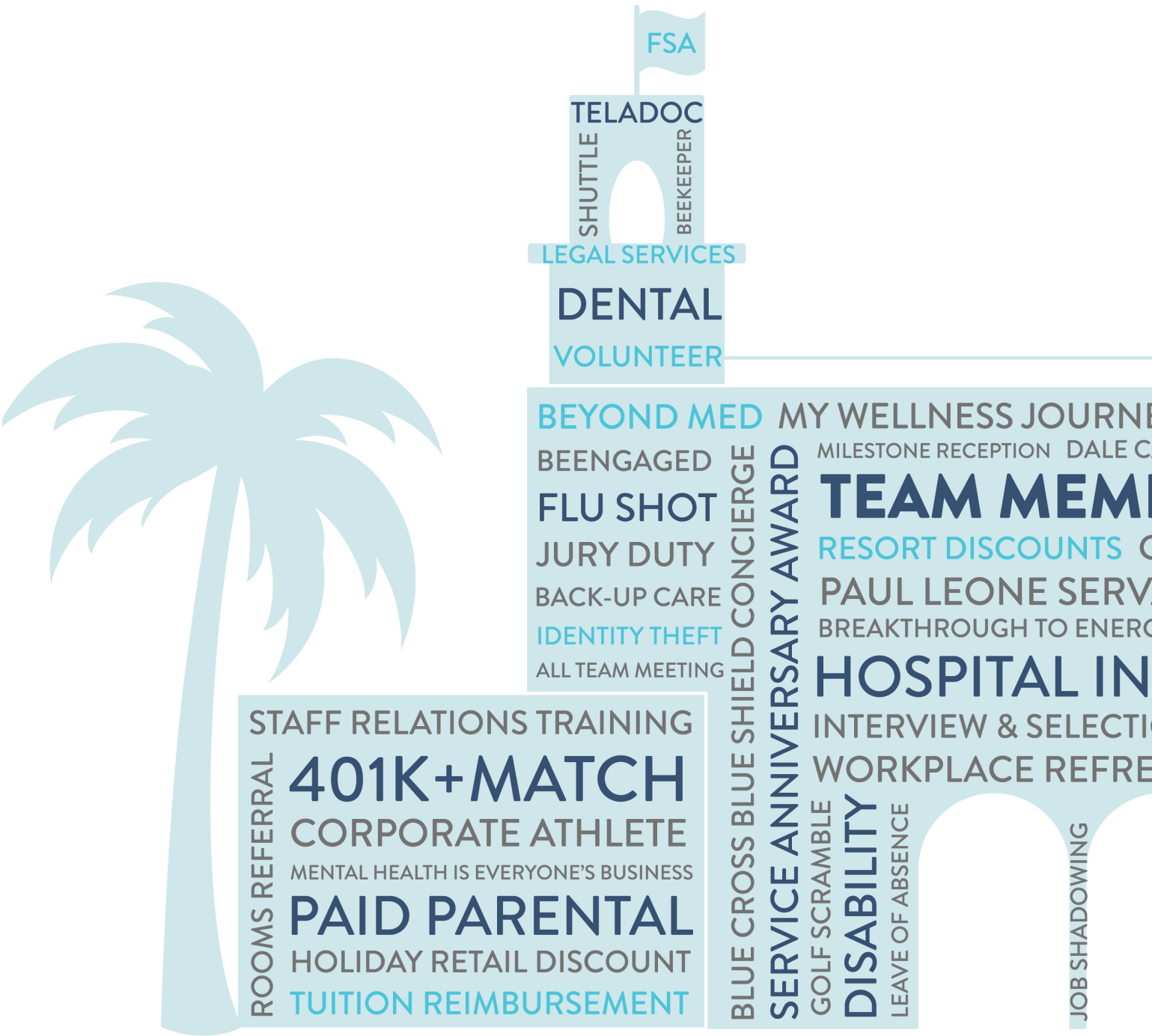
TEAM MEMBER
BENEFITS

2024-2025

FULL-TIME

THE BREAKERS®
PALM BEACH

TEAM MEMBER BENEFITS




GIVES
MEDICAL
TUTORING
ADMIN DAY
LIFE INSURANCE
VISION
UNITED WAY
EY WITH DR. FINLEY
LONG TERM CARE
ARNEGIE LEADERSHIP PROGRAM
BER BENEFITS
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Issued July 30, 2024 | Revised October 9, 2024

The Breakers is pleased to offer our 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
- Accident, Hospital Indemnity & Critical Illness Insurance
- Flexible Spending Accounts (FSA & Dependent Care FSA)
- Beyond Med - Health and Wellness Membership

FINANCIAL WELLNESS

- Basic Life and AD&D Insurance
- Life & Care Benefit - Life Insurance / Long Term Care
- Employer Paid Life Insurance
- Employer Paid Short-Term/Long-Term Disability
- Identity Theft Insurance
- SageView Advisory Group

RETIREMENT & LIFESTYLE

- 401(k) with Company Match
- Legal Insurance
- Back Up Care
- Motivity Care
- Employee Assistance Program
- Pet Insurance

TEAM MEMBER ELIGIBILITY AND GUIDELINES

The Breakers' group insurance "Plan Year" is September 1 through August 31.

Benefit eligible team members are provided an opportunity to enroll in The Breakers' company sponsored benefits program during their first 60 days of employment, after a qualifying life event and Annual Open Enrollment.

Full-time team members working thirty (30) hours per week or greater are eligible. To remain eligible, you are required to average thirty (30) or more hours per week during your annual 12 month hours worked measurement period. We count all hours for which you are paid, including paid leave and paid time off (Personal, Medical Reserve, Vacation and VTO). For additional information on the 12 month hours worked measurement, contact the Benefits Team.

Part-time and on-call team members can refer to the Part-time/On-call Benefits Guide to review the benefits available for enrollment after the completion of 1,040 hours in the measurement period.

TIP: It is important to enroll prior to the date your coverage is effective.
It is recommended to select benefits within the first 30 days of employment.

ENROLLMENT INSTRUCTIONS

As a Breakers full-time team member, you are eligible for insurance benefits on the first of the month following 60 days of employment or change in status.

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

Log on to: **https://thebreakers.wl.alight.com**

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

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

DEPENDENT ELIGIBILITY

A dependent is defined as 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. A dependent child is defined as:

- A natural child
- A step-child
- A legally adopted child
- A child placed for adoption
- A child for whom legal guardianship has been awarded to the covered team member or the team member's spouse
- Unmarried children of any age who become mentally or physically disabled before reaching the age limit

PROOF OF DEPENDENT ELIGIBILITY

Please be prepared to provide proof of relationship (i.e. birth certificate, marriage certificate or previous year tax return) if you are enrolling your spouse or children in any of your plans along with dates of birth and social security numbers for each family member.

BENEFICIARY REMINDER

Full-time team members are required to add beneficiary contact information for the basic life insurance and accidental death and dismemberment coverage that is provided at no cost to you.

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.

ENROLLMENT CHANGES: QUALIFYING EVENT

Coverage elections made during Open Enrollment may not be changed until the next annual Open Enrollment period.

The only exception to this IRS Section 125 Rule is if you experience a "Qualifying Event." A Qualifying Event allows you to make a change to your benefit elections within 30 days of the event.

Examples of Qualifying Events include, but are not limited to:

- Marriage
- Divorce
- Birth, adoption, or legal custody of a dependent child
- Involuntary loss of other group insurance coverage
- Death
- Spouse's Open Enrollment

If you have a Qualified Event that allows or requires you to make a status change, you must contact the Benefits Department within 30 days of the event to make changes to your benefit elections.

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 **https://thebreakers.wl.alight.com**

ENROLLMENT INSTRUCTIONS

Steps to Complete Your Enrollment if you are a new team member, experiencing a qualifying life event or during Annual Open Enrollment

STEP 1

Log on to **https://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** (New Hire, Annual Open Enrollment or Qualifying Life Event)

B. For a Qualifying Event, Select **Begin Enrollment** and then choose the event type that applies to your change (ex: status change, marriage, birth of child, etc.)

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

Enrolling a Spouse or Dependent

If you are enrolling a spouse or dependent in coverage, select Manage People to add dependent records for enrollment. People Manager is where your Personal, Spouse/Dependent and Beneficiary information is stored.

- **Employee:** Review your personal information and make updates if necessary
- **Spouse / Dependent:** Select **Add a Spouse** or **Add a Dependent** to add your spouse and/or dependents' information if you are enrolling them in a benefit plan. Click **Save** when you are finished
- **Beneficiary:** If you are eligible for Basic Life/AD&D or Supplemental Term Life/AD&D coverage, select Add a Beneficiary. Click **Save** when you are finished

Note: Adding spouse/dependent/beneficiary records to this section does NOT assign them to applicable coverage. Once all records have been added, select **Continue**.

Once you choose a benefit, select if you are adding a spouse, children or family plan 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. Based on your selected level of coverage, you may be required to assign a spouse/dependent/beneficiary. To do so, select the box next to each applicable record who should be enrolled in coverage

E. Once all requirements for the benefit have been updated, select **Continue**

STEP 4

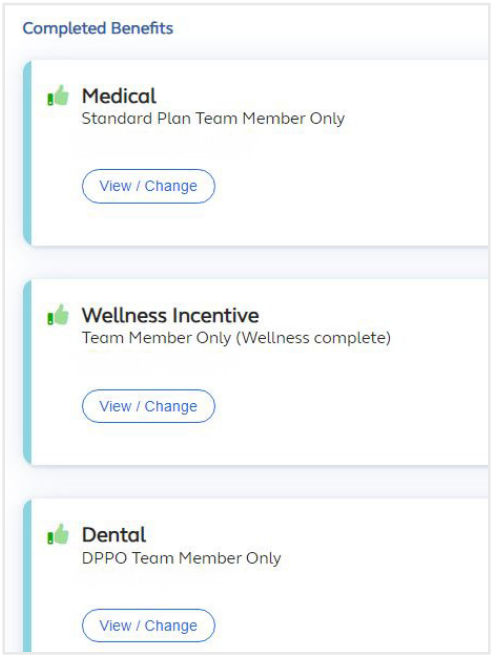
Once all elections are complete, each benefit will have a green light.
To finalize your elections, select **Continue** from the **Benefit Management** page.

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**
- Select **Required Documents** to upload supporting documentation for adding a spouse or dependent

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

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	$100	$161
Team Member + Spouse	$303	$365	$491
Team Member + Child(ren)	$256	$319	$448
Team Member + Family	$310	$382	$517

Without Earned Wellness Incentive Savings (Team Member OR Spouse)			
MEDICAL COVERAGE	**STANDARD PLAN HIGHER DEDUCTIBLE**	**DELUXE PLAN LOWER DEDUCTIBLE**	**CHOICE PLAN**
Team Member Only	$99.08	$123.08	$184.08
Team Member + Spouse	$326.08	$379.08	$514.08
Team Member + Child(ren)	$279.08	$342.08	$471.08
Team Member + Family	$333.08	$405.08	$540.08

Without Earned Wellness Incentive Savings (Team Member AND Spouse)			
MEDICAL COVERAGE	**STANDARD PLAN HIGHER DEDUCTIBLE**	**DELUXE PLAN LOWER DEDUCTIBLE**	**CHOICE PLAN**
Team Member + Spouse	$349.15	$411.15	$537.15
Team Member + Family	$356.15	$428.15	$563.15

DENTAL BI-WEEKLY PAYROLL DEDUCTIONS (PRETAX)

DENTAL COVERAGE	**DHMO PLAN**	**PPO PLAN**
Team Member Only	$6.76	$23.20
Team Member + One	$12.02	$46.40
Team Member + Two or More	$18.58	$69.61

VISION BI-WEEKLY PAYROLL DEDUCTIONS (PRETAX)

VISION COVERAGE	**BASIC PLAN**	**ENHANCED PLAN**
Team Member Only	$1.86	$3.00
Team Member + Spouse	$3.73	$6.01
Team Member + Child(ren)	$3.99	$6.43
Team Member + Family	$6.38	$10.27

Payroll deductions for Voluntary Benefits are available for review on SmartBen

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

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 and family deductibles. Once an individual or a family 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, either individually or combined as a covered family.

After the individual/family 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/family 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 family, 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

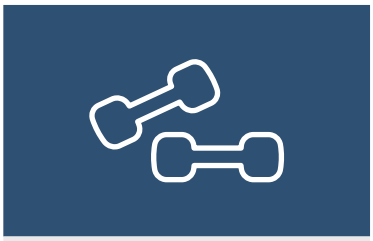
PLAN NAME	STANDARD PLAN HIGHER DEDUCTIBLE	DELUXE PLAN - LOWER DEDUCTIBLE	CHOICE PLAN	
Network Access	In-Network	In-Network	In-Network	Out-of-Network** (Not Covered)
Plan Year Deductibles (PYD)*	Your Responsibility	Your Responsibility	Your Responsibility	
Individual	$1,500¤	$1,000¤	$1,000¤	$1,500¤
Family	$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

Gym Memberships

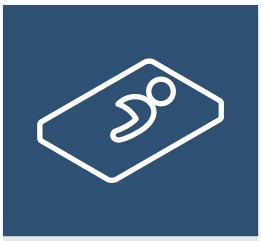
Wearable Fitness Devices

Activewear

Golf Memberships

Home Fitness Equipment

Vitamins and Nutritional Supplements



PERSONAL CARE

Allergy relief

Acupuncture

Chiropractic Services

Massage Therapy

Hair Restoration

Teeth Whitening

LIFESTYLE

Travel Clubs

Vacation Packages

Pet Care

Car Rentals

HEALTHY EATING

Weight Loss Programs

Cookbooks and Recipes

Meal Delivery Services

HEARING & VISION

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:

- Learning more about your coverage
- Checking medical claims
- Viewing your medical history
- Replacing your membership card
- Finding a doctor or hospital

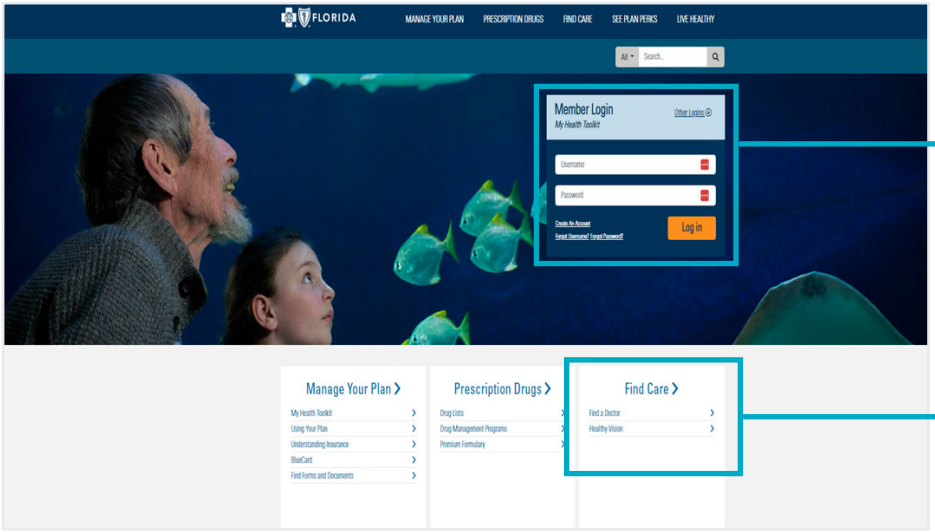
Register in just a few clicks:

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.

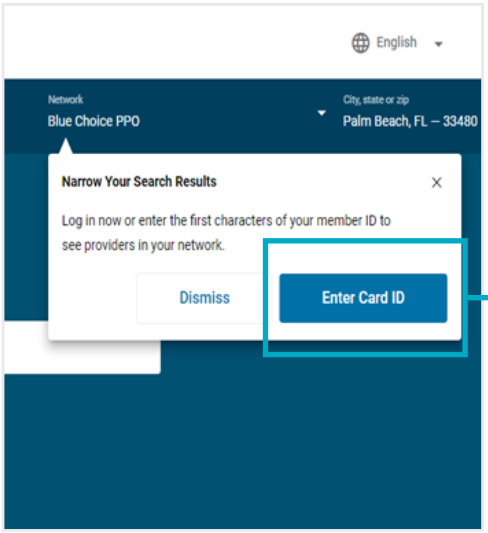
BLUE CROSS BLUE SHIELD OF FLORIDA MEDICAL PROVIDER SEARCH

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



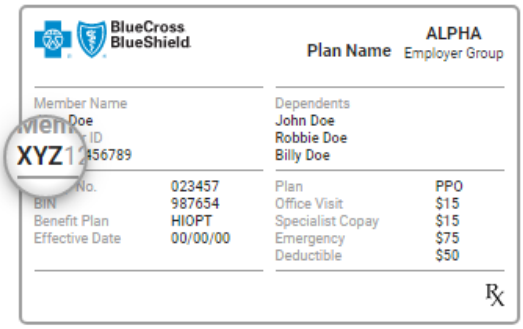
Log In or Create an Account

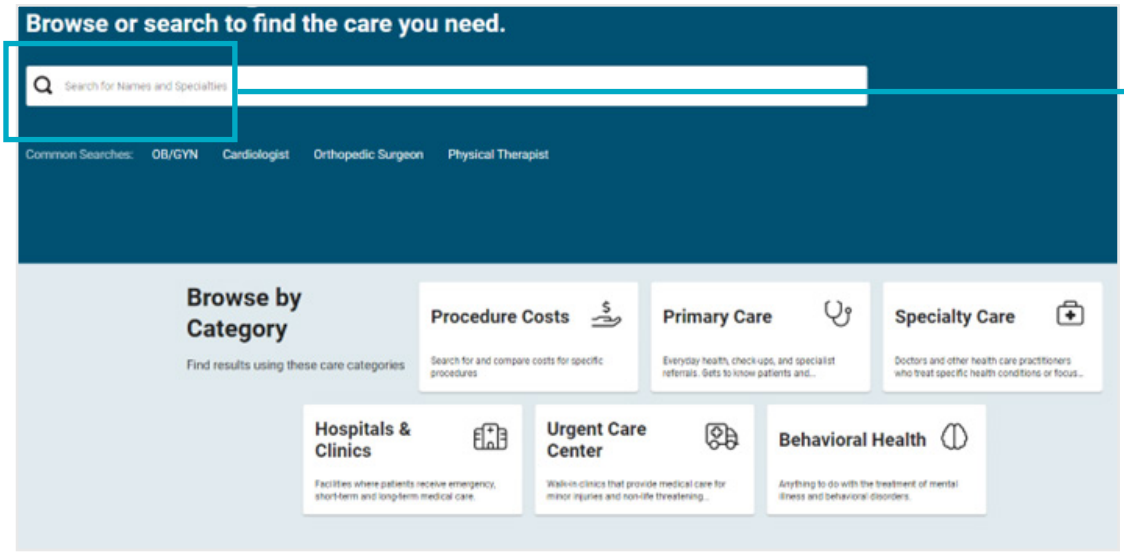
Click on Find a Provider



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**.





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**	• 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. minute clinic®	**$10**	• Infections • Cold or Flu • Minor Injuries or Pain • Shots • Flu Shots • Sore or Strep Throat • Skin Problems • Allergies
YOUR DOCTOR'S OFFICE The best place to go for routine or preventive care, to keep track of medications	**$**	• 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.	**$**	• 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.	**$$**	• Migraines or Headaches • Cuts (that need stitches) • Abdominal Pain • Sprains or Strains • Urinary Tract Infection • Animal Bites • Back Pain • Joint Pain
HOSPITAL EMERGENCY ROOM For immediate treatment of critical injuries or illness. If a situation seems life-threatening, call 911 or go to the nearest emergency room.	**$$$**	• 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 a 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 8 AM to 4:30 PM
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):*

WELLNESS CLINIC AT 40 COCOANUT ROW	**LABCORP** NEAR YOUR HOME	**NEW! YOUR PRIMARY CARE PHYSICIAN**
On-site biometric screenings by appointment	(Lab requisition from the clinic required) LabCorp should only be used with the lab requisition, otherwise it is out-of-network	Complete a form documenting your screening between July 1, 2024 - June 30, 2025. Form is provided by the clinic

*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.

MyBio

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

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.

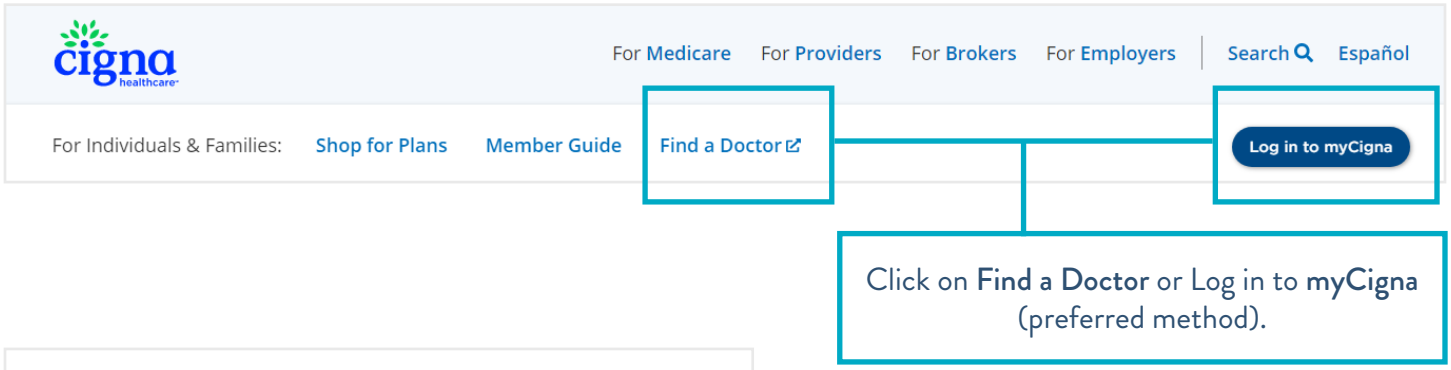
Please Note: PPO - Maximum benefits are based on a plan year. Benefits are subject to a Fee Schedule, located on SmartBen.

	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**	
Network	None		$2,000	
	Your Responsibility		**Your Responsibility**	
Individual Deductible	None	$25	$50	$50
Family Deductible	None	$75	$150	$50
Dental Description				
Preventive-Class I	Fee Schedule**	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	Fee Schedule**	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.

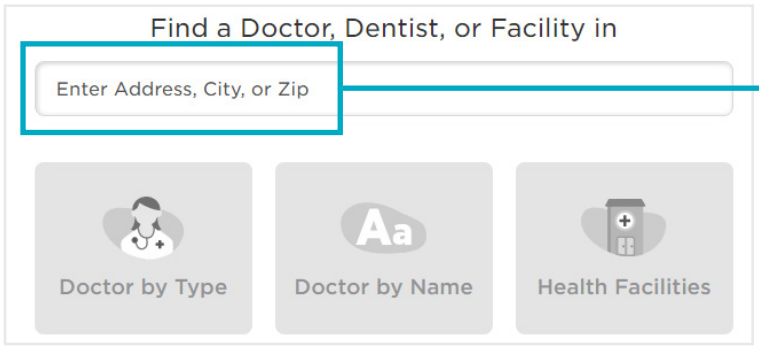
CIGNA DENTAL PROVIDER SEARCH

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.

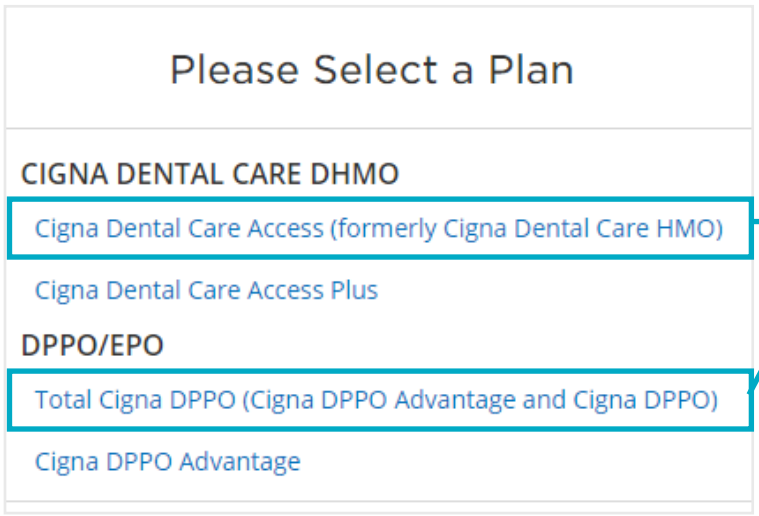


Click on **Find a Doctor** or Log in to **myCigna** (preferred method).

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



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



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 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.

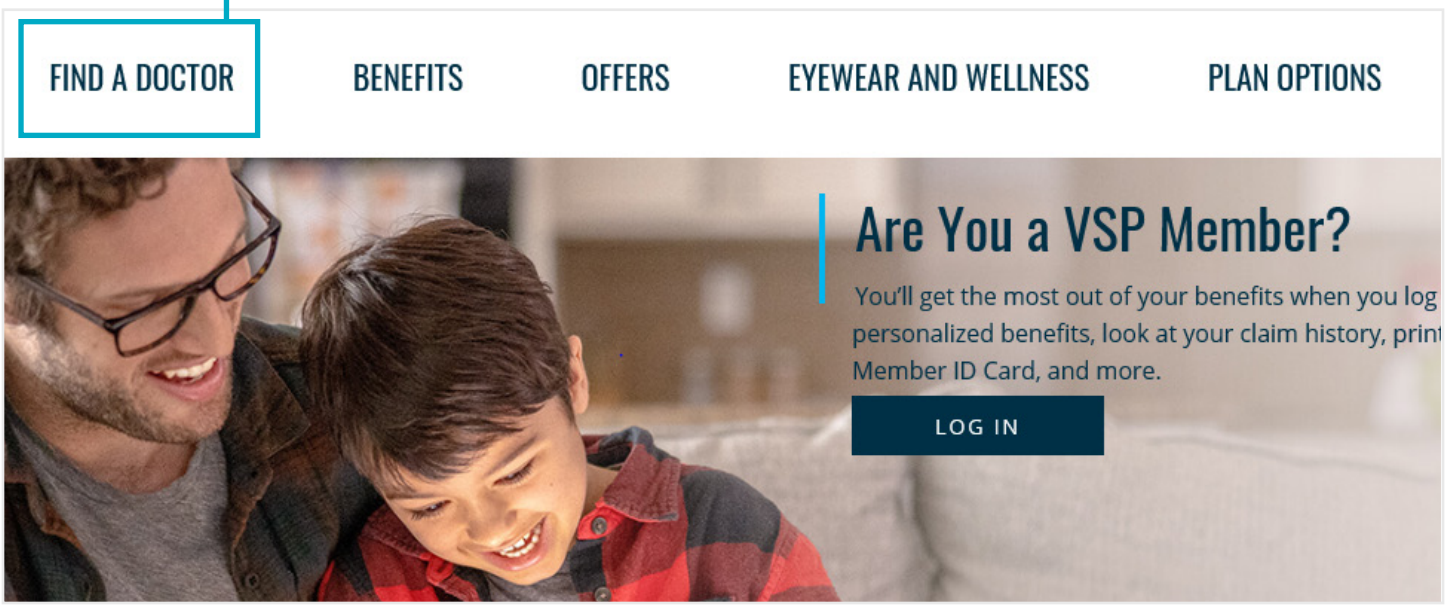
Carefully review the vision care program summary provided and take advantage of this very important benefit.

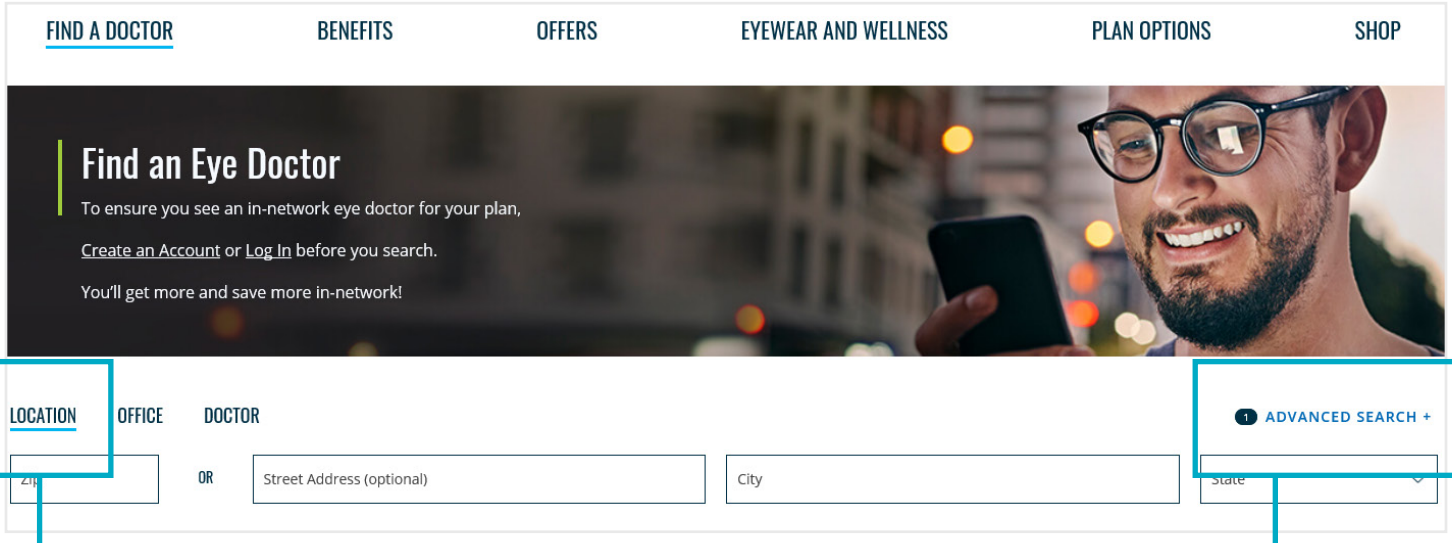
TYPE OF PLAN	BASIC PLAN		ENHANCED PLAN	
Network Access	In-Network	Out-of-Network	In-Network	Out-of-Network
Eye Care Wellness				
Eye Exam	$10 Copay	Reimbursed Up To $45	$10 Copay	Reimbursed Up To $45
Frequency	Once Every 12 Months		Once Every 12 Months	
Lenses				
Single Vision	$25 Copay	Reimbursed Up 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





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.

FLEXIBLE SPENDING ACCOUNT (FSA)

FSA, or Flexible Spending Account, is a benefit you can choose during the FSA Open Enrollment or New Team Member Enrollment. By contributing pre-tax dollars to an FSA, you can save an average of 30% on health and dependent care costs. The money you contribute is not subject to payroll taxes, which can result in substantial tax savings!

- **Plan year: Health Care FSA & Dependent Care FSA - January 1 to December 31**
- Enrollment available on SmartBen during November, effective the following 1st of January
- You are required to re-enroll and re-elect coverage each plan year on SmartBen

How much should I contribute?

You decide how much money you want to contribute for the year up to a maximum of **$3,300**. To receive the maximum savings, you must carefully estimate the amount of eligible out-of-pocket expenses you will have for the year. The amount you designate for the year is divided into equal installments each pay period and placed in an FSA account.

Use it or Lose It - Rollover Allowance

If you do not incur eligible expenses for the full amount you elected to put in your Health Care FSA in the current plan year, federal guidance permits you to rollover unused amounts up to $660 for expenses in the next year. Even if there is not an FSA election for the following plan year, you have the chance to spend up to $660 of your election on out-of-pocket health care expenses in the following year.

Health Care FSA

Choose this FSA to pay for copays, medical equipment, prescriptions, dental and vision expenses you or your family incur.

Eligible Expenses:

- Acupuncture
- Chiropractic care
- Doctor and Dentist copays
- Eyeglasses and contact lenses
- Glucose kits
- Hearing aids and batteries
- Infertility treatment
- LASIK
- Orthodontia
- Prescriptions

To view a list of eligible expenses, visit **ebcflex.com/eligibleexpenses**

Employee Benefits Corporation

FLEXIBLE SPENDING ACCOUNT (FSA)

Dependent Care FSA

Dependent Care FSA funds may be used to pay for expenses you incur for the care of dependent children under age 13 or any disabled dependent who lives with you and who you claim on your taxes.

For a dependent care expense to be eligible for reimbursement from a Dependent Care FSA, the care must enable you and your spouse to work, actively look for work, or attend school full-time.

Up to **$5,000** can be set aside for this purpose if you are single or married and file a joint tax return. If you are married and you and your spouse file separate tax returns, the maximum that each of you can contribute is **$2,500**.

Funds are available after payroll deductions are credited to your Dependent Care FSA account.

Eligible Expenses

Expenses that are eligible for the Dependent Care FSA can also be eligible for a tax credit on your federal tax return. Keep in mind that you cannot claim the same expenses for the Dependent Care FSA and the tax credit. Talk with your personal tax advisor to determine which alternative is best for you.

Child Care

- Child care at home or at a day care facility
- Sick child care center or facility
- 3K or 4K
- Nursery or preschool
- Before and after school programs
- Day camp (may include sports camp, computer camp, etc.)
- Transportation fees provided by the dependent care provider for transportation to/from where care is provided.

Adult Care

- Adult day care center
- Custodial elder care (in-home or away from home)
- Transportation fees provided by the dependent care provider for transportation to/from where care is provided.

For additional details on FSA accounts, log into SmartBen.

THE HARTFORD

LIFE INSURANCE & ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

Basic Life Insurance and AD&D - Employer Paid

Full-time team members are automatically enrolled in The Breakers' basic life insurance and accidental death & dismemberment (AD&D) at no cost to you.

- Hourly team members are provided a $40,000 benefit
- Salaried team members life insurance amount is based on 2xs annual earnings up to a maximum of $500,000

While The Breakers has automatically enrolled you in the life insurance plan, please make sure that your beneficiary is listed on your SmartBen portal. You can ensure it is listed by viewing your Confirmation Page or contacting Human Resources.

Voluntary Life Insurance and AD&D for Full-Time Team Members

You may purchase voluntary life insurance and accidental death & dismemberment (AD&D) for yourself in increments of $10,000 to a maximum of $500,000. Coverage is "Guarantee Issue" (no evidence of insurability required) for amounts up to $250,000, for newly eligible team members during your initial eligibility period.*

Voluntary Life Insurance and AD&D for Your Spouse

You can purchase life insurance and accidental death & dismemberment (AD&D) coverage for your spouse in $5,000 increments not to exceed 50% of full-time team member's life insurance and AD&D amount to a maximum of $250,000. Coverage is "Guarantee Issue" for amounts up to $30,000.*

If you choose to purchase voluntary life insurance and AD&D for yourself (1) in excess of $250,000, (2) more than $30,000 for your spouse, you must complete an Evidence of Insurability (EOI) form and you may be required to submit an attending physician's statement at a later date.*

Voluntary Life Insurance for Your Child(ren)

You may elect life insurance for your dependent child(ren) up to age 26 in $2,000 increments up to a maximum of $10,000. The premium includes all dependent children regardless of the number of children covered. All children will have the same benefit amount.

**Any request to add or increase coverage after initial eligibility will require the submission of an Evidence of Insurance (EOI) form within 30 days of election. The request for coverage is not an automatic approval and no payroll deductions will be made until the request is approved by The Hartford, approval of EOI can take up to 60 days.*

DISABILITY INSURANCE – THE HARTFORD

EMPLOYER PAID

Short Term Disability (STD)

All **full-time hourly and salaried team members** are automatically enrolled in The Breakers' STD program at no cost to you. In the event you become disabled due to either illness or off the job injury and are unable to perform the duties of your job, STD coverage will supplement your lost wages. New mothers are also eligible for STD benefit, either 4 weeks for regular delivery or 6 weeks for cesarean section. STD coverage begins after missing 14 days due to a medically certified illness or injury. Benefits are payable up to a maximum of 11 weeks of disability. The benefit pays 50% of weekly earnings up to $1,000 per week.

Long Term Disability (LTD)

Full-time **salaried** team members are automatically enrolled in The Breakers' LTD program at no cost. After Short-Term Disability is utilized, there is a 90-day elimination period before LTD coverage will start paying you for lost income. If you are approved, the plan will provide for lost wages in the event that you are unable to work due to sickness or an off the job injury, until you reach the maximum benefit period.

Contact The Benefits Team for assistance with filing a claim at benefits@thebreakers.com.

VOLUNTARY BENEFITS – THE HARTFORD

All voluntary benefits are available to full-time team members through post-tax payroll deductions and are portable at the same rate. Your spouse and child(ren) are also eligible for coverage. Any child(ren) must be under age 26.

Voluntary Hospital Indemnity Plan: Provided by The Hartford

Hospital Indemnity insurance works to complement medical coverage and pays in addition to what a medical plan may or may not cover. Pays a flat amount after the first day of hospital confinement ($1,000) and a specific daily amount paid for each additional day of hospital confinement. This plan also pays an additional benefit for confinement in an Intensive Care Unit.

Voluntary Accident Insurance Plan: Provided by The Hartford

Protect against the unexpected costs associated with an accidental injury off-the-job. Provides cash for medical expenses (even if covered by medical insurance) including, but not limited to, hospital admission and confinement, dislocations, fractures, burns, lacerations, emergency room visits, medical appliances and accidental death and dismemberment benefits. This plan includes a Health Screening Benefit in the amount of $100 payable annually per covered person.

Voluntary Critical Illness with Cancer Coverage Plan: Provided by The Hartford

Pays a lump sum benefit directly to you, over-and-above any other coverage presently in-force to help offset the high costs associated with the treatment of a covered critical illness such as heart attack, stroke, end stage kidney failure, cancer and more. There is a Health Screening Benefit in the amount of $50 payable annually per covered person with this policy.

- Guaranteed Issue - No health questions to enroll as a new hire or during our annual open enrollment up to a $30,000 benefit
- Family Coverage Available - Spouses covered at 100% and children under the age of 26 are covered at 50% of your benefit election

Why do I need it?

- Out of pocket expenses add up quickly, since major medical insurance may only pick up part of the tab
- Help ease the unplanned financial burden of an accident
- Complements other insurance you may have, including major medical and disability coverage
- Additional layer of financial protection may make a difference at a time when you and your family need it most

The lump sum benefit can be used towards:

THE HARTFORD

TRUSTMARK LIFE + CARE

If ever there's a time you can't care for yourself, things may get difficult – and expensive. Finding caregiving can be a challenge, and care can cost hundreds of dollars a day.

It can happen at any age, to anyone: something goes wrong, and you start needing assistance with the basics of everyday life. When that happens, Trustmark Life + Care® pays cash benefits that can help you afford the comfort and quality of care that you deserve. Plus, it doubles as life insurance, with a death benefit payable to those who rely on you.

Why Trustmark Life + Care?

1. Two-in-one coverage: receive both permanent life insurance (death benefit) and care benefits for one affordable rate.
2. Benefits can help with the cost of care when the time comes, so you can avoid depleting your Retirement savings or overburdening family members.
3. Care benefits are paid to you when you receive caregiving services from either a professional or a family member.
4. Coverage is available to you on a guaranteed issue basis – no medical questions asked, and you can't be turned down – up to benefit amount limits.
5. Guaranteed to last a lifetime: once you have coverage, your rate doesn't increase as you get older.

How Care Benefits Work

Long Term Care and Life Insurance Policy from Trustmark available in the following increments: $20,000, $35,000, $50,000, $65,000 $80,000, $100,000.

Trustmark Life + Care pays benefits in cash, directly to you, when you require help with at least two of six activities of daily living (for example, eating, bathing, or dressing) or have a severe cognitive impairment (such as Alzheimer's Disease).

Plus, care benefits paid do not reduce the death benefit, so a full death benefit is available to your beneficiaries even after you receive care benefits! This can dramatically increase the maximum value of your coverage. Note: because your condition does not have to be permanent to receive benefits, the money you receive can help you recover your independence.

The death benefit reduces to 33% at age 70 or your 10th certificate anniversary, whichever is later. However, your care benefits never reduce and remain at the same high level into your later years.

Spouse Coverage – Apply for Trustmark Life + Care coverage for your spouse as well as for yourself. Your spouse's plan will include the same features as yours. (Spouse coverage amount is capped at a portion of employee amount.)

Trustmark
benefits beyond benefits

BEYOND MED

Where health, meets wellness. A discount program to enhance your most important investment: yourself.

Why Beyond Med?

Elevate your health and well-being by getting access to a proprietary network of board-certified doctors and licensed providers at reduced rates on elective and cosmetic services.

- 3,000 + Providers
- 15 Specialties
- 2,500+ Offices
- 400+ Treatments

Member Perks

- **Curated Network Access** - to thousands of elective and cosmetic providers at reduced rates
- **Concierge Service** - a concierge team to guide you and an easy-to-use mobile application
- **Unlimited Savings** - no waiting periods and no limits to benefit usage (use it as much as you want.)

Save on Services Like

- Acupuncture
- Anti-Aging
- Bariatric
- Chiropractic
- Dermatology
- Fertility
- Hair Restoration
- Hearing
- Mental Wellness
- Med Spa
- Physical Therapy
- Plastic Surgery
- Surgical Vision
- Vein Therapy
- Veterinary
- Weight Loss

Beyond Med

LEGAL SERVICES: PROVIDED BY PREFERRED LEGAL

The Preferred Legal plan is a comprehensive legal protection program designed to help individuals and their families deal with various legal issues 24 hours a day 7 days a week. This program includes, but is not limited to, free or discounted and confidential services such as:

- Telephonic or face to face legal advice
- Review of legal documents
- Will preparation and simple wills for team member and Spouse
- Financial and asset protection counseling
- Notary Services

IDENTITY THEFT PROTECTION: PROVIDED BY ALLSTATE ID PROTECTION (AIP)

A comprehensive Identity Theft Protection plan is available through Allstate. The plan monitors fraudulent activity so it can be caught sooner. Should you become a victim of identity theft, full service privacy advocate restoration services can begin. Services include lost wallet protection and credit, identity and cyber monitoring. Reimbursement of out-of-pocket expenses related to identity theft of up to $1,000,000 for lost wages, legal fees and more.

PET INSURANCE: PROVIDED BY NATIONWIDE

Pet Insurance through NationWide consists of two plan choices or a combination of both plans to help you choose the pet health plan that best fits your needs. These plans allow you to use your own veterinarian. This benefit is not available through payroll deductions. (direct bill only)

Wellness Services Only Plan:

- Wellness exams
- Vaccinations
- Flea and heartworm prevention

Comprehensive Major Medical Plan:

- Accidents and common illnesses (i.e. ear infection and rashes)
- Serious illnesses (i.e. cancer, allergies and diabetes)
- Surgery
- Rx medications
- Hospitalization

T. ROWE PRICE — 401(K) SAVINGS PLAN

Full-time, part-time and on-call 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.

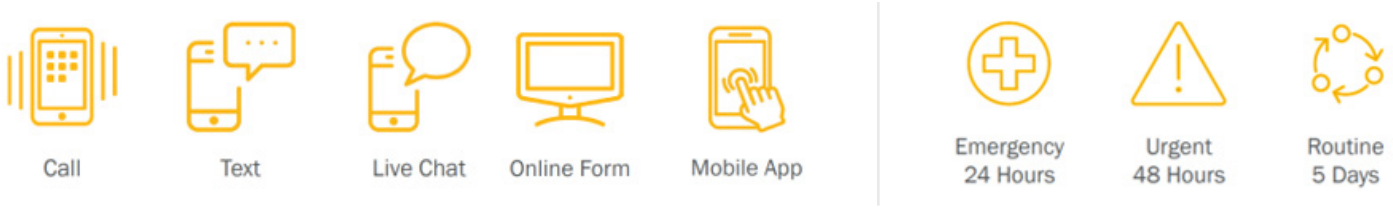
Email: metzig@sageviewadvisory.com

Phone: (561) 284-0699

SAGE VIEW

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.



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

bhs™

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.brighthorizons.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

OTHER BENEFITS

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.

Bright Horizons™

MOTIVITY CARE

Motivity Care takes the complexity out of caregiving management at every stage of adult life. Are you and your loved ones prepared for now and the future with your life information organized, accessible and up to date? Motivity Care offers the solution.

MC Life Intell Platform

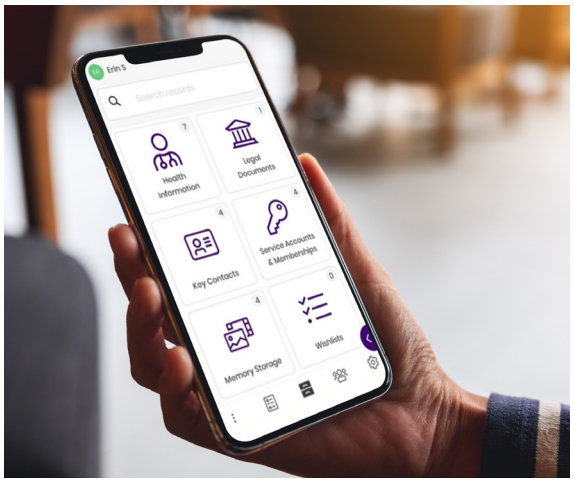
- Desktop and Mobile App in both English and Spanish
- Best in class technology to keep vital medical, legal and personal information secure and accessible 24/7

Employee Benefit

Motivity Care will provide initial onboarding and group training for the MC Life Intell Platform and services.

- Workshops and practical webinars
- Technology support/helpline

Offered as an employee payroll deduction



EXAMPLE

You select to add your father to your Motivity Care account.

Your father lives in another state and has an accident which requires hospitalization for 48 hours. Since you store his important information on Motivity Care, you will be able to identify who his doctors are, what medications he is taking, allergies, and even household items such as pet sitters, what bills are due, passwords, neighbors to contact and much more.

Customized concierge package* available such as:

- Offering referrals and scheduling appointments
- Vetting resources at your request
- Recommendations and coordination for life transitions
- Managing unexpected medical challenges

**Concierge package is an additional cost to Employee Benefit offering*

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
Flexible Spending Account Employee Benefits Corporation	(800) 346-2126 ebcflex.com
Basic and Voluntary Life and AD&D, Short Term Disability and Long Term Disability Insurance The Hartford	(800) 523-2233 thehartford.com/resources/employeechoice
Voluntary Benefits - Hospital Indemnity, Accident Insurance and Critical Illness with Cancer Coverage The Hartford	(800) 523-2233 thehartford.com/resources/employeechoice
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
Life and Care Insurance Trustmark	(866) 813-7192 x3 trustmarkvb.com
Health and Wellness Membership Program Beyond Med	(844) 267-6192 beyondmedplans.com
Legal Services Preferred Legal	(888) 577-3476 preferredlegal.com
Identity Theft Protection Allstate ID Protection	(800) 789-2720 myaip.com
Pet Insurance Nationwide	(800) 540-2016 petinsurance.com/thebreakers
Back-Up Care Advantage Program Bright Horizons	(877) 242-2737 backup.brighthorizons.com
Caregiving Management Services Motivity Care	(844) 424-2021 info@motivitycare.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 45-46 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	ALASKA - MEDICAID
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS - MEDICAID	**CALIFORNIA - MEDICAID**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855)-692-7447	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+)	**FLORIDA - MEDICAID**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA - MEDICAID	**INDIANA - 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	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

IOWA - MEDICAID AND CHIP (HAWKI)

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

KANSAS - MEDICAID

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY - MEDICAID

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
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

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=e n_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

MASSACHUSETTS - MEDICAID AND CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA - MEDICAID

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

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: HHSHIPPProgram@mt.gov

NEBRASKA - MEDICAID

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA - MEDICAID

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE - MEDICAID

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

NEW JERSEY - MEDICAID AND CHIP

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

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: 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 RIte 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 ebsa.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.

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 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 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 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.

**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.

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.