Benefits Booklet

2021

ooda HEALTH

Benefits provided by

SEQUOIA

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

Table of Contents

IMPORTANT NOTE: 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. Please see the last 2 pages of this booklet for more details.

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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

If you are a regular, full-time employee and you choose to enroll in Cigna, you are eligible for benefits on your date of hire.

If you are a regular, full-time employee and you choose to enroll in Kaiser, you are eligible for benefits on the first of the month following your date of hire.

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

Note: Your parents and siblings are not eligible dependents.

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

Zenefits

www.Zenefits.com

Summary of Medical, Dental, and Vision Contributions

What you pay each month to have insurance.

Medical Plan	**Employee Only**	**Employee + Spouse**	**Employee + Child(ren)**	**Employee + Family**
Kaiser Platinum 90 HMO 0/10 + Child Dental Alt	Kaiser plan cost is based on your age and age of any enrolling dependents – please reference Zenefits			
Cigna HealthCare PPO 500	$0.00	$181.79	$135.60	$304.91
Cigna HealthCare Expanded Network PPO 500	$80.93	$368.68	$300.64	$550.08
Cigna HealthCare EPO 20	$0.00	$279.46	$221.86	$433.06
Cigna HealthCare HDHP 2800	$0.00	$0.00	$0.00	$0.00
Cigna HealthCare Expanded Network HDHP 2800	$68.35	$157.91	$139.44	$207.11
Dental Plan	**Employee Only**	**Employee + Spouse**	**Employee + Child(ren)**	**Employee + Family**
Guardian Dental PPO	$0.00	$9.29	$16.51	$29.64
Vision Plan	**Employee Only**	**Employee + Spouse**	**Employee + Child(ren)**	**Employee + Family**
Guardian Vision	$0.00	$2.08	$2.12	$4.62

Please Note the following related to 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.

Employer Contribution to your HSA Account	**Employee Only**	**Employee + Spouse**	**Employee + Child(ren)**	**Employee + Family**
Cigna HealthCare HDHP 2800 HSA Contribution - Monthly	$50.00	$100.00	$100.00	$100.00
Cigna HealthCare *Expanded Network* HDHP 2800 HSA Contribution - Monthly	$50.00	$100.00	$100.00	$100.00

Please Note: IRS Maximums – the IRS annual maximums are inclusive of both your and your employer's contributions. Please consider how much your employer contributes to your HSA when making your annual personal contribution election. In addition, while HSA contributions are tax advantaged for federal tax purposes, states may treat them differently for state tax purposes. Please consult with your tax adviser if you have questions relating to the taxability of your HSA contributions.

Common Insurance Terms

There are many insurance terms, words and phrases you should know. Use the below list to better understand what the terms mean.

Deductible	The amount the member pays for covered health care services before the insurance plan starts to pay.
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, i.e. $20 for a doctor's visit or $20 for a prescription. Copays do not apply to the deductible.
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.
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 are not contracted to provide services to insurance company customers for less than their usual fees and can charge the member any rate they choose.
HMO	HMO stands for Health Maintenance Organization. An HMO is a type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover Out-of-Network care except in an emergency. An HMO may require the member to live or work in its service area to be eligible for coverage. The member's Primary Care Physician (PCP) coordinates medical care and refers the member to specialists (within their medical group) and hospitals as necessary.
PPO	PPO stands for Preferred Provider Organization. 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 (called In-Network).
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.
EPO	EPO stands for Exclusive Provider Organization. An EPO is a managed care plan where services are covered only if the member goes to doctors, specialists, or hospitals in the plan's network (except in an emergency).

Out-of-Network FAQ's

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 more than if you go In-Network.
- 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.

What would the cost to you be if a provider charges $10,000 for services?

In-Network Provider		vs.	Out-of-Network Provider	
Provider's charge for service	**$10,000**		Provider's charge for service	**$10,000**
Provider's allowed amount	**$6,000**		Provider's allowed amount	**$6,000**
Patient's deductible	**$250**		Patient's deductible	**$500**
Patient's coinsurance (10% of allowed amount after deductible)	**10% x $5,750 = $575**		Patient's coinsurance (30% of allowed amount after deductible)	**30% x $5,500 = $1,650**
Insurance pays the rest			*Balance between allowed amount and provider's fee*	
Total patient responsibility	**$825**		Total patient responsibility	**$6,150**
$575 coinsurance + $250 deductible			$10,000 charge - $6,000 allowed amount + 500 deductible + $1650 coinsurance	

Medical HMO Plan (CA Only)

How does this plan work?

- Available in California only.
- The member receives medical care from hospitals and doctors in the HMO network.
- The member's selected Primary Care Physician (PCP) coordinates all healthcare, including office visits, prescription medications, and referrals to specialists.
- In-Network preventative medicine is covered 100% by the member's plan.
- For other office visits and procedures, the member pays a set amount (called a copay).
- Amounts shown below represent what the member will be responsible for paying.
- The accumulators such as deductible and Out-of-Pocket Maximum reset each calendar year, on January 1st.

	Deductible	Out-of-Pocket Max	Co-Insurance	PCP Copay	Prescription Drugs
Kaiser Platinum 90 HMO 0/10 + Child Dental Alt					
IN-NETWORK *Kaiser HMO Network*	Single: $0 Family: $0	Single: $3,000 Family: $6,000	0%	$10 copay per visit	Tier 1: $5 Tier 2: $15 Tier 3: 10% per prescription up to $250 maximum

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".
- The accumulators such as deductible and Out-of-Pocket Maximum reset each calendar year, on January 1st.

	Deductible	Out-of-Pocket Max	Co-Insurance	PCP Copay	Prescription Drugs
Cigna HealthCare PPO 500					
IN-NETWORK *Open Access Plus (OAP) Network*	Single: $500 Family: $1,000	Single: $3,000 Family: $6,000	10%	$20 copay per visit	Tier 1: $10 Tier 2: $30 Tier 3: $50
OUT-OF-NETWORK	Single: $1,000 Family: $2,000	Single: $6,000 Family: $12,000	30%	30% after deductible	Not Covered
Cigna HealthCare Expanded Network PPO 500					
IN-NETWORK *PPO Network*	Single: $500 Family: $1,000	Single: $3,000 Family: $6,000	10%	$20 copay per visit	Tier 1: $10 Tier 2: $30 Tier 3: $50
OUT-OF-NETWORK	Single: $1,000 Family: $2,000	Single: $6,000 Family: $12,000	30%	30% after deductible	Not Covered

*Plan design is identical with each plan, but the Expanded Network uses the PPO network and has a broader network in Utah, including Intermountain Healthcare

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. More on the next page.
- 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".
- The accumulators such as deductible and Out-of-Pocket Maximum reset each calendar year, on January 1st.

	Deductible	Out-of-Pocket Max	Co-Insurance	PCP Copay	Prescription Drugs
Cigna HealthCare HDHP 2800					
IN-NETWORK *Open Access Plus (OAP) Network*	Single: $2,800 Family: $5,600	Single: $3,500 Family: $7,000	0%	$0	Tier 1: $10 Tier 2: $30 Tier 3: $50
OUT-OF-NETWORK	Single: $5,600 Family: $11,200	Single: $7,000 Family: $14,000	20%	20% after deductible	Not Covered
Cigna HealthCare Expanded Network HDHP 2800					
IN-NETWORK *PPO Network*	Single: $2,800 Family: $5,600	Single: $3,500 Family: $7,000	0%	$0	Tier 1: $10 Tier 2: $30 Tier 3: $50
OUT-OF-NETWORK	Single: $5,600 Family: $11,200	Single: $7,000 Family: $14,000	20%	20% after deductible	Not Covered

*Plan design is identical with each plan, but the Expanded Network uses the PPO network and has a broader network in Utah, including Intermountain Healthcare

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Health Savings Account (HSA)

Maximum Pre-Tax Contribution Amount	**EMPLOYEE ONLY**	**EMPLOYEE + FAMILY**
	Up to $3,600 annually for 2021	Up to $7,200 annually for 2021
	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? Note: This Is A Partial List, Refer To Irs.Gov For More Info	**ELIGIBLE EXPENSES**	**INELIGIBLE EXPENSES**
	• Medical, dental, and vision deductibles • Prescription medication copays • Acupuncture and chiropractor • Labs and x-rays	• Over-the-counter medication • Cosmetic or elective surgery • Personal trainers • Marriage or career counseling

Eligibility	The member may participate in an HSA if: • They are covered by a qualified HDHP. • They are not covered by a non-HDHP plan (the member may not contribute to a general-purpose healthcare FSA or a general purpose HRA at the same time as an HSA). • The member is not enrolled in Medicare. • The member cannot be claimed as a dependent on someone else's tax return.
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.
Things To Consider	• Plans eligible for HSAs come with a high annual deductible. • High Deductible Health Plans and Health Savings Accounts can seem more complicated than traditional health plans. Take the time to fully understand how your plan works. • Members will need to save receipts for eligible expenses for tax filing purposes. • If the member chooses to participate in the HSA plan and an FSA plan, the FSA election will need to be for a "limited purpose" FSA account in order to remain eligible. The member can only use the FSA funds in a "limited purpose" account for dental and vision expenses. • Contribution between employer and employee combined cannot exceed annual limits
How To Open Your HSA	Zenefits Instructions: You may open an HSA for the first time through the HSA app on your Zenefits dashboard

**At the time this booklet was created the states of 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.
- Available nationwide.
- 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.
- The accumulators such as deductible and Out-of-Pocket Maximum reset each calendar year, on January 1st.

	Deductible	Out-of-Pocket Max	Co-Insurance	PCP Copay	Prescription Drugs
Cigna HealthCare EPO 20					
IN-NETWORK *Open Access Plus (OAP) Network Network*	Single: $0 Family: $0	Single: $2,500 Family: $5,000	0%	$20 copay per visit	Tier 1: $10 Tier 2: $30 Tier 3: $50

Dental Plan

How does this plan work?

- 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.
- No ID cards needed! 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".
- The accumulators such as deductible and Out-of-Pocket Maximum reset each calendar year, on January 1st.

	Dentist Charges*	Deductible Per Member	Annual Benefit Maximum	Preventive Services**	Basic Services**	Major Services**	Ortho	Ortho Lifetime Maximum
Guardian Dental PPO								
IN-NETWORK *DentalGuard Preferred Network*		$50	$1,500	0%	10%	40%	50% for Child Only	$1,500
OUT-OF-NETWORK	90%	$50	$1,500	0%	10%	40%	50% for Child Only	$1,500

* 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

How does this plan work?

- Vision plans offer flexibility to see any optometrist or specialist In or Out-of-Network.
- Costs are lowest when enrollee visits a participating network provider.
- No ID cards needed! 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 Signature Network*	Every Calendar Year	$10	Every Calendar Year	$20	Every Calendar Year	Amount over $150	Every Calendar Year	80% of amount over $150
OUT-OF-NETWORK		$10		$20		Amount over $120		Amount over $48

Life Plan

How does this benefit work?

- Life insurance is designed to provide protection for the member and their family against loss of income due to accidental death.
- For life insurance, make sure that a beneficiary (or multiple beneficiaries) are designated properly 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 imputed 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.

Basic Life/AD&D

Carrier	Amount	Benefit Maximum	Guarantee Issue
Guardian	1 x Salary	$250,000	$250,000

Voluntary Life Plan

How does this benefit work?

- For additional protection, voluntary life insurance is offered to the member 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 Guarantee Issue amount is only available to first time enrollees (new hires, new dependents, etc.).
- Election for voluntary life insurance outside of new hire election period or the first time the company is offering the benefit, requires completion of an Evidence of Insurability (EOI) form.
- The member must purchase voluntary life coverage as an employee to purchase coverage for a dependent.

Please Note: You may need to fill out an Evidence of Insurability (EOI) form to receive benefit amounts over the Guarantee Issue amount below. Without a completed form, approved by the carrier, your voluntary life insurance benefit amount will be limited to the Guarantee Issue amount.

	Increments	Maximum Limit
EMPLOYEE	Choice $10,000 increments	Not to exceed 10 times salary
SPOUSE	Choice $5,000 increments	Not to exceed 50% of employee amount
CHILD	Flat $10,000	Not to exceed 10% of employee amount

	Employee	Spouse	Child
MINIMUM COVERAGE AMOUNT	$10,000	$5,000	$10,000
MAXIMUM COVERAGE AMOUNT	$250,000	$125,000	$10,000
GUARANTEE ISSUE	$150,000	$50,000	$10,000

Age	Employee	Spouse	Age	Employee	Spouse
<25	0.040000	0.0400	50-54	0.230000	0.2300
25-29	0.040000	0.0400	55-59	0.410000	0.4100
30-34	0.050000	0.0500	60-64	0.660000	0.6600
35-39	0.070000	0.0700	65-69	1.100000	1.1000
40-44	0.100000	0.1000	70-74	1.810000	1.8100
45-49	0.150000	0.1500	75+		

Disability Plan

How does this benefit work?

- 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. Periods below are the maximum allowable.
- Disability benefits coordinate with applicable state disability programs.

Short Term Disability – Pre-Tax

Carrier	Amount	Maximum Weekly Benefit	Benefit Period Max	Elimination Period
Guardian	60%	$2,500	Up to 12 weeks	7/7 Days

Long Term Disability – Pre-Tax

Carrier	Amount	Maximum Monthly Benefit	Benefit Period	Elimination Period
Guardian	60%	$10,000	SSNRA	90 Days

Definitions

Elimination Period	The elimination period is when an employee must satisfy a specified number of days or months before the disability benefit is paid.
Benefit Period	The length of time that the disability benefits will be paid to an employee. Disability benefits will be paid from the end of the elimination period until the earliest of: (1) Completion of the benefit duration (2) Employee's recovery or (3) Employee's death For LTD, the maximum benefit period is determined by the member's age when they become disabled.
Tax Choice (Pre-Tax)	The member does not pay taxes on the benefit until they receive it. If the member were to go out on disability and they selected the pre-tax option, they would receive 60% of their base salary (per the benefit) minus taxes. This is the traditional set up.

Flexible Spending Accounts (FSA)

How does this benefit work?

- Flexible Spending Accounts (FSA) are accounts that can be funded using pre-tax dollars deducted directly from the member's paycheck.
- Eligible Health Care or Dependent Care expenses can be reimbursed from these accounts.
- The member must enroll in the FSA every year in which they plan to participate, even if the member already has an FSA account.
- Healthcare FSA accounts are for health expenses for the member and their tax dependents.
- Dependent Care FSA accounts are for childcare / adult care expenses while the member is working.*
- FSA elections are annual. They can only be changed with a qualifying life event.

Account Type	Vendor	Maximum Pre-Tax Contribution Amount
Healthcare	Zenefits	$2,750 per calendar year
Dependent Care	Zenefits	$5,000 per calendar year
Limited Purpose	Zenefits	$2,750 per calendar year

Please Note: Dependent FSA contribution amount is per household, per calendar year ($2,500 for single filers & for married filing separate).

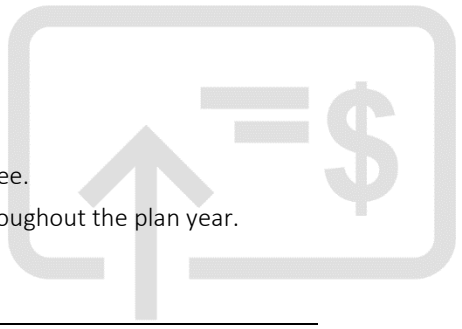
WHAT EXPENSES ARE ALLOWED?	Health Care FSA		Dependent Care FSA	
	Eligible expenses	Ineligible expenses	Eligible expenses	Ineligible expenses
NOTE: This is a partial list, refer to IRS.Gov for more information.	✓ Health related costs (medical, dental, and vision copays) ✓ Prescription medication	✓ Cosmetic surgery ✓ Non-prescription medication ✓ Life insurance premiums	✓ Work day childcare services ✓ Cost of care at a licensed daycare ✓ Before or after-school care	✓ Education expenses ✓ Transportation expenses for childcare
WHAT HAPPENS TO ACCOUNT FUNDS AT THE END OF A YEAR?	Use it or lose it. By IRS regulations, the account holder loses any unclaimed money in the account at the end of the plan year, per the group plan set-up. **Run out period:** A run out period is how long the member has to file a claim for medical costs incurred during the plan year (and during the grace period (if applicable) following the plan year). If employment is terminated, the member will not be able to incur expenses past the termination date, but the run-out period will still apply. Consult the full plan summary for more details.		Use it or lose it. By IRS regulations, the account holder loses any unclaimed money in the account at the end of the plan year, per the group plan set-up. **Run out period:** A run out period is how long the member has to file a claim for dependent care costs incurred during the plan year (and during the grace period (if applicable) following the plan year). If employment is terminated, the member will not be able to incur expenses past the termination date, but the run-out period will still apply. Consult the full plan summary for more details.	
HOW DO I MAKE CHANGES TO MY PARTICIPATION?	The account holder can make changes to their participation and/or contribution amounts during their open enrollment period or with a qualifying life event that would allow a change. The account holder should budget and plan according to their projected Health and Dependent Care needs.			

WHAT IF I PARTICIPATE IN AN HDHP & HSA?	If the member enrolls in a High Deductible Health Plan, they can still enroll in a "limited purpose" healthcare FSA. The limited purpose healthcare FSA may only be used for eligible dental and vision expenses.
WHERE CAN I GET MORE INFORMATION?	IRS Publication 502: Medical and Dental Expenses, and IRS Publication 503: Dependent Care Expenses list eligible expenses. These publications are available online at https://www.irs.gov/forms-instructions, or by calling 1-800-TAX-FORM.

**Expenses are eligible under a Dependent Care FSA if they are incurred to keep an employee (and their spouse) gainfully employed. If an employee is married, dependent care expenses will only be eligible when the employees' spouse:*

- *Is also gainfully employed;*
- *Is in search of gainful employment;*
- *Is a full-time student; or*
- *Is mentally or physically incapable of self-care with the same principal place of abode as the employee for more than half of the year.*

Commuter



How does this benefit work?

- Funds are directly deducted from the member's paycheck.
- The member is able to pay for qualifying monthly commuter and parking expenses tax-free.
- Participation in this benefit and the contribution amount can be changed at any time throughout the plan year.

	Transit	Parking
Vendor	Zenefits	Zenefits
Maximum IRS Pre-Tax Contribution Amount	per month	per month
What Expenses Are Allowed?	• Mass transit fares • Monthly bus passes • Vanpooling fees	• Parking at or near your work location • Parking at a location from which you participate in a carpool or board mass transit
What Expenses Are Not Allowed?	• Taxi fares • Bridge tolls • Cost of auto maintenance	• Parking costs at home • Parking when not commuting to or from work location
How Do I Sign Up?	Instructions: Elect commuter funds through the commuter app on your Zenefits dashboard Deadline: Orders must be placed by 25th of the month prior to the benefit month.	

Additional Benefits

Calm for Kaiser	Calm uses meditation and mindfulness to help lower stress, reduce anxiety, and improve sleep quality.	https://kp.org/selfcareapps
ClassPass Go for Kaiser	Download Go and start an audio workout class taught by the industry's best trainers.	https://classpass.com/go
Happify for Cigna	Overcome negative thoughts, stress, and life's challenges. Happify is the single destination for effective, evidence-based solutions for better mental health.	https://cigna.happify.com/
iPrevail for Cigna	iPrevail is a digital therapeutics platform, designed by experienced clinicians to help you take control of the stresses of everyday life and challenges associated with life's difficult transitions.	https://my.cigna.com/web/public/iprevail
Kaiser Video Visits	Convenient access to your doctor from home or office using your laptop or smartphone.	https://kp.org/mydoctor/videovisits
Petplan	Petplan helps you pay unexpected veterinary bills, so that you can get your pet the best care, regardless of cost. Code: SEQUOIA25	https://www.gopetplan.com/?c=SEQUOIA25&utm_source=sequoia&utm_medium=partnership&utm_campaign=ee_portal&utm_content=2021oe
SmartSpend	Curated gym discounts, travel discounts, and more through SmartSpend.	http://smartspendplus.perkspot.com
SoFi	Sofi provides great service and low rates for student loan refinancing, mortgages, and personal loans.	www.sofi.com/sequoia
Talkspace for Cigna	Online therapy service that connects users to a dedicated, licensed therapist via private messaging (text, voice, video) or live video session, fully HIPAA-compliant, and uses banking- grade encryption to protect data.	https://www.talkspace.com/cigna
Guardian EAP	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.	ibhworklife.com
Guardian Accident Insurance	Extra layer of protection that gives you a cash payment to cover out of pocket expenses when you suffer an unexpected, qualifying accident	www.guardiananytime.com
Guardian Critical Illness Insurance	Cash payment you receive if you ever experience a serious illness like cancer, a heart attack, or a stroke, giving you the financial support to focus on recovery	www.guardiananytime.com
Guardian Hospital Indemnity Insurance	Can cover some of the cost associated with a hospital stay, letting you focus on recovery	www.guardiananytime.com

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

Getting Started with Your Enrollment

It's time for you to choose your benefits coverages for 2021!

Whether you are a new hire, making open enrollment elections, or processing a qualifying life event, you will make all these updates by signing into your benefits portal online.

Login to Your Benefits Portal: www.zenefits.com

Your Employee Advocate can guide you to the answers you need.

Never feel lost when it comes to using your benefits. Our 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.

Employee Advocate

Mon-Fri 8:30am – 5pm PST

PHONE: (844) 891-3045

E-MAIL: oodahealth@help.sequoia.com

The Fine Print

You can find all legal disclosures included 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 Rights Notice
Medicare Part D Creditable Coverage Notice

Looking To Learn More?

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

OODA Health, Inc. Resources

Reach out to the OODA Health, Inc. HR and Benefits team for questions.

Traunza Adams
traunza.adams@ooda-health.com

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

Legal Disclosures and 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 OODA Health, Inc. (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. OODA Health, Inc. 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 OODA Health, Inc. 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:

Traunza Adams

traunza.adams@ooda-health.com

OODA Health, Inc.

100 Montgomery Street

Suite 2100

San Francisco, CA 94104

(415) 496-9302

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, OODA Health, Inc. 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.

- 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)

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.

COBRA coverage may also 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 (note the fee may be greater under Cal-COBRA).

COBRA Termination

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 pre-existing condition limitations or exclusions applying to you or your beneficiaries' health
- You become entitled to Medicare
- OODA Health, Inc. cancels all group plans

Important Note on Domestic Partner Coverage

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 or your Insurance Certificates for specific information as it relates to your plan. Under certain circumstances, a group health plan may extend COBRA rights to domestic partners.

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 January 31, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO –Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: 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

ALASKA – Medicaid	FLORIDA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-800-541-5555	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864

IOWA – Medicaid and CHIP (Hawki)	MONTANA – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp [Under ELIGIBILITY tab, see "what if I have other health insurance?"] Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100

MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2020, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

The public reporting burden for this collection of information is estimated to average approximately 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.

OMB Control Number 1210-0137 (expires 1/31/2023)

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 RIGHTS NOTICE

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.

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:

Traunza Adams
traunza.adams@ooda-health.com
OODA Health, Inc.
100 Montgomery Street
Suite 2100
San Francisco, CA 94104
(415) 496-9302

Important Notice from OODA Health, 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 OODA Health, 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. OODA Health, 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 OODA Health, 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 OODA Health, 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 OODA Health, 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 OODA Health, 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:	01/01/2021
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