California Times

2026 New Hire & Newly Eligible Employee Benefits Guide

Your Benefits Begin Here

Table of Contents

Welcome to Your Benefits Guide!

Please take this time to carefully review your benefit options available to you through California Times and choose wisely to fit your and your family's needs.

Employee Benefits Portal

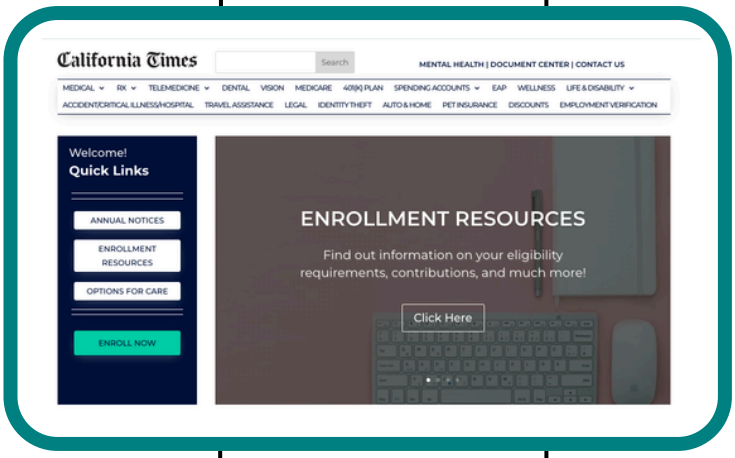
CHECK OUT OUR BENEFITS PORTAL

Nothing to install! Access from a computer, tablet or smartphone.

1. **Visit CA Times - Benefits Portal**
2. **Scan QR Code**

SEARCHABLE
Quickly find service contact information and online resources

GROUP INFORMATION
Access and print generic ID cards with group information



BENEFIT PLANS
Review benefit plan design information and online provider directories

ASK A QUESTION
Connect with Human Resources to get your questions answered

Employee Eligibility Rules

Regular Full-Time (40+/hours per week) or Regular Part-Time (regularly scheduled to work 30-39/hours per week) employees

Benefits will be effective the first of the month following your date of hire or first of the month following the change to a benefit eligible status. If hired on the first of the month or transition to a benefit-eligible status on the first of the month, benefits are effective the same day. Union represented employees should refer to their CBA to determine eligibility.

Regular Part-Time employees (regularly scheduled to work less than 30/hours per week), Temporary employees or Interns

Benefits will be effective after meeting the required hours during a measurement period determined by Patient Protection and Affordable Care Act (ACA). Please contact the Benefits Department for additional details at email: CATimesBenefits@caltimes.com.

Your eligible dependents include:

- Legally married spouse or domestic partner;
- A natural child, step-child, adopted child, legal guardianship, children of your spouse or domestic
- partner up to age 26;
- A child over the age of 26 that has a severe physical or mental condition that makes them indefinitely dependent on you for primary support.

When can I enroll into the 401(k) plan?

Regular Full-Time or Regular Part-Time Employees (regularly scheduled to work 30-39/hours per week) are eligible upon reaching age 21 and completing 30 days of service. You will be able to enroll or waive this benefit after completing 30 days of service not anytime sooner. If no action is taken you will be automatically enrolled into 3% after 60 days.
Regular Part-Time Employees (regularly scheduled to work less than 30/hours per week), Temporary Employees or Interns are eligible upon reaching one year of service and 1,000 hours of work and must be 21 years of age or older.

In order to add any new dependents to your Medical, Dental or Vision, you must provide proof of eligibility directly to Dayforce. This means you will be required to submit documents to verify dependent eligibility.

Dependent documentation must be submitted at the time of enrollment or within 30 days of becoming eligible.

This documentation allows us to ensure that only eligible dependents are added to the CA Times benefits plans.

Find the additional details visit **Benefits Portal,** under Quick Links and Enrollment Resources.

Required Documentation for Dependent Verification

Required Documentation

LEGAL SPOUSE (OPPOSITE AND SAME SEX)

- Copy of Government Issued Marriage Certificate or Copy of Prior Year's Tax Return Showing Spouse
- Marriage certificate should show date of marriage or Tax Return must be the most recent tax year filed

DOMESTIC PARTNER

- Affidavit of Domestic Partner/Domestic Partner Child Qualification and Guidelines and Tax Status Declaration
- To find the two mentioned documents please see the Benefits Portal - Enrollment Resources

CHILD / LEGAL GUARDIAN / STEPCHILD

- Birth Certificate or Court Adoption Documents/Legal Guardianship or Copy of prior year's tax return showing child
- The child's birth certificate, court documents mentioning the employee as the adopted parent or legal guardian or employee tax return showing the dependent. Stepchild birth certificate and marriage certificate showing natural parent and employee are married or employee tax return showing the dependent

DOMESTIC PARTNER'S CHILD

- Affidavit of Domestic Partner/Domestic Partner Child Qualification and Guidelines
- To find the two mentioned documents please see the Benefits Portal - Enrollment Resources

When can I make changes to my benefit elections?

If you fail to enroll or make changes within your first 30 days of benefit eligibility, you can only make certain changes to your benefits if you experience a qualified life event pursuant to IRS Section 125 rules.

You must report any qualifying life event to Dayforce within 30 days of the occurrence of the event to be allowed to make a change. Proof of qualifying event will be requested. Examples of qualified life events include:

- Marriage, divorce, legal separation, domestic partner changes
- Dependent losing or gaining coverage elsewhere
- Birth, adoption, legal guardianship
- Death of a spouse or child
- Become eligible for assistance under a Medicaid plan, State Exchange Plan or Medicare
- Leave of Absence

See the **Qualifying Life Event** document for additional important information and useful examples.
To report your qualify event, go to **Dayforce**, or contact the Benefits Department for additional details at email: **CATimesBenefits@caltimes.com**.

Birth or adoption of a child

Marriage

Divorce and/or legal separation

Death or loss of a dependent (including loss of dependent status)

Change in your spouse's employment status causing loss or gain of benefits coverage

Change in your own employment status

Change in residence that affects the benefits offered to you

Eligibility for Medicare

How To Enroll in Your Online Benefits

1. Benefits are now available in Dayforce. You can Enroll, waive, submit Life Event changes (Qualifying Life Events), make changes to HSA Accounts, and complete Open Enrollment.
2. Start by logging in at Dayforce
3. Select the Benefits in the Navigation bar.
4. Select the update that is needed and click Start Enrollment.
5. You are not considered enrolled in benefits until you click the Submit button AND receive a confirmation that your enrollment has been successfully approved. Dependent coverage will be activated once the required supporting documentation has been reviewed and approved. To ensure a smooth enrollment process, we recommend completing your enrollment in one sitting. Dayforce does not save partial entries, so if you exit before finishing, you will need to start over.

Questions? Contact BENASSIST Call Center

California Times is pleased to provide access to the BenAssist Resource Center, which aims to deliver a responsive, consistent, and hands-on approach to benefit inquiries. Benefit Counselors are available to offer educational support and guidance regarding benefits for which you may require assistance. These counselors are experienced and licensed professionals, dedicated primarily to assisting you in making informed benefit decisions. The counselors at the BenAssist Resource Center are available from Monday to Friday, between 6 AM and 5 PM Pacific Standard Time, at (866) 455-3813. Should you require assistance outside of regular business hours, please leave a message, and one of the Benefit Counselors will return your call promptly by the end of the next business day.

Call the BenAssist Resource Center today!
Call (866) 455-3813 Monday-Friday
between 6 AM to 5 PM PST

Important Reminders

- You can enroll or waive coverages via Dayforce site.
- The elections you make during your new hire or newly eligible enrollment window will remain in effect for the plan year unless you experience a qualifying life event (QLE).
- Dependent verification documents are due to Dayforce no later than 30 days from benefit effective date for any dependent(s) being added to the Medical, Dental and Vision benefit plans.
- If no action is taken during your initial new hire window or new benefit eligibility window, you will only be enrolled into the employer paid Life, Accidental Death & Dismemberment, Short-Term Disability and Employee Assistance Program.
- Failure to elect your benefits within the required timeframe means you will have to wait until open enrollment to have your next opportunity to enroll or you experience a qualifying life event.
- You must actively re-enroll each year in the Health Care FSA, Dependent Care FSA, Health Savings Account (HSA), and Parking/Transit benefit. If you do not re-enroll, your coverage will end for the new plan year. Elections do not carry over; all current elections terminate at the end of each plan year.
- You can watch a recorded presentation to familiarize yourself with the benefit offerings. Go to the Benefits Portal.

Contacts

Refer to this list when you need to contact one of your benefit providers. For general information, contact your CA Times Benefits Department. Visit the CA Times Benefits Portal at Benefits Portal for all benefit collateral information.

Carrier/Provider	Group #	Phone #	Website
CA Times Benefits Department	N/A	(213) 237-2165	Email: CATimesBenefits@CalTimes.com
Dayforce Enrollment Administrator	N/A		http://sso.dayforcehcm.com/nantmedia
Collective Health Medical PPO/HDHP	282016	(833) 440-4367	join.collectivehealth.com/catimes
Express Scripts admin. by RxBenefits, Inc. Prescription coverage for Collective Health Plans	Rx Bin: 610014 Rx Group: RXBNANT	(800) 334-8134	Covered Drug list and Mail Order information: express-scripts.com Member Services: RxHelp@RxBenefits.com Specialty Drugs: Accredo.com
Kaiser Permanente Medical HMO	Northern CA Region: 606131 Southern CA Region: 234268 Mid-Atlantic Region: 26847	(800) 464-4000	www.kp.org
Telemedicine	Collective Health Kaiser Permanente	(888) 548-3435 (866) 454-8855	www.livehealthonline.com www.kp.org
My Benefit Advisor - Medicare	N/A	(916) 767-0436	Benefits Portal/ medicare
Delta Dental	Standard: 19876-0001 Enhanced: 19876-0002	(800) 765-6003	www.deltadentalins.com
EyeMed	Standard: 1019531-1001 Enhanced: 1019531-1002	(866) 939-3633	www.eyemed.com
WEX - FSA	33535	(866) 451-3399	www.wexinc.com
Health Equity - HSA	N/A	(866) 346-5800	www.healthequity.com
Health Equity - Commuter Benefit	CA Times	(877) 924-3967	www.healthequity.com
Lincoln Financial Group Life and AD&D Short-term Disability Long-term Disability	Group ID: CA Times Life/ADD: 1-0267713 Vol Life: 40-0001000-26882 Vol AD&D: 000403007971	(800) 423-2765	www.lfg.com
MetLife - Voluntary Products	217517	(800) 438-6388	www.metlife.com
ComPsych Employee Assistance Program	CA Times	(855) 327-4463	www.GuidanceResources.com Web ID: Lincoln
MetLife Legal Plan	217517	(800) 821-6400	www.legalplans.com
LifeLock - Identity Theft Protection	YIG480	(800) 607-9174	www.lifelock.com
Employee Discounts	EHJ6XN	(866) 664-4621	catimes.benefithub.com Referral Code: EHJ6XN
Nationwide - Pet Insurance	N/A	(877) 738-7874	www.petinsurance.com/catimes
Farmers Insurance - Auto & Home	N/A	(800) 438-6381	www.myautohome.farmers.com
BeneAssist - Call Center	N/A	(866) 455-3813	
Vanguard - 401(k)	094880	(800) 523-1188	www.vanguard.com/actnow

Comparing Health Insurance Plans

HMO - Health Maintenance Organization

- Requires a primary care physician (PCP).
- Everything is determined and coordinated through your PCP.
- All care falls within your local Kaiser network of healthcare providers.

Advantages include:

- You'll probably never have to file a claim
- HMO plans almost always cost less

PPO - Preferred Provider Organization

- You'll enjoy greater flexibility and freedom with your medical providers.
- You can choose to seek care in-network or out-of-network.
- Member pays coinsurance after deductible is met.
- Review Collective Health – PPO Plan overview for more information.

Advantages include:

- You don't need a referral from your PCP to see a specialist
- The specialist can be outside of your network

HDHP - High Deductible Health Plan

- A high deductible is a type of health insurance with higher deductibles but lower monthly premiums.
- You must meet your deductible before your insurance will cover the cost for care for medical and pharmacy.
- Allows you to open a health savings account (HSA).
- Review Collective Health – HDHP Plan overview for more information.

Advantages include:

- Lower premiums
- Contributing to a pre-tax Health Savings Account

Medical Plans with Collective Health

Anthem Blue Cross Network

You have the option of two plans through Collective Health, a PPO and High Deductible Health Plan (HDHP).

- Employees may seek services from in-network and out-of-network providers.
- Utilizing an in-network provider offers an enriched benefit; a lower deductible, a lower co-insurance charge, and expenses over the usual and customary limit are waived.
- If an out-of-network provider is selected, the employee may be responsible for charges above the usual and customary limit. Benefits are paid on covered charges after the deductible is satisfied on certain services under the PPO plan.
- Under the HDHP the full deductible must be satisfied first for all services before benefits are paid.
- Coverage outside the country is only covered in emergency situations.
- If you are currently enrolled in the CA Times Medical Plan and a Medicare plan, please ensure you let your provider know that you are covered by your employer benefits plan. Your provider will need your insurance information for both plans, the CA Times plan is considered primary and then Medicare is secondary. This means that the CA Times plan pays first, and Medicare pays second.

Understanding the Collective Health Plans

Anthem Blue Cross Network

The Collective Health PPO (Preferred Provider Organization) Medical Plan is designed with a preferred network that includes most, but not all, doctors and hospitals. You do not need to designate a primary care physician or a get a referral to see specialists; you can see 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. With the PPO plan you can elect a Health Care Flexible Spending Account (HCFSA), which also offers tax advantages.

The Collective Health High Deductible Health Plan (HDHP) gives you the option to use a Health Savings Account (HSA). An HSA is a tax-advantaged savings account owned by you and can be used to pay for qualified medical expenses that you may incur now or later for you and your dependent(s). You are allowed to fund an HSA by electing a pre-tax contribution.

How the PPO Medical Plan Works

First: Enroll

- Go to Dayforce and complete the enrollment process and choose the Collective Health PPO Plan.
- Employees who participate in the Collective Health PPO plan will be eligible to make contributions into a Health Care Flexible Spending Account (HCFSA).

Then: Reach your deductible

- You'll pay out of your pocket for certain in-network services and prescriptions until you reach your deductible.
- Once you reach your deductible, co-insurance kicks in.
- You can use money in your HCFSA to pay for these expenses

Finally: Insurance pays 100%

- If you reach your out-of-pocket maximum during the calendar year, the plan pays at 100% of any additional eligible expenses.

How the HDHP Medical Plan Works

First: Enroll

- Go to Dayforce and complete the enrollment process and choose the Collective Health HDHP Plan.
- This is also when you elect your HSA contribution, if any. California Times offers an HSA account through Health Equity.

Then: Reach your deductible

- Whenever you need care or a prescription, you'll be responsible for paying the full amount until you reach your deductible.
- Once you reach your deductible, co-insurance kicks in.
- You can use money in your HSA to pay for these expenses.

Finally: Insurance pays 100%

- If you reach your out-of-pocket maximum during the calendar year, the plan pays at 100% of any additional eligible expenses.

Preventative Benefits with Collective Health Plans

Anthem Blue Cross Network

Think of preventive care as a check-in for your body when you are healthy. Preventive care services like immunizations, certain screening tests, and routine check-ups help you avoid illness and improve your physical health and wellbeing. What's covered by your plan as "preventive care" can vary by depending on things like your gender, age, and certain risk factors.

Why preventative care?

- Your plan covers in-network preventive care at $0 out-of-pocket cost to you. At no cost, it is a simple way to get healthcare that you need.
- Preventive care does double-duty; it helps you take care of your current health as well as keeps you informed about potential health risks.
- Early screenings and tests are effective to catch other health conditions sooner which can lead to better treatment outcomes.
- And, if you are unable to find in-network preventive care in your area, Collective Health's member advocates are there to help you with what you need.

Collective Health

Benefits info, handled

- Easily review your medical plan.
- Get a detailed breakdown of your benefits.
- Find an in-network doctor.

Ditch the jargon

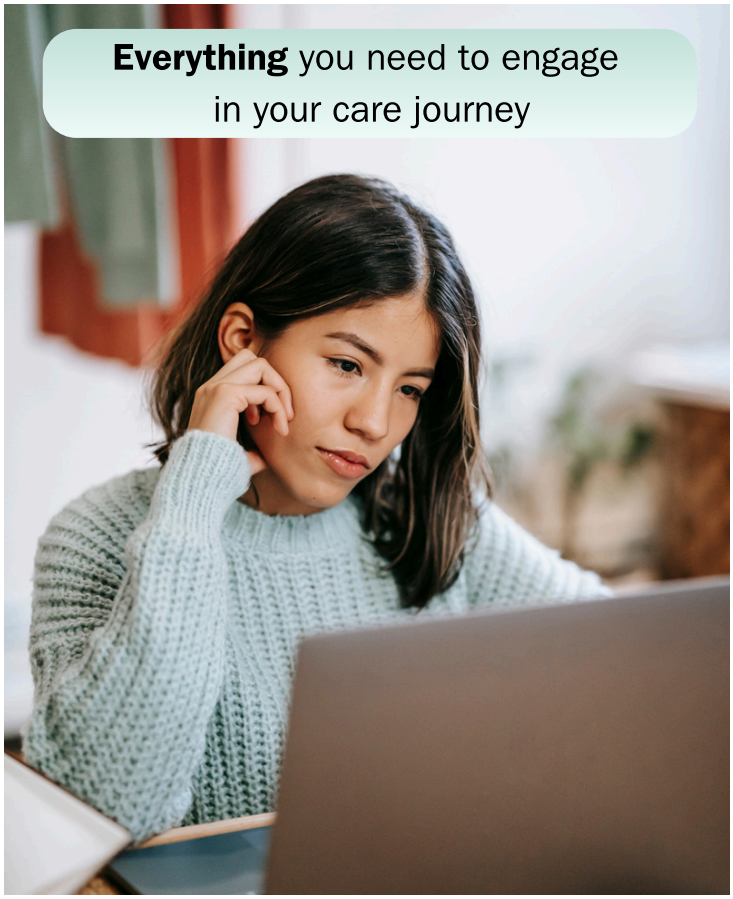
- They've translated the medical speak into understandable language so you can choose and use your health benefits with total clarity.

Pocket-sized ID cards

- Your insurance card and health benefit info fits right into your pocket. Just download the mobile app.

Answers to your questions

- Their help center can help you navigate your account, better understand billing, and decode complicated insurance terms.



Collective Health is here to help!

We partner with Collective Health for the Medical PPO and HDHP plans to empower our health benefits. They're here to make using your benefits easier and more transparent than ever. Collective Health can help you monitor your claims, find local doctors, and simply understand how your benefits work. Any questions you have on the medical PPO or medical HDHP call Collective Health at (833) 440-4367 or go to join.collectivehealth.com/catimes.

GIVE THEM A CALL OR EMAIL THEM

(833) 440-4367

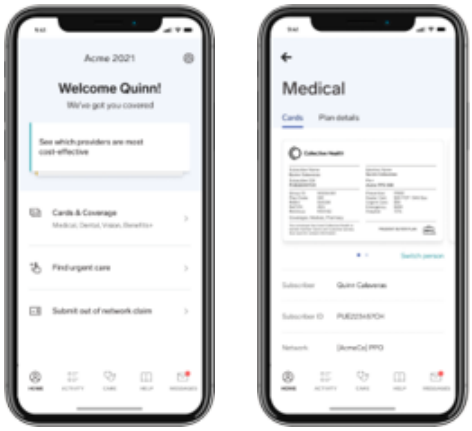
help@collectivehealth.com

Monday-Friday 4 AM to 6 PM PST

Saturday 7 AM to 11 AM PST

With our app, you can:

- Check your plan details
- File claims
- Find doctors in your network
- Get your questions answered
- Have your cards on you, always



Medical Plans with Collective Health

Anthem Blue Cross Network

Please take time to review the medical benefit chart. We want you to make the right choice for you and your family. This chart is a brief summary only. In the event of a discrepancy, plan documents will prevail. Certain limitations and exclusions apply. For exact terms and conditions, please refer to the summary plan description located within **Benefits Portal**.

MEDICAL	Collective Health – PPO (Anthem Blue Cross Network)		Collective Health – HDHP (Anthem Blue Cross Network)	
	In-Network	Out-of-network	In-Network	Out-of-network
Calendar Year Maximum Out Of Pocket (Individual/Family)	$3,000 / $ 6,000	$6,000 / $12,000	$6,750 / $ 13,500	$11,400 / $22,800
Calendar Year Deductible (Individual/Family)	$1,000 / $ 2,000	$3,000 / $6,000	$3,375 / $ 6,750	$6,750 / $13,500
Preventive Care	No Charge*	40% coinsurance	No Charge*	40% coinsurance
Primary Care	$25 copay*	40% coinsurance	20% coinsurance	40% coinsurance
Specialist Visit	$40 copay*	40% coinsurance	20% coinsurance	40% coinsurance
Urgent Care	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Diagnostic Lab & X-Rays **Complex Imaging** (CT/Pet Scans, MRI's)	20% coinsurance 20% coinsurance	40% coinsurance 40% coinsurance	20% coinsurance	40% coinsurance
Chiropractic (limit 30 visits/year)	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Acupuncture (limit 12 visits/year)	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Emergency Room Care	$150 copay/visit*	$150 copay/visit*	20% coinsurance	20% coinsurance
Inpatient Hospital	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Outpatient Surgery	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Mental Health & Substance Abuse	$25 copay office visit*	40% coinsurance	20% coinsurance	40% coinsurance

*Deductible Waived

Employees earning < or = $100,000		
Employee Bi-weekly cost (# of paychecks 26)	**Collective Health | PPO**	**Collective Health | HDHP**
Employee Only	$124.78	$72.94
Employee + Spouse	$368.98	$230.17
Employee + Child	$326.20	$205.14
Employee + Family	$561.51	$357.80
Employees earning > $100,000		
Employee Bi-weekly cost (# of paychecks 26)	**Collective Health | PPO**	**Collective Health | HDHP**
Employee Only	$156.87	$91.17
Employee + Spouse	$429.59	$268.93
Employee + Child	$376.14	$237.02
Employee + Family	$643.52	$410.23

Prescription Drug Coverage with RxBenefits

CA Times pharmacy benefits for the PPO and HDHP are administered by RxBenefits in partnership with Express Scripts. All members and their eligible dependents enrolled in the Collective Health PPO or HDHP will receive one member ID with the Medical and Pharmacy Information. The RxBenefits service model delivers enhanced safety, better cost savings, and top-notch customer service. You will continue to have access to a massive network of more than 60,000 pharmacies nationwide.

PHARMACY	RxBenefits - PPO (Express Scripts Network)		RxBenefits - HDHP (Express Scripts Network)	
	In-Network	Out-of-network	In-Network	Out-of-network
Retail Pharmacy (30-Day Supply)				
Generic Drugs	$10 copay	$10 copay	20% coinsurance	Not Covered
Preferred Brand Drugs	30% coinsurance (Min. $25, Max: $50 copay)	30% coinsurance (Min. $25, Max: $50 copay)	20% coinsurance	Not Covered
Non-Preferred Brand Drugs	45% coinsurance (Min. $40, Max: $80 copay)	45% coinsurance (Min. $40, Max: $80 copay)	20% coinsurance	Not Covered
Specialty Drugs	$125 copay	Not Covered	50% coinsurance	Not Covered
Mail Order Pharmacy (90-Day Supply)				
Generic Drugs	$10 copay	Not Covered	20% coinsurance	Not Covered
Preferred Brand Drugs	$100 copay	Not Covered	20% coinsurance	Not Covered
Non-Preferred Brand Drugs	$160 copay	Not Covered	20% coinsurance	Not Covered
Specialty Drugs	$125 copay	Not Covered	50% coinsurance	Not Covered

Your prescription benefit coverage includes:

Member Services: Dedicated to meeting your prescription benefits needs, RxBenefits can be reached at (800) 334-8134 or RxHelp@rxbenefits.com Monday through Friday from 5 AM to 6 PM PST. After hours you may choose to transfer directly to Express Scripts.

Digital Tools: Register at express-scripts.com and download the Express Scripts mobile app to manage your profile, request refills, locate pharmacies, and more!

Drug Exclusions: Review the Formulary Exclusions List at express-scripts.com and the Exclusions section in the Prescription Benefit Coverage document. Speak with your doctor about moving to a covered alternative if you are prescribed an excluded medication.

Prior Authorization: Certain medications require Prior Authorization (PA) before the prescription can be filled. The PA review process helps ensure FDA prescribing guidelines are met and that you receive the safest and most appropriate drug therapy.

Maintenance Medications: Treat ongoing conditions like diabetes, high blood pressure, and asthma. In addition to local retail pharmacy access, your benefit coverage allows medications to be filled by mail.

Registering with Express Scripts

Online access to savings and convenience

Manage your medicines anywhere, any time with express-scripts.com and the Express Scripts mobile app.

Register now so you can experience:

- **More Savings**: Compare prices of medicines at multiple pharmacies. Get free standard shipping from the Express Scripts Pharmacy.
- **More Convenience**: Get up to 90-day supplies of your long-term medicine sent to your home. Order refills, check order status, and track shipments. Print forms and ID cards, if needed.
- **More Confidence**: Talk with a pharmacist from the privacy of your home any time, from anywhere. Find the latest information on your medicine, including possible side effects and interactions.
- **More Flexibility**: Download the Express Scripts mobile app to manage your medicines, find nearby pharmacies, and get directions, and use your virtual ID card while on the go.

Members who have **touch or facial ID authentication** on their mobile devices can enable it to log in to their Express Scripts account on the mobile app, if desired.

Get Started Today!

Registering is safe and simple. Your information is secure and confidential. Please have your member ID number or SSN available.

- Go to express-scripts.com and select Register, or download the Express Scripts mobile app and select Register.
- Complete the information requested, including personal information and member ID number or SSN. Create your username and password, along with security information in case you ever forget your password.
- Click Register Now and you're registered.
- To set preferences, select Communication Preferences from the menu under Account, then scroll to Communication and Viewing Preferences. Click Edit preferences. Preferences can only be selected via the member website.

Medical Plans with Kaiser

You have the option of two plans through Kaiser Permanente, Traditional HMO and Signature (Deductible) HMO plans. Kaiser is an HMO plan with a closed network of providers. The HMO plan is designed for you to choose a primary care physician from Kaiser's network.

- The Traditional HMO plan covers the cost of services only when authorized with simple copays and coinsurance and no annual deductible applies.
- Through the Signature (Deductible) HMO plan, you will pay the full charges for some services until you reach your deductible. After you reach your deductible, you'll start paying less – a copay or a percentage of the charges (coinsurance) for the rest of the plan year.
- If you are currently enrolled in the CA Times Medical Plan and a Medicare plan, please ensure you let your provider know that you are covered by your employer benefits plan. Your provider will need your insurance information for both plans, the CA Times plan is considered primary and then Medicare is secondary. This means that CA Times plan pays first, and Medicare pays second.

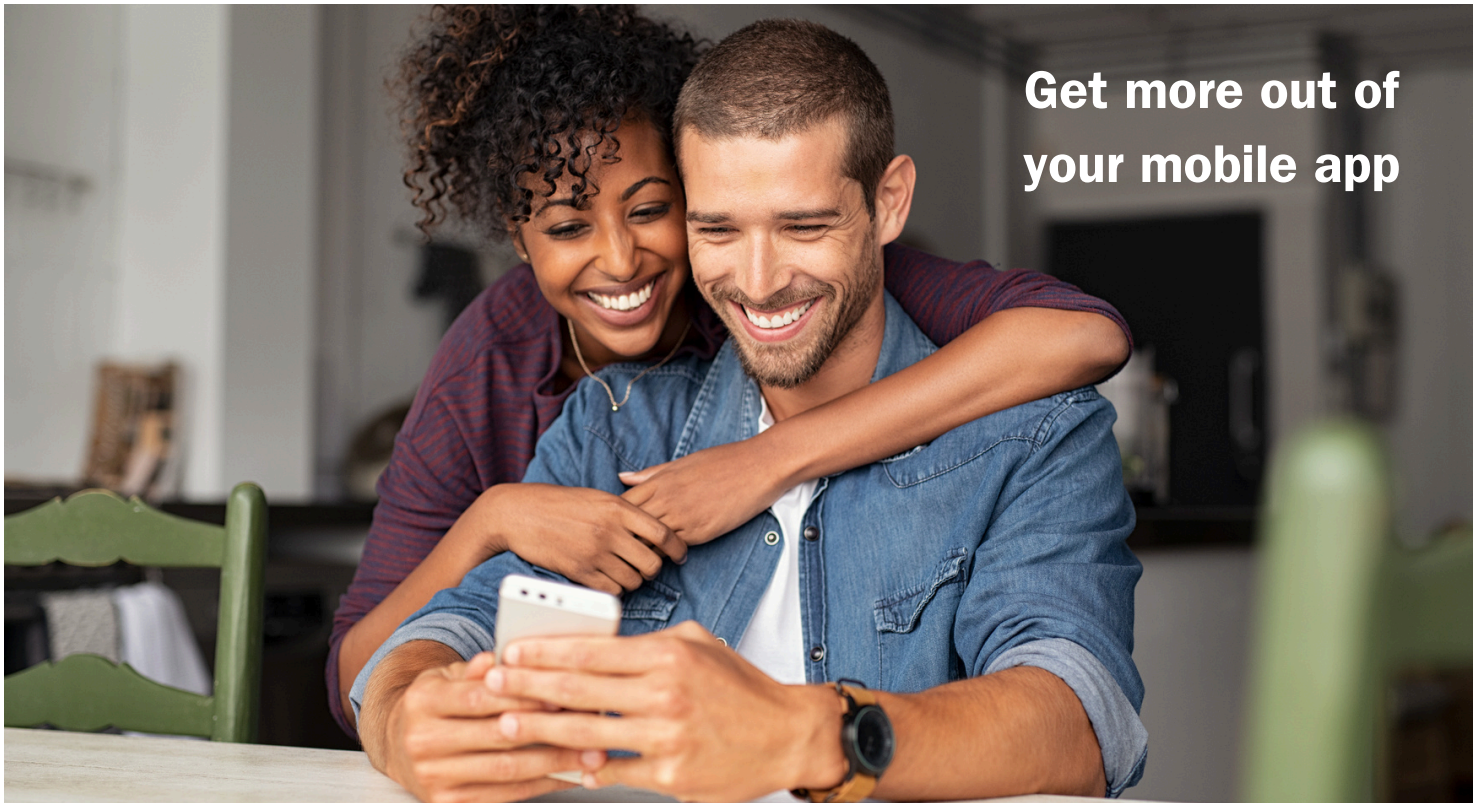
Please take time to review the table that follows. We want you to make the right choice for you and your family. This is a brief summary only. In the event of a discrepancy, plan documents will prevail. Certain limitations and exclusions apply. For exact terms and conditions, please refer to the summary plan description located within **Benefits Portal**.

Medical Plans with Kaiser

MEDICAL	Kaiser Permanente Traditional HMO (CA Only)	Kaiser Permanente Signature (Deductible) HMO (CA and Mid-Atlantic Only)
	In-Network	**In-Network**
Calendar Year Maximum Out Of Pocket (Individual/Family)	$500 / $ 1,000	$3,000 / $ 6,000
Calendar Year Deductible (Individual/Family)	None	$1,000 / $3,000
Preventive Care	No Charge	No Charge*
Primary Care	$15 copay	$25 copay*
Specialist Visit	$25 copay	$40 copay*
Urgent Care	$15 copay	$25 copay*
Diagnostic Lab & X-Rays **Complex Imaging** (CT/Pet Scans, MRI's)	No Charge No Charge	20% coinsurance after deductible 20% coinsurance after deductible
Chiropractic (limit 30 visits/year for both chiropractic & acupuncture)	$15 copay	$15 copay*
Acupuncture (limit 30 visits/year for both chiropractic & acupuncture)	$15 copay	$15 copay*
Emergency Room Care	$50 copay	$150 copay
Inpatient Hospital	$125 copay	20% coinsurance after deductible
Outpatient Surgery	$50 copay	20% coinsurance after deductible
Mental Health & Substance Abuse	$15 copay	$25 copay*
Pharmacy		
Generic Drugs Retail (up to 30-day supply) Mail Order (up to 100-day supply)	 $5 copay $10 copay	 $10 copay* $10 copay*
Preferred Brand Drugs Retail (up to 30-day supply) Mail Order (up to 100-day supply)	 $10 copay $20 copay	 30% coinsurance (up to $50)* 30% coinsurance (up to $50)*
Specialty Drugs Retail (up to 30-day supply)	 $10 copay	 $125 copay*

Deductible Waived*

Employees earning < or = $100,000			
Employee Bi-weekly cost (# of paychecks 26)	**Kaiser Traditional HMO** (CA Only)	**Kaiser Signature HMO** (CA Only)	**Kaiser Signature HMO Mid-Atlantic**
Employee Only	$114.00	$79.93	$37.05
Employee + Spouse	$300.55	$247.96	$114.95
Employee + Child	$265.02	$223.38	$103.55
Employee + Family	$441.20	$379.11	$175.75
Employees earning > $100,000			
Employee Bi-weekly cost (# of paychecks 26)	**Kaiser Traditional HMO** (CA Only)	**Kaiser Signature HMO** (CA Only)	**Kaiser Signature HMO Mid-Atlantic**
Employee Only	$133.25	$94.28	$43.70
Employee + Spouse	$340.53	$286.90	$133.00
Employee + Child	$302.03	$260.26	$120.65
Employee + Family	$498.94	$438.67	$203.30



1. Register on kp.org to get secure access to My Health Manager - your one-stop resource for managing your care online.

2. Download the Kaiser app to access all the convenient features of MyHealth Manager on your smartphone. Download the app for the iPhone or Android from the App Store or on Google Play at no cost.

3. Open the app on your smartphone and sign on using your kp.org registration credentials. Using the app, here's what you can do right from your smartphone:

- Email your doctor's office for routine nonurgent questions.
- View most lab test results.
- Order or refill most prescriptions.
- Join a video visit.
- Schedule or cancel routine appointments.
- Access a digital version of your ID card.
- Pay bills and view payment history.

Digital ID Card

Access your membership information anytime, anywhere with an electric version of your ID card. The integrated photo serves as valid ID.

- Check in for appointments.
- Pick up prescriptions.
- Access your family's membership information.

To use your digital ID card, tap the card icon at the bottom of the Kaiser Permanente app dashboard.

Convenient Ways to Get Care

Same-day, next-day, and weekend appointments are available at most locations, and by phone and video.

Visit us in person at a location near you.

Talk to a health care professional by phone or video.

24-hour virtual care on your schedule

If a trip to the doctor's office doesn't fit your schedule, it's easy to get fast, personalized support - daytime, nighttime, anytime.

- Schedule a phone or video visit with a doctor or clinician.
- Get 24/7 care advice by phone.
- Email your Kaiser doctor's office with nonurgent questions.
- Use our e-visit questionnaire to get personalized care advice for certain conditions, order many tests, and get some prescriptions online.
- Chat online with a Kaiser clinician for advice.

Prescription delivery

Fill prescriptions online or with the Kaiser Permanente app

- Have most delivered directly to your front door.
- Order them for same-day pickup.
- Get same-day or next-day delivery for an additional fee.

Kaiser Permanente app

Manage your health 24/7 with our app. It's an easy, convenient way to do everything described above - anytime. anywhere.

Care away from home

You're covered for urgent and emergency care anywhere in the world. And if you're planning to travel, we can help you stay on top of your health when you're away from home. We'll work with you to see if you need a vaccination, refill prescriptions, and more.

Virtual Medical Visits and Virtual Mental Health Visits

Do you have an ear infection, pink eye, suffering from anxiety, depression or another health issue that needs to be addressed? If you need non-emergency medical attention, virtual medical visits might be a solution. You can have a doctor's appointment from the comfort of your home.

Collective Health PPO Members (In-Network Cost)	Telemedicine Visits With Your Own Provider • Primary Care Doctor - $25 copay • Specialist - $40 copay • Mental Health Visits - $25 copay	LiveHealth Online – livehealthonline.com You have access 24/7 by web, phone or mobile app to medical providers and licensed therapist $10 copay.
Collective Health HDHP Members (In-Network Cost) Deductible Applies	Telemedicine Visits With Your Own Provider • Primary Care Doctor - 20% after deductible • Specialist - 20% after deductible • Mental Health Visits - 20% after deductible	LiveHealth Online – livehealthonline.com You have access 24/7 by web, phone or mobile app to medical providers and licensed therapist 20% after deductible.
Kaiser HMO Members See plan document for coverage level	See physicians and providers for urgent health concerns by video visit. Register at kp.org today to schedule a video visit. You can use the telemedicine service available through kp.org or by calling (866) 454-8855.	

24/7 Nurseline

Nurseline gives you access to a registered nurse 24 hours a day, seven days a week. Use this free service to have your non-emergency questions answered.

Collective Health PPO and HDHP Members call (800) 700-9186 to receive assistance with any health-related questions or concerns.

Kaiser HMO Plan Members call (833) 574-2273 to receive assistance with any health-related questions or concerns.

Medicare 101

If you or your eligible dependent are nearing retirement age, or are over 65 and still working, you may have questions about Medicare.

What Is Medicare?

Medicare is health insurance for people who are age 65 or older, under 65 with certain disabilities, or any age with End-stage Renal Disease (permanent kidney failure).

Original Medicare options:

- **Medicare Part A (known as hospital insurance)** helps cover inpatient care in hospitals, skilled nursing facilities, and hospice and home health care.
- **Medicare Part B (known as medical insurance)** helps cover medical services like doctors' services, outpatient care and other medically necessary services that Part A doesn't cover.

Additional plans offered through private insurers:

- **Medicare Part C (known as Medicare Advantage Plans)** are a combination plans managed by private insurance companies approved by Medicare.
- **Medicare Part D (known as Medicare drug plan)** is prescription medication coverage that pays above and beyond Original Medicare Part A and Part B and is available to everyone with Medicare. It is a separate plan provided by private Medicare-approved companies, and you must pay a monthly premium.
- **Medicare Supplemental Plan (known as Medigap plan)** is insurance designed to work with Original Medicare. Original Medicare does not cover all costs associated with covered health services and supplies. Medigap can cover some of the remaining health care costs, such as coinsurance, deductibles and copayments.

When do I enroll?

- Upon becoming eligible for Medicare, you have seven months to sign up for Part A and/or Part B, this is called the initial enrollment period. Failure to enroll within your enrollment period, may result in penalties determined by Medicare.
- If your Medicare eligibility begins when you turn 65, you can sign up during the 7-month initial enrollment period which begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.
- When you are nearing eligibility, it's important to understand your options so you can make informed decisions. Individual circumstances will ultimately determine when you should enroll in Medicare.

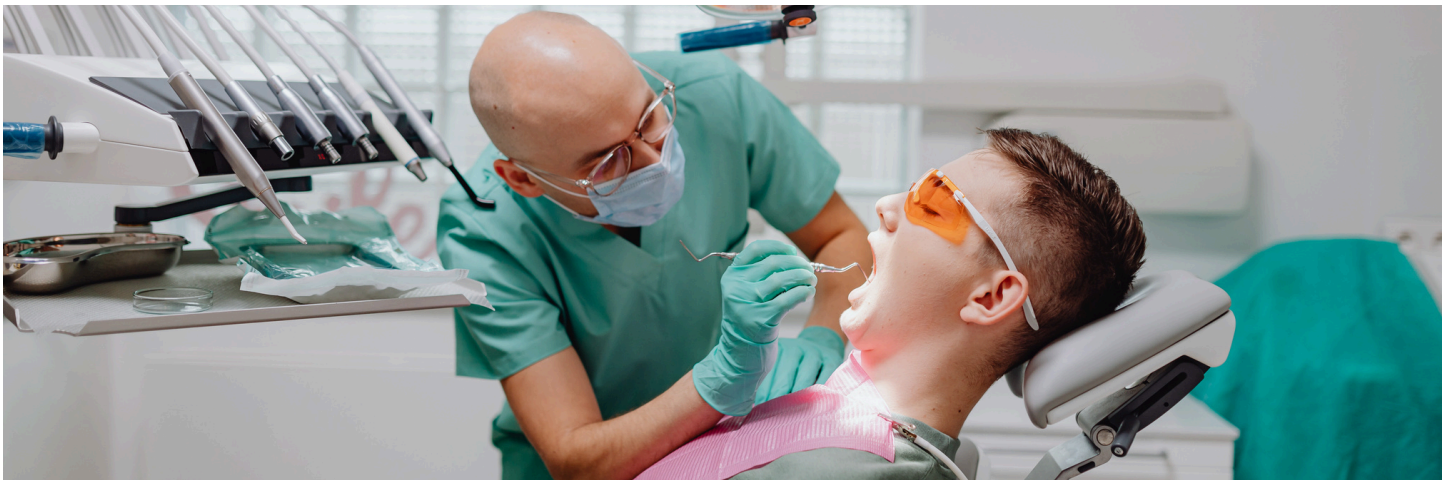
Medicare Resources provided by the company at No Cost to Employees!

MY BENEFIT ADVISOR

- If you are eligible for Medicare or approaching the age of 65, these educational services are completely voluntary at no cost to you. Medicare Advocates are ready to provide personalized guidance. My Benefit Advisor can help you understand the process of choosing an ideal Medicare plan that meets your individual medical and financial needs. Your initial contact with My Benefit Advisor Eligibility Services will be with an Marketplace Expert who will help you determine whether a consultation with one of their licensed agents is appropriate. The Marketplace Expert's role is to assist you in answering general questions around eligibility, benefits and timelines. They can provide guidance on next steps and help you to schedule an appointment to speak with a licensed agent at a time that works with your schedule. If it is determined that you should consult with a licensed agent, the Marketplace Expert will obtain your authorization to have the licensed agent call you, and will schedule an appointment that works with your schedule. During your scheduled consultation with a licensed agent, the agent will provide you with detailed information about the various Medicare plan options and compare plans that are offered in your area to your specific needs, including ensuring providers are in network and reviewing prescription drug costs. Once you find an appropriate fit, the agent will work with you to complete the enrollment application and ensure coverage is in place. These services are also available to your family members who are eligible for Medicare.

Dental Plans with Delta Dental

These plans allow you to select the dentist of your choice. Both you and Delta Dental have a shared responsibility of paying the dentist for services rendered. If you choose a dentist who participates in the Delta Dental PPO network claims will be filed on your behalf. If you select a dentist from the Delta Dental PPO Network, you will pay less in out-of-pocket expenses.

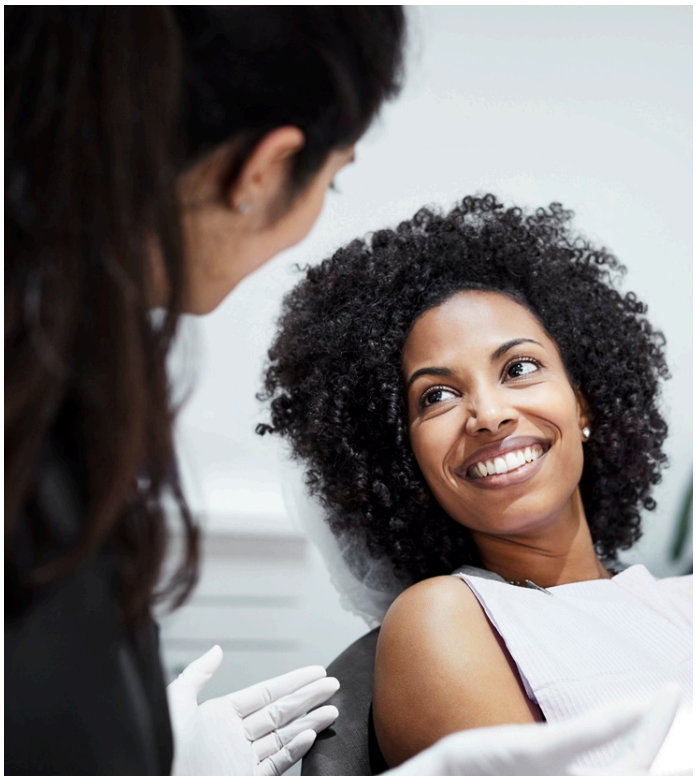


DELTA DENTAL	Delta PPO - Standard Plan		Delta PPO - Enhanced Plan	
Plan Feature	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Maximum Benefit Per Person Per Calendar Year	$1,500	$1,500	$2,000	$2,000
Costs for covered diagnostic and preventive dental services do not accrue against your calendar year maximum at PPO Providers				
Calendar Year Deductible Per Individual Per Family **Waived for Diagnostic & Preventative services and Orthodontics**	$50 $150		$50 $150	
Preventative Services (Exams, cleanings, x-rays and sealants)	You pay 0%		You pay 0%	
Basic Services	You pay 20% after plan deductible		You pay 20% after plan deductible	
Major Services	You pay 50% after plan deductible		You pay 50% after plan deductible	
Orthodontic	Not Covered		You pay 50%	
Orthodontic Lifetime Max	N/A		$2,500/person	
Orthodontic Eligibility	N/A		Children Only (up to age 19)	

Employee Bi-weekly cost (# of paychecks 26)	**Dental - Standard PPO**	**Dental - Enhanced PPO**
Employee Only	$13.36	$14.85
Employee + Spouse	$26.74	$29.70
Employee + Child	$34.76	$38.62
Employee + Family	$48.12	$53.46

Delta Dental Member Resources

Whether you need to check your benefits or select a new dentist, you can do it all with Delta Dental's online tools.



Create an Account

What you can do:

- Check your plan details and eligibility
- Browse claim history
- Download plan documents
- Find an in-network dentist
- View your member ID card or print a paper copy
- Update your settings to paperless

Try it out: Go to deltadentalins.com and choose Log In to create an account or log in to your existing account.

Tip: Access your benefits info on mobile, tablet, or desktop!

Find an In-Network Dentist

What you can do:

- Search by distance, specialty, language spoken, extended office hours, wheelchair accessibility and more
- Browse Yelp ratings and reviews from real patients, and check out DentaQual scores for an objective quality metric based on actual claims data

Go to deltadentalins.com, enter your address or ZIP code and select your network. Not sure which network to choose? Log in to your account first and follow the prompts to find a dentist.

Explore Dental Wellness

What you can do:

- Browse articles on everything from acid reflux to xylitol
- Find delicious recipes for healthy meals
- Check out videos on preventative care and common procedures

Visit www.deltadentalins.com/wellness to start learning.

Download the App

What you can do:

- Check your plan details and eligibility
- Browse claim history
- View your member ID card
- Get a cost estimate
- Find an in-network dentist

Search for Delta Dental in the App Store or Google Play.

Vision Plan with EyeMed

EyeMed offers a large network of contracting providers, including optometrists and ophthalmologists. When a contracting network provider is used, the care is considered "in-network" and the out-of-pocket costs will be less, and the highest level of benefits is received.
If a provider outside the network is used, the care is considered "out-of-network" coverage is still provided, but the out-of-pocket costs will be significantly higher.

Find an eye doctor by visiting www.eyemed.com and search the "Select Network", or download the EyeMed App.

EYEMED VISION	Standard Plan (Select Network)			Enhanced Plan (Select Network)		
Plan Feature	**Plus Providers In-Network**	**In-Network**	**Out-of-Network**	**Plus Providers In-Network**	**In-Network**	**Out-of-Network**
Exam Copay: *Every 12 Months*	$0	$10	Up to $40	$0	$10	Up to $40
Lenses Copay: *Every 12 Months* Single Bifocal Trifocal Lenticular	$25 for all lenses	$25 for all lenses	Up to $40 Up to $40 Up to $60 Up to $80	$10 for all lenses	$10 for all lenses	Up to $40 Up to $40 Up to $60 Up to $80
Frames: *Every 24 months* Allowance and Discount	$180 + 20%	$130 + 20%	Up to $45	$225 + 20%	$175 + 20%	Up to $45
Contacts: *Every 12 months** Conventional Disposable Medically Necessary	$130 + 15% $130 Paid in Full	$130 + 15% $130 Paid in Full	Up to $105 Up to $105 Up to $210	$175 + 15% $175 Paid in Full	$175 + 15% $175 Paid in Full	Up to $105 Up to $105 Up to $210

Employee Bi-weekly cost (# of paychecks 26)	EyeMed - Standard Plan	EyeMed - Enhanced Plan
Employee Only	$2.72	$6.45
Employee + Spouse	$4.81	$11.40
Employee + Child	$5.71	$13.55
Employee + Family	$8.22	$19.28

* PLUS Providers maximize your benefits with extra coverage to help you save more. When searching the Select Network, look for providers with the Plus Provider mark. PLUS Providers are not available in IL, NC, NJ, RI, VA, WA & WV.

EyeMed Membership Perks

New Look. Fresh Features. Same Great Benefits. Whenever you need them.

The revamped EyeMed Mobile App brings you fresh new features to help you get the most from your EyeMed experience - anytime, anywhere.

The Features You Love Plus New Features To Explore

- See benefits and eligibility at-a-glance
- Track your claims
- Grab special offers to help you save more
- Find an in-network eye doctor with the Provider Locator
- View your ID card at-a-shake
- Set upcoming exam and contact lens replacement reminders
- Get answers to your FAQs
- Access interactive vision guides to help you see and live your best
- Use Facial recognition, Touch ID, and Apple Wallet for Apple users

Using the old app? Make sure you download the newest version of the app to keep up with our latest features, as older versions will no longer be supported. Download the new app, enter your existing login info (no need to re-register) and you're all set.

Check out the App Store or Google Play to download the new app.

Flexible Spending Account (FSAs) and Health Savings Account (HSA)

You are offered various Flexible Spending Accounts (FSAs) through WEX, a Health Savings Account (HSA-only available for HDHP members) through Health Equity, and a Commuter Benefit through Health Equity. These plans allow you to contribute on a pre-tax basis to pay for qualified expenses. Please review the below for a comparison of the different types of tax-advantages of these accounts. You must select the amount you want to contribute for the specific spending account, the funds cannot be transferred between accounts. Please refer to **Benefits Portal** for a more information on qualified expenses list and claim forms.

Health Care FSA (HCFSA)	You can contribute up to $3,400 each year (minimum of $100) on a pre-tax basis to pay for eligible medical, dental, and vision expenses incurred by you and your family during the plan year. Our plan has a rollover feature of up to $660 for unused funds at the end of the calendar year.
Limited Purpose FSA (LPFSA)	When enrolled in the High Deductible Health Plan (HDHP) and a Health Savings Account (HSA) you may also elect a Limited Purpose FSA (LPFSA) concurrently, allowing you to receive reimbursement for eligible dental and vision expenses only. If enrolled in the HDHP, but not an HSA, you may enroll in the Full Purpose Healthcare FSA with access to all eligible medical, dental, and vision reimbursements. Same limits as the HCFSA apply for LPFSA.
Dependent Care FSA (DCFSA)	Per IRS rules, the total that each family can elect for a Dependent Care FSA must not exceed $7,500 per household, minimum of $100, ($3,750 each if married and filing separately). Eligible dependent care expenses applies for dependent children through the age of 12 or your spouse or child who is physically or mentally incapable of self-care and lives in your home.
Claims	For 2026, you have until the end of the plan year of 12/31/2026 to incur claims for all FSA plans and request for claim reimbursement must be submitted by 3/31/2027.
When are my FSA funds available?	For the Healthcare and Limited FSA plans, all funds selected will be immediately available to you on day one of your plan, you do not need to wait to accrue the funds. For Dependent Care FSA, you can only use funds as they are deducted from your paycheck and deposited into your account.
Carryover Feature	For the Healthcare and Limited Purpose FSA plans, you may carry over up to $680 from the 2026 plan year to the 2027 plan year. Any balance below $100 or above $680 as of December 31, 2026, will be forfeited. There is no carryover for Dependent Care FSA funds.
Health Savings Account (HSA) (only available to HDHP members)	If you enroll into the HDHP health plan you can contribute up to $4,400 for a single and $8,750 for a family for the 2026 plan year to pay for eligible qualified health care expenses incurred by you and your eligible dependents. Individuals age 55 and over can put an additional $1,000 in “catch-up” contributions annually. You can be reimbursed only up to the amount in your account at the time you request reimbursement. HSA funds are yours for life, you maintain ownership of the account even after you leave the company or retire. By law if you are enrolled Medicare, you may not contribute to an HSA.
Commuter Benefit	A Health Equity Commuter program is a pre-tax benefit that can save you on parking and public transit-that includes train, subway, bus and eligible vanpool as part of your daily commute to work. You can contribute up to $340 pre-tax for public transit per month. CA Times subsidizes up to $70 monthly. Subsidy is only available to employees who commute to work by public transit. By submitting your commuter election/enrollment, you agree to receive a deduction out of your check for any elected benefit over $70. You can also contribute up to $340 pre-tax for parking as part of your daily commute to work. Visit **Benefits Portal** for details on how to enroll. You can enroll anytime during the year.

Flexible Spending Account (FSAs) and Health Savings Account (HSA)

Access your benefits on the go 24/7 with the WEX benefits mobile app. The free app gives you convenient, real-time access to your benefits accounts in one spot. You can find out the status of a recent claim or easily check the balance of your accounts.

With the WEX mobile app, you can:

- Get instant updates on the status of your claims
- File a claim and upload documentation in seconds using your phone's camera
- report a card as lost or stolen, which cancels the card and ships you a new one
- Log in through face recognition or fingerprint (depending on your phone)
- Check your balance and view account activity
- Use your benefit debit card directly from your mobile phone with Apple Pay or Samsung Pay
- Scan an item's bar code to determine if it's an IRS code section 213(d) eligible expense
- Reset login credentials

Maybe you've had an HSA before, but you've never had an HSA like this.

Get support 24/7

Call us day or night. Our US-based service team measures success by problems solved. We'll do whatever it takes.

Say goodbye to hassle

Log in and manage everything via our simple mobile app. Want to submit a claim? Easy. Just snap a photo and you're on your way.

Be inspired

Check out our vast library of webinars, tutorials, videos, calculators, and more. You'll find tips and tricks to make the most out of your HSA.

Join five million+ health savers

For nearly two decades we've empowered some of the biggest companies in the world - and the smartest savers on the block.

If you enrolled in the Collective Health HDHP medical plan and chose to fund an HSA through Health Equity, download the free Benefits Mobile App.
HealthEquity (866) 346-5800 / healthequity.com

Save big on thousands of qualified medical expenses, including:


Pain relievers


Doctor visits


Dental cleaning


Sleep aids


Eyeglasses / contacts


Cold / cough medicine


Chiropractic care


Insulin testing supplies

Life and Accidental Death & Dismemberment (AD&D)

Basic Life/AD&D - Company Paid

CA Times provides you with Basic Term Life and AD&D insurance coverage in the amount of 1 time your base annual earnings to a maximum of $1,000,000.

Supplemental Life - Employee Paid

Plan Features	Benefit Amounts	Guarantee Issue
For You	Choices of: 1x, 2x, 3x, 4x, 5x, 6x, 7x, 8x, 9x or 10x your basic annual earnings, to a maximum of $2,000,000	$650,000 or 3 times your annual salary, whichever is less
Spouse/DP	You may purchase Life Insurance for your spouse: $10,000, $25,000, $50,000, $100,000, $150,000 or $250,000 Amount not to exceed 100% of Employees Benefit	$30,000
Child(ren)	One day to 14 days - $250 15 days to 26 years - $5,000, $10,000, $25,000	Amount elected

- Employee life rate is based on employee's age. Spouse Life rate based on spouse's age.
- Please review benefit summaries saved in the Benefits Portal for additional details.

Evidence of Insurability (EOI) is part of the application process for the Supplemental Life for an employee, spouse and domestic partner. For new hires and newly eligible employees any amounts above the Guarantee Issue requires EOI. Completion of the EOI can be done online through Lincoln Financial. The EOI Link can be found on the benefits portal at Benefits Portal, under the Life tab.

Approval or denial of EOI - In some cases, you may be auto-approved for coverage. If additional manual review with medical information is required, medical underwriters will send a request to employees for the additional information needed. You have 45 days to provide a response to the request. Supplemental Life coverage does not become effective until approval of the EOI.

You have an opportunity to enroll yourself and your spouse up to the guarantee issue without having to complete the Evidence of Insurability (EOI) health questionnaire only available during your initial benefits eligibility window. Any amounts over the guarantee issue, future enrollments or increases to life insurance will require EOI. In order to enroll your dependents, you must enroll in the plan yourself.

Benefit Reduction applies to benefits above upon reaching age 65, 70, 75 and 80. Please review benefit summaries saved in the Benefits Portal for additional details.

Voluntary AD&D - Employee Paid (Benefit not subject to EOI)

Plan Features	Benefit Amounts	Max Coverage Amount
For You	Choices of: Increments of $25,000. Not to exceed 10 times the employee's annual salary. Rounded to the next higher $1,000.	This amount may not exceed $2,000,000
Spouse/DP	You may elect 100% of your coverage amount, in increments of $10,000.	This amount may not exceed $1,000,000
Child(ren)	0 days but under 6 months - $1,000 At least 6 months to 26 years - You may elect up to 100% of your coverage amount, in increments of $5,000.	This amount may not exceed $300,000

Disability Plans with Lincoln Financial

CA Times offers disability insurance that pays for a percentage of your income for a specified amount of time, if you cannot perform the duties of your job due to a qualifying disability as a result of a medical condition or illness, or as a result of an accidental injury.

Short-Term Disability

Short-Term Disability insurance can replace a portion of your regular income while you aren't working due to childbirth, illness or injury. After all, your bills won't stop just because you need to recover. Benefits begin at the end of the elimination period and continue while you are disabled up to the maximum benefit duration. The Short-Term Disability benefit is coordinated with the state benefit. Employees may not receive the full 60% benefit.

Benefit Schedule	60%
Weekly Maximum	$2,308
Elimination Period Accident/Sickness	7 days
Benefit Duration	26 weeks

Voluntary Long-Term Disability

Long-Term Disability Insurance coverage typically begins where Short-Term Disability coverage leaves off, providing benefits for covered illnesses or injuries that have longer recovery periods. Coverage can last from several months to several years. You have an opportunity to enroll without having to complete the Evidence of Insurability (EOI) health questionnaire only available during your initial benefit eligibility window. Evidence of Insurability (EOI) is required for late entrants (enrollments more than 30 days after first becoming eligible).

Benefit Schedule	60%
Monthly Minimum	$100 or 10%, whichever is greater
Monthly Maximum	$15,000
Elimination Period	180 days
Benefit Duration	Up to age 65 or Social Security Normal Retirement Age (SSNRA), whichever is greater

The benefit paid for Short-Term and Long-Term Disability is minus applicable taxes, deductions and other state benefits. The benefit paid at time of claim is based on frozen salary in the month of October. Commission employees' benefit is based on salary + commissions made during fiscal year.

Critical Illness, Accident and Hospital Plans with MetLife

CA Times offers you the ability to enroll in the voluntary worksite benefits that are directly deducted from your paycheck. These products include Accident Insurance, Critical Illness and Hospital Indemnity.

Accident Insurance

With MetLife Accident Insurance, you have a choice of two comprehensive plans a Low Plan and High Plan, which pays money based on the injury or treatment you and/or your eligible dependents receive, whether it's a simple sprain or something more serious, like an injury from a car accident. The Low and High Plans may pay you and/or your dependents a benefit for an emergency room treatment, stitches, crutches, injury-related surgery and certain other accident-related expenses.

Benefit	Low Plan	High Plan
Emergency Room	$25-$50	$50-$100
Hospital Admission	$500	$1,000
Ambulance	$200-$750	$300-$1,000
Fracture Maximum	$3,000	$6,000
Wellness Benefit	$50	$50

Critical Illness

The Critical Illness Insurance through MetLife will help pay you a percentage of the maximum coverage you choose. Diagnosed illnesses like heart attack, stroke, Alzheimer's disease and cancer are among those covered. Rates will vary, as they are based on age, smoker status and family size. Critical Illness insurance will compliment your medical and disability income coverage, which can ease the financial impact of certain critical illnesses.

Benefit	Coverage Amount
Employee	$15,000 or $30,000
Spouse	50% of employee amount
Child(ren)	50% of employee amount
Wellness Benefit	$50

Hospital Indemnity

You are offered two Voluntary Hospital Indemnity Insurance Plans through MetLife for you and your eligible family members. It can complement your medical coverage by helping to ease the financial impact of a hospitalization. A flat amount may be paid for hospital admission and a per day amount may be paid for each day of a covered hospital stay, from the very first day of your stay.

Benefit	Low Plan	High Plan
Hospital Admission	$600	$600
Intensive Care Admission	$600	$600
Daily ICU Confinement	$50	$100
Daily Hospital Confinement	$50	$100
Wellness Benefit	$50	$50

Employee Assistance Program (EAP)

When going through a difficult time, having someone to talk to can make a big difference in your state of mind. You and your loved ones have access to confidential counseling from trained counselors for issues such as:

- **Resiliency** - overcoming stress and crisis at home and at work.
- **Emotional Wellness** - addiction, depression, anxiety and assistance with other emotional wellness issues.
- **Workplace Success** - career goals, team conflict, crisis management support.
- **Wellness and Balance** - work-life balance, stress, relaxation, personal well-being.
- **Personal and Family Goals** - relationship, children and teen or aging loved ones. Changes in finances or personal situations.

EmployeeConnect Plus

Employee Assistance Program Services

24 hours a day, 7 days a week. Call (855) 327-4463, or visit www.guidanceresources.com (web ID: Lincoln).

- Family
- Parenting
- Addictions
- Relationships
- Emotional
- Legal
- Financial
- Stress

CA Times offers this service at no additional cost to you! Available to you, your spouse, and your dependents!

You get

- Unlimited phone access to legal, financial and work-life services
- In-person help with short-term issues
- Up to six in-person sessions per person, per issue, per year

MetLife Legal Plans

You, your spouse, and dependents receive legal assistance for many common personal legal matters, with no waiting periods, deductibles, or claim forms when using a network attorney for a covered issue. You can select an attorney from MetLife's network of prequalified professionals or choose an attorney outside the network and receive partial reimbursement for covered services.

Money Matters	• Debt Collection Defense • Identity Theft Defense • Negotiations with Creditors	• Personal Bankruptcy • Promissory Notes	• Tax Audit Representation • Tax Collection Defense
Home & Real Estate	• Boundary & Title Disputes • Deeds • Eviction Defense • Foreclosure	• Home Equity Loans • Mortgages • Property Tax Assessment • Refinancing of Home	• Sale or Purchase of Home • Security Deposit Assistance • Tenant Negotiations • Zoning Applications
Estate Planning	• Codicils • Complex Wills • Healthcare Proxies • Living Wills	• Powers of Attorney (Healthcare, Financial, Childcare, Immigration)	• Revocable & Irrevocable Trusts • Simple Wills
Family & Personal	• Adoption • Affidavits • Conservatorship • Demand Letters • Garnishment Defense • Guardianship • Immigration Assistance	• Juvenile Court Defense, Including Criminal Matter • Name Change • Parental Responsibility Matter • Personal Property Protection	• Prenuptial Agreement • Protection from Domestic Violence • Review of ANY Personal Legal Document • School Hearings
Civil Lawsuits	• Administrative Hearings • Civil Litigation Defense	• Disputes Over Consumer Goods & Services • Incompetency Defense	• Pet Liabilities • Small Claims Assistance
Elder-Care Issues	Consultation & Document Review for your parents: • Deeds • Leases	• Medicaid • Medicare • Notes • Nursing Home Agreements	• Powers of Attorney • Prescription Plans • Wills
Vehicle & Driving	• Defense of Traffic Tickets • Driving Privileges Restoration	• License Suspension Due to DUI	• Repossession

Identity Theft with Norton LifeLock

LifeLock monitors your identity. When activity occurs involving your information, you're alerted by email, text, or a phone call. You can respond to confirm whether the activity is legitimate, and if it's not, a U.S. based LifeLock Identity Restoration Specialist will help you resolve the issue. CA Times offers employees the choice of two plans.

LifeLock by Norton Essential Plan

The LifeLock by Norton Essential Plan is aimed squarely at what matters to employees: protecting identities and protecting nest eggs. LifeLock Essential Plan protection helps detect potential fraud and brings it to the attention of employees through alerts via email, text, or phone.

- LifeLock Privacy Monitor
- Lost Wallet Protection
- Live U.S. Based Member Support
- Identity Restoration Support
- Data Breach Notifications

LifeLock by Norton Premier Plan

The LifeLock by Norton Premier Plan is an enhanced identity protection plan that offers the features most people want and at a price to fit your budget. It includes bank account protection, credit scores, and credit reports.

- LifeLock Identity Alert System
- Black Market Web Surveillance
- LifeLock Privacy Monitor Tool
- Lost Wallet Protection
- Live U.S. Based Member Support
- Identity Restoration Support
- Data Breach Notification

Employee Discounts

BenefitHub is a fully customizable benefits and rewards platform. BenefitHub believes that an employee often gives the best of themselves to a company that seeks to serve its employees both inside and outside of the workplace. Enjoy discounts, rewards and perks on thousands of the brands you love in a variety of categories:

- Travel
- Auto
- Electronics
- Apparel
- Local Deals
- Education
- Entertainment
- Restaurants
- Health & Wellness
- Beauty & Spa
- Tickets
- Sports & Outdoors

BenefitHub is easy to access and start saving!

- Visit https://catimes.benefithub.com
- Create an account
- Use referral code: EHJ6XN
- Start saving!

Questions? Call (866) 664-4621 or email customercare@benefithub.com.

Automobiles

Food & Dining

Top Brands

Insurance

Local Deals

Well-Being

Travel

Tickets

Pet Insurance with Nationwide

Nationwide pet insurance helps you cover veterinary expenses so you can provide your pets with the best care possible without worrying about the cost. Visit petinsurance.com/catimes or call (877) 738-7874 for a fast, no obligation quote.

My Pet Protection Coverage Highlights

We offer a choice of reimbursement options so you can find coverage that fits your budget. All plans have a $250 annual deductible and a $7,500 maximum annual benefit. Coverage includes:

- Accidents and Illnesses
- Hereditary and congenital conditions
- Cancer
- Dental diseases
- Behavioral treatments
- Rx therapeutic diets and supplements, and more

Plus, every My Pet Protection policy includes these additional benefits to maximize your value:

- Lost pet advertising and reward expense
- Emergency boarding
- Loss due to theft
- Mortality benefit

Included with Every Policy

Vet Helpline

- 24/7 access to veterinary experts ($110 value)
- Available via phone, chat and email
- Unlimited help for everything from general pet questions to identifying urgent care needs

Pet Rx Express

- Save time and money by filling pet prescriptions at participating in-store retail pharmacies across the U.S.
- Rx claims submitted directly to Nationwide
- More than 4,700 pharmacy locations

Additional Highlights

- Exclusive product for employer groups only
- Preferred pricing for employees
- Multiple-pet discounts
- Guaranteed issuance

Home & Auto Insurance with Farmers Insurance

Auto Insurance

Choose your coverage while enjoying savings and benefits like:

- Special group discounts
- Automated payment options
- Claim-free driving rewards
- Enhanced rental car damage coverage
- No deductible repairs for certain windshield damage
- Roadside assistance
- Guaranteed auto repairs for covered losses
- ID protection services

Home Insurance

Choose home insurance coverage along with savings and benefits like:

- Special group discounts
- Replacement cost coverage
- Referral networks
- Automated payment options
- ID protection services

As an employee, you have access to special savings on auto insurance. Others have saved an average of $579 by making the switch.

Get quotes today. Call (800) 438-6381 or visit www.myautohome.farmers.com.

Other policy options include: RV, Renter's, Motorcycle, Boat, and condo!

Vanguard Retirement

Get started in the California Times 401(k)

You'll need your plan number (**094880**) to take some of these actions.

- Join the plan at vanguard.com/jointoday.
- Sign up for online access at vanguard.com/registertoday.
- Get the free mobile app at vanguard.com/mobilenow.
- Name beneficiaries and sign up for electronic delivery by logging in to your account at vanguard.com/actnow.

Join the Plan

Regular Full Time or Regular Part Time Employees (working between 30 – 40 hours per week) are eligible upon reaching age 21 and completing 30 days of service. You will be able to waive or make changes to your contributions after 30 days of service not anytime sooner. Please review automatic enrollment details below.

Regular Part Time Employees (working less than 30 hours per week), Temporary Employees or Interns are eligible upon reaching one year of service and 1,000 hours of work and must be 21 years of age or older.

How much can you contribute?

You can contribute up to 100% of your pay pre-tax, Roth 401(k) after-tax basis (minus applicable taxes and benefit deductions), or a combination of the two. The IRS also sets dollar limits on contributions. For current IRS limits, visit vanguard.com/contributionlimits.

If you make salary deferrals for a given year in excess of the IRS deferral limit because you made salary deferrals under this Plan and a plan of an unrelated employer, you must ask one of the plans to refund the excess amount to you. If you wish to take a refund from this Plan, you must notify the Plan Administrator by March 1 of the next calendar year so earnings may be refunded by April 15.

Important: Beginning in 2026, the Secure 2.0 Act requires certain higher-earning employees to make their 401(k) catch-up contributions as Roth (after-tax) instead of pre-tax.

Affected employees should monitor their contributions and update elections as needed to stay compliant with this change.

401(k) Employer Match

- For every $1 you contribute of the first 2% of your eligible pay, the company will contribute $1.
- For every $1 you contribute of the next 4% of your pay, the company will contribute $0.50.
- So, to get the full amount, contribute at least 6% of your eligible pay to receive a 4% contribution.
- The matching contribution shall be made each pay period where an employee contributes in that pay period.

How to Enroll

You will be able to waive or increase your contributions after 30 days of service by calling Vanguard at (800) 523-1188 or by visiting vanguard.com/jointoday. You'll need your plan number (094880) to take some of these actions.

Automatic Enrollment

If you don't choose a contribution percentage, you'll be automatically enrolled 60 days after your hire date or eligibility date at a 3% contribution rate, which will automatically increase by 1% each year until it reaches a 10% maximum.

401(k) Vesting Rules

Any money you contribute from your paycheck is immediately vested. That means you have complete ownership and can take that money with you if you leave your job. However, the employer's match contribution is vested over time. You will become fully vested after two years of service. A service year is credited after 1,000 hours of service earned during a calendar year.

Employee Contributions for the 2026 Plan Year

CA Times is proud to provide you with competitive benefits and the ability to choose the coverage that meets your needs. Your cost for coverage will vary depending on the option and level of coverage you choose. Medical premiums are based on salary bands, above $100,000 and below $100,000. For new hires, your salary at your hire date is what will be used to determine the salary band. For employees that have been with the company your salary in October is what is used to determine the salary band (frozen salary). Contributions below are based on 26 pay periods. These are the amounts that will be deducted per paycheck for the plan year of 1/1/2026 - 12/31/2026. The cost will remain the same regardless of compensation changes through the year for non-commission employees. The Company reserves the right to update the aforementioned as needed with advance notice. For employees transitioning to a benefits eligible class, the salary will be updated to reflect the salary at transition.

For employees on a commission plan, frozen salary is updated a second time to capture commissions made during the fiscal year. If you are a commission employee your medical premiums will adjust according to your Annual Benefits Base Rate ("ABBR") made during the fiscal year. This is defined as your base salary + the commissions earned during the Fiscal Year. Please note, deductions will adjust in March 2026. Commission employees hired after February, your salary at hire is used for the remainder of the year.

Employees earning < or = $100,000		
Employee Bi-weekly cost (# of paychecks 26)	**Collective Health | PPO**	**Collective Health | HDHP**
Employee Only	$124.78	$72.94
Employee + Spouse	$368.98	$230.17
Employee + Child	$326.20	$205.14
Employee + Family	$561.51	$357.80
Employees earning > or = $100,000		
Employee Bi-weekly cost (# of paychecks 26)	**Collective Health | PPO**	**Collective Health | HDHP**
Employee Only	$156.87	$91.17
Employee + Spouse	$429.59	$268.93
Employee + Child	$376.14	$237.02
Employee + Family	$643.52	$410.23

Employees earning < or = $100,000			
Employee Bi-weekly cost (# of paychecks 26)	**Kaiser Traditional HMO** (CA Only)	**Kaiser Signature HMO** (CA Only)	**Kaiser Signature HMO Mid-Atlantic**
Employee Only	$114.00	$79.93	$37.05
Employee + Spouse	$300.55	$247.96	$114.95
Employee + Child	$265.02	$223.38	$103.55
Employee + Family	$441.20	$379.11	$175.75
Employees earning > or = $100,000			
Employee Bi-weekly cost (# of paychecks 26)	**Kaiser Traditional HMO** (CA Only)	**Kaiser Signature HMO** (CA Only)	**Kaiser Signature HMO Mid-Atlantic**
Employee Only	$133.25	$94.28	$43.70
Employee + Spouse	$340.53	$286.90	$133.00
Employee + Child	$302.03	$260.26	$120.65
Employee + Family	$498.94	$438.67	$203.30

Employee Bi-weekly cost (# of paychecks 26)	**Dental - Standard PPO**	**Dental - Enhanced PPO**	**EyeMed Standard**	**EyeMed Enhanced**
Employee Only	$13.36	$14.85	$2.72	$6.45
Employee + Spouse	$26.74	$29.70	$4.81	$11.40
Employee + Child	$34.76	$38.62	$5.71	$13.55
Employee + Family	$48.12	$53.46	$8.22	$19.28

Employee Contributions for the 2026 Plan Year

Supplemental Life/AD&D – Bi-Weekly Rates Per $1,000 of Coverage. Rate is based on the age on January 1st or age upon entry.

LFG - Supplemental Life	Employee Rate	Spouse/DP (based on age)
Bi-Weekly Rate per $1,000 of Coverage Age < 24	$0.017	$0.019
Age 25-29	$0.017	$0.019
Age 30-34	$0.018	$0.023
Age 35-39	$0.024	$0.031
Age 40-44	$0.033	$0.042
Age 45-49	$0.046	$0.061
Age 50-54	$0.081	$0.096
Age 55-59	$0.126	$0.174
Age 60-64	$0.219	$0.328
Age 65-69	$0.368	$0.561
Age 70+	$0.625	$1.045
Age 75+	$0.625	$1.045
Child(ren) Bi-Weekly Rate Per $1,000 of Coverage	$0.071	

LFG - Voluntary AD&D	Employee Rate	Spouse/DP Rate	Child Rate
Bi-Weekly Rate per $1,000 of Coverage	$0.010	$0.013	$0.013

LFG - Long-Term Disability	LTD
Bi-Weekly Rate per $100 of Covered Payroll	
Age 29 and under	$0.042
Age 30-34	$0.042
Age 35-39	$0.078
Age 40-44	$0.125
Age 45-49	$0.180
Age 50-54	$0.263
Age 55-59	$0.282
Age 60-64	$0.268
Age 65-69	$0.355
Age 70+	$0.374

Employee Contributions for the 2026 Plan Year

MetLife Critical Illness	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Bi-Weekly Rates per $1,000	$0.16	$0.27	$0.25	$0.37
Age 25-29	$0.16	$0.27	$0.26	$0.37
Age 30-34	$0.23	$0.36	$0.32	$0.46
Age 35-39	$0.31	$0.49	$0.41	$0.59
Age 40-44	$0.45	$0.69	$0.55	$0.79
Age 45-49	$0.66	$0.99	$0.75	$1.08
Age 50-54	$0.96	$1.43	$1.06	$1.52
Age 55-59	$1.32	$1.94	$1.41	$2.04
Age 60-64	$1.80	$2.63	$1.89	$2.72
Age 65-69	$2.58	$3.76	$2.68	$3.85
Age 70+	$3.87	$5.66	$3.97	$5.76
Age 75+	$3.87	$5.66	$3.97	$5.76

MetLife Accident Low Plan	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Bi-Weekly Rates	$3.65	$5.61	$6.60	$8.71

MetLife Accident High Plan	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Bi-Weekly Rates	$6.94	$10.76	$12.54	$16.40

MetLife Hospital Low Plan	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Bi-Weekly Rates	$4.36	$7.21	$7.21	$10.38

MetLife Hospital High Plan	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Bi-Weekly Rates	$5.51	$9.01	$9.01	$13.11

LifeLock Identity Theft Essential	Employee Only	Employee + Dependent(s)
Bi-Weekly Rates	$3.69	$6.45

LifeLock Identity Theft Premier	Employee Only	Employee + Dependent(s)
Bi-Weekly Rates	$4.61	$6.91

MetLife Legal Plans	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Bi-Weekly Rates	$7.62	$7.62	$7.62	$7.62

Nationwide Pet Insurance
Monthly rates vary by state and type of animal. Must call Nationwide directly for a quote, not payroll deducted.

Contact BenAssist at (866) 455-3813 for any questions on the benefit offerings or send an email to CATimesBenefits@CalTimes.com.

Reminders

- Benefit enrollment or changes must be made through **Dayforce**.
- Call BenAssist at (866) 455-3813 for any benefits questions.
- Elections are NOT recorded if you fail to complete the enrollment in its entirety.
- You are not considered enrolled in benefits until you click the Submit button and receive a confirmation that your enrollment has been successfully approved.
- Submit dependent verification documents by the deadline for any newly added dependents.
- Complete Evidence of Insurability (EOI) if you enrolled in a voluntary plan that requires it.
- Update your beneficiaries and ensure you have someone listed in Dayforce and Vanguard.
- Retirement Plan elections must be made on the Vanguard website **www.vanguard.com/actnow**
- Review page 4 for benefit eligibility rules. For Retirement Plan Eligibility Rules review page 38.

California Times

This benefits guide covers only the highlights of California Times's benefit programs. While we have tried to be as accurate as possible in developing this information, the official plan documents govern in all cases. California Times intends to continue these programs but reserves the right to change or end them at any time. Participation in the programs does not imply a contract of employment.

Notes

California Times

Important Notices

January 1, 2026

Federal law requires that NantMedia Holdings, LLC dba California Times provide you with certain notices about your rights regarding health care plan eligibility, enrollment, and coverage.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 14 for more details.

NOTICE OF SPECIAL ENROLLMENT EVENTS

Special enrollment events allow you and your eligible dependents to enroll for health coverage outside the Open Enrollment period under certain circumstances if you lose eligibility for other coverage, become eligible for state premium assistance under Medicaid or the Children's Health Insurance Program (CHIP), or acquire newly eligible dependents. This is required under the Health Insurance Portability and Accountability Act (HIPAA). This notice is being provided to help you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

LOSS OF OTHER COVERAGE

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

MARRIAGE, BIRTH OR ADOPTION

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption.

MEDICAID OR CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy. If you make a change due to a special enrollment event within the 30-day timeframe, coverage will be effective on the date of birth, adoption, or placement for adoption. For all other events, coverage will be effective the first of the month following your submission of the enrollment form. In addition, you may enroll in a NantMedia Holdings, LLC dba California Times medical plan if you become eligible for a state premium, or assistance program under Medicaid or CHIP. You must enroll within 60 days after you gain such coverage. Specific restrictions may apply, depending on Federal and State law.

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 of 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours if applicable).

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

The Genetic Information Nondiscrimination Act of 2008 protects employees against discrimination based on their genetic information. Unless otherwise permitted, your employer may not request or require any genetic information from you or your family members.GINA prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA, includes an individual's family medical history, the results of genetic tests, the fact that a member sought or received genetic services, and genetic information of a fetus carried by a member, or an embryo lawfully held by a member receive assistive reproductive services.

MENTAL HEALTH PARITY AND ADDICTION ACT

The Mental Health Parity and Addiction Act of 2008 general requires group health plans and health insurance issuers to ensure that financial requirements (such as copays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For more Information regarding the criteria for medical necessity determinations made under your employer's plan with respect to mental health or substance use disorder benefits, please contact your plan administrator at (see cover page for contact information).

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). The Women's Health and Cancer Rights Act requires group health plans and their insurance companies and HMOs to provide certain benefits for mastectomy patients who elect breast reconstruction. 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. Breast reconstruction benefits are subject to deductibles and co-insurance limitations that are consistent with those establishes for other benefits under the plan. If you would like more information on WHCRA benefits, contact your plan administrator (see cover page for contact information).

MICHELLE'S LAW

When a dependent child loses student status for purposes of the group health plan coverage as a result of a medically necessary leave of absence from a post-secondary educational institution, the group health plan will continue to provide coverage during the leave of absence for up to one year, or until coverage would otherwise terminate under the group health plan, whichever is earlier. For additional information, contact your plan administrator.

GRANDFATHERED HEALTH PLANS

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted.Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing.However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator (see cover page for contact information). You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.This website has a table summarizing which protections do and do not apply to grandfathered health plans.] [For individual market policies and nonfederal governmental plans, insert: You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

CERTIFICATE OF CREDITABLE COVERAGE

You can request a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to COBRA, when COBRA coverage ceases, if you request it before you lose coverage, or if you request it up to 24 months after losing coverage. If you are joining a grandfathered health plan, you may be subject to pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date (if you are age 19 or older) without evidence of creditable coverage from your prior plan.

UNIFORMED SERVICES EMPLOYMENT AND RE-EMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

The Uniformed and Services Employment and Re-Employment rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short Term or Long-Term Disability or Accidental Death & Dismemberment coverage you may have. A full explanation of USERRA and your rights is beyond the scope of this document. If you want to know more, please see the Summary Plan Description (SPD) for any of our group insurance coverage or go to this site: http://www.dol.gov/vets/programs/userra/main.htm. An alternative source is VETS. You can contact them at 1-866-4-USA-DOL or visit this site: http;//www.dol.gov/vets. An interactive online USERRA Advisor can be viewed at http://www.dol.gov/elaws/userra.htm.

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

Form Approved
OMB No. 1210-0149

PART A: GENERAL INFORMATION

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment in 2026 is more than 9.96%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable in 2026 if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.96% of the employee's household income.[1,2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage - is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

HOW CAN I GET MORE INFORMATION?

For more information about your coverage offered by your employer, please check your summary plan description or contact CA Times Benefits Dept. at (213) 237-2165 or CATimesBenefits@caltimes.com.

*1 The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.*

1 An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

1. Employer Name **NantMedia Holdings, LLC dba California Times**		**2. Employer Identification Number (EIN)** **82-4402852**
3. Employer address **2300 E. Imperial Hwy**		**4. Employer phone number** **(213) 237-2165**
5. City **El Segundo**	**6. State** **CA**	**7. Zip Code** **90245**
8. Who can we contact about health coverage at this job? **CA Times Benefits Dept.**		
9. Phone number (if different from above)	**10. Email address** CATimesBenefits@caltimes.com	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☑ Some employees. Eligible employees are:
- Regular full-time employee who works over 30 hours or more per week is eligible to participate in employer benefits.

- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are: Legal spouse, domestic partner, natural child, stepchild or adopted child until the end of the month in which they reach age 26.
  - ☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends this coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

EFFECTIVE DATE: JANUARY 1, 2026

Privacy Officer:	Stefania Bradley
Title:	Benefits Manager
Email:	stefania.bradley@latimes.com
Phone:	(213) 237-2165

YOUR RIGHTS

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

YOUR CHOICES

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

OUR USES AND DISCLOSURES

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

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

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation
- If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- In these cases, we never share your information unless you give us written permission:
- Marketing purposes
- Sale of your information

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

- We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

- We can use your health information and share it with professionals who are treating you.
- Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.
- Example: We use health information about you to develop better services for you.

Pay for your health services

- We can use and disclose your health information as we pay for your health services.
- Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

- We may disclose your health information to your health plan sponsor for plan administration.
- Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.
- How else can we use or share your health information?
- We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

- We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

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

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

- We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid

Website: **http://myalhipp.com/**
Phone: 1-855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program
Website: **http://myakhipp.com/**
Phone: 1-866-251-4861
Email: **CustomerService@MyAKHIPP.com**
Medicaid Eligibility: **https://health.alaska.gov/dpa/Pages/default.aspx**

ARKANSAS – Medicaid

Website: **http://myarhipp.com/**
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program Website:
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: **hipp@dhcs.ca.gov**

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

Health First Colorado Website: **https://www.healthfirstcolorado.com/**
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+: **https://hcpf.colorado.gov/child-health-plan-plus**
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): **https://www.mycohibi.com/**
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: **https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp**
Phone: 678-564-1162, Press 1
GA CHIPRA Website: **https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra**
Phone: 678-564-1162, Press 2

INDIANA – Medicaid

Health Insurance Premium Payment Program
All other Medicaid
Website: **https://www.in.gov/medicaid/**
http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:
Iowa Medicaid | Health & Human Services
Medicaid Phone: 1-800-338-8366
Hawki Website:
Hawki - Healthy and Well Kids in Iowa | Health & Human Services
Hawki Phone: 1-800-257-8563
HIPP Website: **Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)**
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: **https://www.kancare.ks.gov/**
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: **KIHIPP.PROGRAM@ky.gov**
KCHIP Website: **https://kynect.ky.gov**
Phone: 1-877-524-4718
Kentucky Medicaid Website: **https://chfs.ky.gov/agencies/dms**

LOUISIANA – Medicaid

Website: **www.medicaid.la.gov** or **www.ldh.la.gov/lahipp**
Phone: 1-888-342-6207 (Medicaid hotline) or
1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website:
https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: **https://www.mass.gov/masshealth/pa**
Phone: 1-800-862-4840
TTY: 711
Email: **masspremassistance@accenture.com**

MINNESOTA – Medicaid

Website: **https://mn.gov/dhs/health-care-coverage/**
Phone: 1-800-657-3672

MISSOURI – Medicaid
Website: **http://www.dss.mo.gov/mhd/participants/pages/hipp.htm** Phone: 573-751-2005
MONTANA – Medicaid
Website: **http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP** Phone: 1-800-694-3084 Email: **HHSHIPPProgram@mt.gov**
NEBRASKA – Medicaid
Website: **http://www.ACCESSNebraska.ne.gov** Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: **http://dhcfp.nv.gov** Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: **https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program** Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: **DHHS.ThirdPartyLiabi@dhhs.nh.gov**
NEW JERSEY – Medicaid and CHIP
Medicaid Website: **http://www.state.nj.us/humanservices/dmahs/clients/medicaid/** Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: **http://www.njfamilycare.org/index.html** CHIP Phone: 1-800-701-0710 (TTY: 711)
NEW YORK – Medicaid
Website: **https://www.health.ny.gov/health_care/medicaid/** Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: **https://medicaid.ncdhhs.gov/** Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: **https://www.hhs.nd.gov/healthcare** Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: **http://www.insureoklahoma.org** Phone: 1-888-365-3742
OREGON – Medicaid and CHIP
Website: **http://healthcare.oregon.gov/Pages/index.aspx** Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP
Website: **https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html** Phone: 1-800-692-7462 CHIP Website: **Children's Health Insurance Program (CHIP) (pa.gov)** CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
Website: **http://www.eohhs.ri.gov/** Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: **https://www.scdhhs.gov** Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid
Website: **http://dss.sd.gov** Phone: 1-888-828-0059
TEXAS – Medicaid
Website: **Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services** Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website: **https://medicaid.utah.gov/upp/** Email: **upp@utah.gov** Phone: 1-888-222-2542 Adult Expansion Website: **https://medicaid.utah.gov/expansion/** Utah Medicaid Buyout Program Website: **https://medicaid.utah.gov/buyout-program/** CHIP Website: **https://chip.utah.gov/**
VERMONT– Medicaid
Website: **Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access** Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: **https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select** **https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs** Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: **https://www.hca.wa.gov/** Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: **https://dhhr.wv.gov/bms/** **http://mywvhipp.com/** Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: **https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm** Phone: 1-800-362-3002
WYOMING – Medicaid
Website: **https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/** Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512. The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

IMPORTANT: This is a fixed indemnity policy, NOT health insurance.

- This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.
- The payment you get isn't based on the size of your medical bill
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most
- Federal consumer protections that apply to health insurance.
- Looking for comprehensive health insurance?• Visit HealthCare.gov or call 1-800-318-2596 (TTY: 1-855-889-4325) to find health coverage options.
- • To find out if you can get health insurance through your job, or a family member's job, contact the employer. Questions about this policy?

• For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."

• If you have this policy through your job, or a family member's job, contact the employer.

IMPORTANT NOTICE FROM NANTMEDIA HOLDINGS, LLC DBA CALIFORNIA TIMES ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

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

1) NantMedia Holdings, LLC dba California Times has determined that: The prescription drug coverage for the NantMedia Holdings, LLC dba California Times, Anthem BC High Deductible Health Plan (HDHP), Anthem BC PPO, Kaiser HMO Traditional, Kaiser Deductible, Kaiser Mid-Atlantic, United Healthcare Global and HMSA PPO plans are, on average for all plan participants, expected to pay out as much or more as the standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.
However, if you decide to drop your current Anthem BC PPO, Kaiser HMO Traditional, Kaiser Deductible, Kaiser MidAtlantic or HMSA PPO coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan. However, if you are enrolled on the Anthem BC HDHP, you must wait until the next Medicare Part D annual enrollment period to join a Medicare drug plan. You also may pay a higher premium (a penalty) because you did not have creditable coverage under the Anthem BC HDHP.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?
If you decide to join a Medicare drug plan, your current NantMedia Holdings, LLC dba California Times coverage will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed below. The NantMedia Holdings, LLC dba California Times prescription drug coverage is part of our medical plan. If you do decide to join a Medicare drug plan and drop your current prescription drug coverage, your coverage under the NantMedia Holdings, LLC dba California Times medical plan will also end. If coverage ends, you and your dependents may only be able to get this coverage back during open enrollment, unless you experience a status change that allows you to enroll in coverage mid-year.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN? You should also know that if you drop or lose **creditable coverage** and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. The Anthem BC HDHP is not creditable coverage.

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

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.
For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

Or contact the person listed below.
NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through NantMedia Holdings, LLC dba California Times changes. You also may request a copy of this notice at any time.

Effective Date: January 1, 2026

Employer Name: NantMedia Holdings, LLC dba California Times

Contact Name/Title: CA Times Benefits Dept.

Address: 2300 E. Imperial Hwy., El Segundo, CA 90245

Phone: (213) 237-2165

Email: CATimesBenefits@caltimes.com

NOTICE OF HEALTH PLAN PRIVACY PRACTICES

Effective Date: February 16, 2026

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

California Times sponsors certain group health plan(s) (collectively, the "Plan" or "We") to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the "Notice") describes the legal obligations of California Times, the Plan and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act (HIPAA). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

- your past, present or future physical or mental health or condition;
- the provision of health care to you; or
- the past, present or future payment for the provision of health care to you.

IMPORTANT NOTICE REGARDING SUBSTANCE USE DISORDER (SUD) RECORDS

If the Plan creates, receives, or maintains records concerning substance use disorder diagnosis, treatment, or referral for treatment, those records are subject to more stringent privacy protections under federal law (42 CFR Part 2). These protections are more restrictive than those provided by HIPAA and apply in addition to the protections described elsewhere in this Notice.

Key Differences for SUD Records:

- **Treatment, Payment, and Health Care Operations:** Unlike other protected health information covered by HIPAA, the use or disclosure of SUD records for treatment, payment, and health care operations generally requires your specific written consent under Part 2, unless otherwise permitted by law. This means we cannot use or disclose your SUD records for these purposes without your authorization, even though HIPAA would permit such uses and disclosures.

- **Single Consent Option:** You may provide a single written consent for all future uses and disclosures of your SUD records for treatment, payment, and health care operations purposes. This consent may be revoked by you at any time in writing.

- **Legal Proceedings:** SUD records received from programs subject to 42 CFR Part 2, or testimony relaying the content of such records, shall not be used or disclosed in civil, criminal, administrative, or legislative proceedings against you unless based on your written consent, or a court order after notice and an opportunity to be heard is provided to you or the holder of the record, as provided in 42 CFR Part 2. A court order authorizing use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested record is used or disclosed.

- **Redisclosure Restrictions**: Information disclosed from SUD records under Part 2 may be subject to redisclosure by the recipient and may no longer be protected by the Part 2 regulations. However, recipients of Part 2 records are required to include a notice prohibiting further redisclosure without your consent or as otherwise permitted by Part 2.
- **More Restrictive Law Applies:** Where Part 2 is more restrictive than HIPAA, the Part 2 requirements will apply to SUD records. The permitted uses and disclosures described throughout this Notice are limited by Part 2 when applicable to SUD records.

Your Rights Regarding SUD Records: You have specific rights with respect to SUD records protected under Part 2, including the right to receive adequate notice of uses and disclosures of such records, the right to request restrictions on certain uses and disclosures, the right to request an accounting of disclosures, and the right to access and amend your SUD records. These rights are described in greater detail in the "Your Rights" section of this Notice.

Note: If you are covered by one or more fully-insured group health plans offered by California Times, you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier.

Contact Information
If you have any questions about this Notice or about our privacy practices, please contact the California Times HIPAA Privacy Officer:

California Times
Attention: HIPAA Privacy Officer
Stefania Bradley
Benefits Manager
C: 310-426-4808
stefania.bradley@latimes.com

Our Responsibilities under HIPAA
We are required by law to:
- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided in this Notice or on our Benefits Portal. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

How We May Use and Disclose Your Protected Health Information
Under the law, we may use or disclose your protected health information under certain circumstances without your permission. However, please note that for SUD records subject to 42 CFR Part 2, more restrictive rules apply, as described in the Notice. The following categories describe the different ways that we may use and disclose your protected health information.

For Treatment
We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use. For SUD records, your written consent is generally required for such disclosures under Part 2.

For Payment
We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments. For SUD records, your written consent is generally required for such disclosures under Part 2.

For Health Care Operations
We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes. For SUD records, your written consent is generally required for such disclosures under Part 2.

To Business Associates
We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us. Business Associates who receive SUD records are subject to Part 2 requirements and must comply with Part 2 more stringent protections.

As Required by Law
We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws. For SUD records, disclosures in legal proceedings require your written consent or a court order as described in the SUD Records section above.

To Avert a Serious Threat to Health or Safety
We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors
For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information.

Organ and Tissue Donation

If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans

If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation

We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks

We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities

We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested. For SUD records, disclosure in legal proceedings requires your written consent or a court order as described above.

Law Enforcement

We may disclose your protected health information if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

For SUD records, disclosures to law enforcement are subject to Part 2's stricter requirements and generally require your written consent or a court order.

Law Enforcement
We may disclose your protected health information if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

For SUD records, disclosures to law enforcement are subject to Part 2's stricter requirements and generally require your written consent or a court order.

Coroners, Medical Examiners and Funeral Directors
We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities
We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates
If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the in**stitution to provide you with health care; (2) to protect your health and safety or the health and safety of others; o**r (3) for the safety and security of the correctional institution.

Research
We may disclose your protected health information to researchers when:

- the individual identifiers have been removed; or
- when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures
The following is a description of disclosures of your protected health information we are required to make.

Government Audits
We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule. This requirement also applies to SUD records for Part 2 compliance investigations.

Disclosures to You
When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Notification of a Breach
We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA. This notification requirement also applies to breaches of SUD records subject to Part 2.

Other Disclosures

Personal Representatives
We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

- you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
- treating such person as your personal representative could endanger you; or
- in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members
With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations
Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. **This is particularly important for SUD records, which require your written consent for most uses and disclosures for treatment, payment, and health care operations.** You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Your Rights
You have the following rights with respect to your protected health information:

Right to Inspect and Copy
You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

Right to Amend
If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures
You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years (three years for electronic health records) or the period xxx has been subject to the HIPAA Privacy rules, if shorter. Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions
You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had. We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to a Paper Copy of This Notice
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html.

To file a complaint with the Plan, telephone or write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

Document Updated: February 2026

This Notice incorporates all requirements under the 42 CFR Part 2 Final Rule effective February 16, 2026.

2026 Illinois Disclosure

Employer Name:	California Times
Employer State of Situs:	California
Name of Issuer:	Collective Health
Plan Marketing Name:	PPO
Plan Year:	2026

Ten (10) Essential Health Benefit (EHB) Categories:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Laboratory services
- Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)

- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

2020-2026 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)

Item	EHB Benefit	EHB Category	Benchmark Page # Reference	Employer Plan Covered Benefit?
1	Accidental Injury – Dental	Ambulatory	Pgs. 10 & 17	Yes
2	Allergy Injections and Testing	Ambulatory	Pg. 11	Yes
3	Bone anchored hearing aids	Ambulatory	Pgs. 17 & 35	Yes, only when medically necessary
4	Durable Medical Equipment	Ambulatory	Pg. 13	Yes
5	Hospice	Ambulatory	Pg. 28	Yes
6	Infertility (Fertility) Treatment	Ambulatory	Pgs. 23 - 24	Yes
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Ambulatory	Pg. 21	Yes
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Ambulatory	Pgs. 15 - 16	Yes
9	Private-Duty Nursing	Ambulatory	Pgs. 17 & 34	Yes
10	Prosthetics/Orthotics	Ambulatory	Pg. 13	Yes
11	Sterilization (vasectomy men)	Ambulatory	Pg. 10	Yes
12	Temporomandibular Joint Disorder (TMJ)	Ambulatory	Pgs. 13 & 24	Yes
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pg. 7	Yes
14	Emergency Transportation/ Ambulance	Emergency services	Pgs. 4 & 17	Yes
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	Yes
16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 24 - 25	Yes
17	Reconstructive Surgery	Hospitalization	Pgs. 25 - 26, & 35	Yes, there exclusion with this benefit
18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 15	Yes
19	Skilled Nursing Facility	Hospitalization	Pg. 21	Yes
20	Transplants - Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 18 & 31	Yes
21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	Yes
22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	Yes

23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pgs. 8 -9, 21	Yes
24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. 21	Yes
25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pgs. 9 & 21	Yes
26	Tele-Psychiatry	MH/SUD	Pg. 11	Yes
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. 32	Yes
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	Yes
29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 26 - 27	Yes
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Yes
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29 - 34	Yes
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Yes
33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	Yes
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	Yes
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31 - 32	Yes
36	Mammography - Screening	Preventive and Wellness Services	Pgs. 12, 15, & 24	Yes
37	Osteoporosis - Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	Yes
38	Pap Tests/ Prostate- Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	Yes
39	Preventive Care Services	Preventive and Wellness Services	Pg. 18	Yes
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	Yes
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12 - 13	Yes
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 8, 9, 11, 12, 22, & 35	Yes

Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.

2026 Illinois Disclosure

Employer Name:	California Times
Employer State of Situs:	California
Name of Issuer:	Collective Health
Plan Marketing Name:	HDHP
Plan Year:	2026

Ten (10) Essential Health Benefit (EHB) Categories:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Laboratory services
- Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

2020-2026 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)				Employer Plan Covered Benefit?
Item	EHB Benefit	EHB Category	Benchmark Page # Reference	
1	Accidental Injury – Dental	Ambulatory	Pgs. 10 & 17	Yes
2	Allergy Injections and Testing	Ambulatory	Pg. 11	Yes
3	Bone anchored hearing aids	Ambulatory	Pgs. 17 & 35	Yes, only when medically necessary
4	Durable Medical Equipment	Ambulatory	Pg. 13	Yes
5	Hospice	Ambulatory	Pg. 28	Yes
6	Infertility (Fertility) Treatment	Ambulatory	Pgs. 23 - 24	Yes
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Ambulatory	Pg. 21	Yes
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Ambulatory	Pgs. 15 - 16	Yes
9	Private-Duty Nursing	Ambulatory	Pgs. 17 & 34	Yes
10	Prosthetics/Orthotics	Ambulatory	Pg. 13	Yes
11	Sterilization (vasectomy men)	Ambulatory	Pg. 10	Yes
12	Temporomandibular Joint Disorder (TMJ)	Ambulatory	Pgs. 13 & 24	Yes
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pg. 7	Yes
14	Emergency Transportation/ Ambulance	Emergency services	Pgs. 4 & 17	Yes
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	Yes
16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 24 - 25	Yes
17	Reconstructive Surgery	Hospitalization	Pgs. 25 - 26, & 35	Yes, there exclusion with this benefit
18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 15	Yes
19	Skilled Nursing Facility	Hospitalization	Pg. 21	Yes
20	Transplants - Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 18 & 31	Yes
21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	Yes
22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	Yes
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pgs. 8 -9, 21	Yes

24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. 21	Yes
25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pgs. 9 & 21	Yes
26	Tele-Psychiatry	MH/SUD	Pg. 11	Yes
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. 32	Yes
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	Yes
29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 26 - 27	Yes
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Yes
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29 - 34	Yes
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Yes
33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	Yes
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	Yes
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31 - 32	Yes
36	Mammography - Screening	Preventive and Wellness Services	Pgs. 12, 15, & 24	Yes
37	Osteoporosis - Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	Yes
38	Pap Tests/ Prostate- Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	Yes
39	Preventive Care Services	Preventive and Wellness Services	Pg. 18	Yes
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	Yes
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12 - 13	Yes
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 8, 9, 11, 12, 22, & 35	Yes

Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.