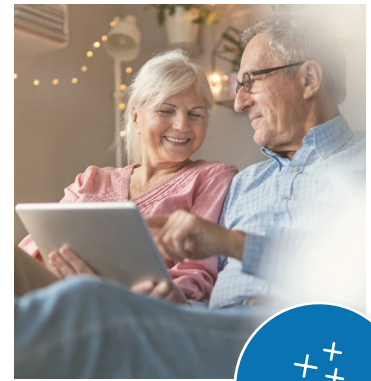




Employee Benefits

2026

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Welcome!



At Streamland Media Midco, LLC we recognize our ultimate success depends on our talented and dedicated workforce. We understand the contribution each employee makes to our accomplishments and so our goal is to provide a comprehensive program of competitive benefits to attract and retain the best employees available. Through our benefits programs we strive to support the needs of our employees and their dependents by providing a benefit package that is easy to understand, easy to access and affordable for all our employees. This brochure will help you choose the type of plan and level of coverage that is right for you.

As you prepare to enroll:

- Consider your benefit coverage needs for the upcoming year. For example, is your family financially protected if you can't work due to an accident or illness?
- Consider other available coverage.
- Gather information you'll need. If you are covering dependents, you will need their dates of birth and Social Security numbers. In addition, as you may need to provide legal documentation verifying their eligibility — such as a marriage license or birth certificate.

You can also view overviews of our benefit plans by logging in to: www.streamlandmediabenefits.com.



Eligibility

Eligible Employees

Employees who work at least 30 hours per week are eligible for the benefits described in this guide.



Eligible Dependents

If you are eligible for our benefits, then your dependents are too. In general, eligible dependents include your spouse, domestic partner and children up to age 26. If your child is mentally or physically disabled, coverage may continue beyond age 26 once proof of the ongoing disability is provided. Children may include natural, adopted, stepchildren and children obtained through court-appointed legal guardianship, as well as children of same sex state-registered domestic partners.

When Coverage Begins

The effective date for the benefits described in this Employee Benefits Guide is January 1, 2026. Newly hired employees and dependents will be effective in Streamland Media Midco, LLC's benefits programs on the first of the month following your date of hire. All elections are in effect for the entire plan year and can only be changed during Open Enrollment unless you experience a family status change.



Family Status Change

A change in family status is a change in your personal life that may impact your eligibility or dependent's eligibility for benefits. Examples of some family status changes include:

- Change of legal marital status (i.e., marriage, divorce, death of spouse, legal separation)
- Change in number of dependents (i.e., birth, adoption, death of dependent, ineligibility due to age)
- Change in employment or job status (spouse loses job, etc.)

If such a change occurs, you must make the changes to your benefits within 30 days of the event date. Documentation may be required to verify your change of status. Failure to request a change of status within 60 days of the event may result in your having to wait until the next Open Enrollment period to make your change. You are able to submit your change of status directly through your applicable ADP system (WFN or Lyric) account.

Helpful Terminology

Brand preferred drugs

A drug with a patent and trademark name that is considered "preferred" because it is appropriate to use for medical purposes and is usually less expensive than other brand-name options.

Brand non-preferred drugs

A drug with a patent and trademark name. This type of drug is "not preferred" and is usually more expensive than alternative generic and brand preferred drugs.

Calendar Year Maximum

The maximum benefit amount paid each year for each family member enrolled in the dental plan.

Coinsurance

The sharing of cost between you and the plan. For example, 80 percent coinsurance means the plan covers 80 percent of the cost of service after a deductible is met. You will be responsible for the remaining 20 percent of the cost.

Copay

A fixed amount (for example \$15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible

The amount you must pay for covered services before your health plan begins to pay.

Elimination Period

The time period between the beginning of an injury or illness and receiving benefit payments from the insurer.



Helpful Terminology (cont.)

Flexible Spending Accounts (FSA)

FSAs allow you to pay for eligible health care and dependent care expenses using tax-free dollars. The money in the account is subject to the “use it or lose it” rule which means you must spend the money in the account before the end of the plan year.

Generic drugs

A drug that offers equivalent uses, doses, strength, quality, and performance as a brand-name drug, but is not trademarked.

In-network

A designated list of health care providers (doctors, dentists, etc.) with whom the health insurance provider has negotiated special rates. Using in-network providers lowers the cost of services for you and the company.

Inpatient

Services provided to an individual during an overnight hospital stay.

Mail Order Pharmacy

Mail order pharmacies generally provide a 90-day supply of a prescription medication for the same cost as a 60-day supply at a retail pharmacy. Plus, mail order pharmacies offer the convenience of shipping directly to your door.

Out-of-network

Health care providers that are not in the plan's network and who have not negotiated discounted rates. The cost of services provided by out-of-network providers is much higher for you and the company. Additional deductibles and higher coinsurance will apply.

Out-of-pocket maximum

The maximum amount you and your family must pay for eligible expenses each plan year. Once your expenses reach the out-of-pocket maximum, the plan pays benefits at 100% of eligible expenses for the remainder of the year. Your annual deductible is included in your out-of-pocket maximum.

Outpatient

Services provided to an individual at a hospital facility without an overnight hospital stay.

Primary Care Provider (PCP)

A doctor (generally a family practitioner, internist, or pediatrician) who provides ongoing medical care. A primary care physician treats a wide variety of health-related conditions.

Reasonable & Customary Charges (R&C)

Prevailing market rates for services provided by health care professionals within a certain area for certain procedures. Reasonable and Customary rates may apply to out-of-network charges.

Specialist

A provider who has specialized training in a particular branch of medicine (e.g., a surgeon, cardiologist, or neurologist).

Specialty drugs

A drug that requires special handling, administration, or monitoring. Most can only be filled by a specialty pharmacy and have additional required approvals.

Medical

If you are newly enrolling in medical benefits, make an appointment with your PCP—even if you're NOT sick, once the plan year has begun. This relationship will set the foundation for staying healthy—today and well into the future.

Preventive Care

You and your family have access to a wide range of preventive services under the Affordable Care Act. These services are 100% covered by your medical plan when using in-network providers. For more details about the covered services, please visit www.healthcare.gov/coverage/preventivecare-benefits.

Common preventive services include:

- Routine physicals (age 18+) or pediatric exams (birth to age 17)
- Well-woman exams
- Blood pressure screening for adults and children
- Immunizations for adults and children

Network Provide/Facility Search

Make sure that your provider or facility is in-network. Both Cigna plans use the OAP (Open Access Plus) provider network.

To locate a network provider, follow the steps below or call 888-806-5042.

- Visit www.cigna.com and click on "Find a Doctor" at the top of the screen. Then, under "How are you Covered?" select "Employer or School." (If you're already registered as a Cigna customer, log in to mycigna.com or the myCigna app to search the plan network.)
- Change the geographic location to the city/state or zip code you wish to search. Select the search type and enter a name, specialty or other search term. Click on the magnifying glass icon to see your results.
- Answer any clarifying questions, and then verify where you live (as that will determine the networks available).

Member Service Portal

Your medical carrier's member portal is your access to secure, personalized services with interactive health tools built around you, your benefit, and your health. Access the myCigna portal at myCigna.com.

Once you are registered your personal health information will be available to you 24/7. Through the portal you can:

- Manage and track claims
- View, fax or email ID card information
- Find doctors and compare cost and quality information
- Review your coverage
- Track your account balances and deductibles

Need your health data on the run? Download the myCigna app from the App Store or Google Play.

At the Doctor's Office

It's recommended that you choose an in-network primary care physician (PCP) for your medical coverage, even though it is not required. A PCP can be your Family Practitioner, Internist, General Medicine, Pediatrician, or an OB/GYN (Obstetrician and Gynecologist). Each member of your family may have a different PCP.

Medical Plan Comparison

	Cigna OAP Low Plan	Cigna OAP HDHP	Kaiser HMO (CA only)
BENEFITS IN-NETWORK			
ANNUAL DEDUCTIBLE			
Individual	\$900	\$1,800	\$250
Family	\$1,800	\$3,600	\$500
OUT OF POCKET (OOP) MAXIMUM			
Individual	\$3,500	\$4,500	\$2,500
Family	\$7,000	\$9,000	\$5,000
COINSURANCE/COPAY (IN-NETWORK)			
Preventive Care	No charge	No charge	No charge
Primary Care Physician (PCP)	\$30 copay	10% after deductible	\$20 copay
Specialist	\$45 copay	10% after deductible	\$30 copay
Virtual Visits (PCP / Specialty)	\$30 / \$45	No charge	No charge
Emergency Room	\$250 then 20% coinsurance	10% after deductible	10% after deductible
Inpatient Hospital	20% after deductible	10% after deductible	10% after deductible
Outpatient Hospital	20% after deductible	10% after deductible	10% after deductible
Urgent Care	\$60 copay	10% after deductible	\$20 copay
Outpatient Surgery	20% after deductible	10% after deductible	10% after deductible
Lab/x-Ray (Outpatient)	No charge	10% after deductible	\$10 copay
OUT OF NETWORK (OON)			
Deductible Individual/Family (OON)	\$1,800 / \$5,000	\$3,600 / \$7,200	N/A
Co-insurance (OON)	40%	30%	N/A
Out of Pocket Individual/Family Maximum (OOP)	\$8,000 / \$16,000	\$9,000 / \$18,000	N/A

Pharmacy Benefits

Pharmacy				
	Tier	Cigna OAP Low Plan	Cigna OAP HDHP	Kaiser HMO (CA only)
Retail 30-day supply	Generic Drugs	\$20 copay	\$20 copay	\$10 copay
	Preferred brand drugs	\$40 copay	\$40 copay	\$30 copay
	Non-preferred brand drugs	\$60 copay	\$60 copay	\$30 copay
	Specialty drugs	20% up to \$250	20% up to \$250	20% up to \$250
	Generic Drugs	\$40 copay	\$40 copay	\$20 Copay
	Preferred brand drugs	\$80 copay	\$80 copay	\$60 copay
	Non-preferred brand drugs	\$120 copay	\$120 copay	\$60 copay
Mail Order 90-day supply	Specialty drugs	—	—	—

Deductible does not apply to prescription drug benefits on the Cigna OAP \$900 or Kaiser HMO plans.



What Are My Options for Care (Cigna Medical Plans)?

You have many options for how and where you can receive care through your Cigna medical plan. But which one is best for your situation? Use the chart below to help you decide and see the benefit grid on the next page for service costs.

CARE CENTER	WHAT IS IT?	WHAT CAN THEY TREAT?
NurseLine	<ul style="list-style-type: none"> Staffed by registered nurses Resource for guidance during natural catastrophes or health outbreaks Available 24/7/365 days a year at NO COST 	<ul style="list-style-type: none"> Answer general questions like “How long should I ice my sprained ankle?” Give advice/referrals of where to go for treatment e.g. ER or primary care doctor
Telemedicine / Virtual Visits	<ul style="list-style-type: none"> Convenient, low-cost option for treating common, non-urgent health concerns A doctor will diagnose the issue over the phone and write a prescription, if necessary. Available 24/7/365 days a year, by web, phone or mobile app 	<ul style="list-style-type: none"> Minor illnesses Minor infections Cold and flu symptoms Bronchitis Allergies Mental health Headaches/migraines And more...
Doctor's Office	<ul style="list-style-type: none"> Routine care or treatment for a current health issue Your primary doctor knows you and your health history To manage your medications To refer you to a specialist Normally available Monday-Friday. Check with your provider for actual office hours. 	<ul style="list-style-type: none"> Routine checkups and preventive services Immunizations Minor injuries, such as sprains Illnesses Manage your general health and chronic conditions
Urgent Care Clinic	<ul style="list-style-type: none"> Treatment of non-life-threatening injuries or illnesses Staffed by qualified physicians Generally open night and weekends; some open 24/7 	<ul style="list-style-type: none"> Cold and flu symptoms Minor accidents or falls Minor sprains or fractures Minor cuts and burns Vomiting, diarrhea
Emergency Room	<ul style="list-style-type: none"> Immediate treatment for serious, life-threatening conditions. Ready to treat any critical situation Can be hospital-based or freestanding Available 24/7/365 days a year 	<ul style="list-style-type: none"> Chest pain Difficulty breathing Severe abdominal pain Broken bones Head injuries Uncontrolled bleeding Seizures Coughing or vomiting blood

Virtual Care From MDLIVE

Log into mycigna.com and Click on “Talk to a doctor”
OR Call MDLIVE at **888-726-3171**

Find a Doctor / Facility

www.cigna.com

Questions? Call **800-244-6224**

Health Savings Account (HSA)



When you are enrolled in the Cigna High Deductible Health Plan (HDHP) and meet the eligibility requirements, the IRS allows you to open and contribute to an HSA Account.

What Is a Health Savings Account (HSA)?

An HSA is a tax-sheltered bank account that you own to pay for eligible health care expenses for you and/or your eligible dependents for current or future healthcare expenses. The Health Savings Account (HSA) is yours to keep, even if you change jobs or medical plans. There is no “use it or lose it” rule; your balance carries over year to year.

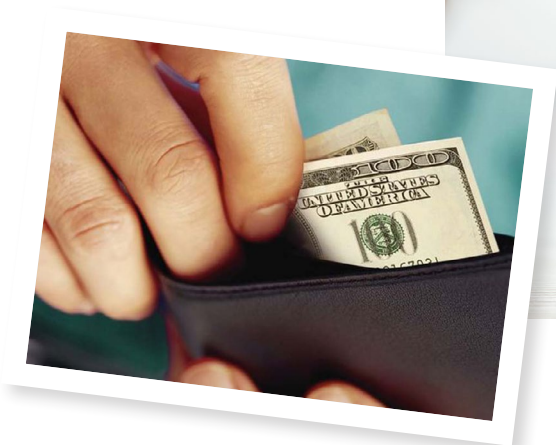
Plus, you get extra tax advantages with an HSA because:

- Money you deposit into an HSA is exempt from federal income taxes;
- Interest in your account grows tax free; and
- You don't pay income taxes on withdrawals used to pay for eligible health expenses. (If you withdraw funds for non-eligible expenses, taxes and penalties apply).
- You also have a choice of investment options which earn competitive interest rates, so your unused funds grow over time.

HSA Contributions

You can contribute to your Health Savings Account on a pre-tax basis through payroll deductions up to the IRS statutory maximums. The IRS has established the following maximum HSA contributions for 2026:

- \$4,400 Individual
- \$8,750 Family
- If you are age 55 and over, you may contribute an extra \$1,000 catch up contribution.



Are You Eligible to Open a Health Savings Account (HSA)?

Although everyone is able to enroll in the Qualified High Deductible Health Plan, not everyone is eligible to open and contribute to an HSA. If you do not meet these requirements, you cannot open an HSA.

- You must be enrolled in a Qualified High Deductible Health Plan (QHDHP).
- You must not be covered by another non-QHDHP health plan, such as a spouse's PPO plan.
- You are not enrolled in Medicare.
- You are not in the TRICARE or TRICARE for Life military benefits program.
- You have not received Veterans Administration (VA) benefits within the past three months.
- You are not claimed as a dependent on another person's tax return.
- You are not covered by a traditional health care flexible spending account (FSA). This includes your spouse's FSA. (Enrollment in a limited purpose health care FSA is allowed).

Select the image below to see a brief video for ways you can optimize your HSA.



How Do I Get Reimbursed for My Eligible Expenses?

The easiest way to use your HSA dollars is by using your HSA Debit Card at the time you incur an eligible expense. Or you can withdraw money from an ATM. But keep your receipts! You must be able to prove that you were reimbursing yourself for an eligible expense if you are audited. If you use your HSA funds for non-eligible expenses, you will be charged a 20% penalty tax (if under age 65) as well as federal income taxes. You can manage your HSA through Health Equity, 24 hours a day, seven days a week. Health Equity provides helpful information about your HSA, including online calculators to help you add up your tax savings and see your HSA's possible future growth. For additional guidelines, please go online or call Health Equity at www.healthequity.com or 866-735-8195.



Flexible Spending Account (FSA)

The Flexible Spending Account (FSA) plan with Health Equity allows you to set aside pre-tax dollars to cover qualified healthcare and dependent care expenses you would normally pay out of your pocket with post-tax dollars. You pay no federal or state income taxes on the money you place in an FSA.

The FSA plan year is January 1st to December 31st each calendar year. You can participate in a Health Care FSA and/or the Dependent Care FSA, but you **MUST** re-enroll in the FSA each plan year. Prior year elections will not carry over. Once you enroll in the FSA, you cannot change your contribution amount during the year unless you experience a qualifying life event.



HEALTH CARE FSA

Contribute up to \$3,400 per year, pretax, to pay for copays, prescription expenses, lab exams and tests, contact lenses and eyeglasses.

LIMITED PURPOSE FSA

Those enrolled in the HDHP can contribute up to \$3,400 per year, pretax, to pay for eligible vision and dental expenses.

DEPENDENT CARE FSA

Contribute up to \$7,500 per year (\$3,750 if married and filing separate tax returns), pretax, to pay for day care expenses associated with caring for elder or child dependents that are necessary for you or your spouse to work or attend school full-time. You cannot use your Health Care FSA to pay for Dependent Care expenses.



USE IT OR LOSE IT

If you do not spend all the money in this FSA by **March 31**, per IRS regulations for pretax contributions, unused dollars will be forfeited.

How an FSA works:

- Choose a specific amount of money to contribute each pay period, pretax, to one or both accounts during the year.
- The amount is automatically deducted from your pay at the same level each pay period.
 - **You have immediate access to the full annual elected amount in your Healthcare FSA as of January 1st.**
 - **You will only be able to access available funds in your Dependent Care FSA, not “future” funds.**
- As you incur eligible expenses, you may use your flexible spending debit card to pay at the point of service OR submit the appropriate paperwork to be reimbursed by the plan.
- Save your receipts! You may be required to produce them during a plan year audit as required by the IRS.

Select the image below to see a video on ways to optimize your FSA.



For more on the FSA, visit www.healthequity.com or call 877-924-3967

Commuter Benefits Program

Use pretax dollars to pay for your parking or public transportation expenses while commuting to work. This program is voluntary for employees residing in NJ, NY, or WA, you may participate on a month-to-month basis. The maximum amount you may contribute is \$340 per month for Transit and \$340 per month for Parking. Both payroll contributions and reimbursements cannot exceed the monthly statutory limits. For 2026, the minimum contribution is \$25 per paycheck, or \$54.17 per month. Any unused funds in any month are rolled over to the next month's contribution. The contribution amounts are current as of the time of this publication but are subject to change by the IRS.

ACCOUNT	USE FOR	CONTRIBUTIONS
Transportation or Public Transit	Monthly passes, tokens, fare cards/ vouchers (transit and vanpool expenses) for you	\$340 monthly maximum
Parking	Fees associate with parking at or near your place of employment or parking at or near public transportation to get to work (e.g. parking at a bus or subway station)	\$340 monthly maximum



Dental

Streamland Media offers two dental plans through Cigna. After considering your anticipated dental needs for the coming year and evaluating the DHMO and PPO dental plan provider networks, you can determine which plan will work best for you by reviewing deductibles, copayments, and services covered under each plan.

The Cigna DHMO Dental Plan (California Residents Only) provides dental care through a network of dentists. There are no deductibles, plan maximums, or claim forms. You must select a Primary Care Dentist from Cigna's DHMO network.

The Cigna Dental PPO Plan covers a wide range of dental services. You have the freedom to go in and out of network for care. You may also visit an out-of-network dentist, where services will be based on a reasonable and customary amount and you will be responsible for any amount owed, after insurance has paid.



Please Note: It is recommended that when a course of treatment is expected to cost \$300 or more, and is of a non-emergency nature, your dentist should submit a treatment plan before he/she begins. This enables you to see what your out-of-pocket expenses will be so you are not surprised and can budget accordingly. There is also a possibility that suggested procedures may be denied, and alternative procedures approved based upon x-rays and supporting documentation.

The chart below is a brief outline of the plans. Please refer to the summary plan description for complete plan details.

DENTAL PLAN DESIGN		
In-Network Plan Features	DPPO	DHMO
Annual Deductible - Individual	\$50	\$0
Annual Deductible - Family	\$150	\$0
Calendar Year Benefits Maximum	\$2,000	N/A
Preventive Care	100%	100%
Basic Services	80%	Refer to Patient Charge Schedule
Major Services	50%	Refer to Patient Charge Schedule
Orthodontia Services	50%	Not covered
Orthodontia Eligibility	Adults and Children	Not covered
Orthodontia Lifetime Benefits Maximum	\$2,000	Not covered

Vision

Eye doctors detect problems in vision, overall eye health, and detect signs of other health conditions like diabetic eye disease, high blood pressure and high cholesterol.

Extra Savings and Discounts With Your Plan

- Extra \$20 to spend on featured frame brands. Go to www.vsp.com/offers for details.
- 30% savings on additional glasses and sunglasses, including lens enhancements, from your VSP provider on your exam day.
- Or get 20% from any VSP provider within 12 months of your last WellVision Exam.
- Laser vision correction (Lasik) average 15% off the regular price or 5% off the promotional price from contracted facilities.



Locate a VSP Signature provider at www.vsp.com select FIND A VSP DOCTOR and enter your zip code. For customer service contact VSP at 800-877-7195 or visit www.vsp.com.

Vision Benefits

VSP VISION PLAN		
	IN-NETWORK BENEFITS	OUT OF-NETWORK BENEFITS
COPAY		
Routine Exams (Annual)	\$10 copay	Up to \$46 off
VISION MATERIALS		
Materials Copay	\$20 copay	Up to \$47
Lenses	Benefit varies by type of lens. Covered every 12 months	80%
Contacts Covered in lieu of frames. Medically necessary contacts may be covered at a higher benefit level	Elective contacts covered every 12 months \$150 allowance	Up to \$105
Frames	Covered at \$20 copay every 12 months \$200 allowance 20% savings on amount over allowance	Up to \$70 off

Life and AD&D Insurance

Basic Life and AD&D Insurance

Streamland Media provides Basic Life and AD&D benefits through Guardian to eligible employees at no cost. The Life insurance benefit will be paid to your designated beneficiary in the event of death while covered under the plan. The AD&D benefit will be paid in the event of a loss of life or limb by accident while covered under the plan.

- **Employee Benefit:** Two times salary up to \$1,000,000

The above benefits will begin to decrease at age 65.



IMPORTANT REMINDER!

Be sure to assign a beneficiary or living trust to ensure your assets are distributed according to your wishes.

Voluntary Life and AD&D Insurance

In addition to the employer paid Basic Life and AD&D coverage, you have the option to purchase additional voluntary life insurance through Guardian to cover any gaps in your existing coverage that may be a result of age reduction schedules, cost of living, existing financial obligations, etc. Your election, however, could be subject to medical questions and evidence of insurability.

You must elect coverage to enroll dependents. Your contributions will depend on your age and the amount of coverage you elect.

- **Employee:** Increments of \$10,000 to a maximum of \$500,000
- **Spouse:** Increments of \$5,000 to a maximum of \$100,000
- **Dependent Child(ren):** \$5,000 or \$10,000

Benefits are reduced beginning at age 65. Additional benefits include conversion, portability, waiver of premium and accelerated benefits.



Disability Insurance & Leave

One of the most important assets to you as an employee is the ability to earn an income. Streamland Media provides short-term and long-term income protection through Guardian in the event you become unable to work due to a non-work-related illness or injury.

Both disability plans are subject to reduction if you receive disability payments from other sources, such as state or federal programs.

Short-Term Disability Insurance

This benefit covers 60% of your weekly base salary up to \$2,500/week. The benefit begins after 8 days of injury or illness and lasts up to 13 weeks. Please see the summary plan description for complete plan details.

Buy-Up Short-Term Disability Insurance Option

This benefit covers 70% of your weekly base salary up to \$3,000/week. The benefit begins after 7 days of injury or illness and lasts up to 13 weeks. Please see the summary plan description for complete plan details.

Long-Term Disability Insurance

This benefit covers 60% of your monthly base salary up to \$10,000/month. Benefit payments begin after 90 days of disability. Benefit duration is to Social Security Normal Retirement Age. Please see the summary plan description for complete plan details.

Leave of Absence Program

Streamland Media's Leave of Absence Program is administered by Guardian. The leave program provides employees with options and supplemental disability pay when an unfortunate illness or injury occurs.

To initiate your claim, contact Guardian at 888-889-2953, Monday through Friday, between 7 a.m. and 7 p.m. CST.

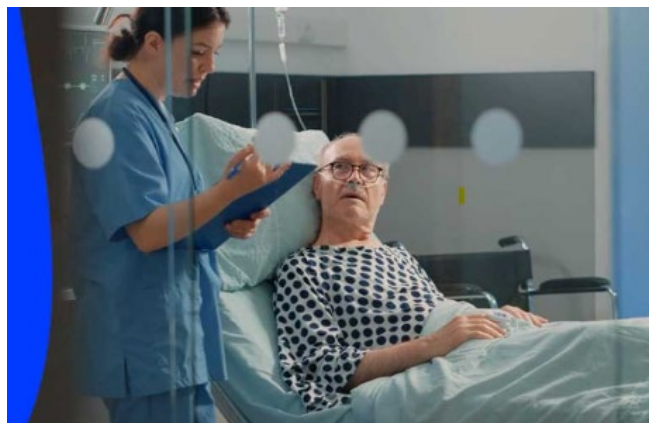
Family Medical Leave Act (FMLA)

If you have been with Streamland Media for 12 months and have worked 1,250 hours, you may be eligible for up to 12 weeks of unpaid leave per year under the Family and Medical Leave Act (FMLA). FMLA can be used for a family member, care for a newborn, and certain other medical needs.



Voluntary Hospital Care Insurance

Cigna's Hospital Care Insurance pays a benefit when a covered person is admitted and confined as an inpatient in a hospital due to an injury or covered sickness. This benefit is only payable once per period of confinement. A hospital is not an institution, or part thereof, used as a place for rehabilitation, a place for rest or for the aged, a nursing or convalescent home, a long-term nursing unit or geriatrics ward or an extended care facility for the care of convalescent, rehabilitative or ambulatory patients.



For Example, You Will Receive Cash When You:

- Are admitted to the hospital
- Stay overnight
- Have a baby
- Need observation

Benefits are paid directly to you, above, beyond, and regardless of any other coverage.

Scan the code below to learn how Cigna Hospital Care Insurance can provide assistance for out-of-pocket expenses during hospital stays.



	BENEFITS	
	LOW PLAN	HIGH PLAN
Hospital Stay – Admission	\$500 (non-ICU and ICU) per admission, 1 benefit(s) every 180 days.	\$1,000 (non-ICU and ICU) per admission, 1 benefit(s) every 180 days.
Hospital Stay – Daily	\$100 a day (non-ICU) – up to 30 days \$200 a day (ICU) – up to 30 days	\$200 a day (non-ICU) – up to 30 days \$400 a day (ICU) – up to 30 days
Inpatient Rehab	\$100 a day, up to 30 days	\$200 a day, up to 30 days
Health Screenings	\$50, max 1 per year per insured	\$50, max 1 per year per insured

Voluntary Accident Insurance

For covered accidental injuries, fixed benefits are paid directly to you regardless of any other coverage you may have, and you can spend it any way you choose. Benefits are paid according to a fixed schedule that includes benefits for hospitalization, fracture and dislocations, emergency room visits, major diagnostic exams, physical therapy and more.

If you or a covered dependent should die as a result of an accidental injury within 365 days while the coverage remains in force, a death benefit is payable.

Key Advantages of Accident Insurance

- Benefits are payable directly to you to be spent any way you choose.
- Pays in addition to any other coverage you may have.
- No health questions or pre-existing conditions limitations.
- Fast and accurate claims services.
- Coverage is fully portable-If you change jobs, you can take your coverage with you.

How It Works

The chart below illustrates the dollar range of benefits paid directly to you based on the covered service by plan.



CASH BENEFIT AMOUNTS PAID FOR COVERED SERVICES		
LOW PLAN	HIGH PLAN	
\$200	\$300	Ambulance
\$500	\$1,000	Hospital Admission
\$100	\$150	Emergency Room Visit
\$100	\$200	Hospital Confinement (1 Day)
Up to \$3,000	Up to \$6,000	Fractures (non-surgically repaired)
Up to \$6,000	Up to \$12,000	Fractures (surgically repaired)
\$40	\$50	X-ray

Voluntary Critical Illness Insurance

For many, a critical illness can expose an individual to an unexpected gap in protection. While health plans may help cover many of the direct costs associated with a critical illness, related expenses such as lost income, childcare, travel to and from treatment; high deductibles and co-pays may quickly diminish savings.

Critical illness insurance pays a fixed benefit upon initial diagnosis of a covered critical illness-while you are living and when you may need it most.

Coverage

- **Employee:** \$10,000, \$20,000, or \$30,000
- **Spouse:** 100% of issued employee benefit amount
- **Dependent Child(ren):** 50% of issued employee benefit amount

Key Advantages of Critical Illness Insurance

- Benefits are payable directly to you to be spent any way you choose.
- Pays in addition to any other coverage you may have.
- Flexible coverage options to meet your individual needs.
- Fast and accurate claims service.

BENEFIT PERCENTAGE PAID FOR COVERED SERVICES	
100%	Invasive Cancer, 1st and 2nd occurrence
100%	Organ Failure and Kidney Disease
100%	Heart Attack and Stroke
100%	ALS, Coma, Parkinson's Disease Loss of Speech, Sight or Hearing
100%	Benign Brain Tumor
50%	Alzheimer's Disease
50%	Huntington's Disease Multiple Sclerosis
25%	Coronary Artery Disease
\$250	Skin Cancer, 1st occurrence

How It Works

The chart above illustrates the benefit percentage paid directly to you based on the covered service.



Additional Benefits

MetLife Coverage

The following benefits are available:

- Farmers (formerly MetLife) Auto & Home coverage
 - Group discounts on your personal auto and home insurance, use **Group Plan Code (GPC) D6Y**
- MetLife Legal Plan – provides access to legal expertise for both expected and unexpected events

Voluntary Identity Theft Protection

This plan through LegalShield is designed to protect your identity and assets through identity, credit, and social monitoring.

- Identity Threat Detection and Alerts – covers up to 10 family members
- Credit Score Tracker
- Continuous Monitoring Lost Wallet, Data Breach notification
- Restoration Services
- Children Identity Theft – up to 8 children up to the age of 26

Individual Only and Family coverage available via payroll deductions.



Voluntary Pet Insurance

You can purchase health insurance, administered by Nationwide Pet Insurance, for your dog, cat, bird, or other exotic animals. Like a regular health insurance plan, a pet insurance policy can help you plan for your pet's health care – and offset costs for routine care and unexpected illness or injury.

Your premium is based on your pet's species, age, the benefits coverage you select, and where you live. For more information, a quote or to enroll, visit:

benefits.petinsurance.com/streamland

401(k) Retirement Savings Plan



Whether retirement is way down the road or just around the corner, it's important to have savings goals and specific investment objectives. To help you meet your goals and objectives, we offer our John Hancock 401(k) and/or Roth IRA retirement savings plans. Key details and features of our plan are listed below.

You are eligible to begin contributing to the 401(k) plan on the 1st of the month following or coinciding with the completion of one month of service. The plan includes a 2% auto-enrollment feature and will increase by 1% every year up to 6% unless you make a different election or decide not to participate in the plan. Your 401(k) contributions are deducted from your paycheck before taxes are taken out of your pay. Contributions to your Roth IRA are deducted after taxes.

You can save on a pre-tax basis (post-tax for the Roth IRA option) up to \$24,500 in 2026. If you are over the age of 50, or will reach 50 during the plan year, you can contribute an additional \$8,000 to your 401(k) or Roth IRA account under the plans catch-up provision.

Visit John Hancock at myplan.johnhancock.com to register and access your account. To speak with a John Hancock representative contact 800-294-3575.

Benefit Costs - Bi-weekly

Your payroll contributions for medical, dental and vision benefits are shown here.

MEDICAL			
	CIGNA OAP LOW PLAN	CIGNA OAP HDHP	KAISER HMO (CA ONLY)
Employee	\$156.86	\$57.85	\$99.80
Employee & Spouse	\$532.19	\$200.76	\$324.22
Employee & Child(ren)	\$406.89	\$154.85	\$260.03
Employee & Family	\$812.68	\$324.17	\$458.55

DENTAL		
	DPPO	DHMO
Employee	\$4.68	\$1.83
Employee & Spouse	\$16.26	\$6.23
Employee & Child(ren)	\$24.91	\$6.51
Employee & Family	\$39.61	\$10.91

VISION	
	VSP Vision Plan
Employee	\$1.25
Employee & Spouse	\$3.39
Employee & Child(ren)	\$3.50
Employee & Family	\$6.71

BASIC LIFE AND AD&D

100% paid for by Streamland Media.

VOLUNTARY LIFE AND AD&D

Provided in the employee portal based on employee/spouse age.

Benefit Costs - Bi-weekly (cont.)

SHORT-TERM DISABILITY AND LONG-TERM DISABILITY

100% paid for by Streamland Media.

BUY-UP SHORT-TERM DISABILITY

Provided in the employee portal based on employee/spouse age.

VOLUNTARY CRITICAL ILLNESS

Provided in the employee portal based on employee/spouse age.

VOLUNTARY ACCIDENT

	EMPLOYEE	EMPLOYEE & SPOUSE	EMPLOYEE & CHILD(REN)	EMPLOYEE & FAMILY
Low Plan	\$3.56	\$5.83	\$6.91	\$9.18
High Plan	\$6.86	\$11.23	\$13.25	\$17.62

VOLUNTARY HOSPITAL CARE

	EMPLOYEE	EMPLOYEE & SPOUSE	EMPLOYEE & CHILD(REN)	EMPLOYEE & FAMILY
Low Plan	\$3.77	\$7.51	\$6.82	\$11.60
High Plan	\$7.53	\$15.00	\$13.64	\$23.19

METLIFE LEGAL PLAN

\$21.00 per month

LEGALSHIELD IDENTITY THEFT

\$8.95 per month for Employee Only coverage
\$18.95 per month for Family coverage

NATIONWIDE PET INSURANCE

Based on Dog or Cat coverage and State of Residence.
For a quote visit benefits.petinsurance.com/streamland



Important Contacts

Carrier Customer Service

Additional information regarding benefit plans can be found at www.streamlandmediabenefits.com.

	CARRIER	GROUP/PLAN NUMBER	PHONE NUMBER	WEBSITE
Medical	Cigna	3345283	800-244-6224	www.myCigna.com
	Kaiser HMO CA	233772	800-464-4000	www.kp.org
Dental PPO	Cigna	3345283	800-Cigna24	www.cigna.com
Managed Dental (CA Only)	Cigna	3345283	800-Cigna24	www.cigna.com
Life and AD&D	Guardian	544122	800-525-4542	www.guardiananytime.com
Short Term Disability (STD)	Guardian	544122	800-268-2525	
Long Term Disability (LTD)	Guardian	544122	800-538-4583	
Employee Assistance Program	Uprise Health	544122	800-386-7055	Uprise Health https://worklife.uprisehealth.com/ click on WorkLife Resource Link Access Code: worklif
Vision	Vision Service Plan	30078588	800-877-7195	www.vsp.com
Health Savings Account	Health Equity	42270	866-735-8195	www.healthequity.com
Flex Spending Accounts	Health Equity	42270	877-924-3967	www.healthequity.com
Commuter Benefit	Health Equity	42270	866-382-3510 To register, contact via email	participant.wageworks.com/ Account/FirstTimeUserRegistration/ Instructions. aspx?SelfIDMode=SignUp
Voluntary Critical Illness	Cigna	CI112902	800-754-3207	www.myCigna.com
Voluntary Hospital Indemnity	Cigna	HC112531	800-754-3207	www.myCigna.com
Voluntary Accident	Cigna	AI112992	800-754-3207	www.myCigna.com
Auto & Home Group Plan Code D6Y	Farmers	Individual Policies	800-438-6381	Contact via phone
Legal Plan	MetLife	5949279	800-821-6400	www.members.legalplans.com
Identity Theft	LegalShield	202886	800-654-7757	www.legalshield.com
401(k) Plan	John Hancock		800-294-3575	Myplan.johnhancock.com
Streamland Media				www.streamlandmediabenefits.com
Streamland Media's HR Ticketing system				HRSupport@streamlandmedia.com

This brochure summarizes the benefit plans that are available to Streamland Media, LLC eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department at www.benefitsatstreamlandmedia.com. Information provided in this brochure is not a guarantee of benefits.

Legal Notices

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, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	LOUISIANA – Medicaid Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
INDIANA – Medicaid Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584	MAINE – Medicaid Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711
IOWA – Medicaid and CHIP (Hawki)	MASSACHUSETTS – Medicaid and CHIP
Medicaid Website: https://hhs.iowa.gov/programs/welcome-iowamedicaid Medicaid Phone: 1-800-338-8366 Hawki Website: https://hhs.iowa.gov/programs/welcome-iowamedicaid/iowa-health-link/hawki Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
KANSAS – Medicaid	MINNESOTA – Medicaid
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672
KENTUCKY – Medicaid	MISSOURI – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
	MONTANA – Medicaid
	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPPProgram@mt.gov
	NEBRASKA – Medicaid
	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
	NEVADA – Medicaid
	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	RHODE ISLAND – Medicaid and CHIP Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)
NEW JERSEY – Medicaid and CHIP Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	SOUTH CAROLINA – Medicaid Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEW YORK – Medicaid Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	SOUTH DAKOTA - Medicaid Website: http://dss.sd.gov Phone: 1-888-828-0059
NORTH CAROLINA – Medicaid Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	TEXAS – Medicaid Website: Health Insurance Premium Payment (HIPPP) Program Texas Health and Human Services Phone: 1-800-440-0493
NORTH DAKOTA – Medicaid Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825; or 1-866-614-6005	UTAH – Medicaid and CHIP Utah’s Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
OKLAHOMA – Medicaid and CHIP Website: http://www.insureoklahoma Phone: 1-888-365-3742	VERMONT– Medicaid Website: Health Insurance Premium Payment (HIPPP) Program Department of Vermont Health Access Phone: 1-800-250-8427
OREGON – Medicaid and CHIP Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	VIRGINIA – Medicaid and CHIP Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924 (regionally-restricted); or 1-855-242-8282
PENNSYLVANIA – Medicaid and CHIP Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	WASHINGTON – Medicaid Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

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

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

IMPORTANT NOTICE TO EMPLOYEES FROM STREAMLAND MEDIA ABOUT CREDITABLE PRESCRIPTION DRUG COVERAGE AND MEDICARE

The purpose of this notice is to advise you that the prescription drug coverage listed below under the Streamland Media medical plan are expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2026. This is known as “creditable coverage.”

Why this is important. If you or your covered dependent(s) are enrolled in any prescription drug coverage during 2026 listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty – as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

If you or your family members aren’t currently covered by Medicare and won’t become covered by Medicare in the next 12 months, this notice doesn’t apply to you.

Please read the notice below carefully. It has information about prescription drug coverage with Streamland Media and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

Notice of creditable coverage

You may have heard about Medicare’s prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals

leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered by one of the Streamland Media prescription drug plans listed below, you'll be interested to know that the prescription drug coverage under the plans is, on average, at least as good as standard Medicare prescription drug coverage for 2025. This is called creditable coverage. Coverage under one of these plans will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

Cigna PPO, Cigna HDHP, Kaiser HMO

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage. In this case, the Streamland Media plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop Streamland Media coverage, Medicare will be your only payer. You can re-enroll in the employer plan at annual enrollment or if you have a special enrollment or other qualifying event, or otherwise become newly eligible to enroll in the Streamland Media plan mid-year, assuming you remain eligible.

You should know that if you waive or leave coverage with Streamland Media and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future – such as before the next period you can enroll in Medicare prescription drug coverage, if this Streamland Media coverage changes, or upon your request.

For more information about your options under Medicare prescription drug coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the Medicare & You handbook. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

Visit www.medicare.gov for personalized help.

Call your State Health Insurance Assistance Program (see a copy of the Medicare & You handbook for the telephone number) or visit the program online at <https://www.shiptacenter.org/>.

- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov or call 800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

For more information about this notice or your prescription drug coverage, contact:

Streamland Media HR Support
3900 West Alameda Avenue, Burbank, CA 91505
323-466-2066
HRSupport@StreamlandMedia.com
10/9/2024

NOTICE OF SPECIAL ENROLLMENT RIGHTS FOR MEDICAL PLAN COVERAGE

As you know, if you have declined enrollment in Streamland Media's medical plan for you or your dependents (including your spouse) because of other health insurance coverage, you or your dependents may be able to enroll in some coverages under these plans without waiting for the next open enrollment period, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Streamland Media will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have 60 days – instead of 30 – from the date of the Medicaid/CHIP eligibility change to request enrollment in the Streamland Media group health plan. Note that this new 60-day extension doesn't apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another medical plan.

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your plan administrator at HRSupport@StreamlandMedia.com.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, contact your plan administrator at (323) 466-2066.

PROVIDER-CHOICE RIGHTS NOTICE

The Streamland Media Medical Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Cigna member support at (800) 244-6224 or www.mycigna.com/. Contact Kaiser member support at (800) 464-4000 or www.kp.org.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Streamland Media Medical Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Cigna member support at (800) 244-6224 or www.mycigna.com/. Contact Kaiser member support at (800) 464-4000 or www.kp.org.

STREAMLAND MEDIA HIPAA PRIVACY NOTICE

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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by Streamland Media health plans. This information, known as protected health information, includes almost all individually identifiable health information held by a plan – whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of these plans: *Cigna OAP \$900*, *Cigna OAP*

HDHP, *Kaiser HMO*. The plans covered by this notice may share health information with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

The Plan's duties with respect to health information about you

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not Streamland Media as an employer – that's the way the HIPAA rules work. Different policies may apply to other Streamland Media programs or to data unrelated to the Plan.

How the Plan may use or disclose your health information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- **Treatment** includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.
- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing "behind the scenes" plan functions, such as risk adjustment, collection, or reinsurance. For

example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.

- **Health care operations** include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include evaluating vendors; engaging in credentialing, training, and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

How the Plan may share your health information with Streamland Media

The Plan, or its health insurer or HMO, may disclose your health information without your written authorization to Streamland Media for plan administration purposes. Streamland Media may need your health information to administer benefits under the Plan. Streamland Media agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Benefits and payroll are the only Streamland Media employees who will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Plan and Streamland Media, as allowed under the HIPAA rules:

- The Plan, or its insurer or HMO, may disclose "summary health information" to Streamland Media, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.
- The Plan, or its insurer or HMO, may disclose to Streamland Media information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.

In addition, you should know that Streamland Media cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by Streamland Media from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs — is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

Workers' compensation

Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws

Necessary to prevent serious threat to health or safety

Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody

Public health activities

Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects

Victims of abuse, neglect, or domestic violence

Disclosures to government authorities, including social services or protective services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)

Judicial and administrative proceedings

Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)

Law enforcement purposes

Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the Plan's premises

Decedents

Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties

Organ, eye, or tissue donation

Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death

Research purposes

Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project

Health oversight activities

Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws

Specialized government functions

Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates

HHS investigations

Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or programs if the Plan is being paid to make those communications. If we keep psychotherapy notes in our records, we will obtain your authorization in some cases before we release those records. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use, or disclosure of your unsecured health information as required by law.

The Plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

Your individual rights

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid out of pocket and in full for the item or service.

Right to receive confidential communications of your health information

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a “designated record set.” This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible on site), the Plan will provide you with one of these responses:

- The access or copies you requested
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn’t maintain the health information but knows where it is maintained, you will be informed where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous, and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan’s cost.

Right to amend your health information that is inaccurate or incomplete

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

- Make the amendment as requested
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an “accounting of disclosures.” You generally may receive this accounting if the

disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- For treatment, payment, or health care operations
- To you about your own health information
- Incidental to other permitted or required disclosures • Where authorization was provided
- To family members or friends involved in your care (where disclosure is permitted without authorization)
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances
- As part of a “limited data set” (health information that excludes certain identifying information)

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You’ll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the Plan upon request

You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the information in this notice

The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on October 1, 2024. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan’s privacy policies described in this notice, you will be provided with a revised privacy notice posted on the company intranet/benefits website.

Complaints

If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You won’t be retaliated against for filing a complaint. To file a complaint, you can file a formal complaint with the U.S. Benefits Team at

HRSupport@StreamlandMedia.com.

Contact

For more information on the Plan’s privacy policies or your rights under HIPAA, contact

HRSupport@StreamlandMedia.com.

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

PART A: General Information

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

What is the Health Insurance Marketplace?

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

Can I Save Money on my Health Insurance Premiums in the Marketplace?

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

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage

to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than **9.96%**¹ of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed **9.96%**¹ of the employee's household income.

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

¹ An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. [For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.](#)

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is **offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by [HealthCare.gov](https://www.healthcare.gov) and either- submit a new application or update an existing application on [HealthCare.gov](https://www.healthcare.gov) between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit [HealthCare.gov](https://www.healthcare.gov) or call the

Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.5.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit <https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/> for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact scruz@streamlandmedia.com.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.healthcare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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.

3. Employer name: Streamland Media, LLC	4. Employer Identification Number (EIN): 83-1508704	
5. Employer address: 3900 West Alameda Avenue	6. Employer phone number: 323-466-2066	
7. City Burbank	8. State: CA	9. Zip code: 91505
10. Who can we contact about employee health coverage at this job? U.S. Health & Benefits Team		
11. Phone number (if different from above)	12. Email address: HRSupport@StreamlandMedia.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: active employees working a minimum of 30 hours per week.
- With respect to dependents:
 - ☒ We do offer coverage. Eligible dependents are: Your legal spouse or domestic partner, your natural, adopted, or stepchildren up to age 26, your dependent children of any age, if disabled and incapable of self-support due to mental or physical disability (child must be disabled prior to reaching 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 your 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*.

Summary of Material Modifications

This enrollment guide constitutes a Summary of Material Modifications to the 2026 Cigna Medical Plan summary plan description (SPD). It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

Cigna OAP HDHP Plan:

- Change in-network deductibles from \$1,600 individual / \$3,200 Individual within family/ \$3,200 family to \$1,650 individual / \$3,300 individual within family / \$3,300 family
- Change in-network deductibles from \$1,650 individual / \$3,300 Individual within family/ \$3,300 family to \$1,800 individual / \$3,400 individual within family / \$3,600 family

- Change out-of-network deductible from \$3,300 individual / \$6,600 individual within family / \$6,600 family to \$3,600 individual / \$7,200 individual within family / \$7,200 family
- Change in-network out-of-pocket maximums from \$3,300 individual / \$3,300 individual within family / \$6,600 family to \$4,500 individual / \$4,500 individual within family / \$9,000 family
- Change out-of-network out-of-pocket maximums from \$6,600 individual / \$6,600 individual within family / \$13,200 family to \$9,000 individual / \$9,000 individual within family / \$18,000 family
- Rx copays changing to the following:
 - Generic: \$20 Retail / \$40 Mail Order
 - Formulary: \$40 Retail / \$80 Mail Order
 - Non-Formulary: \$60 Retail / \$120 Mail Order

Cigna OAP \$750 Plan:

- Change in-network deductibles from \$750 individual / \$1,500 family to \$900 individual / \$1,800 family
- Change out-of-network deductibles from \$1,500 individual / \$4,500 family to \$1,800 individual / \$5,000 family
- Change out-of-network out-of-pocket maximums from \$7,000 individual / \$14,000 family to \$8,000 individual / \$16,000 family
- Rx copays changing to the following:
 - Generic: \$20 Retail / \$40 Mail Order
 - Formulary: \$40 Retail / \$80 Mail Order
 - \$60 Retail / \$120 Mail Order

Cigna OAP \$1500 Plan: this plan has been removed for 2026

Please refer to the 2026 Cigna Benefit Summaries and Summaries of Benefits and Coverages and Evidence of Coverage Documents

These documents will replace any prior version of the documents.

MODEL COBRA CONTINUATION COVERAGE GENERAL NOTICE

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified

beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: along with supporting documentation to:

scruz@streamlandmedia.com.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. The member can provide WageWorks their notice (from the Social Security Administration) at any time over their active COBRA period by emailing it to customerdelivery@wageworks.com, faxing it to 1-866-924-1989 or mailing to PO Box 223646 Dallas, TX 75222-3646.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA continuation coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health

Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit

<https://www.medicare.gov/medicare-and-you>.

² <https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods>

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

HealthEquity
My.benefits@wageworks.com
888-678-4881

NO SURPRISES ACT NOTICE

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain **out-of-pocket costs**, like a **copayment**, **coinsurance**, or **deductible**. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill

you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
 - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact U.S. Department of Health and Human Services. The federal phone number for information and complaints is: 1-800-985-3059. Visit [No Surprises Act | CMS](#) or more information about your rights under federal law.

FIXED INDEMNITY PLAN NOTICE

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

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most federal consumer protections that apply to health insurance.

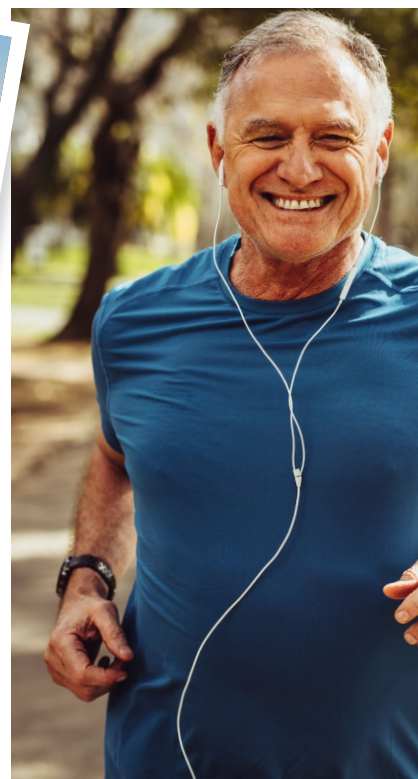
Looking for comprehensive health insurance?

- Visit [HealthCare.gov](https://www.healthcare.gov) or call **800-318-2596** (TTY: 855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your state Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.





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