Confluent EPO Plan Year 2026

Summary of Material Modification

This Summary of Material Modification ("SMM") describes changes to the Confluent EPO (the "Plan") effective January 1, 2026 occurring on account of the plan renewal. This SMM summarizes those changes. You should review this information carefully and share it with your covered dependents. This SMM updates your Summary Plan Description ("SPD") and if there are any discrepancies between the SPD and this SMM, this SMM will govern. Please note that all other Plan rules, limitations, exclusions and requirements stated in your SPD remain in effect. This SMM will be attached to your 2025 plan year SPD on your Collective Health portal. If you keep a separate copy of your SPD, please make sure to attach this supplemental document to your SPD for future reference.

If you have any questions, please contact the Plan Administrator or Collective Health.

ERISA Information

Plan Sponsor: Confluent

Sponsor EIN: 471824387 Plan Year: 2026

Plan Name: Confluent EPO

This SMM constitutes an addendum to the Plan's Summary Plan Description ("SPD"), which is available by calling Collective Health. Nothing in this SMM creates a right to be covered under the Plan. Receipt of this SMM does not guarantee that the recipient is a member under the Plan and/or otherwise eligible for benefits under the Plan. If there is any inconsistency between this document and the official plan documents and contracts, the official plan documents and contracts will control to the extent not amended by this SMM. Plan Sponsor represents and warrants that (a) it is providing this SMM in its capacity as a fiduciary to the applicable plan, and (b) it has thoroughly reviewed the SMM and agrees it is solely responsible for ensuring the SMM is accurate, complete, and in compliance with laws applicable to the plan, including ERISA, COBRA, and HIPAA.

Section | Header	Page(s)	Summary of Change	Previous Language	Updated Language	Effective Date
Throughout Document	7, 13 ,14, 15, 17, 23, 28, 59, 73-79	Medical Network Change	Anthem Blue Cross of California	Blue Shield of California	1/1/2026
Section 2: Enrollment & When Coverage Begins	12	Updated Language on Eligibility	If you are a new or newly eligible employee, your coverage will begin on the first day of the month after or coinciding with the date you become eligible.	If you are a new or newly eligible employee, your coverage will begin on the date of hire.	1/1/2026
Section 4: Quality & Value Programs	23	Medical Network Change	The current list of services requiring prior authorization will always be available from Anthem Blue Cross of California. Please visit www.anthem.com/provider/prior-authorization/ to see which services require a prior authorization.	The current list of services requiring prior authorization will always be available from Blue Shield of California. Please visit www.blueshieldca.com/en/provider/authorizations/authorization-list to see which services require a prior authorization.	1/1/2026
Appendix A: Inter-Plan Arrangements	112-115, see attached appendix	New network description	Appendix A	See attached Appendix A	1/1/2026

Appendix B: Additional Information about Gender Affirming Services	116	New Network description	Appendix B	See attached Appendix B	1/1/2026

Appendix A: Inter-Plan Arrangements

BlueCard Language for SPD-Shared Advantage
Benefits will be provided for Covered Services received outside of California within the United States, Puerto Rico, and U.S. Virgin Islands. The Administrator calculates the Participant's Copayment either as a percentage of the Allowable Amount or a dollar Copayment, as defined in this [SPD/Amendment]. When Covered Services are received in another state, the Participant's Copayment will be based on the local Blue Cross and/or Blue Shield plan's arrangement with its providers. See the BlueCard Program section in this Amendment.
Blue Shield of California has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees") referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of California, the claims for these services may be processed through one of these Inter-Plan Programs, which includes the BlueCard Program.
When you access Covered Services outside of California you may obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Plan"). In some instances, you may obtain care from non-participating healthcare providers. The Administrator]'s payment practices in both instances are described in this Amendment.
Option for when plan uses Blue HPN network:(Administrator require you to use a participating provider within the Blue High Performance Network® (Blue HPN®) if you wish to receive benefits for [covered healthcare services/Covered Services] outside of the geographic area Administrator serve. Services received from a nonparticipating Blue HPN® provider will not be covered unless it's for emergency care[,] [and] urgent care received outside of a Blue HPN® geographic area [or for services approved in advance as authorized services]. The cost for services received from a nonparticipating Blue HPN® provider is determined by the contractual status between the Host Blue and the nonparticipating Blue HPN® provider.)

If you do not see a Participating Provider through the BlueCard Program, you will have to pay for the entire bill for your medical care and submit a claim form to the local Blue Cross and/or Blue Shield plan or to the Administrator for payment. The Administrator will notify you of its determination within 30 days after receipt of the claim. The Administrator or CLIENT NAME] will pay you at the Non-Preferred Provider Benefit level.
Remember, your Copayment is higher when you see a Non-Preferred Provider. You will be responsible for paying the entire difference between the amount paid by the Administrator and the amount billed.

Charges for Services which are not covered, and charges by Non-Preferred Providers in excess of the amount covered by the Plan, are the Participant's responsibility and are not included in

Copayment calculations.
To receive the maximum Benefits of your Plan, please follow the procedure below.
When you require Covered Services while traveling outside of California:
1. call BlueCard Access® at 1-800-810-BLUE (2583) to locate Physicians and Hospitals that participate with the local Blue Cross and/or Blue Shield plan, or go on-line at www.bcbs.com and select the “Find a Doctor or Hospital” tab; and,
2. visit the Participating Physician or Hospital and present your membership card.
The Participating Physician or Hospital will verify your eligibility and coverage information by calling BlueCard Eligibility at 1-800-676-BLUE. Once verified and after Services are provided, a claim is submitted electronically and the Participating Physician or Hospital is paid directly.
You may be asked to pay for your applicable Copayment and Plan Deductible at the time you receive the service.
You will receive an Explanation of Benefits which will show your payment responsibility. You are responsible for the Copayment and Plan Deductible amounts shown in the Explanation of Benefits.
Prior authorization is required for all Inpatient Hospital Services and notification is required for Inpatient Emergency Services. Prior authorization is required for selected Inpatient and Outpatient Services, supplies and Durable Medical Equipment. To receive prior authorization from the Administrator, the out-of-area provider should call the customer service number noted on the back of your identification card.
If you need Emergency Services, you should seek immediate care from the nearest medical facility. The Benefits of this Plan will be provided for Covered Services received anywhere in the world for emergency care of an illness or injury.
Care for Covered Urgent Care and Emergency Services Outside the United States

Benefits will also be provided for covered urgent and emergent services received outside of the United States, Puerto Rico, and U.S. Virgin Islands. If you need urgent care while out of the country, call the BlueCard Worldwide Service Center at either the toll-free BlueCard Access number (1-800-810-2583) or collect (1-804-673-1177), 24 hours a day, seven days a week. In an emergency, go directly to the nearest hospital. If your coverage requires precertification or prior authorization, you should also call the Administrator at the customer service number noted on the back of your identification card. For inpatient hospital care, contact the BlueCard Worldwide Service Center to arrange cashless access. If cashless access is arranged, you are responsible for the usual out-of-pocket expenses (non-covered charges, Deductibles, and Copayments). If cashless access is not arranged, you will have to pay the entire bill for your medical care and submit a claim to the BlueCard Worldwide Service Center. When you receive services from a physician, you will have to pay the doctor and then submit a claim.
Before traveling abroad, call your local Customer Service office for the most current listing of providers world-wide or you can go on-line at www.bcbs.com and select “Find a Doctor or Hospital” and “BlueCard Worldwide.”
BlueCard Program

Under the BlueCard® Program, when you obtain Covered Services within the geographic area served by a Host Plan, the Plan will remain responsible for any payment due, excluding the Participant's liability (e.g., Copayment and Plan Deductible amounts shown in the Benefits Amendment]\). However the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

The BlueCard Program enables you to obtain Covered Services outside of California, as defined, from a healthcare provider participating with a Host Plan, where available. The participating healthcare provider will automatically file a claim for the Covered Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the member copayment and deductible amounts, if any, as stated in this [SPD/Amendment].

Whenever you access Covered Services outside of California and the claim is processed through the BlueCard Program, the amount you pay for Covered Services, if not a flat dollar copayment, is calculated based on the lower of:

1. The billed covered charges for your Covered Services; or
2. The negotiated price that the Host Plan makes available to Blue Shield of California.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Plan pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price the Administrator uses for your claim because they will not be applied
retroactively to claims already paid.

Laws in a small number of states may require the Host Plan to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any Covered Services according to applicable law.

Claims for Covered Services are paid based on the Allowable Amount as defined in this Amendment.

Appendix B: Additional Information about Gender Affirming Services

Gender Affirmation Benefits

The Plan covers gender affirmation services for the treatment of gender dysphoria.
Services and supplies are provided in connection with gender affirmation when the following criteria are met:

- A documented diagnosis of gender dysphoria including all of the following:
  - A strong desire to be treated as a gender other than that assigned; and
  - Disorder is not a symptom of another mental disorder (e.g., schizophrenia); and
  - Disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Coverage includes Medically Necessary services when criteria are met including, but not limited to:

- Gender affirmation surgery;
- Hormone therapy;
- Psychotherapy;
- Speech therapy;
- Vocal modification surgery; and
- Other cosmetic procedures if medically necessary and associated with an approved gender affirmation treatment plan.

This coverage is provided according to the terms and conditions of the plan, including Medical Necessity requirements and utilization management. For more information, please refer to the Medical Management section in the SPD for details about prior authorization, and the Exclusions and Limitations section for benefit exclusions and limitations.