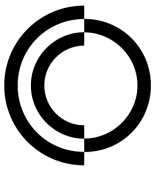

Collective Health®

2025 Plan Details

California Times PPO

Hello!

Welcome to your California Times PPO plan, presented in partnership with Collective Health. We always try to keep things simple at Collective Health. This booklet is not exactly short, but here's why it's important to share it with you: this is your summary plan description (SPD). It describes the benefits of your health Plan and it's something that you can refer to when you have questions. If there are any material changes to this or future SPDs, you will receive a Summary of Material Modifications (SMM) to let you know what the changes are.

This SPD is organized by topic so you can quickly find what you need. Here are some of the topics that you can read about inside:

- What's covered by the Plan, what's not covered, and how much you can expect to pay for your healthcare
    - Who is eligible for coverage, and how to enroll
    - When your coverage begins and ends, and when you might be able to continue coverage
    - How to submit a claim, and what to do if your claim is denied
    - Your rights and responsibilities as a member of this Plan

Collective Health wants to help you understand everything about your healthcare benefits and what's covered for you and your dependents. You can get 24/7 access to information about your plan and your healthcare claims by activating your account at my.collectivehealth.com. If you have any additional questions, get in touch with us by calling 833-440-4367 or chatting with one of our Member Advocates through the Collective Health website or mobile app from 4 am to 6 pm PT, Monday through Friday, and 7 am to 11 am PT on Saturdays. You can also sign into your Collective Health account and use Messages to communicate with a Member Advocate directly.

Here's to a happy and healthy year ahead!

Este folleto tiene un resumen en inglés de los derechos y beneficios de su PPO plan. Si tiene dificultades entendiendo la información que se encuentra aquí, por favor contacte 833-440-4367. También nos puede contactar directamente ingresando a su cuenta de Collective Health y usando la opción "Messages."

本手册含有您 PPO plan 保险计划提供的福利和权利的英文总结. 如果您对本手册的内容有任何疑问，请拨打 833-440-4367. 你也可以登入你的 Collective Health 账号，用 Messages 功能和我们直接交流.

Fast Facts About Your Health Plan

What kind of health Plan is this?

This is a "PPO" (preferred provider organization) plan. This includes a preferred network (Anthem Blue Cross of California) that includes many, but not all, doctors and hospitals. You do not need to designate a primary care physician or get your primary care physician's referrals to see specialists; you can see the doctors you choose for your medical needs. If you see in-network doctors, you will generally pay less than if you see doctors out-of-network.

Who pays?

The California Times PPO is a self-insured healthcare plan. That means there is no health insurance company paying for your claims; NantMedia Holdings, LLC DBA California Times ("California Times") is the Plan sponsor, and they pay doctors and hospitals for the medical care you receive. Collective Health partners with California Times and takes on many administrative responsibilities for this Plan (such as processing your claims and answering your questions). Anthem Blue Cross of California provides the medical network for the Plan, and gives you access to a nationwide network of healthcare providers through the BlueCard program. Express Scripts administered by RxBenefits, Inc. provides pharmacy benefit management services for the Plan. You help pay for the cost of your healthcare under this Plan. More information about cost sharing is in Section 3.

Key Plan Information

- The Plan year begins on January 1 and ends on December 31.
- Depending on how many people you enroll, your in-network deductible will be:
    - $1,000 for an individual
        - $2,000 for your family
- Depending on how many people you enroll, your in-network out-of-pocket maximum will be:
    - $3,000 for an individual
    - $6,000 for your family
- Find information about what's covered in Section 5. Information about what's not covered is in Section 6.

Questions? We're here to help.

Register for 24/7 access to your healthcare information at my.collectivehealth.com. Collective Health Member Advocates are available at 833-440-4367. You can also sign into your Collective Health account and use Messages to communicate with a Member Advocate directly.

Section 1: Who Is Eligible for Coverage

Eligible Employees

Employees are eligible for benefits where they are regularly scheduled to work 30 hours per week annually. Once eligible, those employees who are on an approved Leave of Absence or a Salary Continuation under a policy of NantMedia Holdings, LLC shall continue to remain eligible for the period of the Approved Leave of Absence, or approved extension of such Leave of Absence, or Salary Continuation Period as defined in these policies, which are incorporated by reference.

Employees who are classified as temporary or part-time working less than 30 hours per week or temporary, interns or another class of employee other than a regular employee scheduled to work 30 hours per week annually, are eligible after meeting the required hours during a Measurement Period determined with the Patient Protection and Affordable Care Act (“PPACA”), you will generally be eligible to participate in the medical plan. Please contact the benefits department for additional eligibility details.

Eligible Dependents

When you enroll someone in addition to yourself on your Plan, they are called your “dependent.” They become eligible for coverage when you become eligible for coverage. Your contribution every pay period will be higher if you choose to enroll your dependent(s).

Your spouse is the person to whom you are legally married and who is treated as your “spouse” for tax purposes. You will be required to provide documentation that an individual is your spouse, such as a marriage license or registration certificate. Your domestic partner is the person with whom you are in a committed relationship that is substantially similar to a marriage. You will be required to provide documentation that an individual is your domestic partner.

For a child to be eligible to join this Plan as your dependent, they must be one of the following:

- Your natural child
- Your spouse's natural child (stepchild)
- Your domestic partner's natural child
- Your adopted child
- Your spouse's adopted child
- Your domestic partner's adopted child
- A child placed with you for adoption (meaning the legal process of adoption has begun, and you have taken some responsibility for that child)

- A child placed with your spouse for adoption (meaning the legal process of adoption has begun, and you have taken some responsibility for that child)
- A child placed with your domestic partner for adoption (meaning the legal process of adoption has begun, and you have taken some responsibility for that child)
- A child for whom you have been named legal guardian
- A child for whom your spouse has been named legal guardian
- A child for whom your domestic partner has been named legal guardian
- A child for whom you must provide coverage because of a Qualified Medical Child Support Order (QMCSO)
- A child for whom your spouse must provide coverage because of a QMCSO
- A child for whom your domestic partner must provide coverage because of a QMCSO

A child dependent can be deemed eligible for medical coverage up until the end of the month that they turn age 26. Your child must be a US citizen or a resident of the United States, Mexico, or Canada.
If you have an unmarried child that has a severe physical or mental condition that makes them indefinitely dependent on you for primary support, then they will continue to be eligible after age 26, as long as their condition and dependency persists. You will be required to provide information and documents to prove your children's eligibility for coverage.

Who Cannot Be Your Dependent?

Some people are not eligible to participate in this Plan as your dependents, even if they meet the criteria above:

- Your former spouse, if you are legally separated or divorced
- Your former domestic partner, if your relationship has ended
- Anyone who is separately covered under this plan as an employee
- Any child who is separately covered under this plan as another employee's dependent

Section 2: Enrollment & When Coverage Begins

You must be enrolled in this plan to receive benefits from this plan. If you want your dependents to receive benefits, you must enroll them too. No one can receive the benefits of this Plan without being enrolled for coverage.
Each year, the Company will set the procedures for all eligible employees to enroll themselves and their eligible dependents for health benefits. You must follow these procedures to enroll yourself and your dependents, including authorizing the Company to deduct your contribution every pay period directly from your paycheck.

You can only enroll yourself and your dependents at specific times of the year:

- During the annual open enrollment period
- After you are newly hired or first become eligible
- During a special enrollment period after a qualifying life event

If you miss your enrollment window, you will need to wait until the next plan year's open enrollment period or during a special enrollment period in order for your coverage to begin. You must enroll on time to get covered on time.

Annual Open Enrollment Period

Each year, before the new Plan year begins, there will be an open enrollment period. During the open enrollment period, you may choose whether you would like to be covered by this Plan for the next Plan year, and you may add or remove dependents. If multiple health benefits options are available, you will be able to choose the package you prefer. The Company will determine the start and end dates of the open enrollment period.

The selections you make during open enrollment will become effective at the beginning of the next Plan year, which is January 1st. You won't be able to change your selections again until the next open enrollment period, unless you experience a qualifying life event during the year.

New Hire or Newly Eligible Employee Enrollment

If you begin work at the Company and are eligible for health benefits, you will have an opportunity to choose whether you would like to participate in this Plan, and whether you want to enroll your dependents. The same is true if you become newly eligible while employed at the Company (for example, if you switch from part-time to full-time). You must enroll for coverage within 30 days of becoming eligible.

If you are a new or newly eligible full-time employee, your coverage will begin on the first of the month following date of hire; if hired on the first of month, then coverage will begin on the date of hire.

Special Enrollment Periods

In general, once you make your coverage selections during open enrollment or new hire enrollment, those choices are fixed for the Plan year and can't be changed. But certain events trigger special enrollment periods, where you will be allowed to make changes to your coverage selections outside of open enrollment.

1. **You can enroll mid-year if you lose other healthcare coverage**. You might initially decline coverage because you or your dependents are already covered by another group health plan, or by insurance from another source (including COBRA). For example, you may be a dependent on your spouse's plan, and for that reason you may decline to enroll in your company's health benefits during your initial new hire/newly eligible period or open

enrollment. If you or your dependents lose your healthcare coverage from that other source (or if your dependent's company stops contributing toward that other coverage), you have the right to enroll yourself and all of your eligible dependents in this Plan. But you must enroll within 30 days after the other coverage ends (or the company stops contributing). If you enroll on time, your coverage will be effective as of the date you enroll in the plan.

2. **You can enroll if you get married or have a child.** If you acquire a new dependent as described in the "Eligible Dependents" section through an event such as marriage, birth, adoption, placement for adoption, or a Qualified Medical Child Support Order (QMCSO), you have the right to enroll yourself and your eligible dependents in your company's health plan. But you must enroll within 30 days after that life event (for example, after your marriage or after your child is born). If the special enrollment is due to the birth or adoption of a child, coverage will be retroactive to the date of birth or adoption. Otherwise, your family's coverage will begin on the first day of the month after you submit your enrollment request.

3. **You can enroll if you gain or lose coverage under Medicaid or a state children's health insurance program.** If you or your dependents lose coverage under your state's Medicaid or children's health insurance program (CHIP), or you become eligible for health insurance subsidies under one of those programs, you will have the opportunity to enroll your family in this Plan. You must enroll within 60 days of your Medicaid or CHIP eligibility change.

These special enrollment periods are governed by the Health Insurance Portability and Accountability Act (HIPAA) and will be interpreted to comply with HIPAA regulations and requirements. QMCSOs are governed by ERISA and will be interpreted to comply with ERISA regulations and requirements. Note that the plan also extends the special enrollment rights described above to domestic partners and their children.

There may be more circumstances where you have the right to enroll for coverage in the middle of a Plan year. Contact California Times' Benefits Team for more information.

Section 3: Your Contributions & Costs

Your membership in this Plan includes a responsibility to contribute to the cost of your healthcare benefits. Each pay period, you will be required to pay an employee contribution. In most cases, when you actually receive healthcare services, you must also pay part of the cost of those services. The Plan is designed so you generally pay less when you use providers and facilities in the Anthem Blue Cross of California network.

Employee Contribution

California Times will require you to pay an employee contribution every pay period, via payroll deduction, in order to enroll in this plan. The cost may vary depending on if you have

dependents (and how many) and may also depend on other factors, which are set by California Times. Once you enroll in a plan option, your contribution is fixed: you'll have to pay it whether you use any health services or not. In exchange for your contribution each pay period, you get access to the plan's benefits to help you pay for the healthcare you need. Your contribution will generally remain constant throughout the plan year, but California Times has discretion to change it. If there is a substantial increase in costs each pay period, you may be given an opportunity to change your benefits selections.

How the Network Can Work for You

Your membership in this plan includes access to a network of healthcare service providers (doctors, nurses, and other licensed professionals) and facilities (such as hospitals, urgent care centers, and pharmacies). The providers and facilities in this network have agreed to accept negotiated rates for the services they provide to you and your dependents. Because health services from in-network providers and facilities often cost less than the same services outside the network, this Plan is designed to encourage you to use in-network services whenever possible. Please note that if you have signed a waiver with an in-network provider, they may bill you for amounts in excess of the network's allowed amount. This amount will not be covered by the plan (see Section 4 for other circumstances for which you may be responsible for the full cost of your care).

- Anthem Blue Cross of California is this Plan's preferred medical network. Through Anthem Blue Cross of California, you have access to providers outside of California in the BlueCard program. You can find additional important information about Anthem Blue Cross of California and BlueCard in Appendix A. Anthem Blue Cross of California, an independent member of the Blue Shield Association, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.
- This Plan's preferred pharmacy network is Express Scripts, which includes all major retail pharmacies as well as a mail order pharmacy option.
- The Plan may also have preferential arrangements that provide enhanced benefits if you use specific healthcare facilities or services.

In most circumstances, this plan provides richer benefits for services provided by in-network healthcare providers or facilities. If you receive services out-of-network, you will generally be responsible for a greater share of the cost.

If your in-network doctor refers you to an out-of-network provider or facility for a covered service, or you choose to see an out-of-network provider because there is no in-network provider available, the Plan may authorize the in-network benefits to an out-of-network provider claim. If this applies to your situation, please contact Collective Health in advance of obtaining the covered service. If you receive authorization for in-network benefits to apply to a

covered service received from an out-of-network provider, you may still be responsible for the difference between the allowed amount and the out-of-network provider's billed amount. Ultimately, the choice of which provider or facility to use (whether in- or out-of-network) is yours. To find out whether a doctor is in your network, check my.collectivehealth.com, the mobile app, or contact a Collective Health Member Advocate. Because provider or facility network status may change throughout the year, it is best practice to always double check with the provider or facility on their current status with the Anthem Blue Cross of California network.

This Plan requires your provider to have specific credentials in order to cover your treatment. This helps the Plan ensure that you receive medically necessary, quality care. In most cases, the required credentials are state medical licenses, which must be active and unrestricted in the state where you are receiving care.

If a provider's license is not active or current, your claim will not be covered. If a provider has an active professional certification to provide covered benefits in that state, the claim will be covered. If a mental or behavioral health provider, with the appropriate and relevant training, is practicing under the guidance of a licensed and active provider, the claim will be covered as long as the services rendered are covered benefits on your Plan.

The following table provides examples of specific provider credentials required for Plan coverage. If you choose to visit an out-of-network provider, make sure to confirm that the provider has the appropriate credentials to administer the care you need. You may be responsible for submitting validation of their credentials. Contact Collective Health if you have questions about your specific provider. Remember that services still need to be medically necessary to be covered by your Plan.

Provider Type	Sample Credentials by Provider Type
Acupuncturist	Licensed Acupuncturist (LAc) Doctor of Oriental Medicine (DOM)
Audiologist	Doctor of Audiology (AuD) American Board of Audiology (ABA) Certified Audiologist
Chiropractor	Doctor of Chiropractic (DC)
Dentist	Doctor of Dental Surgery (DDS) Doctor of Medicine in Dentistry (DMD)
Lactation consultant	International Board Certified Lactation Consultant (IBCLC), Academy of Lactation Policy and Practice (ALPP)
Massage Therapist	Licensed Massage Therapist (LMT)

Midwife	Certified Nurse Midwife (CNM) (certified midwives are not covered)
Naturopath	Doctor of Naturopathy (ND) Doctor of Naturopathic Medicine (NMD)
Nurse	Nurse Practitioner (NP) Registered Nurse (RN) Licensed Vocational Nurse (LVN)
Nutritionist or Registered Dietician	Licensed Dietitian (LD) Licensed Nutritionist (LN) Licensed Dietician Nutritionist (LDN)
Occupational Therapist	Registered/Licensed Occupational Therapist (OTR)
Optometrist	Doctor of Optometry (OD)
Pharmacist	Doctor of Pharmacy (PharmD)
Physician	Doctor of Medicine (MD) Doctor of Osteopathic Medicine (DO)
Physical Therapist	Physical Therapist (PT) Master of Physical Therapy (MPT or MSPT) Doctor of Physical Therapy (DPT)
Physician Assistant	Physician Assistant (PA)
Podiatrist	Doctor of Podiatric Medicine (DPM)
Psychiatrist	Doctor of Medicine (MD) Doctor of Osteopathic Medicine (DO)
Psychologist	Clinical Psychologist (PhD) Doctor of Psychology (PsyD)
Respiratory Care Practitioner	Certified Respiratory Therapist (CRT) Registered Respiratory Therapist (RRT)
Speech Therapist/Pathologist	Licensed Speech Language Pathologist (SLP)
Therapist/Counselor/Social Worker	Licensed Clinical Social Worker (LCSW) Licensed Master Social Worker (LMSW) Marriage and Family Therapist (MFT/LMFT)

If you have questions about whether your provider may be covered by your Plan, contact Collective Health.

Allowed Amounts

One benefit of visiting an in-network doctor or hospital is that Anthem Blue Cross of California has negotiated the rates for most healthcare services in advance. When you choose to visit an out-of-network provider or facility for medical treatment, it's much harder to know how much your treatment might cost. The providers may charge a reasonable rate for the services they provide you, or they may charge a lot more.

This Plan will not pay charges that are excessive. Instead, this Plan sets an allowed amount for each medical service, and this allowed amount is the most the Plan will pay for that service when you receive it from an out-of-network provider. Allowed amounts are determined by reference to Medicare. The plan will use Medicare reimbursement rates as a benchmark and will set the allowed amount as 110% of the Medicare reimbursement rate. If Medicare pricing is not available, the plan will use an equivalent rate based on Medicaid. If neither is available, the plan will set the allowed amount to 40% of charges. The allowed amount for out-of-network emergency room and ambulance claims may be based on your medical network's in-network pricing. You may contact Collective Health for more information.

Because the Plan doesn't have contracts in place with out-of-network providers, those providers may charge more than the allowed amount for the treatment you receive. Your benefits under this Plan will be based on the allowed amount, and the provider may bill you for the excess. (This practice is called balance billing.) It is your responsibility to pay any amounts in excess of the allowed amount—in addition to any deductibles, copays, or coinsurance. Balance billed charges can be significant, and they also don't count toward your out-of-pocket maximum. If you choose to see an out-of-network provider, you may want to ask them about their billed charges before you receive care.

If you can gather some information from your out-of-network provider in advance, Collective Health can help you determine whether you're likely to be balance billed. Contact Collective Health for guidance or visit my.collectivehealth.com.

If you are balance billed by an out-of-network provider at an in-network facility, after an out-of-network ambulance ride, or for emergency services rendered outside of the United States, please contact Collective Health. You may be eligible for additional coverage.

Surprise Billing Protections

The following out-of-network services will be covered with in-network cost-sharing (including in-network deductible and out-of-pocket maximum) and your cost-sharing will be calculated based on the lesser of the provider's billed charges or the median in-network rate in the geographic region (also referred to as the qualifying payment amount); the allowed amount will be based on one of the following in the order listed as applicable: the initial payment made by the Plan (which is the median in-network rate in the geographic region), the amount subsequently agreed to by the out-of-network provider or out-of-network emergency facility and the Plan, or the amount determined by the Independent Dispute Resolution (IDR) process

if the parties enter into the IDR process and do not agree on a payment amount before the date when the IDR entity makes a determination:

- **Emergency Services** including services you may get after you're in stable condition, as covered under the No Surprises Act.
- **Non-emergency services provided by out-of-network providers at an in-network hospital or ambulatory surgical center,** including emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services.
- **Air Ambulance Services**

Out-of-network providers cannot balance bill you for these services. However, the prohibition against balance billing does not apply if the provider has satisfied the notice and consent criteria under federal law to obtain your voluntary and informed written consent for the following services: (1) non-ancillary services received at in-network facilities on a non-emergency basis from out-of-network providers, and (2) post-stabilization services if you are able to travel using non-medical transportation or non-emergency medical transportation to an available in-network provider or in-network facility located within reasonable travel distance and the out-of-network provider or out-of-network emergency facility follows detailed notice and consent requirements.

With respect to non-emergency services provided by out-of-network providers at an in-network facility, for ancillary services, non-ancillary services provided without satisfying the notice and consent criteria under federal law, and non-ancillary services for unforeseen or urgent medical needs that arise at the time an item or service is furnished, you are not responsible, and an out-of-network provider may not bill you, for amounts in excess of your applicable copayment, coinsurance, or deductible.

You're <u>never</u> required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your Plan's network. If you believe you've been wrongly billed, you may contact the U.S. Department of Labor Employee Benefits Security Administration at 1-866-487-2365.

Continuity of Care Under the No Surprises Act

When a provider goes out of network, plans must permit individuals who are undergoing treatment for a serious and complex condition, pregnant, receiving inpatient care, scheduled for non-elective surgery, or are terminally ill to elect up to 90 days of continued, in-network covered services. Please contact Collective Health for more information.

Paying for Treatment You Receive

For most healthcare services, the plan pays for some, but not all, of the cost of treatment. Generally, you and the plan share the cost of your care. This plan shares the cost of

healthcare with you in a couple of ways: an annual deductible, copays, coinsurance, and an out-of-pocket maximum (OOPM).
Until you hit your OOPM, you'll have to share the cost of your healthcare with the plan. You'll have to meet an annual deductible, and also pay a copay or coinsurance for most services you receive.

Coverage Tier	In-Network Deductible	Out-of-Network Deductible
Individual	$1,000	$3,000
Family	$2,000	$6,000

What is a deductible?

- A deductible is the amount you'll pay up-front for care until your benefits kick in. This applies only to some benefits.
- Remember that in-network preventive care is fully covered, even if you haven't met your deductible yet.

What is the difference between copays ($) and coinsurance (%)?

- Copays are fixed dollar amounts. You typically pay the copay at the time you receive a medical service or fill a prescription.
- Coinsurance is a percentage of the cost of care. Your provider will typically bill you later.
- The cost sharing for each medical service, and whether or not the deductible applies to the benefit, is listed in the benefits table in Section 5.

What spending counts toward your deductible?

- The amount you pay for covered prescriptions does not accumulate toward your medical deductible. Additionally, you do not need to meet your medical deductible before your pharmacy benefits kick in.
- Benefits can interact differently with your deductible:
    - Some benefits are entirely separate from your deductible. For these benefits, if a service requires a copay or coinsurance, you only pay that amount, even if you haven't met your deductible. However, when you pay these copay or coinsurance benefits, that amount doesn't accumulate toward your deductible.
    - For other benefits, you must pay the full cost of care for services until you meet your deductible for the year. After you've met your deductible, the benefits will kick in, and you'll be responsible only for your copay or coinsurance amount.

- Regardless of whether the medical service was in- or out-of-network, when you spend money on covered expenses, those dollars go toward satisfying both your in- and out-of-network deductibles.
- Your employee contributions don't count toward your deductible, and neither do the amounts you pay for non-covered services or amounts in excess of the allowed amount.

How do deductibles work if you have a family plan?

- Each person on the plan has an individual deductible. After an individual reaches their individual deductible, their coinsurance benefits will kick in. Even on a family plan, no one member will ever have to satisfy more than their individual deductible.
- If you have dependents, then your family has a family deductible. Once your whole family combined has paid enough to meet the family deductible, benefits will kick in for the entire family. This is true even for members who haven't yet hit their individual deductible.

The OOPM is the most you'll be required to pay for covered services in a Plan year.

Coverage Tier	In-Network Out-of-Pocket Max	Out-of-Network Out-of-Pocket Max
Individual	$3,000	$6,000
Family	$6,000	$12,000

What spending counts toward your OOPM?

- All money you pay for covered medical and pharmacy services counts toward your OOPM (including your deductible, copays, and coinsurance).
- The amounts you pay for covered medical services in-network only count toward your in-network OOPM. Likewise, the amounts you pay for covered medical services out-of-network only count toward your out-of-network OOPM.
- Your employee contributions don't count toward your OOPM, and neither do the amounts you pay for non-covered services or balance-billed amounts.

What happens after you hit your OOPM?

- Once you meet your OOPM for in-network care, the plan will pay for all of your covered in-network healthcare costs for the rest of the plan year. Your out-of-network OOPM works the same way.

- Remember that the OOPM only applies to covered services; even after you hit your OOPM, the Plan won't pay for non-covered services or amounts in excess of the allowed amount.

How do OOPMs work if you have a family plan?

- Each person on the plan has an individual OOPM. After an individual reaches their individual OOPM, their healthcare will be fully covered by the plan, and they won't have to share the cost of medical and pharmacy services.
    - Your whole family's costs are also capped at the family OOPM amount. Once your family's covered medical and pharmacy costs hit the OOPM, all enrolled members will have full coverage for the rest of the plan year. This is true even if some individuals haven't yet hit their individual OOPM.

Assignment of Benefits

You (or your dependents) may not assign or transfer in any manner your benefits or other rights that you have under this Plan, to any other person, including a healthcare provider. Any attempt to assign or transfer your rights under this Plan will not be recognized and is void, except to the extent required by law. For convenience, the Plan may pay any undisputed benefit directly to a healthcare provider. The Plan administrator reserves the discretionary authority to determine the validity of any arrangement to direct the payment of benefits to a third party and does not guarantee that any arrangement will be valid under the Plan. Any payment to a third party is not a waiver of the Plan's anti-assignment provision and does not make the provider an assignee or confer any rights on the provider, including any right to receive future payments or ERISA rights.

Section 4: Quality & Value Programs

Maximum Medical Benefits

This Plan does not cap the total aggregate value of medical benefits you can receive, either in a given year or over your lifetime as a Plan member. So long as you remain eligible, and your treatment falls within the scope of the Plan and the allowed amount, your healthcare costs will continue to be covered by the Plan.

If specific services have maximum visits or benefit caps, that information will be clearly stated alongside the service costs in the benefit table in Section 5.

Prior Authorization for Certain Procedures

This Plan requires your provider to receive prior authorization for certain services. This means the provider must get clearance from the Plan in advance, before providing treatment to you. If the provider does not get prior authorization for a service that requires it, the Plan may not pay for the treatment. You may be responsible for the full cost of your care in the following cases:

- Your provider does not apply for prior authorization or a post-service review (also called a “post authorization”) with the medical network.
- The prior authorization or post-service review is denied.
- You sign a waiver promising to pay for charges not allowed by your Plan.

Prior authorization is typically required anytime you will be admitted to the hospital on an elective (non-emergency) basis—for example, if you need to be admitted for a scheduled surgery. Prior authorization may also be required for services such as non-emergency imaging (CT, MRI, MRA, and PET scans), rental or purchase of certain durable medical equipment, and intensive spinal procedures (surgery, injections, and implants). Routine preventive care services never require prior authorization. When a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, could cause severe pain, your provider should request expedited processing.

The prior authorization requirements change from time to time. The current list of services requiring prior authorization will always be available from Anthem Blue Cross of California. Please visit www.anthem.com/provider/prior-authorization/ to see which services require a prior authorization.

If prior authorization is denied, your physician can appeal that denial. You can also file your own appeal with Anthem Blue Cross of California to contest a prior authorization denial (see Section 9).

If you have questions about prior authorization in general, or about whether a specific treatment needs prior authorization, contact Collective Health. If you would like to request a prior authorization, contact Anthem Blue Cross of California.

Case Management Services

This plan’s preferred medical network, Anthem Blue Cross of California, also provides a case management program for members whose healthcare requirements are more complicated than usual. The purpose of case management is to improve both the quality and value of healthcare treatments.

Collective Health and Anthem Blue Cross of California will identify members who are likely to benefit from the case management program. If you are identified, a case manager (usually, a registered nurse) will reach out to you, your caregivers, and your healthcare providers. Your case manager can help you manage your healthcare by explaining your treatment options,

coordinating care between multiple providers or facilities, and dealing with related issues holistically.
Participation in the case management program is completely voluntary. You do not have to speak to the case manager if you prefer not to. Your participation (or not) in the case management program will not affect your benefits.
If you feel you could benefit from case management services but no one has reached out to you, you can contact Collective Health for a referral.

Get a Second Opinion

A second opinion is a process where you consult with an expert in the field of your diagnosis to make sure that your diagnosis is correct and that you are set on the right treatment path. We encourage you to get a second opinion under the following circumstances:

- You have, or are diagnosed with, a rare or complex condition that requires the navigation and understanding of treatment options.
- Whenever your doctor recommends that you have surgery—that is, any surgery that can be scheduled in advance (not an emergency). Even if your doctor recommends surgery, there may be other, less invasive treatment options that could give you as good (or better) results. In some cases, having surgery could actually make your overall health worse.

In these situations, not only can you get a second opinion—you can even get a third opinion if you wish. A second or third opinion is 100% voluntary, and you are not required to get one if you prefer not to. You can choose to get a second or third opinion anytime your doctor recommends elective surgery, for any reason.
The doctor who gives you a second (or third) opinion about your complex condition or elective surgery would be independent from the doctor who either diagnosed you or recommended the surgery in the first place.
How much will this cost? The Plan will cover second and third opinions like other covered services described in Section 5. So, if you visit a specialist's office to get a second opinion, you will pay your regular copay or coinsurance for a specialist doctor visit. When you choose to visit an out-of-network provider or facility for medical treatment, the Plan will cover the allowed amount, and the provider may balance bill you for any excess. It is your responsibility to pay any amounts in excess of the allowed amount—in addition to any deductibles, copays, or coinsurance.

Section 5: What's Covered & How Much It Costs

This section describes your Plan's benefits in detail. Benefits are split into three categories: preventive care, emergency care, and everything else.

This Plan covers most medically necessary healthcare services, except those that are specifically excluded. All services may be subject to a medical necessity review by the medical network or an independent review organization (IRO). The Plan administrator and/or claims administrator has full discretionary authority to adjudicate benefit claims, including taking a holistic view of the member's healthcare needs and condition, and current and future financial implications. Section 6 of this document includes a definition of medical necessity as well as a list of services that are excluded from your Plan.

Preventive Care

Preventive care is generally provided when you are well and is intended to keep you healthy. The federal government—specifically, the U.S. Preventive Services Task Force, the Health Resources and Services Administration, and the Centers for Disease Control and Prevention—has recommended certain healthcare services as preventive care.

This plan must cover the full cost of in-network preventive care services, even if you haven't met your deductible. You can get preventive care services from out-of-network providers if you choose, but this plan will pay for only part of the cost of out-of-network preventive care, and may require you to meet your deductible before benefits kick in. When you choose to visit an out-of-network provider or facility for preventive care services, the plan will cover the allowed amount, and the provider may balance bill you for any excess. If no in-network provider of a specific preventive care service is available in your geographic area, the plan will provide in-network benefits for that out-of-network care.

Certain medical services qualify as "preventive care" depending on your age, biological sex, medical conditions, or timing. The following services are examples of preventive care:

- Breastfeeding supplies and support (including breast pumps) if you become pregnant, both during pregnancy and while nursing.
- Colorectal cancer screening (including colonoscopy) for adults aged 45 to 75.
- Immunizations against whooping cough, measles, chickenpox, and other diseases for children from birth to age 18, at recommended doses and cadence.

Preventive and diagnostic care may occur during the same visit. For more information about which preventive services are recommended for you, visit www.healthcare.gov/coverage/preventive-care-benefits. Services you receive as part of your annual wellness exam may not always be considered preventive and be subject to your plan's regular cost share. Please contact Collective Health for more information on the specific procedure and diagnosis codes that comprise your preventive benefits.

Service	Description	What You Pay
Preventive care for adults	Routine annual physical exam and associated counseling and screening, including immunizations and some lab services. The list of recommended services is available at: www.healthcare.gov/preventive-care-adults	In-network: Fully covered (the plan pays 100%). You do not have to meet your deductible first. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount.
Preventive care for women	Annual well-woman exam and associated counseling and screening, including contraception, routine recommended mammograms, and lab services. Includes preventive care during pregnancy and breastfeeding support and supplies. The list of covered services is available at: www.healthcare.gov/preventive-care-women	In-network: Fully covered (the plan pays 100%). You do not have to meet your deductible first. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount.
Preventive care for babies and children	Periodic exams and associated counseling and screening, including immunizations, behavioral assessments and autism screening, and lab services. Also includes routine care for your healthy newborn child while they are in the hospital immediately after birth. Newborn care charges are only covered if you enroll your newborn within 30 days of birth—otherwise, charges will not be covered. The list of covered services is available at: www.healthcare.gov/preventive-care-children	In-network: Fully covered (the plan pays 100%). You do not have to meet your deductible first. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount.

Emergency Care

Emergency care is designed to diagnose and treat an illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm. You should seek emergency care in an urgent care center or in a hospital's emergency room. Urgent care centers are generally cheaper than emergency rooms, especially if you use an urgent care center in your network. If you are in a position to choose—and if you know your condition is not too serious—you should consider going to a local urgent care center instead of a hospital emergency room. If your condition is life-threatening (or you're not sure), you can and should go to the emergency room.

This Plan provides the same level of cost-sharing for in-network and out-of-network emergency care in an emergency room. The same level of cost-sharing is provided if you need emergency care when you are traveling outside the United States. Out-of-network emergency services, as defined by the No Surprises Act, will be covered at the median in-network rate in the geographic region or as otherwise required by applicable law (see Section 3 for more on surprise billing and balance billing protections). See Appendix A for additional information about access to Anthem Blue Cross of California's network services outside the U.S. These providers will be out-of-network but may assist with coordinating your coverage.

This Plan covers medically necessary emergency air and ground ambulance services. Ground emergency ambulance services are considered medically necessary when all of the following criteria are met:

- The ambulance is equipped with appropriate emergency and medical supplies and equipment;
- The patient's condition is such that any other form of transportation would not be advisable by a physician or other licensed medical provider; and
    - The member is transported to the nearest hospital with the appropriate facilities and requisite level of care for the treatment of the member's illness or injury.

Air ambulance services are considered medically necessary when all of the criteria pertaining to ground transportation (listed above) are met and at least one of the following criteria are met:

- The member's medical condition requires immediate and rapid ambulance transport to the nearest appropriate medical facility that could not be reached by land ambulance;
- The point of pick-up is inaccessible by a ground ambulance;
- Great distances, limited time frames, or other obstacles limit the member's access to the nearest hospital with appropriate facilities for treatment; or
    - The member's condition is such that the time needed to transport the member by land to the nearest appropriate medical facility poses a threat to the member's health.

Service	Description	What You Pay
Emergency ambulance	Medically necessary emergency transport by an air or ground ambulance to the nearest hospital with the appropriate facilities and requisite level of care for the treatment of the member's illness or injury. An ambulance is a specially designed vehicle that is staffed with qualified medical personnel and appropriately equipped to provide life-saving and supportive treatments or interventions during the transportation of ill or injured members. See "Emergency Care" above for more details on ambulance service requirements.	*May require a prior authorization.* In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the allowed amount; the plan pays the remainder of the allowed amount. Regardless of whether you receive services in-network or out-of-network, this benefit is subject to your in-network deductible and out-of-pocket maximum.
Emergency room expenses	Services and supplies in a hospital emergency room (including doctor fees), which are required to stabilize you or initiate treatment in an emergency. Follow-up treatment after you leave the emergency room is covered separately. If you go to an emergency room and you are admitted to the hospital, your emergency room copay is waived.	In-network: You pay a $150 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). Out-of-network: You pay a $150 copay per visit; the plan pays the remainder of the allowed amount. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). Regardless of whether you receive services in-network or out-of-network, this benefit is subject to your in-network out-of-pocket maximum.

Urgent care center expenses	Services and supplies in a licensed urgent care center, for conditions reasonably requiring immediate treatment. An urgent care center is a clinic or acute-care facility that provides outpatient treatment for illnesses or injuries that require immediate treatment but are not necessarily life-threatening.	In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount.

Treatment for Medical Conditions other than Preventive or Emergency Care

The benefits table on the following pages describes what the Plan will pay for medical treatment other than preventive or emergency care. Different medical services may require you to pay different copays or coinsurance, and some services are subject to limits and annual benefit maximums. When you choose to visit an out-of-network provider or facility for medical treatment, the Plan will cover the allowed amount, and the provider may balance bill you for any excess. It is your responsibility to pay any amounts in excess of the allowed amount—in addition to any deductibles, copays, or coinsurance.

The table below may not fully address every possible medical situation. If you have questions about how your unique medical needs may be covered by the Plan, contact Collective Health.

Service	Description	What You Pay
Acupuncture	Acupuncture and associated treatment by a licensed provider.	*Limited to 12 sessions per year per member.* In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount.
Allergy care	Testing and appropriate treatment (including allergy serum and injections) by a healthcare provider.	Allergy testing In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount. Allergy serum/Allergy therapy In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount.

Ambulance (non-emergency)	Medically necessary, non-emergency transport by an air or ground ambulance to the nearest medical facility where you can receive the treatment you need. An ambulance is a specially designed vehicle that is staffed with qualified medical personnel and equipped to transport an ill or injured person.	*May require a prior authorization.* In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the allowed amount; the plan pays the remainder of the allowed amount.
Anesthesia	Medication, supplies, and administration of anesthetics when administered by a healthcare provider.	Anesthesia services and supplies are covered based on where you receive your treatment (for example, in a doctor’s office or in a hospital).

Autism	Diagnosis, care and treatment for adults and children with autism spectrum disorders, including applied behavioral analysis and, physical, occupational, and speech therapies.	Applied behavioral analysis/Applied behavioral therapy *May require a prior authorization.* In-network: You pay a $25 copay per session; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount. Other rehabilitation services for mental health treatment *May require a prior authorization.* In-network: You pay a $25 copay per session; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount. Telemedicine applied behavioral analysis/Telemedicine applied behavioral therapy *May require a prior authorization.* In-network: You pay a $25 copay per session; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount.

		<u>Vision Therapy to treat Autism</u> In-network: Not covered. Out-of-network: Not covered.
Auditory rehabilitation	Auditory rehabilitation, by a licensed therapist, as part of a short-term rehabilitative program following illness or injury.	In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount.
Bariatric surgery	*Coverage for bariatric surgery recipients only.* Surgical procedures performed to induce weight loss in people for whom it is medically necessary. *Travel expenses for bariatric surgery are not covered.*	*May require a prior authorization.* In-network: Services and supplies are covered based on who provides your care and where you receive your treatment. Out-of-network: Services and supplies are covered based on who provides your care and where you receive your treatment.

Cancer treatment	Diagnosis and treatment for cancer, including doctor visits, labs and scans, radiation and chemotherapy treatment, and routine patient care costs for clinical trials (please see "Clinical trials," below). *Travel expenses for cancer treatment are not covered.* Wigs are subject to the durable medical equipment cost share and associated limitations described below.	Specialist visit In-network: You pay a $40 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount. Labs *May require a prior authorization.* In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount. X-rays *May require a prior authorization.* In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount. Scans *May require a prior authorization.* In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest.

		Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount. <u>Chemotherapy & radiation</u> *May require a prior authorization.* In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount.
Cardiac rehabilitation	Cardiac rehabilitation to treat or prevent heart attack, heart failure, or coronary artery disease, or to recover after heart surgery.	In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount.
Chiropractic care	Chiropractic treatment and spinal manipulation by a licensed provider.	*Limited to 30 sessions per year per member.* In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount.

COVID-19 Services	If you're experiencing flu-like symptoms (e.g., cough, shortness of breath, fever) you may have COVID-19.	<u>COVID-19 Antibody Testing</u> Non-medically necessary COVID-19 Antibody Testing is excluded from the medical plan. <u>COVID-19 Asymptomatic Screening</u> Fully covered (the plan pays 100%). You do not have to meet your deductible first. You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount. <u>COVID-19 Telemedicine</u> In-network: Fully covered (the plan pays 100%). You do not have to meet your deductible first. Out-of-network: The plan pays 100% of the allowed amount. You do not have to meet your deductible first. <u>COVID-19 Testing and Screening</u> In-network: Fully covered (the plan pays 100%). You do not have to meet your deductible first. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount. <u>COVID-19 Treatment</u> Coverage is based on where you receive your treatment (for example, in a doctor's office or in a hospital) and the type of care received. Prior authorization may be required depending on the service.

		<u>COVID-19 Vaccine and Booster</u> In-network: Fully covered (the plan pays 100%). You do not have to meet your deductible first. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount. <u>Over-the-counter COVID-19 Tests</u> The medical plan pays the cost of tests for up to 8 tests per covered family member per calendar month. You may submit claims and get reimbursed under a single family member. You don't have to meet a deductible first.
Clinical trials	Routine patient care (as defined by the ACA) costs provided as part of a clinical trial that is recommended by your physician and covered by the Plan as determined upon medical necessity review. Routine patient care includes the non-experimental health services you receive during the clinical trial (doctor's visits, medical equipment, treatment of complications), but does not include the cost of unapproved drugs (including the subject of the trial) or research administration costs.	*May require a prior authorization.* Services and supplies are covered based on who provides your care and where you receive your treatment (for example, an oncologist visit, medical equipment, or labs/scans).

Diabetes	Diagnosis, care, and treatment for adults and children with diabetes (type I and II), including diagnostic testing, doctor visits, foot care, medical equipment, and education and training for diabetes patients in disease management (when recommended by your physician). Certain services related to your diabetes may be considered preventive. Contact Collective Health for more information. Insulin and other prescription medications are covered by your pharmacy benefits.	Specialist visit In-network: You pay a $40 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount. Diabetes self-management training In-network: You pay a $25 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount. Labs *May require a prior authorization.* In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount. Medical equipment *May require a prior authorization.* In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network:

		You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount.
Dialysis	Kidney dialysis services for hemodialysis, peritoneal dialysis, and home dialysis.	In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount.

Doctor’s office visits	Visits and services from your primary care provider or specialist healthcare provider when you need treatment for a medical condition. In-network preventive care visits are free for you. Please contact Collective Health for more information on the specific procedure and diagnosis codes that comprise your preventive benefits.	Primary care provider *Certain services or items provided during your visit may require prior authorization. Please see Section 4 for how to check for prior authorization requirements.* In-network: You pay a $25 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount. Specialist provider *Certain services or items provided during your visit may require prior authorization. Please see Section 4 for how to check for prior authorization requirements.* In-network: You pay a $40 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount. Naprapathic therapy *Limited to 15 sessions per year per member.* In-network: You pay a $40 copay per session; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). Out-of-network: You'll owe the full cost of this service until you've met your deductible. After

		that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount.
Emergency room expenses (non-emergency)	Services and supplies in a hospital emergency room (including doctor fees), which are provided in a non-emergent capacity. Follow-up treatment after you leave the emergency room is covered separately.	Emergency room expenses (non-emergency) In-network: Not covered. Out-of-network: Not covered.
Eye care	Medically necessary eye care related to specific medical conditions, including but not limited to diabetic retinopathy, glaucoma, cataracts, and other diseases and infections of the eye. Routine eye care, such as vision screenings (including refraction), is not covered by this Plan. Some routine eye care may be considered preventive for individuals under the age of 18. Please contact Collective Health for more information on the specific procedure and diagnosis codes that comprise your preventive benefits.	Services and supplies are covered based on what care you receive and who provides it (for example, medical equipment or outpatient surgery).

Family planning	Coverage for preventive contraceptives includes prescription barrier methods, prescription female condoms, generic hormonal methods, implanted devices, and emergency contraception. Coverage for non-preventive contraceptives includes male sterilization. Termination of pregnancy (including elective abortion) is covered. *Travel expenses for women's reproductive services are not covered.*	Preventive contraceptive services (generic) In-network: Fully covered (the plan pays 100%). You do not have to meet your deductible first. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount. Non-preventive covered birth control services Covered based on what care you receive and where (for example, a brand-name prescription, OB/GYN appointment, or outpatient surgery).
Fertility	Coverage for infertility diagnosis (including semen analysis and embryonic genetic testing), pharmaceutical therapies, artificial insemination, oocyte cryopreservation (i.e. egg freezing), and advanced reproductive technologies (IVF, ZIFT, GIFT, and sperm retrieval). In addition to fertility-specific benefits, this plan provides coverage for the diagnosis and treatment of underlying medical conditions (such as endometriosis) that also cause infertility; these treatments are covered outside of your fertility benefits and do not count against your fertility benefits allowance.	Limited to $10,000 per lifetime per member. May require a prior authorization. Fertility diagnosis and treatment In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount. Pharmaceutical therapy The cost will depend on the type of drug. See the “Pharmacy Benefits” section below.

Foot care	Exams by podiatrists, foot care associated with metabolic or peripheral-vascular disease (including related to diabetes), and custom-made foot orthotics, when prescribed by a physician. Pedicures, spa treatments, and cosmetic treatment of corns, calluses, or toenails are not covered.	Podiatrist visit In-network: You pay a $40 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount. Orthotics In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount.

Gender affirming services	*Coverage for gender affirming services recipients only.* Diagnosis and treatment for services related to gender affirming services, including gender affirmation surgery. Hormones will be covered by your pharmacy benefits; see the "Pharmacy Benefits" section below. *Travel expenses for gender affirming services are not covered.*	Counseling (office visit) *Certain services or items provided during your visit may require prior authorization. Please see Section 4 for how to check for prior authorization requirements.* In-network: You pay a $25 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount. Gender affirming surgery *Limited to $75,000 per lifetime per member.* *May require a prior authorization.* In-network: Services and supplies are covered based on who provides your care and where you receive your treatment. Out-of-network: Services and supplies are covered based on who provides your care and where you receive your treatment.
Habilitation	Habilitative services that help you keep, learn, or improve skills and functional abilities for daily living that may not be developing normally, including physical, occupational, and speech therapies.	*May require a prior authorization.* In-network: You pay a $25 copay per session; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount.

Hearing screening & aids	Hearing exams for newborns and children as part of preventive care, or for adults when recommended by a medical provider. Cost sharing of any hearing aid services and additional supplies is based on where the services are obtained.	<u>Preventive hearing screenings for newborns and children (office visit)</u> In-network: Fully covered (the plan pays 100%). You do not have to meet your deductible first. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount. <u>Non-preventive hearing screenings</u> In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount. <u>Hearing aids</u> *Limited to $2,000 per year per member.* *May require a prior authorization.* In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount.

Home-based care	At-home care and treatment of an illness or injury, with a prescription from your doctor that specifies how long you'll need home care. Includes visits by trained medical personnel (including nurses) and supplies.	Home health *Limited to 120 days per year per member.* *May require a prior authorization.* In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount. Private duty nursing *Limited to 60 days per year per member.* *May require a prior authorization.* In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount.
Hospice care	Hospice care is an integrated program that provides comfort and support services for people who are terminally ill (usually meaning they are not expected to live more than six months). Hospice care often includes emotional support services for the immediate family. Respite care provides caregivers a temporary rest from caregiving. Respite care as part of hospice care is covered under this benefit.	*May require a prior authorization.* In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount.

Hospital stays	Inpatient hospital stays (admission for a scheduled procedure, or admission after an emergency). Includes room & board, doctor visits, supplies (like dressings, splints, or other materials), and medications or other substances (like blood, oxygen, fluids) during your stay. See “Surgery” below for more details on costs for surgical procedures.	*May require a prior authorization.* In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount.
Infusion therapy	Intravenous or other infusion-based administration of medication in a medical facility (hospital or outpatient center) or as part of an office or home healthcare visit, under the care of a physician.	*May require a prior authorization.* In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount.
Injectable medications	Injections (other than allergy injections or other benefits separately listed in this chart) administered by a medical provider. Includes, for example, steroid or pain medication injections when medically necessary. Drugs you take yourself (not administered by a healthcare provider) are covered separately, under your pharmacy benefits.	*May require a prior authorization.* In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount.

Medical equipment and supplies	Rental or purchase of durable medical equipment, which is medical equipment that is not disposable and is customarily used for a medical purpose, and associated supplies. A prescription from your physician is required. You may repair or replace equipment that is outgrown or after reasonable wear and tear. Wigs are subject to a $300 benefit maximum per year per member.	*May require a prior authorization.* In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount.

Medical tests	Medically necessary diagnostic tests, including laboratory tests, radiology (such as X-rays or ultrasounds), and advanced imaging (such as MRI, PET, or CT scans), when recommended by a healthcare provider. Preventive care medical tests (for example, routine recommended mammograms) are covered at 100% in-network.	Preventive care tests In-network: Fully covered (the plan pays 100%). You do not have to meet your deductible first. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount. Diagnostic labs *May require a prior authorization.* In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount. Radiology *May require a prior authorization.* In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount. Advanced imaging *May require a prior authorization.*

		In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount.

Mental health	Care and treatment by (or directed by) psychiatrists, psychologists, counselors, social workers, or other qualified medical professionals to address conditions impairing behavior, emotion reaction, or thought process.	Office visits *Certain services or items provided during your visit may require prior authorization. Please see Section 4 for how to check for prior authorization requirements.* In-network: You pay a $25 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount. Rehabilitative services (physical, occupational, and speech therapy) for mental health treatment *May require a prior authorization.* In-network: You pay a $25 copay per session; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount. Intensive Outpatient Treatment *May require a prior authorization.* In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount.

		<u>Inpatient/residential stays</u> *May require a prior authorization.* In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount.
Mouth, tooth & jaw injury	Dental care (such as cleanings or fillings) is not covered by this Plan. Coverage is limited to: • Medical treatment of jaw joint disorders (like TMJ) • Excision of tumors and benign bony growths in the jaw or mouth • Emergency repair of natural teeth after injury • Surgical repair of jaws, cheeks, lips, tongue, and floor/roof of mouth after injury • External incision and drainage of cellulitis • Incision of sensory sinuses, salivary glands or ducts • Removal of impacted teeth	Services and supplies are covered based on who provides your care and where you receive your treatment (for example, in a doctor's office or in a hospital).
Nutritional counseling	Nutritional evaluation and counseling by a registered dietitian or licensed nutritionist.	In-network: Not covered, unless considered a preventive service or a medically necessary condition. Out-of-network: Not covered, unless considered a preventive service or a medically necessary condition.

Occupational therapy	Occupational therapy, by a licensed therapist and under the direction of a physician, as part of a short-term rehabilitative program following illness or injury. Recreational or exercise programs are not covered.	*Limited to 60 sessions per year per member. Note that this session limit is a combined limit with physical therapy and speech therapy. Mental health, substance use disorder, and preventive care claims are not subject to this limit.* *May require a prior authorization.* In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount.
Orthotics	Initial purchase, fitting, and repair of orthotic appliances (like back braces or leg splints) required to support a body part that is disabled after injury or because of a congenital condition. Also includes custom-made foot orthotics, when prescribed by a physician, to treat weak, unstable, unbalanced, or flat feet.	In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount.

Physical therapy	Physical therapy, by a licensed therapist and under the direction of a physician when required, as part of a short-term rehabilitative program following illness or injury. Recreational or exercise programs are not covered.	*Limited to 60 sessions per year per member. Note that this session limit is a combined limit with occupational therapy and speech therapy. Mental health, substance use disorder, and preventive care claims are not subject to this limit.* *May require a prior authorization.* In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount.

Pregnancy & childbirth	Care and treatment during pregnancy and childbirth, including required prenatal care, hospital stays, physician services, surgery, breastfeeding support and supplies, and hospital nursery care for your newborn child. Please keep in mind that some services related to your pregnancy may be considered preventive and will be covered under the Plan's preventive care benefit. The Plan covers inpatient care for at least 48 hours after delivery (96 hours after cesarean section), though your physician may discharge you earlier. Newborn care charges are only covered if you enroll your newborn within 30 days of birth—otherwise, charges will not be covered. If you are pregnant or you have just given birth, rental or purchase of a hospital-grade or commercial breast pump (manual or electric) is covered during and after the pregnancy. Many traditional retailers stock a variety of breast pumps at a comparable cost to in-network breast pumps. To make it easier for you to obtain a breast pump in a timely manner, your plan covers out-of-network breast pumps and accessories with the same cost sharing as your in-network preventive benefit, up to an allowable amount. Please contact Collective Health to find out what the allowable amount is for an out-of-network breast pump based on your geographic area. If the cost of the out-of-network breast pump and supplies you purchase is less than or equal to the allowed amount, they will be covered with no additional cost to	Prenatal care (primary care visits) In-network: You pay a $25 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount. Prenatal care (specialist visits) In-network: You pay a $40 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount. Genetic testing *May require a prior authorization.* In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount. Ultrasounds *May require a prior authorization.* In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network:

	you. If the cost of the out-of-network breast pump and supplies you purchase is greater than the allowed amount, you will be responsible for the difference.	You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount. Hospital admission for delivery *May require a prior authorization.* In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount. Newborn nursery *May require a prior authorization.* In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount. Breastfeeding support and counseling (excluding breast pumps and accessories) In-network: Fully covered (the plan pays 100%). You do not have to meet your deductible first. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount. Breast pumps and accessories In-network:

		Fully covered (the plan pays 100%). You do not have to meet your deductible first. Out-of-network: The plan pays 100% of the allowed amount. You do not have to meet your deductible first.
Prosthetics	Initial purchase, fitting, and repair of artificial limbs and other prosthetic devices to replace body parts that are missing after amputation or because of a congenital condition. Includes replacement for prosthetic devices that have been outgrown or that require replacement due to reasonable wear and tear.	*May require a prior authorization.* In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount.
Pulmonary rehabilitation	Pulmonary rehabilitation, by a licensed therapist, to improve lung function, reduce symptom severity, and improve quality of life as part of a treatment plan for chronic illness.	In-network: You pay a $25 copay per session; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount.
Respiratory rehabilitation	Respiratory rehabilitation, by a licensed therapist, as part of a short-term rehabilitative program following illness or injury.	In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount.

Skilled nursing facilities	Inpatient care at a skilled nursing facility, after or in place of hospitalization or home healthcare, with a doctor's prescription (which specifies how long you should stay at the facility). A skilled nursing facility is licensed by Medicare to provide 24-hour inpatient care by registered nurses, directed by a physician, for patients convalescing from physical illness or injury (also known as a rehab hospital, nursing home, or extended care facility). Coverage includes care by doctors and nurses, supplies (like dressings, splints, or other materials), and medications or other substances (like blood, oxygen, fluids) during your stay.	*Limited to 120 days per year per member.* *May require a prior authorization.* In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount.
Speech therapy	Speech therapy by a licensed therapist as part of a short-term rehabilitative program.	*Limited to 60 sessions per year per member. Note that this session limit is a combined limit with occupational therapy and physical therapy. Mental health, substance use disorder, and preventive care claims are not subject to this limit.* In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount.

Substance Use Disorder	Care by (or directed by) psychiatrists, psychologists, counselors, social workers, or other appropriate licensed healthcare providers to treat the dependency on, and excessive use of, chemical substances. Plan coverage for substance use disorder services depends on the setting of your treatment: in an office visit, in an outpatient facility, or in an inpatient or residential facility. Tobacco: Prescription therapies to quit smoking are covered by your pharmacy benefits.	Office visits *Certain services or items provided during your visit may require prior authorization. Please see Section 4 for how to check for prior authorization requirements.* In-network: You pay a $25 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount. Intensive Outpatient Treatment *May require a prior authorization.* In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount. Inpatient/Residential stay *May require a prior authorization.* In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount.

Surgery	Professional services, supplies, medications, and other services provided with or during surgery. "Surgery" includes open or minimally-invasive surgical operations, sutures and skin grafts, and manipulation of broken bones and dislocations. Surgery performed to improve your appearance is considered cosmetic and is not covered, but reconstructive surgery of abnormal congenital conditions and reconstructive surgery after a mastectomy are covered.	Ambulatory surgery center In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount. Hospital outpatient *May require a prior authorization.* In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount. Hospital inpatient *May require a prior authorization.* In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount.

Telemedicine	Your employer has partnered with LiveHealth Online to provide access to telemedicine services. You are not limited to using LiveHealth Online for telemedicine services. Your plan also covers telemedicine visits with other licensed providers.	LiveHealth Online medical visits In-network: You pay a $10 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). Out-of-network: Not covered. LiveHealth Online mental health visits In-network: You pay a $10 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). Out-of-network: Not covered. Medical visits – primary care (through Anthem Blue Cross of California) In-network: You pay a $25 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount. Medical visits – specialist (through Anthem Blue Cross of California) In-network: You pay a $40 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount. Mental health visits (through Anthem Blue Cross of California) In-network:

		You pay a $25 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount.
Transplants	Transplants are defined as the transplant of organs or tissues from human to human or the transplantation of bone marrow, stem cell or cord blood. If you are the recipient, this plan will cover the cost of your and your donor's evaluations, harvesting and transplant surgeries, transportation of the organ, and post-surgical treatments. If you are the donor, your recipient's plan will pay first, and this plan will cover the allowable amount that is left. *Travel expenses for transplant services at a Blue Distinction Center are reimbursed to a maximum of $10,000 per transplant per member for reasonable expenses when travel exceeds 100 miles from your home. You do not have to meet your deductible first. Reasonable expenses include initial consultations and necessary follow-up services. For more information on eligible expenses, contact Collective Health.* *Search expenses to find an organ donor are not covered.*	*May require a prior authorization.* In-network: You'll owe the full cost of this service until you've met your deductible. After that, the plan pays 100% of the cost. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount.

Vaccines	Immunizations for children and adults at recommended ages and doses, along with additional elective vaccines (for example, if recommended for foreign travel) recommended and administered by a physician. The recommended vaccine schedule is available at www.vaccines.gov.	Preventive vaccines In-network: Fully covered (the plan pays 100%). You do not have to meet your deductible first. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 40% of the allowed amount; the plan pays the remainder of the allowed amount. Travel vaccines In-network: Not covered. Out-of-network: Not covered.

Pharmacy Benefits

The pharmacy benefits in this Plan help you pay for the medications you need. In general, this Plan covers all medically necessary medications prescribed to you by your doctor, except those that are specifically excluded (see Section 6 for more on exclusions).
The benefits described below cover the medications you get from a pharmacy. The drugs administered to you by a healthcare provider during an office visit, outpatient procedure, or hospital stay are covered separately by your medical benefits. In addition, certain infusions or implantable products (such as plasma, blood products, or implantable androgen products) are covered by your medical benefits and not your pharmacy benefits.

Your Pharmacy Network

Express Scripts is the pharmacy benefits manager for this Plan, and most retail pharmacies are in-network. As is the case with the rest of your benefits under this plan, you will typically pay less if you use an in-network pharmacy than if you go out-of-network. To find out whether a pharmacy is in your network, you can contact Collective Health; you can check the Express Scripts website by logging in via my.collectivehealth.com, then navigating to Get Care and clicking on “Pharmacy”; or you can ask the pharmacist whether the pharmacy is in the Express Scripts network.
You can get your medications from an in-network retail pharmacy or Express Scripts' mail order pharmacy. If your drugs are available through mail order, they may cost less overall, for you and for the Plan, so these benefits are designed to encourage you to use mail order

whenever possible. If you use out-of-network retail pharmacies, you will need to submit a claim for reimbursement after you purchase your medication. Contact Collective Health for guidance.

Types of Prescriptions

Certain medications are classified as “preventive care.” (These include medications like hormonal birth control, aspirin for heart attack prevention, and tobacco cessation products.) For preventive care prescriptions, if you use in-network pharmacies and select generic alternatives, your Plan will cover 100% of the cost. If you’d like to know if your medication is considered preventive, you can contact Collective Health for help.

On this Plan, some medications will cost you more than others. Generic prescriptions are less expensive versions of brand name drugs. Generic drugs are considered identical to their brand name equivalents (in terms of efficacy and safety) by the FDA.

If you take a brand name drug, it’s important to know that some brands are treated differently under this Plan. Brand name drugs are more expensive than generics, but your Plan has negotiated discounts on some—these are called preferred brand drugs. Non-preferred brands aren't discounted, so you'll pay more for these. Often, there will be generic options for medications prescribed by your doctor. When you fill your prescription, you can ask the pharmacist whether a generic or preferred brand name version of your medication is available.

You must fill a prescription within the time specified by the doctor. Only the number of refills specified by the doctor will be covered.

What You Pay

- You do not need to meet your medical deductible before your pharmacy benefits kick in, but your medical out-of-pocket maximum does apply.
- Money you spend on covered prescriptions will accumulate toward your out-of-pocket maximum just like money you spend on covered medical care.
- You can get preventive care medications fully covered from in-network pharmacies from day one on this Plan. But to learn how much you will owe for any other medications, see the table below.
- If the total cost for a medication is less than your copay, you’ll only have to pay the lesser amount.
- Maintenance medications are typically prescribed for chronic, long-term conditions and are taken on a regular, recurring basis. Maintenance medications include those used to treat high blood pressure, heart disease, asthma, or diabetes. Your plan allows you to pick up a 30-day supply of your medication two (2) times at a retail pharmacy. After that, your drug will not be covered unless you fill your maintenance medication through a mail-order pharmacy, or you transfer your 90-day refill prescription to a participating

Smart90 Walgreens retail pharmacy. If you would like more information on the Smart90 program, you can contact Collective Health for help.

- If you or your provider choose a brand-name medication when a generic version is available, you'll pay what you normally do for generic drug cost sharing, plus the difference in cost between the generic and brand-name drug. The difference you pay will accumulate towards both your deductible and out-of-pocket maximum. Though you will not be responsible for the drug cost sharing, you will continue to be responsible for the difference in cost after you have met your out-of-pocket maximum.
- Your plan will require you to obtain specialty medications through Express Scripts' home delivery service and specialty pharmacy, Accredo (or Freedom for fertility medications). You may pick up specialty medications that are considered urgent two (2) times at an in-network retail pharmacy before setting up home delivery. However, your next fills will no longer be covered at retail and you will need to move the prescription to home delivery service. If you would like to know if your medication is considered specialty and subject to this restriction, please contact Collective Health for help.
- Your plan is enrolled in a vaccination program that allows you to receive certain vaccinations such as your annual flu shot at retail pharmacies, rather than having to make an appointment at a doctor's office.
    - Insulin pumps and insulin pump supplies are not covered through your pharmacy benefits and are instead covered through your medical benefits.

Some medications are excluded from coverage. Contact your Pharmacy Benefits Manager for more information.

Drug Type	In-Network Retail Pharmacy (30-day supply)	In-Network Mail Order Pharmacy (90-day supply)	Out-of-Network Retail Pharmacy (30-day supply)
Preventive drugs	Fully covered (the plan pays 100%).	Fully covered (the plan pays 100%).	The plan pays 100% of the allowed amount.
Generic drugs	You pay a $10 copay; the plan pays the rest.	You pay a $10 copay; the plan pays the rest.	You pay a $10 copay; the plan pays the rest.
Preferred brand drugs	You pay 30% of the cost (at least $25 and up to $50); the plan pays the rest.	You pay a $100 copay; the plan pays the rest.	You pay 30% of the cost (at least $25 and up to $50); the plan pays the rest.

Non-preferred brand drugs	You pay 45% of the cost (at least $40 and up to $80); the plan pays the rest.	You pay a $160 copay; the plan pays the rest.	You pay 45% of the cost (at least $40 and up to $80); the plan pays the rest.
Specialty drugs	You pay a $125 copay; the plan pays the rest.	You pay a $125 copay; the plan pays the rest.	Not covered.
Fertility medication *This benefit has a maximum of $5,000 per lifetime per member.*	The cost of this medication will depend on whether the drug is generic, preferred brand, or non-preferred brand.		

When you go to an in-network retail pharmacy, you can pick up your medication up to the numbered day supply in the table above. You have the option to enroll in mail order medications through your pharmacy network. See the table above to check if any limits apply to mail order medications.

You will not be able to collect more than the numbered day supply indicated in the above table in one order whether you purchase at an in-network or out-of-network retail pharmacy or mail order pharmacy. You will have to wait until your supply is low before you can refill your prescription.

Please note certain prescriptions may require prior authorization in order to be covered under your pharmacy benefits. For more information about which medications require a prior authorization, contact Collective Health.

Over-the-Counter Medications

Over-the-counter medications (ibuprofen, vitamins, etc.) are not covered by this Plan. In accordance with Affordable Care Act guidelines, there are four exceptions to this exclusion:

- When a drug is prescribed by your doctor and you purchase it behind the counter, from the pharmacist (for example, aspirin or folic acid), then you may be able to use your pharmacy benefits even if the drug is also available over-the-counter.
- Over-the-counter supplies for treating diabetes (such as insulin and blood sugar detection equipment) are not excluded from coverage.
- If covered contraceptives are available over-the-counter in your area, those will be covered by this Plan if prescribed by a doctor.
- Over-the-counter smoking cessation treatments are covered by this Plan if prescribed by a doctor.

If you have questions about your pharmacy benefits, including whether certain medications are preferred, non-preferred, or excluded, you can always contact Collective Health for help.

Section 6: What's Not Covered (Exclusions)

Some treatments and services are not covered by this Plan. Items that are not covered are called exclusions and are listed below. Certain exclusions may also be described in the benefits table in Section 5.

Any service, item, or treatment that is not medically necessary is excluded. Services are medically necessary if all the following criteria are met:

1. Recommended and provided by a licensed physician, dentist or other medical practitioner who is covered by the Plan and practicing within the scope of their license;
2. Generally accepted as the standard of medical practice and care for the diagnosis and treatment of your condition, or for preventive care;
3. Clinically appropriate (in terms of type, frequency, duration, and other factors) for your condition;
4. Not performed mainly for your convenience or the convenience of your doctor;
5. Approved by the FDA, if applicable.

The Plan administrator and/or claims administrator has full discretionary authority to adjudicate benefit claims, including taking a holistic view of the member's healthcare needs and condition, and current and future financial implications. When you choose to visit an out-of-network provider or facility for medical treatment, the Plan will cover the allowed amount, and the provider may balance bill you for any excess. It is your responsibility to pay any amounts in excess of the allowed amount—in addition to any deductibles, copays, or coinsurance. This Plan may not cover all possible medically necessary treatments; in other words, some services are excluded from coverage even if they would be medically necessary for you.

Non-medical services are excluded:

- **Custodial care**, which can be provided by individuals without medical training, and is given principally for personal hygiene or for assistance in daily activities (however, treatment typically considered custodial care is covered if the treatment is considered medically necessary as part of the individual's Adaptive Behavioral Therapy)
- **Dietary or nutrition supplements,** except when prescribed to treat specific medical conditions (such as PKU)
- Any type of **education or training,** except as expressly stated in Section 5 as covered or services that are medically necessary and performed by licensed medical professionals

- **Exercise programs** (except for physician-supervised cardiac rehabilitation, physical therapy, or occupational therapy expressly stated in Section 5 as covered)
- **Hypnotherapy**
- **Personal comfort items,** including:
    - Air conditioners
    - Air purification units
    - Humidifiers
    - Electric heating units
    - First aid supplies
    - Elastic bandages or stockings
    - Non-hospital adjustable beds
    - Orthopedic mattresses
    - Non-prescription drugs and medicines, except as expressly stated in Section 5 as covered
    - Scales
- **Rest cures**
- Charges for **travel or non-medical accommodations,** except as expressly stated in Section 5 as covered

This Plan excludes any care you receive when you are not a member. Healthcare services you receive before your coverage effective date are excluded—even if you are charged for the services after your coverage begins. Services you receive after your coverage ends are excluded—even if you got sick while you were still covered.

This Plan also excludes the following services, supplies, or treatments:

- **Compound medication** ingredients that have not shown clinical benefit over lower-cost alternatives, or bulk ingredients used in compound medications where a standard equivalent exists.
- **Concierge membership fees,** retainers, or premiums paid to a concierge medical practice in order to access the medical services provided by that practice.
- Charges for **cosmetic procedures** or pharmaceuticals, which are procedures performed or medications taken for plastic, reconstructive, or cosmetic purposes, or which are intended primarily to improve, alter, or enhance appearance.
    - Wigs are excluded, except for wigs provided for the loss of hair resulting from alopecia areata, endocrine diseases, chemotherapy or radiation to treat cancer, or permanent loss of hair from an accidental injury.
    - Hair transplants are excluded, except for medically necessary transplants provided for the loss of hair resulting from chemotherapy or radiation to treat cancer.
    - Drugs for cosmetic effect, such as Retin-A or hair removal substances, are excluded unless they are medically necessary to treat a medical condition.

    - Growth hormones, anabolic steroids, and appetite suppressants are excluded unless they are prescribed by a physician to treat a covered medical condition (such as HGH deficiency).
    - Reconstructive surgery to correct congenital abnormality or deformity caused by accident, injury, or illness (including after mastectomy) is not excluded.
- **Dental care,** except specific treatments for mouth, tooth, or gum injury expressly stated in Section 5 as covered.
- Charges for services provided by a **doula**.
- **Excess charges** for services, items, or treatment—in other words, charges by out-of-network providers that exceed the allowed amount for the services provided.
- Care or treatment provided or prescribed by **excluded providers,** including:
    - Yourself;
    - A member of your immediate family by birth, adoption, or marriage;
    - A person residing in your household;
    - A provider operating without a license or operating outside the scope of his or her license.
    - If you are treated by a hospital or other healthcare facility, additional payments to an employee or contractor of that facility are excluded, when the facility is itself obligated to pay that individual for their services.
- Charges associated with **experimental treatments,** which are treatments that are not accepted as good medical practice by most practitioners or that lack credible evidence to support positive short- or long-term outcomes for patients.
    - Treatments include any treatment, procedure, service, device, supply or drug provided to a covered person.
    - Drugs that are not approved by the FDA for any use are considered unproven and experimental and are excluded. Off-Label Drug Use is defined as the use of a drug for a purpose other than that for which it was approved by the FDA. Off-Label Drug Use may be covered on the Plan if:
        1. The drug is not excluded under your Plan; and
        2. The drug has been approved by the FDA; and
        3. It can be demonstrated that the Off-Label Drug Use is appropriate for the condition being treated.
- Clinical trials are not covered by this Plan, unless determined to be eligible for coverage upon medical necessity review and not deemed to be experimental or investigational. Routine patient care costs for approved clinical trials may be covered by this Plan, as described in Section 5.
- Experimental/Investigational treatment is not covered by this Plan.
- Routine **eye care** and vision-correction surgery, except:
    - Care and treatment of aphakia and aniridia.
    - Lenses or shells for use as corneal bandages.

    - As otherwise covered by the Preventive Care provisions of this Plan.
    - As expressly stated in Section 5 as covered.
- Charges beyond the Plan's **financial obligations,** including:
    - Amounts in excess of the "allowed amount."
    - Medical treatments outside the Plan's scope (i.e., services that are not listed as covered benefits).
    - Services, items, medications, or treatment for which there would not have been a charge, if no coverage were available.
    - Expenses actually incurred by other persons (not you or your covered dependents).
    - Charges that should be repaid to the Plan under the subrogation, reimbursement, or third-party responsibility provisions (Section 12).
    - Expenses for services that are also covered under any government-sponsored Plan or program (e.g., Tricare, CHAMPUS, VA), unless the government program expressly provides otherwise.
    - For services you obtain before you were covered under this Plan.
    - For services you obtain after your coverage under this Plan ends.
- **Non-medical foot treatments,** such as pedicure or spa treatments or non-medical treatment of corns, calluses, or toenails.
- **Hearing aids** in excess of the benefit expressly stated in Section 5 as covered.
- **Illegal drugs,** including otherwise legal medications (such as oxycodone) procured through illegal means.
- Care, supplies, medications, and services for the treatment of **infertility,** except as expressly stated in Section 5 as covered, including:
    - Fertility services are not covered if your infertility is the result of a prior voluntary sterilization procedure.
    - The purchase of donor sperm and purchase of donor oocytes or embryos and any charges associated with care of the donor required for donor oocytes retrievals or transfers or gestational carriers, in excess of the benefit expressly stated in Section 5 as covered; all charges associated with a gestational carrier program for the person acting as the carrier (if that person is not a member of this plan), including but not limited to fees for laboratory tests.
    - Home ovulations prediction kits.
    - Services and supplies furnished by an out-of-network provider.
- **Marijuana** or marijuana-derived substances (like THC oil), even if you have a prescription and marijuana is legal in the state where you live.
- Non-emergency medical care outside the United States, including all **medical tourism.**
    - Emergency care outside the United States is covered. This includes services or treatment that you must receive in order to safely travel back to the United States. See Appendix A for more information.

- **Over-the-counter drugs,** except as expressly stated in Section 5 as covered.
- **Pharmaceutical medications** that are specifically excluded by Express Scripts from coverage. Contact your Pharmacy Benefits Manager for more information.
- **Private duty nursing** provided in a setting outside the home.
- **Respite care,** unless received as part of hospice care.
- Treatments for intentionally **self-inflicted injuries** or injuries that you sustain while incarcerated are excluded. However, if the injury is due to a medical or mental health condition, or is the result of domestic violence, this exclusion does not apply.
- Charges for **sterilization reversal** procedures, except as expressly stated in Section 5 as covered.
- **Vitamins** or other dietary supplements, except as expressly stated in Section 5 as covered.
- Charges for health services received as a result of an act of **war** or foreign terrorism.
- Services, items, or treatment for **work-related illness or injury**—that is, an illness or injury that arises from work for wage or profit (including self-employment).

Section 7: When Your Coverage Ends

Certain events will cause your coverage under this Plan to end. If multiple terminating events happen around the same time, your coverage will end on the earliest possible termination date.

Triggering Event		What It Means for You
If you are no longer eligible for coverage.	You and your dependents are only covered under this Plan as long as you and they continue to meet the eligibility requirements described in Section 1 of this SPD.	If you become ineligible, your dependents will also automatically become ineligible. Your coverage and your family's coverage will end on the last day of the month that eligibility ends. You may have the right to continue coverage under COBRA (see Section 10).
If you stop paying for coverage.	If you are required to pay an employee contribution to receive benefits under this Plan, then you must pay each period to continue coverage.	Your coverage and your dependents' coverage will end on the last day of the last fully-paid period.

Triggering Event		What It Means for You
If you defraud the Plan.	Your coverage can be terminated if you commit fraud on the Plan, or if you make an intentional, material misrepresentation to the Plan, in the course of obtaining coverage or benefits. (For example, if you submit false claims for reimbursement.)	California Times has discretion to determine when your coverage or your dependents' coverage will terminate. Your termination may be retroactive—if so, you may be required to repay the Plan for prior coverage (this is called rescission). The Plan administrator or Collective Health will give you 30 days' notice of rescission, and you will have the right to appeal this determination.
If the entire Plan ends.	California Times has the right to terminate this Plan, and any other health Plans (in other words, to stop offering coverage for employees), at any time and for any reason.	Your coverage and your dependents' coverage will end on the date the Plan ends. The Plan administrator is responsible for notifying you that your coverage has ended.

There may be more circumstances where your coverage may terminate in the middle of the Plan year, including factors that give you a right to discontinue your coverage. These circumstances are described in the governing documents describing California Times' employee benefits plans. Contact California Times' Benefits Team for more information.

After your coverage ends, the Plan will still pay claims for services you received before your coverage ended. However, once your coverage ends, your benefits under this Plan end immediately—even if you are hospitalized, and even if you need further treatment for conditions that occurred before your end date.

If your coverage ends, your dependents' coverage will also end. But in some circumstances, if your dependent's coverage ends (for example, if your child turns age 26), you and your remaining dependents may continue to receive coverage.

If your employment with California Times ends, and you are rehired after more than 30 days have passed, you will be treated as a new hire, and you and any family members will need to satisfy all of the eligibility and enrollment requirements detailed in Sections 1 and 2. If you are rehired within 30 days after you leave California Times and are still eligible for benefits, you will be reinstated with the same healthcare benefits when you return.

Section 8: How to File a Claim

When you use in-network services, the provider will generally send a claim to the Plan for payment of your treatment. Sometimes out-of-network providers will do the same. Other times, out-of-network providers may bill you for the total cost of your treatment, and you will need to submit the claim to the Plan to be paid. Whether you pay out-of-pocket or your provider bills the Plan directly, you are still entitled to the same benefits.

Claims are considered filed and received by the Plan when they are received by Collective Health. If you have an HSA, distributions and all other matters relating to your HSA are outside of the Plan and are governed by the agreement between you and the HSA custodian.

There are different kinds of Claims and each one has a specific timetable for each stop in the review process. Upon receipt of the Claim, it will be processed and either approved or denied. You will be notified of the decision as soon as practical and not later than the time specified below for the type of claim. However, if the Claim has not been filed properly, or if it is incomplete, or if there are other matters beyond the control of Collective Health, you may be notified that the period for providing the notification will need to be extended. If the period is extended because more information is needed, you must provide the requested information within the time shown below. Once the claim is complete, a decision will be made. If your claim is denied, in whole or in part, you will receive a written notification setting forth the reasons for the denial and describing your rights, including your right to appeal the decision.

The time period shown below begins at the time the claim or appeal is filed in accordance with the Plan's procedures. Decisions will be made within a reasonable period of time appropriate to the circumstances, but within the maximum time periods listed below. Unless otherwise noted, "days" means calendar days.

In the event a check for reimbursement or payment is not cashed within 12 months from the date of issue, the Plan administrator, as applicable, will deem the right to such benefit waived and the check will be voided. Upon such waiver, the Plan shall have no liability for payment of the benefit otherwise payable, and the amount of such benefit shall be deemed a forfeiture. These funds may be applied only to the payment of benefits (including administrative fees) under the Plan pursuant to ERISA. No funds shall escheat to any state.

If you would like more details about claims procedures and your rights and responsibilities, contact Collective Health.

Regular Post-Service Claims

Post-service claims are non-urgent claims after you have received treatment. (Other types of claims have different timelines and requirements; see below.) Generally, you do not need to file a claim when you receive services from in-network providers—the provider, Anthem Blue Cross of California, and Collective Health will handle the processing of the claim. For bills from out-of-network providers or emergency care providers outside of the United States that will not submit claims to Anthem Blue Cross of California, you may receive reimbursement from the Plan by following this procedure.

You can submit a post-service claim by mail or through my.collectivehealth.com. You will need to provide several pieces of information for Collective Health to be able to process your claim and determine the appropriate Plan benefits:

- The name and birthdate of the patient who received the care
- The member ID listed on the patient ID card
- An itemized bill from the patient's provider, which must include:
    - The facility name, provider's name, address, and license number (if available)
    - The date(s) the patient received care
    - The medical diagnosis and procedure codes for each service provided
    - The place of service (POS) code indicating where the service was provided
    - The charges for each service provided
    - Information about any other health coverage the patient has
    - Proof of payment as needed to substantiate your claim (but is not required upon initial submission to Collective Health)

For travel expenses and breast pumps, a medical bill is not required. Instead, please submit a detailed receipt.

For over-the-counter COVID-19 tests, an itemized medical bill is not required. Instead, please submit the following:

- The name of the member
- The date of purchase
- The vendor's name
- Itemized charges and proof of payment for the test

Claims must be submitted within one year from the date you received the healthcare services. If your claim relates to an inpatient stay, the date you were admitted counts as the date you received the healthcare service for claims purposes. Contact Collective Health if you have any questions on the items above.

Within 30 days of Collective Health receiving the claim, Collective Health will review the claim and a decision is made to either approve or deny the claim in whole or in part. You'll receive a written notice of the claim decision. Claims will be processed when administratively feasible, typically in the order they are received.

If we need more time or information due to matters beyond our control to process a claim, the 30-day period to provide you with a decision may be extended for up to 15 days. We will notify you of the extension, the reason for the delay, request any additional information needed, and the date by which we expect to render a decision. If an extension is necessary because you have not submitted the information necessary to decide the claim, you will have at least 45 days from receipt of the extension notice to submit the required information.

Claims for pharmacy benefits will be reviewed by Express Scripts. Claims for medical (non-pharmacy) benefits will be reviewed by Collective Health and/or Anthem Blue Cross of California depending on the type of claim. If more time is needed to decide your claim due to matters beyond the control of Collective Health and/or Anthem Blue Cross of California, the

Plan may make a one-time extension of not more than 15 days. If this additional time is needed, you will be notified before the end of the initial 30-day period.

Urgent Care Claims

An urgent care claim is a claim for services when a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, could cause severe pain that could not be adequately managed without the care or treatment that is the subject of the claim. An urgent care prior authorization is considered an urgent care claim. Because your provider is the one who initiates prior authorization with Anthem Blue Cross of California, it will usually be your provider who will request expedited processing. If a physician with knowledge of your medical condition determines that the claim is an urgent care claim as described above, then the Plan will treat the claim as an urgent care claim. Urgent care claims will be decided within 72 hours after submission. Urgent care claims filed improperly or missing information may be denied.

If your urgent care claim is denied, you'll receive an explanation of why it was denied and how you can appeal (including how to request expedited review) within the following time frames:

Notification, orally or in writing that there is insufficient information	24 hours
Your response to the notification	48 hours
Notification of the Benefit Determination	48 hours

Concurrent Care Claims

In some cases, you may have an ongoing course of treatment approved for a specific period of time or a specific number of treatments, and you will want to extend that course of treatment. This is called a concurrent care claim or a concurrent care review. Similar to urgent care claims, your provider is typically the one who initiates a concurrent care claim with Anthem Blue Cross of California.

If your extension request is not "urgent" (as defined in the previous section), your request will be considered a new request and will be decided according to the applicable procedures and timeframes. If your request for an extension is urgent and you submit the claim at least 24 hours before the end of the course of treatment, you (or your provider) will be notified of the determination within 24 hours. If you did not submit the request within 24 hours before the end of the course of treatment, but it is still urgent, you will be notified as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the request.

Pre-Service Claims

Pre-Service Claims are claims for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. This can be in the form of a pre-authorization or a decision on medical necessity. Please see Section 4 of this booklet for more information on Prior Authorization.

Pre-Service claims must be decided no later than 15 days after Anthem Blue Cross of California receives the claim. This time period may be extended for up to an additional 15 days if, for reasons beyond the Plan's control, the decision cannot be made within the first 15 days. You will be informed of the reason for the delay and when a final decision is expected before the end of the first 15-day period. If more information is requested from you to make the decision, you have a minimum of 45 days to provide it. A decision will be made upon the date which is earlier of: 15 days after the additional information is supplied or the expiration of the 45 days you have to submit the additional information, whichever comes first.

Notice of an Adverse Benefit Determination

If your claim is denied in whole or in part ("adverse benefit determination"), you'll receive a written explanation of why it was denied and how you can appeal. For Urgent Care Claims, this notification may be oral followed by written or electronic notification within three days of the oral notification. This notice will include:

- Information sufficient to allow you to identify the claim involved (including the date of services, the healthcare provider, and the claim amount, if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to you as soon as feasible upon request.
- The specific reason(s) for the denial;
- Reference to the specific Plan provision(s) on which the denial is based;
- A description of additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
- A description of the Plan's internal and external appeal procedures and applicable time limits including your right to sue the Plan under ERISA section 502; and
- A statement that a copy of any rule, guideline, protocol, or other similar standard relied on in the denial will be provided free of charge upon request.

If the denial is based on medical necessity or experimental treatment, an explanation of the determination will be provided free of charge upon request. Payment for claims that are fully or partially approved for benefits may be sent to you by check through U.S. mail. If a payment issued for your claim is more than 12 months outstanding, your right to the benefit may be waived. You are responsible for informing the Plan Administrator of any change of address.

Section 9: How to Appeal

When you receive a notification of an adverse benefit determination, you have the right to appeal. Appeals of an adverse benefit determination must be specific to you and/or your dependents. You cannot appeal changes to the Plan's terms, termination of the Plan, or other decisions that affect plan members beyond you and your dependents. You generally have 180 days following receipt of the notification in which to file a written request for an appeal of the decision. However, for Concurrent Care Claims, you must file the Appeal prior to the end of the scheduled reduction or termination of treatment. For a claim based on rescission of coverage, you must file the appeal within 30 days.

Anthem Blue Cross of California and Collective Health share the responsibility of rendering appeal determinations. This section describes your appeal rights and the steps you must take to exercise those rights with each party.

If you are confused or dissatisfied about a determination of your benefits (for example, if a particular claim has been paid at a lower rate or denied), we encourage you to contact Collective Health before filing an appeal. You are not required to call Collective Health first, but reaching out to the Member Advocate team may help clear up any preliminary questions you have about why a particular decision was made. The Member Advocate team can also help guide you as you compile the information you need to submit an appeal.

If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claim. This will be provided, as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow you time to respond with any new or additional evidence that is relied upon, considered or generated by or at the direction of the Plan. This evidence shall be provided free of charge.

A document, record, or other information shall be considered relevant to a Claim if it:

- Was relied upon in making the benefit determination.
- Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination.
- Demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all members; or
- Constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

You may have someone else help you to file an appeal. If someone submits an appeal for you, it must include documentation that they are your authorized representative. The documentation must be signed by both you and the authorized representative. Contact Collective Health if you would like to request an authorized representative appointment form.

The section below explains where to submit different types of appeals. If you are still unsure of where to submit your appeal, please reach out to Collective Health for assistance. If your appeal is submitted to the incorrect party, we will coordinate to get it to the right place. Please note the appeal determination timeline begins when the appropriate party receives the appeal.

How to Appeal Prior Authorization and Medical Necessity Determinations

Because your provider is the one who initiates prior authorizations (including urgent claims) with Anthem Blue Cross of California, it will usually be your provider who appeals if prior authorization is denied. Your provider will also usually appeal if a claim is denied based on a medical necessity determination. You can choose to appeal the denial if you wish—for example, if your provider doesn't want to pursue an appeal. If you need or want help navigating this process, you can contact Collective Health for assistance.

You must appeal a denial of prior authorization, urgent care, concurrent care, or medical necessity to Anthem Blue Cross of California, not Collective Health, but if you need or want help navigating this process, you can contact Collective Health at 833-440-4367 and they can transfer you to Anthem Blue Cross of California. You must begin your appeal process within 180 days of receiving the denial. Anthem Blue Cross of California will consider your appeal and make a decision within the applicable legal timeframes.

How do I submit an Expedited Appeal? You have the right to an expedited decision if a delay could seriously jeopardize your life or health or cause you severe pain. To request an expedited appeal, submit your appeal either orally or in writing directly to Anthem Blue Cross of California. You will be notified of the decision within 72 hours from the date Anthem Blue Cross of California receives the appeal. You may also request an expedited review under the External Review Process below.

How to Appeal Non-Clinical Post-Service Adverse Benefit Determinations

This section describes Collective Health's appeals process for any adverse benefit determination other than a prior authorization or medical necessity denial by your network (for example, if coverage for a particular treatment has been denied because it is outside the scope of this Plan).

Use this procedure for medical benefit appeals. For pharmacy appeals, reach out to Collective Health with the information below so we can help route your appeal to the right place. You must submit your appeal within 180 days of receiving the adverse benefit determination.

To appeal, you must submit the following information to Collective Health in writing:

- Enough information to identify the adverse benefit determination that is the subject of your appeal—either attach a copy of the relevant Medical Benefit Statement, or

provide:

- Member ID
- Patient name
- Claim number
- Provider name
- Date of the medical service

- Your explanation of what happened and why you believe the original decision was incorrect
- Any documents or other information that support your appeal—for example:
  - A letter or prescription from your doctor
  - A receipt for money you paid
  - Relevant excerpts of your medical records

You can send the appeal submission and attachments by mail or through Messages in your Collective Health account.

Attn: Appeals Team
Collective Health
1557 W Innovation Way, Suite 300
Lehi, UT 84043
833-440-4367

Collective Health or the medical network will review your appeal and issue a decision within 30 days of receiving your appeal if your appeal is pre-service, and within 60 days if your appeal is post-service. The period of time within which a benefit determination on Appeal is required to be made shall begin at the time an Appeal is filed in writing in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing. The Plan must obtain your consent if it needs more time to review your appeal. Your appeal will be reviewed by someone other than, and not a subordinate of, the person who made the original claim denial. The appeal review will look at all of the information submitted, including any new information, and give no consideration to the original claim decision.

Before a Final Adverse Benefit Determination is issued based on new or additional rationale, you must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the within which a final determination on Appeal is required to allow you time to respond. If it is impossible under the circumstances to give you reasonable time to respond, the period for issuing the Final Adverse Benefit Determination will be delayed until you have a reasonable opportunity to respond. After you respond, or if you fail to do so, the Final Adverse Benefit Determination will be issued as soon as reasonably possible, taking into account the medical exigencies.

If the adverse benefit determination was based on a medical judgment, including whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically

Necessary or appropriate, a health care professional who was not involved in the original benefit determination will be consulted. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. You can request copies of the information relating to your appeal, including billing and diagnosis codes, and the name and title of any experts who assisted with the determination. If Collective Health upholds the original adverse benefit determination, you will receive a notice of final adverse benefit determination that explains the reason for that decision and describes your rights.

Notice of Final Adverse Benefit Determination

If the Appeal of a Claim is denied, in whole or in part, you will receive written notification of the Adverse Benefit Determination on Appeal, or Notice of Final Benefit Determination. This notice will state, in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

- Information sufficient to allow you to identify the Claim involved (including date of service, the healthcare provider, and the claim amount, if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to you as soon as feasible upon request.
- The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim.
- A reference to the specific Plan provisions on which the determination was based.
- A description of any additional material or information necessary for you to perfect the Claim and explanation of why such material or information is necessary.
- A description of the Plan's internal and external review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under Section 502 of ERISA following an Adverse Benefit Determination on review.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim.
- If the Adverse Benefit Determination was based on an internal rule, guideline, protocol or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to you upon request.
- If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan

to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

- Information about the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

Because of this exhaustive review, Collective Health only does one level of appeal. If your internal appeal is denied, you may have the right to an external review as described below. You have four months from the date of the most recent adverse determination to send in additional relevant information or request an external review.

External Review Program

If you are not satisfied with the determination of your internal appeal, you may have the right to request an external review by an independent review organization (IRO). All external reviews are facilitated by Collective Health, regardless of which party rendered the internal appeal determination. The Plan has entered into agreements with three or more IROs that have agreed to perform external reviews. The external review process is available at no charge to you.

External review is available only when the Plan's adverse benefit determination is based on one of the following:

- Medical necessity or clinical reasons (which includes but is not limited to, Plan requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit);
- The claim was denied due to the Plan exclusions for experimental, investigational, or unproven services;
- Rescission of coverage (coverage that was canceled retroactively);
- Whether the Plan is complying with the non-quantitative treatment limitation provisions under certain federal laws;
- An adverse benefit determination that involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in the No Surprises Act; or
- As otherwise required by applicable law.

Every external review request should include all of the following information:

- A specific request for an external review
- The subscriber's name, patient's name, and member ID and group number
- The service that was denied
- Any new, relevant information that was not provided during the internal appeal

The notification of the Final Adverse Benefit Determinations provides information about the external review program including where review requests may be submitted. A request for external review must be made within four months after you receive the internal appeal determination. An external review is the final level of appeal available under the Plan.

Standard External Review

When you submit a request for standard external review, here's what will happen:
First, Collective Health will do a preliminary review of your request within five business days. This preliminary review will confirm that:

- The patient was covered by the Plan at the time they received the healthcare service(s)
- The patient has finished the internal appeal process (this is called "exhaustion")
- The claim or appeal decision is eligible for external review
- All of the required information has been provided

After that, within one business day after completion of the preliminary review, Collective Health will provide a notification to you in writing about its preliminary review. If the request is completed but not eligible for external review, the notification will include the reasons for its ineligibility and current contact information, including the phone number for the Department of Labor, Employee Benefits Security Administration. If the request is not complete, the notification will describe the information or materials needed to complete it. You will have 48 hours or until the last day of the 4-month filing period, whichever is later, to submit the additional information.
If all four criteria above are met and your request is eligible for the External Review process, your case will be assigned to an IRO for review. Collective Health will randomly select from one of the contracted IROs so your review is not biased. The IRO will then confirm with you that your request has been accepted for external review. The notice will include a statement that you may submit in writing, within 10 business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the Plan. The Plan may consider this information and decide to review its denial. If the denial is reversed, the External Review process will end.
If you submit additional information later than 10 business days, the IRO may (but is not required to) consider that additional information. Either way, Collective Health will, within 5 business days after the assignment of the IRO, give the IRO all of the documents and information that were used in making the internal appeal determination (the adverse benefit determination), such as:

- Internal appeal determination letter(s)
- Any other documents relied upon by the Plan
- All other information or evidence that you or your physician submitted for consideration as part of the internal appeal

The IRO will make a decision on the basis of its review. The IRO will provide an unbiased assessment that will not be bound by any decisions or conclusions reached in the initial

appeal determination. The decision of the IRO will be based on all of the information in the record as well as additional information where appropriate and available, such as:

- The medical records;
- The medical provider's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, claimant, or the claimant's treating provider;
- The terms of the Plan;
- Appropriate practice guidelines;
- Any applicable clinical review criteria developed and used by the Plan; and
- The opinion of the IRO's clinical reviewer.

The IRO will provide its final external review decision to you in writing within 45 days after receipt of the request for the external review—unless the IRO requests additional time, and you agree. The notice, including the clinical basis for the determination, will be provided to you and Collective Health. The IRO's decision notice must include the following:

- A general description of the reason for the External Review, including information sufficient to identify the claim;
- The date the IRO received the assignment to conduct the review and the date of the IRO's decision;
- References to the evidence or documentation the IRO considered in reaching its decision;
- A discussion of the principal reason(s) for the IRO's decision;
- A statement that the determination is binding and that judicial review may be available to you; and
- Contact information for any applicable office of health insurance consumer assistance or ombudsman established under the PPACA.

If the IRO reverses the internal appeal determination, the Plan will provide coverage or payment for your claim, in accordance with the terms of the Plan.

Expedited External Review

An expedited external review is just like a standard external review, except shorter. If your case qualifies for expedited external review, you can submit your request before you've completed the internal appeals process.

A case qualifies for expedited external review if:

1. You receive an Adverse Benefit Determination that involves a medical condition for which the time to complete the internal Claims and Appeals procedures would seriously jeopardize the claimant's life or health or the ability to regain maximum function and you have submitted an expedited internal appeal; or
2. You receive a Final Adverse Benefit Determination that involves a medical condition where the time for completion of a standard External Review process would seriously

jeopardize the claimant's life or health other ability to regain maximum function, or if the Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Requests for expedited external review do not need to be submitted in writing; you may request review by phone, by calling Collective Health.

Immediately upon receipt of the request for expedited external review, Collective Health will determine whether the request meets the requirements for expedited external review. Collective Health will immediately send a notice that includes specific information to you regarding the Plan's preliminary review determination. Upon determining that a request is eligible for expedited external review Collective Health will assign an IRO. Collective Health will use the quickest means to submit your case to the IRO, such as by phone or digital transmission. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard external review. In reaching a decision, the IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the internal claims and appeals process. The IRO must make its determination and provide a notice of the decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours of receiving your request. The IRO may notify you of its decision by phone; if so, you'll also receive written confirmation within 48 hours after that.

Limitation on Your Right to Sue

You generally cannot bring any legal action against the Plan, the Plan administrator, or Collective Health unless you first complete all the steps in the appeal process and exhaust your appeal rights. The appeal process is complete only when you have received a final determination from the Plan or claims administrator.

After completing the appeal process, if you want to bring a legal action, you must do so within two years. If you do not sue within two years, you lose any rights to bring such an action against the Plan, the Plan administrator, or Collective Health.

Section 10: Your Rights to Continue Coverage

This Plan is sponsored by your employer; it's intended to cover you (and your dependents, if any) only while you are employed by the Company and you meet the Plan's eligibility requirements. But in some circumstances, you may have the right to continue your

membership in this Plan beyond the time when your coverage would otherwise end. This section describes when and how you can keep yourself and your dependents covered:

- Continuing your benefits coverage under Consolidated Omnibus Budget Reconciliation Act (COBRA).
- Continuing your benefits coverage during uniformed service.
- Continuing your benefits coverage during a leave of absence from work.
- Continuing your benefits coverage during a severance period.

Continuing Your Benefits Coverage Under COBRA

COBRA is a federal law that gives you and your family the opportunity to extend your California Times healthcare benefits in certain circumstances where your coverage would otherwise end. This section describes your COBRA rights and responsibilities. You may also receive a separate notice from California Times' COBRA administrator, which describes COBRA in more detail.

What is COBRA? When something happens that would cause your coverage under this Plan to end (for example, if you lose your job with the Company), COBRA may give you the right to a temporary extension of your coverage. COBRA allows you to continue coverage only in certain circumstances (called qualifying life events), and only if you and your dependents meet certain criteria (if you are qualified beneficiaries). To get COBRA coverage, you will have to follow very specific rules for notifying the plan, you may have to pay more than your normal employee contribution, and you will have to pay on time each month until your COBRA coverage ends. While you have COBRA coverage, your right to participate in open enrollment also continues.

Who is in charge of COBRA administration? California Times uses a company named WageWorks to administer its COBRA program. If you experience a qualifying life event, WageWorks will send you a COBRA packet with information and election instructions. If you elect to receive COBRA benefits, you will send your payments to WageWorks, and they may reach out to you directly as part of their administration responsibilities. You should contact WageWorks with any COBRA-specific questions, or reach out to Collective Health for general assistance.

WageWorks
1100 Park Pl
#400
San Mateo, CA 94403
866-747-0039

What are the qualifying life events that trigger COBRA rights? A qualifying life event includes, but is not limited to, the following events, which would cause you or your dependents to lose your California Times healthcare benefits:

- If you quit your job at the Company, or if you are fired (except if you are fired for gross misconduct).
- If your work hours are reduced enough that you are no longer eligible for benefits under this Plan.
- If your marriage ends by divorce or legal separation.
- If your dependent child stops being eligible for benefits under this Plan (because they turn age 26 or are no longer disabled).
- If you become entitled to Medicare and this results in you losing coverage under this Plan.
- In the case of your dependents' rights to continue coverage, if you die.

If you and/or your dependents experience a qualifying life event, you each may have a right to continue coverage under this Plan.

Who are the qualified beneficiaries who have COBRA rights? You (an employee of the Company), your spouse, and/or your children (including Qualified Medical Child Support Order children) are qualified beneficiaries if you were each enrolled in this Plan the day before the qualifying life event happened, and if the qualifying life event caused you to lose coverage under this Plan.

For example: if you lose your job at the Company, your coverage and your enrolled dependents' coverage will terminate. All of you will be qualified COBRA beneficiaries.

Another example: if you divorce your dependent spouse but retain custody of your children, your spouse's coverage will terminate, but yours (and your enrolled children's) will not. Your spouse will be the only qualified COBRA beneficiary.

If you are covered by COBRA, and you have a child (naturally or through adoption) during your COBRA coverage, your new child is also a qualified beneficiary with COBRA rights.

You can elect to receive COBRA coverage even if you are already entitled to Medicare or you are already covered under another group health plan. However, keep in mind:

- If you are enrolled in Medicare, this plan may reduce its benefits as if you were covered by Medicare.
- If you are covered under another plan, your COBRA coverage may be secondary.

How much will it cost me to have COBRA coverage? California Times will not subsidize your healthcare benefits under this plan. Your COBRA packet will tell you exactly what your COBRA premium will be.

What do I have to do to get COBRA coverage? Your notice responsibilities and the amount of time you have to elect COBRA coverage will vary depending on what qualifying life event you experience.

If you get divorced or separated, or if your dependent child loses eligibility:

- You must notify California Times' Benefits Team in writing within 30 days of the qualifying life event.

- You must provide the notice form to California Times within 60 days of the qualifying life event. THERE ARE NO EXCEPTIONS: if you miss the 60-day notice window, all qualified beneficiaries will lose their right to elect COBRA.
- If your qualifying life event was the end of your marriage, you may be required to provide a copy of your legal divorce decree or legal separation document to California Times.
- Once you notify California Times of the qualifying life event, the COBRA Administrator will send you a COBRA packet with election forms/instructions which you must return by the deadline specified in the packet.
- You must pay your COBRA premium within 45 days of the day you elect COBRA. THERE ARE NO EXCEPTIONS: if you miss the 45-day payment window for your first payment, all qualified beneficiaries will lose their COBRA benefits.

If you lose your job, your hours are reduced, or you become entitled to Medicare:

- You do not need to notify anyone of your qualifying life event or request materials. You should automatically receive a COBRA packet, including election paperwork, in the mail from WageWorks shortly after your qualifying life event. Your packet will have all of the forms and instructions you need to make your election.
- You must return your election form within 60 days of the date you receive your COBRA packet or the date your coverage would terminate, whichever is later.
- You must pay your COBRA premium within 45 days of the day you elect COBRA. THERE ARE NO EXCEPTIONS: if you miss the 45-day payment window for your first payment, all qualified beneficiaries will lose their COBRA benefits.

Notice or election by any other method is not acceptable. You must follow the procedures exactly to ensure you and your dependents receive your COBRA coverage. Contact WageWorks with any specific questions, or reach out to Collective Health for general guidance.

How long does COBRA coverage last? The amount of time you can keep COBRA benefits will vary based on what qualifying life event you experience.

- If you lose your job or have a reduction in work hours, you have up to 18 months of COBRA coverage.
    - If your family has a second qualifying life event during these 18 months—if your dependent child loses eligibility, your marriage ends, you enroll in Medicare, or you die—your dependents' coverage will be extended to 36 months from the date of the original qualifying life event. The same notice requirements apply.
    - If you or your dependents are determined to have been disabled (for Social Security disability purposes) at the time of, or within 60 days after, the COBRA qualifying life event, you may extend your COBRA coverage for all qualified beneficiaries for up to 29 months total, from the date of the original qualifying life event. You must notify WageWorks of the disability determination within 60 days

of the disability determination or the qualifying life event, whichever is later (and before the expiration of the original 18-month period).

- If you became entitled to Medicare while an active employee of the Company and then, within 18 months, lose your job or have a reduction in work hours, your spouse or dependents will have up to 36 months of COBRA coverage from the date you became entitled to Medicare.
- If you have a divorce or legal separation, your dependent loses dependent status, you enroll in Medicare or you die, you (and your family members that are qualified beneficiaries) have up to 36 months of COBRA coverage.

In some cases, your COBRA coverage will end before your 18, 29, or 36 months are up. Your coverage will terminate immediately: (After the first payment, which must be on time, you will have a 30-day grace period for remaining payments.)

- If California Times stops providing healthcare benefits to its employees.
- If you don't pay your COBRA premium on time.
- On the day you begin coverage under another group health Plan after electing COBRA coverage.
- When you first enroll in Medicare after electing COBRA coverage.
- For cause under the Plan (such as if you commit fraud), to the extent permitted by law.
- If Social Security makes a final determination that you or your dependent is not disabled, and this disability was the basis for your COBRA coverage.

I still don't understand COBRA. Help? You're not alone—COBRA can be very confusing, and the procedures you must follow to make sure you retain your COBRA rights are very specific. Don't hesitate to ask questions: contact WageWorks, reach out to Collective Health, or ask California Times' Benefits Team if you need assistance.

Continuing Your Benefits Coverage During Uniformed Service

USERRA (the Uniformed Services Employment and Reemployment Rights Act) protects the job rights of individuals who—voluntarily or involuntarily—leave their jobs to serve in this country's uniformed services. This protection extends to the healthcare benefits that you received as part of your employment.

If you leave your job to perform qualifying service, you have the right to continue your existing employer-sponsored health Plan coverage for you and your dependents (if any) for up to 24 months while you serve. (USERRA continuation coverage will run concurrently with any COBRA continuation coverage.) You must notify California Times or Collective Health that you want USERRA coverage within 60 days of your first day of qualifying service (in other words, within 60 days from the first day you are absent from work because you are performing service). Your coverage will be retroactive to your first day of qualifying service. Unlike COBRA, USERRA doesn't provide independent continuation rights to your dependents: they

will only be eligible for continued coverage if you elect USERRA coverage for yourself. Any USERRA coverage you have runs concurrently with any rights to COBRA coverage. USERRA coverage requires you to pay for your continued benefits. If your service is for less than 31 days, you must pay the same employee contribution that you would usually pay while employed. If your service is for 31 days or more USERRA requires you to pay the USERRA premium, which is the cost of your benefits without the Company's subsidy, plus a 2% administration fee. You will be provided the USERRA premium amount when you inform the plan that you want USERRA coverage. Payment is due on the first day of the month, and you will have a 30-day grace period to make each payment. If you fail to make your payment on time (including the grace period), your coverage will be terminated, and cannot be reinstated until you return to work.

Your USERRA coverage may be terminated if:

- California Times stops providing group health coverage to its employees.
- You fail to return from service or re-apply for employment with the Company.
- There is good cause to terminate your coverage under the terms of this Plan (for example, if you submit fraudulent claims).

Even if you don’t elect to continue coverage during your service, you have the right to be reinstated in your employer-sponsored health Plan when you are re-employed. However, the Plan will not cover service-connected illnesses or injuries (which should be covered by your military insurance).

Continuing Your Benefits Coverage During a Leave of Absence from Work

If you take a leave of absence from work, you may be able to continue receiving coverage under this Plan, in accordance with your company’s policy, for yourself and any dependents, during your leave. Your specific rights and responsibilities are described in the governing documents for California Times' employee benefits plans. Contact California Times' Benefits Team for more information about your rights to continue coverage during a leave of absence, including whether you must pay the full cost of coverage and whether your coverage will be reinstated when you return to work.

Family and Medical Leave: This Plan will comply with the Family and Medical Leave Act of 1993 (FMLA) and the Department of Labor regulations that implement FMLA, along with applicable state and local leave laws. The FMLA provides eligible employees up to 12 work weeks of unpaid, job-protected leave in a 12 month period. While on FMLA leave, your coverage will continue on the same terms (and at the same cost to you per pay period) as you had before your leave began, for the full period of your FMLA leave. If you choose to end your coverage for the period of your FMLA leave or other legally mandated leave, your coverage will be reinstated when you return to work.

Other employer-approved leave of absence: If you take a leave of absence that is approved by California Times and that is a paid leave (meaning you continue receiving your

wages while you are on leave), your coverage will continue on the same terms (and at the same cost to you per pay period) as you had before your leave began. This is true if, for example, you take a statutory, parental, medical, or other contractually protected leave of absence.
If you take a personal unpaid leave of absence during your employment, California Times may continue its contribution towards the cost of your health plan. Contact California Times' Benefits Team for more information about continuing your coverage during an unpaid leave of absence.
While you are on leave, you will have the same rights to participate in open enrollment as all other participating employees who are not on leave. This means that if open enrollment falls during your leave, you will still be able to make elections for coverage for the next plan year, as long as you and your dependents still meet the eligibility requirements. Contact California Times' Benefits Team for information on your open enrollment rights during a leave of absence.
All of these determinations will be made in accordance with California Times' leave of absence policies. Contact California Times' Benefits Team for information about how you can continue coverage while you are on leave.

Continuing Your Benefits Coverage During a Severance Period

If your employment with California Times ends and you receive a severance, it may include continued health benefits coverage for the period of your severance. Please contact California Times' Benefits Team for more information.

Section 11: Coordination of Benefits

This section describes how benefits under this Plan will be coordinated with any other healthcare Plan that provides benefits to you or your dependents. For example, if you are a member of this plan and also enrolled as a dependent on your spouse's employer-sponsored health plan, this plan will coordinate its benefits with your other plan's benefits. One Plan will pay out full benefits first (called primary), and then the other Plan will begin paying benefits (called secondary), until all of the benefits are exhausted or until the allowed amount for your care is paid. Your total benefits from all of your healthcare Plans will never exceed the actual cost of your care.
The rules governing who pays primary and who pays secondary are different depending on the other healthcare benefits Plan you have. This section lays out those rules. If you are confused or have any questions, you can contact Collective Health for guidance.

Definitions

Allowable expense means any health care expense that is covered in full or in part by any of the Plans covering the person. This includes any coinsurance, copayments, or deductible the Plans may apply.

- An expense or a portion of an expense that is not covered by any of the Plans is not an allowable expense.
- Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense.
- When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.
- The amount of the reduction may be excluded from allowable expense when a covered person's benefits are reduced under a primary Plan because the covered person:
    - Does not comply with the Plan provisions concerning second surgical opinions or precertification of admissions for services; or
    - Has a lower benefit for services rendered by out-of-network providers.

Birthday means the month and day in a calendar year and does not include the year in which an individual is born.

Claim means a request that Plan benefits be provided or paid.

COBRA means Consolidated Omnibus Budget Reconciliation Act of 1985. COBRA coverage is provided under a right of continuation pursuant to this federal law.

Coordination of benefits or *COB* means a procedure establishing the order in which Plans will pay their claims, and permitting secondary Plans to reduce their benefits so that the combined benefits of all Plans do not exceed total allowable expenses.

Custodial parent means:

a. The parent awarded custody of a child by a court decree; or
b. In the absence of a court decree, the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Plan means a form of coverage with which coordination is allowed. Separate parts of a Plan for members of a group that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one Plan and there is no "COB" among the separate parts of the Plan.

The term *Plan* does not include:

- Hospital indemnity benefits or other fixed indemnity coverage;
- Accident only coverage or specified accident coverage;
- A supplemental sickness and accident policy excluded from coordination of benefits;
- School accident-type coverage;
- Benefits provided in long term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;

- Medicare supplement policies; or
- A state Plan under Medicaid, or other governmental Plan when, by law, its benefits are in excess of those of any private insurance Plan or other non-governmental plan.

Primary Plan means a Plan whose benefits for a person's health care coverage will be determined without taking the existence of any other Plan into consideration. A Plan is a primary Plan if either of the following conditions is true:

a. A Plan either does not contain order of benefit rules, or has rules which differ from those permitted by this rule; or
b. All Plans which cover the person use the order of benefits determination required by this rule, and under this rule that Plan determines its benefits first.

Secondary Plan means any Plan which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules in this section will determine the order in which their benefits are determined in relation to each other.

Order of Benefit Determinations

Order of benefits will be determined by the first applicable provision set forth in this paragraph:

Non-dependent or dependent. The benefits of a Plan covering the person as an employee, member, insured, subscriber or retiree, other than as a dependent, will be determined before those of a Plan which covers the person as a dependent. However, the benefits of a Plan covering the person as a dependent will be determined before the benefits of a Plan covering the person as other than a dependent if the person is a Medicare beneficiary. Please see the rules regarding Medicare coordination of benefits in this Plan.

Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, Plans covering a dependent child will determine the order of benefits as follows:

a. For a dependent child whose parents are married (not separated or divorced) or are living together, whether or not they have ever been married:
    I. The Plan of the parent whose birthday falls earlier in the calendar year is the primary plan;
    II. If both parents have the same birthday, the Plan which has covered the parent for a longer period of time is the primary plan;
b. For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
    I. If the specific terms of the court decree state that one of the parents is responsible for the health care expenses or health care coverage of the child, and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's Plan is the primary plan. This item will not apply with respect

to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

II. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the birthday rule applies.

III. If the specific terms of the court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses or health care coverage of the child, the Plans covering the child will be subject to the birthday rule.

IV. If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

a. The Plan covering the custodial parent;
b. The Plan covering the custodial parent’s spouse;
c. The Plan covering the non-custodial parent; and then
d. The Plan covering the non-custodial parent’s spouse.

c. For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the order of benefits will be determined, as applicable, as if those individuals were the parents of the child.

Active employee or retired or laid-off employee. The benefits of a Plan which covers a person as an active employee who is neither laid off nor retired, or as that active employee's dependent, is the primary plan. If the other Plan does not have this provision, and if, as a result, the Plans do not agree on the order of benefits, this provision will be ignored. Coverage provided an individual as a retired worker and as a dependent of that individual's spouse as an active worker will be determined under the non-dependent/dependent rules above.

COBRA or state continuation coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following will be the order of benefit determination:

- The Plan covering the person as an employee, member, subscriber or retiree (or as that person’s dependent) is the primary plan;
- The continuation coverage provided pursuant to federal or state law is the secondary plan.

Longer or shorter length of coverage. If none of the preceding provisions determines the order of benefits, the Plan which has covered the person for the longer period of time is the primary Plan and the Plan which covered that person for the shorter period of time is the secondary plan. For the purposes of this provision:

a. The time covered under a Plan is measured from the claimant's first date of coverage under that plan, or, if that date is not readily available for a group plan, the date the claimant first became a member of the group covered by that Plan will be used as the

date from which to determine the length of time the person's coverage under the present Plan has been in force;

b. Two successive Plans will be treated as one if the covered person was eligible under the second Plan within twenty-four hours after coverage under the first Plan ended;
c. The start of a new Plan does not include:
    I. A change in the amount or scope of a plan's benefits;
    II. A change in the entity that pays, provides or administers the Plan's benefits; or
    III. A change from one type of Plan to another, such as, from a single Plan to a multiple employer plan.

If none of the preceding rules determines the order of benefits, the allowable expenses will be shared equally between the Plans.

Determination of Benefits

If this plan is the primary payer for your claim, it will pay or provide its benefits as if the secondary plan does not exist.
If this plan is the secondary payer for your claim, these steps are followed to calculate the secondary payment:
1. When plans have differing allowable expenses, the lower allowable expense will be used. When this plan is secondary to Medicare, Medicare allowable expense will be used.
2. The secondary plan will calculate its benefits, including any deductible, copay, and coinsurance, in absence of the primary plan, using the allowable expense determined in step 1. This benefit amount is the secondary plan's standard benefit amount.
3. The secondary plan will calculate the member liability by subtracting the primary plan paid amount from the allowable expense determined in step 1.
4. The secondary plan will pay the member liability calculated in step 3, but no more than the standard benefit amount calculated in step 2.
The secondary plan will not pay any amount over its standard benefit amount calculated using the lower or Medicare allowable expenses. In no event, when combined with the amount paid by the primary plan, will payments by the secondary plan exceed one hundred per cent of the lower or Medicare expenses allowable under the provisions of the applicable policies and contracts. A secondary plan will not be required to pay for services unless such services are received in accordance with the rules and provisions outlined in its policy, contract or certificate. Any deductible calculated in the secondary plan's standard benefit amount will contribute to your secondary plan's accumulators.
If the primary plan does not cover a service that is covered by the secondary plan. The secondary plan will pay or provide benefits as if it were the primary plan when a covered person for that service.
Nothing in these rules will be construed to prevent a third party payer and a provider from entering into an agreement under which the provider agrees to accept, as payment in full from

any or all plans providing benefits to a beneficiary, an amount which is less than the provider's regular charges.

Medicare Coordination of Benefits

If this plan covers you as a retiree, Medicare pays first.
If you are 65 or older and have group health plan coverage as an active employee under you or your spouse's current employment and the employer has 20 or more employees, this plan pays first.
If you are 65 or older, have group health plan coverage based on your or your spouse's current employment, and the employer has fewer than 20 employees, Medicare pays first.
If you are under 65 and have a disability, have group health plan coverage based on your or a family member's current employment, and the employer has 100 or more employees, this plan pays first.
If you are under 65 and have a disability, have group health plan coverage based on your or a family member's current employment, and the employer has fewer than 100 employees, Medicare pays first.
If you are under 65 and have group health plan coverage based on your or a family member's current employment, and you are eligible for Medicare because of End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant), this plan pays first for the first 30-months after you become eligible to join Medicare.
If you are under 65 and you are eligible for Medicare because of ESRD and are on COBRA, COBRA pays primary for the first 30-months after you become eligible to join Medicare.
If you are 65 or older and covered by Medicare and COBRA, Medicare pays primary.
If you are disabled and covered by Medicare and COBRA, Medicare pays primary.

Medicaid and Tricare Coordination of Benefits

This Plan pays first. Medicaid and Tricare are secondary payers.

No Fault Liability Insurance

No-fault or liability insurance pays primary for accident or other situation-related health care services claimed or released. This Plan pays secondary.

Travel Insurance

If you have travel insurance with medical coverage, the order of payment will be determined by the applicable state regulations and the coordination of benefits rules of your travel insurance.

Section 12: The Plan's Right to Repayment

In some circumstances, this Plan will be entitled to a refund for some or all of the benefits it pays for your medical care—for example, because a third party is responsible for your injuries, your provider over-billed the Plan, the Plan made a payment in error, or you engaged in fraudulent or similar activity. This section describes the Plan's rights to seek recovery from the person responsible for your injuries and refunds of overpayments.
Read this section carefully, because it describes your obligations to the Plan and the potential consequences of not meeting those obligations.

Recovery from the Person Responsible for Your Injuries

Your illness or injury may be someone else's fault. For example, if you are in a car accident and you dislocate your shoulder, the other driver may be held responsible for the accident and for your resulting injuries. The Plan may pay for the treatment of your dislocated shoulder in the first instance after your accident. But if you receive money from the person responsible for your injuries, the Plan is entitled to be paid back from those proceeds. Even if you choose not to pursue your claim, the Plan is entitled to seek recovery from the person who is financially responsible for your injuries (in the car accident example, this could be the other driver or his insurance company or even your own insurance company).
This section describes the rules that apply when another person or entity (a "third party") may be responsible for your injury or illness. Third party includes, but is not limited to, no-fault auto coverage, personal injury protection coverage, medical payment coverage, uninsured and underinsured motorist coverage, and third-party assets and insurance coverage. The rights and obligations described in this section apply to you and also independently to your dependents.
By accepting healthcare benefits under this Plan, you agree to automatically assign to the Plan any rights you may have to recover from third parties for your injuries.

- The Plan has the right to repayment for the full cost of your care (both medical and pharmacy), from the first dollar you recover, up to 100% of what the third party pays you. But the Plan will not seek recovery for amounts over what the Plan paid for your care.
- The Plan is entitled to any funds you recover from the third party, even if they are labeled as something other than medical costs, such as "non-economic damages" or "punitive damages."
- The Plan has the right to recover funds even if you are not made whole. The "make whole" doctrine does not apply.
- The Plan is not required to reimburse you for any attorneys' fees or costs that you incur during the process of seeking damages from a third party. The "common fund," "fund," or "attorneys' fund" doctrines do not apply.

- Whether or not you decide to pursue a claim against the third party responsible for your illness or injury, the Plan can make its own claim against the third party.
- You must cooperate with the Plan's efforts to seek recovery from a responsible third party. Such cooperation includes, but is not limited, to the following, and you must:
    - Respond to any requests for information about any accidents or injuries. These requests may come from someone other than Collective Health.
    - Provide any relevant information requested.
    - Sign, and deliver, any required documents.
    - Notify the Plan of any legal claims you may have against third parties for your injuries or illness.
    - Participate as needed in the Plan's efforts to recover funds, including participating in medical examinations and appearing at legal proceedings (such as depositions or court hearings).
    - If requested, assign to the Plan all rights of recovery you have against third parties, to the extent the Plan paid benefits to you.
- You may not settle or release your claims against the third party without first obtaining the consent of the Plan administrator.
- If you receive any payment from a third party, and the Plan claims that those funds are owed to the Plan, you must hold those funds in trust—either in a separate bank account in your name, or in your attorney's trust account. You must serve as trustee over those funds, to the extent the Plan paid benefits to you.
- You must promptly reimburse the Plan if you receive any recovery related to your injuries or illness.
- The Plan's rights under this section apply even if you die as a result of your injuries, if a third party is responsible to your survivors.

If a child receives benefits from the Plan for an illness or injury caused by a third party, then these rules apply to the parents, guardians, or other representatives of that child.

If you fail to meet your obligations under this section, the Plan may refuse to pay benefits for your injuries, may reduce your future benefits until the Plan has been fully repaid, or otherwise seek payment or reimbursement from you as otherwise permitted by applicable law.

Refund of Overpayments

When you need medical treatment, this Plan may pay benefits first and ask questions later so that your care is not unnecessarily delayed. Sometimes, this approach may result in the Plan paying more for your care than it should. This is called overpayment.

You or your provider may need to submit specific information with a claim, such as medical information and coordination of benefits information. The Plan cannot always wait until all of the information has been submitted, or verify the accuracy of all the information, before the claim is treated as filed. For example, the Plan may pay a physician's invoice for your

treatment, and later discover that the invoice was billed for services you didn't receive. Or, the Plan may pay the provider and reimburse you for the same treatment. In any case where the Plan pays more than it should (even if the mistake was ours), the Plan may seek a refund or other overpayment recovery.

In the case of overpayment, the Plan has the right to seek a refund from you, your physician, a medical facility, another health benefit plan, or other person or entity as appropriate. You agree, as a member of this Plan, to refund the Plan or have your future claims offset if you receive the overpayment, and to assist the Plan in recovering overpayments from others.

If you fail to meet your obligations under this section, the Plan may refuse to pay benefits for your injuries or may reduce your future benefits until the Plan has been fully repaid.

Section 13: Changes to This Plan's Terms

California Times (as the Plan's sponsor) reserves the right to change, interpret, modify, withdraw or add benefits to, or terminate this Plan—at any time, in its sole discretion, and without your approval. Any amendments, changes, or termination are effective on the date specified by California Times. If the terms of this Plan or its costs change substantially, you may be given a right to change your enrollment selection mid-year.

If this Plan is terminated, your rights and benefits are limited to the healthcare services you incurred before termination. California Times may set a deadline for submission of claims after termination of the Plan.

Any amendment to or termination of the Plan will be made in writing, and you will receive notice of termination or any material modification to the Plan. No one has the authority to make any oral modification to this Plan's terms.

Section 14: Plan Administration

Plan Administrator's Responsibilities

NantMedia Holdings, LLC DBA California Times (referred to as "California Times") is the sponsor of this Plan. California Times is also the Plan administrator for this Plan. At its discretion, California Times may appoint an individual or committee to serve as Plan administrator.

The Plan administrator has the sole and exclusive discretion to:

- Interpret this SPD;
- Develop policies, practices, and procedures for this Plan; and

- Administer this Plan in accordance with those policies, practices, and procedures

The Plan administrator will exercise its discretion and fulfill its responsibilities in accordance with the provisions of ERISA. The Plan administrator may delegate some of its responsibilities to Collective Health or to other individuals or entities as appropriate. Collective Health is the claims administrator. This Plan is self-insured; therefore, Collective Health is not an insurer and is not responsible for the payments of benefits or claims.

The Plan administrator serves without compensation. However, all expenses for administration of the Plan (including compensation for hired services) will be paid by the Plan, unless paid by California Times.

Plan Information Summary

Plan name	NantMedia Holdings, LLC DBA California Times PPO plan
Plan sponsor's Employer Identification Number (EIN)	824402852
Plan number	501
Plan year	January 1 through December 31
Type of plan	Group health plan
Type of administration	Self-insured, with Collective Health serving as the third-party administrator
Plan administrator	NantMedia Holdings, LLC DBA California Times 2300 E. Imperial Hwy El Segundo, CA 90245
Plan sponsor	NantMedia Holdings, LLC DBA California Times 2300 E. Imperial Hwy El Segundo, CA 90245
Agent for legal service	NantMedia Holdings, LLC DBA California Times 2300 E. Imperial Hwy El Segundo, CA 90245 Service of legal process may be made to the head of the legal department or to the Plan administrator.
Named fiduciary	NantMedia Holdings, LLC DBA California Times 2300 E. Imperial Hwy El Segundo, CA 90245
Medical claims administrator	Attn: Collective Health Claims Administrators Collective Health Administrators, LLC 1557 W Innovation Way, Suite 300 Lehi, UT 84043 833-440-4367 Not an insurer; does not guarantee benefits

Funding medium and contributions	This Plan is self-insured: benefits are paid from the general assets of the Plan sponsor (NantMedia Holdings, LLC DBA California Times) and not guaranteed under an insurance policy or contract. The operating expenses for this Plan are paid with contributions by the Plan sponsor (NantMedia Holdings, LLC DBA California Times) and contributions by participating employees. Employee contributions will be used first to cover benefits under the Plan.

Section 15: Legal Provisions and Your Legal Rights

Your ERISA Rights

As a participant in this plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- Receive information about your Plan and benefits

You may examine, without charge, at the Plan administrator's office and at other specified locations, all documents governing the Plan.
You may obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan and updated SPD. The Plan administrator may make a reasonable charge for the copies.

- Continue group health plan coverage

You may continue healthcare coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying life event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

- Prudent actions by Plan fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

- Enforce your rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.
Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order,

you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

- Assistance with your questions

If you have any questions about this Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Your HIPAA Privacy Rights

Federal regulations under the Health Insurance Portability and Accountability Act (HIPAA) require group health plans to safeguard the privacy of your protected health information (PHI). However, as explained below, the Plan may use and disclose PHI, including your PHI, in some cases.

PHI is data about a past, present or future physical or medical condition, treatment received, or payment for healthcare that also identifies the person it relates to. Your PHI will not be used or disclosed by the Plan without a written authorization from you, except as described in the HIPAA notice of privacy practices you received from the Plan. The Plan is allowed to use or disclose PHI for a variety of reasons, including (but not limited to): for treatment, payment and healthcare operations, pursuant to your authorization, for public health purposes, to California Times as the Plan sponsor for its Plan administrative purposes, as required by law, and as described in the HIPAA notice of privacy practices. If the Plan discovers an unauthorized access, use, disclosure, modification, or destruction of your PHI (also called a "breach"), the Plan will notify you.

You and your covered dependents will have the rights set forth in the Plan’s HIPAA notice of privacy practices and any other rights and protections required under HIPAA. The notice may periodically be revised.

The Plan’s privacy practices and your rights under HIPAA are contained in the notice of privacy practices that has been distributed to you. To request a copy of the Plan’s notice of privacy practices, you may contact the Plan’s Privacy Officer, whose contact information is provided below. You may receive the notice of privacy practices by email if you wish.

The Plan has established a complaint procedure concerning the handling of PHI, which is explained in the notice of privacy practices. All complaints or issues raised by plan members with respect to the use of their PHI must be submitted in writing to the Privacy Officer.
Attn: Privacy Officer
2300 E. Imperial Hwy
El Segundo, CA 90245
(213) 237-5139
A response will be provided within a reasonable period of time, including time to investigate and resolve any issues, after the receipt of the written complaint. The Privacy Officer has full discretion in resolving the complaint and making any required interpretations and factual determinations. The decision of the Privacy Officer will be final and be given full deference by all parties.

Nondiscrimination Policy

This Plan will not discriminate against any individual based on race, color, religion, national origin, disability, gender, sexual orientation, or age. This Plan will not establish rules for eligibility based on health status, medical condition, claims experience, receipt of healthcare, medical history, evidence of insurability, genetic information, or disability.
This Plan intends to be nondiscriminatory and to meet the requirements under applicable provisions of the Internal Revenue Code of 1986. If the Plan administrator determines before or during any plan year that this Plan may fail to satisfy any nondiscrimination requirement imposed by the Code or any limitation on benefits provided to highly compensated individuals, the Plan administrator shall take such action as the Plan administrator deems appropriate, under rules uniformly applicable to similarly situated covered employees, to assure compliance with such requirements or limitation.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, Plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Qualified Medical Child Support Order Procedures

The Plan will provide benefits as required by any Qualified Medical Child Support Order (QMCSO), as defined in ERISA Section 609(a) or National Medical Support Notice. For a copy of the Plan's QMCSO procedures, please contact California Times' Benefits Team. The healthcare components of the Plan will also provide benefits to dependent children placed with you for adoption under the same terms and conditions as apply in the case of dependent children who are your natural children, in accordance with ERISA Section 609(c).

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the 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. For more information, please contact Collective Health.

Mental Health Parity and Addiction Equity

Pursuant to the Mental Health Parity and Addiction Equity Act of 2008, as amended, this Plan applies its terms uniformly and enforces parity between covered medical/surgical and covered mental health or substance use disorder benefits. Claims that are billed with a primary or principal diagnosis code categorized by the International Statistical Classification of Diseases and Related Health Problems (ICD-10) as a mental health condition, behavioral health condition, or substance use disorder are adjudicated as mental health claims. For further details, please contact Collective Health.

Genetic Information Nondiscrimination Act

This Plan will be operated and maintained in a manner consistent with the Genetic Information Nondiscrimination Act, which provides federal protection from genetic discrimination in health insurance and employment.

Affordable Care Act

This section describes some of the applicable provisions of the federal healthcare reform laws (known as the Affordable Care Act). These provisions have been incorporated into the Plan.

- You can cover your adult children to age 26.

- You do not need prior authorization to see an in-network OB/GYN provider.
- If your medical coverage requires you to designate a primary care physician, you have the right to designate any in-network primary care physician accepting new patients and may designate an in-network pediatrician for your children.
- You may seek emergency medical services at an in-network or out-of-network provider without having to obtain prior authorization and with the same cost sharing.
- Your medical coverage cannot be retroactively canceled, unless you fail to timely pay premiums or commit intentional misrepresentation or fraud or as otherwise permitted by applicable law. In other circumstances, you will generally be provided advance notice of cancellation.
- There are no pre-existing condition exclusions and no aggregate annual or lifetime limits on essential health benefits.
- You are not required to pay a co-payment or other cost sharing for in-network preventive and wellness services, such as routine exams, immunizations, mammograms, and routine baby care (see www.healthcare.gov for more information).
- The plan provides minimum value and is affordable as required under the Affordable Care Act.
- You may be entitled to external review of certain healthcare claims. More detailed information may be found in Section 9.

Appendix A: Inter-Plan Arrangements

Out-of-Area Services

Overview

Anthem has a variety of relationships with other Blue Cross and Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area Anthem serves (the "Anthem Service Area"), the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of the Anthem Service Area, you will receive it from one of two kinds of Providers. Most Providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("nonparticipating providers") don't contract with the Host Blue. Explained below is how both kinds of Providers are paid.

Inter-Plan Arrangements Eligibility – Claim Types

Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are prescription drugs that you obtain from a pharmacy and most dental or vision benefits.

A. BlueCard® Program

Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, Anthem will still fulfill their contractual obligations. But, the Host Blue is responsible for: (a) contracting with its Provider; and (b) handling its interactions with those Providers.

When you receive Covered Services outside the Anthem Service Area and the claim is processed through the BlueCard Program, the amount you pay is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to Anthem.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with that Provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of Providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.
Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will

not affect the price Anthem uses for your claim because they will not be applied after a claim has already been paid.

B. Negotiated (non–BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, Anthem may process your claims for Covered Services through Negotiated Arrangements for National Accounts.

The amount you pay for Covered Services under this arrangement will be calculated based on the lower of either billed charges for Covered Services or the negotiated price (refer to the description of negotiated price under Section A. BlueCard Program) made available to Anthem by the Host Blue.

C. Special Cases: Value-Based Programs

BlueCard® Program

If you receive Covered Services under a Value-Based Program inside a Host Blue's Service Area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Anthem, through average pricing or fee schedule adjustments. Additional information is available upon request.

Value-Based Programs: Negotiated (non–BlueCard Program) Arrangements

If Anthem has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Plan on your behalf, Anthem will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

D. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, we will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

E. Non-participating Providers Outside Our Service Area

The pricing method used for nonparticipating provider claims incurred outside the Anthem Service Area is described in "Claims Payment".

F. Blue Cross Blue Shield Global Core® Program

If you plan to travel outside the United States, call Collective Health to find out your Blue Cross Blue Shield Global Core® benefits. Benefits for services received outside of the United States may be different from services received in the United States.

When you are traveling abroad and need medical care, you can call the Blue Cross Blue Shield Global Core® Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or you can call them collect at 804-673-1177. If you need inpatient hospital care, you or someone on your behalf, should contact us for preauthorization. Keep in mind, if you need Emergency medical care, go to the nearest hospital. There is no need to call before you receive care.
Please refer to the “Pre-Authorization” section in this SPD for further information. You can learn how to get preauthorization when you need to be admitted to the hospital for Emergency or non-emergency care.

How Claims are Paid with Blue Cross Blue Shield Global Core®
In most cases, when you arrange inpatient hospital care with Blue Cross Blue Shield Global Core®, claims will be filed for you. The only amounts that you may need to pay up front are any Copayment, Coinsurance or Deductible amounts that may apply.

You will typically need to pay for the following services up front:

- Doctor services;
- Inpatient hospital care not arranged through Blue Cross Blue Shield Global Core®; and
- Outpatient services.

You will need to file a claim form for any payments made up front.
When you need Blue Cross Blue Shield Global Core® claim forms you can get international claims forms in the following ways:

- Call the Blue Cross Blue Shield Global Core® Service Center at the number above; or
- Online at www.bcbsglobalcore.com.

You will find the address for mailing the claim on the form.