2022-2023

Employee Benefits

A comprehensive guide to understanding your employee benefits program

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For benefit related questions, please contact your dedicated Benefits Specialist:

Sarah Stellabotte

Email: SStellabotte@higginbotham.net

Phone: 470-275-9204

Welcome

We are pleased to offer you a comprehensive benefits package intended to protect your well-being and financial health. This guide is your opportunity to learn more about the benefits available to you and your eligible dependents beginning August 1, 2022.

To get the best value from your health care plan, please take the time to evaluate your coverage options and determine which plans best meet your health care and financial needs. By being a wise consumer, you can support your health and maximize your health care dollars.

Each year during Open Enrollment, you have the opportunity to make changes to your benefit plans. The enrollment decisions you make this year will remain in effect through July 31, 2023. You may make changes to your benefit elections only when you have a Qualifying Life Event. After such an event, you can make changes to your health care coverage within 30 days; otherwise, you cannot make changes to your benefits coverage until the next Open Enrollment period.

Availability of Summary Health Information

Our Employee Benefits Program offers three health coverage options. To help you make an informed choice and compare your options, a Summary of Benefits and Coverage (SBC) is available, which summarizes important information about your health coverage options in a standard format.

The SBC's are available in MyPay.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 18 for more details.

Eligibility

You are eligible for benefits if you are a regular, full-time employee working an average of 30 hours per week. Your coverage is effective the first of the month after your full-time hire date. You may also enroll eligible dependents for benefits coverage. The cost to you for dependent coverage will vary depending on the number of dependents you enroll in the plan and the particular plans you choose. When covering dependents, you must select the same plans for your dependents as you select for yourself.

Eligible Dependents include:

- Your legal spouse
- Children under the age of 26, regardless of student status, dependency or marital status
- Children who are fully dependent on you for support due to a mental or physical disability and who are indicated as such on your federal tax return; coverage may continue past age 26

How to Enroll

Access your MyPay account by visiting, hralliance.net/ee/Login.aspx.

Once you have logged into MyPay, follow prompts to access your electronic enrollment forms.

Qualifying Life Events

Once you elect your benefit options, they will remain in effect for the entire plan year until the following Open Enrollment. You may only change coverage during the plan year if you have a Qualifying Life Event, and you must do so within 30 days of the event.

Qualifying Life Events include:

- Marriage, divorce, legal separation or annulment
- Birth, adoption or placement for adoption of an eligible child
- Death of a spouse or child
- Change in your spouse's employment that affects benefits eligibility
- Change in your child's eligibility for benefits (reaching the age limit)
- Change in residence that affects your eligibility for coverage
- Significant change in coverage or cost in your, your spouse's or child's benefit plans
- FMLA leave, COBRA event, Court Judgment or Decree
- Becoming eligible for Medicare or Medicaid
- Receiving a Qualified Medical Child Support Order

If you have a Qualifying Life Event and want to request a mid-year change, you must notify Human Resources and complete your election changes within 30 days following the event. Be prepared to provide documentation to support the Qualifying Life Event.

Medical Coverage

ML Property Group offers three medical plans, provided by Anthem. The POS and HDHP allow access to both in-network and out-of-network providers, but you will get better discounts and pay less money by remaining in-network. All out-of-network services are subject to Reasonable and Customary (R&C) limitations and you are responsible for all charges over this allowance. **Please keep in mind, that any coinsurance amounts for out-of-network charges are subject to the out-of-network deductible, not the in-network deductible.**

Point of Service Plan (POS)

The POS option offers the freedom to see any provider when you need care. When you use providers from within the Anthem POS network, you receive benefits at the discounted network cost. If you use non-POS providers, you will pay more for services.

High Deductible Health Plan (HDHP)

The HDHP is similar to the POS in that you have the option to choose any provider when you need care. However, in exchange for a lower per-paycheck cost, you must satisfy a higher deductible that applies to almost all health care expenses, including those for prescription drugs. Once your deductible has been met, you will continue to pay a prescription copay until your out-of-pocket maximum is met, then the plan pays 100%.

Health Coverage Reminder

The Patient Protection and Affordable Care Act (PPACA) requires most individuals to have minimum essential health coverage. You may obtain coverage through your employer or through the Marketplace.

- Depending on your income and the coverage offered by your employer, you may be able to obtain lower cost private insurance in the Marketplace.
- If you buy insurance through the Marketplace, you may lose any employer contribution to your health benefits.
- Visit **www.HealthCare.gov** for Marketplace information.

REMINDER: You may only purchase insurance through the Marketplace if you experience a qualifying event OR during Open Enrollment. The Federal Marketplace Open Enrollment dates are November 1 through December 15.

	Base Plan		Buy-Up Plan		HSA Open Access POS	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible						
Individual	$ 3,000	$ 9,000	$ 2,500	$ 7,500	$ 5,000	$ 15,000
Family	$ 9,000	$ 27,000	$ 7,500	$ 22,500	$ 10,000	$ 30,000
Calendar Year Out-of-Pocket Maximum (Includes Deductible)						
Individual	$ 7,900	$ 23,700	$ 7,900	$ 23,700	$ 6,900	$ 20,700
Family	$15,800	$ 47,400	$ 15,800	$ 47,400	$ 13,800	$ 41,400
Lifetime Maximum	Unlimited		Unlimited		Unlimited	
	You pay		**You pay**		**You pay**	
Coinsurance / Copays						
Preventive Care	$ 0 copay	50% after deductible	$0 copay	50% after deductible	$ 0	50% after deductible
Primary Care Physician	$ 30 copay	50% after deductible	$ 30 copay	50% after deductible	0% after deductible	50% after deductible
Specialist	$ 60 copay	50% after deductible	$ 60 copay	50% after deductible	0% after deductible	50% after deductible
Urgent Care	$ 75 copay	50% after deductible	$ 75 copay	50% after deductible	0% after deductible	50% after deductible
Emergency Room	$ 350 copay	50% after deductible	$ 350 copay	50% after deductible	0% after deductible	50% after deductible
Inpatient Hospital Care	20% after deductible	50% after deductible	0% after deductible	50% after deductible	0% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible	0% after deductible	50% after deductible	0% after deductible	50% after deductible
Pharmacy						
Retail RX (up to 31 day supply)/Mail Order RX (up to 90 day supply)						
Tier 1	$ 15 copay/$15 copay	$ 15 copay/Does not apply	$ 15 copay/$15 copay	$ 15 copay/Does not apply	$ 15 copay/$15 copay after deductible	$ 15 copay after deductible/Does not apply
Tier 2	$ 35 copay/$70 copay	$ 35 copay/Does not apply	$ 35 copay/$70 copay	$ 35 copay/Does not apply	$ 35 copay/$70 copay after deductible	$ 35 copay after deductible/Does not apply
Tier 3	$ 60 copay/$180 copay	$ 60 copay/Does not apply	$ 60 copay/$180 copay	$ 60 copay/Does not apply	$ 60 copay/$180 copay after deductible	$ 60 copay after deductible/Does not apply
Tier 4 (for Retail and Mail Order RX, unless noted otherwise)	25% coinsurance, up to $350	25% coinsurance, up to $350 (retail only)	25% coinsurance, up to $350	25% coinsurance, up to $350 (retail only)	25% coinsurance, up to $350	25% coinsurance, up to $350 (retail only)

Health Savings Account

If you enroll in the High Deductible Health Plan (HDHP), you are eligible to open a Health Savings Account (HSA). A HSA is a personal savings account which you can use to pay qualified out-of-pocket medical expenses with pre-tax dollars. You own and control the money in your HSA. The money in your account (including interest and investment earnings) grows tax-free, and as long as the funds are used to pay for qualified medical expenses, they are spent tax-free.

Unlike a Flexible Spending Account, there is no "use-it-or-lose-it" rule—you do not lose your money if you don't spend it in the calendar year, and there are no vesting requirements or forfeiture provisions. The account will automatically roll over year-after-year. Since it is an individual account, if you change health plans or jobs, the balance is yours to keep.

HSA Eligibility

You are eligible to open and contribute to an HSA if you:

- Are enrolled in a HSA-eligible HDHP
- Are **not** covered by other non-HDHP, such as your spouse's health plan, Health Care Flexible Spending Account, or Health Reimbursement Arrangement
- Are **not** eligible to be claimed as a dependent on someone else's tax return
- Are **not** eligible for Medicare or TRICARE
- Have not received Veterans Administration benefits

You can use the money in your HSA to pay for qualified medical expenses now or in the future. Your HSA can be used for your expenses and those of your spouse and dependents, even if they are not covered by the HDHP.

Maximum Contributions

Your 2022 contributions to your HSA may not exceed the annual maximum amount established by the Internal Revenue Service. The annual contribution maximum is based on the coverage option you elect.

- **Individual** $3,650
- **Family (filing jointly)** $7,300

Employees age 55 and older are allowed to make an additional annual "catch-up" contribution of up to $1,000.

Opening the HSA

Once you enroll in the HDHP medical plan, you are automatically enrolled in the HSA administered by ActWise through PNC Bank.

Once you are enrolled, you will receive a debit card from ActWise/PNC Bank for managing your HSA account reimbursements. Funds available for reimbursement are limited to the balance in your HSA. To manage your HSA, go to the **Sydney Mobile** app or **anthem.com,** to register.

You, NOT your employer, are responsible for maintaining ALL records and receipts for HSA reimbursements in the event of an IRS audit.

Always ask your provider/doctor to file your claims with Anthem so network discounts can be applied. Then you can pay the provider with a debit card from your HSA account based on the balance due after discount.

Please note: You may open a HSA at any financial institution of your choice. However, payroll deductions are available only for a HSA opened through ActWise/PNC Bank.

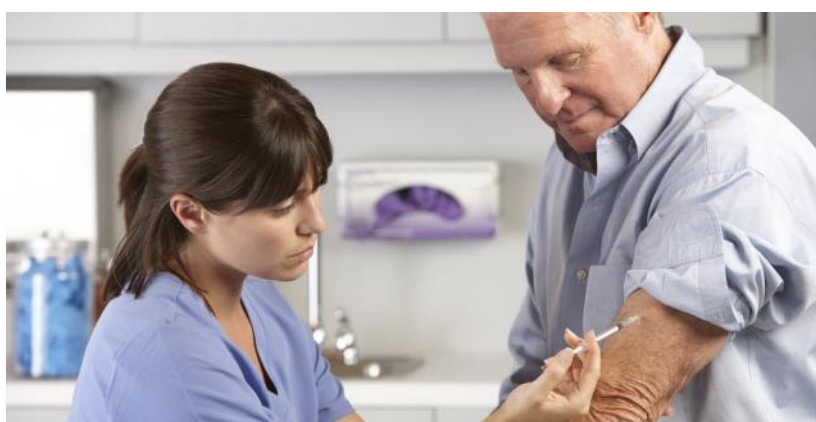
HSA—Basic Information

	HSA
Stands for	Health Savings Account
Who is eligible?	Members enrolled in a high deductible health plan (HDHP) who do not have any other non-HDHP health plan, including coverage under Medicare, a spouse's health plan or Flexible Spending Account (FSA)
Contribution limits	Single coverage: $ 3,650 Family coverage: $ 7,300
Who owns the account?	You
Contributions subject to income tax?	No, as long as they are made via payroll deduction.
Does interest accrue?	Yes
Contributions	Money is deducted (pre-tax) from your salary every pay period. Additional individual contributions up to the maximum contribution amount ARE allowed.
Disbursement of funds	Only funds paid in by you are available for health care expenses.
Catch-up contribution for older workers	Yes. Members aged 55 to 65 may contribute up to $ 1,000 more to their account per year.
Portability and forfeiture	This account is portable. HSA balance is not forfeited when you change employers or health plans.
Expiration	Your funds never expire.
Balance carry over (or rollover)	Yes. Unused funds are carried over to the following year.
Can I change my contribution?	Yes, during your annual open enrollment.
Eligible medical expenses	Qualified medical expenses are defined under Internal Revenue Code 213(d), except for amounts distributed to pay health insurance premiums. HSAs can be used to pay premiums for Temporary Continuation of Coverage, Long Term Care and health insurance for retirees.
Non-medical expenses	HSA funds can be used for non-health care distributions but are included in gross income and subject to a 10% penalty if under age 65.
Proof of expenses required?	No. However, you should be prepared to substantiate to the IRS that the expense has been incurred, the amount of the expense and its eligibility.

Urgent Care Clinics

When you need quick, convenient and affordable treatment for common illnesses but your doctor's office is not open or you need to be seen quickly, urgent care clinics provide simple, non-emergency services to walk-in patients. The nurse practitioners and physician assistants who staff the clinics are certified, licensed health care professionals and are qualified to:

- Diagnose and treat common injuries and minor illnesses
- Prescribe or order medication
- Give most vaccinations



Common Illnesses Treated at Urgent Care Clinics

- Allergy
- Bladder infection
- Flu
- Ear infection
- Upper respiratory infection
- Pink eye or stye
- Sinus infection
- Sore throat
- Insect bite
- Minor burn, rash or skin infection

Did You Know:

The cost of treating MOST common medical conditions can be up to 5 times greater in the Emergency Room than in a physician's office or an urgent care center. Also, persons experiencing a situation requiring prompt medical attention that is not life-threatening may receive faster care at a convenience care clinic or urgent care clinic, or by scheduling a same-day appointment with their primary care physician, if available.

Your out-of-pocket costs are much less in a non-emergency setting :

	Base Plan		Buy-Up Plan		HSA Open Access	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
	You pay		You pay		You pay	
Primary Care Physician	$ 30 copay	50% after deductible	$ 30 copay	50% after deductible	0% after deductible	50% after deductible
Urgent Care	$ 75 copay	50% after deductible	$ 75 copay	50% after deductible	0% after deductible	50% after deductible
Emergency Room (true emergency)	$ 350 copay	50% after deductible	$ 350 copay	50% after deductible	0% after deductible	50% after deductible

Convenience Care Clinics may not be available inside all retail store partners. Check your area for locations.

Dental Coverage

Our dental plan helps you maintain good dental health through affordable options for preventive care, including regular checkups and other dental work. Premium contributions for dental will be deducted from your paycheck on a pre-tax basis.

DPPO Plan

Two levels of benefits are available with the DPPO dental plan depending on whether or not your dentist is in or out of the PPO network. You have the flexibility to select the provider of your choice, but your level of coverage may vary based on the provider you see for services. Staying in-network and going to a contracted DPPO provider will provide you with the highest level of benefits and the deepest discounts your plan has to offer.

How to Find a Dentist

To find an in-network dentist visit, **www.anthem.com**.

	DPPO PLAN
	IN / OUT OF NETWORK
Plan Year[1] Deductible	
Individual	$ 50
Family	$ 150
Plan Year[1] Maximum Benefit	
Individual	$ 5,000 per individual (Basic and Major Services combined)
	You pay
Services	
Office Visit	None
Preventive Procedures Exams, Cleanings, X-rays, Fluoride Treatments	0%
Basic Procedures Fillings, Space Maintainers, Sealants, Extractions, Oral Surgery, Endodontics, Periodontics, Emergency Exams	10%
Major Procedures Crowns, Inlays/Outlays, Dentures, Bridges, Repairs	40%
Orthodontia *(deductible does not apply)*	
Dependent Children Only (up to 19th birthday)	50% up to a lifetime maximum benefit of $ 1,000 per individual

[1]Plan year is August 1 – July 31. Your plan year deductible and benefit maximum will reset to $0 every August 1.

[†]Out-of-Network Providers: When you use out-of-network providers, your benefits will be paid based on a Contracted Fee Schedule (a set amount for each type of service that is determined by Anthem). If your dentist's fee is lower than the Scheduled Fee, the plan will pay benefits based on the actual fee. If the fee is higher, the plan will pay benefits based only on the Scheduled Fee and you ar e responsible for the difference. Pre-treatment Review is highly recommended when dental treatment proposed is over $ 100.

Vision Coverage

The vision plan, offered to you by ML Property Group, is designed to provide your basic eyewear needs and preserve your health and eyesight. In addition to detecting eye problems, vision exams can help identify certain medical conditions such as diabetes or high cholesterol. To help you manage your health, we offer vision coverage through Anthem. You may seek care from any licensed optometrist, ophthalmologist or optician, but plan benefits are higher if you use an Anthem provider.

	Vision Plan	
	IN NETWORK	OUT OF NETWORK
	You pay	**Reimbursement**
Cost		
Exam	$ 10	$ 42
Lenses *(standard plastic)*		
Single Lenses	$ 25	$ 40
Bifocals	$ 25	$ 60
Trifocals	$ 25	$ 80
Frames	$ 130 allowance	$ 45
Contacts in lieu of Frames/Lenses		
Contacts - Medically Necessary	Covered at 100%	$ 210
Contacts - Elective	$ 130 allowance	$ 105
Benefit Frequency		
Exams	Once each calendar year	Once each calendar year
Lenses	Once each calendar year	Once each calendar year
Frames	Once each calendar year	Once each calendar year
Contacts	Once each calendar year	Once each calendar year

Life and AD&D Insurance

Life insurance is an important part of your financial security, especially if others depend on you for support. Even if you are single, your beneficiary can use your Life insurance to pay off your debts, such as credit cards, mortgages and other final expenses.

ML Property Group provides employees with Basic Life insurance and Accidental Death and Dismemberment (AD&D) coverage in the amount of one time your annual salary (up to a maximum of $ 150,000) through Anthem. You are also provided with $ 20,000 of Spouse Basic Life, and $ 5,000 of Child Basic Life.

AD&D coverage helps protect you and your family from the unforeseen financial hardship of a serious accident that causes death or dismemberment. AD&D insurance provides you specified benefits for a covered accidental bodily injury that directly causes dismemberment (i.e., the loss of a hand, foot or eye). In the event that death occurs from an accident, 100% of the AD&D benefit would be payable to your beneficiary(ies).

Voluntary Life and AD&D Coverage

You may purchase additional Life and AD&D insurance for you and your eligible dependents. If you decline Voluntary Life insurance when first eligible or if you elect coverage and wish to increase your benefit amount at a later date, Evidence of Insurability (proof of good health) may be required before coverage is approved.

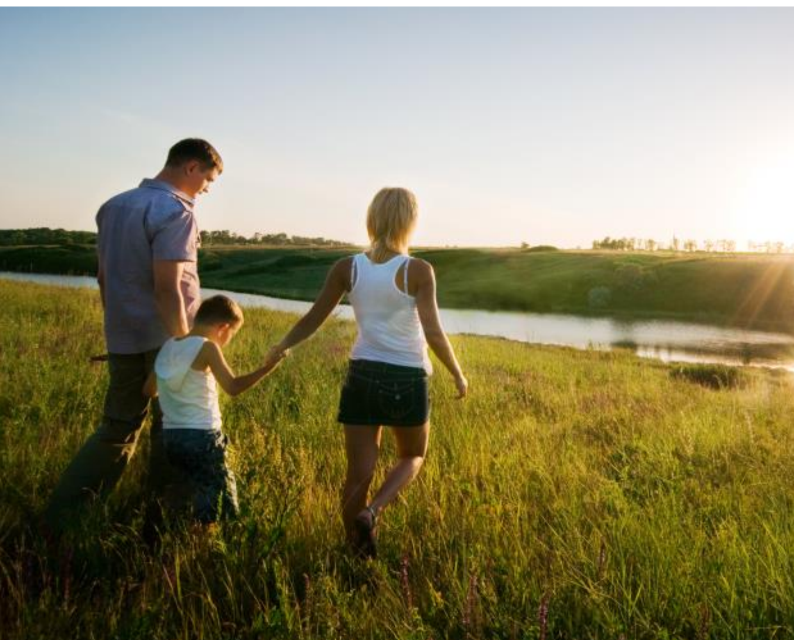
You must elect Voluntary coverage for yourself in order to elect coverage for your spouse or children. Coverage is provided through Anthem.

If you leave ML Property Group, you may take the insurance with you by paying premiums directly to the insurance company.

Designating a Beneficiary

A beneficiary is the person or entity you designate to receive the death benefits of your life insurance policy. You can name more than one beneficiary and you can change beneficiaries at any time. If you name more than one beneficiary, identify the share for each.

Coverage For	Coverage Available
Employee	Employees are eligible for the lesser of $ 500,000, or 5x your annual salary. Guaranteed issue (GI) is $70,000.
Spouse	Spouses are eligible for a maximum of $ 500,000, not to exceed 100% of the employee election. Guaranteed issue (GI) is $15,000.
Child(ren)	Dependent children are eligible for $10,000, ages 6 months to 26 years (if a full-time student).



Voluntary Life and AD&D Rates

Age	Monthly Employee Rate per $ 1,000	Monthly Spouse Rate per $ 1,000
<25	$ 0.096	$ 0.096
25–29	$ 0.105	$ 0.105
30–34	$ 0.141	$ 0.141
35–39	$ 0.210	$ 0.210
40–44	$ 0.320	$ 0.320
45–49	$ 0.499	$ 0.499
50–54	$ 0.734	$ 0.734
55–59	$ 1.051	$ 1.051
60–64	$ 1.352	$ 1.352
65–69	$ 1.924	$ 1.924
70–74	$ 3.640	$ 3.640
75 +	$ 11.252	$ 11.252

Rate	Amount
Employee AD&D Rate	$ 0.034 per $ 1,000
Spouse AD&D Rate	$ 0.038 per $ 1,000
Child Life Rate	$ 0.521 per $ 1,000
Child AD&D Rate	$ 0.089 per $ 1,000

Disability Insurance

If you suddenly become ill or are involved in an accident and are unable to work, it is easy to fall behind on your rent or mortgage, car payment and other expenses. That is why a salary replacement plan is an important benefit for you and your family.

Short Term Disability Insurance

If you become sick or injured and are unable to work, including pregnancy, would you have enough savings to cover your living expenses during that time? ML Property Group provides STD coverage at no cost to you. Coverage is provided through Anthem.

Long Term Disability Insurance

Long Term Disability (LTD) insurance provides long term income protection in the event of sickness or injury. A qualifying disability can occur on or off the job. ML Property Group provides LTD coverage at no cost to you. Coverage is provided through Anthem.

Coverage	Benefit
Short Term Disability	Covers 60% of your base annual earnings, to a $ 500 maximum per week for 22 weeks. Benefits begin on the 15th day of disability.
Long Term Disability	Covers 60% of your base annual earnings to a $ 5,000 maximum per month. Benefit begins after 180 days of disability and continues to age 65 standard ADEA.

Rates

This worksheet helps you calculate your biweekly benefit costs and is not an enrollment form.

2022–2023 Biweekly Cost

Medical Coverage				Medical
	Base	Buy-Up	HSA Open Access POS	$
Employee Only	$88.65	$124.76	$50.55	
Employee + Spouse	$231.86	$317.85	$184.90	
Employee + Child(ren)	$195.02	$252.29	$143.67	
Employee + Family	$409.31	$590.75	$353.70	

HSA Contribution		HSA
HSA	$138.46 (Individual) or $276.92 (Family) Biweekly Maximum Contribution.	$

Dental Coverage		Dental
	DPPO	$
Employee Only	$17.63	
Employee + Spouse	$34.79	
Employee + Child(ren)	$44.10	
Employee + Family	$66.18	

Vision Coverage		Vision
Employee Only	$3.03	$
Employee + Spouse	$6.06	
Employee + Child(ren)	$6.89	
Employee + Family	$10.74	

Subtotal	→	$

Short Term Disability	STD
Employee Only — Paid by ML Property Group	$ 0.00

Long Term Disability	LTD
Employee Only — Paid by ML Property Group	$ 0.00

Basic Life/AD&D	Life/AD&D
Employee Only — Paid by ML Property Group	$ 0.00

Voluntary Employee Life/AD&D

Age	Premium per $1,000	Age	Premium per $1,000	Example of Calculation	Employee
< 25	$0.060	50-54	$0.354	John Doe is 35 years of age and wants $40,000 of Life Insurance.	$
25-29	$0.064	55-59	$0.501	$40,000 ÷ 1,000 = 40	
30-34	$0.081	60-64	$0.640	40 × $0.113 = $4.53	
35-39	$0.113	65-69	$0.916	$4.53 biweekly premium for $40,000 of Employee Life Insurance	
40-44	$0.163	70-74	$1.696		
45-49	$0.246	75+	$5.209		

Voluntary Spouse Life/AD&D

Age	Premium per $1,000	Age	Premium per $1,000	Example of Calculation	Spouse
< 25	$0.062	50-54	$0.356	John Doe is 35 years of age and wants $15,000 of Life Insurance for his wife.	$
25-29	$0.066	55-59	$0.503	$15,000 ÷ 1,000 = 15	
30-34	$0.083	60-64	$0.642	15 × $0.114 = $1.71	
35-39	$0.114	65-69	$0.906	$1.71 biweekly premium for $15,000 of Spouse Life Insurance	
40-44	$0.165	70-74	$1.698		
45-49	$0.248	75+	$5.211		

Voluntary Child Life/AD&D		Child
Per $1,000, Max $10,000	$0.282	$

Your Total 2022—2023 Biweekly Benefit Cost	$

Important Contacts

Coverage	Provider	Contact	Website
Medical	Anthem	855-397-9267	www.anthem.com
Health Savings Account	ActWise / PNC Bank	855-397-9267	www.mywealthcareonline.com/anthem
Dental	Anthem	877-604-2158	www.anthem.com
Vision	Anthem	866-723-0515	www.anthem.com
Life and AD&D	Anthem	800-851-8544	www.anthem.com
Disability	Anthem	800-851-8544	www.anthem.com
Human Resources	Nicole Hill	470-419-5251	NHill@higginbotham.net
Benefit Specialist	Sarah Stellabotte	470-275-9204	SStellabotte@higginbotham.net

Required Notices

Women's Health and Cancer Rights Act of 1998

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a mastectomy is also entitled to the following benefits:

- 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; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

Special Enrollment Rights

This notice is being provided to ensure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage or Becoming Eligible for Medicaid or a state Children's Health Insurance Program (CHIP)

If you are declining coverage for yourself or your dependents because of other health insurance or group health plan coverage, you may be able to later 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 enroll within 31 days after your or your dependents' other coverage ends (or after the employer that sponsors that coverage stops contributing toward the other coverage).

If you or your dependents lose eligibility under a Medicaid plan or CHIP, or if you or your dependents become eligible for a subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents in this plan. You must provide notification within 60 days after you or your dependent is terminated from, or determined to be eligible for such assistance.

Marriage, Birth or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must enroll within 31 days after the marriage, birth, or placement for adoption.

For More Information or Assistance

To request special enrollment or obtain more information, contact:

ML Property Group

Sarah Stellabotte, Benefits Specialist

210 Interstate North Parkway, Suite 400

Atlanta, GA 30339

470-275-9204 or SStellabotte@higginbotham.net

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 ML Property Group and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to enroll in a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or the dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that offers 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.
2. ML Property Group has determined that the prescription drug coverage offered by the ML Property Group medical plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is considered Creditable Coverage. The HSA plan is not considered Creditable Coverage.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare prescription drug plan, as long as you later enroll within specific time periods.

You can enroll in a Medicare prescription drug plan when you first become eligible for Medicare. If you decide to wait to enroll in a Medicare prescription drug plan, you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7 but as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

You should compare your current coverage, including which drugs are covered at what cost, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. See the Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting ML Property Group at the phone number or address listed at the end of this section.

If you choose to enroll in a Medicare prescription drug plan and cancel your current ML Property Group prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage, you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

If you cancel or lose your current coverage and do not have prescription drug coverage for 63 days or longer prior to enrolling in the Medicare prescription drug coverage, your monthly premium will be at least 1% per month greater for every month that you did not have coverage for as long as you have Medicare prescription drug coverage. For example, if nineteen months lapse without coverage, your premium will always be at least 19% higher than it would have been without the lapse in coverage.

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

Contact the Benefits Department at 470-275-9204 .

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 may also request a copy.

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 will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. 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 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you can call them at 800-772-1213. TTY users should call 800-325-0778.

Remember: Keep this Creditable Coverage notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).

Date: 08/01/2022

Name of Entity/Sender: ML Property Group, LLC

Contact Office OR Human Resources: Sarah Stellabotte

Address: 210 Interstate North Parkway, Ste. 400, Atlanta, GA 30339

Phone Number: 470-275-9204

Notice of HIPAA Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can access this information. Please review it carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information known as protected health information (PHI), includes virtually all individually identifiable health information held by a health plan - whether received in writing, in an electronic medium or as oral communication. This notice describes the privacy practices of the Employee Benefits Plan (referred to in this notice as the Plan), sponsored by ML Property Group, hereinafter referred to as the plan sponsor.

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. It is important to note that these rules apply to the Plan, not the plan sponsor as an employer.

You have the right to inspect and copy protected health information which is maintained by and for the Plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask the Human Resources Department to amend the information. For a full copy of the Notice of Privacy Practices describing how protected health information about you may be used and disclosed and how you can get access to the information, contact the Human Resources Department.

Complaints: If you believe your privacy rights have been violated, you may complain to the Plan and to the Secretary of Health and Human Services. You will not be retaliated against for filing a complaint. To file a complaint, please contact the Privacy Officer.

ML Property Group

Human Resources

210 Interstate North Parkway, Ste 400

Atlanta, GA 30339

470-275-9204

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agnecies/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

Continuation of Coverage Rights Under COBRA

Under the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and your eligible dependents are entitled to continue your group health benefits coverage (medical, dental, vision and HCRA) under the Company Name plan after you have left employment with the agency. If you wish to elect COBRA coverage, you have 60 days from the date you receive your election notice to make an election. You have 45 days after electing coverage to pay the initial premium.

Notice Regarding Wellness Program

The employee wellness program is a voluntary program 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 may be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may also be asked to complete a biometric screening, which could include a blood test for certain medical conditions such as diabetes, heart disease, etc. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program may qualify for an incentive. Although you are not required to complete a HRA or biometric screening, the wellness program may specify that only employees who do so will qualify for the incentive. Additional incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes.

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, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Human Resources.

If you choose to participate in a HRA and/or biometric screening, information from your HRA and results from your 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 may use aggregate information it collects to design a program based on identified health risks in the workplace, the wellness 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 that personally 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.

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 Human Resources.

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, 2022. Contact your State for more information on eligibility –

ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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
ALASKA-Medicaid	**COLORADO-Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: 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 711 Health 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.aspx Phone: 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/lahipp Phone: 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.html CHIP 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.html Phone: 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.

OMB Control Number 1210-0137 (expires 1/31/2023)

Notes

Employee Benefits 2022 - 2023

This brochure highlights the main features of the ML Property Group employee benefits program. It does not include all plan rules, details, limitations and exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be an inconsistency between this brochure and the legal plan documents, the plan documents are the final authority. ML Property Group reserves the right to change or discontinue its employee benefits plans at any time.

Higginbotham™