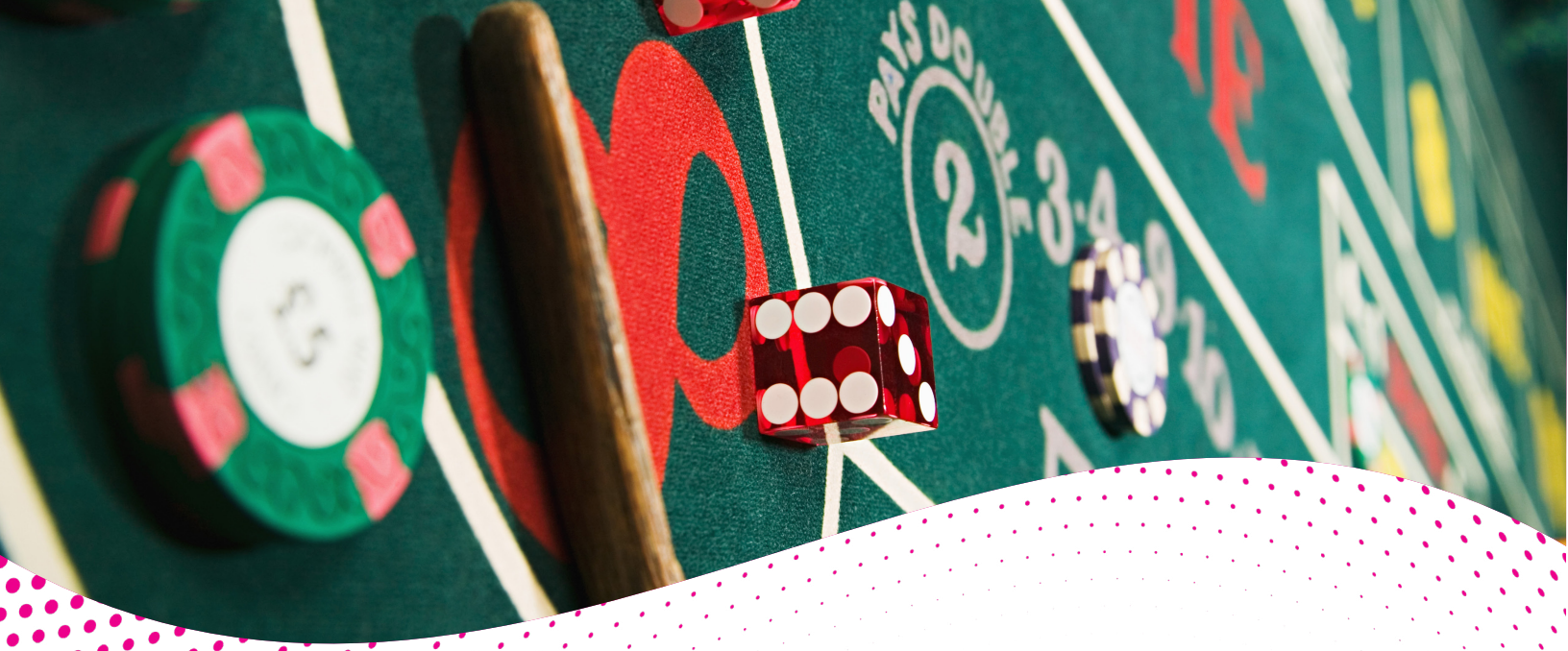
Hialeah Park® CASINO

YOUR 2025

EMPLOYEE BENEFITS GUIDE



WELCOME TO HIALEAH PARK CASINO

Hialeah Park recognizes how important benefits are to you. That's why we're committed to helping you and your family enjoy the best possible physical, financial, and emotional well-being. It's also why we provide you with a comprehensive, highly competitive benefits package, with the flexibility to make the choices that best meet your needs.

Use this guide to better understand the benefits offered by Hialeah Park, then be sure to enroll during your enrollment period, so that you receive the benefits you want for 2025.

INSIDE THIS GUIDE

ELIGIBILITY & ENROLLMENT

Who Is Eligible For Benefits?

If you're a full-time employee at Hialeah Park, you're eligible to enroll in the benefits outlined in this guide. Please contact HR to inquire about your eligibility. In addition, the following family members qualify as eligible dependents:

- Your lawful spouse (proper documentation required if last name is different)
- Dependent Child(ren) are defined as:
  - » Child(ren) up to the age 25, who live with their parent or are a student
  - » Child(ren) up to 30 years old, who are also unmarried and have no dependent child of their own

When Can I Enroll?

A newly hired employee will be allowed to choose benefit plans bases on their eligibility date. If you do not enroll within that time period, you will not have benefits coverage. After your enrollment opportunity ends, you will not be able to make changes to your benefits until the next Open Enrollment period, unless you experience a Qualifying Life Event.

Qualifying Life Events

Unless you experience a Qualifying Life Event, you cannot make changes to your benefits until the next Open Enrollment period. Qualifying Life Events include:

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

MEDICAL BENEFITS
Meritain

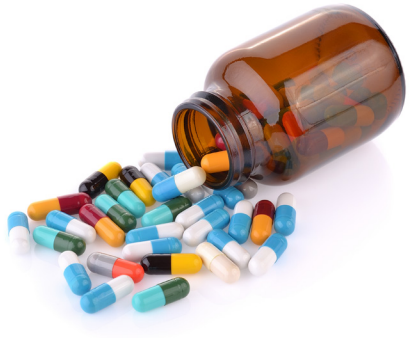
Hialeah Park offers the following medical plan administered by Meritain.
For additional information, please go to **www.meritain.com**

	HIGH PLAN	MEDIUM PLAN	HSA PLAN
IN-NETWORK BENEFITS			
HSA Funding (Individual/Family	N/A	N/A	$1,000 / $2,000
Deductible (Individual/Family)	$1,000 / $2,000	$2,500 / $5,000	$5,000 / $10,000
Out-of-Pocket Maximum (Individual/Family)	$2,000 / $4,000	$5,000 / $10,000	$6,750 / $13,500
Coinsurance	Plan pays 100%	Plan pays 80%	Plan pays 80%
Preventive Care Services	Plan pays 100%	Plan pays 100%	Plan pays 100%
PCP Office Visit	$25 copay	$30 copay	Plan pays 80%*
Specialist Office Visit	$50 copay	$60 copay	Plan pays 80%*
Diagnostic Laboratory	Plan pays 100%*	Plan pays 80%*	Plan pays 80%*
Diagnostic X-Ray/Imaging (MRI, CT-Scan)	Plan pays 100%*	Plan pays 80%*	Plan pays 80%*
Emergency Room	$250 copay, waived if admitted	$250 copay, waived if admitted	Plan pays 80%*
Urgent Care Center	$50 copay	$60 copay	Plan pays 80%*
Inpatient Hospital	Plan pays 100%*	Plan pays 80%*	Plan pays 80%*
Outpatient Surgery	Plan pays 100%*	Plan pays 80%*	Plan pays 80%*
OUT-OF-NETWORK BENEFITS			
Deductible (Individual/Family)	$10,000 / $20,000	$10,000 / $20,000	$10,000 / $20,000
Out-of-Pocket Maximum (Individual/Family)	$20,000 / $40,000	$20,000 / $40,000	$20,000 / $40,000
Coinsurance	Plan pays 50%	Plan pays 50%	Plan pays 50%
Preventive Care Services	Plan pays 50%*	Plan pays 50%*	Plan pays 50%*

* After deductible

PRESCRIPTION BENEFITS

SmithRx



If you are enrolled in one of the medical plans, you are automatically enrolled in the corresponding prescription drug plan.

	HIGH & MEDIUM PLAN		HSA PLAN	
PRESCRIPTION DRUG BENEFITS	RETAIL (Up to a 30-day supply)	MAIL ORDER (Up to a 90-day supply)	RETAIL (Up to a 30-day supply)	MAIL ORDER (Up to a 90-day supply)
Generic	$10	$25	Plan pays 80%*	Plan pays 80%*
Preferred Brand	$50	$125	Plan pays 80%*	Plan pays 80%*
Non-Preferred Brand	$125	$312.50	Plan pays 80%*	Plan pays 80%*

* After medical deductible

PRESCRIPTION BENEFITS
SmithRx

Save on Your Prescriptions with Mail-Order

Whether you are enrolled in the High, Medium, or HSA Plan, you can save money when you use Amazon Pharmacy Home Delivery for your maintenance medications. If enrolled in the High or Medium plan, you can fill a 90 day supply (3 months) for two and half retail copays through Amazon Pharmacy Home Delivery.

If enrolled in the HSA plan, the discounted rate you pay (which goes towards your deductible) is lower when filing your prescription through Amazon Pharmacy Home Delivery.

Compare for yourself:

	Retail Pharmacy	Mail Order	Annual Savings
Formulary Copay	$50	$125	$100 per script
Annual Cost	($50 per month x 12 fills) $600	($125 per order x 4 fills per year) $500	

In addition to the savings, your prescriptions will be delivered right to your home. Here is how you can begin to use the Amazon Pharmacy Home Delivery:

- Visit **www.amazon.com/smithrx** and click on "**Get Started**" If you do not have an Amazon account you will need to sign up for one. During the process you will be prompted to verify your insurance member ID. Please have your card ready to double check all information.
- To transfer a current prescription, Amazon Pharmacy just needs the name of your medication and current pharmacy. They will handle the rest to ensure the prescription is on file and is ready for ordering.
- For new prescriptions, ask your doctor to send your prescription electronically to Amazon Pharmacy Home Delivery or fax a prescription request to **512-884-5981**.

Save with Generic Drugs

Generic Drugs: Safe. Effective. FDA-Approved.
Generic drugs are reviewed and approved by the U.S. Food and Drug Administration (FDA), just as brand drugs are. According to the FDA, compared to its brand counterpart, a generic drug:

- is chemically the same
- works the same in the body
- is as safe and effective
- meets the same standards set by the FDA

The major difference is that the generic drugs often cost much less.

GoodRx

Compare Prescription Drug Prices and Save!
GoodRx is a valuable resource that allows you to compare prescription drug prices at local and mail-order pharmacies and discover free coupons and savings tips.

Learn more about GoodRx and start saving on your prescriptions today by visiting **connerstrong.goodrx.com**.

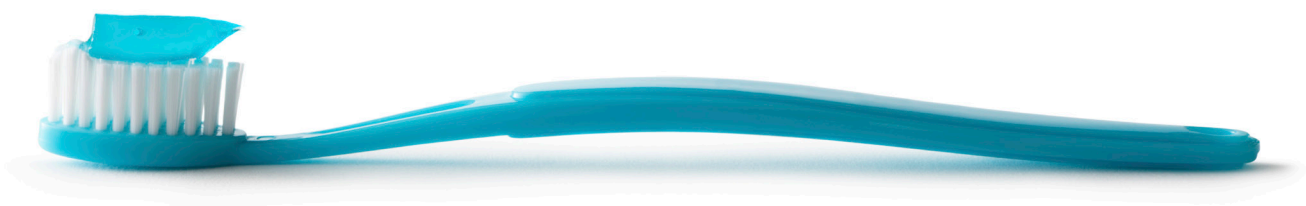
DENTAL BENEFITS
MetLife

Healthy teeth and gums are important to your overall wellness. That's why it's important to have regular dental checkups and maintain good oral hygiene. You have three dental plans to choose from for 2025. You can elect to receive dental coverage even if you are waiving Hialeah Park's medical coverage. Learn about the dental plans available to help you maintain your oral health.

Hialeah Park offers the following dental plan options administered by MetLife. To locate participating providers, visit **www.metlife.com/dental** and use the provider search tool.

	DPPO HIGH PLAN		DPPO LOW PLAN		DHMO PLAN
DENTAL BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**
Calendar Year Deductible	$50 / $150	$50 / $150	$50 / $150	$50 / $150	N/A
Calendar Year Maximum (per patient)	$5,000	$5,000	$1,500	$1,500	N/A
Preventive & Diagnostic Services • Exams, Cleanings, Bitewing X-rays (Each twice in a calendar year) • Fluoride Treatment (Once in a calendar year, children to age 16)	Plan pays 100%	Plan pays 80%	Plan pays 100%	Plan pays 80%	Plan pays 100%
Basic Services Fillings & Extractions Endodontics (root canal) Peridontics & Oral Surgery Sealants	Plan pays 80%*	Plan pays 60%*	Plan pays 80%*	Plan pays 60%*	Refer to Schedule of Benefits
Major Services Crowns & Gold Restorations Bridgework Full & Partial Dentures	Plan pays 50%*	Plan pays 50%*	Plan pays 50%*	Plan pays 50%*	Refer to Schedule of Benefits
Orthodontia Benefits	Plan pays 50%	Plan pays 50%	Plan pays 50%	Plan pays 50%	Refer to Schedule of Benefits
Orthodontia Lifetime Maximum (per patient)	$1,500	$1,500	$1,000	$1,000	Refer to Schedule of Benefits

* After deductible

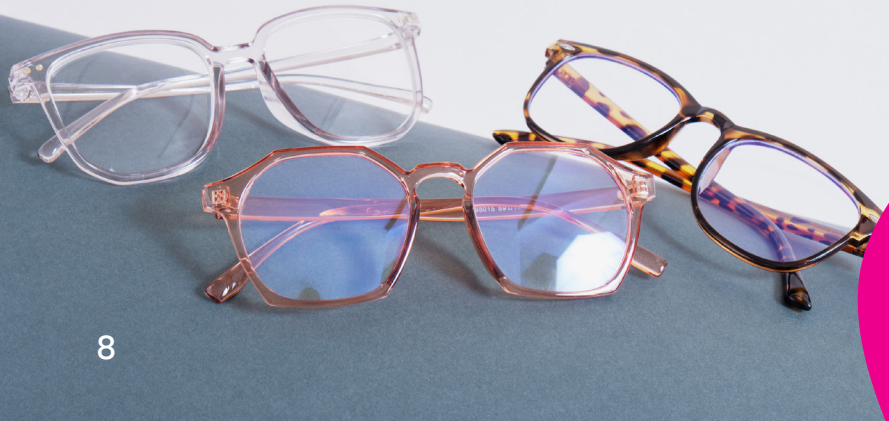


VISION BENEFITS
EyeMed

Having vision coverage allows you to save money on eligible eye care expenses, such as periodic eye exams, eyeglasses, contact lenses, and more for yourself and your covered dependents. **Vision is a separate election**. You can elect to receive vision coverage even if you are waiving Hialeah Park's medical coverage.

Our vision plan is administered by EyeMed and provides coverage for a range of vision care including exams, frames, lenses and contact lenses.

	VISION PLAN	
VISION BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK REIMBURSEMENT**
Exam	$10 copay	Up to $40
Frames	$130 retail allowance; 20% off balance	Up to $65
Lenses		
Single Lenses	$10 copay	Up to $30
Bifocal Lenses	$10 copay	Up to $50
Trifocal Lenses	$10 copay	Up to $70
Lenticular Lenses	$10 copay	Up to $70
Contact Lenses		
In lieu of frames	$130 allowance	Up to $65
Medically Necessary	Covered 100%	Up to $300
Frequency		
Vision Exam	Once every 12 months	Once every 12 months
Lenses	Once every 12 months	Once every 12 months
Frames	Once every 12 months	Once every 12 months



EyeMed Online Resources

Be sure to register online at www.eyemed.com to find a provider, check your claim status, print your member ID card, and review your benefit details. Once registered all resources are also available on the EyeMed Members App.

HEALTH SAVINGS ACCOUNT

HealthEquity

The Health Savings Account (HSA) is available to eligible employees enrolled in the HSA medical plan. The funds in your HSA can be used to offset your out-of-pocket healthcare expenses. Unused account dollars are yours to keep even if you leave Hialeah Park. HSAs are known for their triple tax advantage – contributions are made pre-tax, growth is tax-free and withdraws used for qualified healthcare expenses are also untaxed. A debit card will be provided to pay for eligible expenses.

HSA Contributions

Hialeah Park will contribute to your HSA when you enroll, up to the annual amounts below:

- Single: $1,000
- Family: $2,000

You may also contribute to your HSA on a pre-tax basis via payroll deductions. The maximum amount in 2025 that can be contributed to your HSA (including firm contributions) is set by the IRS at the below amounts:

- Single: $4,150
- Family: $8,300
- The annual catch-up contribution for age 55 and older is $1,000

HSA Eligibility

In order to qualify for an HSA, you must be an adult who meets the following qualifications:

- You have coverage under an HSA-qualified, high deductible health plan (HDHP)
- Do not have disqualifying coverage such as other "first dollar" medical coverage
- Are not enrolled in Medicare
- You cannot be claimed as a dependent on some else's tax return

HSA Eligible Expenses

- Medical and prescription drug deductibles, coinsurance and copayments
- Dental deductibles, coinsurance and copayments
- Orthodontia or other dental care
- Eye exams, contact lenses and glasses

The IRS determines which expenses qualify for reimbursement from an HSA. A full list of eligible expenses can be found at **www.irs.gov/publications/p502**

To register or login to your account please visit www.healthequity.com

LIFE AND AD&D INSURANCE

New York Life

Employee Basic Life/AD&D

The company provides you with basic life and accidental death and dismemberment (AD&D) insurance through New York Life so that you can protect those you love from the unexpected. This coverage comes at no cost to eligible employees.

Voluntary Life/AD&D

If you want added protection, you can purchase voluntary life and AD&D insurance through New York Life for yourself, your spouse, and your children. You pay the full cost through payroll deductions. Premiums are based on age and amount of coverage and are available upon request from Human Resources.

BASIC TERM LIFE AND AD&D INSURANCE	
Benefit Amount	2x annual earnings up to $400,000

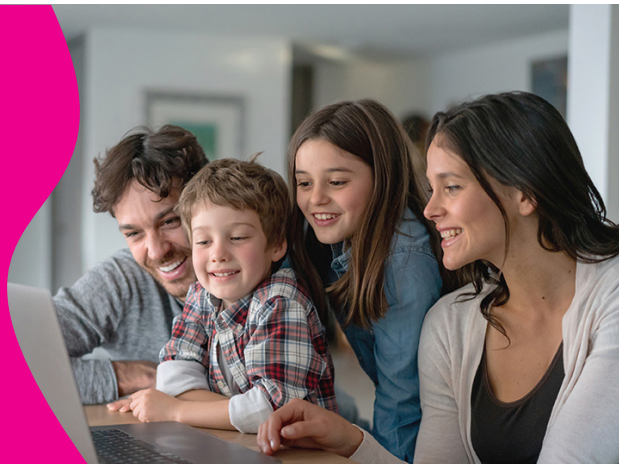
VOLUNTARY EMPLOYEE TERM LIFE PLAN	
Benefit Increments	Increments of $10,000
Maximum Amount	Lesser of $500,000 or 5x annual earnings
Guaranteed Issue	$150,000

VOLUNTARY SPOUSAL TERM LIFE PLAN	
Benefit Increments	Increments of $5,000
Maximum Amount	$250,000 (Cannot exceed 50% of employee amount)
Guaranteed Issue	$30,000

VOLUNTARY CHILDREN TERM LIFE PLAN	
Benefit Increments 14 days to age 19 years old (or 26 if full time student)	Increments of $1,000 to a maximum of $10,000
Guaranteed Issue	$10,000

Evidence of Insurability (EOI) requirement:

All employees/spouses can elect up to 4 units (1 unit is $10,000 for employees and $5,000 for spouses) of coverage with no EOI, up to the guaranteed issue amount, at annual open enrollment. This is for all eligible employees, not just for those who currently have coverage.



DISABILITY INSURANCE

New York Life

Short-Term Disability

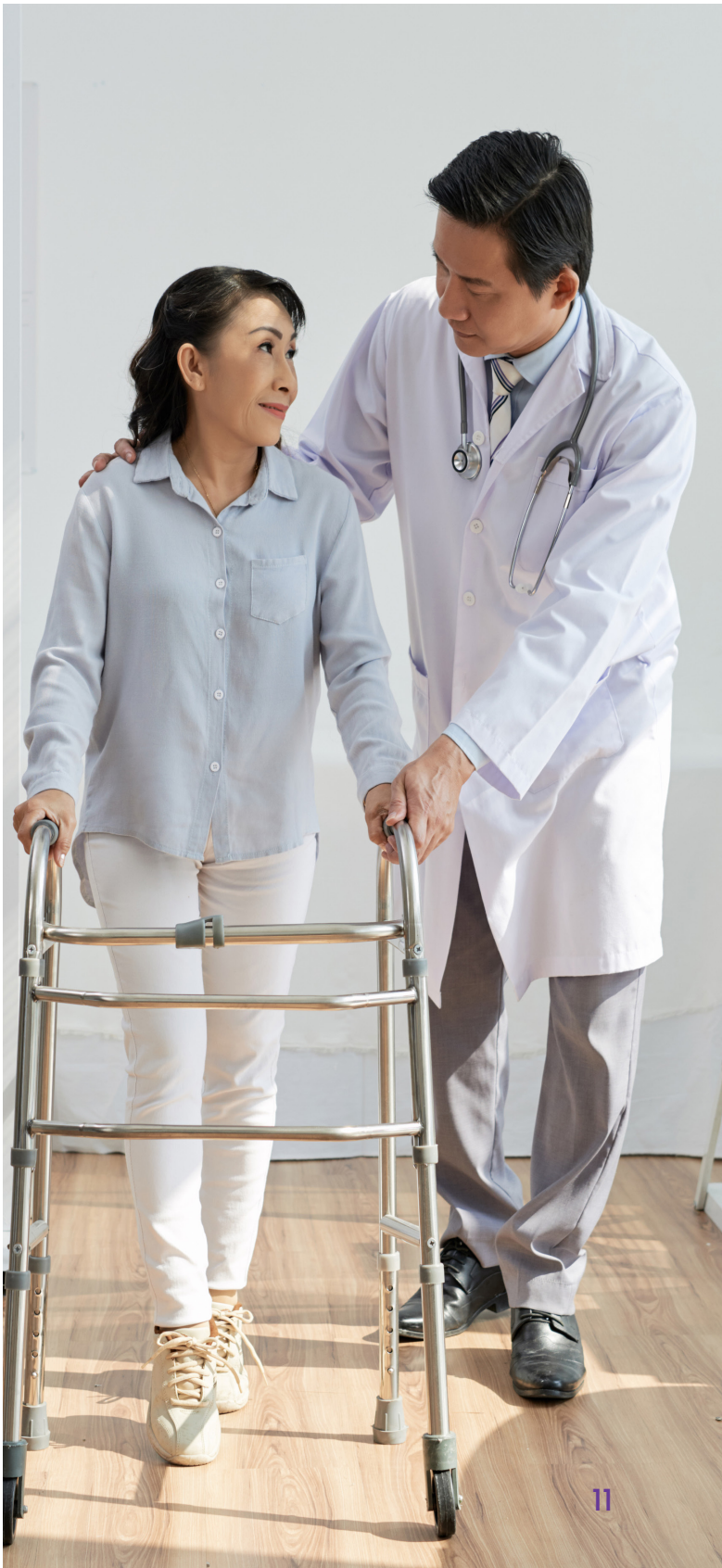
Short-Term Disability (STD) is a type of disability insurance coverage that can help you remain financially stable should you become injured or ill and cannot work. All full-time employees working at least 30+ hours per week are eligible for this benefit, which is 80% employer paid.

SHORT-TERM DISABILITY (STD) PLAN	
Benefits Percent	60% of covered weekly earnings
Benefit Maximum	$1,000 per week
Benefit Duration	11 weeks
Elimination Period—Accident or Sickness	14 days

Long-Term Disability

Long-Term Disability (LTD) provides you with income continuation in the event your illness or injury lasts beyond 90 days. This helps ensure you have a continued income if you are unable to work due to a covered sickness or injury. All full-time employees working at least 30+ hours per week are eligible for this benefit, which is 100% employee paid. Below are the benefit highlights.

LONG-TERM DISABILITY (LTD) PLAN	
Percentage of Income Replaced	60% of covered monthly earnings
Maximum Benefit	$10,000 per month
Elimination Period	90 days
Benefit Duration	Social Security Normal Retirement Age



EMPLOYEE ASSISTANCE & WELLNESS SUPPORT

New York Life

Just when you think you've got it figured out, along comes a challenge. Whether your needs are big or small, New York Life can support you with their Employee Assistance & Wellness Support program. The program provides a suite of well-being resources designed to provide support and guidance through life's challenges. Suite of value-add resources includes:

Employee Assistance Program

Are you feeling overwhelmed by the demands of balancing work and family life? Maybe you have questions about legal or financial concerns? You and your family members now have access to various counseling services including legal, financial, and work-life balance assistance. All counseling calls are answered by a Master's or PhD-level counselor who will collect some general information and discuss your needs. The Employee Assistance Program provides a maximum of three sessions, per issue, per year.

Guidance Resources

When you need information quickly to help handle life's challenges, you can visit **guidanceresources.com** for resources and tools on topics such as health and wellness, legal regulations, family and relationships, work and education, money and investments, moving services and resources, and home and auto insurance. You will also have access to articles, podcast, videos, slideshows, on-demand trainings and "Ask the Expert" which provides personal responses to your questions.

Well-being Coaching

Sometimes you may need help with personal challenges and physical issues that can be overwhelming. To help you achieve your goals, you will have access to a certified coach who will work with you, one-on-one, to address health and well-being issues such as burnout, weight loss, time management, and coping with stress. You have access to five sessions per year. All session are conducted telephonically.

You can access the Employee Assistance & Wellness Support by:

- **Calling 800-344-9752**
- **Visit guidanceresources.com**
  Web ID: NYLGBS

All sessions are free and 100% confidential

VOLUNTARY BENEFITS
Colonial Life

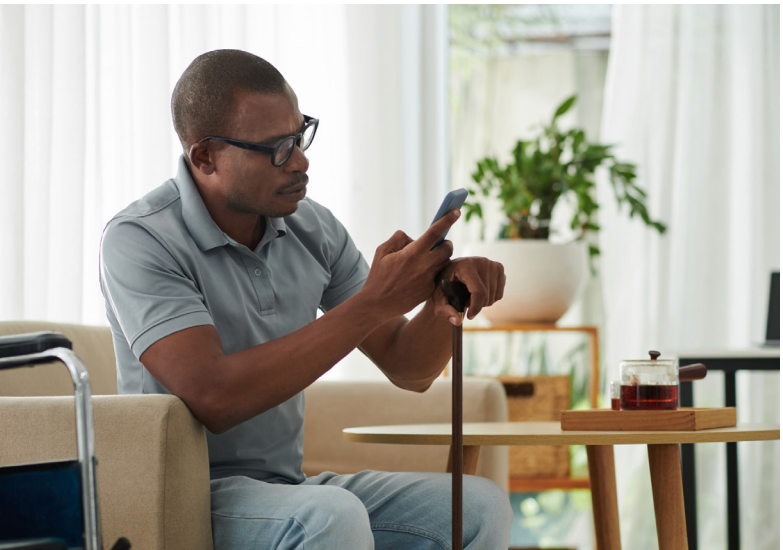
NOTE: These benefits are 100% employee paid.

Critical Illness

We know that everyone has different needs when coping with a critical illness. With Critical Illness insurance, you get a benefit paid directly to the covered person, unless otherwise assigned, if they are diagnosed with a covered critical illness like cancer, heart attack, or stroke.

This plan can help ease some of your financial worries so you can stay focused on your health. You can choose how to spend or save your benefit. It can be used for expenses such as:

- Paying for child care or help around the house
- Travel costs to see a specialist
- Medical treatment and doctors visits
- Copays and deductibles
- Prescription drug costs



Accident Insurance

Accidents happen and they can affect your financial health. With Accident Insurance, you get a benefit to help pay for costs associated with a covered accident or injury. You can use the money however, you'd like.

Accident Insurance covers:

- Initial and emergency care
- Hospitalization
- Fractures and dislocations
- Follow-up care

Hospital Indemnity Insurance

A hospital stay can happen at any time, and it can be costly. Hospital Indemnity insurance helps you and your loved ones have additional financial protection. With hospital indemnity insurance, a benefit is paid directly to the covered person, unless otherwise assigned, after a covered hospitalization resulting from a covered injury or illness. It can be used for expenses such as:

- Copays, deductibles, and coinsurance
- Unexpected costs
- Childcare
- Follow-up services
- Help for the home

VALUE-ADDED SERVICES

Conner Strong & Buckelew

BenefitPerks Rewards Program

With CSB Benefit Perks, members gain access to premium discounts on valuable services and items. CSB Benefit Perks is a discount and rewards program provided by Conner Strong & Buckelew (CSB) that is available to all employees at no additional cost. The program allows employees to receive discounts and cash back for hand-selected shopping online at major retailers.

Use the Benefit Perks website to browse through categories such as:
Automotive, Beauty, Computer & Electronics, Gifts & Flowers, Health & Wellness and much more!

Employees can also print coupons to present at local retailers and merchants for in-person savings, including movie theatres and other services. Start saving today by registering online at **connerstrong.corestream.com**

Husk Marketplace

Achieving optimal health and wellness doesn't have to be complicated or expensive. Access exclusive best-in-class pricing with some of the biggest brands in fitness, nutrition, and wellness with HUSK Marketplace.

Gyms & Fitness Centers
HUSK Marketplace members can access exclusive savings and flexible membership options to a variety of facilities. From national chains to specialty studios, HUSK has something for every workout.

HUSK Nutrition
HUSK Nutrition provides evidence-based virtual health and nutrition programs. You will meet with a Registered Dietician who will implement a complete 1-on-1 nutrition program specifically designed to answer your nutrition related questions, meet your health goals, individual needs, and busy lifestyle.

You have access to additional benefits through HUSK including:

- Discounts on home equipment & tech
- On-demand fitness classes
- Mental health support resources

Learn more at:
marketplace.huskwellness.com

VALUE-ADDED SERVICES
Conner Strong & Buckelew

HealthyLearn

HealthyLearn covers over a thousand health and wellness topics in a simple, straightforward manner. The data and information is laid out in an easy-to-follow format. HealthyLearn includes the following interactive features and services:

- Ask the Coach
- Rotating Health Tip-of-the-Day
- Symptom Checker
- A to Z Encyclopedia
- Health News
- Medical Self-Care Guides for Adults, Children, Adolescents and Seniors
- Women and Men Guides
- Pain Management Guide
- Mental Health Guide
- Home Safety Guide
- Wellness and Disease Management
- Tobacco Cessation
- Stress Management
- Nutrition and Weight Loss
- Health Trackers
- Monthly Wellness Newsletter

Download the HealthyLife Mobile App:

- **Search your app store for "healthylife mobile"**
- **Download and open the app**
- **Enter the Conner Strong & Buckelew special access code: CSB**

PLEASE NOTE: You must use the special access code above each time you open the app.

Learn more and get started on your path to wellness today by visiting HealthyLearn at www.healthylearn.com/connerstrong

BENEFITS MEMBER ADVOCACY CENTER
Conner Strong & Buckelew

Do you need help resolving a benefit issue?

The Benefits Member Advocacy Center (Benefits MAC), provided by Conner Strong & Buckelew, allows you to speak to a specially trained Member Advocate who can help you get the most out of your benefits.

You Can Contact Member Advocacy For Assistance If You:

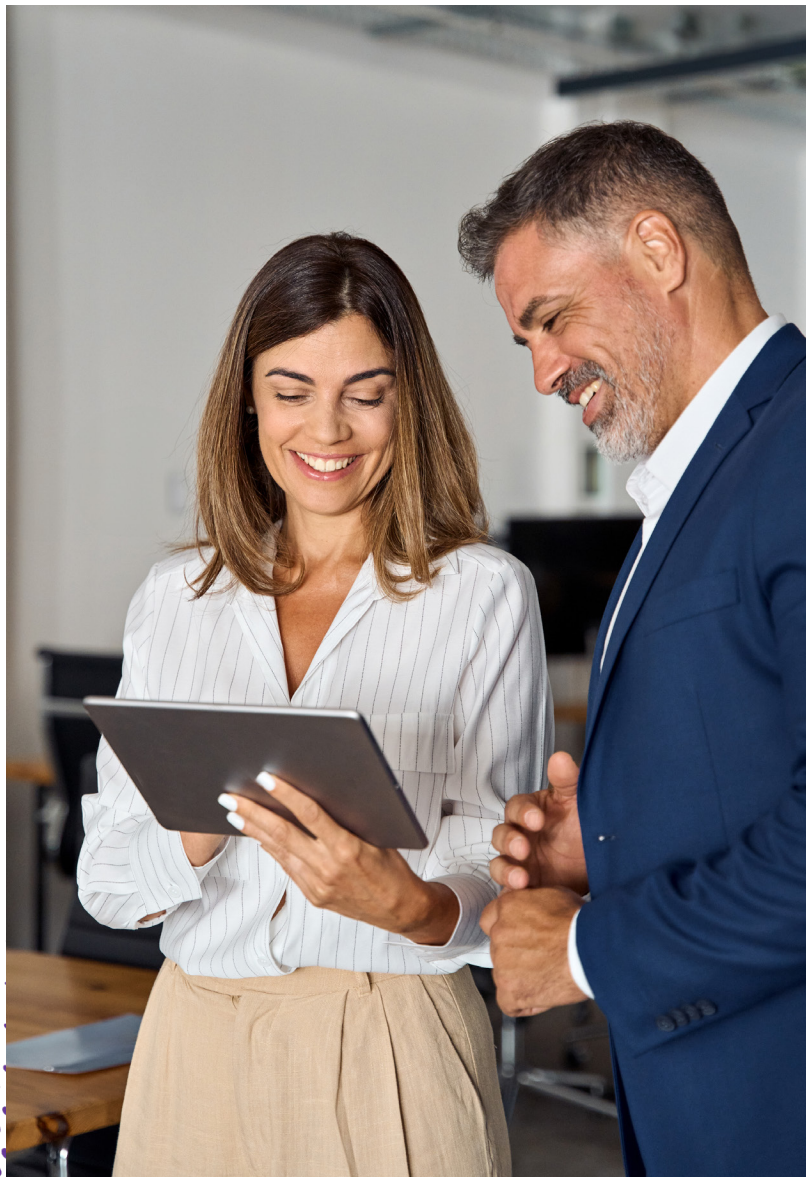
- Believe your claim was not paid properly
- Need clarification on information from the insurance company
- Have a question regarding a medical bill
- Are unclear on how your benefits work
- Need information about adding or removing a dependent
- Need help resolving a benefits problem you've been working on

Member Advocates are available Monday through Friday, 8:30am to 5:00pm (Eastern Time). After hours, you will be able to leave a message with a live representative and receive a response by phone or email during business hours within 24 to 48 hours of your inquiry.

Contact the Benefits MAC

You may contact the Benefits Member Advocacy Center in any of the following ways:

- Via phone: **800.563.9929**, Monday through Friday, 8:30 am to 5:00 pm (Eastern Time)
- Via the web: **connerstrong.com/memberadvocacy**
- Via email: **cssteam@connerstrong.com**
- Via fax: **856.685.2253**



EMPLOYEE CONTRIBUTIONS

Bi-Weekly Cost

MEDICAL HIGH PLAN

Tier	Less than 2 years of service	2-3 years of service	3+ years of service
Employee Only	$145.84	$109.38	$72.92
Employee + Spouse	$320.86	$240.64	$160.43
Employee + Child(ren)	$262.52	$196.89	$131.26
Family	$437.53	$328.15	$218.77

MEDICAL MEDIUM PLAN

Tier	Less than 2 years of service	2-3 years of service	3+ years of service
Employee Only	$137.40	$103.05	$68.70
Employee + Spouse	$302.28	$226.71	$151.14
Employee + Child(ren)	$247.32	$185.49	$123.66
Family	$412.20	$309.15	$206.10

MEDICAL HSA PLAN

Tier	Less than 2 years of service	2-3 years of service	3+ years of service
Employee Only	$124.55	$93.41	$62.27
Employee + Spouse	$274.01	$205.50	$137.00
Employee + Child(ren)	$224.19	$168.14	$112.09
Family	$373.64	$280.23	$186.82

DENTAL PLAN

Tier	DPPO High Plan	DPPO Low Plan	DHMO Plan
Employee Only	$19.26	$17.91	$5.92
Employee + Spouse	$42.61	$40.49	$10.36
Employee + Child(ren)	$39.37	$37.40	$12.43
Family	$64.35	$61.14	$17.46

VISION PLAN

Tier	Vision Plan
Employee Only	$3.52
Employee + Spouse	$6.15
Employee + Child(ren)	$7.63
Family	$9.67

CARRIER CONTACTS

COVERAGE TYPE	CARRIER NAME	CUSTOMER SERVICE PHONE	WEBSITE
Medical	Meritain	800-925-2272	www.meritain.com
Rx	SmithRx	844-454-5201	www.smithrx.com/portal
HSA	HealthEquity	866-346-5800	www.healthequity.com
Dental	MetLife	1-800-942-0854	www.metlife.com/dental
Vision	EyeMed	1-866-939-3633	www.eyemed.com
Life and Disability	New York Life	1-888-842-4462	www.newyorklife.com
Employee Assistance & Wellness Support	New York Life	800-344-9752	www.guidanceresources.com
Accident, Critical Illness, Hospital Indemnity	Colonial Life	1-800-325-4368	www.coloniallife.com
Benefits MAC	Conner Strong & Buckelew	800-563-9929	www.connerstrong.com/member-advocacy

LEGAL NOTICES

Availability of Summary Health Information

As an employee, the health and benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options. Please contact Human Resources if you have any questions or did not receive your SBC.

Eligibility

An eligible employee with respect to the programs described in this Guide is any individual who is designated as eligible to participate in and receive benefits under one or more of the component benefit programs described herein. The eligibility and participation requirements may vary depending on the particular component program. You must satisfy the eligibility requirements under a particular component benefit program in order to receive benefits under that program. Certain individuals related to you, such as a spouse or your dependents, may be eligible for coverage under certain component benefit programs. To determine whether you or your family members are eligible to participate in a component benefit program, please read the eligibility information contained in the Plan Document for the applicable component benefit programs.

Disclaimer Notice

This Guide is intended to provide you with the information you need to choose your 2025 benefits, including details about your benefits options and the actions you need to take during this [year's Annual] Enrollment period. It also outlines additional sources of information to help you make your enrollment choices. If you have questions about your 2025 benefits or the enrollment process, contact Human Resources. The information presented in this Guide is not intended to be construed to create a contract between Hialeah Park and any one of Hialeah Park's employees or former employees. In the event that the content of this Guide or any oral representations made by any person regarding the plan conflict with or are inconsistent with the provisions of the plan document, the provisions of the plan document are controlling. Hialeah Park reserves the right to amend, modify, suspend, replace or terminate any of its plans, policies or programs, in whole or in part, including any level or form of coverage by appropriate company action, without your consent or concurrence.

Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the plan or issuer may pay for a shorter stay if the attending physician (e.g., your physician, nurse, [or midwife], or a physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and insurers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

Women's Health and 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 benefits. If you have any questions, please speak with Human Resources.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services. If you leave your job to perform military service, you have the right to elect to continue your existing employer based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries. For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website at http:// www.dol.gov/vets.

Notice Regarding Special Enrollment

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 (including COBRA 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 Company stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment. When the loss of other coverage is COBRA coverage, then the entire COBRA period must be exhausted in order for the individual to have another special enrollment right under the Plan. Generally, exhaustion means that COBRA coverage ends for a reason other than the failure to pay COBRA premiums or for cause (that is, submission of a fraudulent claim). This means that the entire 18-, 29-, or 36-month COBRA period usually must be completed in order to trigger a special enrollment for loss of 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 (CHIP). If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment. 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 30 days after the marriage, birth, adoption, or placement for adoption. If you request a change within the applicable timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For a new dependent as a result of marriage, coverage will be effective the first of the month following your request for enrollment.

Eligibility for 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 (CHIP) with

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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. If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment.

To request special enrollment or obtain more information, contact Human Resources.

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, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA - MEDICAID
Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO - Health First Colorado
(Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/
flmedicaidtplrecovery.com/hipp/ index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-paymentprogram-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/ childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

INDIANA – Medicaid
Health Insurance Premium Payment Program
All other Medicaid Website: https://www.in.gov/medicaid/
http://www.in.gov/fss/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
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

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: www.mymaineconnection.gob/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: 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/health-care-coverage/
Phone: 1-800-657-3672

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 1-573-751-2005

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: 855-632-7633
Lincoln: 402-473-7000
Omaha: 402-495-1178

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-insurancepremium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

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NEW JERSEY – Medicaid and CHIP Medicaid
Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/
Phone: 800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurancepremium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: https://www.pa.gov/en/agencies/dhs/resources/chip.html
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-premiumpayment-hipp-program
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP)
Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

VERMONT- Medicaid
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-562-3022

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-premiumpayment-hipp-programs
Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP
Website: http://mywvhipp.com/ and https://dhhr.wv.gov/bms/
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: 800-251-1269

To see if any other states have added a premium assistance program since July 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

Important Notice from Hialeah Park 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 Hialeah Park 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. Hialeah Park Center has determined that the prescription drug coverage offered by Cigna 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 Hialeah Park coverage will not be affected.

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 Hialeah Park 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

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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 Human Resources 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 Hialeah Park 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).

Notice of Privacy Practices

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

This Notice of Privacy Practices (the "Notice") describes the legal obligations of Hialeah Park group health plan (the "Plan") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law. We are required to provide this Notice of Privacy Practices to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan that relates to:

1. Your past, present or future physical or mental health or condition;
2. The provision of health care to you; or
3. The past, present or future payment for the provision of health care to you."

If you have any questions about this Notice or about our privacy practices, please contact Human Resources.

This Notice is effective January 1, 2025

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices by mail.

How We May Use and Disclose Your Protected Health Information.
Under the law, we may use or dis-close your protected health information under certain circumstances without your permission. The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use or disclose your protected health information to facilitate medical treatment or ser-vices by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if prior prescriptions contraindicate a pending prescription.

For Payment. We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and ser-vices you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations. We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. If the Plan uses or discloses protected health information for underwriting purposes, including determining eligibility for benefits or premium, the Plan will not use or disclose protected health information that is genetic information for such purposes, as prohibited by the Genetic Information Nondiscrimination Act of 2008 (GINA) and any regulations thereunder.

To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate contract with us.

As Required by Law. We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be

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to someone able to help prevent the threat. For example, we may dis-close your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors. For the purpose of administering the plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations. In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation. If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and trans-plantation.

Military and Veterans. If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government pro-grams, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may disclose your protected health information if asked to do so by a law enforcement official—

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct; and
- about criminal conduct.

Coroners, Medical Examiners and Funeral Directors. We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors, as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correction-al institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research. We may disclose your protected health information to researchers when:

1. the individual identifiers have been removed; or
2. when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits. We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You. When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when request-ed, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Other Disclosures of Your Medical Information Require Your Authorization Written Authorization. Your medical information will not be used or disclosed for any purpose not mentioned above in the "How We May Use and Disclose Your Protected Health Information" section except as permitted by law or as authorized by you. This includes disclosures to personal representatives and spouses and other family members as described below. In the event that the Plan needs to use or disclose medical information about you for a reason other than what is listed in this notice or required by law, we will request your permission to use your medical information and the medical information will only be used as specified in your authorization. You may complete an Authorization form if you want the Plan to disclose medical information about you to someone else.

Any authorization you provide will be limited to the specific information identified by you and you will be required to specify the intended use or disclosure and name then person or organization that is permitted to use or receive the information specified in the authorization form. You have the right to revoke a previous authorization. Requests to revoke an authorization must be in writing. The Plan will honor your request of revocation for the prospective period of time after the Plan has received your request. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. In addition, the Plan will not sell your medical information or use it for marketing purposes (that are not considered as part of treatment or healthcare operations) without a signed authorization from you. Also, if applicably, the Plan will not disclose psychotherapy notes without a signed authorization from you.

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Personal Representatives. We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

1. you have been, or may be, subjected to domestic violence, abuse or neglect by such person; or
2. treating such person as your personal representative could endanger you; and
3. in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

Right to Request Restrictions. You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we dis-close to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had. Except as provided in the next paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

We will comply with any restriction request if: (1) except as otherwise required by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item

or service for which the health care provider involved has been paid out-of-pocket in full.

To request restrictions, you must make your request in writing to Human Resources. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to Human Re-sources. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information. You will receive a notification to your last know address within 60 days of the discovery. The notification will include:

- specific information about the breach including a brief description of what happened
- a description of the types of unsecured medical information involved in the breach
- any steps you should take to protect yourself from potential harm resulting from the breach
- a brief description of the investigation the Plan is performing to mitigate the harm to you and protect you from future breaches
- a contact information where you may direct addition-al questions or get more information about the breach.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact Human Resources.

Complaints. If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact Human Resources. All complaints must be submitted in writing.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.

Continuation of Coverage Rights Under COBRA

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than his or her gross

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse

LEGAL NOTICES

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

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

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The death of the employee;
- The end of employment or reduction of hours of employment; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both)

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Hialeah Park Human Resources

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage. If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage. If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

INSURANCE MARKETPLACE NOTICE

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.

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

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/gettingmedicaid-chip/ for more details.

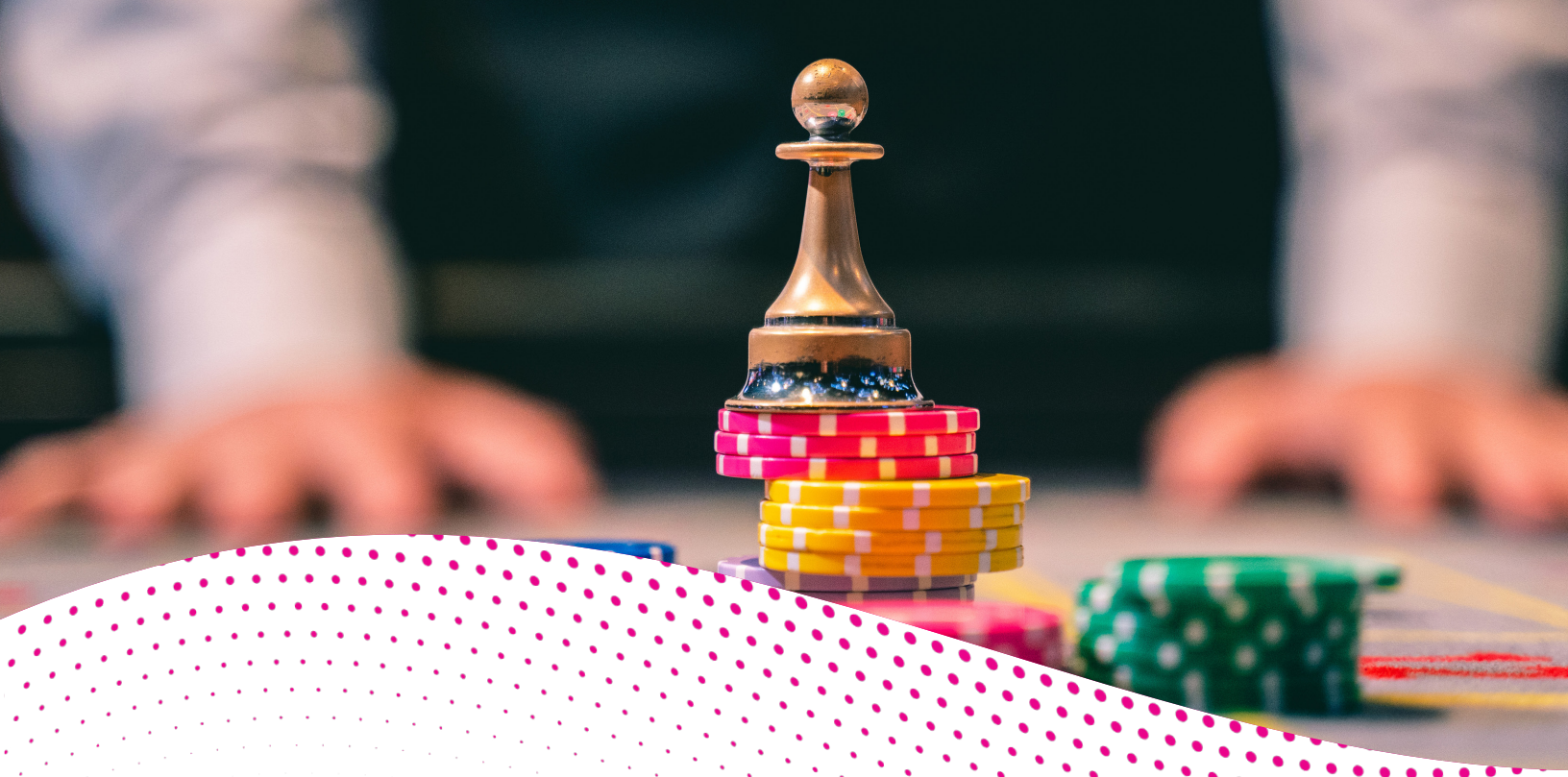
How Can I Get More Information?
For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact.

INSURANCE MARKETPLACE NOTICE

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

<table>
<tr><td colspan="2">3. Employer Name
South Florida Racing Association LLC</td><td>4. Employer Identification Number (EIN)
26-3533587</td></tr>
<tr><td colspan="2">5. Employer Address
2200 East 4th Avenue</td><td>6. Employer Phone Number
305-885-8000</td></tr>
<tr><td>7. City
Hialeah</td><td>8. State
FL</td><td>9. Zip Code
33010</td></tr>
<tr><td colspan="3">10. Who can we contact about employee health coverage at this job?
Nancy Santiago</td></tr>
<tr><td>11. Phone Number (if different from above)
305-885-8000 ext. 5107</td><td colspan="2">12. Email Address
nsantiago@hialeahpark.com</td></tr>
</table>



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This benefit guide provides selected highlights of the employee benefits program at Hialeah Park. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment at Hialeah Park. All benefit plans are governed by master policies, contracts and plan documents. Any discrepancies between any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents. Hialeah Park reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time. The authority to make such changes rests with the Plan Administrator.