Date

Name
Address

Re: Client #

Dear_____,

Welcome to Highmark Blue Cross Blue Shield!

Thank you for being a valued customer. With your upcoming health insurance plan renewal, and the recent merger of Blue Cross of Northeastern Pennsylvania and Highmark Inc., we're looking forward to continuing to serve you in 2016 and counting you among the many satisfied Highmark Blue Cross Blue Shield customers.

Health care coverage remains one of the most important benefits you can offer. It helps you attract and retain valuable employees and keep them healthy and more productive on the job, all of which is key to staying ahead of your competition.

Highmark understands the challenges small businesses like yours face when considering health care coverage for your employees under Health Care Reform. Effective January 1, 2014, changed requirements mean you have more options. We're here to guide you so you can make your coverage decisions with confidence.

- You will notice some changes to your current plan. For 2016, there may be changes in cost share and changes to your prescription drug copay. Please see the benefit change information included with this letter and for a more detailed description of your 2016 benefits, please go to **highmarkbcbs.com** and sign in to self-service.

- If you currently offer a BlueCare Senior option, that plan will not be available in 2016 and will end upon your renewal. We have already sent you a plan withdrawal notice to explain your options. If members enrolled in the BlueCare Senior group are actively employed, they may be eligible to enroll on your active plan.

- You can make changes to your current coverage for 2016 but you cannot change or buy an additional product. You can select to buy any one of our ACA plans.

Our wide range of ACA plans can help you find a health care coverage solution that is a good fit for your organization. Manage your premium costs by choosing from a variety of

deductible options or combine a deductible with coinsurance or copayments. Ask your Highmark sales professional for additional information about the new ACA plan options that can make health care coverage more affordable for you and your employees.

When you choose Highmark, you can take advantage of:

- A wide range of health insurance plan options
- Choices for Health Care Reform (HCR)/Affordable Care Act (ACA)
- Programs that address the sources of rising health care costs
- online services and information to help you easily manage your coverage

Your Premium Rates for the Upcoming Benefit Period

This letter represents written notice concerning the monthly premium rates for the renewal of your health care coverage. The latest changes to Health Care Reform allow you to keep your current coverage and rating structure. The rates below become effective with the 12-month contract period beginning January 1, 2016 and ending December 31, 2016. Your invoice summary will provide you with total premium charges due for the current billing period.

Program	Group	Ind	Ind/Chd	Ind/Chdn	Two Persn	Family

Ind – Individual Only, Ind/Chd – Individual and Child, Ind/Chdn – Individual and Children,
Two Persn – Two Person, Family – Individual and Family members

As an added convenience to you, we are including the "Notice of Rate Schedules," a list of alternative products, which are available to you upon your renewal. If you would like these alternative rates detailed as they are on the Renewal Chart, please contact your authorized Highmark sales professional.

If you have a dental plan through United Concordia, you will receive renewal information separately. If you don't have a dental plan, now is the time to consider enhancing your health care coverage with Blue Edge Dental. A routine dental exam is one way to identify signs of many health conditions in the early stages. This results in reducing medical costs for everyone. Blue Edge Dental allows your employees to enjoy one simple enrollment process, flexible plans and access to one of the nation's largest networks of dentists and specialists. Contact your Highmark sales professional to learn more about adding Blue Edge Dental to your health care coverage.

If you have a vision plan through Davis Vision, you will receive a renewal quote from Highmark, enclosed. If you're missing vision care from your health care coverage, you're missing a key element to your company's success. Did you know that according to the Vision Council of America and the U.S. Department of Health and Human Services:

- Vision disorders account for more than $8 billion annually in sick days.

- Uncorrected vision can decrease employees' job performance by as much as 20 percent.
- More than 70 percent of adult workers and virtually 100 percent of adults approaching retirement age require some form of vision correction.
- Eye pain or irritation, headaches, blurred or double vision and excessive tearing or dry eyes affects more than 90 percent of employees who spend the bulk of their time at the computer.
- Annual eye exams not only correct vision problems—they can also reveal warning signs of more serious undiagnosed health problems such as hypertension, heart disease and diabetes.

Given all these facts, it's no wonder that employers can gain up to $7 for every $1 they spend on vision coverage. If you're interested in adding a vision plan, contact your Highmark sales professional to learn more.

If you have a Blue Cross of Northeastern Pennsylvania health spending account (FSA, HRA or HSA), more information is enclosed on how you can transition it to a Highmark spending account. If not, consider adding one to your coverage. Spending accounts play a key role in helping you enhance your benefit offerings. Spending accounts also help your employees save money while they plan for their share of health care costs. And it couldn't be easier—a Highmark spending account is fully integrated with your medical and pharmacy plan and employees can view claims and spending on one consolidated website!

Summary of Benefits and Coverage Requirement

Highmark has created a Summary of Benefits and Coverage (SBC) for your program of benefits. As an employer/plan sponsor, you are required to provide participants and beneficiaries of your group health plan with an accurate SBC at the times and in the manner required by the Affordable Care Act of 2010, the health care reform legislation. Distribution of the SBC is required at the following times:

- If you distribute written application materials for enrollment, the SBC must be provided on the first day of the annual open enrollment period.
- If you do not distribute written application materials for enrollment, the SBC must be provided no later than the first date the participant is eligible to enroll in coverage.
- If renewal is automatic, the SBC must be provided no later than 30 days prior to the first day of the new plan year.
- The SBC must be provided to special enrollees no later than the date by which a summary plan description must be provided (within 90 days after enrollment).
- The SBC must be provided within 7 business days of receipt of a request for a SBC or summary information about the health coverage.
- If any material modification is made to the coverage that affects the content of the SBC, and is effective mid-year, notice of the modification must be provided no later than 60 days before the date the change becomes effective.

You can access this SBC by going to www.highmark.com/sbc. If you do not have access to the internet, you can request a free paper copy by calling 1-800-241-5704.

You may distribute this SBC in paper or in an electronic format to participants and beneficiaries of your group health plan, including employees and their eligible dependents. (Please note that you must comply with specific federal requirements applicable to electronic distribution and intranet posting.) If providing the SBC electronically, individuals must have the option to receive a paper copy free of charge upon request.

For more information about the SBC and your requirements as an employer, go to the Department of Health and Human Services website at CCIIO.cms.gov.

Additional Information

Group Eligibility Requirements

Highmark has certain requirements related to the level of employee contribution and minimum percentage of your employees who enroll in our products. Group eligibility is contingent upon a total group participation of eligible employees in Highmark health products.

If these requirements are not satisfied, the contract may be terminated.

To eliminate unnecessary paperwork while protecting your confidential information, Highmark uses a simplified process that reduces the number of documents necessary for your authorized Highmark agent to review proprietary information on your behalf. This includes enrollment, disenrollment, demographic and/or premium billing information requested by your authorized Highmark agent for purposes of inputting, updating and/or reviewing this information on your behalf. By accepting these rates, you agree to this simplified process.

Your initial payment of premium rates shall be deemed an acceptance of the premium rates and all terms and conditions of coverage within this letter and the group contract.

Please be aware that the deadline for changing your coverage is 15th of the month prior to the effective date of your new coverage. Requests received after the deadline may result in a delay of up to sixty (60) days beyond the effective date included in this letter; due to SBC requirements.

Thank you for the opportunity to serve you during the current benefit period. We look forward to continuing our relationship with you. If you have any questions, please contact your authorized Highmark agent.

Sincerely,

Sincerely,
Anthony Benevento
Senior Vice President, Regional Markets

Date

Name
Address

Re: Client #

Dear Mr. Joseph Angel, Sr.:

Thank you for your business during this current benefit period. Your vision plan is now due for renewal. We value our relationship with you, and are committed to retaining you as a customer.

Your Premium Rates for the Upcoming Benefit Period

This letter represents written notice concerning the monthly premium rates for the renewal of your vision plan coverage, effective with the 12 month contract period beginning January 1, 2016 and ending December 31, 2016. The monthly premium rates necessary to provide coverage are indicated below.

Program	Group	Ind	Ind/Chd	Ind/Chdn	Two Persn	Family
Fashion Advantage Gold - Opt V						

Ind – Individual Only, Ind/Chd – Individual and Child, Ind/Chdn – Individual and Children, Two Persn – Two Person, Family – Individual and Family members

Additional Information

How Rates are Computed

The rates listed above are computed according to Highmark's rating formula, which includes costs and charges associated with the program of benefits indicated.

Group Eligibility Requirements
Highmark has certain requirements related to the level of employee contribution and minimum percentage of your employees who enroll in our products. Group eligibility is contingent upon a total group participation of eligible employees in Highmark vision and dental products.

Rates may be adjusted, a change may be made in the terms of the financial arrangement, or the contract may be terminated between your group and Highmark if these requirements are not satisfied or if enrollment changes by 10 percent or more from the level existing at the time rates were determined. Information regarding commissions will be made available upon request.

To eliminate unnecessary paperwork while protecting your confidential information, Highmark uses a simplified process that reduces the number of documents necessary for your authorized Highmark agent to review proprietary information on your behalf. This includes enrollment, disenrollment, summary health and/or premium billing information requested by your authorized Highmark agent for purposes of inputting, updating and/or reviewing this information on your behalf. By accepting these rates, you agree to this simplified process.

Your initial payment of premium rates shall be deemed an acceptance of the premium rates and all terms and conditions of coverage within this letter and the group contract.

Thank you for the opportunity to serve you during the current benefit period. We look forward to continuing our relationship with you. If you have any questions, please contact your authorized Highmark Agent or Highmark Representative.

Sincerely,

Kareem G. Corbin
Vice President, Sales & Client Management
Small Group

REVISED
NOTICE OF RATE SCHEDULES
Effective January 1, 2016

Re: Client Alternative Rates that are available

Program	QuoteID	Ind	Ind/Chd	Ind/Chdn	Two Persn	Family

Ind – Individual Only, Ind/Chd – Individual and Child, Ind/Chdn – Individual and Children,
Two Persn – Two Person, Family – Individual and Family members

The above rates are based on the current benefit year demographic factors.

DATE

NAME
ADDRESS

Dear Policy Holder,

We are required to send you the attached Centers for Medicare and Medicaid Services notification about the November 14, 2013 transitional policy. This is in connection with your choice to potentially keep or not keep your current small group health care coverage.

The notice informs you of the right to continue your existing coverage during the upcoming year. It explains what you need to do to keep your policy. It also says what protections under the Affordable Care Act (ACA) may not be provided to you if you elect to renew your current plan.

You have other options, such as switching to a new plan that complies with and provides all of the current protections of the ACA.

Please contact your Highmark agent for a full explanation of all your options. We want you to fully understand all the protections you may or may not have if you elect to renew pre-2014 coverage.

As you read through this required notice and review and compare your existing plan with newer 2016 ACA–compliant coverage options, please consider the following:

- Our pre-2014 ACA plans meet all standards for guaranteed renewals.
- Our pre-2014 ACA plans cover many essential health benefits including preventive screenings, prescription drug coverage and maternity care. Some plans do not meet the ACA requirement for pediatric dental and vision, habilitative care and some mental health provisions.
- All of our small group plans have an out-of-pocket limit on your in-network costs.

Whether you choose to renew your existing plan or choose a new ACA–compliant plan, the new 90-day waiting period requirements will still apply. (The waiting period between when an employee becomes eligible for health care coverage and the date that coverage becomes effective cannot be greater than 90 days.)

In addition, legal requirements that define a small group—50 or fewer employees—still apply. Highmark will continue to audit groups of one or two to verify the existence of employer–employee relationships**.**

Thank you for allowing us to serve your health coverage needs. If you have questions, please contact your authorized Highmark agent.

Sincerely,

Kareem Corbin
Vice President, Small Group Sales

Dear Policy Holder,

We are writing to inform you that, consistent with federal guidance initially announced in November 2013 and extended in February 2014, you may keep your existing coverage for the upcoming policy year.

How Do I Keep My Current Policy?

To keep your current policy, please contact us.

As you think about your options, there are some things to keep in mind. If you choose to renew your current policy, it may NOT provide all of the protections of the Affordable Care Act. These include one or more of the following new protections of the Public Health Service Act (PHS Act) that were added by the health care law and took effect for coverage beginning in 2014. If you choose to renew your current policy, your coverage:

- May not meet standards for fair health insurance premiums, so you might be charged more based on factors such as gender or a pre-existing medical condition, and it might not comply with rules limiting the ability to charge older people more than younger people (PHS Act section 2701).
- May not meet standards for guaranteed availability, so it might exclude consumers based on factors such as a pre-existing medical condition (PHS Act section 2702).
- May not meet standards for guaranteed renewability (PHS Act section 2703).
- If the coverage is an individual market policy, may not meet standards related to pre-existing medical conditions for adults, so it might exclude coverage for treatment of an adult's pre-existing medical condition such as diabetes or cancer (PHS Act section 2704).
- If the coverage is an individual market policy, may not meet standards related to discrimination based on health status (PHS Act section 2705).
- May not meet standards for non-discrimination with respect to health care providers (PHS Act section 2706).
- May not cover essential health benefits or limit annual out-of-pocket spending, so it might not cover benefits such as prescription drugs or maternity care, or might have unlimited cost sharing (PHS Act section 2707).
- May not meet standards for participation in clinical trials, so you might not have coverage for services related to a clinical trial for a life-threatening or other serious disease (PHS Act section 2709)

How Do I Choose A Different Policy?

You have options for getting quality health insurance. [You may shop in the Health Insurance Marketplace, where all policies meet certain standards to help guarantee health care security, and no one who is qualified to purchase coverage through the Marketplace can be turned away or charged more because of a pre-existing medical condition. The Marketplace allows you to

choose a private policy that fits your budget and health care needs. You may qualify for tax credits or other federal financial assistance to help you afford health insurance coverage purchased through the Marketplace.]*

[You can also get new health insurance outside the Marketplace.] All new policies guarantee certain protections, such as your ability to buy a policy even if you have a pre-existing medical condition. [However, federal financial assistance is not available outside the Marketplace.]

You should review your options as soon as possible, because you may have to buy your coverage within a limited time period.

How Can I Learn More?

To learn more about the Health Insurance Marketplace and protections under the health care law, visit HealthCare.gov or call 1-800-318-2596 **or TTY: 1-855-889-4325.**
If you have questions, please contact us.

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*The bracket language does not apply to the U.S. territories that do not have a Marketplace