

2024 Benefits Guide

Platinum

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The benefits illustrated in this guide are meant to serve as a summary of the benefits available under each carrier's plan. Refer to the carrier's plan summary for full benefit information. Should any discrepancies arise, the carrier's documents supersede these illustrations.

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If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. See the last page of this booklet for more details.



Investing in your wellbeing

As an organization, one of our top priorities is to maintain the health and wellbeing of our employees and their families. To achieve this goal, we offer a robust and comprehensive program with a variety of options to best meet your needs.

Eligibility

You are eligible for benefits date of hire if you are a full-time employee (unless otherwise specified by your employer).

Enrolling dependents

You may also enroll eligible dependents for benefit coverage. When covering dependents, you must select the same plans for your dependents as you select for yourself.

Dependents include

Your legal spouse or qualified domestic partner.
Your children, which may include natural, adopted, or stepchildren.
Your qualified domestic partner's children.

Qualifying events

A qualifying event allows you to add or remove dependents from the plan within 30 days of the qualifying event.

Typical qualifying events include marriage, divorce, termination of a qualified domestic partnership; birth or adoption of a child; death of a spouse or dependent; end in your spouse's employment or group insurance coverage.

Your benefits portal

[Sequoia Benefits Portal](#)



Summary of medical, dental, & vision contributions

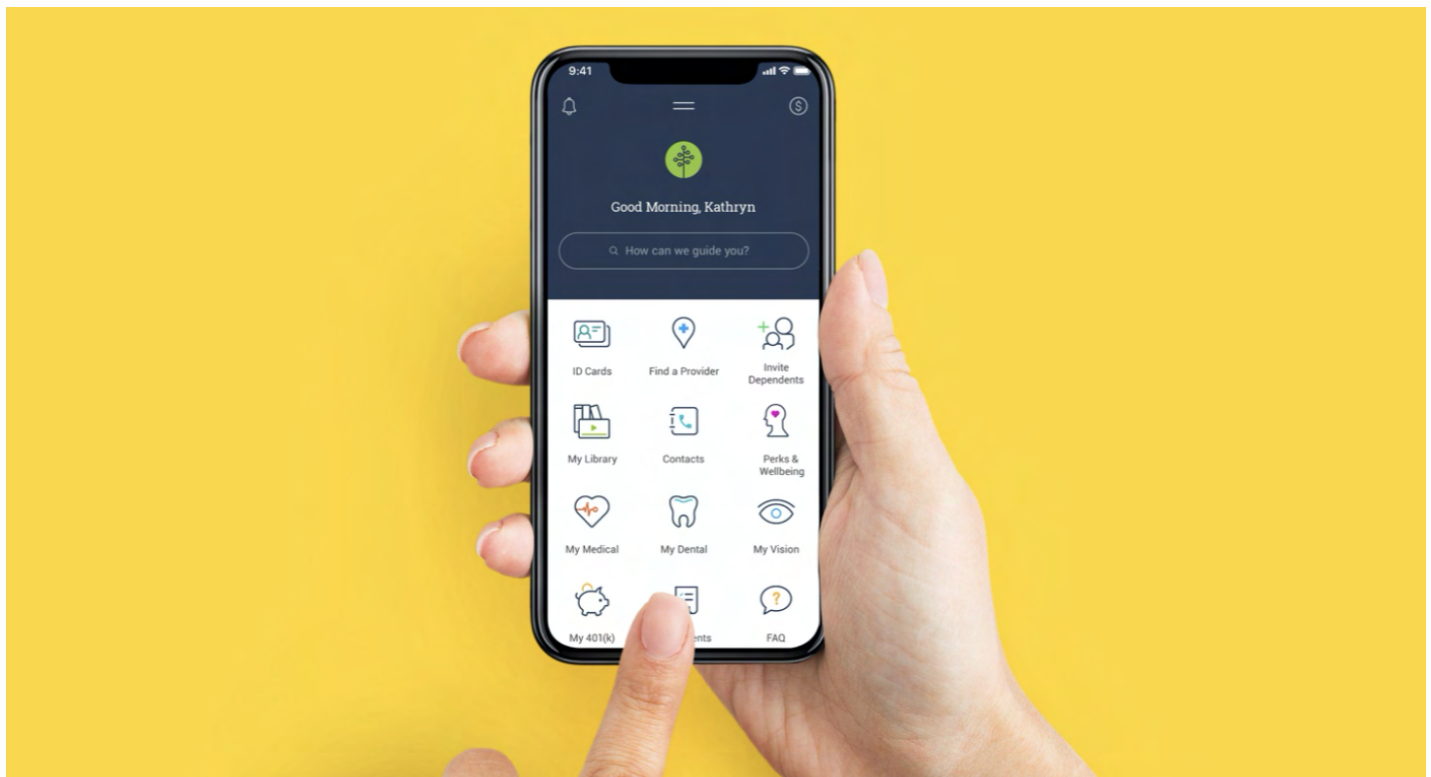
Here's what you'll pay each month to have insurance.

| | Employee only | Employee & spouse | Employee & children | Employee & family |
|-----------------------------|---------------|-------------------|---------------------|-------------------|
| Medical plan | | | | |
| United Healthcare PPO 250 | \$158.58 | \$872.74 | \$605.73 | \$1,472.47 |
| United Healthcare EPO 1000 | \$71.07 | \$688.96 | \$452.59 | \$1,205.56 |
| United Healthcare HDHP 1600 | \$0.00 | \$511.79 | \$304.95 | \$948.23 |
| United Healthcare HDHP 2500 | \$0.00 | \$446.20 | \$250.30 | \$852.98 |
| United Healthcare HDHP 6550 | \$0.00 | \$67.66 | \$0.00 | \$303.19 |
| Kaiser Permanente HDHP 2500 | \$0.00 | \$0.00 | \$0.00 | \$359.51 |
| Dental plan | | | | |
| Guardian Low DPPO | \$9.58 | \$49.06 | \$56.26 | \$102.92 |
| Guardian High DPPO | \$16.74 | \$85.74 | \$98.31 | \$179.85 |
| Vision plan | | | | |
| Guardian Vision | \$0.00 | \$0.00 | \$0.00 | \$0.00 |

Note about domestic partner coverage

Domestic partner contributions are taken on a post-tax basis, per federal IRS regulations. Contributions made by the employer for domestic partners (or domestic partner children) may be subject to imputed income for the employee. State tax laws may vary regarding taxation of domestic partner benefits. Please speak with your tax adviser for more details.





The Sequoia mobile app

You can find information about your employer-provided benefits through the Sequoia mobile app. Use the app to access your insurance cards, check plan coverage, arrange a virtual doctor visit, and more.

Key features:

- View your member ID Cards
- See medical, dental, and vision plan balances and coverage details
- Find a provider
- Get support from an Employee Advocate, a member of our Customer Service team
- Get reimbursements through a Flexible Spending Account
- Link your 401(k) account for balances and fund allocations

To download the app, search for “**Sequoia**” in your app store or click the icons below.



Common insurance terms

As an organization, one of our top priorities is to maintain the health and wellbeing of our employees and their families. To achieve this goal, we offer a robust and comprehensive program with a variety of options to best meet your needs.

Coinsurance

The percentage of the charges the member is required to pay for a medical service in a plan after the deductible has been met. For example, the insurance company may pay 80% of the covered claim, and the member pays the remaining 20%.

Copayment/copay

The fixed amount paid by the member when a medical service is received (e.g., \$20 for a doctor's visit or \$20 for a prescription). Copays do not apply to the deductible.

Deductible

The amount the member pays for covered health care services before the insurance plan starts to pay.

Exclusive provider organization (EPO)

The amount the member pays for covered health care services before the insurance plan starts to pay.

High deductible health plan (HDHP)

A HDHP is a plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but the member pays more health care costs before the insurance company starts to pay its share (the deductible). A high-deductible health plan (HDHP) can be combined with a Health Savings Account (HSA), allowing the member to pay for certain medical expenses with money free from federal taxes.



In-network provider

An in-network provider is a hospital, doctor, medical group, and/or other healthcare provider contracted to provide services to insurance company customers for less than their usual fees.

Out-of-network provider

An out-of-network provider is a hospital, doctor, medical group, and/or other healthcare providers who is not contracted to provide services to insurance company customers for less than their usual fees and can charge the member any rate they choose.

Out-of-pocket maximum (OOP)

The maximum amount the member would have to pay in a plan year for eligible expenses. After reaching the out-of-pocket maximum, the plan pays 100% of the allowable charges for covered services that are “in network” for the remainder of the plan year

Preferred provider organization (PPO)

A PPO is a group of hospitals and physicians that are contracted with insurance companies to provide medical services. Out-of-pocket costs are lower when a provider is used within the PPO network (in-network).

Out-of-network FAQs

What if I choose an out-of-network provider for my medical plan?

Out-of-network providers can charge whatever they want for a service while in-network providers only charge the pre-negotiated rate they have with the insurance company.

Out-of-pocket costs for out-of-network services will be higher than in-network costs.

Since the out-of-network provider can charge whatever they want, you will be “balance billed” for the difference between what the provider charges and the insurance carrier’s allowed amount. You will be responsible for paying the difference.

How much might I pay if a provider charges \$10,000 for services?

| | In-network provider | Out-of-network provider |
|--------------------------------------|---|---|
| Provider’s charge for service | \$10,000 | \$10,000 |
| Provider’s allowed amount | \$6,000 | \$6,000 |
| Patient’s deductible | \$250 | \$500 |
| Patient’s coinsurance | \$10% of allowed amount after deductible (10% of \$5,750) = \$57 | 30% of allowed amount after deductible (30% of \$5,500) = \$1,650 |
| | Insurance pays the rest | Balance between allowed amount and provider’s fee |
| Total patient responsibility | \$825 \$575 coinsurance + \$250 deductible | \$6,150 \$10,000 charge - \$6,000 allowed amount + \$500 deductible + \$1,650 coinsurance |



Medical PPO plan

How does this plan work?

- The member can choose to receive medical care from hospitals and doctors of their choice, but the member gets the greatest cost savings when they utilize providers in the PPO network.
- The member can see specialists at any time without needing a referral from their primary doctor.
- PPO plans have an annual deductible, or set dollar amount, the member must pay before the insurance carrier begins paying their portion of medical expenses.
- After the deductible amount is met, the member is responsible for the coinsurance, which is a percentage of the total cost for services, up to the out-of-pocket maximum, at which point the plan pays 100% of all costs through the end of the calendar year.
- The member pays nothing out-of-pocket for in-network preventive care.
- Amounts shown below represent what the member will be responsible for paying.
- Out-of-network reimbursements are based on the insurance carrier’s “allowed amount.” The member is responsible for the amount their provider charges above the “allowed amount.”
- Accumulated expenses such as deductible and out-of-pocket maximum reset each calendar year on January 1.

| | Deductible | Out-of-pocket maximum | Co-insurance | Primary care provider copay | Prescription drugs |
|--|----------------------------------|-------------------------------------|--------------|--|--|
| United Healthcare PPO 250 | | | | | |
| In-network Choice Plus network | Single: \$250 Family: \$750 | Single: \$2,250 Family: \$4,500 | 10% | \$20 copay per visit (deductible waived) | Tier 1: \$10 Tier 2: \$20 Tier 3: \$40 |
| Out-of-network | Single: \$750 Family: \$2,250 | Single: \$6,500 Family: \$13,000 | 30% | +30% after deductible | Contact United Healthcare for details |



Medical HDHP plan

How does this plan work?

- Members of a high deductible health plan (HDHP) are eligible for a tax-free, pre-tax Health Savings Account (HSA) that helps offset costs associated with the HDHP plan.
- The member can choose to receive medical care from hospitals and doctors of their choice, but there are greater cost savings when the member utilizes providers in the network.
- HDHP plans have a high annual deductible, or set dollar amount, that the member must pay before the insurance carrier begins paying for medical expenses.
- After the deductible amount is met, the member is responsible for the coinsurance, which is a percentage of the total cost for services, up to the out-of-pocket maximum, at which point the plan pays 100% of all costs through the end of the calendar year.
- The member pays nothing out-of-pocket for in-network preventive care.
- Amounts shown below represent what the member will be responsible for paying. Out-of-network reimbursements are based on the insurance carrier's "allowed amount." The member is responsible for the amount the provider charges above the "allowed amount."
- Accumulated expenses such as deductible and out-of-pocket maximum reset each calendar year on January 1.

| | Deductible | Out-of-pocket maximum | Co-insurance | Primary care provider copay | Prescription drugs |
|--|------------------------------------|-------------------------------------|--------------|-------------------------------|--|
| United Healthcare HDHP 1600 | | | | | |
| In-network Choice Plus network | Single: \$1,600 Family: \$3,200 | Single: \$2,500 Family: \$5,000 | 10% | \$0 + 10% after deductible | Tier 1: \$10 Tier 2: \$30 Tier 3: \$50 |
| Out-of-network | Single: \$1,600 Family: \$3,200 | Single: \$5,000 Family: \$10,000 | 30% | +30% after deductible | See summary |
| United Healthcare HDHP 2500 | | | | | |
| In-network Choice Plus network | Single: \$2,500 Family: \$5,000 | Single: \$3,425 Family: \$6,850 | 0% | \$0 + 0% after deductible | Tier 1: \$10 Tier 2: \$30 Tier 3: \$50 |
| Out-of-network | Single: \$2,500 Family: \$5,000 | Single: \$7,000 Family: \$14,000 | 30% | +30% after deductible | See summary |



| | Deductible | Out-of-pocket maximum | Co-insurance | Primary care provider copay | Prescription drugs |
|--|---|--------------------------------------|--------------|---|--|
| Kaiser Permanente HDHP 2500 | | | | | |
| In-network Choice Plus network | Single: \$2,500 Family: \$5,000 | Single: \$4,500 Family: \$9,000 | 10% | \$30 copay per visit (after deductible) + 0% after deductible | Tier 1: \$10 Tier 2: \$30 Tier 3: \$30 |
| Out-of-network | There is no out-of-network coverage for this plan. If you go out-of-network, you are responsible for the total cost. | | | | |
| United Healthcare HDHP 6550 | | | | | |
| In-network Choice Plus network | Single: \$6,550 Family: \$8,550 | Single: \$7,000 Family: \$8,550 | 30% | \$0 + 30% after deductible | Tier 1: \$10 Tier 2: \$30 Tier 3: \$50 |
| Out-of-network | Single: \$8,000 Family: \$16,000 | Single: \$16,000 Family: \$32,000 | 40% | +40% after deductible | See summary |



Health Savings Account (HSA)

| | Employee only | Employee + family |
|--|---|--|
| Maximum pre-tax contribution amount | Up to \$4,150 annually for 2024 | Up to \$8,300 annually for 2024 |
| | Members who are 55 years or older are eligible to make “catch-up” contributions up to an additional \$1,000 annually. | |
| What expenses are allowed? | Eligible Medical, dental, and vision deductibles Prescription medication copays Acupuncture and chiropractor Labs and x-rays | Not eligible Over-the-counter medication Cosmetic or elective surgery Personal trainers Marriage or career counseling |
| This is a partial list. See www.irs.gov for details. | | |
| Advantages of an HSA | HSA funds can be used to pay for medical, dental, vision, alternative medicine, long term care premiums, COBRA, and other covered services. | |
| | When used for eligible medical expenses, HSA funds are tax-free.* | |
| | Contributions are tax-deductible and earnings grow tax-free.* | |
| | HSA funds roll over from year-to-year. | |
| | HSA accounts are portable and yours to keep regardless of your employer or insurance carrier. | |
| | Deposits can be invested in mutual funds. | |
| How to open your HSA | To open your HSA, visit Navia: www.naviabenefits.com | |

*At the time this booklet was created, California and New Jersey did not allow an HSA tax credit for state income tax purposes. New Hampshire and Tennessee also tax HSA earnings. Please consult with your tax adviser for the most up-to-date information.



Medical EPO plan

How does this plan work?

- In-network only coverage.
- The member can see specialists at any time without needing a referral from their primary doctor.
- EPO plans typically have an annual deductible, or set dollar amount, the member must pay before the insurance carrier begins paying their portion of medical expenses.
- After the deductible amount is met, the member is responsible for the coinsurance, which is a percentage of the total cost for services, up to the out-of-pocket maximum, at which point the plan pays 100% of all costs through the end of the calendar year. The member pays a copay, or a fixed dollar amount, for primary care and/or specialist visits.
- The member pays nothing out-of-pocket for in-network preventive care.
- Amounts shown below represent what the member will be responsible for paying.
- Accumulated expenses such as deductible and out-of-pocket maximum reset each calendar year on January 1.

| | Deductible | Out-of-pocket maximum | Co-insurance | Primary care provider copay | Prescription drugs |
|--|------------------------------------|------------------------------------|--------------|--|--|
| United Healthcare EPO 1000 | | | | | |
| In-network Choice Plus network | Single: \$1,000 Family: \$2,000 | Single: \$3,000 Family: \$6,000 | 20% | \$30 copay per visit (deductible waived) | Tier 1: \$10 Tier 2: \$20 Tier 3: \$40 |



Dental plan

Dental plans offer flexibility to see any dentist or specialist in or out-of-network. Costs are lowest when the member visits a participating network provider.

When you visit the dentist, there’s no need for ID cards. Simply provide the identifying information requested by the dental office.

Out-of-network reimbursements are based on the insurance carrier’s “allowed amount.” The member is responsible for the amount their provider charges above the “allowed amount.” Accumulated expenses such as deductible and out-of-pocket maximum reset each calendar year on Jan 1.

| | Dentist charges | Deductible per member | Annual benefit maximum | Preventive services ** | Basic services ** | Major services ** | Ortho | Ortho lifetime maximum |
|--|-----------------|-----------------------|------------------------|------------------------|-------------------|-------------------|-------|---------------------------|
| Guardian Dental PPO Basic | | | | | | | | |
| In-network DentalGuard Preferred network | Fee schedule | \$50 | \$1,500 | 0% | 10% | 40% | N/A | N/A |
| Out-of-network | Fee schedule | \$50 | \$1,500 | 0% | 20% | 50% | N/A | N/A |
| Guardian Dental PPO Premier | | | | | | | | |
| In-network DentalGuard Preferred network | Fee schedule* | \$50 | \$3,000 | 0% | 10% | 40% | \$50 | \$2,000 adults & children |
| Out-of-network | 95%* | \$50 | \$2,000 | 0% | 20% | 50% | \$50 | \$2,000 adults & children |

* Fee Schedule is a different method of reimbursement. It’s based on a set fee for each service (not adjusted based on the costs in your area). Therefore, the member often gets balance billed a higher amount for seeing Out of Network providers using a “fee schedule” type of plan.

** Usual, customary, and reasonable amount (UCR) is the amount reimbursed to providers based on the prevailing fees in a specific area.

*** Please refer to the plan summary for detailed information about these categories of service.



Vision plan

Vision plans offer flexibility to see any optometrist or specialist in- or out-of-network. Costs are lowest when a member visits a participating network provider. When you visit the eye doctor, there's no need for ID cards. Simply provide the identifying information requested by the vision office.

| | Exam frequency | Exam copay | Lenses frequency | Lenses copay | Contact lenses frequency | Contact lenses copay | Frames frequency | Frames copay |
|---|---------------------|------------|---------------------|--------------|--------------------------|---------------------------|------------------------|--------------------------|
| Guardian Vision | | | | | | | | |
| In-network VSP Choice Full Feature Network | Every calendar year | \$20 | Every calendar year | \$20 | Every calendar year | 100% of amount over \$150 | Every 2 calendar years | 80% of amount over \$150 |
| Out-of-network | Every calendar year | \$20 | Every calendar year | \$20 | Every calendar year | Amount over \$100 | Every 2 calendar years | Amount over \$46 |



Additional benefits

Life insurance plan

Life insurance is designed to provide protection for the employee and their family against loss of income due to accidental death. Designate at least one beneficiary to ensure that benefits are paid out according to the member's specifications. Beneficiaries can be changed and updated at any time throughout the year. Employees are subject to accredited income on life insurance amounts over \$50,000 paid by the employer. These benefits are provided at no cost to the member. Accidental Death & Dismemberment insurance provides income protection to the member and their family in case of an accident.

Voluntary life plan

For additional protection, voluntary life insurance is offered to the employee for purchase. Monthly premiums vary based on the desired coverage level and the member's age; this will be deducted directly from the member's paycheck on a post-tax basis. The member must purchase voluntary life coverage as an employee to purchase coverage for a dependent.

For more information, please contact Sequoia at hireart@help.sequoia.com or call 844-421-7704 between 8:30 am and 5 pm Eastern Time.

Disability plan

Disability benefits protect the member and their family by providing a portion of their income during times when they are unable to work. Duration of disability is determined by a treating physician.

For more information please contact Sequoia at hireart@help.sequoia.com or call 844-421-7704 between 8:30 am and 5 pm Eastern Time.



Flexible Spending Accounts

Flexible Spending Accounts (FSA) are accounts that can be funded using pre-tax dollars deducted directly from the member's paycheck. Eligible healthcare or dependent care expenses can be reimbursed from these accounts.

Healthcare FSA accounts are for health expenses for the member and their tax dependents. Dependent care FSA accounts are for childcare and adult care expenses while the member is working. FSA elections are annual and can only be changed when a qualifying life event occurs. Navia offers three different FSA accounts: Health Care FSA, Dependent Care FSA, and Limited Purpose FSA, each of which has a maximum of pre-tax contribution amount.

For more information, visit www.naviabenefits.com.

Commuter

Through Alice, employees can claim pre-tax commuter benefits up to \$270 per month. Participation in this benefit and contribution amount can be changed at any time throughout the year.

For more information, visit www.thisisalice.com.

CommonBond

www.cbpartner.co/sequoia

CommonBond offers the only holistic student loan benefit designed to help all employees and their family members with student debt.

EmpowerDX

www.empowerdxc.com

EmpowerDX offers access to COVID-19 Testing by making it easy and compelling to take action thereby enabling people to live their best lives. They offer an easy at-home specimen collection, that is FDA (EUA) approved, available in all 50 states and provides a HIPAA compliant portal for reviewing your results

Fetch

www.fetchpet.com

Fetch by The Dodo is the most comprehensive pet insurance + health advice. Fetch pays back up to 90% of unexpected veterinary bills, so you can get your pet the best care, regardless of cost. Code: SEQUOIA25

Guardian EAP

www.ibhworklife.com

WorkLifeMatters Employee Assistance Program offers services to help promote well-being and enhance the quality of life for you and your family. Unlimited access to support and helpful resources online, and consultations with a professional counselor.

Kaiser Programs

www.healthy.kaiserpermanente.org/health-wellness

When you use your health care services, there are some important things to know that could save you time and money, and keep you feeling your best, including discounts, health coaching, and more.

SmartSpend

www.smartspendplus.perkspot.com

Curated gym discounts, travel discounts, and more through Perkspot.

SoFi

www.sofi.com/sequoia

SoFi provides great service and low rates for student loan refinancing, mortgages, and personal loans.

UHC Virtual Visits

www.uhc.com/individual-and-family-member-resources/health-care-tools/

When you need care – anytime day or night – Virtual Visits can be a great option. From treating colds and fevers to caring for migraines and allergies, you can connect with a doctor whenever, wherever. Pay \$50 or less with your UHC plan.



Getting started with your enrollment

Whether you are a new hire, making open enrollment elections, or processing a qualifying life event, you can manage your enrollment by signing into your benefits portal online.

Log in to your benefits portal: www.sequoiatech.bswift.com

Your Employee Advocate can guide you to the answers you need

Never feel lost when it comes to using your benefits. Sequoia has a team of Employee Advocates are dedicated to make sure you get the support you need. They are there to help you navigate the benefit process and even help with complex claims issues.

To contact your Employee Advocate:

Call (844) 421-7704

Email hireart@help.sequoia.com

Available Monday to Friday, 8:30 am to 5 pm PT

Physical ID cards

You can access digital, environmentally friendly ID cards in your benefits app. If you'd like to order a physical copy, you can do so by contacting the carriers.

United Healthcare

Dedicated Support: 1-866-414-1959

www.uhc.com

Kaiser Member Services:

800-464-4000

www.kp.org

Guardian Member Services:

800-595-7114

www.guardiananytime.com

Legal disclosures

You can find all legal disclosures online [here](#).

Notice of Privacy Practices

Summary of Benefits and Coverage Information

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

Women's Health and Cancer Rights Act (WHCRA)

Statement of Rights under the Newborns' and Mothers' Health Protection Act (NMHPA)

Special Enrollment Notice

Medicare Part D

Creditable Coverage Notice

Learn more

Helpful guides and more are available online at www.sequoia.com/resources

HireArt Resources

support@hireart.com

or 888-458-7530



Legal disclosures & required documents

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THIS NOTICE APPLIES TO SELF-INSURED GROUP HEALTH PLANS OF Sequoia Consulting Group, IF ANY.

Our Company's Pledge to You

This notice is intended to inform you of the privacy practices followed by the HireArt (the Plan) and the Plan's legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan. This notice is effective May 16, 2019. The Plan often needs access to your protected health information in order to provide payment for health services and perform plan administrative functions. We want to assure the participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. HireArt requires all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

Protected Health Information

Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future.

How We May Use Your Protected Health Information

Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

Payment. We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

Health Care Operations. We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs. However, we are prohibited from using or disclosing protected health information that is genetic information for our underwriting purposes. This does not apply to long term care plans.

Treatment. Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

To Business Associates. We may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.

To the Plan Sponsor. We may disclose protected health information to certain employees of HireArt for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Organ and Tissue Donation Requests. We can share health information about you with organ procurement organizations. We can also share information with a coroner, medical examiner, or funeral director when an individual dies.

Pursuant to your Authorization. When required by law, we will ask for your written authorization before using or disclosing your protected health information. Uses and disclosures not described in this notice will only be made with your written authorization. Subject to some limited exceptions, your written authorization is required for the sale of protected health information or the use or disclosure of protected health information for marketing purposes. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.



As permitted or required by law. We may also use or disclose your protected health information without your written authorization for other reasons as permitted by law. Subject to certain requirements, we are permitted by law to share information without your written authorization, including but not limited to, information on health-related benefits or services that may be of interest to you, respond to a court order, provide information to further public health activities (e.g., preventing the spread of disease), provide information for research purposes, help with product recalls, report adverse reactions to medications, report suspected abuse, neglect, or domestic violence, and prevent or reduce a serious threat to anyone's health or safety. We are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition.

Government Requests. We can use or share health information about you for workers' compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, and for special government functions such as military, national security, and presidential protective services.

YOUR RIGHTS

Right to Inspect and Copy. In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request. Your request to inspect or review your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to inspect and copy your health information. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to amend your health information. If we deny your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.

Right to an Accounting of Disclosures. You have the right to receive an accounting of certain disclosures of your protected health information. The accounting will not include disclosures that were made (1) for purposes of treatment, payment or health care operations; (2) to you; (3) pursuant to your authorization; (4) to your friends or family in your presence or because of an emergency; (5) for national security purposes; or (6) incidental to otherwise permissible disclosures. Your request for an accounting must be submitted in writing to the person listed below. You may request an accounting of disclosures made within the last six years. You may request one accounting free of charge within a 12-month period.

Right to Request Restrictions. You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend. Your request for restrictions must be submitted in writing to the person listed below. We will consider your request, but in most cases are not legally obligated to agree to those restrictions.

Right to Request Confidential Communications. You have the right to receive confidential communications containing your health information. Your request for restrictions must be submitted in writing to the person listed below. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to Choose Someone to Act for You. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Our Legal Responsibilities

We are required by law to maintain the privacy of your protected health information, provide you with this notice about our legal duties and privacy practices with respect to protected health information and notify affected individuals following a breach of unsecured protected health information.

We may change our policies at any time and reserve the right to make the change effective for all protected health information that we maintain. In the event that we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

If you have any questions, please contact:
John Mulvey, Employee Relations Manager
hr@hireart.com
HireArt 135 West 29th St, Ste 500 New York, NY 10001
(888) 458-7530



If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services – Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit www.hhs.gov/ocr for further information. You will not be penalized or retaliated against for filing a complaint with the Office of Civil Rights or with us.

AVAILABILITY OF SUMMARY HEALTH INFORMATION (Summary of Benefits and Coverage)

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury. Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options. These are often made available in paper format, by being emailed to you, or on our online benefits administration system. If you did not receive a copy of the SBC or if you have further questions, please contact your HR team. If you did not receive a paper copy of the SBC and you would like to have one, please contact your HR team and a paper copy will be provided to you.

COBRA CONTINUATION COVERAGE

COBRA Rights

In compliance with COBRA, HireArt offers extended coverage for medical, dental and vision, once the Company becomes a COBRA covered employer (if not already). Extended coverage is offered when coverage under these plans would otherwise end due to a qualifying event. You and your dependents may extend coverage in these plans for 18 months if coverage is lost due to one of the qualifying events listed below. California employees who exhaust their federal COBRA coverage and who are covered under a fully insured plan based in California may continue their medical coverage under Cal-COBRA for an additional 18 months – total of 36 months.

- Voluntary termination
- Involuntary termination (except for termination due to gross misconduct)
- Reduction of hours (strike, layoff, leave of absence [not a FMLA], and change from full-time to part-time)

COBRA coverage may be extended from 18 – 29 months for qualified beneficiaries who are deemed by the Social Security Administration to have been disabled before the end of the first 60 days of COBRA continuation coverage and who timely notify the Plan Administrator. However, once COBRA coverage ends for any reason, it will not be reinstated.

Your dependents may extend coverage for 36 months if any of the following qualifying events occur:

- Death of the employee
- Divorce or legal separation
- Dependent child ceasing to be a dependent.

Even though more than one qualifying event may occur, 36 months of extended coverage is the maximum extension available. You or your dependent(s) pay the full cost of the extended coverage you choose plus a 2% administrative fee (fee may be greater under Cal-COBRA).

Important Note

The IRS does not recognize Domestic Partners and/or children of a Domestic Partner as “Qualified Beneficiaries” for COBRA purposes. Please refer to the Summary Plan Description for specific information as it relates to your plan. Under certain circumstances, a group health plan may extend COBRA rights to domestic partners.

COBRA coverage will terminate due to any one for the following:

- You reach the end of your initial coverage period (18, 29, or 36 months)
- Failure to pay premiums in a timely manner (specified timelines would apply)
- You become covered under another health plan without preexisting condition limitations or exclusions applying to you or your beneficiaries’ health
- You become entitled to Medicare
- HireArt cancels all group plans

Children's Health Insurance Program Notice

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs.

If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply.

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

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

ALABAMA – Medicaid

Website: <http://myalhipp.com/>
1-855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program
<http://myakhipp.com/>
1-866-251-4861 Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
<http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx>

ARKANSAS – Medicaid

<http://myarhipp.com/>
1-855-MyARHIPP (855-692-7447)

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado: <https://www.healthfirstcolorado.com/>
Health First Colorado Member Contact Center: 1-800-221-3943/
State Relay 711 CHP+: <https://www.colorado.gov/pacific/hcpf/child-health-plan-plus>
CHP+ Customer Service: 1-800-359-1991/State Relay 711

FLORIDA – Medicaid

<http://flmedicaidprecovery.com/hipp/>
1-877-357-3268

GEORGIA – Medicaid

<https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>
1-678-564-1162, Ext. 2131

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64
<http://www.in.gov/fssa/hip/> 1-877-438-4479

All other Medicaid

<http://www.indianamedicaid.com>
1-800-403-0864

IOWA – Medicaid

<http://dhs.iowa.gov/Hawki>
1-800-257-8563

KANSAS – Medicaid

<http://www.kdheks.gov/hcf/>
1-785-296-3512

KENTUCKY – Medicaid

<https://chfs.ky.gov>
1-800-635-2570

LOUISIANA – Medicaid

<http://dhh.louisiana.gov/index.cfm/subhome/1/n/331>
1-888-695-2447



MAINE – Medicaid

<http://www.maine.gov/dhhs/ofi/public-assistance/index.html>
1-800-442-6003 TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

<http://www.mass.gov/eohhs/gov/departments/masshealth/>
1-800-862-4840

MINNESOTA – Medicaid

<https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp>
1-800-657-3739

MISSOURI – Medicaid

<http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>
1-573-751-2005

MONTANA – Medicaid

<http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>
1-800-694-3084

NEBRASKA – Medicaid

<http://www.ACCESSNebraska.ne.gov>
1-855-632-7633 Lincoln: 1-402-473-7000
Omaha: 1-402-595-1178

NEW HAMPSHIRE – Medicaid

<https://www.dhhs.nh.gov/oii/hipp.htm>
1-603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP Medicaid:

<http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>
1-609-631-2392

CHIP:

<http://www.njfamilycare.org/index.html>
1-800-701-0710

NEW YORK – Medicaid

https://www.health.ny.gov/health_care/medicaid/
1-800-541-2831

NORTH CAROLINA – Medicaid

<https://medicaid.ncdhhs.gov/>
1-919-855-4100

NORTH DAKOTA – Medicaid

<http://www.nd.gov/dhs/services/medicalserv/medicaid/>
1-844-854-4825

OKLAHOMA – Medicaid and CHIP

<http://www.insureoklahoma.org>
1-888-365-3742

OREGON – Medicaid

<http://healthcare.oregon.gov/Pages/index.aspx>
<http://www.oregonhealthcare.gov/index-es.html>
1-800-699-9075

PENNSYLVANIA – Medicaid

<http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm>
1-800-692-7462

RHODE ISLAND – Medicaid and CHIP

<http://www.eohhs.ri.gov/>
1-855-697-4347, or 1-401-462-0311 (Direct RlTe Share Line)

SOUTH DAKOTA - Medicaid

<http://dss.sd.gov>
1-888-828-0059

TEXAS – Medicaid

<http://gethipptexas.com/>
1-800-440-0493

UTAH – Medicaid and CHIP Medicaid:

<https://medicaid.utah.gov/>
CHIP: <http://health.utah.gov/chip>
1-877-543-7669

VERMONT– Medicaid

<http://www.greenmountaincare.org/>
1-800-250-8427

VIRGINIA – Medicaid and CHIP Medicaid:

http://www.coverva.org/programs_premium_assistance.cfm
1-800-432-5924
CHIP:
http://www.coverva.org/programs_premium_assistance.cfm
1-855-242-8282

WASHINGTON – Medicaid Website:

<https://www.hca.wa.gov/>
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid

<http://mywvhipp.com/>
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

<https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf>
1-800-362-3002

WYOMING – Medicaid

<https://wyequalitycare.acs-inc.com/>
1-307-777-7531



PAPERWORK REDUCTION ACT STATEMENT

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

U.S. Department of Labor

Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA, Ext. 3272

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

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

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

Your plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Please see the Group Health Plan's Benefit Booklet for deductibles and coinsurance for the plan you are enrolling in. If you would like more information on WHCRA benefits, call your Plan Administrator.

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA)

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

If you do not enroll yourself and your dependents in a group health plan after you become eligible or during annual enrollment, you may be able to enroll under the special enrollment rules under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") that apply when an individual declines coverage and later wishes to elect it. Generally, special enrollment is available if (i) you declined coverage because you had other health care coverage that you have now lost through no fault of your own (or employer contributions to your other health care coverage terminate); or (ii) you have acquired a new dependent (through marriage or the birth or adoption of a child) and wish to cover that person. To the extent that your plan documents indicate that when you have previously declined coverage, you must have given (in writing) the alternative coverage as your reason for waiving coverage under the group health plan when you declined to participate, your plan documents will control. In either case, as long as you meet the necessary requirements, you can enroll both yourself and all eligible dependents in the group health plan if you provide notice of enrollment to the Plan Administrator within 30 days after you lose your alternative coverage (or employer contributions to your alternative coverage cease) or the date of your marriage or the birth, adoption, or placement for adoption of your child.

HIPAA SPECIAL ENROLLMENT NOTICE

You may also enroll yourself and your dependents in a group health plan if your or one of your eligible dependent's coverage under Medicaid or the state Children's Health Insurance Program (CHIP) is terminated as a result of loss of eligibility, or if you or one of your eligible dependents become eligible for premium assistance under a Medicaid or CHIP plan. Under these two circumstances, the special enrollment period must be requested within 60 days of the loss of Medicaid/CHIP coverage or of the determination of eligibility for premium assistance under Medicaid/CHIP.

To request special enrollment or obtain more information, contact:

John Mulvey, Employee Relations Manager

hr@hireart.com

HireArt

135 West 29th St, Ste 500

New York, NY 10001

(888) 458-7530



Important notice from HireArt, Inc. about your prescription drug coverage and Medicare

Please read this notice carefully and keep it where you can locate it. This notice has information about your current prescription drug coverage with HireArt, Inc. and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. HireArt, Inc. has determined that the prescription drug coverage offered, on average for all plan participants, is expected to pay out as much as standard Medicare prescription drug coverage pays and, therefore, is considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you join a Medicare drug plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7. However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current plan coverage will not be affected. You can keep your existing coverage or join a Medicare drug plan as a supplement to, or in lieu of, your coverage under HireArt, Inc.'s plan.

If you do decide to join a Medicare drug plan and drop your current plan's coverage, be aware that you and your dependents may not be able to get this coverage back until HireArt, Inc.'s next annual open enrollment (or if you experience a special enrollment event).

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

You should be aware that if you drop or lose your current coverage with HireArt, Inc. and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen (19) months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage: Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through HireArt, Inc. changes. You also may request a copy of this notice at any time.

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

More detailed information about Medicare plans that offer prescription drug coverage is located in the 'Medicare & You' handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

Visit www.medicare.gov

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the 'Medicare & You' handbook for their telephone number) for personalized help

Call 1-800-MEDICARE (1-800-633-4227).

TTY users should call 1-877-486-2048.

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

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

Date: 01/01/2024

Name of Entity/Sender: HireArt, Inc.

Contact--Position/Office:

John Mulvey, Employee Relations Manager

Address: 135 West 29th St, Ste 500,

New York, NY 10001

Email: hr@hireart.com



