



Legal Notices

NMG reserves the right to update or change any benefits, with or without notice, including associate eligibility criteria for NMG benefits, at any time, subject to the requirements of applicable law. Plan documents and Notices can be found on nmgbenefits.com. You may also request a paper copy by calling 1-866-673-0462.

SUMMARY OF BENEFITS AND COVERAGE (SBC)

SBCs provide plan information in a standard format for each of the employer-sponsored medical plans. To obtain more information, please contact NMG Benefit Service Center at 1-866-673-0462 or online at NMGbenefits.com.

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

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

- 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 1-866-673-0462.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA) NOTICE

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

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.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted, and you will continue to pay the same amount as if you were not absent. If the absence is for more than 31 days and not more than 24 months, you may continue to maintain your coverage under the Plan by paying up to 102% of the full amount of premiums. You and your dependents may also have the opportunity to elect COBRA coverage. Contact the NMG Benefit Service Center at 1-866-673-0462.

Also, if you elect not to continue your health plan coverage during your military service, you have the right to be reinstated in the Plan upon your return to work, generally without any waiting periods or pre-existing condition exclusions, except for service-connected illnesses or injuries, as applicable.

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 other medical examinations.

Employees who choose to get a Biometric Screening will receive a premium differential. Although you are not required to participate 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, you may 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 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 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 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. 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 1618 Main Street, Dallas, TX 75201.

THE NEIMAN MARCUS GROUP LLC HEALTH PLANS HIPAA PRIVACY NOTICE

Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by health plans. This information, known as protected health information (PHI), includes almost all individually identifiable health information held by a plan – whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices for health plans offered under 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”).

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 – HR/ Total Rewards
1-214-741-6911

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 the Plans' 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 may request 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 certain cases, 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 the decision 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, you must 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 first accounting you request within a twelve (12) month period will be provided free of charge, but you may be charged for the 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 withdraw or 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 which you 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 that may 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 providing information regarding health-related services that may be available to you under the Plans, or describing treatment alternatives.

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 care operations. 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 you identify, 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 with preventing or controlling disease, injury or disability.

Law enforcement. The Plans may disclose PHI about you for law enforcement purposes as required by law or in response 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 for intelligence, counterintelligence and other national security activities when required to do so and such disclosure is authorized 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 compliance with civil rights laws.

Judicial and administrative proceedings. If you are involved in a lawsuit or a dispute, the Plans may disclose PHI about you 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 of your 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 you to 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 the institution 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 to prevent 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 security concerns, 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, such as 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 and will 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 may be 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 – HR / Total Rewards
1-214-741-6911

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 LLC 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.

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

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

When Can You Join a Medicare Drug Plan?

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

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

If you decide to join a Medicare drug plan and continue your Neiman Marcus Group medical coverage, your current Neiman Marcus coverage will not be affected. You can continue your Neiman Marcus medical and prescription drug coverage and enroll in a Medicare prescription drug plan.

If you elect to enroll in both the Neiman Marcus Group coverage and a Medicare prescription drug plan, you will continue to be responsible for any required contributions under the Neiman Marcus Group plan plus any Medicare Part A, Part B and/or Part D (prescription drug) premium costs.

You (or a dependent) cannot drop Neiman Marcus Group prescription drug coverage and continue only the Neiman Marcus Group medical coverage, because the Neiman Marcus Group medical and prescription drug benefits are bundled. Your Neiman Marcus Group medical and prescription drug coverage will coordinate with your Medicare coverage. In that case, Medicare will be the secondary payor for your prescription drug costs.

Alternatively, if you decide to join a Medicare drug plan but drop your Neiman Marcus Group coverage, then Medicare will be your only payor, and the Neiman Marcus Group health plan will not pay any benefits.

If you do decide to join a Medicare drug plan and drop your current Neiman Marcus Group coverage, be aware that you and your dependents will be able to get this coverage back during the next annual enrollment period if you experience a qualifying status change or if special enrollment rights apply.

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

You should also know that if you drop or lose your current coverage with Neiman Marcus Group and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact the NMG Benefits Service Center at *center number*). Benefits Center Representatives are available to help you Monday through Friday, between 8:00 a.m. and 8:00 p.m. ET. You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Neiman Marcus Group changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the Medicare & You handbook. You'll get a copy of the handbook in the mail 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 give a copy of this notice when you join to show whether or not you have maintained creditable coverage, and therefore, whether or not you are required to pay a higher premium amount (a penalty).

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 about this 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 balance 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.

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, 2024. Contact your State for more information on eligibility –

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

GEORGIA – Medicaid	INDIANA – Medicaid
<p>GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2</p>	<p>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</p>
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
<p>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</p>	<p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660</p>
KENTUCKY – Medicaid	LOUISIANA – Medicaid
<p>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://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms</p>	<p>Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
<p>Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711</p>	<p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com</p>
MINNESOTA – Medicaid	MISSOURI – Medicaid
<p>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</p>	<p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>

<p align="center">MONTANA – Medicaid</p> <p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov</p>	<p align="center">NEBRASKA – Medicaid</p> <p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>
<p align="center">NEVADA – Medicaid</p> <p>Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900</p>	<p align="center">NEW HAMPSHIRE – Medicaid</p> <p>Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218</p>
<p align="center">NEW JERSEY – Medicaid and CHIP</p> <p>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</p>	<p align="center">NEW YORK – Medicaid</p> <p>Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>
<p align="center">NORTH CAROLINA – Medicaid</p> <p>Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100</p>	<p align="center">NORTH DAKOTA – Medicaid</p> <p>Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825</p>
<p align="center">OKLAHOMA – Medicaid and CHIP</p> <p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p>	<p align="center">OREGON – Medicaid and CHIP</p> <p>Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075</p>
<p align="center">PENNSYLVANIA – Medicaid and CHIP</p> <p>Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)</p>	<p align="center">RHODE ISLAND – Medicaid and CHIP</p> <p>Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)</p>
<p align="center">SOUTH CAROLINA – Medicaid</p> <p>Website: https://www.scdhhs.gov Phone: 1-888-549-0820</p>	<p align="center">SOUTH DAKOTA - Medicaid</p> <p>Website: http://dss.sd.gov Phone: 1-888-828-0059</p>
<p align="center">TEXAS – Medicaid</p> <p>Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493</p>	<p align="center">UTAH – Medicaid and CHIP</p> <p>Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669</p>

VERMONT- Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2024, 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

YOUR ERISA RIGHTS

As a participant in the Neiman Marcus Group LLC benefit plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all plan participants shall be entitled to receive information about their plan and benefits, continue group health plan coverage, and enforce their rights. ERISA also requires that plan fiduciaries act in a prudent manner.

Additional information can be found in the plan document and summary plan description.