HIRE RIGHT®

2021 BENEFITS GUIDE

Intern and Temporary Team Members

A MESSAGE FROM YOUR CEO GUY ABRAMO

Team,

Our HR team is constantly evaluating benefits programs to find you the highest quality benefits at the lowest cost to you. We understand that healthcare is important to you and your family, so I encourage you to take charge of your health and safety by reviewing the information in this benefits guide and selecting the plan that is best for you.

HireRight uses a tiered salary contribution model, so how much you will pay for your medical benefits plan will depend on your annual salary.

Please take the time to carefully review the information in this guide. You can also visit **YourBenefitsCenter.com** any time for comprehensive information on HireRight's benefits offerings, including videos, links, and FAQs.

If you have questions, please submit a request through HR4U > Myself > AskHR > Benefits. If you need immediate assistance, you can also call **888-921-0563** to talk to a Benefits representative. This number is active from 8 a.m. through 5 p.m. PST, Monday through Friday, but you can leave a voicemail any time and the team will get back to you as soon as possible.

Regards,

Guy

CONTENTS

MEDICARE PART D NOTICE

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 Important Notices section for more details.

WELCOME TO YOUR BENEFITS GUIDE

This guide is about your benefits, but it is also about you and how to protect your health, your lifestyle, your future, and the people who are important to you.

You will find details about your healthcare, life, disability, and retirement benefits and tips on how to use your benefits.

You will also discover the programs that HireRight provides to help you save time and money, as well as balance your work and home life.

This guide is an overview

The benefits in this summary are effective

January 1, 2021

through

December 31, 2021.

This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs) located on **yourbenefitscenter.com**. The plan benefit booklets determine how all benefits are paid.

WHO'S ELIGIBLE FOR BENEFITS?

WHEN YOU CAN ENROLL

You can enroll in benefits as a new hire or during the annual Open Enrollment period. Coverage begins on the first of the month following your hire date. If you are hired on the first of the month, your coverage begins on your hire date.

If you miss the enrollment deadline, you will need to wait until the next Open Enrollment unless you experience a qualifying life event (birth or adoption of a baby or child, loss of healthcare coverage, eligibility of new healthcare coverage, marriage or divorce).

Team Members

You are eligible if you are a Intern or Temporary Team Member (not a contractor) scheduled to work at least 30 hours per week.

Eligible dependents

- Legally married spouse
- Domestic partner
    - Opposite-sex domestic partners of Team Members who are registered as domestic partners in a local jurisdiction that maintains such a registry
    - A same-sex domestic partner. Same-sex domestic partners must meet all of the following requirements to be eligible:
        - At least 18 years of age
        - Not be legally married, under federal law, to anyone or be part of another domestic partnership during the previous 12 months
        - Currently be in an exclusive, committed relationship with each other that has existed for at least 12 months and is intended to be permanent
        - Currently reside together, have resided together for at least the previous 12 months, and intend to do so permanently
        - Have agreed to share responsibility for each other's common welfare and basic financial obligations
        - Not be related by blood to a degree of closeness that would prohibit marriage under applicable state law
- Natural, adopted or stepchildren up to age 26
- Children over age 26 who are disabled and depend on you for support
- Children named in a Qualified Medical Child Support Order (QMCSO)

For additional information, please refer to the benefit booklets for each benefit located on **yourbenefitscenter.com**.

CHANGING YOUR BENEFITS

Outside of Open Enrollment, you may be able to enroll or make changes to your benefit elections if you have a big change in your life, including:

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in residence that affects access to network providers
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP).

You must submit a request through Your Benefits Center within 30 days of the Qualifying Life Event along with supporting documentation through benefits.plansource.com.

ENROLLING FOR BENEFITS

Your Benefits Center is an online system that enables you to make all your benefit decisions in one place.

Before you enroll

- Know the date of birth, Social Security Number, and address for each dependent you will cover.
- Review your enrollment materials to understand your benefit options and costs for the coming year.

Getting started

- **LOG IN** to **www.YourBenefitsCenter.com** and follow the instructions to begin enrolling in your benefits.

  Username: The first initial of your first name, up to the first six letters of your last name, and the last four digits of your Social Security Number.

  Example: If your name is Jane Williams and the last four digits of your Social Security Number are 1234, your username will look like this: jwillia1234

  Password: You will receive a separate email containing your temporary password. Please log in to the application using your username and temporary password. After you log in, you will be asked to change your password.
- **ADD** your personal and dependent information.
- **SELECT** your benefit plans for the coming year.
- **REVIEW** your choices and costs before finalizing.

MEDICAL & PHARMACY

OUR PLANS

Anthem Blue Cross – Core PPO Plan

Anthem Blue Cross – High Deductible Health Plan 1400

Anthem Blue Cross – High Deductible Health Plan 2000

WHICH PLAN IS RIGHT FOR YOU?

That depends on your healthcare needs, favorite doctors, and budget. Here are some considerations:

Do you prefer specific doctors or hospitals?

If you want to stay with your favorite doctors and facilities, check whether they are in the plan's network. If they are not, but you are comfortable paying a bit more to see them, consider a plan with both in-network and out-of-network benefits.

What are your usual healthcare needs?

Do you have frequent doctor or urgent care visits? Do you have a condition that requires a specialist? Do you take prescription medications? Compare how each plan covers the services you need most often.

Consider the bottom line

How much is the monthly payroll deduction? Do you have to meet a deductible? What is the out-of-pocket maximum? How much of the cost is covered by the plan? How much are any copayments for office visits, prescriptions, etc.? All of these factors together affect your total cost for healthcare.

2021 Anthem Blue Cross – Core PPO Plan

You always pay the deductible and copayment ($). The coinsurance (%) shows what the plan pays after the deductible.

	In-Network	Out-of-Network
Annual Deductible	$5,350 per individual $10,700 family limit	$6,000 per individual $12,000 family limit
Annual Out-of-Pocket Maximum	$6,500 per individual $13,000 family limit	$16,000 per individual $32,000 family limit
Office Visit	$25 copay	50% after deductible
Specialist Visit	$60 copay	50% after deductible
Chiropractic	$25 copay (up to 30 visits per year)	50% after deductible (in-network limitations apply)
Lab and X-ray	100% after deductible	50% after deductible (complex imaging: up to $800 per service, all other in hospital: up to $350 per service)
Urgent Care	$25 copay then 100%	50% after deductible
Emergency Room	$250 copay then 100% after deductible (copay waived if admitted)	$250 copay then 100% after deductible (copay waived if admitted)
Inpatient Hospital Services	100% after deductible	50% after deductible (up to $1,000 per day for non-emergency admission)
Outpatient Surgery	100% after deductible	50% after deductible (up to $350 per service)
PRESCRIPTION DRUGS		
Deductible	Deductible does not apply	Deductible does not apply
Out-of-Pocket Maximum	Prescriptions subject to medical out-of-pocket maximums	Prescriptions subject to medical out-of-pocket maximums
30 Day Supply (Retail Pharmacy)		
Lower Cost Generic	$5 copay	50% (up to $250 per prescription)
Generic	$20 copay	50% (up to $250 per prescription)
Brand (formulary/preferred)	$40 copay	50% (up to $250 per prescription)
Brand (non-formulary/non-preferred)	$55 copay	50% (up to $250 per prescription)
90 Day Supply (Home Delivery)		
Lower Cost Generic	$12.50 copay	Not covered
Generic	$50 copay	Not covered
Brand (formulary/preferred)	$120 copay	Not covered
Brand (non-formulary/non-preferred)	$165 copay	Not covered

2021 Anthem Blue Cross – High Deductible Health Plan 1400

You always pay the deductible and copayment ($). The coinsurance (%) shows what the plan pays after the deductible.

	In-Network	Out-of-Network
Annual Deductible	$1,400 per individual individual in family: $2,800 per individual $2,800 family limit	$2,800 per individual individual in family: $2,800 per individual $5,600 family limit
Annual Out-of-Pocket Maximum	$3,050 per individual individual in family: $3,050 per individual $6,100 family limit	$6,100 per individual individual in family: $6,100 per individual $12,200 family limit
Office Visit	Plan pays 80% after deductible	Plan pays 60% after deductible
Specialist Visit	Plan pays 80% after deductible	Plan pays 60% after deductible
Chiropractic	Plan pays 80% after deductible (up to 30 visits per year)	Plan pays 60% after deductible (in-network limitations apply)
Lab and X-ray	Plan pays 80% after deductible	Plan pays 60% after deductible (complex imaging: up to $800 per service, all other in hospital: up to $350 per service)
Urgent Care	Plan pays 80% after deductible	Plan pays 60% after deductible
Emergency Room	Plan pays 80% after deductible	Plan pays 80% after deductible
Inpatient Hospital Services	Plan pays 80% after deductible	Plan pays 60% after deductible (up to $1,000 per day for non-emergency admission)
Outpatient Surgery	Plan pays 80% after deductible	Plan pays 60% after deductible (up to $350 per service)
PRESCRIPTION DRUGS		
Deductible	Prescriptions subject to medical deductible	Prescriptions subject to medical deductible
Out-of-Pocket Maximum	Prescriptions subject to medical out-of-pocket maximums	Prescriptions subject to medical out-of-pocket maximums
30 Day Supply (Retail Pharmacy)		
Lower Cost Generic	$5 copay	40% after deductible (up to $250 per Rx)
Generic	$15 copay	40% after deductible (up to $250 per Rx)
Brand (formulary/preferred)	$40 copay	40% after deductible (up to $250 per Rx)
Brand (non-formulary/non-preferred)	$60 copay	40% after deductible (up to $250 per Rx)
90 Day Supply (Home Delivery)		
Lower Cost Generic	$12.50 copay	Not Covered
Generic	$37.50 copay	Not Covered
Brand (formulary/preferred)	$120 copay	Not Covered
Brand (non-formulary/non-preferred)	$180 copay	Not Covered

2021 Anthem Blue Cross – High Deductible Health Plan 2000

You always pay the deductible and copayment ($). The coinsurance (%) shows what the plan pays after the deductible.

	In-Network	Out-of-Network
Annual Deductible	$2,000 per individual individual in family: $2,800 per individual $4,000 family limit	$4,000 per individual individual in family: $4,000 per individual $8,000 family limit
Annual Out-of-Pocket Maximum	$6,500 per individual individual in family: $6,500 per individual $13,000 family limit	$13,000 per individual individual in family: $13,000 per individual $26,000 family limit
Office Visit	Plan pays 80% after deductible	Plan pays 60% after deductible
Specialist Visit	Plan pays 80% after deductible	Plan pays 60% after deductible
Chiropractic	Plan pays 80% after deductible (up to 30 visits per year)	Plan pays 60% after deductible (in-network limitations apply)
Lab and X-ray	Plan pays 80% after deductible	Plan pays 60% after deductible (complex imaging: up to $800 per service, all other in hospital: up to $350 per service)
Urgent Care	Plan pays 80% after deductible	Plan pays 60% after deductible
Emergency Room	Plan pays 80% after deductible	Plan pays 80% after deductible
Inpatient Hospital Services	Plan pays 80% after deductible	Plan pays 60% after deductible (up to $1,000 per day for non-emergency admission)
Outpatient Surgery	Plan pays 80% after deductible	Plan pays 60% after deductible (up to $350 per service)
PRESCRIPTION DRUGS		
Deductible	Prescriptions subject to medical deductible	Prescriptions subject to medical deductible
Out-of-Pocket Maximum	Prescriptions subject to medical out-of-pocket maximums	Prescriptions subject to medical out-of-pocket maximums
30 Day Supply (Retail Pharmacy)		
Lower Cost Generic	$5 copay	40% after deductible (up to $250 per Rx)
Generic	$15 copay	40% after deductible (up to $250 per Rx)
Brand (formulary/preferred)	$40 copay	40% after deductible (up to $250 per Rx)
Brand (non-formulary/non-preferred)	$60 copay	40% after deductible (up to $250 per Rx)
90 Day Supply (Home Delivery)		
Lower Cost Generic	$12.50 copay	Not Covered
Generic	$37.50 copay	Not Covered
Brand (formulary/preferred)	$120 copay	Not Covered
Brand (non-formulary/non-preferred)	$180 copay	Not Covered

PREVENTIVE CARE SCREENING BENEFITS

TYPICAL SCREENINGS FOR ADULTS

- Blood pressure
- Cholesterol
- Diabetes
- Colorectal cancer
- Depression
- STIs

Preventive care for women should include breast and gynecological exams

For men, preventive care should include a prostate cancer screening and a testicular exam

You take your car in for maintenance. Why not do the same for yourself?

Annual preventive checkups can help you and your doctor identify your baseline level of health and detect issues before they become serious.

What is preventive care?

The Affordable Care Act (ACA) requires health insurers to cover a set of preventive services at no cost to you, even if you have not met your yearly deductible. The preventive care services you will need to stay healthy vary by age, gender, and medical history. Visit **cdc.gov/prevention** for recommended guidelines. **Preventive care is covered in full only when obtained from an IN-NETWORK provider.**

Not all exams and tests are considered preventive

Exams performed by specialists are not generally considered preventive and may not be covered at 100 percent. Additionally, certain screenings may be considered diagnostic, not preventive, based on your current medical condition. You may be responsible for paying all or a share of the cost for those services. If you have a question about whether a service will be covered as preventive care, contact your medical plan.

Should I skip my checkup due to COVID-19?

Staying safe from the coronavirus doesn't necessarily mean skipping preventive healthcare. Talk to your doctor about whether you need a checkup right away or if you can delay until there is a lower risk of being exposed to COVID-19. Depending on your medical needs, you may be treated with a combination of telehealth and in-person care.

Consider scheduling a flu shot at your local pharmacy to avoid a potential combined infection of COVID-19 and the flu. And, of course, seek medical care right away if you have symptoms that need immediate attention. Nearly every doctor's office has added new practices to ensure the safety of patients, providers, and other team members.

ARE PRESCRIPTION DRUGS BREAKING YOUR BUDGET?

FORMULARY DRUG TIERS DETERMINE YOUR COST

$	Lower Cost Generic
$$	Generic
$$$	Preferred Brand Name Drug
$$$$	Non-Preferred Brand Name Drug

Understanding the formulary can save you money

If your doctor prescribes medicine, especially for an ongoing condition, do not forget to check your health plan's drug formulary. It is a powerful tool that can help you make informed decisions about your medication options and identify the lowest cost selection.

What is a formulary?

A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into four or five drug categories, or "tiers". These groupings range from least expensive to most expensive cost to you. "Preferred" drugs generally cost you less than "non-preferred" drugs.

- Click **here** to view Anthem's searchable formulary list
- Click **here** to view Anthem's PDF formulary list

Get the most from your coverage

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to perform the same as brand-name drug counterparts.

To find out if a drug is on your plan's formulary, visit the plan's website or call the customer service number on your ID card.

SPENDING ACCOUNT

OUR PLAN

Anthem Health Savings Account (HSA)

Why sign up for a Spending Account?

Spending accounts are an easy way to pay for healthcare and childcare expenses that you have today, and save for expenses you may have in the future.

HEALTH SAVINGS ACCOUNT (HSA)

Click to play video

ARE YOU ELIGIBLE?

The HSA is not for everyone. You are eligible only if you are:

1. Enrolled in the HDHP 1400 or HDHP 2000 Plan.
2. Not enrolled in other non-HDHP medical coverage, including Medicare, Medicaid, or Tricare.
3. Not a tax dependent.
4. Not enrolled in a healthcare Flexible Spending Account (FSA), unless it's a "limited purpose" FSA for dental and vision expenses.

Find out more

- To access your account, log in at **anthem.com/ca** or use the Anthem Sydney App available in all app stores
- **Eligible Expenses** – now include more over-the-counter items!
- **Ineligible Expenses**

A personal savings account for healthcare

A Health Savings Account (HSA) is an easy way to pay for healthcare expenses that you have today, and save for expenses you may have in the future.

Four reasons to love an HSA

1. **Tax-free.** No federal tax on contributions, or state tax in most states. Withdrawals are also tax-free as long as they are for eligible healthcare expenses.
2. **No "use it or lose it."** Your balance rolls over from year to year. You own the account and can continue to use it even if you change medical plans or leave the company.
3. **Use it now or later.** Use your HSA for healthcare expenses you have today or save it to use in the future.
4. **Boosts retirement savings.** After you retire, you can use your HSA for healthcare expenses tax-free, or for regular living expenses which are taxable but with no penalties.

How the Anthem 2021 HSA works

- If you enroll in the 2000 or 1400 Plan, you will receive an HSA debit card from Anthem.
- The money is taken directly from your HSA, so you should only use the card for eligible expenses. If your provider sends you a bill, you can write your Anthem debit card number on the bill and submit it for payment. To obtain additional cards, contact Anthem at the phone number on the back of your card.

Employee contributions:

- You can contribute up to the limit set by the IRS (includes company amount).

  Individual: $3,600 per year
  Family: $7,200 per year

- Are you age 55+? You can contribute an additional $1,000 per year.
- You can use your HSA debit card to pay for eligible expenses like office visits, lab tests, prescriptions, dental and vision care, and even some drugstore items.

Employer contributions:

- HireRight will **match** your HSA contributions up to the maximums listed below if complete an online Health Survey through the Anthem Sydney App and a Annual Preventive Wellness exam.
- 2021 match maximum contribution amount(s):
  Team Member Only: $400
  Team Member + dependent(s): $800

EARNING AN EMPLOYER INCENTIVE

Earning an employer incentive

Your whole health is important to us and we want to help you maintain it or get on track! HireRight understands the definition of wellness is wide-ranging, therefore we've decided to revamp our employer incentives. For information on how to complete each activity, visit **www.YourBenefitsCenter.com** and scroll down the page to see the information for the HSA and Core Plans.

PLAN	INCENTIVE FOR COMPLETING TWO ACTIONS	WHEN YOU WILL RECEIVE YOUR INCENTIVE	DEADLINE TO EARN YOUR 2021 INCENTIVE
Anthem Blue Cross: 2000 or 1400 HDHP Plan with a Health Savings Account	HireRight will match your HSA contribution up to $400 for employee only coverage and $800 for other coverage levels (employee + spouse, employee + child(ren) or family coverage*) if a Health Survey is completed through Anthem's Sydney portal along with an annual Preventative Wellness Exam * HDHP Plan Incentive: Eligible dependents must be 18 or older to participate and complete their own Health Survey and Exam	To receive the incentive you must complete both the health survey and wellness exam. You will receive your HSA match by the end of the month after you and your dependents* complete both healthy activities. (Ex. You complete activities on February 12. The deposit to your HSA will be made by March 31). Exam completion is based on provider claim submission this may take 20-90 days for HireRight to receive reporting.	Actions must be completed by November 30, 2021.
Anthem Blue Cross: Core PPO Plan through Anthem's Get Control Wellness Program	Earn up to $650 for employee only coverage and $1,300 for employee + spouse in cash rewards via a MasterCard by completing various wellness activities including: • Flu shot and wellness visit • Telephonic Well-being Coach • ConditionCare for those with a chronic conditions • Healthy habit tracking with Sydney Health Activities	Your MasterCard cash reward is processed within in 12-40 days after you complete the wellness activity. As you complete multiple activities your MasterCard is reloaded thereafter which takes 5-7 days. All transactions can be tracked within the Anthem Sydney portal or mobile app.	All wellness activities must be completed before the end of the plan year, December 31, 2021. All transactions can be tracked within the Anthem Sydney portal https://www.anthem.com/ca/ or download the free Sydney Health mobile app.

FINANCIAL WELLNESS

PLANS TO HELP YOU SAVE

401(k) Retirement Savings Plan

Transportation & Parking Benefits

Is it time for a “financial wellness” checkup?

Are you worried about money—making your paycheck last? Paying down debt? Making a big purchase like a car or home? And can you even think about preparing for retirement?

Ignoring your financial health can take a toll on your quality of life today and block opportunities for the future. And worrying about money matters can make you stressed, even to the point of physical illness.

We offer benefits and resources to help you make the most of your money now and in the future.

SAVE NOW, ENJOY LATER

WHAT ARE YOUR PLANS?

Whether your retirement dreams include traveling the world, enjoying a hobby, or relaxing with family, you need a plan to get there.

Our 401(k) Plans provides a convenient and tax-advantaged way to save so you can achieve your retirement goals.

The earlier you start, the more you will save!

How is the Roth 401(k) similar to the Traditional 401(k) ?

- Contributions are based on eligible compensation just like your traditional pre-tax contributions
- Your Roth 401(k) contribution limits are part of the same IRS limits set for your Traditional pre-tax 401(k) contribution
- 2021 contribution limit: $19,500 or $26,000 if the Age 50 Catch-Up applies

How is the Roth 401(k) different from the Traditional 401(k)?

- The Roth 401(k) contributions are after tax
- Roth earnings are tax-free as long as the withdrawal is qualified

Traditional Pre-Taxed 401(k) & 401(k) Roth Retirement Savings Plans

A 401(k) is a retirement savings plan. Through this plan, you may elect to have a percentage of your paycheck deposited to a retirement savings account with Fidelity Investments. For the Traditional 401(k), the money is deducted from your paycheck before federal and, in most states, state and local income taxes and is not subject to taxes until you withdraw the funds from your account. For the 401(k) Roth, contributions will be deducted after taxes.

Visit the Fidelity website at **www.401k.com** to manage your account, investments, and contributions. Or contact Fidelity by phone at **1-800-835-5097**. Your 401(k) paycheck deductions, and the employer match, will begin generally one to two paychecks following your enrollment. You may change, stop, or re-enroll in the 401(k) Plans at any time.

Maximum annual contribution limit	You may elect to have from 1% to 60% of your eligible gross compensation withheld from each paycheck on a pretax basis up to the annual IRS limit of $19,500 for 2021. Employees age 50 or older may elect to contribute up to 100% of their pay each pay date. If you are or will be 50 years old or older in 2020, you are eligible to make additional "catch-up contributions" up to the IRS annual limit of $6,500 for 2021.
HireRight matching contributions	The Company will match 100% of your first 4% in eligible earnings that you contribute each pay period. All Team Members will be immediately 100% vested in employer matching contributions.

Rollovers

You may roll over your pre-tax assets from another qualified retirement plan, such as a former employer's 401(k) Plan, at any time. The 401(k) Plan rollover form and instructions can be found in the 401(k) Plan Enrollment Guide which is available on **www.YourBenefitsCenter.com** or by contacting Fidelity Investments at **1-800-835-5097**.

Investments

The Plan offers a variety of investments including Fidelity and non-Fidelity mutual funds.

SAVE ON COMMUTE EXPENSES

MINIMUM CONTRIBUTION AMOUNT

The **minimum contribution** amount for our Transportation Spending Account is **$125**

Transportation Savings Account

Transit benefits, administered by Anthem, lets you set aside before-tax dollars to pay for employment-related out-of-pocket transportation expenses. You can contribute a minimum of $125 up to the contribution limit set by the IRS is $270/month. There are two options available: mass transit or parking.

You may enroll in one or both options through the Anthem website:

- Visit **anthem.com/ca** and log in or register**.**

HOSPITAL INDEMNITY INSURANCE

Hospital Indemnity Insurance

Hospital Indemnity Insurance from Aetna can enhance your current medical coverage. The plan pays a lump sum, tax-free benefit when you or an enrolled dependent is admitted or confined to the hospital for covered accidents and illnesses. You can use the money you receive under the plan however you see fit, for paying medical bills, child care, or for regular living expenses like groceries—you decide. You can enroll in this program during Open Enrollment or as a result of a Qualifying Life Event

YOU ARE UNIQUE—AND SO ARE YOUR BENEFIT NEEDS

Voluntary benefits are optional coverages that help you customize your benefits package to your individual needs.

You pay the entire cost for these plans, but rates may be more affordable than individual coverage, and you get the added convenience of paying through payroll deduction.

Voluntary benefits are just that: voluntary. You have the freedom and flexibility to choose the benefits that make sense for you and your family. Or, you do not have to sign up for voluntary benefits at all. The choice is yours.

ADDITIONAL RESOURCES

SYDNEY APP

Meet Sydney Health — your digital connection to your health and your health plan. Sydney Health is simple and personalized, with convenient reminders and instant access to information about your Anthem or Empire medical, dental and vision plans anytime, anywhere. Visit the App Store or Google Play Store to download Sydney Health.

LIVEHEALTH ONLINE

LiveHealth Online lets you have a video visit with a board certified doctor using your smartphone, tablet or computer with a webcam. No appointments, no driving and no waiting at an urgent care center. Doctors are available 24/7 to assess your condition and, if it's needed, they can send a prescription to your local pharmacy.

Use LiveHealth Online if you have pinkeye, a cold, the flu, a fever, rashes, infections, allergies or another common health condition. It's faster, easier and more convenient than a visit to an urgent care center. To learn more or schedule a visit, go to **livehealthonline.com.**

HEAL™

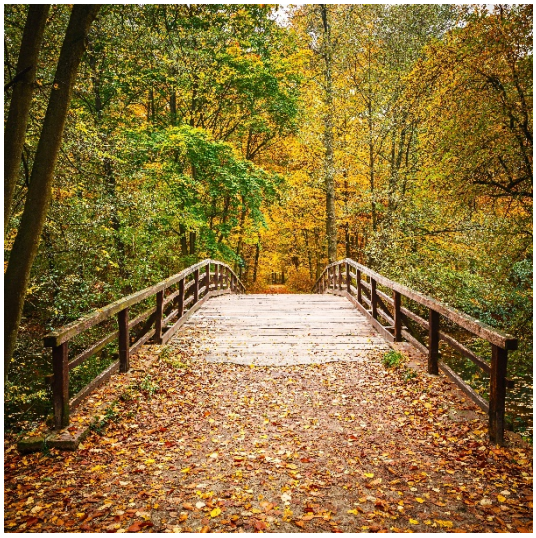
Heal™ is a service that lets you see a doctor at a time and place that is best for you. Heal doctors provide urgent care, preventive care, and more. On-demand visits are available to PPO members throughout California, Georgia, Virginia, New Jersey, New York, and Washington. Heal tells you how much a doctor's visit will cost before you book your appointment. For preventive care covered under your PPO plan, you pay nothing. For more detailed cost information, please check your plan documents. Home visits with Heal doctors are available 8 a.m. to 8 p.m. PST daily. To learn more or schedule a visit, go to heal.com or, call **(844) 644-4325**.

KNOW WHERE TO GO

Where you get medical care can have a significant impact on the cost. Here is a quick guide to help you know where to go, based on your condition, budget and time.

Type	Appropriate for	Examples	Access	Average Cost*
Nurseline 	Quick answers from a trained nurse 1-866-787-6371	• Identifying symptoms • Deciding if immediate care is needed • Home treatment options and advice	24/7	No Cost
Online visit 	Minor illnesses and conditions Livehealthonline.com	• Common cold, flu, fever • Headache, migraine • Skin conditions • Allergies	24/7	$ Varies by Plan
At-home visit 	Minor illnesses and conditions http://www.heal.com/ 1-844-644-4325	• Common cold, flu, fever • Headache, migraine • Skin conditions • Allergies	Business Hours	$ Varies by Plan
Office visit 	Routine medical care and overall health management	• Preventive care • Illnesses, injuries • Managing existing conditions	Office Hours	$$
Urgent care, Walk-in clinic 	Non-life-threatening conditions requiring prompt attention	• Stitches • Sprains • Animal bites • Ear-nose-throat infections	Vary, up to 24/7	$$$
Emergency room	Life-threatening conditions requiring immediate medical expertise	• Suspected heart attack or stroke • Major bone breaks • Excessive bleeding • Severe pain • Difficulty breathing	24/7	$$$$

TIME AWAY FROM WORK



2021 Paid holidays

HireRight provides 9 paid holidays per year for regular full-time and regular part-time Team Members scheduled to work 20 or more hours per week.

Holiday hours for Team Members scheduled to work less than 40 hours per week will be prorated based on the number of scheduled work hours per week.

Team Members scheduled to work less than 20 hours per week, as well as intermittent, contingent, and temporary Team Members, are not eligible for paid holidays, unless required by law.

New Year's Day	Jan. 1
MLK Day	Jan. 18
Presidents' Day	Feb. 15
Memorial Day	May 31
Independence Day	Jul. 5
Labor Day	Sep. 6
Thanksgiving Day	Nov. 25
Day after Thanksgiving	Nov. 26
Christmas	Dec. 24

2 Floating Holidays

Use the 2 floating holidays on or between Jan. 1 – Dec. 31, 2021

Must be hired 90 days prior to using floating holidays, except California/Montana; California/Montana Team Members must be hired 30 days prior to using floating holidays

IMPORTANT PLAN INFORMATION

In this section, you will find important plan information, including:

- Your medical benefit contributions for 2021
- Contact information for our benefit carriers and vendors
- A summary of the health plan notices you are entitled to receive annually, and where to find them
- A Benefits Glossary to help you understand important insurance terms

YOUR BI-WEEKLY BENEFIT COSTS

The total amount that you pay for your benefits coverage depends on the plans you choose, how many dependents you cover, and, for medical coverage, how much you earn. Your healthcare costs are deducted from your pay on a pre-tax basis — before federal, state, and Social Security taxes are calculated — so you pay less in taxes.

MEDICAL Earnings Less Than $30,000

	Core PPO Plan	HDHP 1400	HDHP 2000
TEAM MEMBER ONLY	$31.62	$63.09	$36.05
TEAM MEMBER + SPOUSE OR DOMESTIC PARTNER	$82.20	$163.98	$93.69
TEAM MEMBER + CHILD(REN)	$67.25	$134.17	$76.66
TEAM MEMBER + FAMILY	$133.62	$266.54	$152.31

MEDICAL Earnings Between $30,000 - $59,999

	Core PPO Plan	HDHP 1400	HDHP 2000
TEAM MEMBER ONLY	$40.25	$80.31	$45.88
TEAM MEMBER + SPOUSE OR DOMESTIC PARTNER	$101.17	$201.83	$115.34
TEAM MEMBER + CHILD(REN)	$82.75	$165.09	$94.34
TEAM MEMBER + FAMILY	$160.34	$319.85	$182.77

YOUR BI-WEEKLY BENEFIT COSTS

The total amount that you pay for your benefits coverage depends on the plans you choose, how many dependents you cover, and, for medical coverage, how much you earn. Your healthcare costs are deducted from your pay on a pre-tax basis — before federal, state, and Social Security taxes are calculated — so you pay less in taxes.

MEDICAL Earnings Between $60,000 - $99,999

	Core PPO Plan	HDHP 1400	HDHP 2000
TEAM MEMBER ONLY	$43.11	$86.03	$49.15
TEAM MEMBER + SPOUSE OR DOMESTIC PARTNER	$107.49	$214.43	$122.54
TEAM MEMBER + CHILD(REN)	$87.92	$175.43	$100.25
TEAM MEMBER + FAMILY	$169.25	$337.62	$192.92

MEDICAL Earnings Greater Than $100,000

	Core PPO Plan	HDHP 1400	HDHP 2000
TEAM MEMBER ONLY	$45.97	$91.66	$52.38
TEAM MEMBER + SPOUSE OR DOMESTIC PARTNER	$113.77	$226.98	$129.69
TEAM MEMBER + CHILD(REN)	$93.09	$185.68	$106.11
TEAM MEMBER + FAMILY	$178.15	$355.38	$203.08

PLAN CONTACTS

HELPFUL RESOURCES

Your Benefits Center
www.yourbenefitscenter.com

HireRight Benefits Department
1-888-921-0563
M – F 8:00 a.m. – 5:00 p.m. PT

MEDICAL

Anthem Blue Cross of California
www.anthem.com
1-800-888-8288
M – F 8:00 a.m. – 6:00 p.m. ET

LiveHealth Online
www.livehealthonline.com
No Phone Number
24/7

SPENDING ACCOUNTS

Health Savings Account
www.anthem.com/ca
1-844-860-3535

Transportation/ Commuter Accounts
www.anthem.com/ca
1-844-860-3535
M–F 8:00 a.m. – 11:00 p.m. ET

LEAVE OF ABSENCE

Leave of Absence and STD
www.MySedgwick.com
1-877-576-8149
Intake Call Center: 24/7
Customer Service Call Center:
M–F 7:00 a.m. – 8:30 p.m. CT

401(K)

Fidelity Investments
www.401k.com
1-800-835-5097
M–F 8:30 a.m. – 8:00 p.m. ET

HOSPITAL INDEMNITY

Aetna
www.Aetna.com
1-800-571-4015

GLOSSARY

-A-

Allowed Amount
The maximum amount your plan will pay for a covered healthcare service.

Ambulatory Surgery Center (ASC)
A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.

Annual Limit
A cap on the benefits your plan will pay in a year. Limits may be placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service. After an annual limit is reached, you must pay all associated healthcare costs for the rest of the plan year.

-B-

Balance Billing
In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is $100 but the plan's allowable charge is only $70, an out-of-network provider may bill YOU for the $30 difference.

Beneficiary
The person (or persons) that you name to be paid a benefit should you die. Beneficiaries are requested for life, AD&D, and retirement plans. You must name your beneficiary in advance.

Brand Name Drug
A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine.

-C-

COBRA
A federal law that may allow you to temporarily continue healthcare coverage after your employment ends, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim
A request for payment that you or your healthcare provider submits to your healthcare plan after you receive services that may be covered.

Coinsurance
Your share of the cost of a healthcare visit or service. Coinsurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 70%, your coinsurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.

Copayment
A flat fee you pay for some healthcare services, for example, a doctor's office visit. You pay the copayment (sometimes called a copay) at the time you receive care. In most cases, copays do not count toward the deductible.

-D-

Deductible
The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

-E-

Eligible Expense
A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.

Excluded Service
A service that your health plan doesn't pay for or cover.

-F-

Formulary
A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.

-G-

Generic Drug
A drug that has the same active ingredients as a brand name drug, but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor.

Grandfathered
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

-H-

Health Reimbursement Account (HRA) An account funded by an employer that reimburses employees, tax-free, for qualified medical expenses up to a maximum amount per year. Sometimes called Health Reimbursement Arrangements.

High Deductible Health Plan (HDHP) A medical plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more healthcare costs (the deductible) before the insurance company starts to pay its share. A high deductible plan (HDHP) may make you eligible for a Health Savings Account (HSA) that allows you to pay for certain medical expenses with money free from federal taxes.

-I-

In-Network
In-network providers and services contract with your healthcare plan and will usually be the lowest cost option. Out-of-network services will cost more, or may not be covered. Check your plan's website to find doctors, hospitals, labs, and pharmacies that belong to the network.

GLOSSARY

-M-

Mail Order
A feature of a medical or prescription drug plan where medicines you take routinely can be delivered by mail in a 90-day supply.

-O-

Open Enrollment
The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Open Enrollment is held one time each year. Outside of open enrollment, you can only make changes if you have certain events in your life, like getting married or adding a new baby or child into the family.

Out-of-Network
Out-of-network providers (doctors, hospitals, labs, etc.) cost you more because they are not contracted with your plan and are not obligated to limit their maximum fees. Some plans, such as HMOs and EPOs, do not cover out-of- network services at all.

Out-of-Pocket Cost
A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA, or HRA.

Out-of-Pocket Maximum
Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year.

Outpatient Care
Care from a hospital that doesn't require you to stay overnight.

-P-

Participating Pharmacy
A pharmacy that contracts with your medical or drug plan and will usually result in the lowest cost for prescription medications.

Plan Year
A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug
Each health plan has a preferred drug list that includes prescription medicines based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

Preventive Care Services
Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is covered.

Primary Care Provider (PCP)
The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP, and require care and referrals to be directed or approved by that provider.

-T-

Telehealth / Telemedicine / Teledoc
A virtual visit to a doctor using video chat on a computer, tablet or smartphone. Telehealth visits can be used for many common, non-serious illnesses and injuries and are available 24/7. Many health plans and medical groups provide telehealth services at no cost or for much less than an office visit.

-U-

UCR (Usual, Customary, and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury, or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

Vaccinations
Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.

Voluntary Benefit
An optional benefit plan offered by your employer for which you pay the entire premium, usually through payroll deduction.

REQUIRED PLAN NOTICES

HEALTH PLAN NOTICES

These notices must be provided to plan participants on an annual basis and are available on yourbenefitscenter.com under the “Regulatory Notices” tab.

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of Open Enrollment
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents

COBRA CONTINUATION COVERAGE

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.

HIRE RIGHT®