

California Times



2024 OPEN ENROLLEMENT BENEFITS GUIDE

January 1, 2024 – December 31, 2024



YOUR JOURNEY TO HEALTH & WELLNESS

Table of Contents

Employee Benefits Portal	3
Employee Eligibility Rules	4
Documents for Dependent Verification	5
When Can I Make Changes?	6
How to Enroll	7
Contacts	8
Comparing Health Plans	9
Collective Health Medical Plans	10
Prescription Drug Coverage with RxBenefits	15
Kaiser Permanente Medical Plans	17
Virtual Medical Visits and Virtual Mental Health Visits	21
Medicare Resources	22
Dental Plans with Delta Dental	23
Vision Plans with EyeMed	25
FSA, HSA & Commuter Benefit	27
Life and Accidental Death & Dismemberment (AD&D) Insurance	29
Disability Plans	30
Critical Illness, Accident and Hospital Plans	31
Employee Assistance Program	32
MetLife Legal Plans	33
Identity Theft	34
Employee Discounts	35
Pet Insurance	36
Home & Auto	37
Save for Retirement	38
Employee Contributions for 2024 Plan Year	40
2024 Employee Notices	46

Employee Benefits Portal



CHECK OUT OUR BENEFITS PORTAL

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

- 1) Visit <https://benefits.caltimes.com>
- 2) Or scan QR Code to launch app

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

California Times

2024 | CALIFORNIA TIMES
BENEFITS PORTAL

Q Search...

MENTAL HEALTH

DOCUMENT CENTER

CONTACT US

MEDICAL ▾

RX ▾

TELEMEDICINE ▾

DENTAL

VISION

MEDICARE

401(K) PLAN

SPENDING ACCOUNTS ▾

EAP

WELLNESS

LIFE & DISABILITY ▾

ACCIDENT/CRITICAL ILLNESS/HOSPITAL

TRAVEL ASSISTANCE

LEGAL

IDENTITY THEFT

AUTO & HOME

PET INSURANCE

DISCOUNTS

QR CODE



WELCOME! QUICK LINKS

ENROLLMENT
RESOURCES

OPTIONS FOR CARE

ENROLL NOW

VIEW HOW TO ENROLL
INSTRUCTIONS HERE

ENROLLMENT RESOURCES

Find out information on your eligibility requirements, contributions, and much more!

Click Here

Employee Eligibility Rules

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

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's 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 (PPACA). 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.

Pressroom Union Represented Employees, 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.



Required Documentation for Dependent Verification

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

Employees are expected to provide copies of documents to verify relationships to add dependents within **30 days of the date of the event. For new hires, the date of the event is considered the hire.** This documentation allows us to ensure that only eligible dependents are added to the CA Times benefits plans.

Find the additional details visit <https://benefits.caltimes.com>, under Quick Links and Enrollment Resources.



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 Resources section on Empyrean site or Benefits App-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 Resources section of Empyrean site or Benefits App-Enrollment Resources

When can I make changes to my benefit elections?

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

Qualifying life events must be reported to Empyrean, our Benefits Administrator, within **30 days of the date of the event**. For new hires, the date of the event is considered the hire date. 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 Empyrean at <https://compass.empyreanbenefits.com/CATimes>, or contact the Benefits Department for additional details at email: CATimesBenefits@caltimes.com.



HOW TO ENROLL IN YOUR ONLINE BENEFITS

1

Start by logging in at <https://compass.empyreanbenefits.com/CATimes>

If you are a new user, you must register first. User ID is your company email address.

Please note: If you are a new hire, you will be able to make your elections in Empyrean 5 to 7 business days from your hire date. Empyrean must receive your new hire information from Workday first to create your profile.

If you experience technical issues, reach out to Empyrean directly at (833) 269-2137.

2

Review and confirm all your election within 30 days of Empyrean activating your benefit profile **YOU MUST SUBMIT YOUR BENEFIT ENROLLMENT IN ORDER TO RECEIVE A CONFIRMATION NUMBER.** Elections are NOT recorded if you fail to complete the enrollment in its entirety.

You will show as active in the different carrier partners sites within 5 to 7 business days of finalizing your enrollment. You will then be able to download the digital ID cards by login onto each carrier site. You will only receive a medical ID Card in the mail, no ID cards are mailed for other benefits.

Remember to Submit Dependent Verification within 30 days of date of event. For new hires, the date of the event is considered the hire date. Evidence of Insurability (EOI) must be submitted for any Supplemental Life amounts above the Guaranteed Issue (GI) for you and your spouse. Amounts over the GI will not be effective until required documents are submitted and approved by Lincoln Financial.

3

You also have the option to make your elections by downloading the EmpyreanGO App or over the phone by calling CA Times Benefits Service Center administered by Empyrean at (833) 269-2137.

CA Times Benefits Service Center business hours are from 8am to 5pm PST Monday through Friday.

Important Reminders

4

- You can enroll or waive coverages via Empyrean site.
- The elections you make will stay in effect during the plan year from January 1 and ending December 31, 2024.
- Dependent verification documents are due to Empyrean within 30 days of the date of the event. For new hires, the date of the event is considered the hire 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 yearly into the Health Care FSA, Dependent Care FSA, Health Savings Account (HSA) and Parking / Transit benefit. Failing to re-enroll will waive your coverage for the new plan year. There is no carry over enrollment, current elections will terminate at the end of each plan year.
- You can watch a recorded presentation to familiarize yourself with the benefit offerings. Go to the [CA Times 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 <https://benefits.caltimes.com/> for all benefit collateral information.

Carrier / Provider	Group #	Phone #	Website
CA Times Benefits Department	N/A	(213) 237-2165	Email: CATimesBenefits@CalTimes.com
Empyrean Enrollment Administrator	N/A	(833) 269-2137	https://compass.emyreanbenefits.com/CATimes
Collective Health Medical PPO / HDHP	282016	(833) 440-4367	join.collectivehealth.com/catimes
Express Scripts administered 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	(800) 464-4000	www.kp.org
	Southern CA Region: 234268		
Telemedicine	N/A	(888) 548-3432	www.livehealthonline.com www.kp.org
		(866) 454-8855	
My Benefit Advisor - Medicare Assistance	N/A	(707) 779-1061	https://benefits.caltimes.com/medicare/
Delta Dental	Standard 19876-00001	(800) 765-6003	www.deltadentalins.com
	Enhanced 19876-00002		
EyeMed - Vision	1019531-1001 Standard	(866) 939-3633	www.eyemed.com
	1019531-1002 Enhanced		
WEX- FSA	33535	(866) 451-3399	www.wexinc.com customerservice@wex.com
Health Equity - HSA	N/A	(866) 735-8195	www.healthequity.com memberservices@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: CATIMES 1-0267713 Life/ADD 40-0001000-26882 Vol. Life 000403007971 – Voluntary AD&D	(800) 423-2765	www.lfg.com
	000010247437 STD	(800) 423-2765	
	000010247436 LTD		
MetLife - Voluntary Products	217517	(800) 438-6388	www.metlife.com
CompPsych Employee Assistance Program	California 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	EJH6XN	(866) 664-4621	catimes.benefithub.com / Referral Code: EJH6XN
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
Vanguard - 401(k) / DCRP	094880 / 094625	(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 out of the country are 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 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 Empyrean 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 percent.

- 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 Empyrean 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 percent.

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

Preventive Benefits with Collective Health (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 preventive 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.



Everything you need to engage in your care journey

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

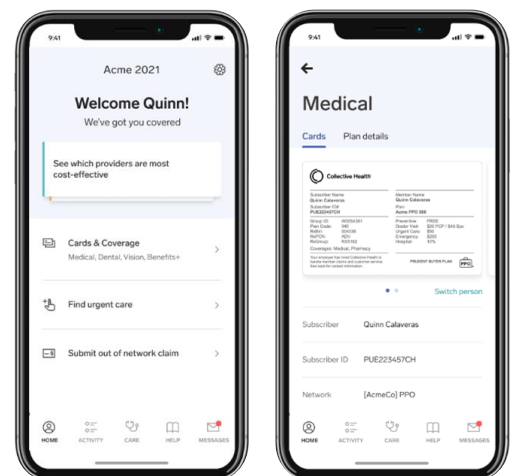
GIVE THEM A CALL OR EMAIL THEM
(833) 440-4367

help@collectivehealth.com

Monday – Friday 4am to 6pm PST
Saturday 7am to 11am PST

With our app, you can:

1. Check your plan details
2. File claims
3. Find doctors in your network
4. Get questions answered
5. 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 <https://benefits.caltimes.com>

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	\$76.36	\$35.89
Employee + Spouse	\$225.80	\$113.26
Employee + Child	\$199.62	\$100.94
Employee + Family	\$343.62	\$176.06
Employees earning > \$100,000		
Employee Bi-weekly cost (# of paychecks 26)	Collective Health PPO	Collective Health HDHP
Employee Only	\$96.00	\$44.86
Employee + Spouse	\$262.89	\$132.33
Employee + Child	\$230.18	\$116.63
Employee + Family	\$393.81	\$201.86

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 High Deductible Health Plan (HDHP) Non-Creditable Coverage Under Medicare (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 (Min. \$40, Max \$80 copay)	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 7am to 8pm CT. 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](https://www.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 shipping¹ from the Express Scripts PharmacySM.
- 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.

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](https://www.express-scripts.com) and select **Register**, or download the **Express Scripts mobile app** for free from your mobile device's app store and select **Register**.
- Complete the information requested, including personal information and member ID number or Social Security number (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,² 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.

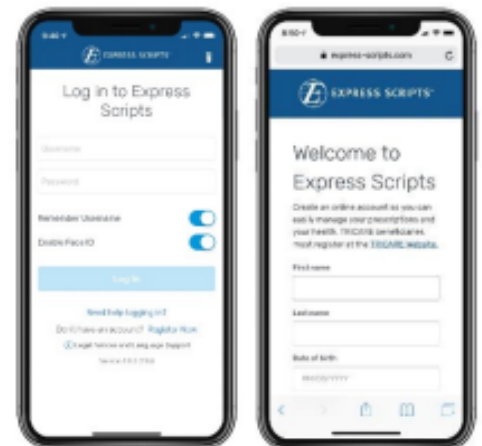
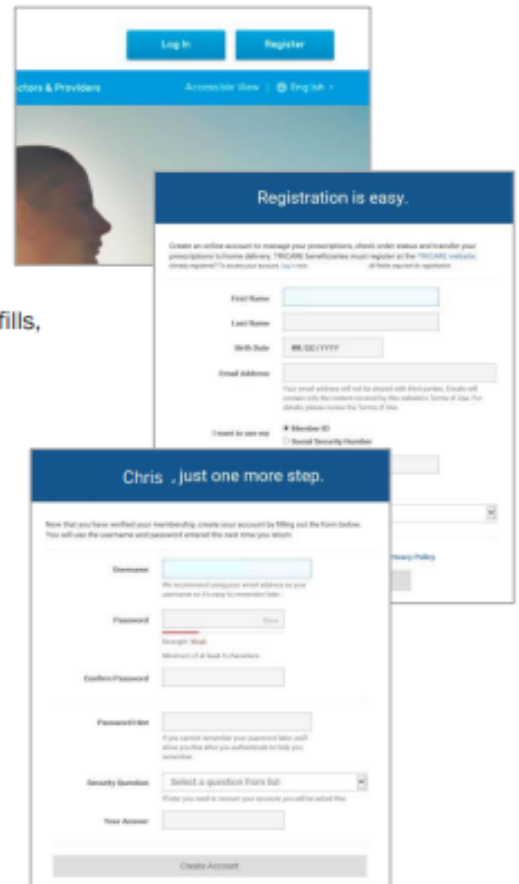
Members who have **touch or facial ID authentication** on their mobile devices can enable it to log in to their Express Scripts account on the mobile app, if desired.

¹ Standard shipping costs are included as part of your prescription plan benefit.

² Preferences include the option to share your prescription information with other adult members of your household (aged 18+) covered under your prescription drug plan.

- All covered adults (aged 18+) in the household need to register separately.
- When you grant permission to share your prescription information with other registered household members, they can view your information, place orders on your behalf and more.

The Express Scripts mobile app is available for iPhone®, iPad®, and Android™ mobile devices.



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 <https://benefits.caltimes.com>.

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 / \$2,000
Preventive Care	No Charge	No Charge*
Primary Care Specialist Visit	\$15 copay \$25 copay	\$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 20% coinsurance
Chiropractic (limit 30 visits/year)	\$15 copay	\$15 copay*
Acupuncture (limit 30 visits/year)	\$15 copay	\$15 copay*
Emergency Room Services	\$50 copay	\$150 copay
Inpatient Hospital	\$125 copay	20% coinsurance
Outpatient Surgery	\$50 copay	20% coinsurance
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	\$95.05	\$57.29	\$39.00
Employee + Spouse	\$250.59	\$177.71	\$121.00
Employee + Child	\$220.96	\$160.09	\$109.00
Employee + Family	\$367.86	\$271.71	\$185.00
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	\$111.10	\$67.57	\$46.00
Employee + Spouse	\$283.92	\$205.62	\$140.00
Employee + Child	\$251.82	\$186.53	\$127.00
Employee + Family	\$416.00	\$314.40	\$214.00

Get more out of your mobile app

- 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 Permanente app to access all the convenient features of My Health Manager on your smartphone. Download the app for the iPhone® or Android™ from the App Store® or on Google Play™ at no cost.¹
- 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.
 - Schedule or cancel routine appointments.
 - View most lab test results.
 - Access a digital version of your ID card.
 - Order or refill most prescriptions.
 - Pay bills and view payment history.
 - Join a video visit.²

Digital ID card

Access your membership information anytime, anywhere with an electronic 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.²



Visit us in person
at a location near you.



Talk to a health care professional
by phone or video.²



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.²
- Get 24/7 care advice by phone.
- Email your Kaiser Permanente 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 Permanente clinician for advice.

When connecting to care virtually, you may save money as well as time. Telehealth is covered at no cost with most plans.³



Prescription delivery

Fill prescriptions online or with the Kaiser Permanente app.⁴

- 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.⁵



Kaiser Permanente app

Manage your health 24/7 with our app. It's an easy, convenient way to do everything described above – anytime, anywhere.⁶

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.

<p>Collective Health PPO Members (In-Network Cost)</p>	<p>Telemedicine Visits With Your Own Provider</p> <ul style="list-style-type: none"> • Primary Care Doctor - \$25 copay • Specialist - \$40 copay • Mental Health Visits - \$25 copay 	<p>LiveHealth Online – livehealthonline.com You have access 24/7 by web, phone or mobile app to medical providers and licensed therapist \$10 copay.</p>
<p>Collective Health HDHP Members (In-Network Cost) Deductible Applies</p>	<p>Telemedicine Visits With Your Own Provider</p> <ul style="list-style-type: none"> • Primary Care Doctor - 20% after deductible • Specialist - 20% after deductible • Mental Health Visits - 20% after deductible 	<p>LiveHealth Online – livehealthonline.com You have access 24/7 by web, phone or mobile app to medical providers and licensed therapist 20% after deductible.</p>
<p>Kaiser HMO Members See plan document for coverage level</p>	<p>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.</p>	

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 Plan 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.
- If you are eligible for Medicare or approaching the age of 65, call My Benefit Advisor at (707) 779-1061 for help understanding Medicare and your options.

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

My Benefit Advisor provides personalized guidance to employees and their families to help them understand the Medicare health coverage options that are available to them.

The Eligibility Services Medicare advocates at My Benefits Advisor provide Medicare-focused insurance services, including personal guidance and enrollment support to any individual who is eligible to receive Medicare. When you work with them, you will work with experienced licensed insurance agents that will support you through the entire process.

- They work with you to understand your needs.
- They keep you informed of their responsibilities during the enrollment period to avoid penalties.
- They compare supplemental plans from a broad number of well-known insurance carriers who serve your region, including Aetna, United Healthcare, AARP, Mutual of Omaha, and more.
- They check to see which physicians and prescription drugs are in-network and covered.
- Once the ideal supplemental coverage plan is identified, they will complete the enrollment application for you.
- Best of all, there is no cost to you for their services. Their agents are compensated on a commission basis from private carriers who offer the additional Medicare Products.

For more details visit:

<https://benefits.caltimes.com/medicare/>

Call My Benefit Advisor at (707) 779-1061 for help understanding Medicare and your options.



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	Dental PPO – Standard Plan		Dental 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				
Calendar Year Deductible Per Individual Per Family	\$50 per person \$150 per family		\$50 per person \$150 per family	
Preventive 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 per 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	\$13.26	\$14.72
Employee + Spouse	\$26.53	\$29.44
Employee + Child	\$34.49	\$38.28
Employee + Family	\$47.75	\$52.99

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.



Try it out: 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 preventive care and common procedures.



Try it out: Visit 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.

Try it out: Search for Delta Dental in the App Store or Google Play.

Tip: Don't need another app? Just visit deltadentalins.com on your smartphone or tablet and log in to your account.



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”, download the EyeMed App or call (800) 988-4221.

Plan Feature	EyeMed Vision Plan					
	Standard Plan (Select Network)			Enhanced Plan (Select Network)		
	Plus Providers In-Network	In-Network	Out-of-Network	Plus Providers In-Network	In-Network	Out-of-Network
Exam: Every 12 months	\$0 copay	\$10 copay	Up to \$40	\$0 copay	\$10 copay	Up to \$40
Lenses: Every 12 months						
Single	\$25 copay	\$25 copay	Up to \$40	\$10 copay	\$10 copay	Up to \$40
Bifocal	\$25 copay	\$25 copay	Up to \$40	\$10 copay	\$10 copay	Up to \$40
Trifocal	\$25 copay	\$25 copay	Up to \$60	\$10 copay	\$10 copay	Up to \$60
Lenticular	\$25 copay	\$25 copay	Up to \$80	\$10 copay	\$10 copay	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	\$130 + 15%	\$130 + 15%	Up to \$105	\$175 + 15%	\$175 + 15%	Up to \$105
Disposable	\$130	\$130	Up to \$105	\$175	\$175	Up to \$105
Medically Necessary	Paid in full	Paid in full	Up to \$210	Paid in full	Paid in full	Up to \$210

*In-Lieu of Frames and Lenses

Employee Bi-weekly cost (# of paychecks 26)	EyeMed Standard Plan	EyeMed Enhanced Plan
Employee Only	\$2.31	\$5.49
Employee + Spouse	\$4.09	\$9.70
Employee + Child	\$4.86	\$11.53
Employee + Family	\$6.99	\$16.41



* **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.

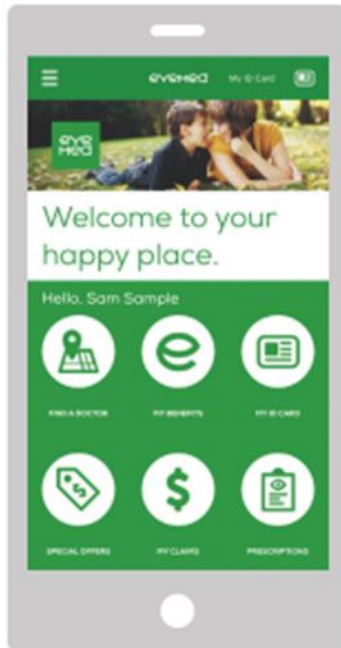
EyeMed Membership Perks

EYEMED MOBILE APP

On the go? Now your benefits are, too.

NEW LOOK. FRESH FEATURES. SAME GREAT BENEFITS. WHENEVER YOU NEED THEM.

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



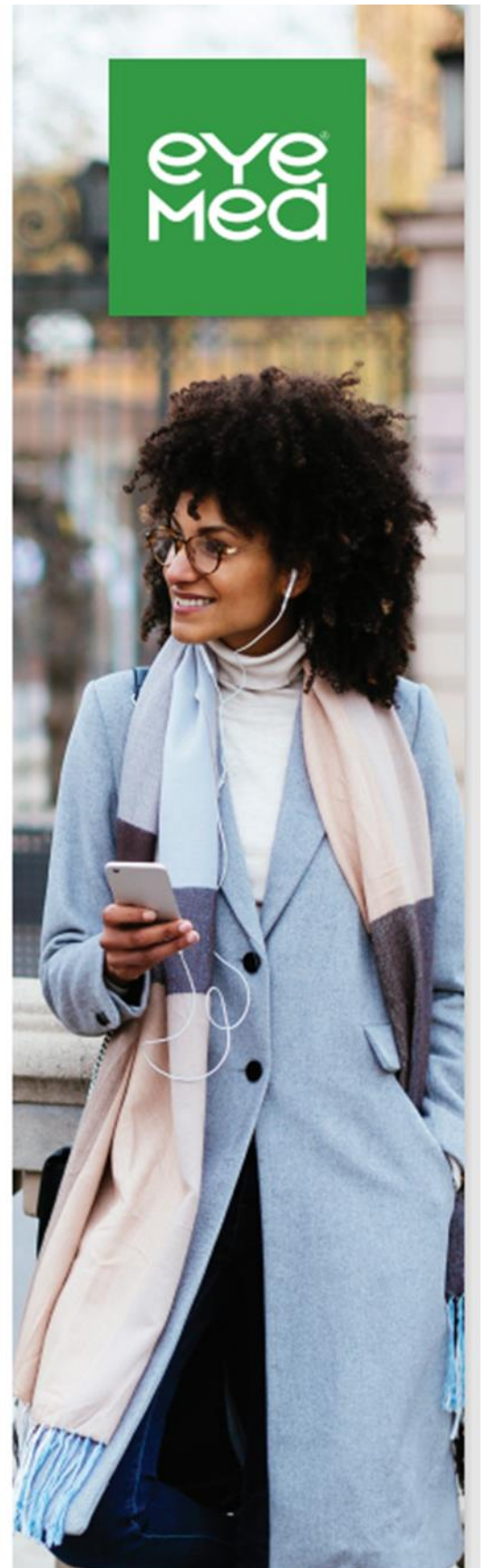
The features you love plus new features to explore

- 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 Accounts (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 <https://benefits.caltimes.com/> for a more information on qualified expenses list and claim forms.

Health Care FSA (HCFSA)	You can contribute up to \$3,200 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 \$640 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 \$5,000 per household, minimum of \$100, (\$2,500 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 2024, you have until the end of the plan year of 12/31/2024 to incur claims for all FSA plans and request for claim reimbursement must be submitted by 3/31/2025.
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	<p>For the Healthcare and Limited FSA plans, you can carry over funds between \$100 to \$640 from the 2024 to the 2025 plan year, any balances below \$100 or over \$640 as of 12/31/2024 will be forfeited. The minimum Full Purpose Health Care FSA & Limited Purpose Health Care FSA carryover amount is \$100 and will be administered as follows:</p> <ul style="list-style-type: none"> • A participant has less than \$100 remaining in their FSA at the end of the run-out period and is NOT ENROLLED in the next plan year, the remaining funds in the participant's account DO NOT carry over and are forfeited. • A participant has less than \$100 remaining in their FSA at the end of the run-out period and is ENROLLED in the next plan year, the remaining funds in the participant's account WILL carry over to the next plan year. <p>There is no carryover of unused Dependent Care FSA funds.</p>
Health Savings Account (HSA) (only available to HDHP members)	If you enroll into the HDHP health plan you can contribute up to \$4,150 for a single and \$8,300 for a family for the 2024 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 \$315 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 \$315 pre-tax for parking as part of your daily commute to work. Visit CA Times Benefit portal for details on how to enroll. You can enroll anytime during the year.

Flexible Spending Accounts (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 our benefits mobile app, you can:

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

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 (844) 341-4934 / healthequity.com

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

 <p>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.</p>	 <p>Say goodbye to hassle Log in and manage everything via our simple mobile app.⁵ Want to submit a claim? Easy. Just snap a photo and you're on your way.</p>
 <p>Be inspired Check out our vast library of webinars, tutorials, videos, calculators, and more. You'll find tips and tricks to make the most of your HSA.</p>	 <p>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.</p>

Save big on thousands of qualified medical expenses, including:

 <p>Pain relievers</p>	 <p>Doctor visits</p>	 <p>Dental cleaning</p>	 <p>Sleep aids</p>	 <p>Eyeglasses/contacts</p>	 <p>Cold/cough medicine</p>	 <p>Chiropractic care</p>	 <p>Insulin testing supplies</p>
---	--	--	---	--	--	--	---



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 Employee 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 <https://benefits.caltimes.com/>, 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 Employee 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

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 Benefit 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 Benefit Minimum	\$100 or 10%, whichever is greater
Monthly Benefit 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



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 (ICU)	\$600	\$600
Daily ICU Confinement	\$50	\$100
Daily Hospital Confinement	\$50	\$100
Wellness Benefit	\$50	\$50

Employee Assistance Program (EAP)



Your employer 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

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 PlusSM

EMPLOYEE ASSISTANCE PROGRAM SERVICES

24 hours a day, 7 days a week. Call 855-327-4463, or visit us online at www.GuidanceResources.com (Web ID = Lincoln)

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





MetLife Legal Plans

For a monthly fee, you, your spouse and dependents get legal assistance for some of the most frequently needed personal legal matters, with no waiting periods, no deductibles and no claim forms when using a network attorney for a covered matter. You can choose one from MetLife's network of prequalified attorneys or use an attorney outside of MetLife's network and be reimbursed some of the cost.

Money Matters	<ul style="list-style-type: none"> • Debt Collection Defense • Identity Theft Defense • Negotiations with Creditors 	<ul style="list-style-type: none"> • Personal Bankruptcy • Promissory Notes 	<ul style="list-style-type: none"> • Tax Audit Representation • Tax Collection Defense
Home & Real Estate	<ul style="list-style-type: none"> • Boundary & Title Disputes • Deeds • Eviction Defense • Foreclosure 	<ul style="list-style-type: none"> • Home Equity Loans • Mortgages • Property Tax Assessments • Refinancing of Home 	<ul style="list-style-type: none"> • Sale or Purchase of Home • Security Deposit Assistance • Tenant Negotiations • Zoning Applications
Estate Planning	<ul style="list-style-type: none"> • Codicils • Complex Wills • Healthcare Proxies • Living Wills 	<ul style="list-style-type: none"> • Powers of Attorney (Healthcare, Financial, Childcare, Immigration) 	<ul style="list-style-type: none"> • Revocable & Irrevocable Trusts • Simple Wills
Family & Personal	<ul style="list-style-type: none"> • Adoption • Affidavits • Conservatorship • Demand Letters • Garnishment Defense • Guardianship • Immigration Assistance 	<ul style="list-style-type: none"> • Juvenile Court Defense, Including Criminal Matters • Name Change • Parental Responsibility Matters • Personal Property Protection 	<ul style="list-style-type: none"> • Prenuptial Agreement • Protection from Domestic Violence • Review of ANY Personal Legal Document • School Hearings
Civil Lawsuits	<ul style="list-style-type: none"> • Administrative Hearings • Civil Litigation Defense 	<ul style="list-style-type: none"> • Disputes Over Consumer Goods & Services • Incompetency Defense 	<ul style="list-style-type: none"> • Pet Liabilities • Small Claims Assistance
Elder-Care Issues	Consultation & Document Review for your parents: <ul style="list-style-type: none"> • Deeds • Leases 	<ul style="list-style-type: none"> • Medicaid • Medicare • Notes • Nursing Home Agreements 	<ul style="list-style-type: none"> • Powers of Attorney • Prescription Plans • Wills
Vehicle & Driving	<ul style="list-style-type: none"> • Defense of Traffic Tickets² • Driving Privileges Restoration 	<ul style="list-style-type: none"> • License Suspension Due to DUI 	<ul style="list-style-type: none"> • Repossession

Identity Theft

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.

BENEFIT ELITE PLAN

The LifeLock Benefit Elite Protection Plan is aimed squarely at what matters to employees: protecting identities and protecting nest eggs. LifeLock Benefit Elite 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

ADVANTAGE PLAN

The LifeLock Advantage 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



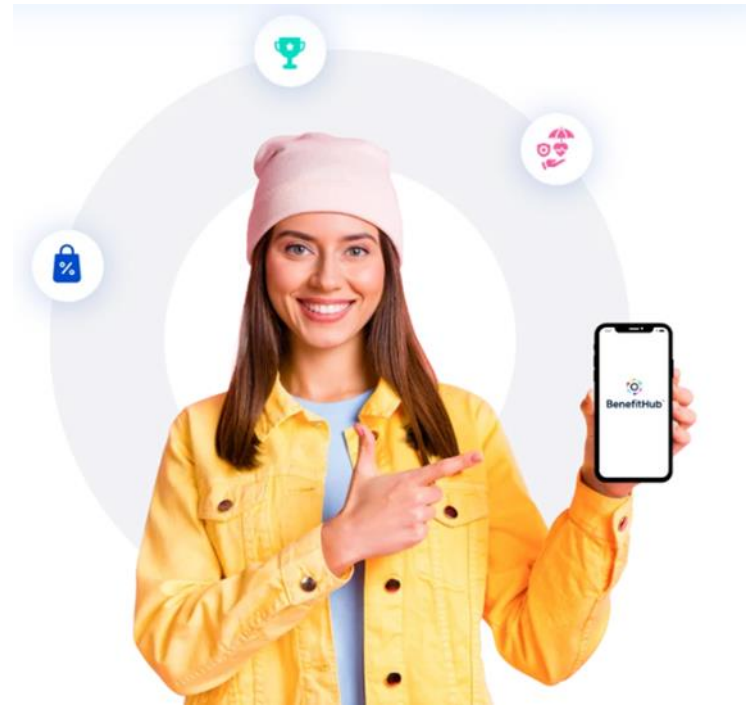
Employee Discounts



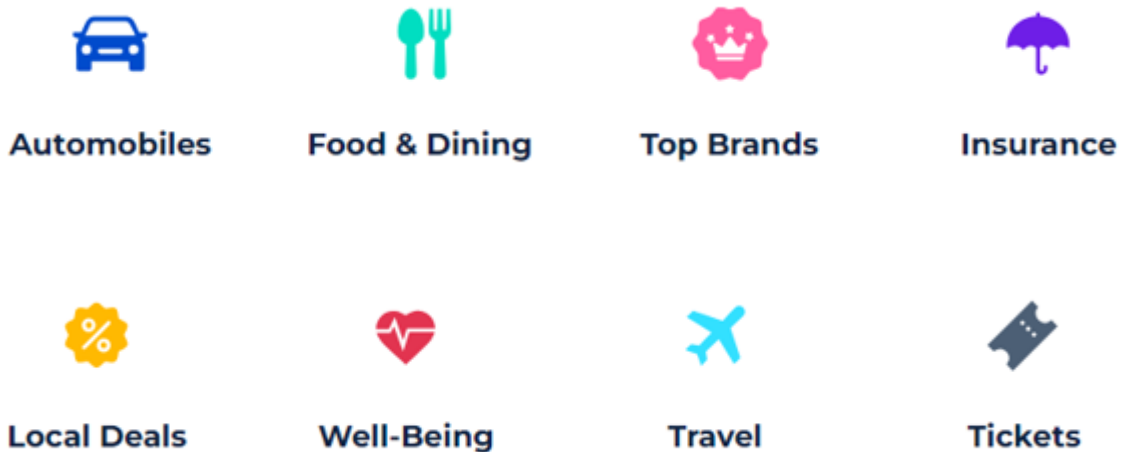
BenefitHub is a fully customizable benefits and rewards platform. BenefitHub believes that an employee often gives the best of themselves to a company that seeks to serve its employees both inside and outside of the workplace. Enjoy discounts, rewards and perks on thousands of the brands you love in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

BenefitHub is easy to access and start saving!

- Visit <https://catimes.benefitHub.com>
 - Create an account
 - Use referral code: EHJ6XN
 - Start saving!
-
- Travel
 - Entertainment
 - Auto
 - Restaurants
 - Electronics
 - Health and Wellness
 - Apparel
 - Beauty and Spa
 - Local Deals
 - Tickets
 - Education
 - Sports & Outdoors



Questions? Call (866) 664-4621 or email customer-care@benefitHub.com



Pet Insurance

Nationwide pet insurance helps you cover veterinary expenses so you can provide your pets with the best care possible without worrying about the cost.

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 \$7,500 maximum annual benefit. Coverage includes*:

- Accidents
- 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

vethelpline®

- 24/7 access to veterinary experts (\$10 value)
- Available via phone, chat and email
- Unlimited help for everything from general pet questions to identifying urgent care needs

PetRxExpress™

- 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 and Auto



Switch today to see how much you could save! Get quotes today.

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 services¹

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 services¹

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

Call today, 800-438-6381 or visit
www.myautohome.farmers.com

Other Policy Options

By purchasing auto, home, and other policies from Farmers GroupSelect, you could save even more! Others saved \$751^{*} on average!



RV



Renter's



Motorcycle



Boat



Condo



Save For 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.

When can you 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.

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 no action is taken to choose a contribution percentage, you will be automatically enrolled 60 days after your hire date at 3% contribution, increasing by 1% per year to a 10% cap.

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.

Save For Retirement



Get started in the California Times Defined Contribution Retirement Plan (Pressroom Union Represented Employees Only)



You'll need your plan number (**094625**) 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.

When can you join the plan?

Regular Full Time or Regular Part Time Employees (Pressroom Union Represented Employees Only) are eligible upon reaching 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 on pre-tax (minus applicable taxes and benefit deductions). The IRS also sets dollar limits on contributions. For current IRS limits, visit vanguard.com/contributionlimits. Catch-up contributions are not allowed under this Plan.

DCRP Employer Match

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

How to Enroll

To enroll please call Vanguard at **(800) 523-1188** or visit vanguard.com/jointoday. You'll need your plan number (094625) to take some of these actions.

DCRP 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 vested in the matching contribution as follows;

<u>Years of Vesting Services</u>	<u>Vested Percentage</u>
Less than 1 Year	0%
2 Years	20%
3 Years	40%
4 Years	60%
5 Years	100%

Employee Contributions for 2024 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 1/1/2024 - 12/31/2024. 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 2024. Commission employees hired after February, your salary at hire is used for the remainder of the year.

Medical	Employees earning < or = \$100,000				
Bi-weekly cost (# of paychecks 26)	Collective Health PPO	Collective Health HDHP	Kaiser Traditional HMO (CA Only)	Kaiser Signature HMO (CA Only)	Kaiser Signature HMO Mid-Atlantic
Employee Only	\$76.36	\$35.89	\$95.05	\$57.29	\$39.00
Employee + Spouse	\$225.80	\$113.26	\$250.59	\$177.71	\$121.00
Employee + Child	\$199.62	\$100.94	\$220.96	\$160.09	\$109.00
Employee + Family	\$343.62	\$176.06	\$367.86	\$271.71	\$185.00
Medical	Employees earning > \$100,000				
Bi-weekly cost (# of paychecks 26)	Collective Health PPO	Collective Health HDHP	Kaiser Traditional HMO (CA Only)	Kaiser Signature HMO (CA Only)	Kaiser Signature HMO Mid-Atlantic
Employee Only	\$96.00	\$44.86	\$111.10	\$67.57	\$46.00
Employee + Spouse	\$262.89	\$132.33	\$283.92	\$205.62	\$140.00
Employee + Child	\$230.18	\$116.63	\$251.82	\$186.53	\$127.00
Employee + Family	\$393.81	\$201.86	\$416.00	\$314.40	\$214.00

Bi-weekly cost (# of paychecks 26)	Delta Dental Standard PPO	Delta Dental Enhanced PPO	EyeMed Standard Plan	EyeMed Enhanced Plan
Employee Only	\$13.26	\$14.72	\$2.31	\$5.49
Employee + Spouse	\$26.53	\$29.44	\$4.09	\$9.70
Employee + Child	\$34.49	\$38.28	\$4.86	\$11.53
Employee + Family	\$47.75	\$52.99	\$6.99	\$16.41

Employee Contributions for 2024 Plan Year

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

Lincoln Financial Group Supplemental Life	Employee Rate	Spouse Rate/DP (based on spouse/DP 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

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

Lincoln Financial 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 2024 Plan Year

MetLife Voluntary Critical Illness	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Bi-Weekly Rate Per \$100				
Age < 24	\$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

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

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

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

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

LifeLock Identity Theft Benefit Elite	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Bi-Weekly Rates	\$3.69	\$7.38	\$6.46	\$10.14

LifeLock Identity Theft Advantage	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Bi-Weekly Rates	\$7.38	\$14.76	\$11.07	\$18.45

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

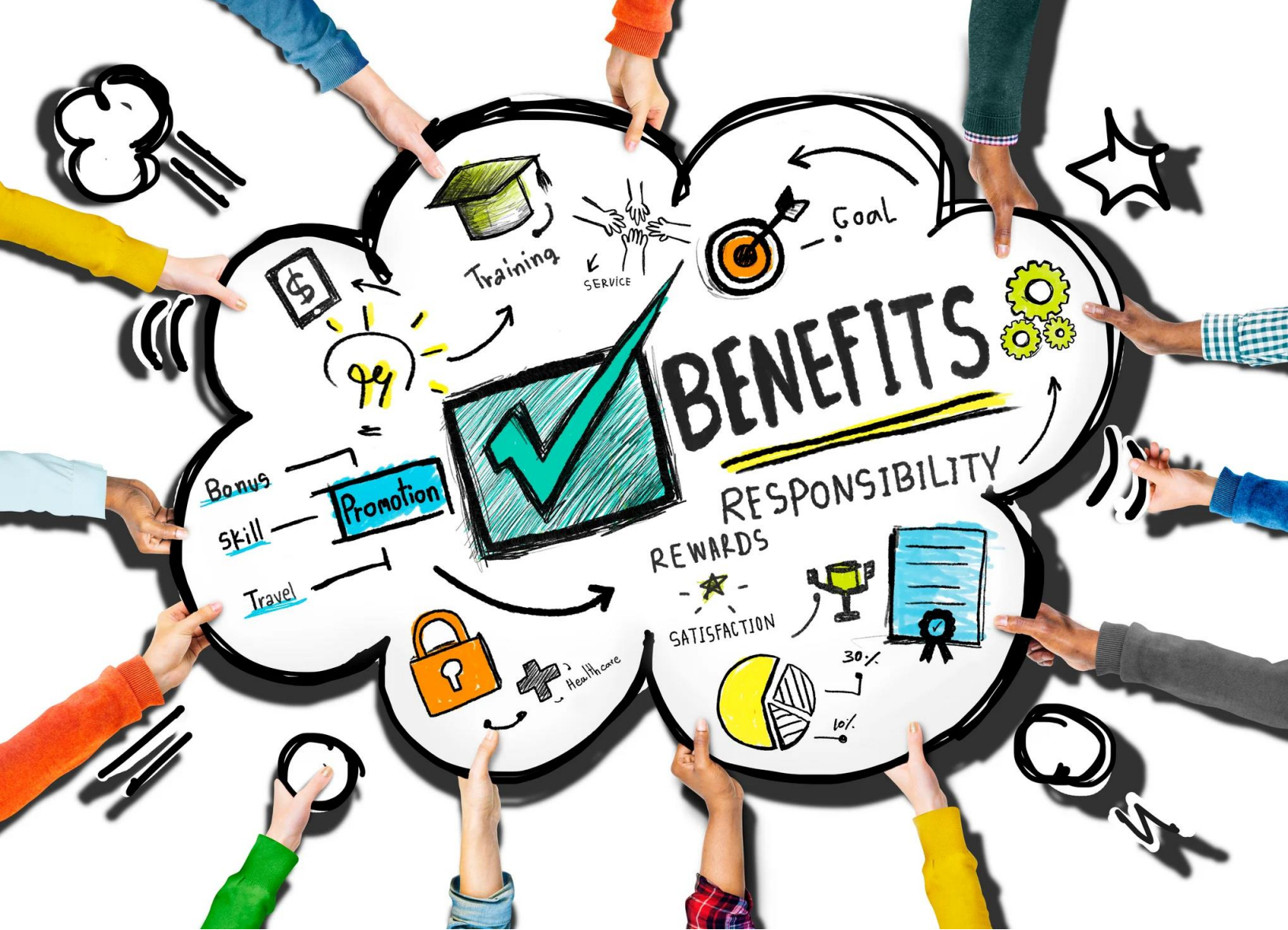
Nationwide | Pet Insurance

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

Contact

CalTimes Benefits Department for any question on
the benefit offerings

CATimesBenefits@CalTimes.com



REMINDERS:

- ✓ Benefit enrollment or changes must be made through Empyrean.
- ✓ Elections are NOT recorded if you fail to complete the enrollment in its entirety.
- ✓ YOU MUST SUBMIT YOUR BENEFIT ENROLLMENT IN ORDER TO RECEIVE A CONFIRMATION NUMBER AND GET YOUR ELECTIONS SAVED.
- ✓ You are able to download the EmpyreanGO App.
- ✓ Call the CA Times Benefits Service Center at (833) 269-2137 or go online to make updates <https://compass.empyreanbenefits.com/CATimes>
- ✓ 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 pages 38-39.

DISCLAIMER

This 2024 Benefit Guide provides an overview of some of your benefit plan options. It is for informational purposes only. It is not intended to be an agreement for continued employment. Neither is it a legal plan document. This highlights the key features of the plan. It is intended to serve only as a summary of the benefits available to you and does not include all plan rules and details. This is not to be considered a certificate of coverage. Please refer to your plan documents for complete information and more detailed explanations as to coverage. If there is a disagreement between this guide and the plan documents, the plan documents will prevail.

California Times

Important Notices

January 1, 2024

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 13 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 co-pays 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

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

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. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

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 meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax 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 meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

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](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.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, 2024

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 (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility.

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	FLORIDA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html Phone: 1-877-357-3268

ARKANSAS – Medicaid	GEORGIA – Medicaid
<p>Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)</p>	<p>Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131</p>
CALIFORNIA – Medicaid	INDIANA – Medicaid
<p>Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov</p>	<p>Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584</p>
IOWA – Medicaid and CHIP (Hawki)	MONTANA – Medicaid
<p>Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562</p>	<p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084</p>
KANSAS – Medicaid	NEBRASKA – Medicaid
<p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884</p>	<p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>
KENTUCKY – Medicaid	NEVADA – Medicaid
<p>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: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov</p>	<p>Medicaid Website: http://dhcfnv.gov Medicaid Phone: 1-800-992-0900</p>
LOUISIANA – Medicaid	NEW HAMPSHIRE – Medicaid
<p>Website: www.medicicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>	<p>Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218</p>

MAINE – Medicaid	NEW JERSEY – Medicaid and CHIP
<p>Enrollment Website: https://www.maine.gov/dhhs/ofl/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711</p> <p>Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofl/applications-forms Phone: -800-977-6740. TTY: Maine relay 711</p>	<p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710</p>
MASSACHUSETTS – Medicaid and CHIP	NEW YORK – Medicaid
<p>Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840</p>	<p>Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>
MINNESOTA – Medicaid	NORTH CAROLINA – Medicaid
<p>Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739</p>	<p>Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100</p>
MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
<p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>	<p>Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825</p>
OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
<p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p>	<p>Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669</p>
OREGON – Medicaid	VERMONT– Medicaid
<p>Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075</p>	<p>Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427</p>
PENNSYLVANIA – Medicaid	VIRGINIA – Medicaid and CHIP
<p>Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIP P-Program.aspx Phone: 1-800-692-7462</p>	<p>Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282</p>
RHODE ISLAND – Medicaid and CHIP	WASHINGTON – Medicaid
<p>Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)</p>	<p>Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022</p>
SOUTH CAROLINA – Medicaid	WEST VIRGINIA – Medicaid
<p>Website: https://www.scdhhs.gov Phone: 1-888-549-0820</p>	<p>Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)</p>

SOUTH DAKOTA - Medicaid	WISCONSIN – Medicaid and CHIP
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	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 January 31, 2023, 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 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:

A) The prescription drug coverage for the NantMedia Holdings, LLC dba California Times **Anthem BC PPO, Kaiser HMO Traditional, Kaiser Deductible, Kaiser Mid-Atlantic, 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.**

B) The prescription drug coverage offered by the **Anthem BC High Deductible Health Plan (HDHP)** is, on average for all plan participants, **NOT** expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Anthem BC High Deductible Health Plan (HDHP). **This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.** You can keep your current coverage from Anthem BC HDHP. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

Read this notice carefully – it explains your options.

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, 2024

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