

TEAM MEMBER BENEFITS



2024-2025



INTERNATIONAL
ASSOCIATES PROGRAM

THE BREAKERS®
PALM BEACH

TEAM MEMBER BENEFITS



FSA

TELADOC

SHUTTLE

BEEKEEPER

LEGAL SERVICES

DENTAL

VOLUNTEER

BEYOND MED

MY WELLNESS JOURN

BEENGAGED

FLU SHOT

JURY DUTY

BACK-UP CARE

IDENTITY THEFT

ALL TEAM MEETING

STAFF RELATIONS TRAINING

ROOMS REFERRAL

401K+MATCH

CORPORATE ATHLETE

MENTAL HEALTH IS EVERYONE'S BUSINESS

PAID PARENTAL

HOLIDAY RETAIL DISCOUNT

TUITION REIMBURSEMENT

BLUE CROSS BLUE SHIELD CONCIERGE

SERVICE ANNIVERSARY AWARD

GOLF SCRAMBLE

DISABILITY

LEAVE OF ABSENCE

BLUE CROSS BLUE SHIELD CONCIERGE

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The Breakers is pleased to offer our International Associate team members a comprehensive and competitive employee benefits package. This benefits guide will provide you with coverage highlights, important contact information and The Breakers' annual team member disclosures.



HEALTH & WELLNESS

- Medical
- Dental
- Vision
- On-site Wellness Clinic



FINANCIAL WELLNESS

- SageView Advisory Group



RETIREMENT & LIFESTYLE

- 401(k) with Company Match
- Back Up Care
- Employee Assistance Program

TEAM MEMBER ELIGIBILITY AND GUIDELINES

International Associate team members are provided an opportunity to enroll in The Breakers' company sponsored benefits (Medical, Dental and Vision) upon their first day of work.

Medical Insurance will be effective on your first day of work. If you choose to enroll in Dental and/or Vision, the plans will begin on the first of the month following sixty (60) days.

TIP: It is important to enroll within your first week of arrival.

ENROLLMENT INSTRUCTIONS

Log into our self-service enrollment platform, SmartBen, to complete your enrollment.

For enrollment assistance, please contact benefits@thebreakers.com.



Log on to thebreakers.wl.alight.com

A. Username: Your Team Member ID (Ex: 123456)

B. Password: 8 digit DOB in the mmddyyyy format (Ex: 05021997)

VERIFY ELECTIONS

After you enroll in The Breakers' company sponsored benefits program, it is your responsibility to check on ADP's portal to ensure the benefits you elected are included and the correct amount is being deducted from your paycheck. Any corrections must be made within the first 30 days of enrollment.

Please be advised that this guide provides you with *only* a general summary of the benefits available to you and your eligible dependents. Please refer to the Summary Plan Description, the medical Summary of Benefits and Coverage, the carrier summaries and Certificates of Coverage for detailed coverage descriptions and provisions, located on thebreakers.wl.alight.com.

ENROLLMENT INSTRUCTIONS

Steps to Complete Your Enrollment.

STEP 1

Log on to thebreakers.wl.alight.com

A. Username: Your Team Member ID (Ex: 123456)

B. Password: 8 digit DOB in the mmddyyyy format (Ex: 05021997)

STEP 2

Once logged in, you can begin your enrollment

A. Select **Begin Enrollment** under Qualifying Life Event

STEP 3

Review and Elect Benefits

A. Review your enrollment options and make your benefit elections

B. To enroll, make changes or waive coverage, click on a benefit

BENEFITS OVERVIEW

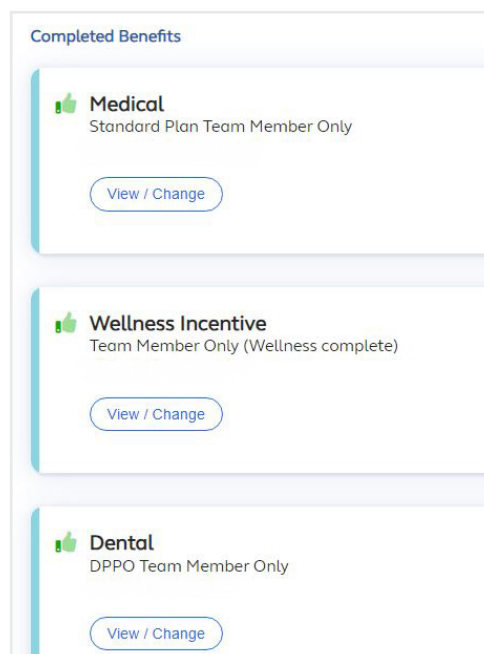
Once you choose a benefit, select **Employee Only**, under **Who's Being Covered**

- A. This will update the plan options to the appropriate level of coverage
- B. Once you've decided on your desired plan and level of coverage, click **Select** under the applicable plan
- C. The option will turn green and you can then select **Continue**
- D. Once all requirements for the benefit have been updated, select **Continue**

STEP 4

Once all elections are complete, each benefit will have a green light.
To finalize your elections, select **Continue** from the **Benefit Management** page.

- A. Review your **Elected Benefits** to confirm each is illustrated as expected
 - If changes need to be made, select **Return to Lights**
 - If everything is reflected correctly, complete your required **Agreement** and select **Complete Enrollment**
 - **Select waive for the benefits you do not wish to enroll in**
- B. Next Steps
 - You will receive notice that your enrollment has successfully completed
 - You can then print your **Confirmation Page** for your records





SMARTBEN NOW APP

The app allows you to access up-to-date information about your benefits provided by The Breakers, keeping you plugged into your benefits when and where you need it.

SmartBen NOW Provides:

- Access to benefit information anywhere
- Current balances and contributions
- One-touch launch to benefit portals on-the-go
- Current status of deductibles and out-of-pocket balances
- Easy to access all of your ID cards from one location
- Available for Apple or Android devices

Logging on to SmartBen NOW

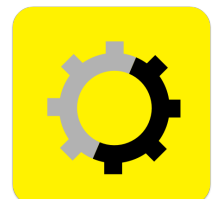
Once installed, open SmartBen NOW on your mobile device.

Enter your username and password.



Username: Your Team Member ID (Ex: 123456)

Password: 8 digit DOB in the mmddyyyy format (Ex: 05021997)



MEDICAL BI-WEEKLY PAYROLL DEDUCTIONS (PRE-TAX)

With Earned Wellness Incentive Savings			
MEDICAL COVERAGE	STANDARD PLAN HIGHER DEDUCTIBLE	DELUXE PLAN LOWER DEDUCTIBLE	CHOICE PLAN
Team Member Only	\$76.00	\$100.00	\$161.00

Without Earned Wellness Incentive Savings (Team Member)			
MEDICAL COVERAGE	STANDARD PLAN HIGHER DEDUCTIBLE	DELUXE PLAN LOWER DEDUCTIBLE	CHOICE PLAN
Team Member Only	\$99.08	\$123.08	\$184.08

DENTAL BI-WEEKLY PAYROLL DEDUCTIONS (PRETAX)

DENTAL COVERAGE	DHMO PLAN	PPO PLAN
Team Member Only	\$6.76	\$23.20

VISION BI-WEEKLY PAYROLL DEDUCTIONS (PRETAX)

VISION COVERAGE	BASIC PLAN	ENHANCED PLAN
Team Member Only	\$1.86	\$3.00

MEDICAL BENEFITS

MEDICAL INSURANCE

The Breakers provides three plan options through Blue Cross Blue Shield of Florida. The plans offered are:

STANDARD IN-NETWORK ONLY	DELUXE IN-NETWORK ONLY	CHOICE PLAN IN OR OUT-OF-NETWORK
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The **Standard** and **Deluxe Plans** are In-Network only plans, however all three plans are open-access and do not require you to select a Primary Care Physician (PCP) or obtain a referral to seek care from contracted specialists.

The **Choice Plan** provides benefits when you seek care from providers Out-of-Network. While you have the flexibility of seeking care from non-contracted providers, your benefits will be reduced and may be subject to balance billing for amounts over Blue Cross Blue Shield of Florida's recognized charges. You will receive maximum levels of benefits when you use Blue Cross Blue Shield of Florida's preferred providers.

EXPLANATION OF PLAN YEAR DEDUCTIBLE & PLAN YEAR OUT-OF-POCKET MAXIMUM

Plan Year Deductible

The Plan Year Deductible is a specified dollar amount that you must pay for certain covered services per plan year. There are individual deductibles. Once a deductible has been satisfied, then coinsurance applies, if applicable. Coinsurance is your share of the costs of a health care service. It is the amount a member pays after the deductible has been met.

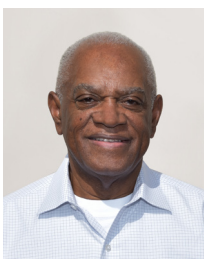
Plan Year Out-of-Pocket Maximum

The Plan Year Out-of-Pocket Maximum is the amount of covered expenses, (including deductible, coinsurance, and copayments and pharmacy copayments) that must be paid by you, individually.

After the individual out-of-pocket maximum has been satisfied in a plan year, payment for in-network covered services requiring copayment and coinsurance for that covered individual will be payable by Blue Cross Blue Shield of Florida at the rate of 100% for the remainder of the plan year, subject to any other terms, limitations and exclusions.

Blue Cross Blue Shield Concierge

The Breakers provides a dedicated concierge to assist you with choosing the correct plan for you and your medical claim issues, finding an in-network provider, and answers any questions you may have.



CONTACT DENNIS ASHWOOD

Availability: Monday, Wednesday, Thursday

Hours: 8 AM to 4:30 PM

Phone: (786) 459-8813

Email: dennis.ashwood@bcbsfl.com

PLAN COMPARISON

PLAN NAME	STANDARD PLAN HIGHER DEDUCTIBLE	DELUXE PLAN - LOWER DEDUCTIBLE	CHOICE PLAN	
Network Access	In-Network	In-Network	In-Network	Out-of-Network** (Not Covered)
Plan Year Deductibles (PYD)*	Your Responsibility	Your Responsibility	Your Responsibility	
Individual	\$1,500 [▮]	\$1,000 [▮]	\$1,000 [▮]	\$1,500 [▮]
Family	\$3,000 [▮]	\$2,000 [▮]	\$2,000 [▮]	\$3,000 [▮]
Out-of-Pocket Plan Year Max				
Individual	\$4,500	\$3,500	\$2,500	\$4,000
Family	\$9,000	\$7,000	\$5,000	\$8,000
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	
Physician Office Services				
Primary Care Physician (PCP) Office Visits	\$30 Copay	\$25 Copay	\$25 Copay	30% After PYD*
Teladoc (includes Mental Health & Nutritional Counseling)	Free	Free	Free	Free
Specialist Office Visits	\$50 Copay	\$40 Copay	\$30 Copay	30% After PYD*
Preventive Care (Primary / Specialist)	No Charge	No Charge	No Charge	30% After PYD*
Convenient Care (Minute Clinic)	\$10 Copay	\$10 Copay	\$10 Copay	30% After PYD*
Urgent Care and Emergency Room				
Urgent Care Facility	\$100 Copay	\$100 Copay	\$100 Copay	30% After PYD*
Emergency Room Facility Services (Waived if admitted)	\$400 Copay	\$300 Copay	\$250 Copay	
Diagnostic Services				
Independent Lab / Independent X-Ray	No Charge	No Charge	No Charge	30% After PYD*
MRI, CT Scan, PET Scan	\$300 Copay	\$250 Copay	\$150 Copay	30% After PYD*
Diagnostic Colonoscopy / Mammogram	\$250 Copay	\$250 Copay	\$250 Copay	30% After PYD*
Hospital / Facility Services				
In-Patient Hospital	20% After PYD*	10% After PYD*	10% After PYD*	30% After PYD*
Out-Patient Hospital / Surgical Facility	20% After PYD*	10% After PYD*	10% After PYD*	30% After PYD*
Pharmacy Services				
Tier 1	\$10 Copay	\$10 Copay	\$10 Copay	Not Covered
Tier 2	\$40 Copay	\$35 Copay	\$30 Copay	
Tier 3 / Tier 4 *Qualified Rx \$0 Copay	\$70 Copay	\$60 Copay	\$55 Copay	
Mail Order Pharmacy & Retail Maintenance (90 Day Supply) 3x Copay	\$30 \$120 \$210	\$30 \$105 \$180	\$30 \$90 \$165	

*PYD (Plan Year Deductibles) must be met before coinsurance applies.

**Out-of-Network benefits are subject to Balance Billing for charges over the carrier's reimbursement schedule not covered.


▮ PYD - applicable only to hospital facilities and patient care.

*Qualified Rx will have a \$0 copay through the Variable Copay Program.

MEMBER PERKS THROUGH BLUE CROSS BLUE SHIELD

DISCOUNTS FOR YOU — BLUE365

Team members enrolled in the medical plan have access to exclusive discounts on a variety of products and services. Go to myhealthtoolkitfl.com and select the **Member Discounts** tab.

				
FITNESS	PERSONAL CARE	LIFESTYLE	HEALTHY EATING	HEARING & VISION
Gym Memberships Wearable Fitness Devices Activewear Golf Memberships Home Fitness Equipment Vitamins and Nutritional Supplements	Allergy relief Acupuncture Chiropractic Services Massage Therapy Hair Restoration Teeth Whitening	Travel Clubs Vacation Packages Pet Care Car Rentals	Weight Loss Programs Cookbooks and Recipes Meal Delivery Services	Hearing Aids Lasik Eye Surgery Eyewear

24-HOUR NURSE ADVISOR

When you need immediate health care advice, call 24-Hour Nurse Advisor toll free at (866)-323-0664. This service can help you avoid needless worry, out-of-pocket charges and hours sitting in an emergency room.

When you call, a registered nurse will help you decide:

- If you can take care of the problem at home
- If you need to see your doctor
- If it is safe to wait or if you need help right away
- What you should watch for if you don't need care right away

You can also ask the nurse about:

- Questions you forgot to ask your doctor
- The latest health information
- Making important health care decisions
- Your medicines or other treatments

ESSENTIAL ADVOCATE

The health care system can seem confusing when you're trying to get reliable information. That's why we offer Essential Advocate as a free service of your health plan.

Call Essential Advocate at (888) 521-2583 any time of the day, any day of the week. A care coordinator will connect you with a registered nurse or other expert who can provide information, support or health pointers. For example, you can get help with:

- Concerns about medications and side effects
- Finding a doctor, specialist or urgent care center
- Scheduling an appointment with your doctor
- Comparing costs before scheduling medical treatment
- Preparing for surgery and taking steps for a healthy recovery
- Locating helpful programs and resources in your community

MY HEALTH TOOLKIT—BLUE CROSS BLUE SHIELD

My Health Toolkit is the one-stop shop for answers about your health care — customized just for you! It has everything you need to understand your health plan coverage and manage your benefits. All members ages 16 and older, including spouses and dependents, should sign up for an account. It's easy to register and it's free.

You can locate a participating Blue Cross Blue Shield of Florida physician by contacting Blue Cross Blue Shield of Florida's Member Services or by going directly to their website at myhealthtoolkitfl.com. Enter the first three characters of your member ID (TBY) to browse providers within your plan.

The My Health Toolkit can assist you with:

- Learn more about your coverage
- Check medical claims
- View your medical history
- Replace your membership card
- Find a doctor or hospital

Register in just a few clicks:

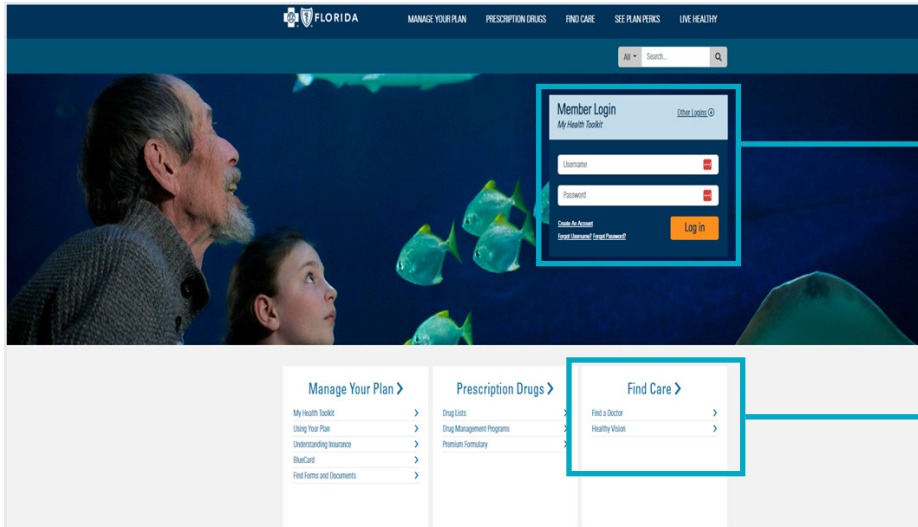
1. Go to myhealthtoolkitfl.com
2. Click the **Register Now** button on the right-hand side of the page
3. Enter your **Member ID** located on your membership card
4. Follow the instructions to **Create Your Profile**

Machine Readable Files: <https://member.myhealthtoolkitfl.com/web/public/fl/>

This link leads to the machine readable files that are made available in response to the federal Transparency in Coverage Rule and includes negotiated service rates and out-of-network allowed amounts between health plans and healthcare providers. The machine-readable files are formatted to allow researchers, regulators and application developers to more easily access and analyze data.

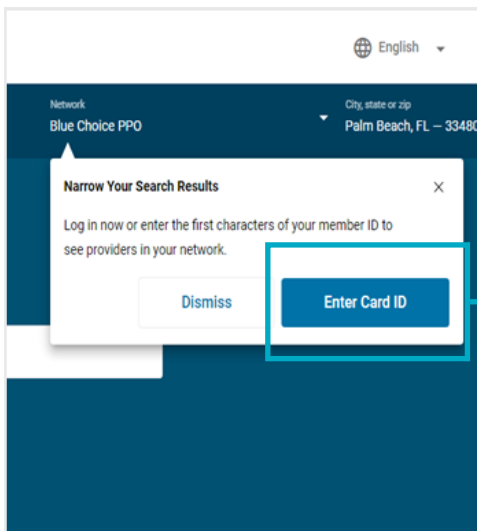
BLUE CROSS BLUE SHIELD OF FLORIDA MEDICAL PROVIDER SEARCH

To find participating providers, hospitals and more visit: myhealthtoolkitfl.com



Log In or
Create an Account

Click on
Find a Provider

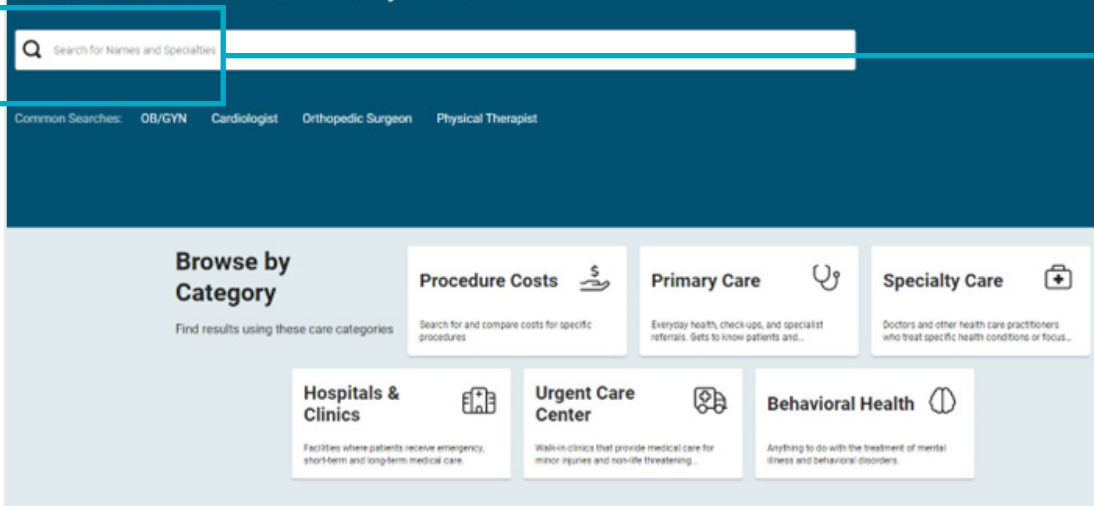


Enter your
card ID or log into
your account.

Enter the **first 3 characters** of your member ID number found on your insurance card for **care options in your network**.

		Plan Name ALPHA Employer Group	
Member Name John Doe Member ID XYZ123456789		Dependents John Doe Robbie Doe Billy Doe	
Plan No.	023457	Plan	PPO
BIN	987654	Office Visit	\$15
Benefit Plan	HIOPT	Specialist Copay	\$15
Effective Date	00/00/00	Emergency	\$75
		Deductible	\$50

Browse or search to find the care you need.



On the Provider Search screen, you can search by provider, service, condition, or category.

TIP: Make sure your location is set to the correct area.

KNOW BEFORE YOU GO

Choosing the right kind of care for a medical situation can be challenging and confusing. Understanding the different levels of care and when to use each one can help save time and money, and create peace of mind.

If you require assistance with determining where to locate care, please do not hesitate to contact our Blue Cross Blue Shield Concierge, Dennis Ashwood.

	TYPE OF FACILITY	AVERAGE COST	EXAMPLES OF HEALTH ISSUES
	TELADOC Provides 24/7 access to care when your primary care doctor or your child's pediatrician cannot see you right away. Doctors are available to treat non-emergency illnesses via web, phone or mobile app.	FREE	<ul style="list-style-type: none"> • Sinus Infections • Cold and Flu • Cough / Sore Throat • Mental Health Counseling • Rash • Allergies • Stomach Ache • Nausea
	CONVENIENCE CARE CLINIC Treats minor medical concerns. Staff located in retail stores and pharmacies. Often open nights and weekends. 	\$	<ul style="list-style-type: none"> • Infections • Cold or Flu • Minor Injuries or Pain • Shots • Flu Shots • Sore or Strep Throat • Skin Problems • Allergies
	YOUR DOCTOR'S OFFICE The best place to go for routine or preventive care, to keep track of medications	\$	<ul style="list-style-type: none"> • Fever, Colds, or Flu • Sore Throat • Rashes • Minor Burns • Ear or Sinus Pain • Preventive Care • Shots • Minor Allergic Reactions
	VIRTUAL VISITS Best for routine ailments; lets you see and talk to a doctor from the comfort of your home or office without an appointment.	\$	<ul style="list-style-type: none"> • Allergies • Cold and Flu • Nausea • Stomach Ache • Sinus Infections • Asthma • Pink Eye • Headaches
	URGENT CARE CENTER For conditions that aren't life threatening. Staffed by nurses and doctors and usually have extended hours.	\$\$	<ul style="list-style-type: none"> • Migraines or Headaches • Cuts (that need stitches) • Abdominal Pain • Sprains or Strains • Urinary Tract Infection • Animal Bites • Back Pain • Joint Pain
	HOSPITAL EMERGENCY ROOM For immediate treatment of critical injuries or illness. If a situation seems life-threatening, call 911 or go to the nearest emergency room.	\$\$\$	<ul style="list-style-type: none"> • Chest Pain, Stroke • Seizures • Head or Neck Injuries • Sudden Numbness • Fainting, Dizziness • Uncontrolled Bleeding • Problems Breathing • Broken Bones

TELADOC

Teladoc gives you 24/7/365 access to a board-certified physician through the convenience of phone or video. This is a complimentary service with a \$0 copay for team members enrolled in our medical plan. Grab your insurance card and go to teladoc.com or call (866) 789-8155 to set up your account.



- 24/7 access to U.S. licensed doctors by phone or video
- Doctors diagnose, treat and prescribe medications when needed
- Quality care from wherever you are

Teladoc can assist with:

- Cold and flu symptoms
- Allergies
- Bronchitis
- Urinary tract infections
- Respiratory infections
- Sinus problems
- Dermatology concerns
- Mental Health counseling
- And more!

TELADOC PERSONALIZED NUTRITION COUNSELING

Team members enrolled in our medical plan are able to work with a registered dietitian to receive personalized nutrition counseling, including custom meal plans and shopping guides. All for a \$0 copay!



Teladoc dietitians can assist with:

- Weight loss
- Food allergies
- Digestive issues
- Pregnancy diets
- Diabetes
- High blood pressure
- Sports nutrition
- Vegetarian or Vegan diets
- Meal planning
- Pediatric nutrition
- Building healthy habits
- And more

TELADOC NUTRITIONAL COUNSELING

- Get a personalized diet plan to meet your health needs
- Schedule your visit 7 days a week (7 AM to 9 PM local time)
- Speak with a registered dietitian from anywhere

TELADOC & NUTRITIONAL COUNSELING HAVE A \$0 COPAY!

THE BREAKERS WELLNESS CLINIC OPERATED BY MARQUEE HEALTH

Available to team members and spouses on The Breakers health plan, at no cost:

- Biometric Screening - for incentive completion
- Wellness and Lifestyle Coaching - in-person, telephonic or online

Offered periodically to eligible team members:

- My Wellness Journey with Dr. Finley
A comprehensive evidence-based course promoting overall well-being and a healthy lifestyle.

WELLNESS CLINIC OPERATIONS

Location: 40 Cocoanut Row, Palm Beach, FL 33480

Hours: Monday — Friday by appointment

Phone: (561) 650-6976 Ext. 6976

Email: thebreakerswellnessclinic@mywellportal.com

Website: thebreakers.com/wellnessclinic



CONTACT CHAD PIERRE

Marquee Wellness Coach

Weekly biometric screening events and personalized one-on-one health consultations.

Phone: (561) 650-6976

Email: cpierre@marqueehealth.com

ONSPOT DERMATOLOGY

Mobile onsite dermatological care for team members and spouses on The Breakers health plan, with no deductible or copays. Wellness exams, diagnosis, and treatment of skin conditions. Offered periodically throughout the year.



WELLNESS INCENTIVE

Team members and spouses enrolled in The Breakers health plan are strongly encouraged to participate in the Wellness Incentive. Completion of a biometric screening is all that is required to earn the monetary savings incentive.

- **Why screen?** Knowing your key health metric numbers can safeguard your health, indicate your risk for certain health conditions and prompt appropriate action to reduce chances of developing heart disease, diabetes and other major illnesses.
- **When to screen?** Once you are enrolled in The Breakers medical insurance.
- Team members and spouses on The Breakers’ medical plan can each earn a \$600 savings on their annual insurance plan premium by completing one easy step - a biometric screening.
- For team members currently on the medical plan, screenings completed between September 1, 2024 - June 30, 2025 are eligible to earn the savings for plan year beginning September 1, 2025.
- Team members (and spouses) new to the plan can schedule a biometric screening once your SmartBen enrollment is completed.
- There is no cost to the team member or spouse for the screening.
- All personal health information including screening results are managed by Marquee Health through an electronic medical record and HIPAA compliant portal.
- No individual’s personal health information will be shared with The Breakers.
- Lab results will be shared confidentially with the team member or spouse by Marquee Health.
- A biometric screening includes measurements for height, weight, waist circumference, blood pressure, glucose (fasting), triglycerides and cholesterol.
- To learn more about your biometric screening results and overall well-being, health coaching is offered at no-cost by the Marquee Health team in the Wellness Clinic.

Three options to complete the screening include *(lab results through any other source are not accepted)*:

<p>WELLNESS CLINIC AT 40 COCOANUT ROW</p> <p>On-site biometric screenings by appointment</p>	<p>LABCORP NEAR YOUR HOME</p> <p>(Lab requisition from the clinic required) LabCorp should only be used with the lab requisition, otherwise it is out-of-network</p>	<p>NEW! YOUR PRIMARY CARE PHYSICIAN</p> <p>Complete a form documenting your screening between July 1, 2024 - June 30, 2025. Form is provided by the clinic</p>
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*LabCorp is an out-of-network provider that should only be utilized for a biometric screening that has a lab requisition from the Wellness Clinic. Without the requisition, you will be subject to a bill from LabCorp as they are not in-network with Blue Cross Blue Shield. Please utilize in-network labs, such as Quest, for all other lab work.

For appointments, lab requisitions and physician forms and general information, please visit: thebreakers.com/wellnessclinic or email: thebreakerswellnessclinic@mywellportal.com



Questions or need assistance scheduling?
Call The Breakers Wellness Clinic at Ext. 6976 or (561) 650-6976.



DENTAL BENEFITS

DENTAL INSURANCE

The Breakers provides dental insurance through Cigna. You have a choice of a DHMO or PPO plan. The DHMO plan offers In-Network only coverage and requires you to select a Primary Care dentist. The PPO plan has three levels of care: PPO Advantage contracted dentists, PPO contracted dentists and Out-of-Network (non-contracted dentists) coverage.

DHMO IN-NETWORK	PPO IN OR OUT-OF-NETWORK
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The chart below highlights the advantages of these three levels. When you choose a dentist outside of the Cigna PPO network, your out-of-pocket costs will be higher and you may be subject to “balance billing” for provider fees that exceed the contracted or Usual Customary & Reasonable (UCR) fees allowed by the Cigna contract. You can locate participating (In-Network) dental providers by visiting the Cigna website.

If enrolled in the PPO plan, simply let your dentist know you are covered by Cigna. A member ID card is not necessary. If you want a card, you may download the app or go to the secure Cigna member website.

Please Note: PPO - Maximum benefits are based on a plan year. Benefits are subject to a Fee Schedule, located on SmartBen.

	PLAN 1	PLAN 2		
NETWORK ACCESS	IN-NETWORK	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Plan Type/Design	DHMO	PPO Advantage	PPO	PPO
Network	Cigna Dental Care	Cigna Dental PPO		
Plan Year Maximum Benefits	None		\$2,000	
	Your Responsibility	Your Responsibility		
Individual Deductible	None	\$25	\$50	\$50
Dental Description				
Preventive-Class I		No Charge	No Charge	No Charge*
Basic-Class II		10% After PYD	20% After PYD	20% After PYD*
Major-Class III		40% After PYD	50% After PYD	50% After PYD*
Routine Exams - 9430		No Charge	No Charge	No Charge*
Teeth Cleaning (every 6 months) - 1110		No Charge	No Charge	No Charge*
Full Mouth / Panoramic X-Rays - 0330		No Charge	No Charge	No Charge*
Fillings - 2140		10% After PYD	20% After PYD	20% After PYD*
Endodontics - 3330		10% After PYD	20% After PYD	20% After PYD*
Periodontal Scaling - 4341		10% After PYD	20% After PYD	20% After PYD*
Inlays and Onlays - 6600 / 6608		40% After PYD	50% After PYD	50% After PYD*
Full or Partial Dentures - 5110		40% After PYD	50% After PYD	50% After PYD*
Crowns - 6750		40% After PYD	50% After PYD	50% After PYD*
Child and Adult Orthodontia		Child Only to Age 19		
Benefit		50%, No Ortho PYD		
Lifetime Maximum Copay		\$1,500		


*Out-of-Network charges are subject to a higher deductible and Cigna's recognized charge limitations.

**Fee Schedule located on SmartBen.

CIGNA DENTAL PROVIDER SEARCH

To find participating providers (In-Network), please visit cigna.com. If you want a card, you may download the app or go to the secure member website at mycigna.com, click to **sign up** as a **Cigna member** and you can print a card for you and your dependents.






[For Medicare](#)
[For Providers](#)
[For Brokers](#)
[For Employers](#)

[Search](#)
[Español](#)


[For Individuals & Families:](#)
[Shop for Plans](#)
[Member Guide](#)
[Find a Doctor](#)
[Log in to myCigna](#)

Click on **Find a Doctor** or **Log in to myCigna** (preferred method).


How are you Covered?



Employer or School



Healthcare.gov or Direct Purchase




Medicare

Click on **Employer or School** under How are you Covered?


Find a Doctor, Dentist, or Facility in

Enter Address, City, or Zip


Enter your location under **Find a Doctor, Dentist, or Facility** in and select the type of dentist under **Doctor by Type**.



Doctor by Type



Doctor by Name



Health Facilities

Please Select a Plan

CIGNA DENTAL CARE DHMO

Cigna Dental Care Access (formerly Cigna Dental Care HMO)

Cigna Dental Care Access Plus

DPPO/EPO

Total Cigna DPPO (Cigna DPPO Advantage and Cigna DPPO)

Cigna DPPO Advantage

Under Select a Plan pick the **Cigna Dental Care Access Network** for the DHMO plan or the **Total Cigna DPPO Network** for the PPO plan.



VISION BENEFITS

VISION INSURANCE

The Breakers provides vision insurance through VSP. The VSP vision program provides affordable and quality vision care. Through VSP's provider network, you can obtain a comprehensive vision examination, as well as eyeglasses (lenses and frames) or contact lenses in lieu of eyeglasses.

Simply let your eye care provider know you are covered by VSP. A member ID card is not necessary. If you want a card, you may go to the secure VSP member website at vsp.com, click to sign up as a VSP member and you can print out a VSP Member Vision Card.

Carefully review the vision care program summary provided and take advantage of this very important benefit.

TYPE OF PLAN	BASIC PLAN		ENHANCED PLAN	
Network Access	In-Network	Out-of-Network	In-Network	Out-of-Network
Eye Care Wellness				
Eye Exam	\$10 Copay	Reimbursed Up To \$45	\$10 Copay	Reimbursed Up To \$45
Frequency	Once Every 12 Months		Once Every 12 Months	
Lenses				
Single Vision	\$25 Copay	Reimbursed Up To \$30	\$25 Copay	Reimbursed Up To \$30
Bifocals	\$25 Copay	Reimbursed Up To \$50	\$25 Copay	Reimbursed Up To \$50
Trifocals	\$25 Copay	Reimbursed Up To \$65	\$25 Copay	Reimbursed Up To \$65
Frequency	Once Every 12 Months		Once Every 12 Months	
Frames				
Selected Frames	\$170 Retail Allowance + 20% Off Balance	Reimbursed Up To \$70	\$200 Retail Allowance + 20% Off Balance	Reimbursed Up To \$70
Suncare Enhancement	\$170 Retail Allowance with a \$25 copay for Non-Prescription Sunglasses in lieu of Prescription Glasses or Contacts	N/A	\$200 Retail Allowance with a \$25 copay for Non-Prescription Sunglasses in lieu of Prescription Glasses or Contacts	N/A
Frequency	Once Every 24 Months		Once Every 12 Months	
Contacts	In Lieu of Any Other Eyewear Benefits			
Elective	\$130 Retail Allowance; exam fitting & evaluation not to exceed \$60 copay	Reimbursed Up To \$105	\$150 Retail Allowance; exam fitting & evaluation not to exceed \$60 copay	Reimbursed Up To \$105
Frequency	Once Every 12 Months		Once Every 12 Months	

VSP VISION PROVIDER SEARCH

To find participating providers (In-Network), please visit vsp.com.
You can call VSP's Customer Service Center at (800) 877-7195 with any questions you may have regarding contracted providers or coverage.



Click on
Find a Doctor

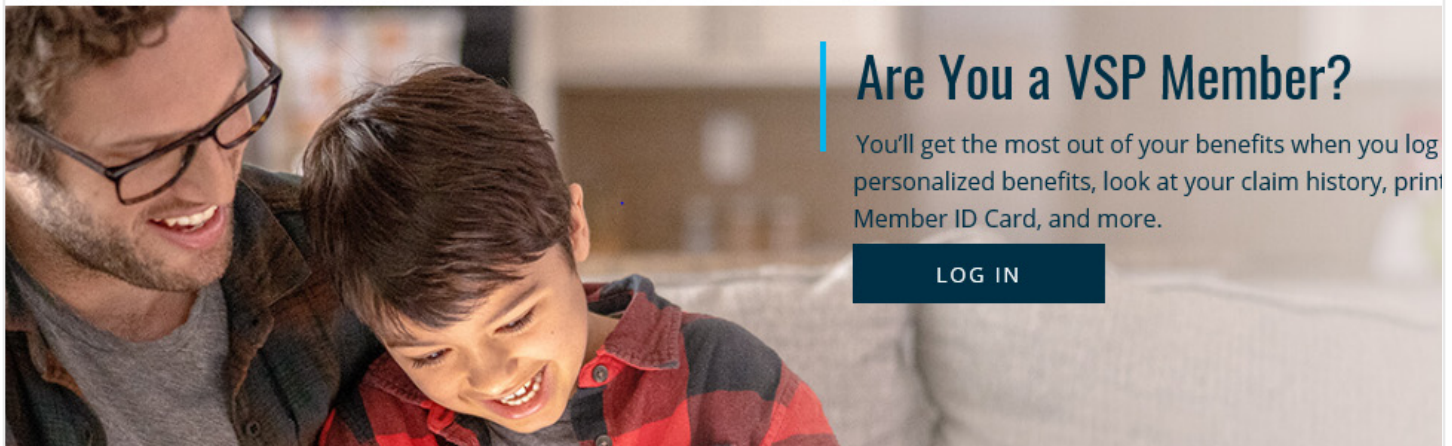
FIND A DOCTOR

BENEFITS

OFFERS

EYEWEAR AND WELLNESS

PLAN OPTIONS



FIND A DOCTOR

BENEFITS

OFFERS

EYEWEAR AND WELLNESS

PLAN OPTIONS

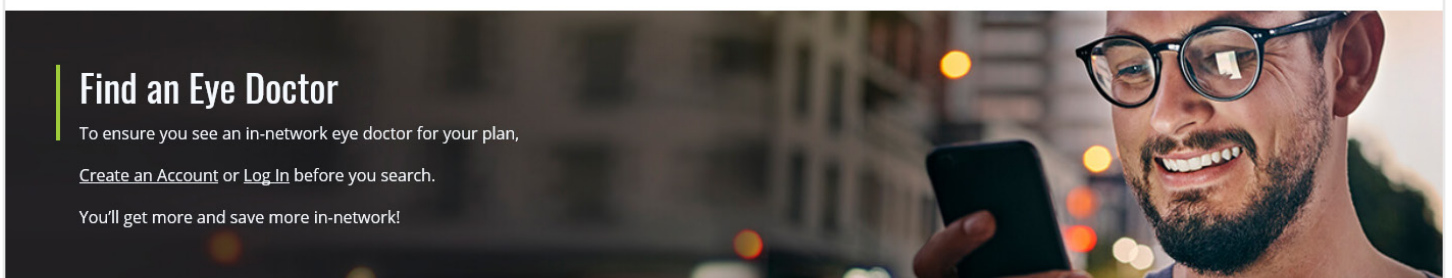
SHOP

Find an Eye Doctor

To ensure you see an in-network eye doctor for your plan,

[Create an Account](#) or [Log In](#) before you search.

You'll get more and save more in-network!



LOCATION

OFFICE

DOCTOR

1 ADVANCED SEARCH +

Zip

OR

Street Address (optional)

City

State

Search by Zip Code or
Address, City and State

Select **Doctor Network** by clicking on
Advanced Search and then selecting
Choice OR - If you log into your account,
you can bypass this step as it will
recognize your plan.

OTHER BENEFITS

T. ROWE PRICE — 401(K) SAVINGS PLAN

All H-2B team members (ages 18+) are eligible to participate in The Breakers' 401(k) Retirement Savings Plan and may elect to contribute 1 - 50% of their gross earnings. A 401(k) includes personal contributions and the company's match benefit.



Plan Benefits

- Team members own 100% of any personal financial contribution invested in their 401(k)
- The Breakers' matches the first 6% of gross earning contributions, dollar for dollar, on a quarterly basis
- The Breakers' match is 100% fully owned by a team member after completing five (5) years of employment; for each year of service completed during years 1 – 5, team members retain 20% of the matched contribution (for example: 20% after year one, 40% after year two, etc).
- Roth 401(k) and Traditional Pre-tax 401(k) are offered
- Team members may roll over previous employers retirement plan(s) into The Breakers' 401(k)

Enrollment Details

- Enrollment eligibility is 60 days after hire date
- Contributions start on the first day of the following month
- Each year, team member contributions automatically increase by 1% until a max contribution of 15% is reached (adjustments may be made manually at any time)

How To Enroll or Make Adjustments

- Visit troweprice.com
- Download the T. Rowe Price app
- Call (800) 922-9945
- Schedule time with a SageView Financial Advisor



FINANCIAL WELLNESS PROGRAM

SageView Advisory Group, a retirement plan advisory firm, provides free financial education and investment counseling for all team members.

Services Include

- 401(k) retirement enrollment and planning
- Financial planning: paycheck analysis and saving/budgeting/investment strategies
- Answering questions: Medicare, Social Security, debt management, estate planning/loans and 529 Education Savings Plans



CONTACT MARESSA ETZIG

Schedule a private consultation in person or via phone; group sessions also available.

Email: metzig@sageviewadvisory.com

Phone: (561) 284-0699



EMPLOYEE ASSISTANCE PROGRAM (EAP)

It's easy to connect with BHS - Employee Assistance Program (EAP). Six counseling sessions are provided, per topic. 24 hours a day, 7 days a week. Confidential care that you and your household members can access at no cost.



Call



Text



Live Chat



Online Form



Mobile App



Emergency
24 Hours



Urgent
48 Hours



Routine
5 Days

EAP Services Include

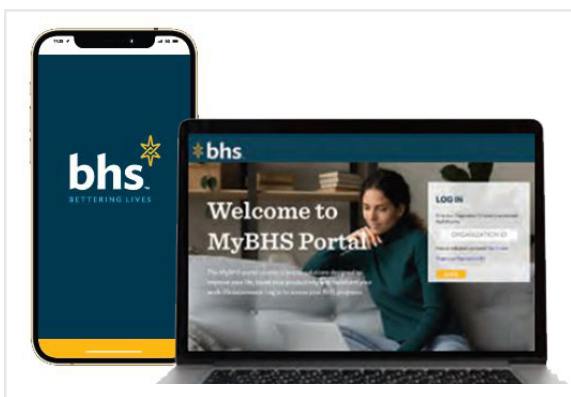
- In the moment support and crisis counseling
- A wide variety of topics such as, Emotional, Financial, Legal, and Relationship challenges
- Personalized care planning
- Appointment facilitation
- Ongoing support and follow up

Mental Health Coaching, Short-term Counseling and Higher Levels of Care

1. Contact BHS and connect with a dedicated master's level Care Coordinator
2. The Care Coordinator will timely secure an appointment for you, based on your preferences (location, in-person, telephone or virtual)

Help is just a phone call away.

Call or text to access services



Call 800-327-2251

Free, confidential, in-the-moment support is available 24/7 to help with personal or work-related problems that may interfere with your responsibilities. A Care Coordinator will confidentially answer your call and assist with emergencies and connect you to appropriate resources.

Text 800-327-2251

Ask questions about the program, get in-the-moment support or initiate services. All text will be answered within one business day.



EAP LOGIN

Website: portal.bhsonline.com

Organization ID: THEBREAKERS



OTHER BENEFITS

BRIGHT HORIZONS

Benefits include: Back-Up Care, Tutoring and Enhanced Supports.

Back-Up Care Advantage Program

All team members can rely on the Bright Horizons Back-Up Care Advantage Program, where and when you need it most. Breakdowns in your regular child or adult/elder care arrangements cause stressful disruptions that can affect your ability to successfully balance competing personal and professional demands.

When To Use Back-Up Care

- Regular caregiver/stay-at-home spouse is unavailable
- Your child or adult/elder relative is mildly ill
- School closes for vacations, holidays or in-service days
- You, your child or adult/elder relative is recovering from medical treatment
- Transition between child or adult/elder care arrangements
- Transition following maternity leave

Back-Up Care Is Available For:

- Child Care
- Elder Care

Plan Ahead: Register and Reserve Care

Our care consultants are available 24 hours a day, 365 days per year to assist you by finding and scheduling care on your behalf so you can go to work with the assurance of knowing that your child or adult/elder relative is in good hands.



THREE EASY STEPS

1. Register for care online or by phone
2. Make a reservation online or by phone
Phone: (877) 242-2737
Website: backup.bright Horizons.com
3. Complete your Care Profile

Limits and Cost

- Up to 15 days of care per team member per fiscal year
- Center-based copay = \$15 per child per day, max \$25 per family per day
- In-home copay = \$6 per hour per caregiver

Adult Virtual or In-Person Tutoring

Virtual tutoring for adults can assist learners ages 18+ in 3,000 subjects, including professional certifications. Whether you're trying to figure out your kids' homework, going back to school and managing your own schoolwork, trying to learn a new language, studying to earn a new certification, wanting to learn a professional skill such as public speaking, or all of the above, your Bright Horizons® tutoring benefit makes life easier. Plus, it's very affordable compared to other tutoring programs.

- Meet one-on-one with experts from Sylvan Learning and Varsity Tutors
- 4 Hours of tutoring = 1 credit with a copay of \$15
- Booked sessions must be used within 90 days or you lose them
- Available to you and your dependents age 5+, including college students

Child Virtual or In-Person Tutoring

Reserve an experienced tutor to help your 5 to 18-year-old stay on track during the school year or summer break. Get instant homework help in 300+ subjects for targeted support in math or reading.

Virtual Camp

Offered weekdays from 9 AM – 8 PM ET for children ages 3 – 12, this virtual offering gives your child a wide variety of interactive activities all led by engaging instructors. Use your back-up care benefit to reserve your child's spot and keep them entertained from the comfort of your own home.



To register, create an account with Bright Horizons and complete your Care Profile.



IMPORTANT CONTACTS

RESOURCE / SERVICE PROVIDER	DETAILS
Medical Insurance Blue Cross Blue Shield of Florida	(800) 830-1501 myhealthtoolkitfl.com
Dennis Ashwood Blue Cross Blue Shield of Florida Concierge	(561) 653-6362 Ext. 7043 dennis.ashwood@bcbsfl.com
The Breakers Wellness Clinic Operated by Marquee Health	(561) 650-6976 Ext. 6976 thebreakerswellnessclinic@mywellportal.com thebreakers.com/wellnessclinic
Dental Insurance Cigna	(800) 244-6224 mycigna.com
Vision Insurance VSP	(800) 877-7195 vsp.com
Employee Assistance Program BHS	(800) 327-2251 portal.bhsonline.com (ID: THEBREAKERS)
401(k) Savings Plan T. Rowe Price	(800) 922-9945 troweprice.com
Financial Wellness Program Maressa Etzig - SageView Advisory Group	(561) 284-0699 metzig@sageviewadvisory.com
Back-Up Care Advantage Program Bright Horizons	(877) 242-2737 backup.brighthorizons.com
Cara Striluk Benefits Services Manager	(561) 653-6661 cara.striluk@thebreakers.com
Jewel Lepoff Benefits Services Specialist	(561) 653-6646 jewel.lepoff@thebreakers.com
Stephanie Twohill Benefits Services Coordinator	(561) 653-6362, ext. 7510 stephanie.twohill@thebreakers.com

2024 ANNUAL ENROLLMENT NOTICES & DISCLOSURES

THE BREAKERS PALM BEACH SEPTEMBER 1, 2024

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 35-36 where Notice of Creditable Coverage begin for more details.

WOMEN'S HEALTH & CANCER RIGHTS ACT

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

Plan 1: Standard Plan - High Deductible (Individual: 20% coinsurance and \$1,500 deductible; Family: 20% coinsurance and \$3,000 deductible)

Plan 2: Deluxe Plan - Low Deductible (Individual: 10% coinsurance and \$1,000 deductible; Family: 10% coinsurance and \$2,000 deductible)

Plan 3: Choice Plan (Individual: 10% coinsurance and \$1,000 deductible; Family: 10% coinsurance and \$2,000 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at (561) 653-6661 or cara.striluk@thebreakers.com.

NEWBORNS' & MOTHERS' HEALTH PROTECTION ACT

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

PREMIUM ASSISTANCE UNDER MEDICAID & THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid

or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2024. Contact your State for more information on eligibility –

ALABAMA - MEDICAID Website: http://myalhipp.com/ Phone: 1-855-692-5447	ALASKA - MEDICAID The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS - MEDICAID Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855)-692-7447	CALIFORNIA - MEDICAID Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
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://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	FLORIDA - MEDICAID Website: https://www.flmedicaidtplecovery.com/flmedicaidtplecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA - MEDICAID GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	INDIANA - MEDICAID Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584

LEGAL NOTICES

<p>IOWA - MEDICAID AND CHIP (HAWKI)</p> <p>Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562</p>	<p>KANSAS - MEDICAID</p> <p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660</p>
<p>KENTUCKY - MEDICAID</p> <p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms</p>	<p>LOUISIANA - MEDICAID</p> <p>Website: www.medicaid.la.gov or www.ldh.la.gov/la hipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>
<p>MAINE - MEDICAID</p> <p>Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711</p>	<p>MASSACHUSETTS - MEDICAID AND CHIP</p> <p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com</p>
<p>MINNESOTA - MEDICAID</p> <p>Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739</p>	<p>MISSOURI - MEDICAID</p> <p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>
<p>MONTANA - MEDICAID</p> <p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPPProgram@mt.gov</p>	<p>NEBRASKA - MEDICAID</p> <p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>
<p>NEVADA - MEDICAID</p> <p>Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900</p>	<p>NEW HAMPSHIRE - MEDICAID</p> <p>Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218</p>
<p>NEW JERSEY - MEDICAID AND CHIP</p> <p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710</p>	<p>NEW YORK - MEDICAID</p> <p>Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>

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: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	RHODE ISLAND - MEDICAID AND CHIP Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)
SOUTH CAROLINA - MEDICAID Website: https://www.scdhhs.gov Phone: 1-888-549-0820	SOUTH DAKOTA - MEDICAID Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS - MEDICAID Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program Phone: 1-800-440-0493	UTAH - MEDICAID AND CHIP Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT - MEDICAID Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	VIRGINIA - MEDICAID AND CHIP Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON - MEDICAID Website: https://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 January 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebssa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

HIPAA NOTICE OF PRIVACY PRACTICES REMINDER

Protecting Your Health Information Privacy Rights

The Breakers Palm Beach is committed to the privacy of your health information. The administrators of the Breakers Palm Beach Health Plan (the “Plan”) use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan’s policies protecting your privacy rights and your rights under the law are described in the Plan’s Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting **Cara Striluk – Benefit Services Manager** at (561) 653-6661 or cara.striluk@thebreakers.com

HIPAA SPECIAL ENROLLMENT RIGHTS

The Breakers Palm Beach Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Breakers Palm Beach Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its “special enrollment provision” if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program)

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing 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).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption

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 new dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact **Cara Striluk – Benefit Services Manager** at (561) 653-6661 or cara.striluk@thebreakers.com

IMPORTANT WARNING

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

NOTICE OF CREDITABLE COVERAGE

Important Notice from The Breakers Palm Beach About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with The Breakers Palm Beach 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. The Breakers Palm Beach has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as 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.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current The Breakers Palm Beach coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current The Breakers Palm Beach coverage, be aware that you and your dependents may not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with The Breakers Palm Beach 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 drug plan later.

LEGAL NOTICES

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

For More Information About This Notice or Your Current Prescription Drug Coverage...

Contact the person listed below for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through The Breakers Palm Beach changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for 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:	September 1, 2024
Name of Entity/Sender:	The Breakers Palm Beach
Contact—Position/Office:	Cara Striluk – Benefits Services Manager
Office Address:	One South County Road Palm Beach, FL 33480 United States
Phone Number:	(561) 653-6661

MARKETPLACE NOTICE

New Health Insurance Marketplace Coverage Options and Your Health Coverage

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 income².

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 of these factors in determining whether to purchase a health plan through the Marketplace.

¹ Indexed annually; see <https://www.irs.gov/pub/irs-drop/rp-22-34.pdf> for 2023.

² An employer-sponsored or other employment-based health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the “minimum value standard,” the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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 Cara Striluk.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.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 The Breakers Palm Beach		4. Employer Identification Number (EIN) 59-0246320	
5. Employer address One South County Road		6. Employer phone number 561.653.6661	
7. City Palm Beach	8. State Florida	9. ZIP code 33480	
10. Who can we contact about employee health coverage at this job? Cara Striluk			
11. Phone number (if different from above)		12. Email address Cara.striluk@thebreakers.com	

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

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

☐ All employees.

☒ Some employees. Eligible employees are:

Full-time team members who work an average of 30 or more hours per week. You are eligible for insurance benefits on the first of the month following 60 days of employment or change in status.

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are: a covered team member's legal spouse or an unmarried dependent child of the team member or team member's spouse. Dependent child(ren) will be covered through the end of the month in which they turn age 26.

☐ We do not offer coverage.

☒ 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.

LEGAL NOTICES

******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 will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

DISCLAIMER

The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out-of-network services, please note the maximum allowed amount for an eligible procedure may not be equal to the amount charged by your out-of-network provider. Your out-of-network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number of schedules such as a percentage of reasonable and customary or a percentage of Medicare. The plan document or carrier's master policy is the controlling document, and this Benefit Highlight does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language. Contact your claims payer or insurer for more information.

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

[illegible]



The information in this guide is a summary of the benefits available to you and should not be intended to take the place of the official carriers' Member Certificates or Benefit Summaries. This guide contains a general description of the benefits to which you and your eligible dependents may be entitled as a full-time employee. This guide does not change or otherwise interpret the terms of the official plan documents. To the extent that any of the information contained in this guide is inconsistent with the official plan documents, the provisions of the official documents will govern in all cases and the plan documents and carrier certificates will prevail.

This guide highlights recent plan design changes and is intended to fully comply with the requirements under the Employee Retirement Income Security Act ("ERISA") as a Summary of Material Modifications and should be kept with your most recent Summary Plan Description. The Summary Plan Description can be located on SmartBen.

The Breakers reserves the right, in its sole and absolute discretion, to amend, modify or terminate, in whole or in part, any or all of the provisions of the benefit plans.