HIGHMARK COMPANIES

YOUR EMPLOYEE BENEFITS

An overview of the employee benefits provided by
HIGHMARK COMPANIES, LLC
Plan Year August 1, 2023 – July 31, 2024

WE'VE GOT YOU COVERED

Highmark Companies, LLC is proud to offer a comprehensive benefits package for you and your family. Our program is designed to take great care of you when you need it.

Make sure you explore all the options provided to help make the selections that best meet your needs.

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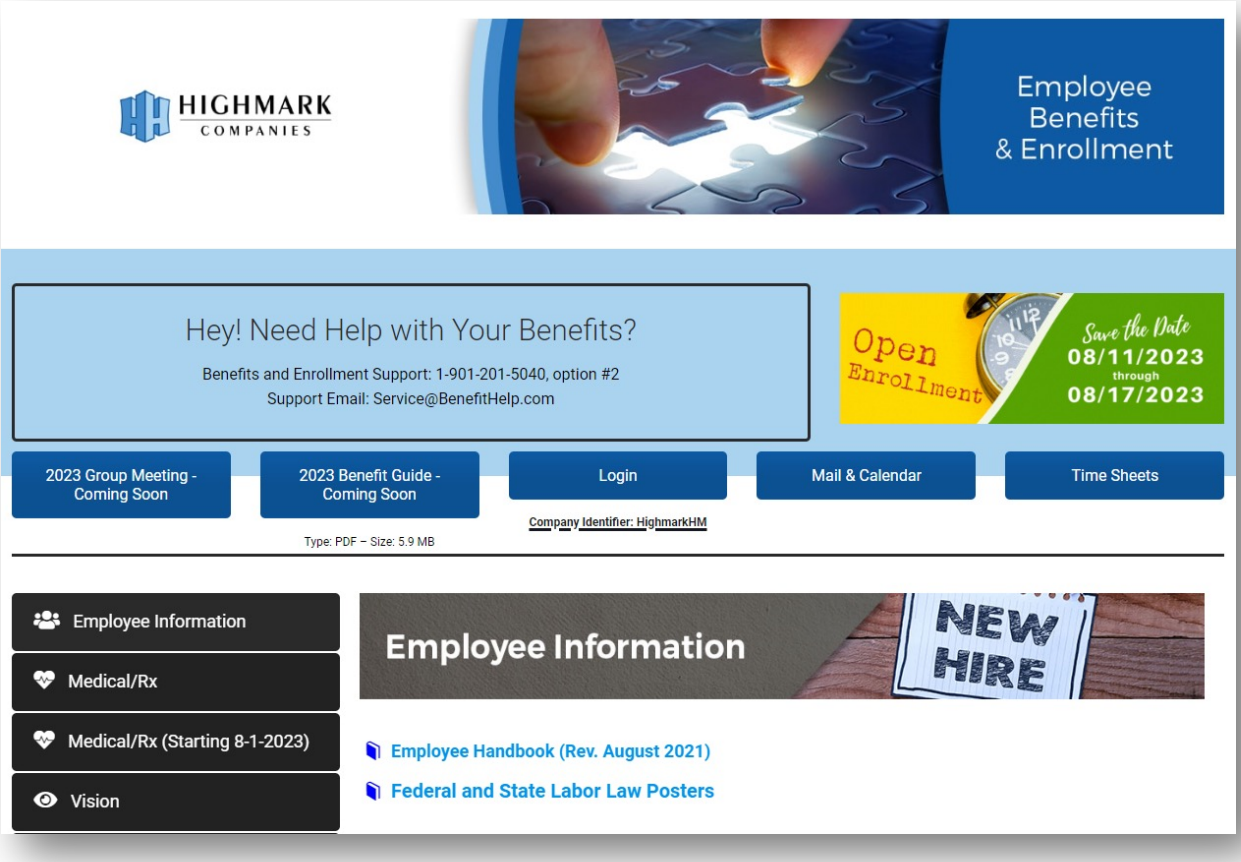
MyHighmarkBenefits.com

Where do I enroll and get more information about my benefits?



Have you ever had trouble locating information about your benefits?
What about trying to remember how to find a participating doctor or dentist?

Not to worry, with MyHighmarkBenefits.com you are just an internet connection away from...

- Important Phone Numbers
- Carrier Information
- Provider & Facility Searches
- Employee Benefit News
- Important Documents
- Videos about Specific Benefits

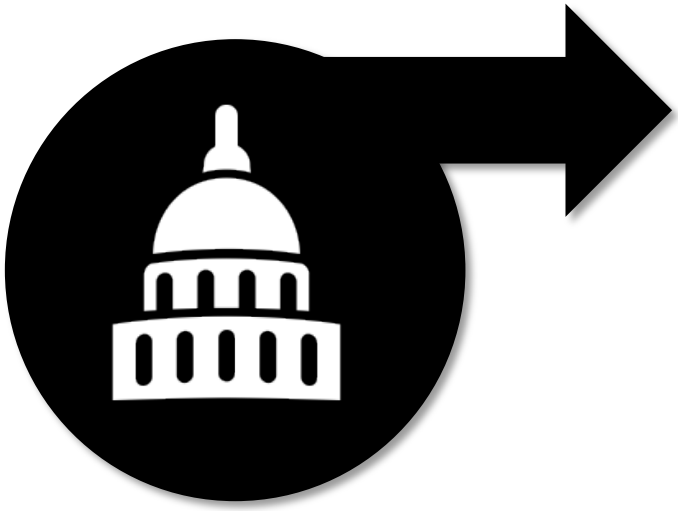
INTRODUCTION

As an employee of Highmark Companies, LLC, enjoying your work and making valuable contributions to business are equally vital. The health, satisfaction and security of you and your family are important, not only to your well-being, but ultimately, in terms of achieving the goals of our organization.

For the 2023 - 2024 plan year, Highmark Companies, LLC has worked hard to offer a competitive total rewards package that includes valuable and competitive benefits plans. These programs reflect our commitment to keeping our staff healthy and secure. We understand that your situation is unique, and we are offering an overall benefits package that can be shaped and molded by you to fit your needs.

This benefits booklet is a summary description of your Highmark Companies, LLC benefit plans. If there is a discrepancy between these summaries and the written legal plan documents, the plan documents shall prevail. This booklet and plan summaries do not constitute a contract of employment.

We hope this benefits booklet, along with our additional communication and decision-making tools, will help you make the best health care choices for you and your family.



UPDATE ON HEALTH CARE REFORM

- Our plan is designed to be affordable and in compliance with Healthcare Reform requirements; however, you may be able to find a lower cost plan through the Marketplace. With that said, the Marketplace coverage may not be as rich of a plan.
- Employees who choose to purchase coverage through the Marketplace may not be eligible to receive a premium tax credit from the government.
- Marketplace open enrollment is typically held from November 1 through December 15 with the earliest effective date for coverage being January 1, 2024.
- If you missed the annual enrollment deadlines for the Marketplace or our health plan, you will not be able to enroll in health insurance coverage unless you experience certain life events, such as the birth or adoption of a child or a termination of employment.

ENROLLMENT INSTRUCTIONS

Participation Required

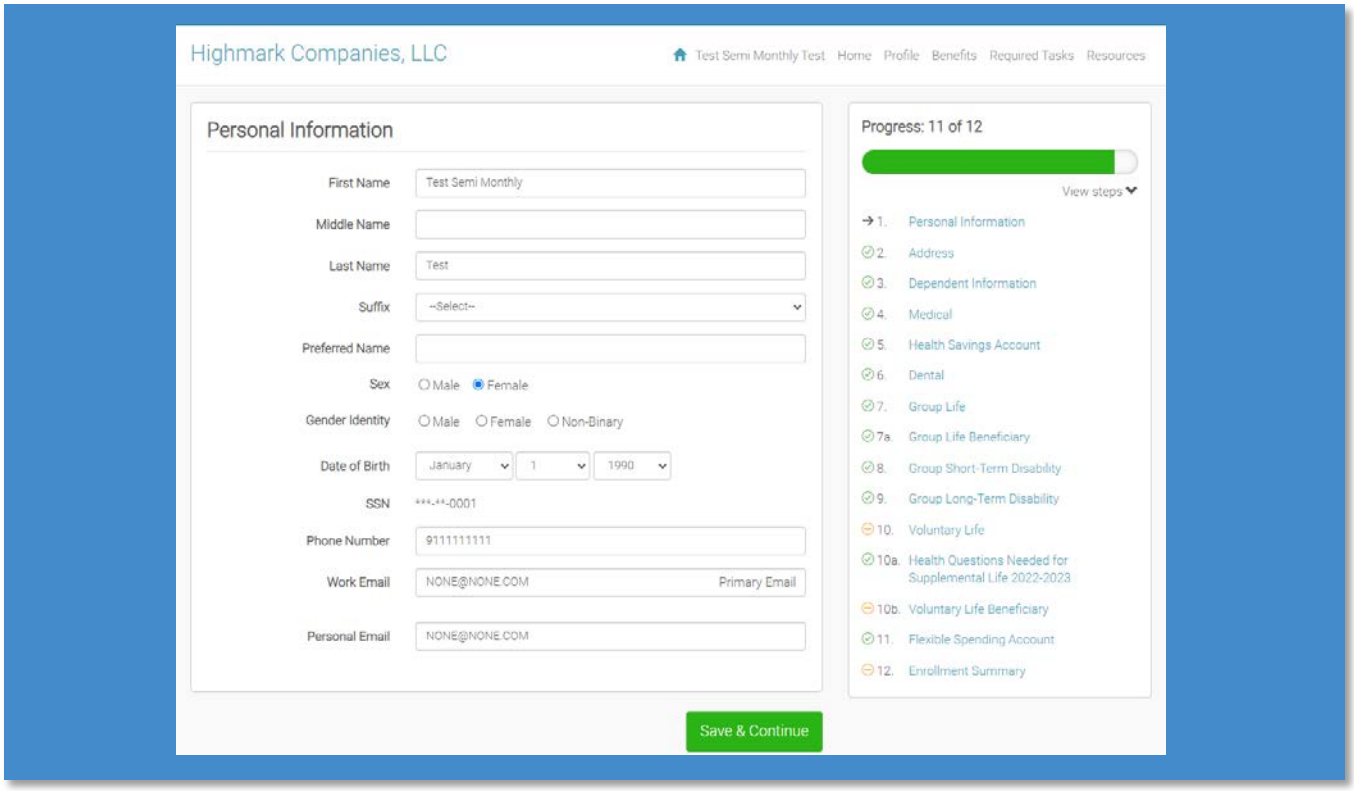
What does Mandatory Enrollment mean?

All employees are **REQUIRED** to log into the Enrollment System to elect, change, confirm or waive benefits during Annual Enrollment. All dependents must be added or confirmed in the Enrollment System during Annual and New Hire Enrollment to receive benefits.

System Login Instructions and Reminders:

- Go to **MyHighmarkBenefits.com** and click on the "Enrollment Login" button.
- You will then click on "Register as a new user" and use the Company Identifier of **HighmarkHM**
- You will then establish your login credentials.
- Dates of birth and social security numbers are required for each family member that you intend to enroll in coverage. You will not be able to proceed with enrollment if this information is not entered into the enrollment system.
- Once you have reviewed your current elections and selected coverage for the plan year, be sure to "Click to Sign" to submit your enrollment.
- The benefit plans and benefit selections go into effect on: August 1, 2023

Please make your selections carefully as you are not able to make changes during the year unless you experience a qualifying life event. Examples of a qualifying event include, but are not limited to: marriage, divorce, birth, adoption, death, loss of coverage.



THE FOUR BASIC NEEDS

To make the most of your benefits, you must first understand yours and your family's needs and how your employee benefit package fits into those specific needs. Every consumer has four basic areas to cover:

Health Coverage basically paying the medical, Rx, dental, and vision expenses.

Earnings Protection (Disability), protecting your income in the event of an accident or illness.

Life Coverage, protecting your family or loved ones in the event of your premature death.

Planning (Retirement), having money for those golden years.

OVERVIEW OF BENEFITS

Highmark Companies, LLC provides an array of benefits that can help you enjoy increased well-being, deal with an unexpected illness or accident, build and protect your financial security, balance your personal and professional life and meet everyday needs. These benefits are affordable, comprehensive and competitive. The table below summarizes the benefits available to full time eligible staff and their dependents. These benefits are described in greater detail in this booklet.

BENEFITS AT-A-GLANCE

Coverage	Carrier
Medical	Cigna
Flexible Spending Accounts (FSA)	Flores
Health Savings Account (HSA)	FURTHER by HealthEquity
Dental Plan	Cigna
Vision Plan	Cigna
Term Life and AD&D	Hartford
Supplemental Life and AD&D	Hartford
Short Term Disability	Hartford
Long Term Disability	Hartford
401(k)	Northwest Plan Services (NWPS)
Employee Assistance Plan	Ability Assist

ELIGIBILITY

All full-time employees working 30 hours or more per week are eligible for benefits. Benefits begin on the 1st of the month following date of hire (if date of hire is on the 1st of the month, then benefits begin immediately). Benefits terminate at the end of the month following date of termination (life and disability benefits terminate on the last day of employment).

Eligible children (natural, step, adopted, foster, court ordered) may be covered under medical, dental and vision from birth to age 26 and supplemental life from age 14 days to age 26. Domestic partners are eligible for medical, dental, vision, and supplemental life.

OVERVIEW OF BENEFITS

CHANGES AND QUALIFYING EVENTS

WHEN COVERAGE BEGINS AND ENDS

As a full-time employee, you are eligible to enroll in the benefit plans effective the 1st of the month coinciding with or following your date of employment. Your coverage under the benefits plans will end the last day of the month if you no longer meet the eligibility requirements, your contributions are discontinued, or the Group Insurance Policy is terminated.

QUALIFYING EVENTS

Eligible employees may enroll or make changes to their benefits elections during the annual open enrollment period. As with most benefits, once you elect an option you are bound to that choice for the entire plan year unless you experience a "Qualifying Event". These may include, but are not limited to:

- Changes in employment status
- Changes in legal marital status
- Changes in number of dependents
- Taking an unpaid leave of absence
- Dependent satisfies or ceases to satisfy eligibility requirement
- Family Medical Leave Act (FMLA) leave
- A COBRA-qualifying event
- Entitlement to Medicare or Medicaid
- A change in the place of residence of the employee, resulting in the current carrier not being available

BENEFIT CHANGES CAN BE MADE DURING YOUR ANNUAL OPEN ENROLLMENT

VALUE OF PRE-TAX BENEFITS

SECTION 125 PLAN

Highmark Companies, LLC operates a Premium Only Section 125 Plan, which allows you to reduce your total taxable income by your portion of medical, dental and vision group insurance premiums. In effect, this is just like getting a raise - your withholding taxes are reduced, and your take-home pay increases!

Example: Employee earning $30,000 annually, paying $200/month for benefits

	Without Pre-Tax Benefits	With Pre-Tax Benefits
Gross Pay	$30,000	$30,000
Insurance Deductions/Payments	$0	$2,400
Taxable Income	**$30,000**	**$27,600**
Taxes at 25%	$7,500	$6,900
After-Tax Income	**$22,500**	**$20,700**
After-Tax Payment for Benefits	$2,400	$0
Take-home Pay	**$20,100**	**$20,700**
INCREASE IN TAKE-HOME PAY		**+$600**

HEALTH

(MEDICAL, Rx, DENTAL, VISION, FSA, HSA)

PREVENTIVE SERVICES

Understanding the full value of covered benefits allows you to take responsibility for maintaining good health and incorporating healthy habits into your lifestyle. Some examples include getting regular physical examinations, mammograms and immunizations. Through the plans offered by Highmark Companies, LLC, all covered individuals and family members are eligible to receive routine wellness services like the above, at no cost; all copays, coinsurance, and deductibles are waived.

WHICH PREVENTIVE CARE SERVICES ARE COVERED?

The US Preventive Services Task Force maintains a regular list of recommended services that all Affordable Care Act (aka Health Care Reform) compliant insurance plans should cover at 100% for in-network providers. Below is a list of common services that are included in the plans offered this year:

"AN OUNCE OF PREVENTION IS WORTH A POUND OF CURE"

- Routine Physical Exam
- Well Baby and Child Care
- Well Woman Visits
- Immunizations
- Routine Bone Density Test
- Routine Breast Exam
- Routine Gynecological Exam
- Screening for Gestational Diabetes
- Obesity Screening and Counseling
- Routine Digital Rectal Exam
- Routine Colonoscopy
- Routine Colorectal Cancer Screening
- Routine Prostate Test
- Routine Lab Procedures
- Routine Mammograms
- Routine Pap Smear
- Smoking Cessation Programs
- Health Education/Counseling Services
- Health Counseling for STDs and HIV
- Testing for HPV and HIV
- Screening and Counseling for Domestic Violence

TERMS TO REMEMBER

ANNUAL DEDUCTIBLE

The amount you must pay each year before the plan starts paying a portion of medical expenses. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.

COPAYS AND COINSURANCE

These expenses are your share of cost paid for covered health care services. Copays are a fixed dollar amount and are usually due at the time you receive care. Coinsurance is your share of the allowed amount charged for a service and is generally billed to you after the health insurance company reconciles the bill with the providers.

OUT-OF-POCKET MAXIMUM

This is the total amount you can pay out of pocket each calendar year before the plan pays 100 percent of covered expenses for the rest of the calendar year. Most expenses that meet provider network requirements count toward the annual out-of-pocket maximum, including expenses paid to the annual deductible, copays and coinsurance.

IN-NETWORK & OUT-OF-NETWORK

Your plan allows for both in and out-of-network coverage, and you can choose any provider you wish. However, if you choose to see a provider that is not currently in the network, you will pay a greater share of the cost. Determining whether a provider is in-network is your responsibility.

MEDICAL PLAN

Highmark Companies, LLC offers you the option to participate in Medical Coverage. You may receive medical services from any provider; however, you will have a higher benefit level at a participating provider. You may find participating providers by visiting **MyHighmarkBenefits.com** and selecting Find a Doctor.

Reminders/Updates

- Your routine, preventive visits and screenings are covered at no cost to you.
- You may cover your adult children under your medical plan until they reach their 26th birthday, regardless of their student, financial or marital status.

How Can You Get The Most Out of Your Health Coverage?

It is all about educating yourself on the options available. Balancing cost and coverage are the keys. Find out the plan coverage levels, applicable deductibles and copays. Know what your money is buying.

Every year the cost of healthcare increases faster than just about every other product or service you buy. For most of us, the ways to go about saving money on healthcare expenses are not always obvious. It is a lot like the ways you save money on other things - by learning everything you can about the product and taking advantage of discounts wherever you can find them.

Do you always check to see if you doctor is part of the network?

Please be advised, our medical plans cover much less when an out-of-network provider is used. The only exception is when there is a life-threatening emergency. So, check the provider directory online at **MyHighmarkBenefits.com** to see if your physician, hospital and pharmacy are in the network in order to receive the highest level of benefits.

MEDICAL PLAN

Plan Features	HDHP	Buy Up Plan
	Open Access Plus	Open Access Plus
In Network		
Plan Year Deductibles (Indiv / Family)	$2,850 / $5,700 (Indiv within a Family: $3,000)	$1,000 / $2,000
Preventive Care	No Charge	No Charge
Primary Care Visit	Deductible & 70%	$25
Specialist Visit	Deductible & 70%	$75
Diagnostic Testing (x-ray, blood work)	Deductible & 70%	No Charge
Complex Images (CT/PET/MRI)	Deductible & 70%	Deductible & 80%
Outpatient Procedure	Deductible & 70%	Deductible & 80%
Inpatient Visit	Deductible & 70%	Deductible & 80%
Emergency Room	Deductible & 70%	$300
Urgent Care	Deductible & 70%	$50
Plan Year Out-of-Pocket Max (Indiv / Family)	$6,550 / $13,100 (Indiv within a Family: 6,550	$4,500 / $9,000
Out-of-Network		
Plan Year Deductibles (Indiv / Family)	$5,700 / $11,400 (Indiv within a Family: $6,000)	$2,000 / $4,000
Preventive Care	Deductible & 50%	Deductible & 50%
Primary Care Visit	Deductible & 50%	Deductible & 50%
Specialist Visit	Deductible & 50%	Deductible & 50%
Diagnostic Testing (x-ray, blood work)	Deductible & 50%	Deductible & 50%
Complex Images (CT/PET/MRI)	Deductible & 50%	Deductible & 50%
Outpatient Procedure	Deductible & 50%	Deductible & 50%
Inpatient Visit	Deductible & 50%	Deductible & 50%
Emergency Room	Deductible & 70%	$300
Urgent Care	Deductible & 50%	Deductible & 50%
Plan Year Out-of-Pocket Max (Indiv / Family)	$11,400 / $22,800 (Indiv within a Family: $11,400)	$9,000 / $18,000

PRESCRIPTION DRUG PLAN

Prescription Drug Plan Summary of Benefits (Retail)		
Benefit Highlights	**HDHP**	**Buy Up Plan**
Prescription Drugs (**30-day Retail**)	**after medical deductible…**	
Tier 1	$10	$10
Tier 2	$35	$35
Tier 3	$70	$75
Tier 4	$150	$250

Prescription Drug Plan Summary of Benefits (90 Day)		
Benefit Highlights	**HDHP**	**Buy Up Plan**
Prescription Drugs (**90-day**)	**after medical deductible…**	
Tier 1	$30	$30
Tier 2	$105	$105
Tier 3	$210	$225

What is a Drug Tier?

Tiers are the different cost levels you pay for a prescription drug. Each tier is assigned a cost (copay, deductible or coinsurance), your employer or health plan determines. This is how much you pay when you fill a prescription. If you have a high deductible plan, the tier cost levels may apply once you hit your deductible. Check your Evidence of Coverage or member handbook for plan details.

PRESCRIPTION DRUG PLAN

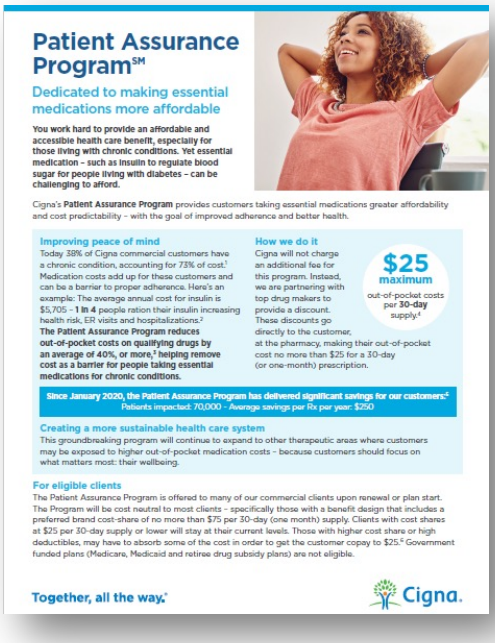
Patient Assurance Program –

Included on both the **HDHP** and **Buy-Up** Plans

The Patient Assurance Program reduces out-of-pocket costs on qualifying drugs by an average of 40%, or more, helping remove cost as a barrier for people taking essential medications for chronic conditions.

How Cigna does it

Cigna partners with top drug makers to provide a discount. These discounts go directly to the customer, at the pharmacy, making your out-of-pocket cost **no more than $25** for a 30-day (or one-month) prescription.


Patient Assurance Program℠

Dedicated to making essential medications more affordable

You work hard to provide an affordable and accessible health care benefit, especially for those living with chronic conditions. Yet essential medication – such as insulin to regulate blood sugar for people living with diabetes – can be challenging to afford.

Cigna's **Patient Assurance Program** provides customers taking essential medications greater affordability and cost predictability – with the goal of improved adherence and better health.

Improving peace of mind

Today 38% of Cigna commercial customers have a chronic condition, accounting for 73% of cost.[1] Medication costs add up for these customers and can be a barrier to proper adherence. Here's an example: The average annual cost for insulin is $5,705 - **1 in 4** people ration their insulin increasing health risk, ER visits and hospitalizations.[2]

The Patient Assurance Program reduces out-of-pocket costs on qualifying drugs by an average of 40%, or more,[3] helping remove cost as a barrier for people taking essential medications for chronic conditions.

How we do it

Cigna will not charge an additional fee for this program. Instead, we are partnering with top drug makers to provide a discount. These discounts go directly to the customer, at the pharmacy, making their out-of-pocket cost no more than $25 for a 30-day (or one-month) prescription.

$25 maximum out-of-pocket costs per 30-day supply.[4]

Since January 2020, the Patient Assurance Program has delivered significant savings for our customers:[5]
Patients impacted: 70,000 - Average savings per Rx per year: $250

Creating a more sustainable health care system

This groundbreaking program will continue to expand to other therapeutic areas where customers may be exposed to higher out-of-pocket medication costs - because customers should focus on what matters most: their wellbeing.

For eligible clients

The Patient Assurance Program is offered to many of our commercial clients upon renewal or plan start. The Program will be cost neutral to most clients – specifically those with a benefit design that includes a preferred brand cost-share of no more than $75 per 30-day (one month) supply. Clients with cost shares at $25 per 30-day supply or lower will stay at their current levels. Those with higher cost share or high deductibles, may have to absorb some of the cost in order to get the customer copay to $25.[6] Government funded plans (Medicare, Medicaid and retiree drug subsidy plans) are not eligible.

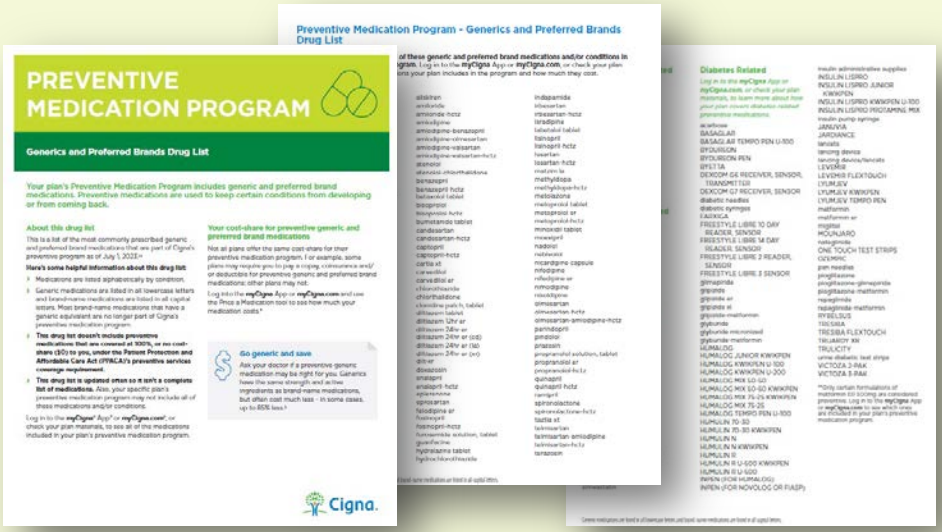
Together, all the way.®

Cigna.

Preventive Rx –

Included on the **HDHP** Plan

Preventive Rx for tier 1 and tier 2 drugs & supplies on preventive list – deductible, coinsurance, and copays are waived – members pay nothing (**Rx covered at 100%)**



FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts (FSAs) enable you to put aside money for important expenses and help you reduce your income taxes at the same time. Highmark Companies, LLC offers two types of Flexible Spending Accounts, a Healthcare FSA and a Dependent Care FSA. These accounts allow you to set aside pre-tax dollars to pay for certain out-of-pocket healthcare or dependent care expenses. **Note: If you are enrolled in the HDHP medical plan, you are not eligible to participate in the Medical Spending Account.**

The plan year for the Flexible Spending Account runs from August 1 through July 31. Remember to calculate your expenses conservatively when making your FSA elections. You can only submit claims for expenses incurred during the Plan Year while an active participant in the Plan. Such reimbursement requests must be submitted with appropriate documentation (completed claim and provider receipts) no later than 90 days after the end of the Plan Year or 90 days after termination of plan participation, whichever comes first.

How Flexible Spending Accounts Work

Flores
Better Benefits Experience.

1. Each year during the Flexible Spending Open Enrollment, you decide on how much to set aside for healthcare and/or dependent care expenses.
2. Your contributions are deducted from your paycheck on a pre-tax basis in equal installments throughout the calendar year.
3. When you incur eligible healthcare or dependent care expenses, funds may be deducted from your account through a debit card. Or you may submit a claim form for reimbursement. Amounts paid using your debit card may require verification, so you may be asked to provide a receipt to substantiate the charge.

Please note that these accounts are separate, and you may choose to participate in one, both or neither.
You cannot use money from the Healthcare FSA to cover expenses eligible under the Dependent Care FSA or vice versa.

Plan	Annual Maximum Contribution	Examples of Covered Expenses
Healthcare Flexible Spending Account	$1,500	Copays, deductibles, prescriptions, orthodontia, eyeglasses, etc.
Dependent Care Flexible Spending Account	$5,000	Day care, nursery school, elder care expenses, etc.

FSA EXAMPLE			
WITHOUT a Flexible Spending Account:		WITH a Flexible Spending Account:	
Gross Annual Pay	$30,000	Gross Annual Pay	$30,000
Estimated Tax	$ 7,500	FSA Pretax Contribution for Unreimbursed Expenses	$ 1,000
Take Home Pay	$22,500	Lower Taxable Income	$29,000
Unreimbursed Expenses	$ 1,000	Estimated Tax	$ 7,250
Total Take Home Pay	$21,500	Greater Total Take Home Pay	$ 21,750

HEALTH SAVINGS ACCOUNT / HSA

An HSA is a personal savings account that can help you build a nest egg for future healthcare expenses. When you need healthcare in the future you can use the account to pay for qualified healthcare expenses, even once you have retired. You do not pay taxes on your contributions, earnings or withdrawals, if you use the account for qualified expenses. Any unused money in your account at the end of the year remains yours to use on eligible medical expenses in the future.

Highmark Companies, LLC will contribute the following amounts during the plan year.

	Semi-Monthly Pay Schedule	Bi-Weekly Pay Schedule
Employee Only	$25	$23.08
Employee + Spouse	$50	$46.16
Employee + Child(ren)	$50	$46.16
Family	$75	$69.23

Who is eligible to participate?

Employees who enroll in the High Deductible Health Plan (HDHP) are eligible to participate in the Health Savings Account. However, if you have coverage through Medicare, Medicaid, TriCare or any other insurance plan that is not considered a High Deductible Health Plan, you are not eligible for participation in the HSA.

How much can I contribute?

IRS rules define how much you can contribute to a Health Savings Account (HSA). For 2023, you may contribute up to the following amounts:

- Individuals under the age of 55 - $3,850
- If you are under the age of 55 and cover your family, you may contribute up to $7,750
- The IRS does allow for a “catch-up” contribution if you are over the age of 55. You may contribute an additional $1,000 per year to your Health Savings Account if you are over 55 years of age.

Highmark Companies, LLC contributions do count toward your annual contribution limit.

FURTHER℠
by HealthEquity

A full list of eligible expenses can be found on the IRS Web site: www.IRS.gov in IRS Publication 502.

DENTAL PLAN

Dental Member Advantages

With our dental plan you can receive care from any dentist. However, our plan has contracts with a large network of dentists who have agreed not to charge more than a specified amount for services. If you use one of these network dentists, you won't have to worry about being charged for additional amounts above the allowable (UCR) amount covered by the plan.

PLAN FEATURES	In-Network	Out-of-Network
Preventive Care	Covered at 100%	
Basic Care	Covered at 80% after deductible	
Major Care	Covered at 50% after deductible	
Orthodontia	Covered at 50% (child only to age 19) to a lifetime maximum of $1,000	
Calendar Year Deductible	$50 individual / $150 family	
Annual Maximum	$1,500	
UCR Level	Negotiated Fee	90th percentile

VISION PLAN

Plan Features	Vision
In Network	**Coverage**
Vision Exam Copay	$10
Materials Copay	$25
Lenses	
Single	Covered in full after copay
Bifocal	Covered in full after copay
Trifocal	Covered in full after copay
Progressive	Covered in full after copay
Frames	$130 retail frame allowance, then 20%
Elective Contact Lenses	Up to $110
Medically Necessary Contact Lenses	Covered in full after copay
Out of Network	**Coverage**
Vision Exam	Up to $45
Materials	See below
Lenses	
Single	Up to $32
Bifocal	Up to $55
Trifocal	Up to $65
Progressive	Up to $80
Frames	Up to $71
Elective Contact Lenses	Up to $98
Medically Necessary Contact Lenses	Up to $250
Frequency (Months)	
Exam	Once every 12 months
Lenses	Once every 12 months
Frames	Once every 24 months
Contacts (in lieu of lenses & frames)	Once every 12 months

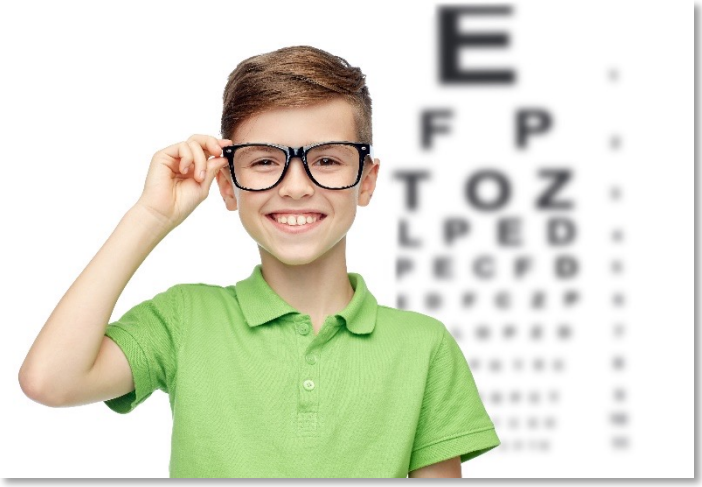
Vision Member Advantages

Under the Vision Plan you may receive care from the vision care provider of your choice.

Our Vision Plan has an extensive nationwide network of doctors who provide eye care and eye wear.

When you receive care through these vision care providers, you simply pay the appropriate copayment.

If you visit an out-of-network provider, be aware that your out-of-network benefits do not guarantee full payment.



EARNINGS (DISABILITY)

SHORT TERM DISABILITY PLAN

If you become disabled, you could be out of work for a short period of time. Without your income, how would you pay for your everyday living expenses? Fortunately, Disability Insurance offers financial protection options that can help you.

What can cause a disability?

Regardless of your age or health, a disability could keep you out of work for weeks or months. Some of the most common conditions associated with short-term disability claims are arthritis, pregnancy, back problems, dislocations/sprains and fractures.

How reliable is your safety net?

While many with disabilities look to workers' compensation or Social Security Disability Insurance for help, these resources aren't always reliable. Even if they can help, you still might be unable to meet all your financial obligations

Your Short-Term Disability plan is offered to you by your employer. To use theses benefits, he plan requires that you be out of work, and certified disabled by your doctor, due to illness or injury.

ONLY 48%

of American adults say they have enough savings to cover three months of living expenses in the event they're not earning any income.

Council for Disability Awareness, The Crisis of Disability Coverage in America, 2018

Plan Features (Employer Provided)

$25 - $2,000 weekly
(not to exceed 66.67% of your salary)

Elimination Period
7 days

Benefit Duration
13 weeks

Coverage for off job disabilities

The cost of the premium for this benefit will show on your W-2 as imputed income. This is done to ensure the benefit is paid tax-free should you ever become disabled.

LONG TERM DISABILITY PLAN

If you become disabled, you could be out of work for a longer period of time. Without your income, how would you pay for your everyday living expenses? Fortunately, Disability Insurance offers financial protection options that can help you.

What can cause a disability?

Regardless of your age or health, a disability could keep you out of work for months or years. Some of the most common conditions associated with long-term disability claims are stroke, paralysis, illness, and blindness.

How reliable is your safety net?

While many with disabilities look to workers' compensation or Social Security Disability Insurance for help, these resources aren't always reliable. Even if they can help, you still might be unable to meet all your financial obligations

Your Long-Term disability plan is provided at no cost to you. The plan includes an elimination period, that is the amount of time you are disabled by your doctor and unable to work. Once you complete your elimination period the plan will begin paying a monthly benefit until you are able to return to work or you reach the age of 65, whichever occurs first.

Plan Features (Employer Provided)

Up to $7,500
Monthly Maximum
(not to exceed 60% of your salary)

Elimination Period
90 days

Benefit Duration
SSNRA
(to Social Security Normal Retirement Age)

If you are diagnosed or treated for a condition 3 months prior to enrollment, you will have a 12 month wait for that condition.

The cost of the premium for this benefit will show on your W-2 as imputed income. This is done to ensure the benefit is paid tax-free should you ever become disabled.

LIFE INSURANCE

TERM LIFE AND AD&D

Highmark Companies, LLC provides an employee benefits program that is intended to protect you and your family from catastrophic financial losses.

As an eligible employee, you receive $50,000 in Life and AD&D coverage and we provide this benefit at no cost to you.

Benefits terminate at end of employment or retirement, however you may “port” this term life coverage up to age 85.

Please visit **MyHighmarkBenefits.com** for more details.

Plan Features	Amount of Benefit
Employee Term Life Benefit Amount	$50,000
Employee AD&D Benefit Amount	Up to $50,000
Employee Term Life Accelerated Benefits	Up to 80% of Benefit (with life expectancy less than 12 months)
The following shows how much benefits are reduced at certain ages:	
At Age	Benefit Reduction
65	Reduces to 65%
70	Reduces to 40%
75	Reduces to 25%
80	Reduces to 15%

SUPPLEMENTAL LIFE

Plan Features	Benefit
Employee Benefit Amounts	$25,000 increments up to the lesser of $150,000 or 5x earnings
Spouse Benefit Amounts	$5,000 increments up to lesser of 50% of employee amount or $75,000
Child(ren) Benefit Amount	$10,000 (age 14 days to age 26) not to exceed 50% of employee amount
Group Life Accelerated Benefits	Up to 80% of Benefit (with life expectancy less than 12 months)
Benefit	**Guaranteed Issue Amount (no medical questions)**
Employee	$50,000
Spouse	$20,000
Children	$10,000
The following shows how much benefits are reduced at certain ages:	
At Employee Age	Benefit Reduction
65	Reduces to 65%
70	Reduces to 40%
75	Reduces to 25%
80	Reduces to 15%

If a covered person is eligible for any amount in excess of the guaranteed issue amount shown above, the employee must furnish evidence of insurability, which is subject to carrier approval.

If currently enrolled, you may apply for one increment of coverage without EOI if below the Guarantee Issue amount.

Conversion and Portability Options Available

PLANNING (RETIREMENT)

401K PLAN

NWPS

Who is eligible to participate?

You are eligible to participate in the 401(k) on the first day of the month once you have completed either 250 hours within the three-month time period following date of hire - or – 1000 hours within first 12-month period; after that, 1000 hours per year. Age requirement of 21.

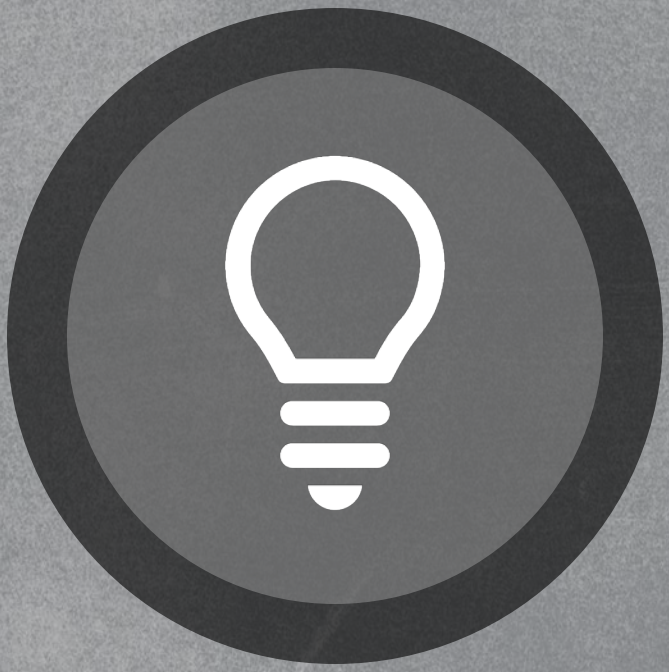
Why should you participate in a 401(k) plan?

Here are some of the top reasons:

- You may contribute up to 100% of your eligible compensation up to $22,500 per year (subject to IRS limits). Highmark Companies, LLC will match 100% of your contributions up to 3% of eligible compensation, plus 50% on the next 2%. If you contribute 5% of your eligible compensation, you will receive the maximum match of 4% of eligible compensation.
- Your money grows and compounds tax-deferred. This simply means your contributions are deducted before federal income taxes are withheld and you do not pay any taxes on the gains until you take the money out at retirement.
- You can take your account with you if you change jobs.

Additional information is available from your Human Resources Department.

Remember… It's Never too Late to Save for Retirement!



ADDITIONAL BENEFITS

Ability Assist®

Life can pull you in many directions.

Find your balance.

Highmark Companies, LLC has long provided all employees and their families access at no cost to a full-service Employee Assistance Program (EAP). We recognize the importance of providing convenient confidential access to professional guidance and counseling. All of us must cope with many forms of stress in our daily lives that can negatively affect our jobs, our families and our health. Sometimes we need help, and we want to ensure that help is always available.

Help for personal challenges, big and small

Some of the services included in our EAP include:

- Workplace effectiveness
- Managing stress, overcoming anxiety or depression
- Drug or alcohol dependency
- Parenting issues and family conflicts
- Strengthening personal relationships
- Legal and financial concerns
- Coping with grief and loss
- Referrals to community resources

Remember the Following Key Points About Our EAP:

It's **FREE** – Access to licensed counselors for EAP assessment, short-term problem resolution, and/or linkage to community resources is all included.

It's **CONFIDENTIAL** – The services are delivered within legal parameters for counseling services. The participating employer receives a "statistics only" report unless information is disclosed to a counselor that is either safety sensitive or involves suspected child or elder abuse and reporting laws apply.

It's **VOLUNTARY** – It's your choice to utilize our EAP services.

It's **PROFESSIONAL** – Licensed counselors are available 24 hours a day.

ADDITIONAL BENEFITS

Flexible Time Off (Salaried Employees Only)

The Company's current policy provides for eligible employees to take time off when they require it, enabling employees to balance the responsibility of both their work and home lives. This time can be used for either sick leave or vacation leave. Employees must comply with the FTO policy's time off request and approval process. Time off in excess of thirty business days within a calendar year requires management and corporate approval.

Benefits under the Paid Leave plan are subject to change at the Company's election.

Additional…

- Flexible Work Arrangements (including flextime and compressed workweek – dependent upon supervisor and/or client approval).
- Automatic deposit of paychecks.
- Leaves of Absence -- Family & Medical Leave (without pay), Parental Leave (without pay), Personal Leave (without pay), Military Leave (with pay for reserve and without pay for Active Duty), and Court-Duty Leave with pay.
- Candidate Referral Bonus. Paid to staff members who refer a candidate that is successfully hired and placed on an assignment. New employee must complete 90 days of service.
- New Business Opportunity Rewards Program. Paid to employees who refer business opportunities into new accounts, after work is begun.

Eligibility for all benefits depends upon the successful completion of applicable eligibility requirements.

EMPLOYEE CONTRIBUTIONS

EMPLOYEE CONTRIBUTIONS

Employee contributions are the employee's share of premium cost and are made through payroll deductions. Payroll deductions, as listed below, are deducted on a pre-tax basis.

MEDICAL & VISION (HDHP)	Monthly	Semi-Monthly	Bi-Weekly
Employee	$113.00	$56.50	$52.15
Employee & Spouse	$562.00	$281.00	$259.38
Employee & Child(ren)	$486.00	$243.00	$224.31
Family	$790.00	$395.00	$364.62

MEDICAL & VISION (Buy-Up)	Monthly	Semi-Monthly	Bi-Weekly
Employee	$272.00	$136.00	$125.54
Employee & Spouse	$942.00	$471.00	$434.77
Employee & Child(ren)	$816.00	$408.00	$376.62
Family	$1328.00	$664.00	$612.92

DENTAL	Monthly	Semi-Monthly	Bi-Weekly
Employee	$34.70	$17.35	$16.02
Employee & Spouse	$70.10	$35.05	$32.35
Employee & Child(ren)	$83.40	$41.70	$38.49
Family	$119.00	$59.50	$54.92

EMPLOYEE CONTRIBUTIONS

STD	EMPLOYEE COST
Employee	$0, Highmark Companies, LLC pays 100% of cost

LTD	EMPLOYEE COST
Employee	$0, Highmark Companies, LLC pays 100% of cost

BASIC LIFE and AD&D	EMPLOYEE COST
Employee	$0, Highmark Companies, LLC pays 100% of cost

SUPPLEMENTAL LIFE - EMPLOYEE	MONTHLY EMPLOYEE COST
AGE	$25,000 (Example)
0-34	$1.75
35-39	$2.50
40-44	$3.75
45-49	$6.00
50-54	$9.00
55-59	$15.50
60-64	$25.25
65-69	$41.00
70-74	$66.25
75+	$111.75

EMPLOYEE CONTRIBUTIONS

SUPPLEMENTAL LIFE - SPOUSE	MONTHLY EMPLOYEE COST (Based on Age of Employee)
AGE	$5,000 (Example)
0-34	$0.35
35-39	$0.50
40-44	$0.75
45-49	$1.20
50-54	$1.80
55-59	$3.10
60-64	$5.05
65-69	$8.20
70-74	$13.25
75+	$22.35

SUPPLEMENTAL LIFE – CHILD(REN)	MONTHLY EMPLOYEE COST
Coverage	$10,000
14 days to age 26	$1.70

LEGAL NOTICES

Please visit MyHighmarkBenefits.com to view your complete Summary Plan Description

LEGAL NOTICES

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that addresses the privacy and security of certain individually identifiable health information, called protected health information (or PHI). You have certain rights with respect to your PHI, including a right to see or get a copy of your health and claims records and other health information maintained by a health plan or carrier. For a copy of the Notice of Privacy Practices, describing how your PHI may be used and disclosed and how you get access to the information, contact Human Resources.

Women's Health and Cancer Rights Act Enrollment Notice

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

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

These will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this benefits plan. Therefore, the plan deductibles and coinsurance apply. If you would like more information on WHCRA benefits, contact your plan administrator: Courtney Akers, Vice President, Administration| Phone: 919-803-5848 | Email: cakers@highmarkcompanies.com

Newborns' and Mothers' Health Protection Act Disclosure

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

Patient Protection Notice

Your carrier generally may require the designation of a primary care provider. You have the right to designate any primary care provider who participates in your network and who is available to accept you or your family members. Until you make this designation, your carrier may designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Cigna at 877.501.7990.

For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from your carrier 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 your network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Cigna at 877.501.7990.

LEGAL NOTICES

HIPAA Special Enrollment Notice

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 toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy. To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact the plan administrator Courtney Akers, Vice President, Administration| Phone: 919-803-5848 | Email: cakers@highmarkcompanies.com

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

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

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

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

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

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

LEGAL NOTICES

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)	Website: Health Insurance Premium Payment (HIPP) Program 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

LEGAL NOTICES

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: 1-800-766-9012
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	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: (617) 886-8102
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

LEGAL NOTICES

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: http://www.nd.gov/dhs/services/medicalserv/medicaid/ 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 http://www.oregonhealthcare.gov/index-es.html 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: http://gethipptexas.com/ 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://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp 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

LEGAL NOTICES

Genetic Information Nondiscrimination Act (GINA) Disclosures
Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that 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.

USERRA Notice

Your Rights Under USERRA

A. The Uniformed Services Employment and Reemployment Rights Act

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

B. Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

C. Right to Be Free from Discrimination and Retaliation

If you:

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service; then an employer may not deny you
  - Initial employment;
  - Reemployment;
  - Retention in employment;
  - Promotion; or
  - Any benefit of employment because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

D. Health Insurance Protection

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

E. Enforcement

- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its Web site at *http://www.dol.gov/vets.* An interactive online USERRA Advisor can be viewed at *http://www.dol.gov/elaws/userra.htm*.

- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the Internet at this address: *http://www.dol.gov/vets/programs/userra/poster.htm*. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees. U.S. Department of Labor, Veterans' Employment and Training Service, 1-866-487-2365.

COBRA

Model General Notice of COBRA Continuation Coverage Rights

(For use by single-employer group health plans)

**** 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.

LEGAL NOTICES

COBRA

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).

LEGAL NOTICES

COBRA

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 your Cobra administrator.

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, Medicaid, 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**.

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/agencies/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 Contact: Courtney Akers, Vice President, Administration| Phone: 919-803-5848 | Email: cakers@highmarkcompanies.com

LEGAL NOTICES

COBRA

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LEGAL NOTICES

Medicare Part D

Important Notice from Highmark Companies, LLC about your Prescription Drug Coverage and Medicare

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

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

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **Highmark Companies, LLC has determined that the prescription drug coverage offered by the Highmark Companies, LLC Health Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Highmark Companies, LLC coverage will not be affected. Medicare eligible individuals have available to them when they become eligible for Medicare Part D] (e.g., they can keep this coverage if they elect part D and this plan will coordinate with Part D coverage; *See* pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.]

If you do decide to join a Medicare drug plan and drop your current Highmark Companies, LLC coverage, be aware that you and your dependents will be able to get this coverage back.

LEGAL NOTICES

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Highmark Companies, LLC and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact: Courtney Akers, Vice President, Administration| Phone: 919-803-5848 | Email: cakers@highmarkcompanies.com

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Highmark Companies, LLC changes. You also may request a copy of this notice at any time.

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 you have maintained creditable coverage and, therefore, whether you are required to pay a higher premium (a penalty).

LEGAL NOTICES

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 7-31-2023)

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one–stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or visit **MyHighmarkBenefits.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.

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

LEGAL NOTICES

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 919-779-3055
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 this employer:

- As your employer, we offer a health plan to:
  - □ Eligible employees working 30+ hours per week, 1st of month following/on date of hire

With respect to dependents:

We do offer coverage. Eligible dependents are your spouse, domestic partner, children under age 26 that are classified as natural, adopted, step, foster, court ordered, under full time employees. A handicapped child, age 26 years or over, who was insured under the medical plan before reaching age 26, is also eligible.

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

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

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

NOTES

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Visit MyHighmarkBenefits.com to learn more about your employee benefits.