Annual Notices

Eligible Employees and Beneficiaries of Welfare Benefit Plan 2024 sponsored by Highmark Companies, LLC

PREPARED BY AND PROVIDED EXCLUSIVELY TO CLIENTS OF

MAIN STREET
EST. 1898

Electronic Notice Disclosure

These Annual Notices provide important information to eligible employees and beneficiaries of the various benefits offered by Highmark Companies, LLC through the Plan. If you received these annual notices electronically, you have the right to request and obtain a paper version of such document, and you will receive a paper copy at no cost to you. Please contact Courtney Akers at (919)803-5848 or cakers@highmarkcompanies.com to make that request.

Contents

You may access copies of plan benefit descriptions and/or certificates of coverage (where applicable) online at:

Your benefit administration system or see employer.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 7 for more details.

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 t**o find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

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

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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+)	FLORIDA – Medicaid
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	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – 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	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – 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://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**

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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	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	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	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, 2023, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

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

Notice of Grandfathered Group Health Plan

Name of Plan Sponsor: Highmark Companies, LLC

Date of Notice: August 01, 2024

Grandfathered Status for Current Plan Year: NON-GRANDFATHERED

The health plan provided by the Plan Sponsor listed above for the eligible participants is NON-GRANDFATHERED under the federal Patient Protection and Affordable Care Act (PPACA).

Courtney Akers

Requests for further information or questions (such as which protections apply to Courtney Akers Non-Grandfathered health plan and how a change in plan status affects employees) about this notice can be directed to the individual listed below or you may also contact the Employee Benefits Security Administration, which is a part of the U.S. Department of Labor at 1-866-444-3272 or visit their website at www.dol.gov/ebsa/healthreform.

If you have any questions on these notices, please contact:
Courtney Akers
(919)803-5848
cakers@highmarkcompanies.com

Health Insurance Marketplace Notice

Your Health Coverage and Coverage Options

Form Approved
OMB No. 1210-0149
(expires 8-31-2023)

For Employees of Highmark Companies, LLC

Introduction

Since key parts of the health care law went into effect in 2014, there has been a new way to buy health insurance: Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by Highmark Companies, LLC.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. The most recent annual open enrollment for health insurance coverage through the Marketplace ended on January 15, 2023. The enrollment period for 2024 is expected to be open for 2024 between November 1, 2023, and January 15, 2024. However, in some situations, you may be eligible to enroll in the Marketplace if there was a Special Enrollment Event.

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

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

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of the lowest-cost medical plan offered of a plan from your employer that would cover just you as an employee is more than 9.12% for calendar year 2023 of your household income, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs).

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

Under new rules for 2023, the members of your family (spouse and/or tax-dependent children) could be eligible for subsidized coverage through the Marketplace even if the coverage offered to you meets the affordability standard referenced above. If the cost of covering your spouse and/or children exceeds 9.12% of your household income, then they may be eligible for subsidized coverage. Use the contact information below to be connected with an agent who can help you look at your options.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your Summary of Benefits and Coverage or contact Courtney Akers at (919)803-5848 or cakers@highmarkcompanies.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** 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 **Highmark Companies, LLC**	4. Employer Identification Number (EIN) **20-1838009**	
5. Employer address **PO Box 5459**	6. Employer phone number **(919)803-5848**	
7. City **Cary**	8. State **NC**	9. ZIP code **27512**
10. Who can we contact about employee health coverage at this job? **Courtney Akers**		
11. Phone number (if different from above) **(919)803-5848**	12. Email address **cakers@highmarkcompanies.com**	

Here is some basic information about health coverage offered by Highmark Companies, LLC:
As your employer, we offer a health plan to:

☐ OPTION 1: All employees.

☒ OPTION 2: Some employees. Eligible employees are: Those employees who work, on average, 30 or more hours per week.

With respect to dependents:

☒ OPTION 1: We do offer coverage. Eligible dependents are: Legally married spouse, same and opposite sex domestic partner, and children up to the age of 26

☐ OPTION 2: We do not offer coverage to dependents.

Based on the information available at the time of preparation of this Notice, the health benefits provided by Highmark Companies, LLC meets the minimum value standard, and the cost of this coverage to you does not exceed the maximum allowable 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), or you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

As a result, employees in the group health benefits sponsored by Highmark Companies, LLC are likely not eligible for premium subsidies in the Marketplace. Effective, January 1, 2023, eligible dependents who are eligible to participate in the group health plan offered by Highmark Companies, LLC (whether enrolled or not) may still be eligible for subsidized coverage through the Marketplace if the cost for those eligible dependents under the lowest-cost employer-

sponsored plan exceeds 9.12% of the household income. However, if an eligible dependent has access to a group health plan through their employer (whether enrolled or not), and chooses not to participate in that employer-sponsored plan, that dependent may not be eligible for subsidized coverage through the exchange.

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

You may also contact Aaron Bender of Main Street Insurance Group at 877-872-4578 or abender@mainstreetins.com to help walk you through the process to determine eligibility.

Medicare Part D Notice

Important Notice About Your Prescription Drug Coverage and Medicare

All employers who offer a group health plan that provides pharmacy coverage are required to send a notice to all plan participants who are eligible for Medicare about your options under Medicare's prescription drug coverage. Because we do not track which of our employees or if your dependents are eligible for Medicare, we are meeting this obligation by providing this notice to all employees who are eligible for our benefits program. This notice does not apply to you if you or your dependents are not Medicare eligible. If you or a covered dependent are Medicare eligible, or will become Medicare eligible during this Plan Year or the next calendar year, this notice is important to you and contains important, time sensitive information which could help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Please read it carefully, keep it where you can find it and act to protect your interests.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Based on the standards established by CMS, we have determined that the prescription drug coverage offered as part of the Highmark Companies, LLC group health and prescription drug plan is, on average for all plan participants, to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

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

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

Date:	August 01, 2024
Name of Entity/Sender:	Highmark Companies, LLC
Contact--Position/Office:	Courtney Akers
Address:	PO Box 5459
	Cary, NC 27512
Phone Number:	(919)803-5848

Annual Notices Required by Applicable Law

No Pre-Existing Condition Provisions

With the passage and implementation of the Affordable Care Act, individual and group health plans are prohibited from containing pre-existing condition limitations at renewals that occur on or after January 1, 2014. This group health plan does not restrict coverage for medical conditions present before an individual's enrollment.

Notice of Special Enrollment and Nondiscrimination Rights under HIPAA

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

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 dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact Courtney Akers at (919)803-5848 or cakers@highmarkcompanies.com.

- ➔ Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

Prohibition against discrimination based on a health factor. Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

For more information. If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at 1-866-444-3272 (for free HIPAA publications ask for publications concerning changes in health care laws). You may also contact the CMS publication hotline at 1-800-633-4227 (ask for "Protecting Your Health Insurance Coverage"). These publications and other useful information are also available on the Internet at: http://www.dol.gov/ebsa, the DOL's interactive web pages - Health *E*laws, or **http://www.cms.gov/Regulations-and-Guidance/Health-Insurance-Reform/HealthInsReformforConsume/index.html.**

Newborn and Mothers' Health Protection Act Notice

Under Federal and state law you have certain rights and protections regarding your maternity benefits under the Plan. Under the "Newborns' and Mothers' Health Protection Act of 1996" (Newborns' Act) group health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting

with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Waiting Period Protection for Rehires

For Applicable Large Employers Only: Under the Employer Shared Responsibility Penalty regulations adopted in accordance with the Affordable Care Act, Highmark Companies, LLC will waive waiting periods for previously eligible employees who were rehired to a full-time eligible position within 13 weeks (26 for educational institutions such as schools) of the date of their termination.

Women's Health and Cancer Rights Act Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at (919)803-5848 for more information.

Women's Preventative Health Services

The following women's health services will be considered preventative and will generally be covered without a member cost share when using an in-network provider:

- Annual well-woman visits
- Routine preventative prenatal visits
- Breastfeeding support, supplies and counseling
- Gestational diabetes screening
- Human papillomavirus (HPV) DNA testing
- Sexually transmitted infections screening/counseling
- Human immunodeficiency virus (HIV) screening/counseling
- Interpersonal and domestic violence screening/counseling
- Generic formulary contraceptives, certain brand formulary contraceptives, and FDA-approved over the counter female contraceptives with prescription are covered without a member cost share. Certain religious organizations or employers may be exempt from offering contraceptive services and therefore not be covered under the employer sponsored health plan.

Mental Health Parity & Addiction Equity Act Notice

The Mental Health Parity & Addiction Equity Act (MHPAEA), as amended by the Patient Protection and Affordable Care Act (the Affordable Care Act), generally requires that group health plans and health insurance issuers offering group or individual health insurance coverage ensure that the financial requirements and treatment limitations on mental health or substance use disorder (MH/SUD) benefits they provide are no more restrictive than those on medical or surgical benefits. This is commonly referred to as providing MH/SUD benefits in parity with medical/surgical benefits.

MHPAEA generally applies to group health plans that provide coverage for MH/SUD benefits in addition to medical/surgical benefits.

DOL has primary enforcement authority with regard to MHPAEA over private sector employment-based group health plans, while HHS has primary enforcement authority over nonfederal governmental group health plans, such as those sponsored by state and local government employers. HHS also has primary enforcement authority for MHPAEA over issuers selling products in the individual and fully insured group markets in states that have notified HHS' Centers for Medicare & Medicaid Services that they do not have the authority to enforce or are not otherwise enforcing MHPAEA. In all other states, generally the state is responsible for directly enforcing MHPAEA with respect to issuers.

Unless a plan is otherwise exempt, MHPAEA generally applies to both grandfathered and non-grandfathered group health plans and large group health insurance coverage. Also, the Affordable Care Act requires all issuers offering coverage in the individual and small group markets to cover certain essential health benefits (EHB), including MH/SUD benefits. Final

rules issued by HHS implementing EHB requirements specify that MH/SUD benefits must be consistent with the requirements of the MHPAEA regulations. See 45 CFR 156.115(a)(3).

Under the MHPAEA regulations, if a plan or issuer provides MH/SUD benefits in any classification described in the MHPAEA final regulation, MH/SUD benefits must be provided in every classification in which medical/surgical benefits are provided. Under PHS Act section 2713, as added by the Affordable Care Act, non-grandfathered group health plans are required to cover certain preventive services with no cost-sharing, which include, among other things, alcohol misuse screening and counseling, depression screening, and tobacco use screening. However, the MHPAEA regulations do not require a group health plan or a health insurance issuer that provides MH/SUD benefits only to the extent required under PHS Act section 2713, to provide additional MH/SUD benefits in any classification.

Highmark Companies, LLC is compliant with the MHPAEA requirements for the current plan year.

Michelle's Law Notice

Beginning January 1, 2010, if you have a dependent child older than age 18 who is enrolled at a post-secondary institution (e.g., college or university) on a full-time basis, he or she may be eligible to continue to be covered as a dependent if he or she loses full-time student status due to a serious injury or illness. In order to be eligible to continue coverage as a dependent under Michelle's Law:

- the dependent child must be enrolled in our group health plan based on full-time student status immediately before the first day of the medically necessary leave of absence;
- a doctor's written certification of the medically necessary leave of absence must be submitted to the health insurer; and
- proof of full-time student status before the leave of absence may also be required to be submitted to the health insurer.

Continued dependent coverage will be extended for at least one year after the first day of the leave of absence, but may end earlier if the dependent child does not meet the dependent eligibility requirements under our group health plan, such as meeting the limiting age for dependent eligibility under the plan. If dependent coverage under Michelle's Law ends, the dependent may be eligible for continuation coverage under the provisions of our group health plan.

If an eligible dependent remains enrolled in our group health plan under Michelle's Law, the dependent child will continue to be in the same medical benefit options that he or she was in prior to the medical leave of absence.

To obtain additional information about Michelle's Law, please contact:

Courtney Akers, Highmark Companies, LLC
PO Box 5459
Cary, NC 27512
(919)803-5848
cakers@highmarkcompanies.com

Rescission of Coverage

Coverage may only be rescinded (meaning coverage retroactively revoked) due to fraud, intentional misrepresentation of a material fact, or due to failure to pay premiums. A 30-day advance notice is now required before coverage can be rescinded.

Notice on Dependent Child Coverage to Age 26

Name of Plan Sponsor: Highmark Companies, LLC
Date of Notice: August 01,2024
Under the Patient Protection and Affordable Care Act ("PPACA"), health plans are now required to offer dependent coverage for all children of enrolled employees up to age 26. This notice is being furnished to you in compliance with the requirements of the law.

- Children under age 26 who were not eligible, or whose coverage ended due to an age limitation or due to marriage, are eligible to enroll or re-enroll in the plan. Coverage begins on the first day of the plan year beginning thereafter.

- Children under age 26 are eligible for coverage without regard to student status, marital status, primary residence status, tax dependent status, or the amount of financial support from the parent.
- Coverage/premiums for children under age 26 will be the same as that offered to other dependent children.
- Coverage will end at the end of the month in which the child turns 26 years of age, or until coverage otherwise terminates as defined by the plan.

If you have any questions, or need the form to enroll a dependent child, please contact:

Courtney Akers
(919)803-5848
cakers@highmarkcompanies.com

Qualified Medical Support Order (QMSO) Notice

In accordance with federal law, Highmark Companies, LLC is required to comply with valid state or federal court orders related to extending health care coverage to the children of an eligible parent-employee who is not currently covered on the group health (meaning health, dental and/or vision, as applicable) plan offered by Highmark Companies, LLC (known as Qualified Medical Support Orders (QMSO) or National Medical Support Notice (NMSN)). Compliance with these requirements may, depending on the terms and conditions of the various benefit plans offered under the Plan, necessitate the enrollment of an employee who is not enrolled at the time of the order. Highmark Companies, LLC has adopted procedures to comply with QMSOs that are received from a court with valid jurisdiction and that also satisfy requirements that may also existed under applicable state law. A copy of these procedures may be obtained at no cost by contacting Courtney Akers by phone at (919)803-5848 or by email at cakers@highmarkcompanies.com.

Family & Medical Leave Act Compliance & Related or Similar State or Local Laws

Where applicable, Highmark Companies, LLC will comply with relevant federal, state or local laws related to leave, which may be paid or unpaid depending on state or local law, related to family or medical purposes. Highmark Companies, LLC shall provide posted notice of their obligations which are not included in this Annual Notice Packet. However, to the extent such leave (if available to an eligible, enrolled employee) requires the continuation of applicable benefits, Highmark Companies, LLC shall comply with those obligations as provided under the law.

Patient Protection Disclosure

Highmark Companies, LLC sponsors a Group Health Plan that may, in some situations, require or allow a beneficiary to designate a primary care provider. In the event that the ability or requirement to designate a primary care provider is a component of the benefit package:

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

You do not need prior authorization from the Group Health 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.

Until you make this designation, the claims administrator will designate one for you. For information on how to select a primary care provider, and to verify that the need or the option to designate a primary care physician applies to your benefits, as well as for a list of the participating primary care providers, contact the Courtney Akers at (919)803-5848 or cakers@highmarkcompanies.com.

Life Insurance Conversion Rights

What is the conversion privilege? The right of an individual insured under the Highmark Companies, LLC's Group Life Insurance policy to replace all or part of the Life Insurance Benefit with an individual policy if all or part of his coverage under the group policy terminates. No medical examination or other evidence of good health is required for a conversion policy.

The converted policy will be effective 31 days after coverage under the group policy terminates. This 31-day period is referred to as the conversion period. The group policy and your certificate may specify a different conversion period. If a person insured under the group policy dies within the conversion period, any death benefit provided by the group policy will be paid.

When can you convert? An individual eligible to convert, as described below, can convert during the conversion period, which follows immediately after the date s/he ceases to be eligible under the group policy.

Who is eligible to convert?

1. An Insured whose Life Insurance ends for any reason except for nonpayment of premiums is eligible to convert. If coverage ends because the group policy terminates, or because the class of insureds to which the insured belongs is

terminated, the additional limitations, described below, apply.

2. An Insured whose Life Insurance is reduced or terminated because of age, retirement, or change in benefit amounts, is eligible to convert the amount reduced or terminated.
3. An Insured's covered dependent may convert if the dependent ceases to be eligible because the insured ceases to be eligible, or because the dependent ceases to be an eligible dependent, as defined in the Group Policy. Each dependent eligible to convert must complete an application for an individual policy.

How much can be converted?

1. An insured employee or an insured dependent, whose coverage terminates because the employee or the dependent ceases to be eligible under the group policy, may convert up to the amount of coverage terminating under the group policy.
2. If the group policy terminates, or if coverage for a class of employees terminates, insured employees and dependents who were covered under the group life insurance policy for at least three years may convert $10,000 or the amount of terminating group insurance, if less. Insurance regulations in some states require that an insured be permitted to convert after being insured under the group policy for a shorter period, or be permitted to convert a greater amount of terminating coverage. Please consult your Group Insurance Certificate or your Plan Administrator for details of your eligibility and amounts of coverage available to you.

Who receives the insurance benefits in the event of the insured's death? The beneficiary(ies) named on the application will receive the death benefit of the insured person. If one person, the Primary Beneficiary, is named, that individual will receive the entire death benefit. If two or more persons are named, they will share equally in the death benefit unless a percentage is specified for each individual. A contingent beneficiary who will receive the benefits in case the Primary Beneficiary should die before or at the same time as the insured, may also be named. This should be indicated in a manner similar to this:

Primary Beneficiary: Marilyn Smith, wife*

Contingent Beneficiary: William P. Smith, Jr., son

** If a beneficiary is a married woman, use her given name, for example, Mary J. Smith and not Mrs. William Smith. If there is no relationship between the insured and the beneficiary, the application should indicate "no relationship" and the beneficiary's address and social security number must be entered on the application.*

What type of policy can you convert to? Conversion may be to any permanent Life Insurance Policy, except term insurance. Benefits other than pure life insurance (such as Waiver of Premium, AD&D or Accelerated Benefits) is not included in the individual policy (unless specified in the group contract).

How to apply for conversion

1. Complete Notice of the Right to Covert form (included within the Life Insurance Conversion packet in the group life insurance policy – you may need to request from your employer).
2. Select the amount of insurance you want to convert and indicate this amount on the application.
3. Calculate your premium for the amount you selected.
4. Send the completed application and premium payment to the address indicated in the packet. The premium payment should be by check or money order (do not send cash) and made payable as indicated in the packet.

GINA Notice

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by law.

To comply with this law, we are asking that you not provide any genetic information when responding to any request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact than an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. Further, you will not be subject to any adverse employment or benefit eligibility for failure to provide genetic information to your employer or group health plan.

USERRA Notice

The Uniformed Services Employment and Re-Employment Rights Act of 1994 ("USERRA") established requirements that employers must meet for certain Employees who are involved in the Uniformed Services (defined below). In addition to the rights that you have under COBRA (described in the section on COBRA), you are entitled under USERRA to continue the coverage you had under this Plan.

Your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to the continuation coverage elected. If COBRA and USERRA give you (or your covered Spouse or Children) different rights or protections, the law that provides the greater benefit will apply. The administrative policies and procedures described in the COBRA section (for example, the procedures for how to elect COBRA coverage and for paying premiums for COBRA coverage) also apply to USERRA coverage. COBRA and USERRA coverage run concurrently.

"Uniformed Services" means the U.S. Armed Services (including the Coast Guard), the Army National Guard and the Air National Guard (when engaged in active duty for training, inactive duty training or Full-Time National Guard duty), and the commissioned corps of the Public Health Service. Moreover, the President is authorized to expand the categories of Uniformed Services through the exercise of emergency or war powers.

"Service in the Uniformed Services" or "Service" means the performance of duty on a voluntary or involuntary basis in the Uniformed Services under competent authority, including active duty, active duty for training, inactive duty training, Full-Time National Guard duty and the time necessary for a person to be absent from employment for an examination to determine the fitness of the person to perform any of these duties.

Duration of USERRA Coverage and Premium Payments

General rule: 24-month maximum. When a Covered Person takes a leave for Service in the Uniformed Services, USERRA coverage for the Employee (and covered Spouses and Children for whom coverage is elected) begins the day after the Employee loses coverage under the Plan, and it continues for up to twenty-four (24) months. There are situations in which USERRA coverage will terminate before the maximum USERRA period expires.

COBRA and USERRA coverage are concurrent. This means that both COBRA coverage and USERRA coverage begin upon commencement of the Employee's leave, and COBRA coverage continues for up to eighteen (18) months while USERRA coverage continues for up to twenty-four (24) months, up to six (6) months longer than COBRA. COBRA coverage (but not USERRA coverage) may continue for longer, as described in the COBRA section. For example, George takes a Leave of Absence for service in the Uniformed Services beginning on August 1, 2006. George elects COBRA/USERRA continuation coverage and pays the required one hundred two percent (102%) of the premium each month for the next eighteen (18) months. Although George's COBRA coverage would terminate at the end of this eighteen (18) month period, USERRA coverage could continue for another six (6) months, unless coverage is terminated earlier due to non-payment of premiums or other permitted event.

If you elect to continue your health coverage (or your Spouse or Children's coverage) pursuant to USERRA, you will be required to pay one hundred two percent (102%) of the full premium for the coverage elected (the same rate as COBRA). However, if your Uniformed Service Leave of Absence is less than thirty-one (31) days, you are not required to pay more than the amount that you pay as an active Employee for that coverage.

Notice Informing Individuals About Nondiscrimination and Accessibility Requirements and Nondiscrimination Statement

Discrimination is Against the Law. Highmark Companies, LLC complies with applicable Federal civil rights laws and does not discriminate and does not exclude people or treat them differently on the basis of race, color, national origin, age, disability, or sex. Highmark Companies, LLC provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, contact Courtney Akers at cakers@highmarkcompanies.com or (919)803-5848.

If you believe that Highmark Companies, LLC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail, fax, or email with:

Courtney Akers
Highmark Companies, LLC
PO Box 5459
Cary, NC 27512
cakers@highmarkcompanies.com
(919)803-5848

If you need help filing a grievance, Courtney Akers is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, DC 20201
800-868-1019
800-537-7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html.**

Preventative Care

Health plans will provide in-network, first dollar coverage, without cost-sharing for preventative services and immunizations as determined under health care reform regulations. These include, but not limited to, cancer screenings, well-baby visits and influenza vaccines. For a complete list of covered services, visit: **www.HealthCare.gov/coverage/preventive-care-benefits.**

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 balanced 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 the federal phone number for information and complaints at 1-800-985-3059].*

Visit *www.cms.gov/nosurprises/consumers* for more information about your rights under federal law.

HIPAA Notice of Privacy Practices for Personal Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND RETAIN A COPY FOR YOUR RECORDS.

Dear Employee:

This is your Notice of Privacy Practices from Highmark Companies, LLC Welfare Benefits Plan ("Plan"). Please read it carefully. The Plan strongly believes in protecting the confidentiality and security of information we collect about you. This notice refers to the Plan as "us", "we", or "our".

This notice describes how we protect the protected health information we have about you which relates to your Plan's benefits and how we may use and disclose this information. Protected Health Information includes individually identifiable information that relates to your past, present or future health, treatment or payment for health care services. This notice also describes your rights with respect to your Protected Health Information and how you can exercise those rights.

NOTICE OF PRIVACY PRACTICES

Under applicable law, the Plan is required to protect the privacy of your individual health information (which we refer to in this notice as "Protected Health Information" or "PHI"). PHI includes all information that relates to the past, present, or future physical or mental health of an individual; the provision of health care to an individual; and the past, present, or future payment for the provision of health care to an individual. We are required to provide you with this notice regarding our policies and procedures regarding your Protected Health Information, and to abide by the terms of this notice, as it may be updated from time to time.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We are permitted to make certain types of uses and disclosures under applicable law for treatment, payment, and healthcare operations purposes without obtaining your authorization.

For treatment purposes, we may use and disclose your PHI for the purpose of providing, coordinating, or managing the delivery of healthcare services to you by one or more healthcare providers, including doctors, nurses, technicians, medical students or other hospital personnel who are involved in taking care of you. For example, your primary care physician may consult with us regarding your condition or treatment. We do not limit the use or disclosure of your PHI for purposes of your care or treatment. Otherwise, we limit use and disclosure of PHI to that which is reasonably necessary for a permitted purpose. Disclosure for the work-related purposes (such as job-specific purposes permitted by the ADA, workplace safety and drug testing, or under the Family Medical Leave Act, if applicable), or for claims for benefits under workers' compensation or disability are not protected by HIPAA or this notice.

For payment purposes, we may use and disclose your PHI to obtain payment or reimbursement for providing healthcare services, such as when we request payment from your insurer, health plan, or a government benefit program.

For healthcare operations purposes, we may use and disclose your PHI internally in a number of ways, including for quality assessment and improvement, for planning and development, management, and administration. Your information could be used, for example, to assist in the evaluation of the quality of services that you were provided. Healthcare operations also includes conducting training programs in which students, trainees or practitioners in areas of health care learn under supervision to practice or improve their skills.

- In addition, we may contact you to provide reminders or information about health-related benefits and services that may be of interest to you.
- Where applicable, we may disclose your health information to your health plan sponsor. This applies to a group health plan, a health insurance issuer, or a Health Maintenance Organization (HMO) with respect to a group health plan, and solely for the plan administration purposes and then only to those individuals who been

designated to have access to the information, and who are aware of their special responsibilities to protect your PHI.

We may use and disclose your PHI, without your authorization, for treatment, payment, and health care operations purposes, with health care providers, health plans, and those that process health care claims, benefits and related information. We are also permitted to share your PHI, without your authorization, in the other limited instances.

We may also use or disclosure your PHI as permitted or required by law, including, for example:

- To public health authorities for the purposes of preventing or controlling disease or other public health needs;
- To appropriate government authorities to report incidents of suspected abuse, neglect, or domestic violence;
- To the Food and Drug Administration to report quality, safety, or effectiveness of the FDA-regulated products or activities;
- To qualified health authorities for purposes of conducting health oversight activities;
- In response to subpoenas, discovery requests, or other lawful legal processes in the course of a judicial or administrative proceeding;
- To law enforcement authorities as required or permitted by law such as, for example, to report a death, to report a crime on our premises, or if it appears necessary to alert law enforcement to respond to an emergency;
- To persons involved with respect to matters pertaining to a decedent, or relating to cadaveric organ, eye or tissue donation;
- In certain instances, for research purposes;
- We may disclose your PHI if we believe, in good faith, that it is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and
- We may disclose your PHI for certain specialized government functions such as, for example, to Armed Forces Authorities with reference to military personnel or for national security purposes.

Unless you object, we may also disclose to a member of your family or other relative, to a close personal friend, or to any other person identified by you, PHI that is directly relevant to that person's involvement with your care or payment related to your care. In addition, unless you object, orally or in writing, to another employee or our Privacy Officer, we may use or disclose the PHI to notify, identify, or locate a member of your family, your personal representative, another person responsible for your care, or certain disaster relief agencies of your location, general condition, or death. If you are incapacitated, there is an emergency, or you otherwise do not have the opportunity to object to this use or disclosure, we will do what in our judgment is in your best interest regarding such disclosure and will disclose only the information that is directly relevant to the person's involvement with your healthcare. We will also use our judgment and experience regarding your best interest in allowing people to pick up filled prescriptions, medical supplies, test results, or other similar actions involving disclosure of PHI.

Other uses and disclosures will be made only with your written authorization, and you may revoke your authorization by notifying us by contacting our Privacy Officer as described below. We may not sell your protected health information.

Contact Information. We are required to provide this Notice to you by the Health Insurance Portability and Accountability Act (HIPAA). For additional information regarding our HIPAA Medical Information Privacy Policy or our general privacy policies, please contact Courtney Akers, or you may submit questions in writing directly to:

Highmark Companies, LLC Welfare Benefit Plan
Courtney Akers
PO Box 5459 Cary, NC 27512

Changes to This Notice: We reserve the right to change the terms of this notice at any time. We reserve the right to make the revised or changed notice effective for PHI we already have about you as well as any PHI we receive in the future. You will receive a copy of any revised notice from the Plan by mail, email, hand delivery or other appropriate means.

DESIGNATION OF PRIVACY AND SECURITY OFFICERS

Employer designates the following as the Privacy & Security Officer for its health care components:

Courtney Akers
(919)803-5848
cakers@highmarkcompanies.com

Employer has designated the Privacy & Security Officer for its Group Health Plans, which is contained in the HIPAA Notice of Privacy Practices found in this Annual Notice Packet. Please refer to that document for details.
For any questions about Employer's compliance with applicable HIPAA or state privacy and security laws and regulations regarding individually identifiable health information, please contact one of these officers.

NON-RETALIATION POLICY

Employer, its health care components and personnel shall not intimidate, threaten, coerce, discrimination against, or take other retaliatory action against anyone for exercising his/her right under the privacy regulations or participating in any process established by the privacy regulations; nor for filing a complaint, participating in an investigation or audit or review proceeding conducted by Employer or a government agency under the privacy regulations, or opposing any act or practice made unlawful by the privacy regulations. Any individual who believes that some form of retaliation under the privacy regulations has occurred or is occurring should report such concern to the relevant privacy officer designated above. The privacy officer will then conduct an investigation and, if the retaliation is substantiated, will impose sanctions in accordance with Employer’s confidentiality and information security policies.

Highmark Companies, LLC Welfare Benefits Plan
Summary Plan Description

Amended and Restated Effective
August 01,2024

1. Definitions

Capitalized terms used in the Plan have the following meanings:

"Code" means the Internal Revenue Code of 1986, as amended.

"Employee" means any common-law employee of the Plan Sponsor who satisfies the eligibility provisions of Section 4 and who is not excluded from participation by the terms of an applicable component benefit program.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"Plan" means Highmark Companies, LLC Welfare Benefits Plan.

"Plan Administrator" means Highmark Companies, LLC.

"Plan Sponsor" means Highmark Companies, LLC, or any successor thereto.

"USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994.

2. Introduction

The Plan Sponsor maintains the Plan for the exclusive benefit of its eligible employees and eligible dependents. The Plan provides benefits through the following component benefit programs:

Benefit	Included in Wrap Plan?	How Funded?	Vendor
Premium Only Conversion (POP) Plan	Yes	N/A	Main Street Insurance
Group Health Benefits	Yes	Self-Funded	Cigna
Group Dental Benefits	Yes	Fully-Insured	Cigna
Group Term Life Benefits	Yes	Fully-Insured	Mutual of Omaha
Vision Benefits	Yes	Fully-Insured	Cigna
Group Short-Term Disability Benefits	Yes	Fully-Insured	Mutual of Omaha
Group Long-Term Disability Benefits	Yes	Fully-Insured	Mutual of Omaha
Flexible Spending Accounts	Yes	Self-Funded	Flores
Dependent Care Flexible Spending Accounts	Yes	Self-Funded	Flores
Health Reimbursement Arrangement	No		
Cancer, Hospital Indemnity, Critical Illness	No		

Each of the component benefit programs is summarized by a certificate of insurance booklet issued by an insurer, a summary plan description (SPD) prepared specifically for that component benefit program, or another written governing document prepared by the Plan Sponsor. Some of these component benefit programs require completion of application forms, annual elections, and/or other administrative forms.

Note: Not all of the component benefit programs are subject to ERISA. They are described as part of the Plan for

purposes of convenience and because there may be other applicable laws (for example, the Internal Revenue Code) that require a written document.

Purpose of This Wrap SPD Document

You are being provided this document to give you an overview of the Plan and to address certain information that may not be addressed in Documents contained in the above URL. This document, together with the documents contained in the URL, is the SPD required by ERISA §102, but you must read the Documents and this Wrap SPD together to understand your benefits. This document is not intended to give you any substantive rights to benefits that are not already provided by the Documents. If you want to receive paper copies of the Documents contained in the above URL, contact the Human Resources Manager of Highmark Companies, LLC.

Electronic Forms

To facilitate efficient operation of the Plan, the Plan may allow forms (including, for example, election forms and notices), whether required or permissive, to be sent and/or made by electronic means.

3. General Information About the Plan

Plan Name

Highmark Companies, LLC Welfare Benefits Plan

Type of Plan

The Plan is a welfare plan that provides those benefits identified in Section 2. Note: The Plan may also include benefits under other tax code sections (e.g., premium only conversion under Code §125), which are not subject to ERISA.

Plan Year

The Plan Year begins August 01,2024 and ends July 31,2025, and for each twelve-month period thereafter.

Plan Number

The Plan number is 501.

Effective Date

The effective date of the Plan amendment/restatement is August 01,2024. The Plan has been amended several times since its original effective date of November 01,2023.

Plan Sponsor

Highmark Companies, LLC
PO Box 5459
Cary, NC 27512
(919)803-5848

Employer Identification Number: 20-1838009

Funding Medium and Type of Plan Administration

Some benefits under the Plan are self-funded, and other benefits are fully insured (as listed in Section 2 of this Wrap Plan SPD). The Plan Sponsor and the insurers (as indicated) share responsibility for administering the component benefit programs under the Plan.

The Plan Sponsor is responsible for paying claims with respect to the self-funded component benefit programs. The insurers, not the Plan Sponsor, are responsible for paying claims with respect to the insured component benefit programs.

Insurance premiums for employees and their eligible family members are paid in part by the Plan Sponsor out of its general assets and in part by employees on a pre-tax basis. The Plan Administrator provides a schedule of the applicable premiums during the initial and subsequent open enrollment periods and upon request for each of the component benefit programs, as applicable. Contributions for the self-funded component benefit programs are also made by

employees on a pre-tax basis through the cafeteria plan component benefit program under the Plan. Neither the Plan nor any of the component benefit programs offered through it have a trust.

Service Providers

Benefits are provided through third party administration for the following lines of coverage:

Health Equity Lines of Coverage: HSA
15 W. Scenic Pointe Dr.
Draper, UT 84020
(866) 346-5800
Website: www.healthequity.com

Flores & Associates Lines of Coverage: Flexible Spending Account
1218 S. Church Street
Charlotte, NC 28203
Phone: 800-532-3327
Fax: 800-726-9982 Website: www.flores247.com

Insurers

Benefits are provided through insurance contracts with the Insurers listed below.

Cigna Lines of Coverage: Health Plan Administration, Dental, Vision
900 Cottage Grove Rd. (including pharmacy benefit) Bloomfield, CT 06002
Phone: 800-997-1654
Website: www.cigna.com

Mutual of Omaha Lines of Coverage: Life/AD&D, STD, LTD, GEAP
3300 Mutual of Omaha Plaza and Voluntary Life/AD&D
Omaha, NE 68175
Phone: 800-775-6000
Website: www.mutualofomaha.com

Plan Administrator and Named Fiduciary

Highmark Companies, LLC
PO Box 5459
Cary, NC 27512
Attention: Human Resources Manager
(919)803-5848
cakers@highmarkcompanies.com

Named Fiduciary (for Insured Benefit Claims)

For each of the insured component benefit programs, the applicable Insurer is a Named Fiduciary with respect to decisions regarding whether a claim for benefits will be paid under the insurance contract.

Agent for Service of Legal Process

President
Highmark Companies, LLC

PO Box 5459
Cary, NC 27512
(919)803-5848

Service for legal process may also be made on the Plan Administrator.

Important Disclaimer

Benefits hereunder are provided pursuant to an insurance contract or governing written plan document adopted by the Plan Sponsor. If the terms of this Wrap SPD document conflict with the terms of such insurance contract or governing plan document, then the terms of the insurance contract or governing plan document will control, rather than this Wrap SPD document, unless otherwise required by law.

4. Eligibility and Participation Requirements

Eligibility and Participation

An eligible employee with respect to the Plan is any common-law employee of the Plan Sponsor who is eligible to participate in and receive benefits under one or more of the component benefits programs. The eligibility and participation requirements may vary depending on the particular component program and are described in the Plan Documents. You must satisfy the eligibility requirements under a particular component benefit program in order to receive benefits under that program (including completing any waiting period as noted in the Plan Documents). To determine whether you or your family members are eligible to participate in a component benefit program, please read the eligibility information contained in the Plan Documents for the applicable component benefit programs.

Eligibility to enroll on our group health plan may be impacted by your ACA Benefit Status, which is reflected in our counting policy. These rules, based on regulations adopted under the Affordable Care Act, are integrated into this Summary Plan Description to determine eligibility for full-time and other non-seasonal positions. Seasonal employees, if any, are not eligible to participate on the group health plan.

Application of Counting Policy Rules (ACA Eligibility for Health Plan)

Plan Sponsor has adopted a Counting Policy and Procedure to determine when a newly hired variable hour employee would become eligible, and also to adopt a measurement period to determine on a regular basis when each employee would either be determined to be eligible, to lose their eligibility or to continue their eligibility based on the 30 hour per week/130 hours per month thresholds mandated by the Affordable Care Act. Please refer to Plan Sponsor's Counting Policy to determine if you are subject to special eligibility determination.

Need for Enrollment: Time Limits

In general, eligible employees must complete an application form (available through the Human Resources Manager of Highmark Companies, LLC) to enroll themselves and/or their eligible dependents. New employees must generally enroll within certain time periods after being hired, as described in the Plan Documents. Thereafter, enrollment is generally limited to the annual open enrollment period that occurs before the beginning of each plan year.

Special Enrollment Rights

In certain circumstances and with respect to particular component benefit programs, enrollment may occur at times outside the open enrollment period (this is referred to as "special enrollment"), as explained in the Plan Documents. The Plan's Special Enrollment Notice also contains important information about your potential special enrollment rights. Contact the Human Resources Manager of Highmark Companies, LLC if you need another copy.

When Participation Begins

Once you, as an eligible employee, have completed the necessary enrollment paperwork, your coverage under the Plan may begin. Requirements may vary depending on the component benefit program. For information about when coverage begins, please read the eligibility and participation information contained in the Plan Documents.

Termination of Participation

In general, your coverage under this Plan ends on the day on which you terminate employment with the Plan Sponsor

(but this day may be different based on the benefit plans and administrative rules). Coverage also terminates if you fail to pay your share of the premium, if your hours drop below the required eligibility threshold, if you submit false claims, lose eligibility and for certain other reasons described in the Plan Documents. Coverage for your eligible and enrolled dependents stops when your coverage stops and for other reasons specified in the Plan Documents (for example, divorce or a dependent's attaining age limit). Coverage also ceases for participants upon termination of the Plan.

Coverage under a particular component benefit program stops according to the terms and conditions reflected in the Plan Documents. Note that termination of coverage under a particular component benefit program does not necessarily mean your coverage under the Plan in general terminates. You may still have coverage under another component benefit program.

Anti-Alienation Clause

You may not anticipate, exchange, pledge, encumber or otherwise assign any rights, benefit or payments under this Plan except where specifically allowed, or that you designate a Beneficiary, when applicable

5. Summary of Plan Benefits

Available Benefits and Contributions

In general, the cost of the benefits provided through the component benefit programs will be funded in part by Company contributions and in part by pre-tax employee contributions. The Plan Sponsor will determine and periodically communicate your share of the cost of the benefits provided through each component benefit program, and the Plan Sponsor may change that determination at any time.

The Plan Sponsor will make its contributions in an amount that (in the Plan Sponsor's sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions. With respect to the insured component benefit programs, the Plan Sponsor will remit its contribution and your contributions to the insurer. With respect to benefits that are self-funded, the Plan Sponsor will use these contributions to pay benefits directly to (or on behalf of) you or your eligible family members from the Plan Sponsor's general assets. Your contributions toward the cost of a particular benefit will be used in their entirety prior to using Company contributions to pay for the cost of such benefit.

What you pay toward the cost of your benefits, if applicable, are included as an Appendix to this Wrap Plan Summary Plan Description (SPD).

Qualified Medical Child Support Orders

With respect to the component benefit programs, the Plan extends benefits to an employee's non-custodial child, as required by any qualified medical child support order (QMCSO), under ERISA §609(a). The Plan has procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Human Resources Manager of Highmark Companies, LLC.

Administrative Requirements and Timelines

As described in the Plan Documents, there may be other reasons that a claim for benefits is not paid, or is not paid in full. For example, claims must generally be submitted for payment within a certain period of time, and failure to submit within that time period may result in the claim being denied. In this regard, please consult the benefit materials referenced above.

6. How the Plan Is Administered

Plan Operations

Because benefits under the Plan are provided both through insurance contracts and on a self-funded basis, the Plan is administered by Highmark Companies, LLC and, where applicable, the insurers.

Plan Administration

Highmark Companies, LLC is the Plan Administrator. As the Plan Administrator, Highmark Companies, LLC responsible for satisfying certain legal requirements under ERISA with respect to the Plan (for example, distributing SPDs). The Human Resources Manager of Highmark Companies, LLC is the person who acts on behalf of the Plan Administrator. Highmark Companies, LLC has agreed to indemnify the Human Resources Manager for any liability that he or she incurs

as a result of acting on behalf of the Plan Administrator, unless such liability is due to his or her gross negligence or misconduct.

The principal duty of the Plan Administrator is to see that the Plan functions according to its terms, and for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, authorizing benefit payments, and gathering information necessary for administering the Plan. The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s), and expressly describes the nature and scope of the delegated responsibility. The Plan Administrator has the discretionary authority to interpret the Plan to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan. The Plan Sponsor will bear its incidental costs of administering the Plan.

Power and Authority of Insurer(s)

Certain benefits under the Plan are fully insured. Benefits are provided under a group insurance contract entered into between Highmark Companies, LLC and the applicable Insurer. For those benefits, claims are sent to the applicable Insurer, who is responsible for determining and paying claims, not Highmark Companies, LLC. The applicable Insurer is responsible for (a) determining eligibility for a benefit and the amount of any benefits payable under the Plan; and (b) providing the claims procedures to be followed and the claims forms to be used by eligible individuals pursuant to the Plan. As Named Fiduciary for benefit determinations, the applicable Insurer has the discretionary authority to interpret the Plan in order to make benefit determinations. The Insurer also has the authority to require eligible individuals to furnish them with such information as they determine necessary for the proper administration of the Plan.

Your Questions

If you have any general questions regarding the Plan (including, for example, whether you are eligible to participate in the Plan or a particular component benefit program offered through the Plan, or the amount of any benefit payable under the self-funded component benefit plans), please contact the Human Resources Manager, who acts on behalf of the Plan Administrator. If you have any question regarding your eligibility for, or the amount of, any benefit payable under the fully insured component benefit plans, please contact the appropriate Insurer.

7. Circumstances That May Affect Benefits

Denial, Recovery, or Loss of Benefits

Your benefits (and the benefits of your eligible family members) will cease when your participation in the Plan terminates. See Section 4. Your benefits will also cease upon termination of the Plan.

Other circumstances can result in the termination, reduction, recovery (through subrogation or reimbursement), or denial of benefits. For example, benefits may be denied if you have a preexisting condition (but not health benefits) or must incur costs within the exclusionary period under the certain benefit programs. See the referenced documents for additional details.

8. Amendment or Termination of the Plan

Amendment or Termination

Highmark Companies, LLC, as the sponsor of the Plan, has the general right to amend or terminate the Plan at any time. The Plan may be amended or terminated by a written instrument signed by the Highmark Companies, LLC President or the Human Resources Manager, both of whom are authorized to amend or terminate the Plan and to sign insurance contracts with the insurers, including amendments to those contracts. Note, for this purpose, that an insurance contract is not necessarily the same as the Plan. (An insurance contract is how benefits under a particular component program offered through the Plan are provided.) Consequently, termination of an insurance contract does not necessarily terminate the Plan.

Highmark Companies, LLC, as Plan Sponsor, has the right to amend or terminate the Plan at any time. The Plan may be amended or terminated by a written instrument duly adopted by Plan Sponsor or any of its delegates.

The Human Resources Manager of Highmark Companies, LLC may sign insurance contracts for the Plan on behalf of the

Plan Sponsor, including amendments to those contracts, and may adopt (by a written instrument) amendments to the Plan that he or she considers to be administrative in nature or advisable in order to comply with applicable law.

9. No Contract of Employment

No Contract of Employment

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and the Plan Sponsor to the effect that you will be employed for any specific period of time.

10. Claims Procedures

Claims for Fully Insured Benefits

For purposes of determining the amount of, and entitlement to, benefits of the component benefit programs provided under insurance or contracts, the respective insurer is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance contract.

To obtain benefits from the insurer of a component benefit program, you must follow the claims procedures under the applicable insurance contract, which may require you to complete, sign, and submit a written claim on the insurer's form. (See the Plan Documents for more information.)

The insurer will decide your claim in accordance with its reasonable claim's procedures, as required by ERISA (if ERISA applies) and other applicable law. The insurer has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the insurer denies your claim in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the insurer for a review of the denied claim. The insurer will decide your appeal in accordance with its reasonable claim's procedures, as required by ERISA (if ERISA applies) and other applicable law. If you do not appeal on time, you will lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing suit in state or federal court). Note that under certain circumstances, you may also have the right to obtain external review (that is, review outside of the Plan). (See the Plan Documents for more information.)

Claims for Self-Funded Benefits

For purposes of determining the amount of, and entitlement to, benefits under the component benefit programs provided through the Plan Sponsor's general assets, the Plan Administrator is the named fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided through a self-funded arrangement.

To obtain benefits from a self-funded arrangement, you must complete, execute, and submit to the Plan Administrator a written claim on the form available from the Plan Administrator. The Plan Administrator has the right to secure independent review and to require such other evidence as it deems necessary to decide your claim.

The Plan Administrator will decide your claim in accordance with reasonable claims procedures, as required by ERISA. If the Plan Administrator denies your claim in whole or in part, then you will receive a written notification setting forth the reason(s) for the denial. (See the Plan Documents for more information.)

If your claim is denied, you may appeal to the Plan Administrator for a review of the denied claim. The Plan Administrator will decide your appeal in accordance with reasonable claims procedures, as required by ERISA. If you do not appeal on time, you will lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court).

See the referenced materials for information about how to appeal a denied claim and for details regarding the insurer's appeals procedures.

11. Statement of ERISA Rights

Note that certain benefits are not covered by ERISA and this Statement of ERISA Rights does not apply to those benefit programs under this Plan.

Your Rights

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series, if required) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual 5500 report (if required) and updated summary plan description (SPD). The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case Highmark Companies, LLC, as Plan Administrator, is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500, for plans with 100 or more participating employees), from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require Highmark Companies, LLC, as Plan Administrator, to provide the materials and pay you up to $110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan (discussed in Section 10), you may file suit in a state or federal court.

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

Assistance with Your Questions

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

Appendix A

Employee Contributions Per Pay Period:

Payroll Deductions

Highmark Companies, LLC.

8/1/2024-7/31/2025

Medical + Vision					
HDHP	**Premium**	**ER**	**EE Monthly**	**24 Pay Periods**	**26 Pay Periods**
EE	$674.09	$558.09	$116.00	$58.00	$53.54
ES	$1,489.12	$913.12	$576.00	$288.00	$265.85
EC	$1,284.12	$786.12	$498.00	$249.00	$229.85
EF	$2,099.52	$1,289.52	$810.00	$405.00	$373.85

Buy Up				24 Pay Periods	26 Pay Periods
EE	$932.84	$636.84	$296.00	$148.00	$136.62
ES	$2,079.46	$1,053.46	$1,026.00	$513.00	$473.54
EC	$1,794.25	$906.25	$888.00	$444.00	$409.85
EF	$2,932.01	$1,484.01	$1,448.00	$724.00	$668.31

HSA Employer Contribution			
HDHP	**ER**	**24 Pay Periods**	**26 Pay Periods**
EE	$50.00	$25.00	$23.08
ES	$100.00	$50.00	$46.15
EC	$100.00	$50.00	$46.15
EF	$150.00	$75.00	$69.23

Dental				24 Pay Periods	26 Pay Periods
EE	$43.33	$8.63	$34.70	$17.35	$16.02
ES	$87.49	$17.39	$70.10	$35.05	$32.35
EC	$104.22	$20.82	$83.40	$41.70	$38.49
EF	$148.35	$29.35	$119.00	$59.50	$54.92

Vision (included in medical)

Your Premium Conversion Plan—A Brief Description

Highmark Companies, LLC has established a Premium Conversion Plan, which lets you pay for your employer-sponsored benefits with pre-tax dollars. This is a tax benefit, the effect of which is to lower the cost to you of your premiums for employer-sponsored medical insurance.

This is a brief description of the Premium Conversion Plan. The Premium Conversion Plan is governed by an official plan document. If there are any differences between this description and the official plan document, the official plan document will govern.

What is the Premium Conversion Plan and how does it work?

The Premium Conversion Plan is set up under Section 125 of the Internal Revenue Code and provides you with a tax benefit. This is how it works: A portion of your pay is withheld by Highmark Companies, LLC for the purpose of paying your share of your medical premium. The money withheld for premiums is not subject to federal income, Medicare, or Social Security (FICA) taxes, and in most cases, state and local taxes. Accordingly, you will save on most federal, state, and local taxes (the exact savings depends upon your tax bracket and your state of residence). Here's an example:

John earns $2500 each month. His federal income tax bracket is 15%, his FICA tax rate is 7.65%, and his state income tax rate is 4.75%, for a total tax rate of 27.4%. His employer sponsors a medical plan, and employees must contribute $300 per month for employee only coverage. By paying for his portion of the premiums with pre-tax dollars, John's take-home pay only decreases by $217.80 each month. John saves $82.20 by paying for his share of the premiums with pre-tax dollars.

	If John pays for his share of his coverage with after-tax dollars	If John participates in the premium conversion plan and pays with pre-tax dollars
Gross monthly income	$2,500	$2,500
Pre-tax deduction for employee share of medical premiums	0	$300
Taxable income for the month	$2,500	$2,200
Taxes (taxable income multiplied by total tax rate of 27.4%)	$685	$602.80
Net pay for the month	$1,815	$1,597.20
After-tax payment of employee share of medical premiums	$300	$0
Take-home pay after employee contribution for medical coverage	$1,515	$1,597.20 (savings of $82.20)

Am I eligible to participate?

You are eligible to participate in the Premium Conversion Plan if you are a common law employee of Highmark Companies, LLC and satisfy the minimum hour requirements and waiting period for new employees. You are not eligible to participate if your employer determines that you are:

- Self-employed
- An independent contractor
- A consultant or advisor

May premiums for my family's coverage be paid by Premium Conversion?

Generally, yes—but there is an exception. Under IRS rules, pre-tax dollars may only be used to pay for the premiums of someone who is your dependent, as defined under the Internal Revenue Code. If an individual is a dependent for purposes of your medical coverage but not a dependent as defined by the Internal Revenue Code, your payments toward that individual's coverage may not be paid with pre-tax dollars through this Premium Conversion Plan but must be paid instead on an after-tax basis. You may want to consult your tax advisor for information about whether someone is your tax dependent. Highmark Companies, LLC may ask for information about the tax status of your dependents to ensure that you comply with the terms of the Premium Conversion Plan.

How do I enroll?

You are automatically enrolled in the Premium Conversion Plan as of the day the Premium Conversion Plan is established, or your date of hire if you are hired after the Premium Conversion Plan is established. Your participation will continue automatically unless you elect not to participate.

Can I choose not to participate in the Premium Conversion Plan?

Yes. To opt-out of the Premium Conversion Plan, you need to complete a written waiver/election form and return it to Highmark Companies, LLC's Human Resources Department. If you do not pay federal income tax, you should consider waiving participation in the Premium Conversion Plan (but your contributions will still be treated as post-tax for the purpose of FICA obligations).

How does participation in the Premium Conversion Plan affect my other benefits, such as Social Security?

Participating in the Premium Conversion Plan could slightly lower your Social Security benefit. This is because your Social Security benefit is calculated based on your taxable earnings. Participating in the Premium Conversion Plan will reduce your taxable earnings and accordingly affect your Social Security benefit calculation. You may experience a similar effect on other benefits such as life insurance, disability, or pension benefits, depending upon how these other benefits define compensation. If these benefits, like Social Security, are calculated based on your taxable earnings, your participation in the Premium Conversion Plan could result in lower benefits.

May I change my Premium Conversion Plan participation?

Each year, we will have an open enrollment period during which you may change your participation in the Premium Conversion Plan. During open enrollment, you may elect to participate if you haven't been doing so, you may cancel your participation, or you may make a change to your election—such as increasing your participation level to add a dependent to your medical coverage.

Except for annual open enrollment, you cannot change your Premium Conversion Plan participation unless you experience a "change in status" as defined by the Internal Revenue Service. If you experience a change in status, you may only change your participation status within 30 days of the event, and your requested change must be consistent with the change in status that you experience.

The following is a list of changes in status that may allow you to make a change to your elections.

- **Legal marital status:** Any event that changes your legal marital status, including marriage, divorce, death of a spouse, legal separation, and annulment.
- **Number of eligible dependents:** Any event that changes your number of eligible dependents including birth, death, adoption, legal guardianship, and placement for adoption.
- **Employment status:** Any event that changes your or your eligible dependents' employment status that results in gaining or losing eligibility for coverage. Examples include:
  - Beginning or ending employment;
  - A strike or lockout;
  - Starting or returning from an unpaid leave of absence;
  - Changing from part-time to full-time employment or vice versa; and
  - A change in work location.
- **Dependent status:** Any event that causes your dependents to become eligible or ineligible for coverage because of age, student status, or similar circumstances.
- **Residence:** A change in the place of residence for you or your eligible dependents if the change results in your or your eligible dependents living outside your medical or dental plan's network service area.
- **Loss of Other Coverage**: If you decline enrollment for yourself or your eligible dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and your eligible dependents in the Premium Conversion Plan if you or your eligible dependents lose eligibility for that other coverage (or if the other employer stops contributing towards your or your dependents' other coverage).
- **Government coverage:** If you or your eligible dependents become entitled to or lose entitlement to Medicare or Medicaid, or lose entitlement to certain other governmental group medical programs.

Please note that in order to change your benefit elections due to a change in status, you may be required to show proof verifying that these events have occurred (e.g., copy of marriage or birth certificate, or divorce decree, etc.)

What happens if I take a leave of absence or terminate employment?

If you take a leave of absence, you may be able to revoke your election. See your employer about information about your rights. If you stop working for your employer, whatever the reason, your participation in the Premium Conversion Plan will automatically terminate. This means that any premiums for medical coverage after you stop working must be paid with after-tax dollars.

Summary of State-Mandated Short-Term Disability and Paid Family Leave Benefits

State-mandated benefits are required for all employers with employees working in states with these laws in place. Short-term disability coverage required by the state is commonly referred to as "Paid Medical Leave" or "PML." Many states require both PML and "Paid Family Leave" or "PFL." PFL is paid time away from work to bond with a new child, take care of a sick family member, or for a military-related leave.

California PML

Also call State Disability Insurance (SDI). www.edd.ca.gov . California also includes PFL.

Type of coverage allowed:

State plan or stat-approved private plan. Private plans must be approved by a majority of employees and must be more generous than the state plan.

Eligibility:

Employee must have contributed to the PML program during the previous 18 months, and earned at least $300 in gross wages during the base period during which PML deductions were taken.

Benefit percentage & maximum benefit:

For employees who make up to 1/3 of the state's average weekly wage (SAWW), 70% of the employee's quarterly base wages.

For those who make more than 1/3 of the SAWW, 60% of the employee's quarterly base wages.

Maximum weekly benefit = $1,540

Waiting period (elimination period):

PML: 7 days

PFL: None

Maximum duration:

PML: 52 weeks

PFL: 8 weeks

Maximum employee contribution:

1.1% of first $145,600 of annual gross earnings. Maximum annual contribution is $1,601.60. This cost includes PML and PFL

Cost to employer:

Employer may elect to pay all or part of employee contribution

Hawaii PML

Also called Temporary Disability Insurance (TDI). www.labor.hawaii.gov/dcd/

Type of coverage allowed:

No state plan. All employers must provide PML benefits through a state-approved private plan from an authorized carrier or a self-funded plan

Eligibility:

Employee must have at least 14 weeks of Hawaii employment during each of which the employee was paid for 20 hours or more and earned not less than $400 in the 52 weeks preceding the first day of disability. The 14 weeks need not be consecutive nor with only one employer. The employee must also be in current employment to be eligible

Benefit percentage & maximum benefit:

58% of average weekly earnings. If average weekly wage is less than $26, PML benefit = average weekly wage but not more than $14

Maximum weekly benefit = $697

Waiting period (elimination period):

7 days

Maximum duration:

26 weeks

Maximum employee contribution:
Up to one-half of plan cost, but not more than 0.5% of average weekly earnings or $6.00 per week, whichever is less
Cost to employer:
The employer is required to fund the additional cost of the private plan above the employee maximum contribution limit

New Jersey PML

Also called Temporary Disability Insurance (TDI). www.myleavebenefits.nj.gov/worker/tdi/
New Jersey also includes PFL coverage (also called Family Leave Insurance or FLI)
Employee vote and approval from majority of NJ employees is required to opt out of state plan
Type of coverage allowed:
State plan, state-approved private plan, or self-funded private plan
Eligibility:
To qualify, a worker must have worked 20 weeks earning at least $240 weekly, or have earned a combined total of $12,000 in the base year
Benefit percentage & maximum benefit:
85% of average weekly wage
Maximum weekly benefit = $993
Waiting period (elimination period):
PML: 7 days; retroactive to first day after 22 consecutive days of disability
PFL: None
Maximum duration:
PML: Up to 26 weeks, but capped at one-third base-year wages
PFL: 12 weeks, but capped at one-third base-year wages
Maximum employee contribution:
PML: 0.14% of $151,900 taxable wages
PFL: 0.14% of $151,900 taxable wage base
Cost to employer:
Private PML plan: Employer will fund the additional cost of the private plan above the employee maximum contribution limit. The employer can pay all or part of the employee contribution
State PML plan: Rate varies from 0.1% to 0.75% with $39,800 wage cap
PFL: Funded 100% by employees unless employer chooses to pay all or part of contribution

New York PML

http://www.wcb.ny.gov/content/main/DisabilityBenefits/lp_disability-benefits.jsp
www.paidfamilyleave.ny.gov
New York also includes PFL coverage
New York also includes provisions for payment for mandatory or precautionary orders of quarantine as a result of COVID-19
Type of coverage allowed:
A policy written by an approved carrier in NY State (including the NY State Insurance Fund, an insurance company created by the State of NY which operates under the same premise as all other approved disability benefit carriers in NY)
Through participation in a Workers' Compensation Board approved union, association or trust, or
Being approved as a self-insured employer by the self-insurance unit of the Worker's Compensation Board
Eligibility:
PML: Employee must have worked at least 4 weeks in New York for the same covered employer
PFL: Full-time employees will be eligible for coverage after 26 consecutive weeks of covered NY employment. Part-time employees working less than 20 hours per week will be eligible after 175 work days of covered NY employment for the same covered employer
Benefit percentage & maximum benefit:
PML: 50% of average weekly wage
Maximum weekly benefit = $170
PFL: 67% of average weekly wage
The max weekly benefit = 67% of state average weekly wage $1,068.36
Waiting period (elimination period):

PML: 7 days
PFL: None

Maximum duration:

PML: 26 weeks
PFL: 12 weeks Combined: 26 weeks

Maximum employee contribution:

PML: 0.5% of first
$120 of weekly wages up to a maximum of $0.60 per week
PFL: 0.511% of employee's gross wage to annual maximum of $423.71

Cost to employer:

PML: Employer will fund the additional cost of the private plan above the employee maximum contribution limit. The employer can pay all or part
of the employee contribution
PFL: Funded 100% by employees unless employer chooses to pay all or part of contribution

Rhode Island PML

https://dlt.ri.gov/tdi/

Rhode Island also includes PFL coverage (also called Temporary Caregiver Insurance or TCI)

Type of coverage allowed:

State plan only. Rhode Island does not allow private plans.

Eligibility:

Employee must have been paid wages in Rhode Island and have paid into the Temporary Disability Insurance (TDI)/TCI fund; and have been paid at least $12,600 in the base period, or earned at least $2,100 in one quarter, with total taxable wages at least 1.5 times the highest quarter of earnings, and base-period taxable wages equal to at least $4,200.

Benefit percentage & maximum benefit:

4.62% of total base period high quarter wages
Minimum weekly benefit = $107
Maximum weekly benefit = $978
Maximum weekly benefit amount with 5 dependents = $1,320

Waiting period (elimination period):

Leave must last 7 or more consecutive days to be eligible for benefits

Maximum duration:

PML: 30 weeks
PFL: 5 weeks
6 weeks (2023)
Combined: 30 weeks

Maximum employee contribution:

1.1% of the first $81,500 earned
Covers both PML and PFL

Cost to employer:

None required

Washington PFML

www.paidleave. wa.gov/

Type of coverage allowed:

State plan or private plan

Eligibility:

Worked at least 820 hours of employment during the qualifying period. Voluntary plan eligibility requirements are employer choice.

Benefit percentage & maximum benefit:

Employees receive up to 90% of their average weekly wage on a sliding scale
Maximum weekly benefit = $1,327

Waiting period (elimination period):

7 calendar days (excluding child bonding and qualifying exigency)

Maximum duration:

PML: 12 weeks

PFL: 12 weeks

(14 weeks for a pregnancy that results in incapacity)

Combined: 16 weeks (18 weeks for a pregnancy that results in incapacity)

Maximum employee contribution:

Total PFML cost is .6% of an employee's gross wages capped at annual Social Security maximum ($147,000 in 2022)

The employee maximum contribution is 73.22% of the total cost

Cost to employer:

Employers pay 26.78% of the total cost

Employers can pay some or all of the premium on their employees' behalf

Employers with fewer than 50 employees are not required to pay the employer portion of premium

District of Columbia PML and PFL

www.does.dc.gov/

Type of coverage allowed:

State plan only. Private plans are not allowed

Eligibility:

Workers must have worked over 50%

of the time in D.C. in the 52 calendar weeks immediately preceding the leave; or regularly spend a substantial amount of time working in D.C. and work less than 50% of their time in another jurisdiction

Benefit percentage & maximum benefit:

Employees receive up to 90% of their average weekly wage on a sliding scale

Maximum weekly benefit = $1,009

Waiting period (elimination period):

7 calendar days in 52 calendar-week period

Waiting Period waived 10/1/21–7/25/22 for COVID-19 public health emergency

Maximum duration:

PML: 6 weeks

PFL: 8 weeks to bond with a new child; 6 weeks to care for a sick family member

Combined: 8 weeks

Maximum employee contribution:

The D.C. program is fully funded by employers

Cost to employer:

Covered employers must pay a 0.62% quarterly payroll tax based on the immediate past quarter of gross or total wages paid, much like the unemployment insurance tax

Massachusetts PFML

www.mass.gov/guides/workers-guide-to-paid-family-and-medical-leave

Type of coverage allowed:

State plan or private plan

Eligibility:

Employee must have earned at least $5,700 in the last four completed calendar quarters and at least 30 times the weekly unemployment benefit amount that person would be eligible to collect

Benefit percentage & maximum benefit:

Employees receive up to 80% of their average weekly wage on a sliding scale

Maximum weekly benefit = $1,085

Waiting period (elimination period):

7 calendar days

Maximum duration:

PML: 20 weeks PFL: 12 weeks

Military caregiver: 26 weeks

Combined: 26 weeks

Maximum employee contribution:

Total PFML cost is 0.68% (Effective 2022) of an employee's gross wages capped at the annual Social Security maximum of $147,000. The employee maximum contribution is 34% of the total cost

Cost to employer:

Employers fund the additional cost of the above-the-employee-maximum-contribution limit. The employer can pay all or part of the employee contribution. Employers with fewer than 25 employees are not required to pay the employer portion of the premiums

Oregon PFML

Contributions begin 1/1/23

Benefits to begin 9/3/23

www.oregon.gov/employ/PFMLI/Pages/default.aspx

Type of coverage allowed:

Employers may use the state or a private plan. Private plans must be approved by the state

Eligibility:

Employees who have contributed to the PFML Insurance Fund and have earned at least $1,000 in wages during the base (first 4 of the last 5 completed calendar quarters) or alternate base (last 4 completed calendar quarters) year

Benefit percentage & maximum benefit:

Employees receive up to 100% of their average weekly wage on a sliding scale

Maximum weekly benefit = 120% of the state average weekly wage

Waiting period (elimination period):

None specified (but could be added during rule making)

Maximum duration:

12 weeks of paid leave per benefit year (14 weeks if employee was disabled due to pregnancy-related limitations)

No more than 16 total weeks of leave (paid or unpaid) when combined with leave taken under Oregon Family Leave Act (18 weeks if disabled by pregnancy)

Maximum employee contribution:

Total PFML rate may not exceed 1% of an employee's wages capped at maximum wage base indexed annually to the Consumer Price Index for All Urban Consumers, West Region. The Oregon Employment

Dept. will set the rate

Employee max contribution will be 60% of the total rate.

Cost to employer:

Employers will pay at least 40% of the final rate. Employers may pay employee contributions

Employers that employ fewer than 25 employees are not required to pay the employer contributions

Colorado PFML

Contributions begin 1/1/23

Benefits begin 1/1/24

https://famli.colorado. gov/

Type of coverage allowed:

Employers may use the state or a private plan

Eligibility:

Individuals are eligible to receive the benefits after they have earned

$2,500 in wages that were subject to the Paid Family and Medical Leave (PFML) premiums, and have been employed by the employer for at least 180 days

Benefit percentage & maximum benefit:

Employees receive up to 90% of their average weekly wage on a sliding scale

Maximum weekly benefit = $1,100

Waiting period (elimination period):

None specified

Maximum duration:

12 weeks

An additional four weeks of leave are allowed for pregnancy or childbirth complications

Maximum employee contribution:

Contribution rate of 0.9% (that may increase to 1.2%) will be split evenly between employees and employers

Cost to employer:

Contribution rate of 0.9% (that may increase to 1.2%) will be split evenly between employees and employers
Employers can choose to pay a larger percentage of the cost up to 100%
The initiative exempts businesses with fewer than 10 employees from paying the premium

New Hampshire: Granite State PFML

Contributions and Benefits begin
01/01/2023

Type of coverage allowed:

Private employers and non-state public employers may choose to provide this coverage through the carrier that is awarded the state's business; however, they are not mandated to provide coverage. Employees working for an employer that does not provide coverage may purchase coverage through the carrier that is awarded the state's business. Voluntary Paid Medical Leave extends only to the individual opt-ins

Eligibility:

Mandated coverage for New Hampshire State Government

Benefit percentage & maximum benefit:

60% of an employee's average weekly wage capped at the Social Security Wage base

Waiting period (elimination period):

Waiting period for state employees = none; waiting period for individuals who opt in = 7 months
Elimination period for all = 7 days*
*The period of time between the qualifying event and the day benefits begin

Maximum duration:

6 weeks

Maximum employee contribution:

No cost to state employees; if employees choose to opt into a private plan it will be the defined state rate Maximum EE contribution – for individuals who opt in, no more than $5/week

Cost to employer:

None

Required MassHealth Coverage

This notice is meant to help you understand health insurance Marketplaces, which were set up to make it easier for consumers to compare health insurance plans and enroll in coverage. In Massachusetts, the state Marketplace is known as the Massachusetts Health Connector. Your employer is required by law (§ 1512 of the ACA, which creates 29 U.S.C. 218b) to provide you the information contained in this notice. You may or may not qualify for subsidized health insurance through the Health Connector. If you are offered coverage by your employer that is considered "affordable" and meets a "minimum value" standard according to federal definitions (see below), you most likely will not qualify for the subsidized coverage offered through the Health Connector described in this notice. However, it may still be helpful for you to read and understand the information included here. Please ask your employer for more information if you have questions.

Overview:

As a result of the Affordable Care Act (ACA), there is an easy way for many individuals and small businesses in Massachusetts to buy health insurance: the Massachusetts Health Connector. This notice provides some basic information about the Health Connector, and how coverage available through the Health Connector relates to any coverage that may be offered by your employer. You can find out more by visiting www.MAhealthconnector.org.

What is the Massachusetts Health Connector?

The Health Connector is our state's health insurance Marketplace. It helps individuals, families, and small businesses find health insurance that meets their needs and fits their budget. The Health Connector offers "one-stop shopping" to easily find and compare private health insurance options from the state's leading health and dental insurance companies. Some individuals and families may also qualify for a federal tax credit that lowers their monthly premium right away, as well as cost sharing reductions that can lower out-of-pocket expenses. This tax credit is enabled by §36B of the Internal Revenue Code.

The next open enrollment for individuals and families to buy health insurance coverage through the Health Connector is scheduled to begin on November 1, 2022, through January 23, 2023. Individuals and families who experience a qualifying event can shop outside of open enrollment periods. You can find out more by visiting **www.MAhealthconnector.org** or calling 1-877 MA ENROLL (1-877-623-6765).

Can I qualify for federal and state assistance that reduces my health insurance premiums and out-of-pocket expenses through the Health Connector?

Depending on your income, you may qualify for federal and/or state tax credits and other subsidies that reduce your premiums and lower your out-of-pocket expenses if you shop through the Health Connector. You can find out more about the income criteria for qualifying for these subsidies by visiting **www.MAhealthconnector.org** or calling 1-877 MA ENROLL (1-877-623-6765).

Does access to employer-sponsored coverage affect my eligibility for help paying for coverage through the Health Connector?

An offer of health coverage from your employer could affect your eligibility for subsidies through the Health Connector. If your income meets the eligibility criteria, you will qualify for subsidies through the Health Connector if:

- Your employer does not offer coverage to you, ***or***
- Your employer does offer you coverage, ***but***:
  - Your employer's offer of coverage for just you (not including other family members) would require you to spend more than the following percentage(s) of your household income:

Is your employer's individual health insurance coverage affordable?

Coverage for 2021	9.83% of household income
Coverage for 2022	9.61% of household income

- ***Or,*** the coverage your employer provides does not meet the "minimum value" standard set by federal law (which says that the plan offered has to cover at least 60 percent of total allowed costs).

If you have coverage through your employer but are interested in shopping through the Health Connector, be sure to check with your employer on the rules around how and when you can disenroll from your employer's group coverage. If you purchase a health plan through the Health Connector instead of accepting health coverage offered by your employer, please note that you will lose the employer contribution (if any) for your health insurance. Also, the amount that you and your employer contribute to your employer-sponsored health insurance is often excluded from federal and state income taxes.

Please note: You can find the most up to date percentages used to calculate affordability here: www.mehealthconnector.org/esi-affordability-calculator.

Continuation Coverage Rights Under COBRA

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: Courtney Akers, Highmark Companies, LLC, (919)803-5848 or cakers@highmarkcompanies.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.

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[1] 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**.

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

Highmark Companies, LLC
Courtney Akers
(919)803-5848
cakers@highmarkcompanies.com

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