Neiman Marcus | Group

Legal Notices - August 1, 2022

Women's Health and Cancer Rights Act Notice

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact the NMG Benefit Service Center at (866) 673-0462.

Notice of Special Enrollment Rights under the Health Insurance Portability and Accountability Act (HIPAA)

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage (including COBRA), 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).

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.

Also, you may be able to enroll yourself and your dependents in this plan if your or your dependents' coverage under a Medicaid plan or a State Children's Health Insurance Program (CHIP) plan terminates due to loss of eligibility for such coverage or if you or your dependents become eligible for premium assistance under a Medicaid plan or a CHIP plan. However, you must request enrollment within 60 days 1) after your or your dependent's coverage ends under Medicaid or CHIP plan, or 2) after your or your dependent's determination of eligibility for premium assistance under a Medicaid or CHIP plan.

To request special enrollment or obtain more information, please contact The Neiman Marcus Group Benefit Service Center by logging on to **NMGbenefits.com**. If you do not have internet access, you can call (866) 673-0462, Monday through Friday (excluding New York Stock Exchange holidays) between 8:00 a.m. and 8:00 p.m. Eastern time to speak with a Customer Service Associate. Coverage will be effective for all individuals who become covered under this Plan because of a loss of other coverage as soon as administratively practicable following a timely application for special enrollment. Coverage for a new dependent will be effective on the date of marriage, birth, adoption or placement for adoption, provided that timely application for special enrollment is made.

NOTICE OF PRIVACY PRACTICES
for
THE NEIMAN MARCUS GROUP LLC BENEFIT PROGRAM,
POST-65 RETIREE MEDICAL BENEFIT PROGRAM AND CAFETERIA PLAN

Effective Date: January 1, 2022

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") requires The Neiman Marcus Group LLC Benefit Program, The Neiman Marcus Group LLC Post-65 Retiree Medical Benefit Program and The Neiman Marcus Group LLC Cafeteria Plan (collectively, the "Plans") to maintain the privacy of your Protected Health Information ("PHI") for medical, dental and other health benefits offered under the Plans – whether received in writing, in an electronic medium, or as an oral communication.

The Plans are committed to protecting the privacy of your PHI and to providing you with a notice of their legal duties and privacy practices with respect to your PHI, pursuant to HIPAA. This Notice of Privacy Practices ("Notice") describes how the Plans may use and disclose PHI about you to carry out treatment, payment or health care operations and for other specified purposes that are permitted or required by law. The Notice also describes your rights with respect to your PHI.

The Plans are required to follow the terms of this Notice. The Plans will not use or disclose PHI about you without your written authorization, except as described in this Notice. These policies and procedures may be changed from time to time as the need arises. Any changes will be applicable to all PHI maintained by the Plan. If changes are made to the policies and procedures, you will be provided with an updated notice. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

It is important to note that these rules apply to the Plans, not The Neiman Marcus Group LLC ("NMG" or the "Company") as an employer. Different policies may apply to other NMG programs or to data unrelated to the Plan.

How to Contact the Plans

If you have any questions or need further information about this Notice, you can either write to or call:

The Neiman Marcus Group LLC
1618 Main St.
Dallas, TX 75201
Attn: Vice-President – Total Rewards 1-214-757-2888

Your Individual Rights

You have the following rights with respect to the PHI the Plans maintain about you. These rights are subject to certain limitations, as discussed below.

- *Obtain a paper copy of the Notice upon request.* At any time, you may request a copy of this Notice, as it may be modified from time to time. To obtain a paper copy, please contact the Plans using the contact information provided above.

- *Request a restriction on certain uses and disclosures of PHI.* You have the right to request additional restrictions on thePlans' use or disclosure of your PHI by sending a written request to the HIPAA Privacy Official at the address provided above. Please clearly and concisely identify: (a) the information you wish to be restricted; (b)

how you want the information restricted; and (c) to whom you want the limits to apply. The Plans are not required to agree to any such restrictions. The Plans will not use or disclose your PHI in violation of any restrictions the Plans agree to, other than as required by law, in an emergency or when the information is necessary to treat you.

- *Inspect and obtain a copy of PHI.* You have the right to access and copy your PHI that may be used to make decisions about you – a "designated record set" – for as long as the Plans maintain the PHI. This right is limited to enrollment, payment, claims adjudication, and case or medical management record systems maintained by the Plans, as well as records used to make decisions about individuals. The Plans generally are required to provide you with access to your PHI within thirty (30) days after receipt of your request. To inspect or copy your PHI, you must send a written request to the HIPAA Privacy Official at the address noted above. You also may request that copies of your health information be sent to another entity or person, so long as that request is clear, specific and directs where the copies are to be sent. You may be charged a reasonable fee for the costs of copying, transmitting and/or mailing your PHI. The Plans may deny your request to inspect and copy your PHI in certain limited circumstances. If you are denied access to your PHI, you may request that the denial decision be reviewed by sending a written request to the HIPAA Privacy Official at the address noted above.

- *Request an amendment of PHI.* If you feel that PHI the Plans maintain about you is incomplete or incorrect, you mayrequest that the Plans amend the PHI. You may request an amendment for as long as the Plans maintain the PHI. To request an amendment, you must send a written request to the HIPAA Privacy Official at the address provided above. In addition, you must include with your written request a specific reason that supports your request. In certaincases, the Plans may deny your request for amendment and, if so, will inform of the reason for the denial within sixty (60) days. If your request for an amendment is denied, you have the right to file a statement of disagreement with thedecision by sending your statement to the HIPAA Privacy Official at the address provided above and the Plans may provide a rebuttal to your statement.

- *Receive an accounting of disclosures of PHI.* You have the right to receive an accounting of certain disclosures of your PHI made by the Plans for the six (6) years prior to the date you request the accounting. This right applies to most disclosures that are made for purposes *other than* treatment, payment or health care operations. The accounting will exclude disclosures the Plans have made directly to you, disclosures to friends or family members involved in your care, and disclosures for notification purposes. The right to receive an accounting is subject to certain other exceptions, restrictions and limitations, all of which are set out in HIPAA. To request an accounting, youmust submit your request in writing to the HIPAA Privacy Official at the address provided above. Your request must specify the time period for which you want an accounting, but that time period may not exceed six (6) years. The firstaccounting you request within a twelve (12) month period will be provided free of charge, but you may be charged forthe cost of providing additional accountings within the same twelve (12) month period. Following your request for an accounting, you will be notified of the cost associated with providing the accounting and you may choose to withdrawor modify your request at that time.

- *Request communications of PHI by alternative means or at alternative locations.* You may request that the Plans contact you about medical matters only in writing or at a different residence or post office box than the one at whichyou receive your other mail. To request confidential communication of your PHI, you must submit your request in writing to the HIPAA Privacy Official at the address provided above. Your request must specify how or where you would like to be contacted. The Plans will accommodate all reasonable requests for communicating via alternative means or locations, and the Plans must accommodate your request if you inform the Plans that you would be in danger if such request was denied.

- *Receive notice of breach of unsecured PHI.* The Plans are required to promptly notify you if a breach occurs thatmay have compromised the privacy or security of your information.

- *Choose someone to act for you.* If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. The Plans will ensure the person has this authority and can act for you before taking any action.

How the Plan May Use or Disclose Your Protected Health Information

The following categories describe and provide examples of different ways that the Plans may use and disclose PHI about you. Note that the examples listed do not constitute an exhaustive list but merely illustrate some of the ways PHI may be used and disclosed.

- *Treatment.* The Plans may use or disclose your PHI in coordinating or managing your health care and its related services with your health services providers. For example, the Plans' third-party administrator may be required to review your medical information to assist you in obtaining pre-certification of certain health services or hospital admissions. During that pre-certification process, the third-party administrator may disclose the reasons you have requested treatment to your health services provider. The Plans also may use or disclose your PHI when providinginformation regarding health-related services that may be available to you under the Plans, or describing treatmentalternatives.

- *Payment.* The Plans may use or disclose PHI submitted by you or your health care provider in making determinations concerning coverage or eligibility, such as when itemized medical bills are submitted to the Plans or their third-party administrators for reimbursement. The submitted medical bills will usually include information that identifies you, as well as the services or procedures provided and supplies used.

- *Health care operations.* The Plans may use or disclose your PHI in a number of ways involving plan administration. The Plans may use your PHI to provide you and your dependents with customer service in resolving Plan claims. Your information could also be used in arranging or conducting medical or legal review of Plan claims. The Plans also may disclose your PHI to plan sponsor personnel in connection with these activities. If you are covered under an insured health plan, the insurer also may disclose PHI to the plan sponsor in connection with payment, treatment or health careoperations. Although the Plans may use or disclose your PHI for health care operations, the Plans cannot use or disclose PHI that is genetic information for underwriting purposes (generally, eligibility determinations, premium computations, application of pre-existing condition exclusions, and any other activities related to the creation, renewal, or replacement of health benefits). Genetic information includes information regarding genetic tests for you and your family members, information regarding the manifestation of a disease or disorder in your family members, and any request for (or receipt of) genetic services, including participation in clinical research trials that involve genetic services.

- *Communication with individuals involved in your care or payment for your care.* The Plans may, using the Plans' professional judgment, disclose your PHI to a family member, other relative, close personal friend or any person youidentify, if the PHI is relevant to that person's involvement in your care or payment related to your care.

- *As required by the Secretary of Health and Human Services.* The Plans may be required to disclose your PHI to the Secretary of Health and Human Services so that the Secretary may investigate or determine the Plans' compliance with HIPAA.

- *Workers' compensation.* The Plans may disclose PHI about you to the extent authorized by and to the extent necessary to comply with state laws relating to workers' compensation or other similar programs established by law.

- *Public health.* The Plans may disclose PHI about you to public health or legal authorities charged withpreventing or controlling disease, injury or disability.

- *Law enforcement.* The Plans may disclose PHI about you for law enforcement purposes as required by law or inresponse to a validly issued subpoena or other legal process. This includes state and federal prescription use monitoring programs.

- *National security and intelligence activities.* The Plans may release PHI about you to authorized federal officials forintelligence, counterintelligence and other national security activities when required to do so and such disclosure isauthorized by law.

- *As required by law.* The Plans must disclose PHI about you when required to do so by law.

- *Health oversight activities.* The Plans may disclose PHI about you to an oversight agency for activities

authorized or monitored by law. These oversight activities include audits, investigations and inspections as needed for the Plans’ licensure and for the government to monitor the health care system and government programs, as well as compliancewith civil rights laws.

- *Judicial and administrative proceedings.* If you are involved in a lawsuit or a dispute, the Plans may disclose PHI aboutyou in response to a court or administrative order. The Plans may also disclose PHI about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the requested PHI.

- *Research.* The Plans may disclose PHI about you to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy ofyour information.

- *Coroners, medical examiners, and funeral directors.* The Plans will not release PHI about you to a coroner, medical examiner or funeral director without your authorization unless required to do so by law. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Plans may also disclose PHI to funeral directors to assist them in carrying out their responsibilities, provided such disclosure is consistent with applicable law.

- *Organ or tissue procurement organizations.* The Plans may, consistent with applicable law, disclose PHI about youto organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.

- *Correctional institution.* If you are or become an inmate of a correctional institution, the Plans may disclose to theinstitution or its agents PHI necessary for your health and the health and safety of others.

- *To avert a serious threat to health or safety.* The Plans may use and disclose PHI about you when necessary toprevent a serious threat to your health and safety or the health and safety of the public or another person.

- *Specialized government functions.* The Plans may disclose PHI for purposes related to the military or national securityconcerns, such as for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits. The Plans may also release PHI about foreign military personnel to the appropriate military authority.

- *Victims of abuse, neglect or domestic violence.* The Plans may disclose PHI about you to a government authority, suchas a social service or protective services agency, if the Plans reasonably believe you are a victim of abuse, neglect or domestic violence. The Plans will only disclose this type of information to the extent required by law, if you agree to disclosure or if the disclosure is allowed by law and the Plans believe it is necessary to prevent serious harm to you or someone else, or if the law enforcement or public official that is to receive the report represents that it is necessary andwill not be used against you.

Other Permitted Uses or Disclosure of Protected Health Information

The Plans will obtain your written authorization before using or disclosing PHI about you for purposes other than those soon as reasonably possible following receipt of the written revocation, the Plans will stop using or disclosing PHI about provided for above or as otherwise permitted or required by law. Your authorization is required for any use or disclosure of PHI for marketing communications or sales of PHI that involve financial remuneration to the Plans. You may revoke an authorization at any time by submitting a written revocation to the HIPAA Privacy Official at the address provided above. As you,except to the extent that the Plans have already taken action in reliance on the authorization. Please note that the Plans maybe required by applicable law to retain certain PHI about you.

Other Restrictions on Uses and Disclosures of PHI

The uses and disclosures of your PHI described above are permitted or required by federal law. Whenever the

Plans use, disclose or request medical information, the Plans will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose for the use, disclosure or request, taking into consideration practical and technological limitations. In general, until regulations are issued, disclosure will be limited to limited data set information unless more information is needed.

Complaints

If you believe that your privacy rights have been violated, you may complain to the Plan in writing at the location described below or to the U.S. Department of Health and Human Services Office for Civil Rights in writing at 200 Independence Avenue, S.W., Washington, D.C. 20201, by calling 1-877-696-6775, or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. You will not be retaliated against for filing a complaint.

You may contact the Plan to exercise the rights described in this notice by contacting:

The Neiman Marcus Group LLC
1618 Main St.
Dallas, TX 75201
Attn: Vice-President – Total Rewards
1-214-757-2888

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 moreinformation, visit **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 dependentsmight be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or **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 **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, 2021. Contact your State for more informationon eligibility.

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

GEORGIA-Medicaid	MAINE-Medicaid
A 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	Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711
INDIANA-Medicaid	**MASSACHUSETTS-Medicaid and CHIP**
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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840
IOWA-Medicaid and CHIP (Hawki)	**MINNESOTA-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://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
KANSAS-Medicaid	**MISSOURI-Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KENTUCKY-Medicaid	**MONTANA-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.aspxPhone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
LOUISIANA-Medicaid	**NEBRASKA-Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahippPhone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA-Medicaid	SOUTH CAROLINA-Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEW HAMPSHIRE-Medicaid	**SOUTH DAKOTA-Medicaid**
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345,ext 5218	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW JERSEY-Medicaid and CHIP	**TEXAS-Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.htmlCHIP Phone: 1-800-701-0710	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW YORK-Medicaid	**UTAH-Medicaid and CHIP**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH CAROLINA-Medicaid	**VERMONT-Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH DAKOTA-Medicaid	**VIRGINIA-Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OKLAHOMA-Medicaid and CHIP	**WASHINGTON-Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
OREGON-Medicaid	**WEST VIRGINIA-Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.htmlPhone: 1-800-699-9075	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)
PENNSYLVANIA-Medicaid	**WISCONSIN-Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP- Program.aspx Phone: 1-800-692-7462	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002

RHODE ISLAND-Medicaid and CHIP	WYOMING-Medicaid
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://health.wyo.gov/healthcarefin/medicaid/programs- and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2022, 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.

Wellness Program

The Living Well Program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a biometric screening, which will include a blood test for cotinine, Hemoglobin A1c, Cholesterol, and Triglycerides. You are not required to participate in the blood test or othermedical examinations.

Employees who choose to get a Biometric Screening will receive a premium differential. Although you are not required toparticipate in the biometric screening, only employees who do so will receive full differential.

Additional incentives are available for employees who do not pass the biometric screening. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, youmay be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or alternative standard by contacting the Benefits Service Center at 866-673-0462. The information

fromyour biometric screening will be used to provide you with information to help you understand your current health and potential risks and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and the Neiman Marcus Group may use aggregate information it collects to design a program based on identified health risks in the workplace, the Living Well Program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information thatpersonally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individuals who will receive your personally identifiable health information are a health coach and clinical team in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact The Neiman Marcus Group Corporate Benefits Department at 1201 Elm St., Suite 2912, Dallas, TX 75270.

Important Notice 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 under The Neiman Marcus Group Benefit Program and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription 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.

The following notice applies to you if you are covered under the Bronze, Bronze Plus, Silver, Gold, or Gold II plans. We have determined that the prescription drug coverage offered under each of these plan options is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay

and is therefore considered creditable coverage. Because your existing coverage under the Bronze, Bronze Plus, Silver, Gold, or Gold II plan is, on average, at least as good as standard Medicare prescription drug coverage, you can keep your existing prescription drug coverage under your plan option and not pay a higher premium (a penalty) if you later decide to enroll in Medicare prescription drug coverage.

When Can You Join a Medicare Drug Plan? Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from October 15 through December 7. If you lose your current creditable coverage under the Plan through no fault of your own, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare prescription drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan? If you decide to enroll in a Medicare prescription drug plan and drop your current prescription drug coverage under the plan, be aware that you and your dependents may not be able to get this coverage back. If you or a covered dependent decides to enroll in a Medicare prescription drug plan and do not drop your current prescription drug coverage under the plan, Medicare will be the secondary payer for prescription drug costs. In other words, eligible prescription drug claims will be paid under the plan first. If there are prescription drug claims that are not covered or are only partially covered under the plan, Medicare may pay for eligible expenses that are not paid under the plan.

Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

You should compare your current prescription drug coverage (including which drugs are covered) and costs under theBronze, Bronze Plus, Silver, Gold, or Gold II plan, as applicable, to the plans offering Medicare prescription drug coverage in your area. By comparing the coverage and costs of the plans, you can determine if adding the Medicare prescription coverage will be beneficial to you.

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

Since, under the Bronze, Bronze Plus, Silver, Gold, or Gold II plan, as applicable, you now have prescription drug coverage that, on average, is as good as Medicare coverage, you can choose to join a Medicare prescription drug plan later. You will not have to pay the higher premium (described below) as long as you do not go 63 continuous days or longer without prescription coverage that is as good as Medicare.

You should also know that if you drop or lose your coverage under the Bronze, Bronze Plus Silver, Gold, or Gold II plan, as applicable, and don’t enroll in Medicare prescription drug coverage within 63 continuous days after your current coverage ends, you may have to pay a higher premium (a penalty) to enroll in Medicare prescription drug coverage later. Specifically, if you go 63 continuous days or longer without prescription drug coverage that’s at least as good as Medicare’s prescription drug coverage, your monthly premium for Medicare prescription drug coverage will go up at least one percent (1%) of the Medicare base beneficiary premium per month for every month after your initial enrollment period that you did not have that coverage.

For example, if you go 19 months without coverage, your premium may consistently be at least 19% higher than what most other people pay. You’ll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next October to enroll.

For more information about this notice or your current prescription drug coverage

Regardless of whether you are covered under the Bronze, Bronze Plus, Silver, Gold, or Gold II plan, you may call The Neiman Marcus Group Benefit Service Center toll-free at (866) 673-0462, Monday through Friday (excluding New York Stock Exchange holidays) between 8:00 a.m. and 8:00 p.m. Eastern time to speak with a Customer Service Associate about your prescription drug coverage. Note: You will receive this notice annually and at other

times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage changes. You also may request a copy 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 from Medicare. You may also be contacted directly by Medicare prescription drug plans.

You can also get more information about Medicare prescription drug plans from the following:

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

Remember: Keep this notice.

If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may need to givea copy of this notice when you join to show whether or not you have maintained creditable coverage, and therefore, whether or not you are required to pay a higher premium amount.

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

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

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, such as a copayment, coinsurance, and/or a deductible. You may have other 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" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay 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 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.

You are 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 the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). 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 may 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 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 care out-of-network. You can choose a provider or facility in your plan's network.

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

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:

    - Cover emergency services without requiring you to get approval for services in advance (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 deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the Department of Health and Human Services.

Visit: https://www.cms.gov/nosurprises/consumers or call 1-800-985-3059 for more information about your rights under federal law.