

Nelson Mullins Riley & Scarborough LLP
October 1, 2025

With office locations in:

**California | Colorado | District of Columbia | Florida | Georgia | Illinois |
Maryland | Massachusetts | Minnesota | New York | North Carolina |
Ohio | Pennsylvania | South Carolina | Tennessee | Texas | Virginia |
West Virginia**

2026 Annual Notices Booklet

Nelson Mullins

**If you have any questions, contact the Human
Resources Department in Columbia at:**

**Nelson Mullins Riley & Scarborough LLP
Human Resources Department
P.O. Box 11070
Columbia, SC 29211
Ph: 803-799-2000 or 1-800-237-2000**

Annual Notices Booklet

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STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.

No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan reviewed and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 per day, until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

CONTACT INFORMATION

Questions regarding any of this information can be directed to:

Jan Berger / Benefits Administrator
Human Resources Department
1320 Main Street, 17th Floor
Columbia, South Carolina United States 29201
803-255-9314
jan.berger@nelsonmullins.com

**Medicaid and the Children's Health Insurance Program (CHIP)
Offer Free Or Low-Cost Health Coverage To Children And Families**

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 July 31, 2025. Contact your State for more information on eligibility.

State – Program	Contact Information
ALABAMA – Medicaid	Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA – Medicaid	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	Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)

State – Program	Contact Information
CALIFORNIA – Medicaid	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+)	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
FLORIDA – Medicaid	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162 ext 2131
INDIANA – Medicaid	Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Phone 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	Website: <i>Iowa Medicaid Health & Human Services</i> Medicaid Phone: 1-800-338-8366 Hawki Website: https://hhs.iowa.gov HIPP website: https://hhs.iowa.gov HIPP Phone: 1-888-346-9562
KANSAS – Medicaid	Website: http://www.kdheks.gov/hcf Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	Website: http://chfs.ky.gov Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms
LOUISIANA – 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)
MAINE – Medicaid	Website: http://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP	Website: http://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3739
MISSOURI – Medicaid	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov

State – Program	Contact Information
NEBRASKA – Medicaid	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	Website: https://dhcfp.nv.gov Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurnace-premiums-program Phone: 603-271-5218 HIPP program: 1-800-852-3345, ext 5218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 TTY: 711
NEW YORK – Medicaid	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
NORTH DAKOTA – Medicaid	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid and CHIP	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	Website: http://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	Website: http://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	Website: http://www.gethipptexas.com/ Phone: 1-800-440-0493
UTAH – Medicaid and CHIP	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Email: upp@utah.gov Phone: 1-888-222-2542
VERMONT – Medicaid	Website: https://dvha.vermont.gov/members/Medicaid/hipp-program Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP	Medicaid Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurnace-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282

State – Program	Contact Information
WASHINGTON – Medicaid	Website: http://www.hca.wa.gov Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP	Website: https://dhhr.wv.gov/bms/http://mywvhipp.com Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid	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 July 31, 2019, 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. Dept. of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Option 4, Ext. 61565

NELSON MULLINS RILEY & SCARBOROUGH LLP
IMPORTANT NOTICE OF PRIVACY POLICY AND PROCEDURES

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

This Notice is provided to you on behalf of:

Group Medical Benefits Plan for Employees of Nelson Mullins Riley & Scarborough LLP
Nelson Mullins Riley & Scarborough LLP Dental Plan
Nelson Mullins Riley & Scarborough LLP Vision Care Plan
Nelson Mullins Riley & Scarborough LLP Flexible Benefits Plan

These plans comprise what is called an “Affiliated Covered Entity,” and are treated as a single plan for purposes of this Notice and the privacy rules that require it. For purposes of this Notice, we’ll refer to these plans as a single “Plan.”

The Plan’s Duty to Safeguard Your Protected Health Information.

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered “Protected Health Information” (“PHI”). The Plan is required to extend certain protections to your PHI, and to give you this Notice about its privacy practices that explains how, when and why the Plan may use or disclose your PHI. Except in specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

The Plan is required to follow the privacy practices described in this Notice, though it reserves the right to change those practices and the terms of this Notice at any time. If it does so, and the change is material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other fashion. This Notice, and any material revisions of it, will also be provided to you in writing upon your request (ask your Human Resources representative, or contact the Plan’s Privacy Official, described below), and will be posted on any website maintained by Nelson Mullins Riley & Scarborough LLP that describes benefits available to employees and dependents.

You may also receive one or more other privacy notices, from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI, and your rights with respect to the PHI they maintain.

How the Plan May Use and Disclose Your Protected Health Information.

The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative (e.g., a person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the Plan’s uses and disclosures of your PHI.

- **Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.**
 - **Treatment:** Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it’s important for your treatment team to know your blood type, the Plan could disclose that PHI to the team in order to allow it to more effectively provide treatment to you.
 - **Payment:** Of course, the Plan’s most important function, as far as you are concerned, is that it *pays* for all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan receives a substantial amount of PHI about you. For example, doctors, hospitals and pharmacies that provide you care send the Plan detailed information about the care they provided, so that they can be paid for their services. The Plan may also share your PHI with other plans, in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this Plan, and your spouse’s plan, or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.

- **Health care operations:** The Plan may use and disclose your PHI in the course of its “health care operations.” For example, it may use your PHI in evaluating the quality of services you received or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverage.
- **Other Uses and Disclosures of Your PHI Not Requiring Authorization.** The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:
 - **To the Plan Sponsor:** The Plan may disclose PHI to the employers (such as Nelson Mullins Riley & Scarborough LLP) who sponsor or maintain the Plan for the benefit of employees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and disenrollments, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage and other disputes related to the Plan’s provision of benefits.
 - **Required by law:** The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities that monitor compliance with these privacy requirements.
 - **For public health activities:** The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.
 - **For health oversight activities:** The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.
 - **Relating to decedents:** The Plan may disclose PHI relating to an individual's death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
 - **For research purposes:** In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research.
 - **To avert threat to health or safety:** In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
 - **For specific government functions:** The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.
- **Uses and Disclosures Requiring Authorization:** For uses and disclosures beyond treatment, payment and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. Your authorizations can be revoked at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.
- **Uses and Disclosures Requiring You to have an Opportunity to Object:** The Plan may share PHI with your family, friend or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

Your Rights Regarding Your Protected Health Information.

You have the following rights relating to your protected health information:

- **To request restrictions on uses and disclosures:** You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the

agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.

- **To choose how the Plan contacts you:** You have the right to ask that the Plan send you information at an alternative address or by an alternative means. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.
- **To inspect and copy your PHI:** Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.
- **To request amendment of your PHI:** If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors, you may request, in writing, that the record be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its vendor and/or not part of the Plan's or vendor's records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.
- **To find out what disclosures have been made:** You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

How to Complain about the Plan's Privacy Practices.

If you think the Plan or one of its vendors may have violated your privacy rights, or if you disagree with a decision made by the Plan or a vendor about access to your PHI, you may file a complaint with the person listed in the section immediately below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

Contact Person for Information, or to Submit a Complaint.

If you have questions about this Notice, please contact the Plan's Privacy Official or Deputy Privacy Official(s) (see below). If you have any complaints about the Plan's privacy practices or handling of your PHI, please contact the Plan's Privacy Official (see below).

Privacy Official.

The Plan's Privacy Official, the person responsible for ensuring compliance with this Notice, is:

Jamie Weymers
Assistant Deputy General Counsel
Telephone Number: (803) 255-9732

The Plan's Deputy Privacy Official(s) is/are:

Mary Kate Kaminski
Director of Human Resources
Telephone Number: (803) 255-9746

Organized Health Care Arrangement Designation.

The Plan participates in what the federal privacy rules call an “Organized Health Care Arrangement.” The purpose of that participation is that it allows PHI to be shared between the members of the Arrangement, without authorization by the persons whose PHI is shared, for health care operations. Primarily, the designation is useful to the Plan because it allows the insurers who participate in the Arrangement to share PHI with the Plan for purposes such as shopping for other insurance bids.

The members of the Organized Health Care Arrangement are:

Group Medical Benefits Plan for Employees of Nelson Mullins Riley & Scarborough LLP
Nelson Mullins Riley & Scarborough LLP Dental Plan
Nelson Mullins Riley & Scarborough LLP Vision Care Plan
Nelson Mullins Riley & Scarborough LLP Flexible Benefits Plan
Wachovia Insurance Services, Inc. (August 1, 2008)
Name changed 2009 to: Wells Fargo Insurance Services
Name changed 2017 to: USI Insurance Services

Effective Date.

The effective date of this Notice is: October 15, 2025.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a Federal law, Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under Federal law, you should either review the Plan's Summary Plan Description or get a copy of the Plan Document from the Plan Administrator.

The Plan Administrator is:

Nelson Mullins Riley & Scarborough LLP
Meridian Building
1320 Main Street, Suite 1700
Columbia, SC 29201

The COBRA Administrator is:

Flores & Associates
2013 W Morehead St, Suite B
Charlotte, NC 28208
800.532.3327

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. These plans may have lower premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse plan), even if that plan generally doesn't accept late enrollees.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of your current Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in the notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

- (1) Your hours of employment are reduced, or
- (2) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

- (1) Your spouse dies;
- (2) Your spouse's hours of employment are reduced;
- (3) Your spouse's employment ends for any reason other than his or her gross misconduct;
- (4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
- (5) You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- (1) The parent-employee dies;
- (2) The parent-employee's hours of employment are reduced;
- (3) The parent-employee's employment ends for any reason other than his or her gross misconduct;
- (4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- (5) The parents become divorced or legally separated; or
- (6) The child stops being eligible for coverage under the Plan as a "dependent child."

The Plan will offer COBRA continuation to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event. In addition, if the Plan provides retiree health coverage, then commencement of a proceeding in a bankruptcy with respect to the employer is also a qualifying event where the employer must notify the Plan Administrator of the qualifying event.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to the Plan Administrator's address listed on the first page of this notice.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to the Plan Administrator's address listed on the first page of this notice. If the disability occurred prior to the qualifying event, send a copy of the Notice of Award along with the enrollment form when electing continuation of coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator's address listed on the first page of this notice.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact Flores & Associates' COBRA Customer Service or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Group Health Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). This includes enrollment for eligible adult children under age 26.

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 dependent(s). However, you must request enrollment within 31 thirty days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- o Coverage is lost under Medicaid or a State CHIP program; or
- o You or your dependents become eligible for a premium assistance subsidy from the State.

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In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the Human Resources Department in Columbia.

Jan Berger, Benefits Administrator
jan.berger@nelsonmullins.com
803-255-9314

Carrie Hilton, Benefits Coordinator
carrie.hilton@nelsonmullins.com
803-255-9212

Nelson Mullins Riley & Scarborough LLP
Human Resources Department
P.O. Box 11070
Columbia, SC 29211
803-799-2000

NEWBORNS ACT of 1996 DISCLOSURE - FEDERAL

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (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 preformed;
- 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 the Group Health Plan. Therefore, the following deductibles and coinsurance apply:

- o For the Standard PPO Plan - \$1,000 single deductible and 20% coinsurance.
- o For the High Deductible Plan - \$2,500 single deductible and 10% coinsurance.

If you would like more information on WHCRA benefits, contact:

Jan Berger, Benefits Administrator
jan.berger@nelsonmullins.com
803-255-9314

Carrie Hilton, Benefits Coordinator
carrie.hilton@nelsonmullins.com
803-255-9212

Nelson Mullins Riley & Scarborough LLP
Human Resources Department
P.O. Box 11070
Columbia, SC 29211
803-799-2000

IMPORTANT NOTICE FROM NELSON MULLINS RILEY & SCARBOROUGH LLP ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

You are receiving this Notice because you or a covered dependent will turn age 65 in 2026. We are required to send you this Notice regarding prescription coverage for 2026 when you are eligible to enroll in 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 the Nelson Mullins Group Medical Plan and about your options under Medicare's prescription drug coverage. This Information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Nelson Mullins has determined that the prescription drug coverage offered by the Nelson Mullins Group Medical Plan for 2026 is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is therefore considered **Creditable Coverage**. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan. However, if you are enrolled in the High Deductible Health Plan, depending on your individual circumstances, it may not pay out as much, in the beginning, as standard Medicare prescription drug coverage would pay as your drug costs, in this plan, are credited towards the deductible before the plan begins to pay any costs.

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 after from **October 15th through December 7th**. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) months Special Enrollment Period (SEP) to join a Medicare Part D 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, the following options may apply:

- You may stay in the Nelson Mullins group health plan and not enroll in the Medicare prescription drug coverage at this time. You may be able to enroll in the Medicare prescription drug program at a later date without penalty either:
 - o During the Medicare prescription drug annual enrollment period, or
 - o If you lose Nelson Mullins group health plan creditable coverage.
- You may stay in the Nelson Mullins group health plan and also enroll in a Medicare prescription drug plan. The Nelson Mullins group health plan will be the primary payer for prescription drugs and Medicare Part D will become the secondary payer.
- You may decline coverage in the Nelson Mullins group health plan and enroll in Medicare as your only payer for all medical and prescription drug expenses. If you do not enroll in the Nelson Mullins group health plan, you are not able to receive coverage through the plan unless and until you are eligible to reenroll in the plan at the next open enrollment period or due to a status change under the cafeteria plan or special enrollment event.

The following information is an explanation of the 2026 prescription drug coverage available for a participant in the Nelson Mullins Group Medical Plan:

<i>STANDARD PLAN</i>	<i>PARTICIPATING PHARMACIES</i>	<i>MAIL SERVICE PHARMACY</i>
YOU PAY	Tier 1 = \$10 each generic prescription Tier 2 = 20% co-insurance (\$200 max) Tier 3 = 20% co-insurance (\$200 max) Tier 4 = 30% co-insurance (\$250 max)	Tier 1 = \$20 co-pay Tier 2 = 20% co-insurance (\$500 max) Tier 3 = 30% co-insurance (\$500 max) Tier 4 = N/A
DAYS SUPPLY LIMIT	30-day supply	90-day supply
REFILL LIMIT	None	None

<i>HIGH DEDUCTIBLE PLAN</i>	<i>PARTICIPATING PHARMACIES</i>	<i>MAIL SERVICE PHARMACY</i>
YOU PAY	After satisfaction of the deductible, you generally pay 10% of applicable cost.	After satisfaction of the deductible, you generally pay 10% of applicable cost.
DAYS SUPPLY LIMIT	30-day supply	90-day supply

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 coverage with Nelson Mullins and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare prescription drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without 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 Human Resources Department for further information. This notice is updated each year in October before the next Medicare Open Enrollment period begins where you can join a Medicare drug plan. We will also notify participants if the Nelson Mullins health plan drug coverage changes within a plan year. You may also request a copy of this notice at any time. Subsequent notices will be included in the Firm's Annual Notices Booklet that is available on our benefits website: <https://benefits.nelsonmullins.com>.

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 receive 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 drug coverage:

- Visit www.medicare.gov;
- Call your State Health Insurance Assistance Program for personalized help (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number); or
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for a Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date: 10/01/2025
Name of Entity/Sender: Nelson Mullins Riley & Scarborough LLP
Contact – Position/Office: Jan Berger, Benefits Administrator
Address: Meridian 17th Floor
1320 Main Street
Columbia, SC 29201
Phone Number: (803) 255-9314



Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%¹ of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.²

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution – as well as your employee contribution to employment-based coverage – is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023, and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023, and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit <https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/> for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact:

Name of Entity/Sender:	Nelson Mullins
Contact--Position/Office:	Jan Berger / Benefits Supervisor
Address:	1320 Main St. 17 th Floor, Columbia, SC 29201
Phone Number:	(803) 255-9314

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name Nelson Mullins		4. Employer Identification Number (EIN)	
5. Employer address 1320 Main Street, 17 th Floor		6. Employer phone number (803) 255-9314	
7. City Columbia		8. State SC	9. ZIP code 29201
10. Who can we contact about employee health coverage at this job? Jan Berger			
11. Phone number (if different from above)		12. Email address Jan.berger@nelsonmullins.com	

Here is some basic information about health coverage offered by this employer:

- As our employer, we offer a health plan to:

☒ All employees. Eligible employees are:

Employees scheduled to work 30 or more hours per week and are not temporary

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Dependents include your spouse/domestic partner and children up to age 26. If your child is mentally or physically disabled, coverage may continue beyond age 26

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

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

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

Illinois Essential Health Benefit Disclosure

Employer Name:	Nelson Mullins
Employer State of Situs:	South Carolina
Name of Issuer:	BCBS of South Carolina (TPA)
Plan Marketing Name:	Nelson Mullins Group Health Plan
Plan Year:	2026

Ten (10) Essential Health Benefit (EHB) Categories:

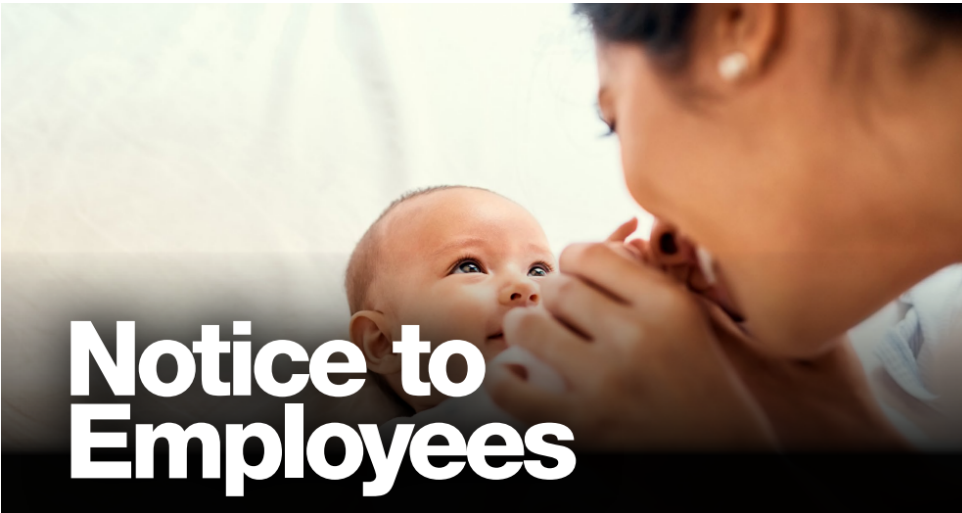
- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Laboratory services
- Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

2020-2025 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)

Item	EHB Benefit	EHB Category	Benchmark Page # Reference	Employer Plan Covered Benefit?
1	Accidental Injury -- Dental	Ambulatory	Pgs. 10 & 17	Yes
2	Allergy Injections and Testing	Ambulatory	Pg. 11	Yes
3	Bone anchored hearing aids	Ambulatory	Pgs. 17 & 35	Yes
4	Durable Medical Equipment	Ambulatory	Pg. 13	Yes
5	Hospice	Ambulatory	Pg. 28	Yes
6	Infertility (Fertility) Treatment	Ambulatory	Pgs. 23 - 24	Yes
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Ambulatory	Pg. 21	Yes
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Ambulatory	Pgs. 15 - 16	Yes
9	Private-Duty Nursing	Ambulatory	Pgs. 17 & 34	Yes
10	Prosthetics/Orthotics	Ambulatory	Pg. 13	Yes
11	Sterilization (vasectomy men)	Ambulatory	Pg. 10	Yes
12	Temporomandibular Joint Disorder (TMJ)	Ambulatory	Pgs. 13 & 24	Yes
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pg. 7	Yes
14	Emergency Transportation/ Ambulance	Emergency services	Pgs. 4 & 17	Yes
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	No
16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 24 - 25	Yes
17	Reconstructive Surgery	Hospitalization	Pgs. 25 - 26, & 35	Yes
18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 15	Yes
19	Skilled Nursing Facility	Hospitalization	Pg. 21	Yes
20	Transplants - Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 18 & 31	Yes

21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	Yes
22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	Yes
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pgs. 8 -9, 21	Yes
24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. 21	
25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pgs. 9 & 21	Yes
26	Tele-Psychiatry	MH/SUD	Pg. 11	Yes
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. 32	Yes
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	Separate Dental Plan
29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 26 - 27	Separate Vision Plan
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Yes
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29 - 34	Yes
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Yes
33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	Yes
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	Yes
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31 - 32	Yes
36	Mammography - Screening	Preventive and Wellness Services	Pgs. 12, 15, & 24	Yes
37	Osteoporosis - Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	Yes
38	Pap Tests/ Prostate- Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	Yes
39	Preventive Care Services	Preventive and Wellness Services	Pg. 18	Yes
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	Yes
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12 - 13	Yes
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 8, 9, 11, 12, 22, & 35	Yes
Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.				

Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. Information provided in this disclosure is not a guarantee of benefits.



Notice to Employees



Your employer is registered with and reporting wages to the Employment Development Department (EDD) as required by law. Wages are used for the following benefit programs, which are available to you.

Disability Insurance

You may be eligible for partial wage-replacement benefits through Disability Insurance (DI) when you are unable to work due to a non-work-related illness, injury, pregnancy, or disability.

Your employer must provide the *Disability Insurance Provisions* (DE 2515) brochure to each newly hired employee to describe benefits and eligibility requirements. You must meet all eligibility requirements to receive disability benefits.

- Request claim forms from your licensed health professional, employer, or from any California State Disability Insurance (SDI) Claims Management office. You can also order claim forms online by visiting [EDD Forms and Publications](https://forms.edd.ca.gov/forms) (forms.edd.ca.gov/forms).
- File your *Claim for Disability Insurance (DI) Benefits* (DE 2501) within 49 days of the first day of your disability to avoid losing benefits.
- If you have disability coverage under your employer's voluntary plan, get disability claim forms from your employer or the designated third-party administrator.
- Visit [Disability Insurance](https://edd.ca.gov/Disability/Disability_Insurance.htm) (edd.ca.gov/Disability/Disability_Insurance.htm) to learn how to apply for benefits.

Paid Family Leave

You may be eligible for partial wage-replacement benefits through Paid Family Leave (PFL) when you stop working or reduce your work hours to:

- Care for a family member who is seriously ill.
- Bond with a new child.
- Take part in a qualifying event resulting from a family member's military deployment to a foreign country.

Your employer must provide a copy of the *California Paid Family Leave* (DE 2511) brochure to each newly hired employee to describe benefits and eligibility requirements. You must meet all eligibility requirements to receive family leave benefits.

- Request claim forms from your licensed health professional, employer, from any California SDI Claims Management office. You can also order claim forms online by visiting [EDD Forms and Publications](https://forms.edd.ca.gov/Forms) (forms.edd.ca.gov/Forms).
- File your *Claim for Paid Family Leave (PFL) Benefits* (DE 2501F) within 41 days of the first day of your family leave to avoid losing benefits.
- If you have PFL coverage under your employer's voluntary plan, get PFL forms from your employer or designated third-party administrator.

For more information about DI and PFL, visit [State Disability Insurance](https://edd.ca.gov/Disability) (edd.ca.gov/Disability).

DI: Call 1-800-480-3287. TTY (for deaf or hearing-impaired individuals only) 1-800-563-2441.

PFL: Call 1-877-238-4373. TTY (for deaf or hearing-impaired individuals only) 1-800-445-1312.

State Government employees should call 1-866-352-7675 for DI and 1-877-945-4747 for PFL.

The EDD is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. Requests for services, aids, and/or alternate formats need to be made by calling 1-866-490-8879 (voice). TTY users, please call the California Relay Service at 711.

DE 1858 Rev. 7 (4-22) (INTERNET)

Page 1 of 1

MASSACHUSETTS PAID FAMILY AND MEDICAL LEAVE
NOTICE TO EMPLOYEES
(25 or more Workers)

Please read this notice carefully. It contains important information about your rights, obligations, and eligibility under the Massachusetts Paid Family and Medical Leave law. Please keep this notice for your records.

Nelson Mullins Riley & Scarborough, LLP
(Employer Name)
One Financial Center, Suite 3500
(Employer Street Address)
Boston, MA 02111
(Employer City, State, Zip)
570215445
(Federal Employer ID Number) (FEIN)

An employer may apply for an exemption from the medical leave contribution, family leave contribution, or both. Your employer has elected to provide benefits as follows:

Nelson Mullins Riley & Scarborough LLP
(Employer Name)

XX Does not have an approved private plan and is providing all leave benefits through the Department;
___ Has an approved private plan for both family and medical leave benefits;
___ Has an approved private plan for family leave benefits only, and is providing medical leave benefits through the Department;
___ Has an approved private plan for medical leave benefits only and is providing family leave benefits through the Department.

I. Explanation of Benefits

Leave Allotments. Under the PFML Law, you may be entitled to up to:

- 12 weeks of paid family leave in a benefit year for the birth, adoption, or foster care placement of a child; to care for a family member with a serious health condition; or because of a qualifying exigency arising out of the fact that a family member is on active duty or has been notified of an impending call to active duty in the Armed Forces;
- 20 weeks of paid medical leave in a benefit year if they have a serious health condition that incapacitates them from work;
- 26 weeks of paid family leave in a benefit year to care for a family member who is a covered service member undergoing medical treatment or otherwise addressing consequences of a serious health condition relating to the family member’s military service;
- 26 total weeks, in the aggregate, of paid family and medical leave in a single benefit year.

A “benefit year” is the 12 months preceding the Sunday immediately before your leave begins.

Other Leaves. Any leave you take – paid or unpaid – for the same qualifying reasons listed above will count towards your amount of leave for that benefit year. However, no leave taken before January 1, 2021 will count towards your available leave. Similarly, leave to care for a family member with a serious health condition that was taken before July 1, 2021, also will not count towards your family leave allotment.

Eligibility. You will be eligible for leave and wage-replacement benefits if you meet the earnings test. You must have earned at least \$5,700 in wages in Massachusetts in the four completed quarters before you apply for benefits. In the same period, you also must have earned at least 30 times your maximum potential benefit amount. (This is the amount calculated in the “Wage Replacement Payments” section below.)

Wage Replacement Payments. When you take leave for any of the reasons described above, you will be eligible to apply to the Department or to your employer’s private plan for wage replacement benefits. These benefits will be a proportion of your average weekly earnings. Your maximum potential benefit amount will be as follows:

- 80% of earnings up to 50% of the State Average Weekly Wage
- 50% of earnings above the State Average Weekly Wage
- In no event more than a maximum amount. **For 2025, this maximum benefit amount is \$1,170.64.** This amount will be adjusted annually based on increases in the State Average Weekly Wage.

Private plans may choose to provide higher benefits but may not provide lower amounts than what the Department would pay.

Note: Any pay benefits from Nelson Mullins Disability Pay programs will be offset by Wage Replacement payments from Massachusetts. Read the Short Term Disability Policy in the Policy Guide, found on NMConnect on the Human Resources Department Page.

Concurrent Benefits Payments. If you receive benefits from other sources while you are also receiving benefits from the Department, the benefits you receive from the Department may be reduced. Certain types of other benefits will cause a one-for-one reduction in benefits you receive from the Department. This means that for each dollar you receive from these benefits, your benefit from the Department will decrease by a dollar. Benefits that will have this effect include:

- Workers’ Compensation
- Unemployment Insurance
- Permanent Disability Policies or Programs
- Extended Illness Leave Bank Leave

Other forms of benefits will not reduce the benefits you receive from the Department unless you are receiving more than your average weekly wage in total benefits. Benefits that will have this effect include:

- Temporary Disability Policies or Programs (including both Short-Term Disability and Long-Term Disability)
- Employer-run Family and/or Medical Leave Policies or Programs

Topping off PFML benefit payments. For applications filed on or after November 1, 2023, employees receiving PFML benefits may supplement (or “top off”) their PFML benefits with any available accrued paid leave (sick time, vacation, PTO, personal time, etc.). For employees who choose to supplement their PFML benefits in this way, the combined weekly sum of PFML benefits and employer-provided paid leave benefits cannot exceed the employee’s Individual Average Weekly Wage (IAWW). Employers will be responsible for monitoring and ensuring that the combined weekly sum of employer-provided paid leave benefits and PFML benefits does not exceed an employee’s IAWW. Employers are also responsible for managing any payments made to an employee that exceed

the employee’s IAWW. The Department is not involved in the repayment process for top off overages. This process is solely the responsibility of the employer and the employee.

If the application is filed on or after November 1, 2023, applications filed retroactively for a leave that began before November 1, 2023, are eligible for topping off.

II. Employee Rights and Protections

Job Protection. Generally, if you take family or medical leave, once you return to work, your employer must restore you to your previous position or to an equivalent position, with the same status, pay, employment benefits, length-of-service credit, and seniority as of the date you started your leave. This may not apply if your position was eliminated due to economic reasons unrelated to your use of leave.

Continuation of Health Insurance. Your employer must continue to provide for and contribute to your employment-related health insurance benefits, if any, at the level and under the conditions coverage would have been provided if you had continued working for the duration of such leave. Your employer may require you to continue to pay your portion of your health insurance premium on the same terms and conditions as before your leave.

No Retaliation. It is unlawful for any employer to discriminate or retaliate against you for exercising any right to which you are entitled under the paid family and medical leave law. An employee or former employee who is retaliated against for exercising rights under the law may, not more than three years after the violation occurs, institute a civil action in the superior court.

III. Contribution Amounts

To help fund paid leave benefits available under the PFML law, your employer may make a contribution, funded in part by a deduction from your wages, which will either be remitted to the Trust Fund or to the operator of your employer’s private plan. An employer who contributes to the Trust Fund will be required to contribute the following amounts:

Family Leave Contribution	Medical Leave Contribution	Total Contribution Amount
0.18% of earnings*	0.70% of earnings*	0.88 of earnings*

Because your employer has 25 or more covered workers, the total contribution amount is 00.88% of wages.

Under the law, employers are responsible for a minimum of 60% of the medical leave contribution (.42% of wages) but are permitted to deduct from employees’ wages up to 40% of the medical leave contribution (.28% of wages) and up to 100% of the family leave contribution (.18% of wages) for a total of .46% of wages. Whether your employer has a private plan or participates in the state Trust Fund, your employer cannot deduct more than these percentages from your wages.

Your employer has elected to allocate the contribution amount as follows:

Medical Leave	Total Required Contribution: .70%*		
	Nelson Mullins	will contribute	60% of the medical leave contribution

Family Leave	(Employer Name)		40%	will be deducted from your earnings	
	and the remaining				
	Total Required Contribution: .18%*				
	Nelson Mullins		0%	of the family leave contribution	
(Employer Name)					
and the remaining		100%	will be deducted from your earnings		

Please initial here to indicate that you understand that this percentage of your wages earned in a pay period will be deducted from your pay each pay period: _____

*The numbers provided are through 2025. These rates may be adjusted on an annual basis, effective January 1 of each calendar year.

IV. Notifying your Employer

BEFORE you take leave or apply for benefits, you MUST notify your employer that you need to take leave. You are required to provide at least 30 days' notice of your need for leave. If 30 days' notice is not possible due to circumstances beyond your control, you must provide notice as soon as practicable, and in any event, before you file any application for benefits.

When you notify your employer of your need for leave, you must provide the following information:

1. The anticipated start date of leave;
2. The anticipated length of the leave;
3. The expected date of return from leave;
4. Whether you will need intermittent leave (leave taken in separate blocks of two or more) or reduced leave (leave that involves a reduced schedule of fewer hours or days per week), and
5. If you need intermittent or reduced leave schedule, the expected frequency of leave and expected duration of each instance of leave.

If any of this information changes, you must tell your employer as soon as you are aware of the change.

V. Submitting an application

To apply for Paid Family and Medical Leave benefits, you will need the following information about your employer:

Nelson Mullins Riley & Scarborough LLP
 (Employer Name)

 1320 Main Street, Suite 1700
 (Employer Street Address)

57-0215445

(Federal Employer ID Number) (FEIN)

Contact: Human Resources

Jan.Berger@nelsonmullins.com | 803.255.9314

Employees must file claims for paid family and medical leave benefits with the DFML using the Department's forms. Forms and claim instructions are available on the Department's website www.mass.gov/DFML.

Nelson Mullins contributes to the Massachusetts Trust Fund for benefits to be payable to eligible Massachusetts employees. You must file a claim for benefits with the Department.

You may file this claim in one of two ways:

1. You can create an account to apply online through the Department's Claimant Portal at <https://paidleave.mass.gov/login/>
2. You can call the Department's call center at (833) 344-7365 to complete an application over the phone.

Forms and claim instructions are available on the Department's website at: www.mass.gov/info-details/get-ready-to-apply-for-paid-family-and-medical-leave-pfml-benefits

VI. For More Information

For more detailed information, please consult the Department's website: www.mass.gov/DFML. You may contact the Department of Family and Medical Leave at:

The Massachusetts Department of Family and Medical Leave

PO Box 838

Lawrence, MA 01842

Contact Center: (833) 344-7365

www.mass.gov/DFML

ACKNOWLEDGEMENT

Your signature below acknowledges receipt of the information above within 30 days from the start date of your employment.

Signature

Date

Name (Print)

Your signed acknowledgement will be retained by your employer. Keep a copy for your own reference.



Paid Family Leave

NOTICE TO EMPLOYEES

Paid Family Leave Insurance
Coverage Provided by:

Sun Life Insurance Company

INSERT INSURER NAME HERE

Covering Employees of:

Nelson Mullins Riley & Scarborough LLP

INSERT EMPLOYER NAME HERE

Paid Family Leave is insurance that provides job protected paid time off to:

- **Bond** with a newly born, adopted, or fostered child
- **Care** for a family member with a serious health condition
- **Assist** loved ones when a family member is deployed abroad on active military service

How to File:

- **Notify** your employer at least 30 days in advance, if foreseeable, or as soon as possible
- **Submit** the Request for Paid Family Leave form to your employer
- **Complete** and attach the additional documentation as instructed on the request form and submit to the insurance carrier listed below

Employers should NEVER discriminate or retaliate against anyone who requests or takes Paid Family Leave

FOR MORE INFORMATION AND HELP:
Visit **ny.gov/PaidFamilyLeave**
or call **(844) 337-6303**

You can get forms to take Paid Family Leave from

- Your employer,
- The insurance carrier below, or
- ny.gov/PaidFamilyLeave

Name, Address, and Telephone Number of Insurer

Sun Life and Health Insurance Company
One Sun Life Executive Park
Wellesley Hills, MA 02481-5699

Phone: 855-629-8811
M – F 8:00 a.m. – 8:00 p.m. ET
Email completed claim to:
myclaimdocuments@sunlife.com

POLICY #: 943028-001 (Group Plan # is 958931)

EFFECTIVE FROM: 1/1/2026– 12/31/2026

Statutory

- Under a Plan or Agreement

Class(es) of Employees Covered:

All employees eligible under New York State Law

NOTICE OF COMPLIANCE

Prescribed by the Chair, Worker's Compensation Board

This Notice must be posted in and about the Employer's place or places of business

NOTICE TO EMPLOYEES

Information on Paid Family Leave in the District of Columbia

Your employer is subject to the District of Columbia's Paid Family Leave law, which provides covered employees paid time off from work for qualifying parental, family, medical, and prenatal events. For more information about the Paid Family Leave program, please visit the Office of Paid Family Leave's website at dcpaidfamilyleave.dc.gov.

Covered Workers

To receive benefits under the Paid Family Leave program, you must work for a covered employer in DC. To find out if you are a covered worker, you can ask your employer or contact the Office of Paid Family Leave using the contact information below. Your employer is required to tell you if you are covered by the Paid Family Leave program. Additionally, your employer is required to provide you information about the Paid Family Leave program at these three (3) times:

1. At the time you were hired;
2. At least once a year; and
3. If you ask your employer for leave that could qualify for benefits under the Paid Family Leave program.

Covered Events

There are four (4) kinds of Paid Family Leave benefits:

1. Parental leave - receive benefits to bond with a new child for up to 12 weeks in a year;
2. Family leave - receive benefits to care for a family member for up to 12 weeks in a year;
3. Medical leave - receive benefits for your own serious health condition for up to 12 weeks in a year; and
4. Prenatal leave - receive benefits for prenatal medical care for up to 2 weeks in a year.

Maximum Leave Entitlement

Each kind of leave has its own eligibility rules and its own limit on the length of time you can receive benefits in a year. The maximum amount of leave for any combination of parental, family, and medical leave is 12 weeks. However, there is an exception for pregnant women who take prenatal leave. Pregnant women are eligible for 2 weeks of prenatal leave while pregnant and 12 weeks of parental leave after giving birth, for a maximum of 14 weeks.

For more information about Paid Family Leave, please visit the Office of Paid Family Leave's website at dcpaidfamilyleave.dc.gov, call 202-899-3700, or email does.opfl@dc.gov.

Applying for Benefits

If you have experienced an event that may qualify for benefits, be sure to apply no more than 30 days after your event. You can learn more about applying for benefits with the Office of Paid Family Leave at dcpaidfamilyleave.dc.gov.

Benefit Amounts

Paid Family Leave benefits are based on the wages your employer paid to you and reported to the Department of Employment Services. If you believe your wages were reported incorrectly, you have the right to provide proof of your correct wages. The current maximum weekly benefit amount is \$1,118.

Employee Protection

The Office of Paid Family Leave does not administer any job protections for District workers who take leave from work. However, some job protections may be available under laws and regulations administered by the District's Office of Human Rights (OHR).

Under the Universal Paid Leave Act, the Office of Paid Family Leave is required to provide notice of the following:

1. That retaliation by a covered employer against a covered employee for requesting, applying for, or using paid-leave benefits is prohibited;
2. That an employee who works for a covered employer with under 20 employees shall not be entitled to job protection if he or she decides to take paid leave pursuant to this act; and
3. That employees have a right to file a complaint with OHR if they feel they have been retaliated against for requesting, applying for, or using paid leave.

For more information on OHR and job protections, please visit the following web address: ohr.dc.gov.

Life happens. FAMLI has you covered.

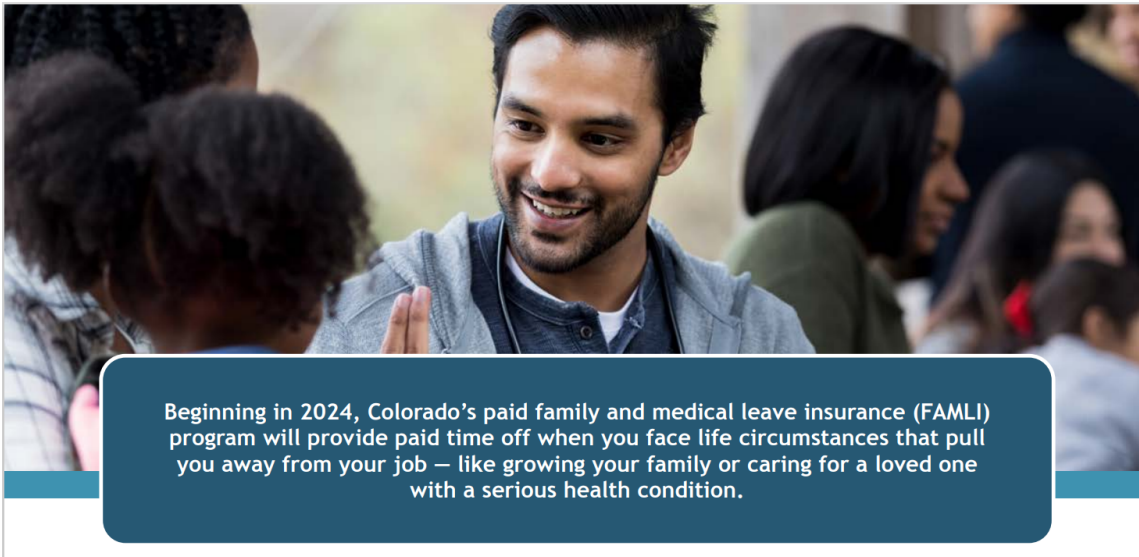
Learn more at famli.colorado.gov.



COLORADO

Family and Medical Leave Insurance Program (FAMLI)

Department of Labor and Employment



Beginning in 2024, Colorado's paid family and medical leave insurance (FAMLI) program will provide paid time off when you face life circumstances that pull you away from your job — like growing your family or caring for a loved one with a serious health condition.

How does it work?

Beginning on January 1, 2024, nearly every Colorado worker who earns at least \$2,500 in yearly wages within the state will be eligible to take **paid family and medical leave** during covered circumstances:

- » To care for a new child, including adopted and fostered children
- » To care for themselves, if they have a serious health condition
- » To care for a family member with a serious health condition
- » To make arrangements for a family member's military deployment
- » To address the immediate safety needs and impact of domestic violence and/or sexual assault.

Depending on your income, when using paid leave, you will receive between 37% and 90% of your normal weekly wages. **Benefits are capped at \$1,100 per week.**

Most workers are eligible to receive up to 12 weeks of paid family and medical leave. Those who experience pregnancy or childbirth complications may receive an additional four weeks.

Who pays for FAMLI?

Contributions to Colorado's FAMLI program will be shared between employers and workers. Beginning on January 1, 2023, your employer may begin deducting up to 0.45% of your pay to cover your portion of the FAMLI premium.

What are my rights?

Eligible Colorado workers have the right to take paid family and medical leave for covered circumstances.

Once you have served in your job for at least 180 days (about six months), your job is protected under the law. As long as you are eligible and qualify to use paid leave, your employer cannot prevent you from taking it, and cannot penalize or fire you for taking paid leave.



COLORADO

Family and Medical Leave Insurance Program (FAMLI)

Department of Labor and Employment

MINNESOTA PAID LEAVE

Effective January 1, 2026

Minnesota Paid Leave provides payments and job protections when you need time off to care for yourself or your family.

What can I use Paid Leave for?

Medical Leave:

- To care for your own serious health condition, including care related to pregnancy, childbirth, and recovery

Family Leave:

- **Bonding Leave** – to care for and bond with a new child welcomed through birth, adoption, or foster placement
- **Caring Leave** – to care for a family member with a serious health condition
- **Military Family Leave** – to support a family member called to active duty
- **Safety Leave** – to respond to issues related to domestic violence, sexual assault, or stalking for yourself or a family member

Generally, conditions must last more than seven days and be certified by a healthcare provider or other professional.

Am I covered by Paid Leave?

Most workers in Minnesota are covered by Paid Leave. You are covered no matter the size of your employer, or the hours or days you work. Independent contractors and self-employed individuals are not automatically covered but may opt in. You may qualify for payments if you've been paid a minimum amount for work in Minnesota in the last year (\$3,900 for the start of Paid Leave in 2026).

How long can I take leave?

You may qualify to take up to 12 weeks of family or medical leave per benefit year. If you need both family and medical leave in the same benefit year, you may qualify for up to 20 weeks in total.

How much will I get paid?

When you use Paid Leave, the state makes payments to you. Paid Leave will pay up to 90% of your wages, based on your income level, with a maximum weekly amount set at the state's average weekly wage. This amount changes each year, and is \$1,423 for the start of Paid Leave in 2026.

Who pays for Paid Leave?

Paid Leave is funded by premiums paid by employees and employers. The initial premium rate is 0.88% of covered wages. Your employer may deduct up to 0.44% of your wages to fund your portion of the premium.

What are my employment protections?

- **Job protections:** Generally, you must be restored to your job or an equivalent position when returning from leave. Job protections take effect 90 days after your date of hire.
- **Health insurance continuation:** Generally, employers must continue to fund their portion of healthcare insurance premiums while you are on leave.
- **No retaliation or interference:** Employers must not interfere with or retaliate against you if you apply for or use Paid Leave. Employers cannot take your Paid Leave payments.

For inquiries related to Paid Leave, please contact Minnesota Paid Leave at 651-556-7777 or visit our website.

If you think your employer is violating employment protections, contact the Labor Standards Division at the Minnesota Department of Labor and Industry.



This information can be provided in alternative formats to people with disabilities or people needing language assistance by calling the Paid Leave Contact Center at 651-556-7777 or 844-556-0444 (toll-free).

m MINNESOTA
PAID LEAVE

7/2025

Minnesota Paid Leave | 180 E 5th St Suite 1200 | Saint Paul, MN 55101

NELSON MULLINS RILEY & SCARBOROUGH LLP SUMMARY ANNUAL REPORT FOR THE HEALTH AND WELFARE PLAN

This is a summary of the annual report of the NELSON MULLINS RILEY & SCARBOROUGH LLP HEALTH AND WELFARE PLAN, a health, life insurance, dental, vision, temporary disability and long-term disability plan (Employer Identification Number 57-0215445, Plan No. 509), for the plan year 01/01/2024 through 12/31/2024. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

NELSON MULLINS RILEY & SCARBOROUGH LLP has committed itself to pay certain health, dental, and short-term disability claims incurred under the terms of the plan. The plan has administrative service only (ASO) contracts with BlueCross BlueShield of South Carolina and Delta Dental.

Insurance Information

The plan has contracts with Fidelity Security Life Insurance Company, and Prudential Life Insurance Company of America to pay vision, life insurance, long-term disability, and AD&D claims incurred under the terms of the plan. The total premiums paid for the plan year ending December 31, 2024, were \$1,986,617.

Your Rights To Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

- insurance information, including sales commissions paid by insurance carriers;

To obtain a copy of the full annual report, or any part thereof, write or call the office of NELSON MULLINS RILEY & SCARBOROUGH LLP, HUMAN RESOURCES, at PO BOX 11070, COLUMBIA, SC 29211, or by telephone at (803) 799-2000. The charge to cover copying costs will be \$0.00 for the full annual report, or \$0.00 per page for any part thereof.

You also have the legally protected right to examine the annual report at the main office of the plan at: NELSON MULLINS RILEY & SCARBOROUGH, LLP, 1320 Main Street, 17th Floor, Columbia SC, 20201, and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N-1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

SUMMARY ANNUAL REPORT FOR THE NELSON MULLINS RETIREMENT PLAN

This is a summary of the Form 5500 Annual Return/Report of Employee Benefit Plan for the NELSON MULLINS RETIREMENT PLAN, EIN 57-0215445, Plan 002, for period January 1, 2024 through December 31, 2024. The Form 5500 annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA). Your plan is a defined contribution, age/service weighted or new comparability, profit-sharing, ERISA section 404(c), total participant-directed account, Code section 401(k), participant-directed brokerage account, automatic enrollment, default investment account, covered self-employed individuals, pre-approved, single employer type of plan.

Basic Financial Statement

Benefits under the plan are provided through a trust fund. Plan expenses were \$66,901,460. These expenses included \$839,483 in administrative expenses and \$66,061,977 in benefits paid to participants and beneficiaries. A total of 2635 persons were participants in or beneficiaries of the plan at the end of the plan year.

The value of plan assets, after subtracting liabilities of the plan, was \$678,896,478 as of December 31, 2024, compared to \$617,393,440 as of January 1, 2024. During the plan year, the plan experienced an increase in its net assets of \$61,503,038. This increase includes unrealized appreciation or depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. The plan had total income of \$128,404,498, including employer contributions of \$18,897,336, employee contributions of \$21,621,050, other contributions of \$9,665,864, earnings from investments of \$62,119,687 and other income of \$16,100,561.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report.

- An accountant's report
- Financial information and information on payments to service providers
- Assets held for investment
- Information regarding any common or collective trusts, pooled separate accounts, master trusts or 103-12 investment entities in which the plan participates

To obtain a copy of the full annual report, or any part thereof, write or call the office of NELSON MULLINS RILEY & SCARBOROUGH LLP, 1320 MAIN STREET 17TH FLOOR, COLUMBIA, SC, 29201, 803-799-2000.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes will be included as part of that report.

You also have the legally protected right to examine the annual report at the main office of the plan, 1320 MAIN STREET 17TH FLOOR, COLUMBIA, SC, 29201 and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, N1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. The annual report is also available online at the Department of Labor website www.efast.dol.gov.

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 less than one minute per notice (approximately 3 hours and 11 minutes per plan). 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, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 or email DOL_PRA_PUBLIC@dol.gov and reference the OMB Control Number 1210-0040.