



**Porthole Hospitality, LLC
March 1, 2025 – February 28, 2026
Employee Benefit Guide**

**An overview of the wide array of benefits provided
Porthole Hospitality, LLC to help you enjoy increased well-being
and financial security.**



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Welcome

Benefits for March 1, 2025 – February 28, 2026

OUR EMPLOYEES ARE OUR MOST VALUABLE ASSET.

That's why The Porthole Hospitality, LLC strives to provide you and your family with a comprehensive benefits package. We want you to pick the best benefits for you and your family. We've put together this Benefit Guide for open enrollment and for new employees hired during the year.

Open enrollment is an important time - it is a short period each year when you can make changes to your benefits. The IRS allows employees to select certain benefits through pre-tax salary reductions, which lowers taxes and saves money. Because of these tax savings, after your initial benefits selection at the time you're hired, the IRS allows you to make changes only during an open enrollment period, unless you experience a qualified status change. Since this is your one opportunity to enroll in or make changes to your benefits this year, please carefully consider your anticipated needs for the upcoming plan year. Elections you make during open enrollment will be **effective on March 1, 2025**.

This Guide outlines the different benefits The Porthole Hospitality, LLC offers, so you can identify which offerings are best for you and your family. The Guide also provides definitions for important terms, contact information for each of the carriers, as well as some important annual notices you should be aware of.

This Benefit Guide includes summary descriptions of The Porthole Hospitality, LLC benefit plans. If there is a discrepancy between these summaries and the written legal plan documents, the plan documents shall prevail. This Guide and plan summaries do not constitute a contract of employment and benefits described in this Guide may be changed by the employer.

Welcome (continued)



Benefits for March 1, 2025 – February 28, 2026

If you have questions or need further information, please do not hesitate to contact your The Porthole Hospitality, LLC Hospitality, LLC Human Resources Representative or our dedicated broker representatives at Cross Benefit Solutions.

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Eligibility and Enrollment

Benefits for March 1, 2025 – February 28, 2026

Who Is Eligible?

If you're an eligible employee at The Porthole, you can enroll in the benefits outlined in this Guide and as an eligible employee, the following family members are also eligible for Medical coverage:

- Spouse or domestic partner
- Dependent child under the age of 26, regardless of that child's marital or student status
- Disabled dependent child regardless of age

The minimum required hours you must work in order to be eligible are 30 hours per week. The waiting period before you can enroll is first of the month following 60 days. **Please see each benefit section in this guide for eligibility details.**

How to Enroll During Open Enrollment

Are you ready to enroll? The first step is to review your current benefits. Did you move recently or get married? Verify all of your personal information and make any necessary changes.

Once all your information is up to date, it's time to make your benefit elections. The decisions you make during open enrollment can have a significant impact on your life and finances, so it is important to weigh your options carefully.

When to Enroll

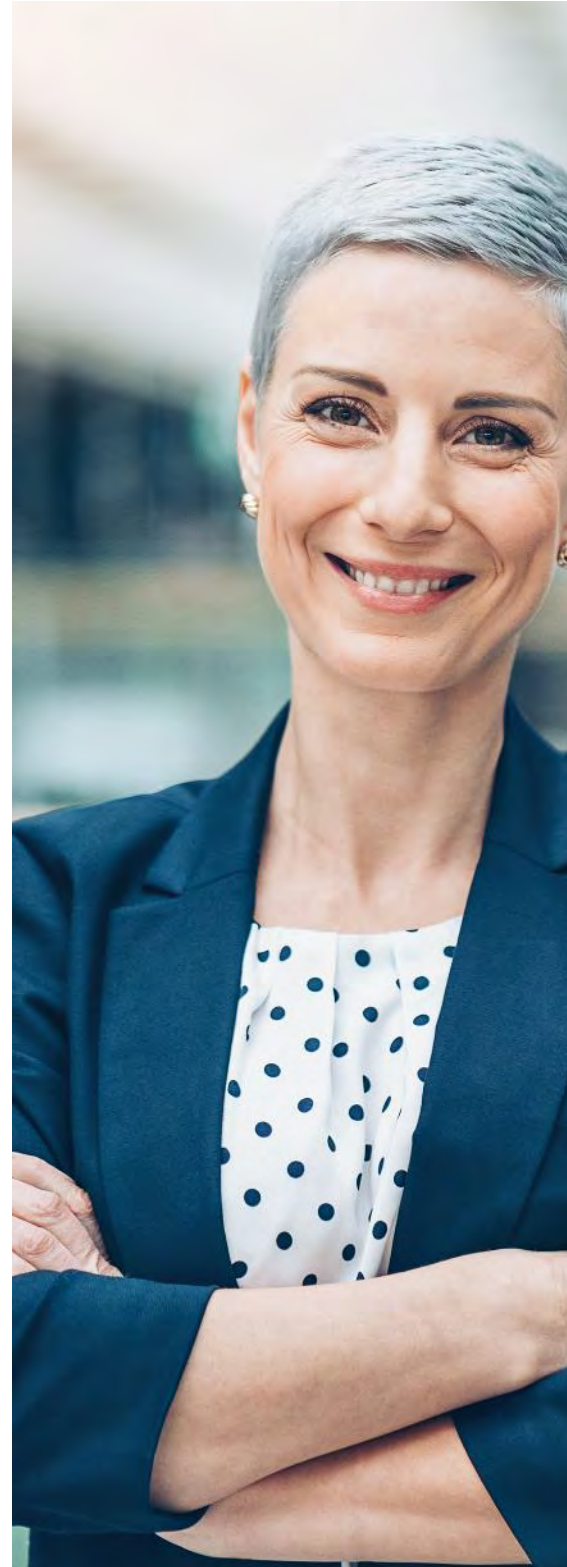
The benefits you choose during Open Enrollment will become **effective on March 1, 2025**. For newly hired or newly eligible employees who are enrolling, coverage will begin first of the month following 60 days.

How to Make Changes

Unless you experience a life-changing Qualifying Event, you cannot make changes to your benefits until the next Open Enrollment Period. Qualifying events include things like:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Change in residence, in certain instances
- Death of a spouse, child or other qualified dependent
- Change in child's dependent status
- Change in employment status or a change in coverage under another employer-sponsored plan

If you have a qualifying life event, in most cases changes must be made within 30 days of the event, or you will need to wait until the next Open Enrollment.



Medical

Benefits for March 1, 2025 – February 28, 2026



Key Terms to Remember

Annual Deductible

The amount you pay each year before the plan starts paying a portion of medical expenses. All family members' expenses that count toward a health plan deductible accumulate together in the aggregate; however, each person also has a limit on their own individual accumulated expenses (the amount varies by plan).

Annual Out-of-Pocket Maximum

This is the total amount you can pay out-of-pocket each calendar year before the plan pays 100% of covered expenses for the rest of the calendar year. Most expenses that meet provider network requirements count toward the annual out-of-pocket maximum, including expenses paid to the annual deductible*, copays and coinsurance.

*Except for Grandfathered medical plans

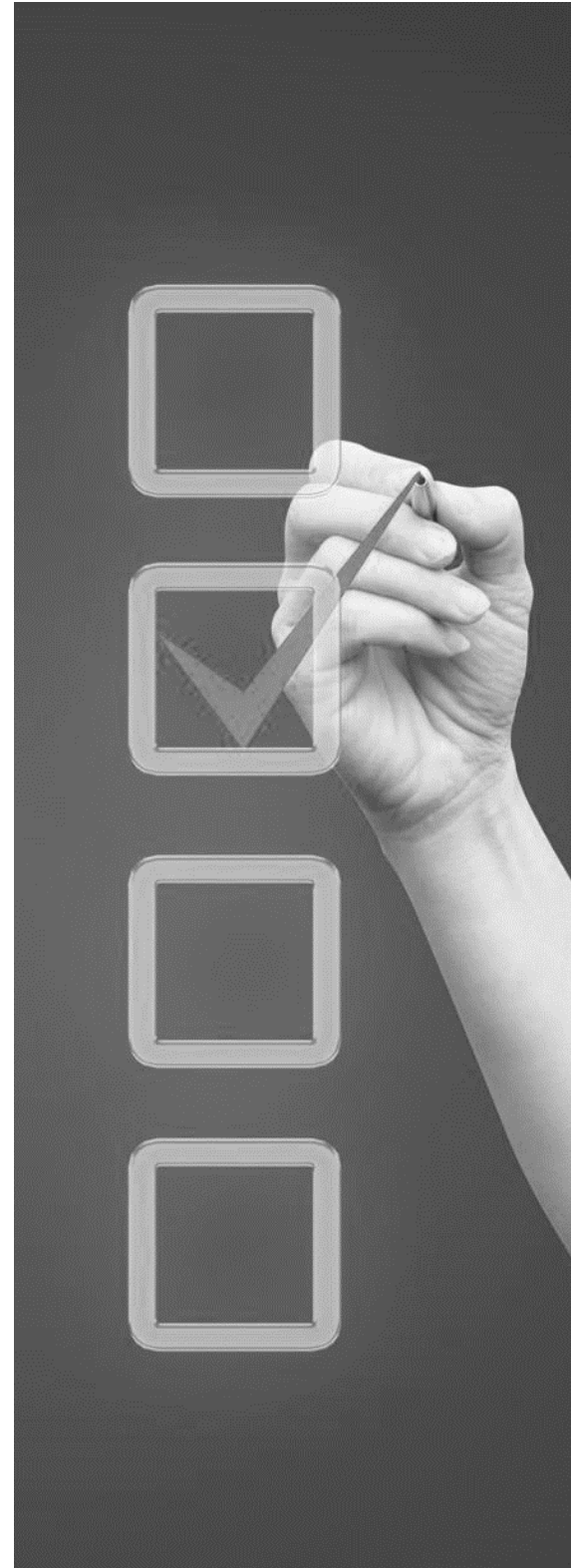
Plan Types

Preferred Provider Organization (PPO) – A network of doctors, hospitals and other health care providers that does not require you to select a Primary Care Physician (PCP) or get referrals to see a specialist. This is a nationwide network of providers.

High Deductible Health Plan (HDHP) – A plan that has higher annual deductibles in exchange for lower premiums. The Balanced Blue Choice PPO 5500 HSA is an HDHP, you can set up a Health Savings Account (HSA) to accompany this plan.

Copays and Coinsurance

These expenses are your share of cost paid for covered health care services. Copays are a fixed dollar amount and are usually due at the time you receive care. Coinsurance is your share (a percentage) of the allowed amount charged for a service and is generally billed to you after the health insurance company reconciles the bill with the provider.



Medical (continued)

Benefits for March 1, 2025 – February 28, 2026

Preventive Care

Understanding the full value of covered benefits allows you to take responsibility for maintaining good health and to incorporate healthy habits into your lifestyle. Some examples include: getting regular physical examinations; mammograms; and immunizations. Through the plans offered by The Porthole, all covered individuals and family members are **eligible to receive routine wellness services like these at no cost - all copays, coinsurance, and deductibles are waived.**

Which Preventive Care Services Are Covered?

The US Preventive Services Task Force maintains a regular list of recommended services that all Affordable Care Act compliant plans should cover at 100% for in-network providers. Below is a list of common services that are included in the plans offered:

“An ounce of prevention is worth a pound of cure”

- Routine Physical Exam
- Well Baby and Child Care
- Well Woman Visits
- Immunizations
- Routine Bone Density Test
- Routine Breast Exam
- Routine Gynecological Exam
- Screening for Gestational Diabetes
- Obesity Screening and Counseling
- Routine Digital Rectal Exam
- Routine Colonoscopy
- Routine Colorectal Cancer Screening
- Routine Prostate Test
- Routine Lab Procedures
- Routine Mammograms
- Routine Pap Smear
- Smoking Cessation
- Health Education/Counseling Services
- Health Counseling for STDs and HIV
- Testing for HPV and HIV
- Screening and Counseling for Domestic Violence
- Depression Screening
- Blood Pressure Screening

Medical (continued)



Benefits for March 1, 2025 – February 28, 2026

Who Is Eligible and When?

Benefits are available to employees working 30 or more hours per week. New employees are eligible for benefits on the first of the month following 60 days from the date of hire. Family members listed in Eligibility and Enrollment section are eligible.

Benefits You Receive

The Porthole Hospitality, LLC offers 3 medical plans to choose from Anthem.

Summary of Coverage and Employee Contributions

Plan Features	Plan 1 - Balanced Blue Choice PPO 750 (88K6) Benefits Run on a Calendar Year Basis	
	IN-NETWORK	OUT-OF-NETWORK
Embedded Deductible (Ind/Family)	\$750 / \$2,250	\$2,250 / \$4,500
Out-of-Pocket Maximum (Ind/Family)	\$4,500 / \$9,000	\$13,500 / \$27,000
Coinsurance Percentage	You pay 20%	You pay 30%
PCP Office Visits -Preventive Care -Sick Care	No Charge \$20 Copay	Deductible, then 30%
Specialist Office Visits	\$40 Copay	Deductible, then 30%
Advanced Diagnostic Imaging	Deductible, then 20%	Deductible, then 30%
Emergency Room Care	\$350 Copay after Deductible	
Urgent Care – Walk-In	\$20 Copay	Deductible, then 30%
Inpatient Hospital Care	Deductible, then 20%	Deductible, then 30%
Chiropractic Care	\$20 Copay	Deductible, then 30%
Physical, Speech and Occupational Therapy (Office)	\$20 Copay	Deductible, then 30%
Prescription Drugs (Rx) Tiers Tiers 1a, 1b, 2 (Retail) Tiers 1a, 1b, 2 (Home Delivery) Tier 3 / 4 (Retail or Home Delivery)	Tier 1 \$5 / \$15 / \$50 \$13 / \$38 / \$150 \$100 / \$550 Copay	Tier 2 \$15 / \$25 / \$60 Not Covered \$200 / \$650 Copay
Preventive Medications	N/A	
Type of Coverage	Weekly Employee Deduction	
Employee Only	\$65.37	
Employee & Spouse	\$196.08	
Employee & Child(ren)	\$176.48	
Family	\$339.87	

*Benefits shown are for a 30-day supply. Coverage for up to a 90-day supply is available for certain drugs through the home delivery pharmacy. Specialty Drugs are limited to a 30-day supply.

Refer to your Medical plan documentation for more information.

Medical (continued)



Benefits for March 1, 2025 – February 28, 2026

Who Is Eligible and When?

Benefits are available to employees working 30 or more hours per week. New employees are eligible for benefits on the first of the month following 60 days from the date of hire. Family members listed in Eligibility and Enrollment section are eligible.

Benefits You Receive

The Porthole Hospitality, LLC offers 3 medical plans to choose from Anthem.

Summary of Coverage and Employee Contributions

Plan Features	Plan 2 – Balanced Blue Choice PPO 2000 (88KP) Benefits Run on a Calendar Year Basis	
	IN-NETWORK	OUT-OF-NETWORK
Embedded Deductible (Ind/Family)	\$2,000 / \$4,000	\$6,000 / \$12,000
Out-of-Pocket Maximum (Ind/Family)	\$6,000 / \$12,000	\$18,000 / \$36,000
Coinsurance Percentage	You pay 25%	You pay 35%
PCP Office Visits -Preventive Care -Sick Care	No Charge \$25 Copay	Deductible, then 35%
Specialist Office Visits	\$50 Copay	Deductible, then 35%
Advanced Diagnostic Imaging	Deductible, then 25%	Deductible, then 35%
Emergency Room Care	\$350 Copay after Deductible	
Urgent Care – Walk-In	\$25 Copay	Deductible, then 35%
Inpatient Hospital Care	Deductible, then 25%	Deductible, then 35%
Chiropractic Care	\$25 Copay	Deductible, then 35%
Physical, Speech and Occupational Therapy (Office)	\$25 Copay	Deductible, then 35%
Prescription Drugs (Rx) Tiers 1a, 1b, 2 (Retail) Tiers 1a, 1b, 2 (Home Delivery) Tier 3 / 4 (Retail or Home Delivery)	Tier 1 \$5 / \$15 / \$50 \$13 / \$38 / \$150 \$100 / \$550	Tier 2 \$15 / \$25 / \$60 N/A \$200 / \$650
Preventive Medications	N/A	
Type of Coverage	Weekly Employee Deduction	
Employee Only	\$55.24	
Employee & Spouse	\$175.83	
Employee & Child(ren)	\$157.74	
Family	\$308.48	

*Benefits shown are for a 30-day supply. Coverage for up to a 90-day supply is available for certain drugs through the home delivery pharmacy. Specialty Drugs are limited to a 30-day supply.

Refer to your Medical plan documentation for more information.

Medical (continued)



Benefits for March 1, 2025 – February 28, 2026

Who Is Eligible and When?

Benefits are available to employees working 30 or more hours per week. New employees are eligible for benefits on the first of the month following 60 days from the date of hire. Family members listed in Eligibility and Enrollment section are eligible.

Benefits You Receive

The Porthole Hospitality, LLC offers 3 medical plans to choose from Anthem.

Summary of Coverage and Employee Contributions

Plan Features	Plan 3 – Balanced Blue Choice PPO 5500 HSA (88K8) Benefits Run on a Calendar Year Basis	
	IN-NETWORK	OUT-OF-NETWORK
Embedded Deductible (Ind/Family)	\$5,500 / \$11,000	\$16,500 / \$33,000
Out-of-Pocket Maximum (Ind/Family)	\$7,050 / \$14,100	\$21,150 / \$42,300
Coinsurance Percentage	You pay 30%	You pay 40%
PCP Office Visits -Preventive Care -Sick Care	No Charge \$30 Copay, after Deductible	Deductible, then 40%
Specialist Office Visits	\$60 Copay, after Deductible	Deductible, then 40%
Advanced Diagnostic Imaging	Deductible, then 30%	Deductible, then 40%
Emergency Room Care	\$350 Copay after Deductible	
Urgent Care – Walk-In	\$30 Copay, after Deductible	Deductible, then 40%
Inpatient Hospital Care	Deductible, then 30%	Deductible, then 40%
Chiropractic Care	\$30 Copay, after Deductible	Deductible, then 40%
Physical, Speech and Occupational Therapy (Office)	\$30 Copay, after Deductible	Deductible, then 40%
Prescription Drugs (Rx) Tiers 1a, 1b, 2 (Retail) Tiers 1a, 1b, 2 (Home Delivery) Tier 3 / 4 (Retail or Home Delivery)	Tier 1 \$5 / \$15 / \$50, after Deductible \$13 / \$38 / \$150, after Deductible 40%, after Deductible	Tier 2 \$15 / \$25 / \$60, after Deductible Not Covered 50%, after Deductible
Preventive Medications	Deductible is waived for certain medications	
Type of Coverage	Weekly Employee Deduction	
Employee Only	\$32.40	
Employee & Spouse	\$130.14	
Employee & Child(ren)	\$115.48	
Family	\$237.66	

*Benefits shown are for a 30-day supply. Coverage for up to a 90-day supply is available for certain drugs through the home delivery pharmacy. Specialty Drugs are limited to a 30-day supply.

Refer to your Medical plan documentation for more information.

Health Savings Account (HSA)

Benefits for March 1, 2025 – February 28, 2026

Who Is Eligible and When?

When you are enrolled in the medical plan, The Porthole Hospitality, LLC offers you an employer-sponsored Health Savings Account (HSA) with a bank of your choice. With an HSA, employees can save money and budget for qualified medical expenses. HSAs are tax-advantaged savings accounts that accompany High Deductible Health Plans (HDHPs). Plan 3 Balanced Blue Choice PPO 5500 HSA compatible plans for you to set up an HSA account.

How Do I Benefit from an HSA?

The main purpose of this account is to offset the cost of a qualifying HDHP and provide savings for your out-of-pocket eligible health care expenses – those you and your tax dependents may have now, in the future, and during your retirement.

This is a “portable” account. You own your HSA! It’s included in your employee benefits package, but after you set up your account, it’s yours to keep, even if you change jobs or retire.

What Expenses are Covered Under an HSA?

Once your HSA is established, you can contribute pre-tax dollars into the account. You can then use your HSA dollars tax-free to pay for eligible health care expenses. You save money on expenses you’re already paying for, such as doctors’ office visits, prescription drugs, and much more. Best of all, you decide how and when to use your HSA dollars.



Health Savings Account (HSA) (continued)

Benefits for March 1, 2025 – February 28, 2026

Why Is It a Good Idea to Have an HSA?

HSAs benefit everyone who is eligible to have this account – single individuals, families, and soon-to-be retirees. You save money on taxes in three ways:

- **Tax-free deposits** – The money you contribute to your HSA isn't taxed (up to the IRS annual limit).
- **Tax-free earnings** – Your interest and any investment earnings grow tax-free.
- **Tax-free withdrawals** – The money used toward eligible health care expenses isn't taxed – now or in the future.

Setting aside pre-tax dollars into your HSA means you pay fewer taxes and increase your take-home pay by your tax savings. You save money on eligible expenses that you are paying for out of your pocket. The amount you save depends on your tax bracket. For example, if you are in the 30 percent tax bracket, you can save \$30 on every \$100 spent on eligible health care expenses.

HSA funds roll over from year to year and accumulate in your account. There is no “use-it-or-lose-it” rule with HSAs, and you decide how and when to use your HSA funds, which can be used for eligible expenses you have now, in the future, or during retirement. And when you have a certain balance in your HSA, investment opportunities are available.

How Much Can I Contribute to the HSA Each Year?

The maximum amount that you can contribute to an HSA in 2025:

- **\$4,300 if you have individual coverage**
- **\$8,550 if you have family coverage.**

Additionally, if you are age 55 or older, you may make an additional “catch-up” contribution of \$1,000. You may change your contribution amount at any time throughout the year as long as you don't exceed the annual maximum.

Refer to your HSA documentation for more information.



PreventiveRx covers drugs that may keep you healthy because they may prevent illness and other health conditions. You can get the products on this list at low or no cost to you depending on your benefit.

This list includes only prescription products. Brand-name drugs are listed with a first capital letter. Non-brand drugs (generics) are in lowercase letters.

Most brand-name drugs that have a generic equivalent available are not covered under this PreventiveRx benefit.

Drugs* listed below may be covered for plans with the Essential Drug List. If your plan has a different drug list, please check to see if these drugs are included on your drug list. PreventiveRx Plus drugs are only covered if they are included on your specific drug list.

*Some drugs and supplies may be excluded from your benefits. Please refer to your Certificate or Evidence for Coverage for coverage limitations and exclusions.

HEART HEALTH AND HIGH BLOOD PRESSURE

acebutolol
 amlodipine/ benazepril
 atenolol
 atenolol/ chlorthalidone
 benazepril
 benazepril/ hctz
 betaxolol
 bisoprolol fumarate
 bisoprolol/ hctz
 captopril
 captopril/ hctz
 carvedilol
 enalapril
 enalapril/ hctz
 fosinopril
 fosinopril/ hctz
 labetalol
 lisinopril
 lisinopril/ hctz
 metoprolol succinate er
 metoprolol tartrate
 metoprolol/ hctz
 moexipril
 nadolol
 nebivolol
 perindopril
 pindolol
 propranolol
 propranolol er
 propranolol/ hctz
 quinapril
 quinapril/ hctz
 ramipril
 sorine
 sotalol

sotalol af
 timolol
 trandolapril
 trandolapril/ verapamil

OSTEOPOROSIS

alendronate sodium
 amabelz
 calcitonin salmon
 Climara Pro
 Combipatch
 dotti
 estradiol
 estradiol/ norethindrone
 evamist
 Fosamax Plus D
 fyavolv
 ibandronate sodium
 jinteli
 lopreeza
 mimvey
 mimvey lo
 Premarin (oral)
 Premphase
 Prempro
 raloxifene
 risedronate
 risedronate DR

ASTHMA

Advair Hfa
 Amuity Ellipta
 Breo Ellipta
 budesonide suspension
 budesonide/ formoterol
 Flovent Diskus
 Flovent HFA

fluticasone/ salmeterol inhalation powder
 fluticasone/ vilanterol formoterol nebulization solution
 QVAR RediHaler
 Symbicort
 Trelegy Ellipta
 wixela inhub

DIABETES

Diabetic supplies including blood glucose meters, test strips and lancets require a prescription to be covered by this plan. Only blood glucose test strips by Lifescan & Roche will be covered by this benefit.

acarbose
 alogliptin
 alogliptin/metformin
 alogliptin/pioglitazone
 Farxiga
 glimepiride
 glipizide
 glipizide er
 glipizide xl
 glipizide/ metformin
 glyburide
 glyburide micronized
 glyburide/ metformin
 Glyxambi
 Humalog
 Humalog Junior Kwikpen
 Humalog Kwikpen
 Humalog Mix 50/50

Humalog Mx 50/50 Kwikpen
 Humalog Mx 75/25
 Humalog Mx 75/25 Kwikpen
 Humulin 70/30
 Humulin 70/30 Kwikpen
 Humulin N
 Humulin N Kwikpen
 Humulin R
 Humulin R U-500
 Humulin R U-500 Kwikpen
 Insulin Glargine
 Insulin Glargine Solostar
 Insulin Lispro
 Insulin Lispro Junior Kwi
 Insulin Lispro Kwikpen
 Insulin Lispro Protamine
 Janumet
 Janumet XR
 Januvia
 Jardiance
 Lantus
 Lantus Solostar
 Levemir
 Levemir Flextouch
 Lyumjev
 Lyumjev KwikPen
 metformin
 metformin er (generic for Glucophage XR)
 miglitol
 nateglinide
 Ozempic
 pioglitazone
 pioglitazone/ metformin
 pioglitazone/ glimepiride

repaglinide
Rybelsus
Soliqua
Symlinpen 120
Symlinpen 60
Synjardy
Synjardy Xr
tolbutamide
Toujeo Max Solostar
Toujeo Solostar
Tresiba
Tresiba Flextouch
Trijardy XR
Trulicity
Victoza
Xigduo XR
Xultophy

simvastatin

MENTAL HEALTH

citalopram
escitalopram oxalate
fluoxetine
fluoxetine DR
fluvoxamine
fluvoxamine ER
paroxetine
paroxetine ER
sertraline

**HIGH
CHOLESTEROL**

amlodipine/
atorvastatin
atorvastatin
ezetimibe/
simvastatin
fluvastatin
lovastatin
pravastatin
rosuvastatin

This list may change without notice which may affect your benefit coverage. To be sure your medication is covered under the PreventiveRx benefit, call the member services number located on your ID card.

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. Copies of Colorado network access plans are available on request from member services or can be obtained by going to anthem.com/colonetworkaccess. In Connecticut: Anthem Health Plans, Inc. In Georgia: Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE™ Managed Care, Inc. (RTI), Healthy Alliance® Life Insurance Company (HAUC) and HMO Missouri, Inc. RTI and certain affiliates administer non-HMO benefits underwritten by HALC and HMO benefits underwritten by HMO Missouri, Inc. RTI and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in PPO policies offered by CompCare Health Services Insurance Corporation (CompCare) or Wisconsin Collaborative Insurance Corporation (WOC). CompCare underwrites or administers HMO or POS policies. WOC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

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You can receive primary care and urgent care clinic visits at no cost

when selecting a ConvenientMD value-based provider as your PCP.

You now have access to quality, concierge-style, coordinated care for a **\$0 cost share**. All you need to do is choose a ConvenientMD value-based provider as your primary care provider (PCP) and receive your primary care from that chosen PCP. Primary care services are available in person through ConvenientMD facilities in Portland, Maine, and Portsmouth, New Hampshire, as well as virtually.

Additional benefits of using a value-based PCP include:

- **Same- and next-day appointments.**
- **Longer primary care visits** that start on time.
- **Virtual video visits**, available seven days a week.
- **24/7 connection to care** with a PCP service line.

You also can receive health services such as X-rays, urgent care clinic visits, and routine lab tests from ConvenientMD's physician offices and urgent care clinics. Health services at other locations are still available to you at the usual cost share. If you have a health plan with a health savings account (HSA), you may select a ConvenientMD provider but the \$0 copay benefit is not available.

What is a value-based provider?

A value-based provider is a doctor or facility, by virtue of their contract with Anthem, that is rewarded for efficiency, coordination of care, health outcomes, and care experience, rather than on the amount of care provided under the traditional fee-for-service model.

Advantages of value-based care

By selecting a ConvenientMD value-based provider as your PCP, you are supported by a care-navigation team who understands your unique health needs. Your team will coordinate your care and guide you through referrals, diagnostics, and prescriptions. You will have access to care from a ConvenientMD value-based provider through office visits, urgent care clinics, or virtual services at a \$0 cost share.

This could mean lower healthcare costs for you overall because you may avoid unnecessary emergency room visits and improve your health outcomes through highly coordinated care.

To take advantage of this benefit, you will need to select a ConvenientMD value-based provider as your PCP.

To select a value-based provider PCP, follow these steps:

- Log in to [anthem.com](https://www.anthem.com). Select **Find Care**, and choose **Primary Care** under **Search by Care Provider**.
- On the filters section on the left, scroll down to **Recognitions**, and then check **Value-Based Provider**.
- Select **Assign as PCP**.



The following services are available at no cost when using a ConvenientMD value based provider as your PCP:



PCP visits



X-rays



Routine laboratory services



Urgent care clinic visits

Call the Customer Service number on the back of your member ID card for more information about ConvenientMD's value based providers or visit [convenientmd.com/anthem](https://www.convenientmd.com/anthem).

In addition to using in-person or telehealth services provided by your value-based provider for a \$0 cost share, you can receive in-person or virtual care from healthcare professionals in your plan's network. If you receive care from a doctor or healthcare professional not in your plan's network, your share of the costs may be higher. You may also receive a bill for any charges not covered by your health plan. Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Maine, Inc. Independent licensee of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc. 1044393M/EM/VA/BS/BV/01/23



Anthem 

Convenience or savings? No need to choose.

You get both with Rx Choice Tiered Network.

With your plan, you have lots of choices about where to get your prescription medicines. And with the Rx Choice Tiered Network, you can choose a pharmacy that saves you money.

Your pharmacy network offers two levels of coverage:

\$ Level 1

These are our preferred pharmacies, where your copay or share of the prescription cost is lower. There are more than 25,000* Level 1 pharmacies across the country, including well known chains like:

- CVS
- Target
- Hannaford Food & Drug
- Walmart

\$\$ Level 2

You'll pay a little more for your prescriptions at a Level 2 pharmacy. There are 40,000* of these around the country, including:

- Walgreens
- Rite Aid

Questions?

Call the Pharmacy Member Services number on the back of your plan ID card.

It's easy to find a pharmacy in the Rx Choice Tiered Network

- Visit [anthem.com](https://www.anthem.com), choose **Manage Your Prescriptions** and log on.
- On the *Pharmacy* page, choose **Find a Pharmacy**.
- Enter your ZIP code and how far you want to search to find pharmacies near you.

*InzaniaRx data, 2019.

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Say hi to Sydney

Anthem's new app is simple, smart — and all about you

With Sydney, you can find everything you need to know about your Anthem benefits – personalized and all in one place. Sydney makes it easier to get things done, so you can spend more time focused on your health.

Get started with Sydney
Download the app today!



Simple

Ready for you to use quickly, easily, seamlessly —with one-click access to benefits info, Member Services, wellness resources and more.

Smart

Sydney acts like a personal health guide, answering your questions and connecting you to the right resources at the right time. And you can use the chatbot to get answers quickly.

Personal

Get alerts, reminders and tips directly from Sydney. Get doctor suggestions based on your needs. The more you use it, the more Sydney can help you stay healthy and save money.

With just one click, you can:

- “ Find care and check costs
- “ Check all benefits
- “ See claims
- “ Get answers even faster with our chatbot
- “ View and use digital ID cards

Already using one of our apps?

It's easy to make the switch. Simply download the Sydney app and log in with your Anthem username and password.

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You've got quick access to your health care!

Register on [anthem.com](https://www.anthem.com) or the **Sydney** mobile app.* Have your member ID card handy to register



From your computer

- 1 Go to [anthem.com/register](https://www.anthem.com/register)
- 2 Provide the information requested
- 3 Create a username and password
- 4 Set your email preferences
- 5 Follow the prompts to complete your registration

From your mobile device

- 1 Download the free **Sydney** mobile app and select **Register**
- 2 Confirm your identity
- 3 Create a username and password
- 4 Confirm your email preferences
- 5 Follow the prompts to complete your registration

It's easy. Everything you need to know about your plan —including medical —in one place. Making your health care journey simple, personal —all about you.

Need help signing up?
Call us at **1-866-755-2680**.



Anthem Blue Cross and Blue Shield is the trade name of: In Colorado, Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. Copies of Colorado network access plans are available on request from member services or can be obtained by going to [anthem.com/colonetworkaccess](https://www.anthem.com/colonetworkaccess). In Connecticut, Anthem Health Plans, Inc. In Georgia, Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. In Indiana, Anthem Insurance Companies, Inc. In Kentucky, Anthem Health Plans of Kentucky, Inc. In Maine, Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area), Right Choice® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HAUC), and HMO Missouri, Inc. RT and certain affiliates administer HMO benefits underwritten by HAUC and HMO benefits underwritten by HMO Missouri, Inc. RT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada, Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. dba HMO Nevada. In New Hampshire, Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thomson Health Plan, Inc. In Ohio, Community Insurance Company. In Virginia, Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service areas are all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin, Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or administers PPO and indemnity policies and underwrites the out-of-network benefits in PPO policies offered by Compare Health Services Insurance Corporation (Compare) or Wisconsin Collaborative Insurance Corporation (WOC). Compare underwrites or administers HMO or PPO policies. WOC underwrites or administers Well Priority HMO or PPO policies. Independent licensees of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Where you go matters

Use Site of Service providers to save on your out-of-pocket costs for lab tests, X-rays and high-cost imaging

Would you pay more for a direct flight from Portland to Orlando when you could get the same quality flight for less at another airline? Then why would you pay more for your health care when you don't have to? That's where Anthem's cost-saving programs can help. With some Anthem plans, you may save hundreds of dollars—even thousands—when you go to lower-cost independent providers identified as a Site of Service care location found with anthem.com's Find Care tool.

Pay less for all of these services when you use Site of Service providers*



Lab tests

Pay no more than a \$25 copay



Radiology (such as X-rays and ultrasounds)

Pay no more than a \$75 copay



Advanced diagnostic imaging (such as MRIs and CAT scans)

Pay no more than a \$250 copay

Important: In some plans, your out-of-pocket costs will be higher when you get these services at a non-Site of Service location.



You can also get cash back for using lower-cost care options!

SmartShopper™ is a program that offers most Anthem members in our group health plans up to \$500 in cash rewards for getting common health services at lower-cost facilities. The first step toward your own savings is to visit [smartshopper.com](https://www.smartshopper.com) or call 1-844-328-1582 when you need care. Then choose a lower-cost option identified by SmartShopper and get your cash reward!

*Applies to select Anthem group plans. Be sure to refer to your Summary of Benefits to find out whether this benefit applies.

Find a Site of Service location near you in just minutes!

To find Site of Service locations, log in to [anthem.com](https://www.anthem.com) and search the service in the Find Care tool. Site of Service will be listed on the search page next to the lower-cost locations—it's as easy as that!



Lab

If a lab appears with the Site of Service designation in **Find Care**, then you can save on out-of-pocket costs depending on your health plan. Make sure to contact the provider to confirm services.



Radiology and advanced diagnostic imaging

For services such as X-rays, ultrasounds, MRIs or CAT scans, you have a low copay when you choose a Site of Service location. Make sure to contact the provider to confirm services.



Use our app to search from anywhere

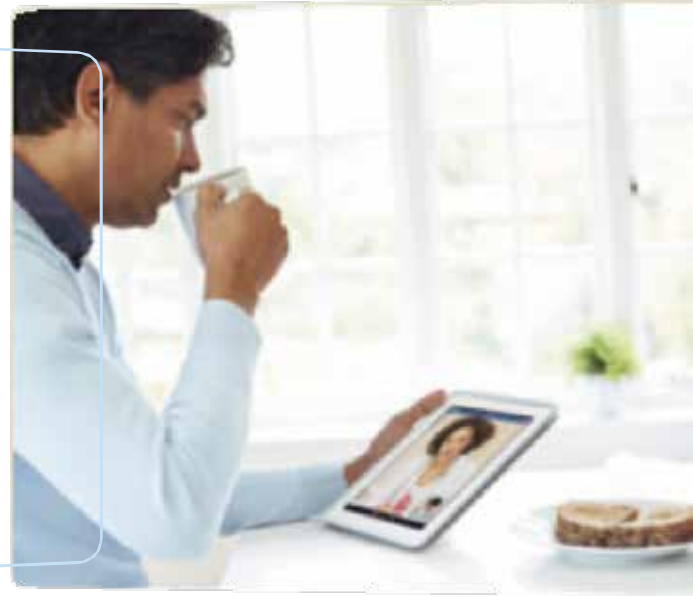
Download our free Sydney Health app from the App Store® or Google Play™.

The Smart Shopper program is provided by Sapphire Digital, an independent company.

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At home or on the go, doctors and mental health professionals are here for you.

Use LiveHealth Online, anytime, for a private video visit with a doctor or mental health professional.



When you're not feeling well you can get the support you need easily using LiveHealth Online. Whether you have a cold, you're feeling anxious or need help managing your medication, doctors and mental health professionals are right there, ready to help you feel your best. Using LiveHealth Online you can have a video visit with a board-certified doctor, psychiatrist or licensed therapist from your smartphone, tablet or computer from home or anywhere.

On LiveHealth Online, you can:

- **See a board-certified doctor 24/7.** You don't need an appointment to see a doctor. They're always available to assess your condition and send a prescription to the pharmacy you choose, if needed.¹ It's a great option when you have pink eye, a cold, the flu, a fever, allergies, a sinus infection or another common health issue.
- **Visit a licensed therapist in four days or less.**² Have a video visit with a therapist to get help with anxiety, depression, grief, panic attacks and more. Schedule your appointment online or call **1-888-548-3432** from **8 a.m. to 8 p.m.**, seven days a week.
- **Consult a board-certified psychiatrist within two weeks.**³ If you're over 18 years old, you can get medication support to help you manage a mental health condition. To schedule your appointment call **1-888-548-3432** from **8 a.m. to 8 p.m.**, seven days a week.

You've got access to affordable and convenient care

Your Anthem plan includes benefits for video visits using LiveHealth Online, so you'll just pay your share of the costs — usually \$59 or less for medical doctor visits, and a 45-minute therapy or psychiatry session usually costs the same as an office mental health visit.

Sign up for LiveHealth Online today – it's quick and easy

Go to livehealthonline.com or download the app and register on your phone or tablet.





When your employees can shop, *everyone* saves





Did you know that prices for the same quality medical services can differ by thousands of dollars from location to location? With SmartShopper, an engagement and incentive program that is included with your health plan,¹ your employees can shop for healthcare services and compare prices for common procedures and tests. In addition to helping them find lower-cost locations for care, SmartShopper rewards them for making cost-effective choices.

The example below shows how costs can vary by location for the same procedure.

Medical procedure	Colonoscopy
Provider A cost	\$1,182
Provider B cost	\$2,932
Provider C cost	\$4,749

Examples shown are for specific locations and time periods and may not represent actual costs for procedures in your area.

How does SmartShopper work?

-  The doctor recommends a medical test or procedure.
-  Your employee shops for the service by phone or online at smartshopper.com.
-  Your employee has the procedure at a reward-eligible location.
-  Once the claim is paid, your employee is sent a reward in the mail.

Sample procedures and rewards²

Procedure	Reward	Procedure	Reward
Physical Therapy	\$150	Mammogram	\$50
Colonoscopy	\$150	Outpatient labs	\$25
Hernia repair	\$250	Infusion Drugs	\$25-\$500³
Knee surgery	\$750	Ultrasound	\$50

For more information, your employees can call the Personal Assistant team at **866-488-5441** or go to smartshopper.com.

¹ Availability may vary; please contact your Anthem representative to see if you're eligible for this program.

² Reward payments may be taxable.

³ The reimbursement for infusion services depends on the drug administered.

The SmartShopper program is provided by Sapphire Digital, an independent company. Incentives available for select procedures only. Rewards may be delivered by check or an alternative form of payment. Members with coverage under Medicaid or Medicare are not eligible to receive incentive rewards under the SmartShopper program. Rewards are for select procedures only and reward payments may be taxable.

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Voluntary Dental

Benefits for March 1, 2025 – February 28, 2026

Who is Eligible and When?

Benefits are available for purchase to employees working **30 or more hours per week**. New employees are eligible for benefits on the first day of the month following 60 days from the date of hire. Family members listed in **Eligibility and Enrollment** are eligible.

Benefits You Receive

The Porthole Hospitality, LLC offers a Group PPO Dental plan you can purchase from Ameritas.

Summary of Coverage and Employee Deductions

PPO Dental	In-Network
Annual Deductible (Per Person/Family) (Applies ONLY to Basic and Major Restorative Services)	\$50 / \$150
Type 1 - Diagnostic and Preventive Services – No Waiting Period	100%
Type 2 - Basic Restorative Services - No Waiting Period	80%
Type 3 - Major Restorative Services – 12 Month Waiting Period	50%
Calendar Year Maximum per Individual	\$1,000
Carryover Benefit	\$250 / year \$500 Threshold \$1,000 Max Carryover
Vision Fusion Plan Benefit (Total benefits paid between the Dental/Vision coverages will not exceed \$1,000)	\$1,000 Dental Allowance \$150 Vision Allowance

Type 1 – Diagnostic/Preventive Services	Type 2 – Basic Restorative Services	Type 3- Major Restorative Services
Routine Exam (2 per benefit period)	Fillings for Cavities	Onlays
Bitewing X-rays (1 per benefit period)	Restorative Composites (anterior and Posterior teeth)	Crowns (1 in 5 years per tooth)
Full mouth/panoramic X-rays (1 in 5 years)	Simple extractions	Crown Repair
Periapical X-rays	Complex Extractions	Endodontics (nonsurgical) Endodontics (surgical)
Cleaning (3 per benefit period)	Anesthesia	Periodontics (Nonsurgical) Periodontics (Surgical)
Fluoride for Children 16 and under (1 per benefit period)		Denture Repair
Sealants (age 16 and under)		Prosthodontics (fixed Bridge: removable complete/partial dentures (1 in 5 years)
Space Maintainers		
Type of Coverage	Weekly Employee Deduction	
Employee Only	\$2.54	
Employee + Spouse	\$12.11	
Employee + Child(ren)	\$17.02	
Full Family	\$26.59	

*Refer to your Dental plan documentation for more information.

Vision



Benefits for March 1, 2025 – February 28, 2026

Who is Eligible and When?

Benefits are available for purchase to employees working 30 or more hours per week. New employees are eligible for benefits on the first day of the month following 30 days from the date of hire/eligibility. Family members listed in Eligibility and Enrollment are eligible.

Benefits You Receive

Porthole Hospitality LLC, offers a Vision Plan you can purchase from Ameritas.

Summary of Coverage and Employee Contribution

Plan Features	Vision	
	EyeMed Insight Network	
	In-Network	Non-Network Reimbursement
	Your Cost	Plan Pays Up To
Vision Exam – every 12 months	\$10 Copay	Up to \$52
Frames– every 24 months	\$150 Allowance	Up to \$120
Lenses– Standard - every 12 months		
Single	Covered in full	Up to \$68
Bifocal	Covered in full	Up to \$96
Trifocal	Covered in full	Up to \$129
Lenticular	20% discount	No Benefit
Progressive	See lens options	N/A
Contact Lens Fit and Follow-up – Standard Lenses	\$40 Copay	No Benefit
Contact Lens Fit and Follow-up – Premium Lenses	10% off Retail	No Benefit
Contacts– every 12 months		
Conventional	Up to \$150	Up to \$120
Disposable	Up to \$150	Up to \$120
Medically Necessary	Covered in full	Up to \$200
Type of Coverage	Weekly Employee Deductions	
Employee	\$1.68	
Employee & Spouse	\$3.73	
Employee & Child(ren)	\$3.04	
Family	\$5.09	

Refer to your Vision plan documentation for more information.



Women's Health and Cancer Rights Act Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Woman'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:

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

These will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this benefits plan. If you would like more information on WHCRA benefits, please contact your health plan administrator at 855-752-0167.

HIPAA Notice of Privacy Practices

The Plan's HIPAA Notice of Privacy Practices is available upon request. To obtain a copy of the Plan's HIPAA Notice of Privacy Practices, please contact the HR Department. For more information on the Plan's privacy policies or your rights under HIPAA, contact the HR Department at 617-833-7922.

HIPAA Special Enrollment Rights

HIPAA requires we notify you about your right to later enroll yourself and eligible dependents for coverage in Porthole Hospitality, LLC's health plan under "special enrollment provisions" briefly described below.

- Loss of Other Coverage. If you decline enrollment for yourself or for an eligible dependent because you have other group health plan coverage or other health insurance, you may be able to enroll yourself and your dependents under Porthole Hospitality's health plan if you or your dependents lose eligibility for that other coverage, or if the other employer stops contributing toward your or your dependents' other coverage. You must request enrollment within 30 days after your or your dependents' other coverage ends, or after the other employer stops contributing toward the other coverage.
- New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you gain a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents under Porthole Hospitality, LLC's health plan. You must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. In the event you acquire a new dependent by birth, adoption, or placement for adoption, you may also be able to enroll your spouse, if your spouse was not previously covered.
- Enrollment Due to Medicaid/CHIP Events. If you or your eligible dependents are not already enrolled in Porthole Hospitality health plan, you may be able to enroll yourself and your eligible dependents if: (i) you or your dependents lose coverage under a state Medicaid or children's health insurance program (CHIP), or (ii) you or your dependents become eligible for premium assistance under state Medicaid or CHIP. You must request enrollment within 60 days from the date of the Medicaid/CHIP event. The CHIP Model Notice containing additional information about this right as well as contact information for state assistance is included below. You may also request a copy from the Plan Administrator.

Please contact the Plan Administrator at 617-833-7922 for details, including the effective dates of coverage applicable to each of these special enrollment provisions. Additional information regarding your rights to enroll in group health coverage is found in the applicable group health plan summary plan descriptions or insurance contract.



Important Notice From The Porthole Hospitality, LLC Hospitality, LLC 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 Porthole Hospitality, LLC 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. Porthole Hospitality, LLC has determined that the prescription drug coverage offered by the 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 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) 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 coverage through Porthole Hospitality, LLC may be affected. You can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop Porthole Hospitality, LLC medical plan with prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back at a later date.

Legal Notices (continued)



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 Porthole Hospitality, LLC 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 percent 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 percent 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 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**. You can call 24 hours a day, 7 days a week.

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: March 1, 2025

Contact: Stephanie Lanman

Name of Entity/Sender: The Porthole Hospitality, LLC Hospitality, LLC

Address: 20 Custom House Wharf, Portland, ME 04101

Phone Number: 617-833-7922

Legal Notices (continued)



Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility.

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

Legal Notices (continued)



GEORGIA – Medicaid	INDIANA – Medicaid
<p>GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2</p>	<p>Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584</p>
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
<p>Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562</p>	<p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660</p>
KENTUCKY – Medicaid	LOUISIANA – Medicaid
<p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms</p>	<p>Website: www.medicicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
<p>Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711</p>	<p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com</p>
MINNESOTA – Medicaid	MISSOURI – Medicaid
<p>Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739</p>	<p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>
MONTANA – Medicaid	NEBRASKA – Medicaid
<p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPPProgram@mt.gov</p>	<p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>

Legal Notices (continued)



NEVADA – Medicaid		NEW HAMPSHIRE – Medicaid	
Medicaid Website: http://dhcftp.nv.gov Medicaid Phone: 1-800-992-0900		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		NEW YORK – Medicaid	
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		Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	
NORTH CAROLINA – Medicaid		NORTH DAKOTA – Medicaid	
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100		Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	
OKLAHOMA – Medicaid and CHIP		OREGON – Medicaid	
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742		Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	
PENNSYLVANIA – Medicaid and CHIP		RHODE ISLAND – 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)		Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RItE Share Line)	
SOUTH CAROLINA – Medicaid		SOUTH DAKOTA - Medicaid	
Website: https://www.scdhhs.gov Phone: 1-888-549-0820		Website: http://dss.sd.gov Phone: 1-888-828-0059	
TEXAS – Medicaid		UTAH – Medicaid and CHIP	
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493		Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	
VERMONT– Medicaid		VIRGINIA – Medicaid and CHIP	
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427		Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select ; https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924	
WASHINGTON – Medicaid		WEST VIRGINIA – Medicaid and CHIP	
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022		Website: https://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		WYOMING – Medicaid	
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002		Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269	

Legal Notices (continued)



To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

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

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance, or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other healthcare provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a healthcare facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility can bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain states have enacted balance billing protections for patients receiving emergency services. For example, New Hampshire, Maine, Massachusetts, and Vermont all have laws protecting patients from balance billings. Specific laws related to balance billing are different in each state. If you have questions, check with your plan administrator or state insurance regulator.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

Legal Notices (continued)



If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

State law prohibitions against balance billing may also apply. Specific laws related to balance billing are different in each state. If you have questions, check with your plan administrator or state insurance regulator.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
 - Cover emergency services without requiring you to get approval for services in advance (also known as “prior authorization”).
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact your insurance carrier by calling the number on your insurance card. You may also contact the state insurance regulator or the No Surprises helpdesk at 1-800-985-3059.

Visit <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act> for more information about your rights under federal law.

Newborns' and Mothers' Health Protection Act of 1996

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

Employee Benefits and Remote Work

To the extent that The Porthole Hospitality LLC permits remote work, you must notify Human Resources of your remote work location and any changes to that location, *especially* if that location is in another state. Different states have specific requirements such as workers compensation, state and local taxes, and state paid family leave requirements. Failing to provide Human Resources with accurate information may result in state-imposed fines or other adverse consequences. Please contact Human Resources at 617-833-7922 with any questions or updates or to request a copy of the Remote Work Policy.

Legal Notices (continued)



Notice Regarding Health Insurance Marketplace Coverage Options

PART A: General Information

When key parts of the healthcare law took effect in 2014, there were new ways to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by your employer.

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. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins November 1, 2023 and ends December 15, 2023 for coverage starting as early as January 1, 2024.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax 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 meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 8.39% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution, as well as your employee contribution to employer-offered coverage, is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact HR at **617-833-7922**.

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

¹An employer-sponsored 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.

Legal Notices (continued)



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 Porthole Hospitality, LLC		4. Employer Identification Number (EIN) 46-1835331	
5. Employer address 20 Custom House Wharf		6. Employer phone number 207-833-7922	
7. City Portland	8. State ME	9. ZIP code 04101	
10. Who can we contact about employee health coverage at this job?			
11. Phone number (if different from above)		12. Email address SLanman@UPMGT.org	

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

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

All employees. Eligible employees are:

Employees working 30 hours per week or more

Some employees. Eligible employees are:

- With respect to dependents:

We do offer coverage. Eligible dependents are:

Employees, Spouses, Domestic Partners, and children

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](https://www.healthcare.gov) will guide you through the process.

Contacts



Plan Type	Carrier Name	Website	Phone Number
Medical	Anthem	www.anthem.com	800-482-0966
Dental	Ameritas	www.ameritas.com	800-300-9566
Vision	Ameritas	www.ameritas.com	800-300-9566

Benefits Brought to You by:



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