be automatically enrolled.

Q. How do I file a claim?

A. Contact the TeleTech Benefit team who will provide guidance and help you get the proper forms submitted to MetLife. After the claim has been submitted you can check the status by contacting MetLife directly 800.638.6420

Q. Who can I call if I would like more information about Basic AD&D coverage?
A. Please open an AskNOW ticket for more information.

Supplemental Life Insurance

Q. What is Supplemental Life Insurance?
A. Supplemental Life insurance is additional life insurance that you can purchase on top of the Basic Life Insurance coverage that the company provides. These additional life insurance benefits, if purchased, will be paid to your designated beneficiaries (e.g., spouse, dependents, parents, siblings, or anyone you designate) upon your death. You may change your beneficiaries at any time on the MetLife website www.metlife.com/mybenefits . Please visit https://mybenefits.teletech.com for more details.

Q. Who can be covered by Supplemental Life Insurance?
A. You may choose to cover yourself, your spouse and/or your children. If you would like to cover your spouse or children, you must also purchase Supplemental Life Insurance coverage for yourself, in order to purchase coverage for your dependents.

Q. How much coverage do I need?
A. The amount of coverage you need, if any, will vary and should be based on your current living expenses. As you consider how much you will need, be sure to include expenses such as your current credit card debts, mortgage, day care expenses, car payments, etc. - all the expenses for your family that are currently being supported by your income. If you have questions about your personal circumstances and how much you need, we recommend that you consult with your financial or tax advisor to determine the right amount of coverage for you.

Q. How much does Supplemental Life Insurance cost?
A. The cost of supplemental life insurance coverage will depend on who you want to cover (yourself or your spouse/children), their age and the amount of coverage you elect. Please visit http://mybenefits.teletech.com which outlines the cost for supplemental life insurance coverage.

Q. How do I calculate my per pay period cost?
A. The cost will depend on who the coverage is for, their age and the amount of coverage you select. Once you have determined “how much” coverage you wish to elect, take the amount of coverage you select, divide by 1000 and then multiply that number by the applicable rate. Rates can be found at http://mybenefits.teletech.com. If you want to calculate your per pay period cost, take your monthly cost and multiply by 12 (months) and then divide by 26 (pay periods) to get your per pay period cost. Oracle will also calculate the cost for you during your enrollment. Once you elect an amount in Oracle, click on recalculate to see how the per pay period rate changes to reflect the cost of the coverage you have elected.

Q. What is evidence of insurability (EOI)?
A. Evidence of insurability is where the insurance company (MetLife) confirms that you are in good health and that there is an insurable risk. An insurable risk means that you have a legitimate reason to have an insurance policy, or your financial circumstances would be directly impacted upon the death of the insured. As part of this process you and/or your physician may be asked to complete a questionnaire. In some cases, a physical exam may be required for your physician to provide the requested information. Charges, if any, for such an exam would be your responsibility.

Q. When do I need to provide evidence of insurability (EOI)?
A. If you are a new hire (within the first 30 days of employment), or become newly eligible for the coverage (change from Part Time Regular to Full Time Regular status) you will have to provide evidence of insurability

if you wish to elect Supplemental Life Insurance coverage over $150,000 for yourself or $20,000 for your spouse. If you are a current employee, you will have to provide evidence of insurability if you enroll in supplemental life coverage for the first time, or if you wish to increase your current level of coverage. During the benefit elections process, Oracle will show the election as "suspended" if you are required to provide MetLife with Evidence of Insurability, which must be printed from mybenefits.teletech.com, completed and mailed directly to MetLife for consideration.

Q. How do I file a claim?
A. Contact the TeleTech Benefits team for guidance and help to get the proper forms submitted to MetLife. After the claim has been submitted you can check the status by contacting MetLife directly 800.638.6420

Q. How do I designate a beneficiary?
A. To complete the life insurance beneficiary designation visit www.metlife.com/mybenefits.

Need More Help? Review the Supplemental Life and AD&D Insurance certificate on http://mybenefits.teletech.com or contact MetLife or Health Advocate directly. All benefit vendor contact information can be located on http://mybenefits.teletech.com within the contact page.

Supplemental Accidental Death and Dismemberment (AD&D) Insurance

Q. What is Supplemental AD&D Insurance?
A. Supplemental accidental death and dismemberment insurance is additional insurance that you can purchase on top of the Basic AD&D insurance coverage that the company provides. Your amount of supplemental AD&D coverage will be equal to the amount of supplemental life insurance coverage, if any, that you elected. This insurance will pay a lump sum benefit to you, if you are seriously injured (e.g., paralyzed, lose an arm or leg) or to your designated beneficiaries (e.g., spouse, dependents, parents, siblings, or anyone you designate) if you die as a result of a covered accident. Please visit http://mybenefits.teletech.com for more details.

Q. Who can be covered by Supplemental AD&D Insurance?
A. You may choose to cover yourself and/or your spouse. If you would like to cover your spouse, you must also purchase Supplemental AD&D insurance coverage for yourself.

Q. How much coverage do I need?
A. The amount of your supplemental AD&D coverage will be equal to your supplemental life insurance amount. And, the amount of supplemental life insurance coverage you need, if any, will vary based on your current living expenses. (See Supplemental Life Q&A).

Q. How much does Supplemental AD&D Insurance cost?
A. The cost will depend on your age and the amount of coverage you select. Visit http://mybenefits.teletech.com to view the cost per $1,000 of coverage for you and/or your spouse.

Q. Who can I call if I would like more information about Supplemental AD&D coverage?
A. Please submit an AskNow ticket for more information.

Q. How do I calculate my per pay period cost?
A. The cost will depend on your age and the amount of coverage you select. Once you have determined "how much" coverage you wish to elect, take the amount of coverage you elect, divide by 1000 and then multiply that number by the applicable rate. Visit http://mybenefits.teletech.com to get your monthly cost. If you want to calculate your per pay period cost, take your monthly cost and multiply by 12 (months) and then divide by 26 (pay periods).

Q. How do I file a claim?
A. Contact the TeleTech Benefits team for guidance and help to get the proper forms submitted to MetLife. After the claim has been submitted you can check the status by contacting MetLife directly 800.638.6420

Q. Who can I contact if I would like more information about Supplemental AD&D coverage?
A. Please review the Supplemental Life and AD&D Insurance certificate on http://mybenefits.teletech.com or open an AskNOW ticket for more information

Need More Help?

Click here to review the Resources section of the Supplemental Life and AD&D Insurance page or contact MetLife directly. All benefit vendor contact information can be located on http://mybenefits.teletech.com within the contact page.

Pet Insurance

Q. I have heard we offer a type of Pet Insurance, is it also pre-tax?
A. We do have Pet insurance through VPI. All employees will receive a group discount however the insurance is not pre-tax. You may enroll in VPI at any time but there is a 30-day waiting period to use it.

Q. How does the Pet Insurance work?
A. You enroll by contacting VPI directly, send premiums to VPI (no payroll deductions). Visit any vet, submit a claim and receive reimbursement, that's it.

Q. Do I elect the pet insurance in Oracle during Open Enrollment?
A. No, you can enroll in the pet insurance at any time by calling VPI directly.

Need More Help?

Click here to review the VPI information or contact VPI directly. All benefit vendor contact information can be located on http://mybenefits.teletech.com within the contact page.

Commuter Plan

Q. What is a Commuter Plan?
A. A Commuter Plan allows you to set aside money from each pay check (before taxes come out) to pay for work related public transportation and parking expenses.

Q. Why should I use a Commuter Plan?
A. If you pay for commuting expenses to get to work, enrolling in a commuter plan allows you to pay these expenses with pre-tax dollar and lowers your taxable wages, which will save you money.

Q. How do I enroll in the Commuter Plan?
A. You enroll in the commuter plan through the Employee Self Service System and contribute through payroll deduction on a pre-tax basis.

Q. How do I file for reimbursement?
A. Submit receipts for transportation to Discovery Benefits for reimbursement from your Commuter Plan account. Contact Discovery Benefits at 1.866.451.3399 www.discoverybenefits.com

Employee Assistance Program (EAP)

Q. What is an Employee Assistance Program?
A. The Employee Assistance Program is a service that is available to all employees and their families. An EAP provides short term counseling for any legal, financial, childcare, emotional or work-life issues that you may be facing. They have lots of resources to share and can help you find a childcare provider, financial advisor and much more. To reach them, call 866-379-0898 or visit www.guidanceresources.com for more information.

Q. How does the Employee Assistance Program work?
A. To take advantage of the EAP benefits provided by TeleTech all you need to do is call Guidance Resources 24 hours a day, 7 days a week at 1.866.379.0898 or you can visit their website at www.guidanceresources.com, and use TeleTech's company ID is MY2102X. They can help you to find childcare, plan for college, and much more.

Q. How much does the Employee Assistance Program cost?
A. This benefit is provided and paid for by TeleTech, there is no cost to you for this benefit.

Q. Is the EAP only available to current employees?
A. No, all employees have access to the EAP services for up to 18 months after separation from the company.

Qualifying Life Event (QLE) Information

Q. What is a qualifying life event?
A. ERISA qualifying events are marriage, divorce, legal separation, birth or adoption of a child, legal custody of a child, dependent no longer eligible due to reaching age 26 or gaining employment through an employer's group plan, death of a dependent, termination of employment or insurance of a dependent, reduction of hours of dependent (i.e. dependent goes to or from full-time regular status), plan ends benefits to a class of similarly situated individuals, court order requiring coverage of a dependent, active duty or returning from active duty, child gains or ends coverage under CHIP or Medicaid or becomes eligible for State premium assistance under those programs, or an employee or dependent becomes eligible for Medicare. In order to change any benefits during the year on "pre-tax" basis, you must have a qualifying life event, submit proper documentation and make your elections within 31 days of the event date. During a Qualifying Life Event you are only able to change the coverage level of the plan you have in place, a QLE does not allow you to change plans.

Q. Can I make any changes I want to if I have a qualifying life event?
A. No, each qualifying life event is specific to certain possible changes. For example, if you have a baby, you can add your child to your coverage however you would not have an option to cancel coverage. If you lose other coverage you would have the option to add coverage, not cancel coverage.

Q. What changes can I make within each life event?
A. You can add coverage within 31 days of the below life events:

- New Hire
- Rehire
- You or a dependent loses other coverage
- Moving from temporary to regular employment status

You can add dependents to your coverage within 31 days of the below life events:

- Your spouse loses employment/other coverage
- You gain a child or legal custody
- Marriage/Common Law/Domestic Partner
- Your dependent loses other coverage

You can remove coverage within 31 days of the below life events:

- You gain other coverage
- Moving from regular to temporary status

You can remove dependents from your coverage within 31 days of the below life events:

- Death of a dependent
- Divorce/legal separation
- Your dependent gains other coverage
- Your dependent turns 26 and becomes ineligible for coverage (this happens automatically on the last day of the month in which your dependent turns 26)

Q. We are having a baby, how do I add the baby to my health insurance and is this a qualifying event?

A. To add your new baby to your insurance you would access Oracle (from a non-company computer you would go to https://erp.teletech.com) and select Employee Self Service, select the benefits folder, select Update Benefits, Accept the disclaimer, enter the dependents information and use the reason code birth/adoption click next. Create an AskNOW ticket and provide the birth certificate (if the birth certificate has not yet been issued you can provide the crib sheet from the hospital that shows the date of baby's birth is within the past 31 days). Once your AskNOW ticket is addressed, you will be notified within your ticket when your enrollment window is open in Oracle Self Service. It will be your responsibility to elect coverage for your newborn in Oracle during your enrollment period. If you miss the timeline your next opportunity to make changes would be the next qualifying event or open enrollment.

Q. We are adopting a child, how do I add the child to my benefits?

A. To add your new child to your insurance you would access Oracle (from a non-company computer you would go to https://erp.teletech.com) select Employee Self Service, select the benefits folder, select Update Benefits, Accept the disclaimer, enter the dependents information and use the reason code birth/adoption click next. Create an AskNOW ticket and attach the supporting documentation. Once your AskNOW ticket is addressed, you will be notified within your ticket when your enrollment window is open in Oracle Self Service. It will be your responsibility to make changes to your benefits in Oracle during your enrollment period. Select the program US Employee Benefits and follow the prompts. You have 31 days from the date of birth/adoption to add the new child to your benefits and provide a copy of the adoption/placement papers. Please create an ASKNOW ticket and attach a copy of the adoption/placement papers. If you miss the timeline your next opportunity to make changes would be the next qualifying event or open enrollment.

Q. We have legal custody of a child, how do I add the child to my benefits?

A. If you have recently gained legal custody of a dependent, please create an ASKNOW ticket requesting your benefit window be opened so you can elect coverage and attach documentation showing the custody date, child's name, etc. You only have 31 days from the date the court document is signed. Once the window is open (from a non-company computer you would go to https://erp.teletech.com) select Employee Self Service, select the benefits folder, select Update Benefits, Accept the disclaimer, skip the contact page and click next. Select the option US Employee Benefits and follow the prompts. If you miss the timeline your next opportunity to make changes would be the next qualifying event or open enrollment.

Q. I'm getting married, how do I add my spouse to my benefits?

A. If you are getting married and wanted to add your new dependent(s) you would access Oracle (from a non-company computer you would go to https://erp.teletech.com) select Employee Self Service, select the benefits folder, select Update Benefits, Accept the disclaimer, enter the dependents information and use the reason code marriage, click next. Create an AskNOW ticket and attach the supporting documentation. Once your AskNOW ticket is addressed, you will be notified within your ticket when your enrollment window is open in Oracle Self Service. It will be your responsibility to make changes to your benefits in Oracle during your enrollment period. Select the program US Employee Benefits and follow the prompts. Create a ticket and attach a copy of the marriage certificate. You only have 31 days from the date of marriage to add your new spouse.

Q. My child is moving back home with me, is this a qualifying event?

A. A child moving to or from one parent to the next is not a qualifying event unless there is an update to the custody order. If there is an update to the custody order, please create an ASKNOW ticket, attach a copy of the revised custody order showing the effective date and the date the document was signed by the judge. You only have 31 days from the custody order date to make changes to your benefits. You would access Oracle (from a non-company computer you would go to https://erp.teletech.com select Employee Self Service, select the benefits folder, select Update Benefits, Accept the disclaimer, enter the dependents information and use the reason code birth/adoption click next. Select the program US Employee Benefits and follow the prompts. Create a ticket and attach a copy of the revised custody order. If you miss the timeline your next opportunity to make changes would be the next qualifying event or open enrollment.

Q. My spouse gained coverage with another employer, how do I make changes to my plan?

A. If your spouse gained coverage with another plan, you would need to create an AskNOW ticket requesting your benefit window be opened so you can elect coverage and attach documentation from a spouse's employer/insurance company showing the date the new insurance begins. You only have 31 days from the date the coverage begins. Once the window is open you would go to https://erp.teletech.com) or from a work computer you would access Oracle. Select Employee Self Service, select the benefits folder, select Update Benefits, Accept the disclaimer, skip the contact page and click next. Select the program US Employee Benefits and follow the prompts. If you miss the timeline your next opportunity to make changes would be the next qualifying event or open enrollment.

Q. If my dependent passes away, how do I change my benefits?

A. You may change your benefits if a dependent passes away. You would need to email benefits.teletech.com to request your benefit window be opened so you can change coverage and attach a copy of the death certificate. Once the window is open you would go to https://erp.teletech.com or from a work computer you would access Oracle. Select Employee Self Service, select the benefits folder, select Update Benefits, Accept the disclaimer, skip the contact page and click next. Select the program US Employee Benefits and follow the prompts.

Q. Can I change my elections if I go on or come back from Active Duty?

A. You may change your benefits if you are called to active duty or returning from active duty. You would need to create an AskNOW ticket requesting your benefit window be opened so you can elect coverage and attach a copy of the active duty paperwork. You would access Oracle (from a non-company computer you would go to https://erp.teletech.com) or from a work computer you would access Oracle. Select Employee Self Service, select the benefits folder, select Update Benefits, Accept the disclaimer, skip the contact page and click next. Select the program US Employee Benefits and follow the prompts. You only have 31 days from the event date to make your changes. If you miss the timeline your next opportunity to make changes would be the next qualifying event or open enrollment.

Q. If I become eligible for Medicaid, can I change my elections?

A. You may change your elections if you become eligible for Medicaid. You only have 31 days to make those changes from the date you became eligible. You would need to create an ASKNOW ticket and attach the Medicaid award letter showing the name of the covered person and the effective date. You will receive a response within your ticket stating you can now go in and make your elections. You would access Oracle (from a non-company computer you would go to https://erp.teletech.com) and select Employee Self Service, select the benefits folder, select Update Benefits, Accept the disclaimer, skip the contact page and click next. Select the program US Employee Benefits and follow the prompts. If you miss the timeline your next opportunity to make changes would be the next qualifying event or open enrollment.

Q. If I become eligible for Medicare, can I change my elections?

A. You may change your elections if you become eligible for Medicare. You only have 31 days to make those changes from the date you became eligible. You would need to create an ASKNOW ticket and

attach the Medicare award letter showing the name of the covered person and the effective date. You will receive a response within your ticket stating you can now go in and change your elections. You would access Oracle (from a non-company computer you would go to https://erp.teletech.com) or from a work computer you would access Oracle. Select Employee Self Service, select the benefits folder, select Update Benefits, Accept the disclaimer, skip the contact page and click next. Select the program US Employee Benefits and follow the prompts. If you miss the timeline your next opportunity to make changes would be the next qualifying event or open enrollment.

Q. Can I change my elections if I become eligible/covered for Exchanges or MarketPlace?

A. You may change your elections if you become eligible for coverage through the exchange or MarketPlace. You only have 31 days to make those changes from the date you became eligible. You would need to create an AskNOW ticket and attach the award letter showing the name of the covered person and the effective date. You would access Oracle (from a non-company computer you would go to https://erp.teletech.com) or from a work computer you would access Oracle. Select Employee Self Service, select the benefits folder, select Update Benefits, Accept the disclaimer, skip the contact page and click next. Select the program US Employee Benefits and follow the prompts. If you miss the timeline your next opportunity to make changes would be the next qualifying event or open enrollment.

Q. My dependent lost their job, can I make changes to my plan?

A. You may change your elections if your dependent loses their job or insurance coverage. You only have 31 days to make those changes from the date their employed ended or when their insurance ended. You would need to create an ASKNOW ticket and attach a copy of a letter from their prior employer or insurance carrier showing the loss of coverage and the effective date. You would access Oracle (from a non-company computer you would go to https://erp.teletech.com) or from a work computer you would access Oracle. Select Employee Self Service, select the benefits folder, select Update Benefits, Accept the disclaimer, skip the contact page and click next. Select the program US Employee Benefits and follow the prompts. If you miss the timeline your next opportunity to make changes would be the next qualifying event or open enrollment.

Q. I am getting a divorce, when can I make changes to my elections?

A. If you are in the process of getting a divorce, you can change your benefits when the divorce is final, when you have a legal separation or at open enrollment. You have 31 days from the event date to provide the documentation via an AskNOW ticket and make your benefit changes. If you miss the timeline your next opportunity to make changes would be the next qualifying event or open enrollment.

Q. What documentation do I need to provide for a qualifying life event?

A. The documentation you would need to insure a qualifying event would be paperwork showing the event, effective date and the members that are affected. You only have 31 days from the event date to provide the documentation via AskNOW and make changes to your benefits in Oracle Self Service. If you miss the timeline your next opportunity to make changes would be the next qualifying event or open enrollment.

Q. What are the qualifying events to gain coverage under the MarketPlace?

A. A qualifying life event to gain coverage under the MarketPlace includes such life events as: moving to a different state, certain types of changes to your income, and changes in your family size (for example, if you marry, divorce, or have a baby). For a complete list of qualifying event for the MarketPlace, please go to https://www.healthcare.gov. *Moving to a different state is not considered a qualifying life event to change your group coverage because the same benefits are offered in all states.

Q. Who can I contact if I have more questions about Qualifying Life Events?

A. You can open an AskNOW ticket or call the benefits message line 800.503.2626.

Need More Help?

To find out more information regarding the state MarketPlace, please go to: www.healthcare.gov for questions regarding qualifying life events, you may contact the Global Benefits message line at 1.800.503.2626 or open an AskNOW ticket https://asknow.teletech.com

Medical Support Order

Q. What is a medical Support Order?
A. A medical Support Order requires the company to give children benefits. Benefits could be medical, dental and/or vision coverage.

Q. Can I receive a copy of the Medical Support Order from the company?
A. Copies are only available from the courts. We as a company cannot give you a copy of the order we receive.

Q. How do I stop the Medical Support Order?
A. You would need to go to the court that issued the order and work with them on why the order needs to be stopped. If they agree the order should be stopped they should mail the stop order to TeleTech Services, Inc. 9197 S. Peoria St., Englewood, CO 80112 or fax to: 303-649-1024.

Q. Can I cover other dependents that aren't listed on the order?
A. The medical support order is to cover the dependent(s) listed and the plans the courts require. You cannot change or make additional elections when we receive a medical support order.

Need More Help?

For additional information regarding your Medical Support order, please work with the court that issued the order.

AskNOW Tickets

Q. How can I access AskNOW outside of work?
A. Visit https://asknow.com and log in with your Windows NT credentials.

Q. What if I can't access AskNOW with my Windows NT credentials?
A. Work with your team lead or manager who can open an AskIT ticket on your behalf.

Q. Where can I find an AskNOW job aid?
A. You can find a job aid for AskNOW within Mosaic by clicking here or by searching 'Ask Now Self Service: Getting Started**.**

Benefits After Separation

To learn more about benefits after separation, please visit the Enroll and Change Benefits tile on http://mybenefits.teletech.com

Q. If a former employee needs assistance, how to they get the answers they need?

A. Former employees can visit AskNOW by typing in formeremployee.teletech.com in their browser, or through the direct link: https://asknow.service-now.com/former-employee.do

The landing page on the website is used for various requests and there is an FAQ section where the following links are housed:

- How to print check stubs: https://ipay.adp.com and http://formeremployee.teletech.com
- How to confirm when their benefits cease: https://mybenefits.teletech.com and http://formeremployee.teletech.com
- Who to contact regarding benefit questions: https://mybenefits.teletech.com and http://formeremployee.teletech.com
- For documents such as DHS forms for proof of employment: https://formeremployee.teletech.com
- For refunds or concerns about their company kitchen account: https://companykitchen.com

Marketplace Coverage

Q. What happens if I don't have health insurance that meets the Health Care Reform Requirements on and after January 1, 2017?

A. If you don't have health insurance, through TeleTech, a private insurance company or the Government that meets the Health Care Reform basic minimum standards, you may be required to pay an income tax penalty to the federal government. The penalty will be assessed for every month in which you do not have qualifying health coverage beginning on January 1, 2017. You will be required to pay the accumulated penalty amount in full each year by reporting the amount on your federal income tax return.

Q. What is a health insurance "marketplace?"

A. The marketplace (or "exchange") is an online portal that allows you to shop and compare health plans (outside of TeleTech's employee plans). It can help you to explore all of the available options. With one application, you can:

- learn if you can get lower costs based on your income
- compare your coverage options side-by-side and enroll
- get answers to questions
- find out if you qualify for Medicaid
- determine if you are eligible for tax credits for private insurance
- enroll in a health plan that meets your needs

Marketplace representatives will be your primary resource for determining your eligibility for your state's Medicaid benefits. As a result of Health Care Reform, some states have expanded Eligibility for Medicaid.

Q. If I want to get my 2017 health insurance through my state's marketplace, what's the process?

A. Your state's marketplace will remain open through January 31, 2017, for plans that will provide benefit coverage in the 2017 plan year. Start at the www.healthcare.gov website to find the link to your state's marketplace information.

Changing Employment Status

Q. What happens if I change from Regular Full Time to Regular Part Time status or vice versa?

A. After a status change as a regular employee, all benefits end on the last day of your current status and you would have 31 days to elect new benefits in Oracle Self Service. Benefits do not roll over automatically. Please visit http://mybenefits.teletech.com

Nothing changes about your 401K, it remains in effect. Changes to your 401K can be made at www.benefits.ml.com. All benefits currently in place will end on the last day of your current status and you would have to re-elect any benefits you want to have within the first 31 days of changing your status. Deductibles for dental start over at that time.

Q. When do my benefits start after I change from Full Time to Part Time or vice versa?
A. If you have been employed for longer than 30 days, your part-time benefit effective date will be the same as your status change date. If you have not been employed for longer than 30 days, benefits begin on the first of the month following your first 30 days of employment.

Things to consider when changing from Full Time to Part Time:

- ✓ Losing coverage is considered a Qualifying Life Event which would allow you 30-60 days to obtain coverage elsewhere i.e. https://www.healthcare.gov/ or www.ehealthinsurance.com
- ✓ If adding coverage for any dependents that have not been covered on a TeleTech plan before, you must provide dependent verification via AskNOW within the first 31 of coverage e.g. birth certificates for any children, and either a marriage certificate or the most recent tax return (front page only) that shows you filed married. If covering a same sex domestic partner, you must request an Affidavit via AskNOW and provide proof of shared residency.

Q. How does the status change happen?
A. Once your Team Lead changes your status in Oracle, your current benefits end on the last day of your current status and a 31-day benefit window opens for you to elect new benefits. This is considered a QLE (Qualifying Life Event).

Important Contact Information

Plan	Website	Phone Number	Group Number
Prescriptions *Express-Scripts*	www.express-scripts.com/teletech	1.855.687.3854	
Medical *Anthem*	www.anthem.com	1.844.301.5620	174199
Dental *Delta Dental PPO of CO*	www.deltadentalco.com/subscriber.aspx	1.800.610.0201	0109
Vision *VSP*	www.vsp.com/home.html	1.800.877.7195	12193699
EAP	www.guidanceresources.com	1.866.379.0898	MY2102X (case sensitive)
	www.connectyourcare.com	1.877.292.4040	

FSA ***Connect Your Care***			
Commuter Plan	www.discoverybenefits.com	1.866.451.3399	
Life Insurance, AD&D, STD, and LTD. Group Accident Plan ***MetLife***	www.metlife.com/mybenefits Hyatt Legal access code is **6090815**	1.800.638.6420	143329
401(k) ***Merrill Lynch***	www.benefits.ml.com	1.800.228.4015	
Cobra ***Discovery Benefits***	www.discoverybenefits.com	1.866.451.3399	