2024 Guide to Benefits

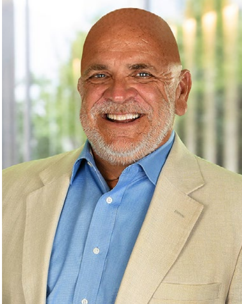
FOR U.S. AND U.S.V.I. ASSOCIATES

MVW

FLEXIBLE BENEFITS FOR EVERY LIFE

Total Rewards

Welcome to MVW



At MVW, we put You First. You are the heart of our company and the reason for our success. That's why we're committed to providing you with the same care and support you show our Owners, Members, guests, and each other.

This Caring Culture includes a wide variety of benefits – thoughtfully selected with you and your family in mind. The offerings are relative to personal situations, diversity, and competitiveness, because we know health and financial security are essential aspects of living a Life, Fulfilled.

Please take the time to read this guide thoroughly. It's part of a vast array of tools and resources available to help you choose the benefits that most closely align with your needs.

We hope these benefits provide you with peace of mind and demonstrate our commitment to enhancing the lives of you and your family – now and in the future.

Thank you, from the bottom of my heart, for the immense care you put into your work every day. I'm so proud to be a part of this team.

Be well.

Michael E. Yonker
EVP & Chief Human Resources Officer

MVW OFFERS A VARIETY OF BENEFITS FOR TODAY'S WORKFORCE.

Health/Welfare

- Medical, Dental and Vision Coverage
- Health Savings Account
- Flexible Spending Accounts
  - Health Care
  - Dependent Care
  - Limited Use
- Commuter Benefits
- 401(k) Retirement Plan
- Employee Stock Purchase Plan
- Deferred Compensation Plan

Work/Life

- Employee Assistance Program
- Quit for Life, MVW's Smoking Cessation Program
- Business Travel Accident Insurance
- Federal Credit Union
- Payroll Cards
- Paid Time Off
- Floating Holidays
- Tuition Reimbursement

BenefitHub Online Discounts

- Pet Insurance, Travel, Entertainment, Electronics, and more.

Income Protection

Employer-Paid:

- Basic Life Insurance
- Short Term Disability
- Executive Long Term Disability

Supplemental Options:

- Term Life Insurance*
- Accidental Death & Dismemberment *
- Short Term Disability
- Long Term Disability

**Associates & Dependent(s) Coverage*

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Have questions?

Visit **www.ybr.com/benefits/mvwc** or contact the myMVWBenefits Service Center at **1-855-252-6947** between 9:00 a.m. and 6:00 p.m., Eastern Time, Monday through Friday. Translators are available.

If you're calling from outside the United States, Puerto Rico, Guam, the U.S. Virgin Islands, or Canada, call **1-281-882-5813** (This is a toll call). For TDD service, call your local relay number.

How to Enroll

Enroll Online

Go to **www.ybr.com/benefits/mvwc**

Enroll by Phone

Call the myMVWBenefits Service Center at **1-855-252-6947**.

START YOUR ENROLLMENT HERE:
www.ybr.com/benefits/mvwc

To Enroll

ENROLL AS A NEW HIRE

All associates except Hawaii. **Benefits are effective after 30 days of employment.** You are able to enroll from your date of hire through 31 days after the effective date. Enroll early to avoid back charges.

NEW HIRE: HAWAII ASSOCIATES

Benefits are effective after 28 days of employment. You are able to enroll from your date of hire through 31 days after the effective date. Enroll early to avoid back charges.

ENROLL DURING ANNUAL ENROLLMENT (AE)

Annual Enrollment takes place in the Fall. Coverage becomes effective on January 1st of the following year.

WHAT IF I DON'T ENROLL?

For 2024, Annual Enrollment, this year is a passive enrollment. "Passive enrollment" means that there is no action required unless you want to enroll, update your coverage and/or participate in a savings/spending account.

Please note, Utah associates enrolled in a SelectHealth plan in 2023, your coverage will be transitioned to a new comparable Aetna Utah medical plan for 2024.

NEWLY ELIGIBLE

You must actively enroll in benefits. Depending on your eligibility, you may have up to 31 days to enroll for status change, marriage, or loss of coverage. You may have up to 60 days to enroll due to death, or birth/ adoption. Please contact the myMVWBenefits Service Center for further details and verification of effective date. You may be responsible for back charges.

IF YOU WORK IN HAWAII

If you don't want medical coverage, you must complete a medical coverage waiver form (HC-5 form). A copy of the form can be ordered from **www.ybr.com/benefits/mvwc** or by calling **1-855-252-6947**.

IF YOU WORK IN MASSACHUSETTS

Under the Massachusetts Health Care Reform Act, residents who do not have coverage may be required to pay a tax penalty. Visit **www.mahealthconnector.org** for more information.

IF YOU WORK IN SAN FRANCISCO

If coverage is waived, you will be provided a voluntary healthcare waiver form to complete and return to the myMVWBenefits Service Center.

IF YOU'RE ON A LEAVE OF ABSENCE (LOA)

Before you take a Leave of Absence, contact the myMVWBenefits Service Center for key information, including how to pay for your benefits while on your LOA.

If you're on a LOA during Annual Enrollment, you can enroll only in Medical, Dental, and Vision benefits. When you return to work, you can enroll in or make changes to the rest of your benefits within 30 days of return. You must continue to pay for your benefits while you're on a LOA or risk your benefits being canceled.

There are some benefits that will not be active during your leave. These may be activated upon your return to work. For further information, please call the myMVWBenefits Service Center at **1-855-252-6947**.

Dependents

When adding a new dependent, you must provide their Social Security number.

CHOOSE A BENEFICIARY

MVW provides up to $50,000 of Life Insurance coverage to all associates—at no cost to you. You must choose a beneficiary; their Social Security number is required.

SURCHARGES FOR SPOUSAL COVERAGE AND TOBACCO

Where applicable, if your spouse or domestic partner is eligible for medical coverage through his or her employer, and is not employed by MVW, there is a surcharge to enroll your spouse or domestic partner in an MVW medical plan.

Where applicable, if you and/or your dependent(s) use any nicotine products (cigarettes, pipes, cigars, e-cigarettes, smokeless tobacco, chewing tobacco, etc.), and are enrolled in an MVW medical plan, a surcharge will be added. If you and/or your covered dependent(s) complete a smoking cessation program, the applicable surcharge can be terminated.

ID Cards

Medical Plan: If you did not make plan changes during AE, you will not receive new ID cards. If you enroll or change coverage, medical and prescription cards are mailed to your home address. You should receive a separate prescription ID card from Express Scripts to use at the pharmacy if you enroll in an Aetna Plan. Associates enrolled in other MVW medical plans will not receive a separate prescription ID card. Please note, associates enrolled in SelectHealth in 2023 will automatically receive new Aetna Utah medical plan ID cards for 2024.

Dental Plan: You will not receive ID cards for the Dental Plans; however, cards can be printed online.

Vision Plan: If you did not make plan changes during AE, you will not receive new ID cards. If you enroll or change coverage, ID cards are mailed to your home address.

Health Savings Account, Health Care Flexible Spending Account & Limited Use Flexible Spending Account: If you are newly enrolled in these accounts, your debit card will be mailed to your home. Previous participants will not receive a new card if they re-enroll.

During the Year

REVIEW YOUR BENEFITS PERIODICALLY

Your annual pay determines your disability, life, and accident coverage. Visit **www.ybr.com/benefits/mvwc** in January to see your updated benefits. If you do not agree with the coverage, you must contact the myMVWBenefits Service Center by January 31 or within 30 days of your enrollment date.

CHANGES AFTER ENROLLMENT

You must make any changes by the last day of Annual Enrollment or within your 30-day enrollment window. Make changes at **www.ybr.com/benefits/mvwc** or call the myMVWBenefits Service Center at **1-855-252-6947**.

QUALIFIED LIFE EVENTS

After enrollment, you can only make changes to your benefits if you have a qualified life event, such as having a baby, getting married, or losing coverage from another plan. You must contact the myMVWBenefits Service Center within 31 days of the event (60 days if you're having or adopting a child).

MEDICAL, DENTAL AND VISION COVERAGE

Our Plans

MVW offers a wide selection of medical, dental, and vision plans to our associates. The next page shows which plans are available in your region. The following pages describe each plan in more detail, along with other programs and options.

	U.S. Mainland Associates[1]	Boston Associates	Arizona Associates[2]	Southern CA Associates[2,3]	Utah Associates	Hawaii Associates	U.S.V.I. Associates
Medical Plans							
Aetna $500 EPO - Aetna Select	●	●	●	●	●		
Aetna $1,000 EPO - Aetna Select	●	●	●	●	●		
Aetna $2,000 HDHP - Choice POS II	●	●	●	●	●		
Aetna $3,000 HDHP - Choice POS II	●	●	●	●	●		
Aetna Boston High Option		●					
Aetna Utah Whole Health Select					●		
Aetna Utah Whole Health HDHP					●		
SIMNSA HMO			●	●			
Kaiser HMO				●		●	
HMSA Health Plan Hawaii (HPH) HMO						●	
HMSA PPO						●	
Cigna U.S.V.I. PPO							●
Dental Plans							
MetLife Basic or Plus Plans	●	●	●	●	●		
Hawaii Dental Services (HDS) High or Low Plans						●	
Cigna DPPO (Included with Medical Plan)							●
Vision Plans							
VSP Basic or Plus Plans	●	●	●	●	●		
HMSA HMO or PPO Plans: (Included with Medical Plans)						●	
Kaiser HMO (Included with Medical Plan)						●	
Cigna Vision Plan (Included with Medical Plan)							●

[1]Depending on where you live, you may also have access to the Aetna Premier Care Network (APCN), providing you with lower cost plan options than the non-APCN plans.

[2]You may also select the SIMNSA HMO Plan (certain Southern California and Arizona zip codes, and Mexico).

[3]You may also select the Kaiser HMO Plan.

U.S. Mainland

Select from four Aetna medical plans

- Two **EPO Plans** offer lower in-network out-of-pocket costs, but you must use providers in the Aetna network.
- Two **HDHP options** offer in-network care and give you access to out-of-network providers at a higher cost.
- **The Aetna Premier Care Network (APCN)** is available in some states on all Aetna plans, offering lower-cost care premiums in a refined network.
- Our **Dental** and **Vision** plans let you see any provider, but it will cost you less if you stay in-network.

Medical Plans
Aetna $500 EPO - Aetna Select
Aetna $1,000 EPO - Aetna Select
Aetna $2,000 HDHP - Choice POS II
Aetna $3,000 HDHP - Choice POS II

Dental Plan
MetLife Basic or Plus Plans

Vision Plan
VSP Basic or Plus Plans

Boston

Includes Aetna Boston High Option Plan

- The **Aetna Boston High Option Plan** offers affordable care in-network with no deductibles in the Boston, Massachusetts area.
- Boston-area associates also have access to the same **Medical**, **Dental,** and **Vision** plans as other U.S. Mainland associates.

Medical Plans
Aetna $500 EPO - Aetna Select
Aetna $1,000 EPO - Aetna Select
Aetna $2,000 HDHP - Choice POS II
Aetna $3,000 HDHP - Choice POS II
Aetna Boston High Option Plan

Dental Plans
MetLife Basic or Plus Plans

Vision Plans
VSP Basic or Plus Plans

Arizona

Includes SIMNSA HMO Plan

- The **SIMNSA HMO Plan** offers affordable care in-network with no deductibles in certain zip codes in Arizona.
- Arizona associates also have access to the same **Medical**, **Dental,** and **Vision** plans as other U.S. Mainland associates.

Medical Plans
Aetna $500 EPO - Aetna Select
Aetna $1,000 EPO - Aetna Select
Aetna $2,000 HDHP - Choice POS II
Aetna $3,000 HDHP - Choice POS II
SIMNSA HMO

Dental Plans
MetLife Basic or Plus Plans

Vision Plans
VSP Basic or Plus Plans

Southern California

Includes SIMNSA and Kaiser Plans

- The **Kaiser HMO** and **SIMNSA HMO Plans** (available to certain Southern California and Arizona zip codes, and Mexico) offer in-network only coverage.
- California associates also have access to the same **Medical**, **Dental,** and **Vision** plans as other U.S. Mainland associates.

Medical Plans

- Aetna $500 EPO - Aetna Select
- Aetna $1,000 EPO - Aetna Select
- Aetna $2,000 HDHP - Choice POS II
- Aetna $3,000 HDHP - Choice POS II
- Kaiser HMO
- SIMNSA HMO

Dental Plans

- MetLife Basic or Plus Plans

Vision Plans

- VSP Basic or Plus Plans

Utah

Includes Aetna Utah Whole Health Select and Aetna Utah Whole Health HDHP

- The **Aetna Utah Whole Health Select** offers lower out-of-pocket costs with specific Utah network care, as well as the full Aetna network.
- The **Aetna Utah Whole Health HDHP** offers in-network care and gives you access to out-of-network providers at a higher cost. This includes specific Utah network care, as well as the full Aetna network.
- Utah associates also have access to the same **Medical**, **Dental,** and **Vision** plans as other U.S. Mainland associates.

Medical Plans

- Aetna $500 EPO - Aetna Select
- Aetna $1,000 EPO - Aetna Select
- Aetna $2,000 HDHP - Choice POS II
- Aetna $3,000 HDHP - Choice POS II
- Aetna Utah Whole Health Select
- Aetna Utah Whole Health HDHP

Dental Plans

- MetLife Basic or Plus Plans

Vision Plans

- VSP Basic or Plus Plans

INTEGRITY FIRST

"We lead with **Integrity First** in all areas of our business, including our benefits program. We treat our associates like we treat our Owners – with the utmost respect and honor – by providing substantial benefits and ample resources to help you make informed decisions."

John Geller
President and CEO

Hawaii
Kaiser and HMSA Plans

- Two **HMO Plans** offer in-network coverage only, while the **PPO Plan** offers both in- and out-of-network options, but you'll pay more for out-of-network coverage.
- When you select an **HMSA Plan**, Hawaii associates can select from two plans for both dental and vision. If you choose the **Kaiser HMO** medical plan, you have a choice of **two dental plans. Vision is included i**n the medical plan.

Medical Plans

Kaiser HMO

HMSA HPH HMO

HMSA PPO

Dental Plans

Hawaii Dental Services (HDS)
High or Low Plans

Vision Plans

Vision is included with:
- **HMSA HPH HMO and PPO**
- **Kaiser HMO**

U.S. Virgin Islands
Cigna Plan

- With the **Cigna U.S.V.I. Plan**, you can see any health care provider or use any hospital—in-network or out-of-network—but you'll pay more for out-of-network providers.
- U.S.V.I. associates who elect the Cigna Plan will have **Medical, Dental,** and **Vision** Coverage.

Medical Plan

Cigna U.S.V.I. PPO

Dental Plan

Cigna DPPO Plan

Vision Plan

Cigna Vision Plan

EXCELLENCE ALWAYS

"We strive for **Excellence Always** by aiming to exceed the expectations of our Owners, Members, and guests, as well as our associates. It is just as vital to offer top-of-the-line benefits as it is to provide world-class experiences and services."

Raman Bukkapatnam
Chief Information Officer

Medical Plan Types

MVW offers plan options that cover care in different ways. Some require you to choose a primary care physician and offer low deductibles, while others might include a high deductible but allow you to see any provider. Below is the break-down of the types of plans you can select.

SUMMARY OF BENEFITS AND COVERAGE (SBC)
Always refer to your Summary of Benefits and Coverage (SBC) for details on the benefit plans and how they work. You can also request a paper copy by calling the myMVWBenefits Service Center. Your SBC detailing your medical coverage is available online at **www.ybr.com/benefits/mvwc**.

EPO Plans

Exclusive Provider Organization (EPO)

IN-NETWORK CARE WITH A LARGER NETWORK
With an EPO, you must use health care providers and medical facilities (like hospitals) from your plan's network.

- You may need to choose a primary care physician (PCP). You may need a referral from your PCP if you require a specialist.
- Out-of-pocket expenses and deductibles are generally lower than for HDHP plans.
- Depending on where you live, you may also have access to the Aetna Premier Care Network (APCN).

Two Aetna EPO plans are offered to all U.S. Mainland associates (**page 12**). Boston associates can select the Aetna Boston High Option plan (**page 13**). Utah associated can select the Aetna Utah Whole Health Select **(page 16).**

PPO Plans

Preferred Provider Organization (PPO)

HIGHER PREMIUMS, LOWER COSTS FOR CARE
With a PPO, you may see any health care provider or use any hospital—in-network or out-of-network.

- Out-of-network, you'll pay a larger portion of your expenses and you may need to file your own claim forms.
- Premiums are generally lower than other plans.

PPO plans are offered by HMSA in Hawaii **(page 17)** and Cigna in the U.S. Virgin Islands, **(page 18)**.

HDHP Plans

High Deductible Health Plan (HDHP)

HDHP WITH OUT-OF-NETWORK COVERAGE
With an HDHP, you may see any health care provider or use any hospital, in- or out-of-network. You'll pay more for out-of-network providers.

- The Deductible—the amount you pay before coverage begins—is higher than on other plans.
- The HDHP plan is paired with a Health Savings Account (HSA) that lets you pay for qualified medical expenses before taxes are taken out of your paycheck.

Two Aetna HDHP options are offered to all U.S. Mainland associates **(page 12)** and one additional plan for Utah associates **(page 16).**

HMO Plans

Health Maintenance Organization (HMO)

A LOW-COST, HIGHLY STRUCTURED NETWORK PLAN
With an HMO, you must get all care within your plan's network. HMO plans are usually local, so they are only available in some regions.

- You must use health care providers and medical facilities (like hospitals) that participate in your plan's network.
- You will probably need to choose a primary care physician (PCP). You may need a referral from your PCP if you require a specialist.
- You won't need to file claims.

HMO plans are offered by Kaiser to associates in some parts of California **(page 15)** and Hawaii **(page 17).**

U.S.MAINLAND

Aetna Plans

Plan	U.S. MAINLAND, BOSTON, ARIZONA, SO. CALIFORNIA, UTAH			
	Aetna Select $500 EPO In-Network Only	**Aetna Select $1,000 EPO** In-Network Only	**Aetna Choice POS II $2,000 HDHP*** In-Network & Out-of-Network	**Aetna Choice POS II $3,000 HDHP*** In-Network & Out-of-Network
Annual Deductible				
IN-NETWORK	Individual $500 Family $1,000	Individual $1,000 Family $2,000	Individual $2,000 Family $4,000	Individual $3,000 Family $6,000
OUT-OF-NETWORK	Not covered	Not covered	Individual $4,000 Family $8,000	Individual $6,000 Family $12,000
Coinsurance	Your share of medical costs after you meet the deductible.			
IN-NETWORK	You pay 10%	You pay 20%	You pay 20%	You pay 30%
OUT-OF-NETWORK	Not covered	Not covered	You pay 50%	You pay 50%
Annual Out-of-Pocket Max.	The most you will pay each year in eligible medical and Rx costs. Medical /Rx combined-applies to deductible and coinsurance.			
IN-NETWORK	Individual $4,500 / Family $8,500		Individual $6,900 / Family $13,800	
OUT-OF-NETWORK	Not applicable		Individual $23,700 / Family $47,400	
Office Visits	What you pay for providers			
PREVENTIVE CARE	No cost to you	No cost to you	No cost to you	No cost to you
PRIMARY CARE PHYSICIAN	You pay $25 copay	You pay $25 copay	You pay 20% coinsurance	You pay 30% coinsurance
SPECIALIST	You pay $40 copay	You pay $40 copay	You pay 20% coinsurance	You pay 30% coinsurance
Other Services	Hospital and emergency services			
INPATIENT HOSPITALIZATION	You pay 10% coinsurance	You pay 20% coinsurance	You pay 20% coinsurance	You pay 30% coinsurance
EMERGENCY ROOM (copay waived if admitted)	You pay $350 copay	You pay $350 copay	You pay 20% coinsurance	You pay 30% coinsurance
URGENT CARE (emergency use only)	You pay $50 copay	You pay $50 copay	You pay 20% coinsurance	You pay 30% coinsurance
Prescription Drug (Rx)				
RETAIL GENERIC (30-day supply)	You pay $10 copay			
RETAIL FORMULARY (30-day supply. $30 minimum, up to $75 per prescription after deductible)	You pay 30% coinsurance			
RETAIL NON-FORMULARY (30-day supply)	You pay 100% of the discounted price			
SPECIALTY (up to $200 per prescription after deductible)	You pay 30% coinsurance			
MAIL ORDER (90-day supply)	You pay 2.5 times the retail cost			

*Deductibles must be met before the plan pays for benefits.

BOSTON

Aetna Boston High Option Plan

Plan	BOSTON Aetna Boston High Option In-Network Only
Annual Deductible	
IN-NETWORK	No deductible
OUT-OF-NETWORK	Not covered
Coinsurance	Your share of medical costs after you meet the deductible.
IN-NETWORK	Non-applicable, copays apply to certain services
OUT-OF-NETWORK	Not covered
Annual Out-of-Pocket Max.	The most you will pay each year in eligible medical costs (applies to deductibles and coinsurance).
IN-NETWORK	Individual $1,000 / Family $2,000
OUT-OF-NETWORK	Not covered
Office Visits	What you pay for providers
PREVENTIVE CARE	No cost to you
PRIMARY CARE PHYSICIAN	You pay $30 copay
SPECIALIST	You pay $45 copay
Other Services	Hospital and emergency services
INPATIENT HOSPITALIZATION	You pay $350 copay per admission
EMERGENCY ROOM (copay waived if admitted)	You pay $100 copay
URGENT CARE (emergency use only)	You pay $45 copay
Prescription Drug (Rx)	
RETAIL GENERIC (30-day supply)	You pay $10 copay
RETAIL FORMULARY (30-day supply)	You pay $30 copay
RETAIL NON-FORMULARY (30-day supply)	You pay $50 copay
SPECIALTY	You pay 100%
OUT-OF-POCKET MAX.	Individual $1,600 / Family $3,200

ARIZONA, SO. CALIFORNIA, MEXICO

SIMNSA Plan

Plan	SO. CALIFORNIA, ARIZONA, MEXICO* SIMNSA HMO In-Network Only
Annual Deductible	
IN-NETWORK	No deductible
OUT-OF-NETWORK	Not covered
Coinsurance	Your share of medical costs after you meet the deductible.
IN-NETWORK	No cost to you
OUT-OF-NETWORK	Not covered
Annual Out-of-Pocket Max.	The most you will pay each year in eligible medical and Rx costs. Medical /Rx combined-applies to deductible and coinsurance.
IN-NETWORK	Individual $6,350 / Family $12,700
OUT-OF-NETWORK	Not covered
Office Visits	What you pay for providers
PREVENTIVE CARE	No cost to you
PRIMARY CARE PHYSICIAN	You pay $7 per visit
SPECIALIST	You pay $7 per visit
Other Services	Hospital and emergency services
INPATIENT HOSPITALIZATION	No cost to you
EMERGENCY ROOM (copay waived if admitted)	You pay $250 per visit in and out of Plan Service Area
URGENT CARE (emergency use only)	You pay $25 copay in Mexico You pay $50 copay outside of Mexico
Prescription Drug (Rx)	
RETAIL GENERIC (30-day supply)	You pay $10 copay
RETAIL FORMULARY (30-day supply)	You pay $10 copay
RETAIL NON-FORMULARY (30-day supply)	You pay $10 copay
SPECIALTY	You pay $10 copay
MAIL ORDER (up to 100-day supply subject to formulary guidelines)	Refer to SIMNSA Summary

*Available only to certain CA and AZ zip codes, and Mexico

SO. CALIFORNIA, HAWAII

Kaiser Plans

Plan	SO. CALIFORNIA Kaiser HMO In-Network Only	HAWAII Kaiser HMO In-Network Only
Annual Deductible		
IN-NETWORK	Individual $500 / Family $1,000	No deductible
OUT-OF-NETWORK	Not covered	Not covered
Coinsurance	Your share of medical costs after you meet the deductible.	
IN-NETWORK	You pay 20%	No cost to you
OUT-OF-NETWORK	Not covered	Not covered
Annual Out-of-Pocket Max.	The most you will pay each year in eligible medical and Rx costs. Medical /Rx combined-applies to deductible and coinsurance.	
IN-NETWORK	Individual $3,000 / Family $6,000	Individual $2,500 / Family $7,500
OUT-OF-NETWORK	Not covered	Not covered
Office Visits	What you pay for providers	
PREVENTIVE CARE	No cost to you	No cost to you
PRIMARY CARE PHYSICIAN	You pay $25 copay	You pay $15 copay
SPECIALIST	You pay $35 copay	You pay $15 copay
Other Services	Hospital and emergency services	
INPATIENT HOSPITALIZATION	You pay 20% coinsurance	You pay $75 copay per day
EMERGENCY ROOM (copay waived if admitted)	You pay 20% coinsurance	You pay $75 copay
URGENT CARE (emergency use only)	You pay $25 copay	You pay $15 copay per visit at a Kaiser Permanente facility within the Hawaii service area; 20% of applicable charges at a non-Kaiser Permanente facility outside the Hawaii service area.
Prescription Drug (Rx)		
RETAIL GENERIC (30-day supply)	You pay $10 copay	You pay $10 copay
RETAIL FORMULARY (30-day supply)	You pay $30 copay after $100 deductible	You pay $35 copay
RETAIL NON-FORMULARY (30-day supply)	You pay $30 copay after $100 deductible	You pay $35 copay
SPECIALTY	You pay $30 copay after $100 deductible	$200 copay
MAIL ORDER (90-day supply)	Same as retail (up to 100-day supply subject to formulary guidelines)	You pay $20 generic / $70 formulary and non-formulary

UTAH

Aetna Utah Plans

Plan	Aetna Utah Whole Health Select In-Network	Aetna Utah Whole Health HDHP In-Network & Out-of-Network
Annual Deductible		
IN-NETWORK	Individual $500 / Family $1,000	Individual $2,000 / Family $4,000
OUT-OF-NETWORK	Not covered	Individual $4,000 / Family $8,000
Coinsurance	Your share of medical costs after you meet the deductible.	
IN-NETWORK	You pay 10%	You pay 20%
OUT-OF-NETWORK	Not covered	You pay 50%
Annual Out-of-Pocket Max.	The most you will pay each year in eligible medical and Rx costs. Medical /Rx combined-applies to deductible and coinsurance.	
IN-NETWORK	Individual $4,500 / Family $8,500	Individual $6,900 / Family $13,800
OUT-OF-NETWORK	Not covered	Individual $19,350 / Family $38,700
Office Visits	What you pay for providers	
PREVENTIVE CARE	No cost to you	No cost to you
PRIMARY CARE PHYSICIAN	You pay $25 copay	You pay 20% coinsurance
SPECIALIST	You pay $40 copay	You pay 20% coinsurance
Other Services	Hospital and emergency services	
INPATIENT HOSPITALIZATION	You pay 10% coinsurance after deductible	You pay 20% coinsurance
EMERGENCY ROOM (copay waived if admitted)	You pay $350 copay	You pay 20% coinsurance
URGENT CARE (emergency use only)	You pay $35 copay	You pay 20% coinsurance
Prescription Drug (Rx)		
RETAIL GENERIC (30-day supply)	You pay $10 copay	You pay $10 copay
RETAIL FORMULARY (30-day supply) $30 min. up to $75 max. per prescription, after deductible	You pay 30% coinsurance	You pay 30% coinsurance
RETAIL NON-FORMULARY	You pay 100% of the discounted price	You pay 100% of the discounted price
SPECIALTY	You pay 30% coinsurance for medical or pharmacy	You pay 30% coinsurance for medical, 10% coinsurance for pharmacy
MAIL ORDER (90-day supply)	You pay 2.5 times retail cost	You pay 2.5 times retail cost

HAWAII

HMSA Plans

Plan	HMSA HPH HMO* In-Network Only	HMSA PPO* In-Network & Out-of-Network
Annual Deductible		
IN-NETWORK	No deductible	No deductible
OUT-OF-NETWORK	Not covered	Not covered
Coinsurance	Your share of medical costs after you meet the deductible.	
IN-NETWORK	You pay 20%	You pay 20%
OUT-OF-NETWORK	Not covered	You pay 20%
Annual Out-of-Pocket Max.	The most you will pay each year in eligible medical and Rx costs.	
IN-NETWORK	Individual $2,500 / Family $7,500	Individual $2,500 / Family $7,500
OUT-OF-NETWORK	Not covered	Individual $2,500 / Family $7,500
Office Visits	What you pay for providers	
PREVENTIVE CARE	No cost to you	No cost to you
PRIMARY CARE PHYSICIAN	You pay $20 copay	You pay $14 copay
SPECIALIST	You pay $20 copay	You pay $14 copay
Other Services	Hospital and emergency services	
INPATIENT HOSPITALIZATION	You pay 20% coinsurance	You pay 20% coinsurance
EMERGENCY ROOM (copay waived if admitted)	You pay 20% coinsurance	You pay 20% coinsurance
URGENT CARE (emergency use only)	You pay $20 copay	You pay $20 copay
Prescription Drug (Rx)		
RETAIL GENERIC (30-day supply)	You pay $7 copay	You pay $7 copay
RETAIL FORMULARY (30-day supply)	You pay $30 copay	You pay $30 copay
RETAIL NON-FORMULARY (30-day supply)	$30 copay + $45 cost share**	$30 copay + $45 cost share**
SPECIALTY (30-day supply)	$100 formulary / $200 copay non-formulary	$100 formulary / $200 copay non-formulary
MAIL ORDER (90-day supply)	You pay $11 generic / $65 formulary / $65 copay plus $135 cost share non-formulary	You pay $11 generic / $65 formulary/ $65 copay plus $135 cost share non-formulary
OUT-OF-POCKET MAX.	Individual $3,600 / Family $4,200	Individual $3,600 / Family $4,200

*HMSA plans have five prescription drug tiers. Please refer to your SBC for more information.
**The portion that you pay out of your own pocket in addition to a copay or coinsurance.

U.S.V.I.

Cigna Plan

Plan	Cigna U.S.V.I. PPO In-Network & Out-of-Network
Annual Deductible	
IN-NETWORK & OUT-OF-NETWORK	Individual $350 / Family $1,050
Coinsurance	Your share of medical costs after you meet the deductible.
IN-NETWORK & OUT-OF-NETWORK	You pay 20%
Annual Out-of-Pocket Max.	The most you will pay each year in eligible medical costs. Medical /Rx combined-applies to deductible and coinsurance.
IN-NETWORK & OUT-OF-NETWORK	Individual $3,000 / Family $6,000
Office Visits	What you pay for providers
PREVENTIVE CARE	No cost to you
PRIMARY CARE* PHYSICIAN	You pay $30 copay
SPECIALIST*	You pay $45 copay
Other Services	Hospital and emergency services
INPATIENT HOSPITALIZATION	You pay $350 per admission copay, then 20% coinsurance, no plan deductible
EMERGENCY ROOM (copay waived if admitted)	You pay $100 copay, no plan deductible
URGENT CARE (emergency use only)	You pay $50 copay, no plan deductible
Prescription Drug (Rx)	
RETAIL GENERIC (30-day supply)	You pay $15 copay
RETAIL FORMULARY (30-day supply)	You pay $25 copay
RETAIL NON-FORMULARY (30-day supply)	You pay $40 copay
SPECIALTY	Copay based on drug tier (generic, formulary, non-formulary)
MAIL ORDER (90-day supply)	You pay $15 generic / $25 formulary / $40 copay non-formulary

*Outside of U.S., office visits are 20% coinsurance after plan deductible.

What is a Provider Network?

Almost every health plan comes with a provider network: health care providers, hospitals, labs, pharmacies, physical therapists, mental health professionals, and other clinicians that are part of your health plan. Not all providers and hospitals in a community are part of a plan's provider network. So it is important for you to know if your provider or hospital is in the network before signing up for a health plan. It is also important to know your plan's rules for seeking care from providers who are not in your network. Choosing an in-network provider will save you the most money without sacrificing quality of care.

In-Network Providers

In-network providers have agreed to accept a discounted rate for covered services under your health plan when they provide you with care. This helps keep costs low. You pay less out of your own pocket when you get care from in-network providers.

Out-of-Network Providers

When you visit an out-of-network provider, you will pay more. Out-of-network providers have no arrangement with your medical plan, and they are free to charge whatever they like. Your plan may not pay the entire price; in fact, your plan may pay nothing at all.

Example	In-Network Provider	Out-of-Network Provider
Health provider's bill	$250	$250
Reduced bill negotiated by your plan	$200	$250
Your share of the cost	20% coinsurance	50% coinsurance
Your plan pays	$160	$125
You pay	$40	$125

This is an example of cost-sharing and does not apply to a particular health plan.

CARING CULTURE

"We are devoted to caring for our associates, like we do for our customers, because we know that happy and healthy associates means a job well done. Our benefits program aims to help you balance your work and personal responsibilities, so you can prioritize the needs of yourself, your family, and your community. These are pillars of our **Caring Culture**."

Stephanie Butera
EVP & Chief Operating Officer, HVO

Aetna Premier Care Network (APCN)

A smaller network of providers. Lower contributions without sacrificing quality of care.

Depending on where you live, you may have the option to choose a plan that includes the Aetna Premier Care Network (APCN). If you choose this option, you'll have the same plan with a smaller specialist network.

HOW IS IT DIFFERENT FROM THE OTHER AETNA PLAN CHOICES?

An APCN plan is identical to a standard Aetna plan – except for lower contributions and the network. An APCN plan features a smaller network of providers.

The copays, coinsurance, and other features are the same as the broad Aetna network plans. You still have a choice of top-tier providers, but others will not be available, and some hospitals may not offer the specialists you need. The advantage of an APCN plan is that we pass along the savings from this preferred network to you in the form of lower contributions per paycheck.

ARE MY PROVIDERS IN THE ACPN?

The APCN is a special network that is not available everywhere. If you do not see a lower cost APCN option when you go to enroll, it is because the option is not yet available for your area. If an APCN is available in your area, you will be able to select the APCN plan from the list and search for providers.

REMINDERS

- You have one opportunity each year to make your benefit choices. If you enroll in the APCN plans and then decide the APCN is not for you, you will have to wait until the next enrollment period to change your plan option.
- Even if you select the APCN, you can seek emergency care from any Emergency Room when needed.

To see if your provider(s) participates in the APCN:

- **Go to www.aetna.com**
- **Click on "Find a Doctor"**
- **Select "Guests"**
- **Select "Plan from an Employer"**
- **In the box, enter your home location (zip, city, county or state)**
- **Then click on "Search"**

If an APCN is available in your area, you will be able to select the APCN plan from the list and search for providers.

High Deductible Health Plans (HDHP)

If you enroll in one of Aetna's High Deductible Health Plan options, you are eligible to open a Health Savings Account (HSA). *(Not available in New York, Hawaii, or U.S.V.I.)*

Health Savings Account

- When you contribute to an HSA, the money comes out of your paycheck tax-free. Your funds aren't taxed when you pay for qualified medical expenses such as doctor visits, prescriptions, eyeglasses, etc.
- **For 2024, you can contribute up to $4,150 for individual coverage and $8,300 for family coverage. If you are age 55 or older by December 31, 2024, you may contribute an additional $1,000.** You may also make contributions directly to your HSA with after-tax dollars, up to IRS limits. You can change the amount you save at any time throughout the year.
- All unused funds roll over each year and, you won't lose a penny if you change jobs, change health plans, or change HSA providers. If invested, funds may grow tax-free, helping you build savings for future medical expenditures.

OPENING AN HSA

You are responsible for opening the HSA, paying any account fees, and for making any contributions. You will receive an HSA debit card in the mail. You can also manage your account online. The following rules apply:

- You must not be covered under any other health plan that is not an HDHP.
- You must not be enrolled in Medicare.
- You must not be eligible to be claimed as a dependent on another person's tax return.

Limited Use Flexible Spending Account (LUFSA)

- If you open an HSA, you will not be eligible to participate in a Health Care Flexible Spending Account (HCFSA); however, you may participate in a Limited Use Flexible Spending Account (LUFSA).
- The LUFSA can only be used for dental, vision, and orthodontia expenses.

QUESTIONS?

Contact myMVWBenefits Service Center at 1-855-252-6947 for more information.

Health Savings Account	Limited Use Flexible Spending Account
You must be enrolled in the HDHP to open an HSA. You are not eligible to participate in the HCFSA, but you may participate in the Dependent Care Flexible Spending Account and a LUFSA.	All eligible associates can participate.
Contribute up to $4,150 for individual coverage and $8,300 for family coverage. You can contribute an additional $1,000 if you are 55 or older during the year.	Contribute up to $3,050*.
Funds can be used to pay for qualified medical expenses.	Funds can only be used for dental, vision and other non-healthcare related expenses.
Funds roll over each year. There is no limit on the amount of funds that can carry over.	Carry over up to $570 for non-healthcare expenses only.

**Contribution limits are announced by the IRS each year. Information in this guide represents 2023 limits.*

U.S. MAINLAND

Dental & Vision Plans

U.S. Mainland associates have a choice of two Dental and two Vision Plans: Basic or Plus Plan

DENTAL PLAN

The Dental Plan is administered by MetLife. You can go to any dentist, but it will cost you less if you see an in-network dentist in the MetLife Preferred Dentist Network. There are no ID cards required.

VISION PLAN

The Vision Plan is administered by Vision Service Plan (VSP). You may go to any provider, but it will cost you less if you see an in-network provider. ID cards are not required to receive vision services.

DENTAL PLAN OPTIONS: METLIFE

Dental Plan Costs	Basic Plan	Plus Plan
Preventive Care	Covered 100% (deductible does not apply)	
Annual Deductible	Individual $50 / Family $150 (in-network)	
Annual Benefit Maximum	$1,500 per person	$2,500 per person
Basic Services	20% coinsurance after deductible	10% coinsurance after deductible
Major Services	50% coinsurance after deductible	
Orthodontia (deductible does not apply)	No orthodontia coverage	Adult and child orthodontia
Orthodontia Lifetime Maximum	Not applicable	$2,500

Note: The plan pays the percentage indicated after you pay the deductible, unless otherwise noted.

VISION PLAN OPTIONS: VSP

Vision Plan Costs	Basic Plan	Plus Plan
Annual Exam	$20 copay	$0
Lenses (single/bifocal)	$20 once a year	$0
Frame Allowance	$150	$180
Contact Lens Allowance	$150	$180
Contact Lens Fitting & Evaluation	$40	$40

HAWAII

Dental & Vision Plans

Hawaii associates have two Dental Plan options. Your Vision Plan depends on the medical plan you select.

DENTAL PLAN

The Dental Plan is administered by Hawaii Dental Services (HDS).

VISION PLAN

If you enroll in a HMSA medical plan or a Kaiser medical plan, **vision care is included**. **You do not need to make a separate vision election**.

DENTAL PLAN OPTIONS: HAWAII DENTAL SERVICES (HDS)

Dental Plan Costs	Low Plan	High Plan
Preventive Care	Covered 100% (2 exams per calendar year)	
Annual Deductible	Individual $50 / Family $150 (in-network)	
Annual Benefit Maximum	$1,000 per person	$1,500 per person
Basic Services	30% coinsurance after deductible	20% coinsurance after deductible
Major Services	50% coinsurance after deductible	
Orthodontia (deductible does not apply)	No orthodontia coverage	Adult and child orthodontia
Orthodontia Lifetime Maximum	Not applicable	$1,500

Note: The plan pays the percentage indicated after you pay the deductible, unless otherwise noted.

VISION PLAN OPTIONS: HMSA MEDICAL PLANS

(Included with your medical plan. No election required)

Vision Plan Costs	HMSA HPH HMO	HMSA PPO
Annual Exam	$20 copay	$10 copay
Lenses (single/bifocal)	$10 copay	$10 copay
Frame Allowance	$15 copay	$15 copay
Contact Lens Allowance	$25 copay up to $130 allowance	$25 copay up to $130 allowance
Contact Lens Fitting & Evaluation	Pay all charges less $45 plan payment	Pay all charges less $45 plan payment

VISION PLAN: KAISER HMO PLAN

(Included with your medical plan. No election required)

Vision Plan Costs	
Annual Exam	$15 copay
Frame and Contact Lens Allowance	Adult: $150 allowance every 12 months Pediatric: No Charge every 12 months

U.S.V.I.

Dental & Vision Plans

Dental and Vision Plan coverage are included with Cigna medical enrollment.

DENTAL PLAN

The Dental Plan is provided by Cigna.

VISION PLAN

The Vision Plan is provided by Cigna. You may go to any provider, but it will cost you less if you see an in-network provider.

DENTAL PLAN

Dental Plan Costs	Cigna DPPO Plan
Preventive Care	Covered 100%
Annual Deductible	Individual $50 / Family $150 (in-network)
Annual Benefit Maximum	$1,500 per person
Basic Services	20% coinsurance after deductible
Major Services	50% coinsurance after deductible
Orthodontia (child)	You pay 50% coinsurance (deductible does not apply)
Orthodontia Lifetime Maximum	$1,500

Note: The plan pays the percentage indicated after you pay the deductible, unless otherwise noted.

VISION PLAN

Vision Plan Costs	Cigna Basic Plan
Annual Exam	$45 allowance
Lenses (single/bifocal)	$10 copay
Frame Allowance	$32 single / $55 bifocal / $65 trifocal / $80 lenticular allowance every 24 months
Contact Lens Allowance	$25 copay up to $130 allowance
Contact Lens Fitting & Evaluation	$87 every 12 months

INTEGRITY FIRST

“We put **Integrity First** during all stages of the associate experience. From the interview process to the first day of work and beyond, we continually strive to conduct our business with the utmost integrity and apply our high standards to everything we do.”

James Hunter
EVP & General Counsel

Take Advantage of Your Free Benefits

Free Preventive Care

You have access to free preventive care when you stay in-network, such as:

- Annual physical exams (when you're not sick)
- Routine baby and child exams and immunizations
- Mammograms, cholesterol, routine heart and prostate screenings
- HPV testing, counseling and screening for HIV
- Screening and counseling for interpersonal and domestic violence
- Prenatal care
- Breastfeeding support, counseling, and supplies
- Female contraceptive methods and counseling

Frequency and age restrictions may apply.

Free Health Assessment*

If you are enrolled in an Aetna plan, you can complete an online Health Assessment. The Health Assessment can help identify your likelihood of developing medical problems in the future and provides guidelines on improving your health now.

Free Help With Your Health Needs*

Call a health representative for one-on-one counseling to help you:

- Find a health care provider
- Explain your medical benefits
- Provide you with support if you have a chronic medical condition like asthma, diabetes, or a heart condition
- Stop smoking

Free Pregnancy and Healthy Baby Benefits*

MVW offers special, confidential programs for expectant mothers.

Once you sign up, you can speak to a trained labor and delivery nurse any time, day or night, who can answer your pregnancy-related questions.

** Not all services are available with all plans. Call your plan provider for more information regarding these benefits.*

CUSTOMER OBSESSED

"The continued success of our company directly relates to the fact that we are **Customer Obsessed**. Our associates are dedicated to building long-lasting relationships with our Owners, Members, and guests, and we are dedicated to building those same connections with our associates. By offering solid benefits, we want to empower you and your family to live fulfilling lives."

Jeanette Marbert
President, Exchange and Third-Party Management

KEEP MORE OF THE MONEY YOU EARN

Flexible Spending Accounts

You save money when you enroll in a Flexible Spending Account (FSA). The money you contribute is deducted from your pay before taxes are withheld. You can use the monies to pay for eligible health care and/or dependent care expenses. You can enroll in one, both, or neither type of FSA.

Health Care FSA (HCFSA)

You may contribute up to **$3,050* annually** and you may **carry over up to $570** into the following year to pay for eligible expenses such as deductibles, coinsurance, copays, eye glasses, orthodontia services, immunizations/vaccinations (including flu shots), prescription drugs and more.

Dependent Care FSA (DCFSA)

You may contribute between **$200 and $5,000* annually** for expenses such as day care, before and after school programs, nursery school or preschool, and even adult day care.

HIGHLY COMPENSATED EMPLOYEES

If you are a Highly Compensated Employee (HCE), defined by the Internal Revenue Services (IRS), your election is limited to $750 to comply with tax regulations. Please note: pending nondiscrimination testing, contribution limits for HCE's may change.

Use it or Lose it

Per IRS regulations, these accounts are "use it or lose-it", so we recommend planning your elections carefully. Please contribute an amount based on anticipated expenses.

- With the HCFSA, you can only rollover $570 into the following plan year.
- With a DCFSA, you must spend all the money in the account by the end of the plan year or you will lose it.

Please Note: If you enroll in one of Aetna's High Deductible Health Plan (HDHP) options, you are eligible to open a Health Savings Account (HSA) and a Limited Use Flexible Spending Account (LUFSA). Please see **(page 21)** for details.

**Contribution limits are announced by the IRS each year. Information in this guide represents 2023 limits.*

FSA EXAMPLE: MARIA SAVED $490 WITH AN FSA!
In the example below, Maria estimates she will spend $1,500 on medical expenses this year.

An FSA in Action	Without an FSA	With an FSA
Maria's annual income	$35,000	$35,000
Maria's pre-tax contribution	$0	$1,500
Maria's taxable Income (assumes a 22% tax bracket)	$35,000	$33,500
Taxes	$7,852	-$7,362
Maria's yearly savings	**$0**	**$490**

Lower Your Medical Costs

Do your homework

REVIEW YOUR BENEFIT CHOICES
Read this guide and visit **www.ybr.com/benefits/mvwc** to learn about your benefits.

CHOOSE WHO'S COVERED
Decide which eligible dependents you will need to cover.

COMPARE PLANS
Compare deductibles, copays, and coinsurance and choose a plan based on your needs.

FIND A HEALTH CARE PROVIDER
To find a provider, go to the applicable health plan's website, with addresses on **www.ybr.com/benefits/mvwc** or see the Plan Contacts on page 39.

GET FREE PREVENTIVE CARE
Annual adult wellness visits and well-child exams are free.

AM I COVERED IN-NETWORK?
Don't ask your provider "Do you take my insurance?" You should ask, "Is this in-network?" for every aspect of your health care, from lab tests to the anesthesiologist who is scheduled for your surgery.

CONTRIBUTE TO A HEALTH CARE FLEXIBLE SPENDING ACCOUNT
Set aside money before taxes to pay for eligible health care expenses such as copays, deductibles, coinsurance, and dental and vision expenses.

USE TELEMEDICINE OR URGENT CARE
For non-emergency needs, telemedicine and urgent care offer more affordable same-day care than the emergency room.

Your health care costs consist of the premium that comes out of your paycheck, plus out-of-pocket costs when you receive care (such as copays and coinsurance).

Terms to Know

PREMIUM: The amount that comes out of your paycheck for your benefits.

COPAY: A flat fee you pay when you visit your health care provider's office, and when you receive certain other services.

DEDUCTIBLE: What you must pay in out-of-pocket costs each calendar year before your health plan begins to cover your care.

COINSURANCE: The percentage you pay once you've met your deductible and paid any applicable copays.

OUT-OF-POCKET COSTS: Your share of the costs.

SAVE MONEY ON PRESCRIPTION DRUGS

Lower Your Rx Costs

Every health insurance plan comes with prescription drug coverage, but not every plan covers every medication. Within a plan, how much you pay for medications will vary, depending on the drug.

Are my drugs covered under the plan?

When you're looking at a plan, ask to see the plan's formulary, which is the list of drugs covered by the plan. Your health plan may only pay for medications that are on the formulary.

What is a formulary?

Health plans cover drugs based on effectiveness and cost. The formulary determines which drugs are covered and how much you will pay.

- **Generic:** The least expensive drugs.
- **Formulary:** More expensive generic and brand-name drugs.
- **Non-Formulary:** More expensive brand-name drugs. These drugs will cost you a significant amount out-of-pocket.
- **Specialty:** These are the most expensive drugs, often used to treat complex conditions.

How do I find a plan's formulary?

To find a plan's formulary, check the plan's website.

You save money when you use generics. Ask your health care provider if a generic medication is available for your condition.

Terms to Know

GENERIC DRUG: Generic drugs contain the same active ingredients as brand-name drugs, but they cost much less. Not all drugs are available as a generic.

FORMULARY: Each medical plan has its own list of brand-name drugs called a "formulary." Your costs for these brand name drugs are typically lower when you choose drugs on this list.

NON-FORMULARY: These are brand-name drugs that are not on the formulary list. These brand name drugs could cost you more.

Urgent Care Centers

For immediate treatment of injuries or illnesses that are not life-threatening, visit your local urgent care center or pharmacy center. You don't need an appointment and most locations offer evening and weekend hours.

CUSTOMER OBSESSED

"We believe that taking great care of our customers starts with taking great care of our associates. Your annual benefits package is just one piece of that strategy, and we hope that you think it adds good value to your overall relationship with the company."

Brian Miller
President, Vacation Ownership

Virtual Visits

When you need care for a non-emergency illness or injury, visit with a health care provider online or go to your local urgent care or pharmacy center.

Aetna Teladoc

Aetna members may use Teladoc, which connects you and your eligible dependents with U.S. board-certified physicians 24/7/365 via phone or video.

GENERAL MEDICAL

Talk to a U.S. board-certified doctor by phone or video 24/7 for non-urgent needs such as coughs, colds, UTIs, and more.

DERMATOLOGY

Start an online skin review with a dermatologist for conditions such as rashes, eczema and acne. Get a custom treatment plan in 24 hours.

MENTAL/BEHAVIORAL HEALTH SERVICES

Completely confidential, counselors are available to help you with issues such as depression, stress, alcohol and drug misuse, and work-related pressures.

GET STARTED!

- Go to **Teladoc.com/Aetna** or download the Teladoc mobile app. You can also call Teladoc at **1-855-TELADOC (1-855-835-2362)**.
- Request a visit with a provider by web, phone, or mobile app. If medically necessary, a prescription will be sent to the pharmacy of your choice.

Please note that not all services are available in all states.

Kaiser Permanente Telehealth

With Kaiser Permanente, you have many options available to get the world-class care you depend on for all your health needs with Telehealth — day or night.

CONVENIENT WAYS TO RECEIVE CARE

PHONE VISIT

Talk with a clinician over the phone for the same high-quality care as an in-person visit. Schedule an appointment or get fast, personalized support 24/7.

VIDEO VISIT

Meet face-to-face with a clinician by video from your smartphone, tablet, or computer. Appointments are optional.

E-VISIT

Fill out a short questionnaire about your symptoms online and get personalized self-care advice from a Kaiser Permanente clinician.

HMSA and Cigna Telehealth

TAKE ADVANTAGE!

HMSA and Cigna offer a safe, valuable option that helps you communicate with your doctor from your home or office. Talk to your doctor about the telehealth option that's best for you, whether it's a video visit or email check-in.

Life and Accidental Death & Dismemberment Benefits

Life Insurance

Life Insurance pays money to your beneficiary—any person you choose to receive money if you die. You're automatically covered for free under the Basic Life Insurance Plan for up to one times your annual pay (up to a maximum of $50,000). You can also purchase Additional Life Insurance coverage for yourself up to eight times your annual pay (up to a maximum of $3 million).

If you buy Additional Life Insurance for yourself, you can also buy Spouse Life Insurance in increments of $10,000 (up to a maximum of $250,000). You can also buy Child Life Insurance for your child(ren) at $5,000 or $10,000 per child.

Generally, if you're enrolling in Additional or Spouse Life Insurance for the first time or increasing coverage, you must complete an Evidence of Insurability (EOI) form and be approved before your coverage becomes effective. (See your Summary Plan Description (SPD) for details on the coverage amount available without an EOI.)

Accidental Death & Dismemberment (AD&D) Insurance

Accidental Death & Dismemberment Insurance pays your beneficiary money if you die in a covered accident, or pays you money if you lose your vision, hearing, speech or limbs in a covered accident. You can choose to purchase AD&D Insurance for yourself and your family. If you purchase AD&D coverage for yourself, you can choose one to eight times your annual pay (up to a maximum of $1.5 million).

Business Travel Accident (BTA) Insurance for Salaried Associates

Salaried associates and associates eligible for salaried benefits who travel on business are automatically covered for free under the Business Travel Accident (BTA) Insurance.

BTA provides benefits to your beneficiary for accidental death and to you for dismemberment that may occur while you're traveling on company business. The beneficiary you choose for the free Life Insurance will be the same beneficiary for the BTA insurance.

Disability Benefits

Short Term Disability (STD)

MVW provides STD benefit payments if you have a baby, get sick, or have certain injuries and can't work for seven consecutive calendar days or more.

- You may receive benefit payments up to 26 weeks.
- Your benefits will be 50% of your annual pay up to a maximum weekly benefit of $1,500.

SUPPLEMENTAL OPTION

- Your benefits will be 60% of your annual pay, up to a maximum of $3,461 per week.

DO YOU WORK IN CALIFORNIA, HAWAII, NEW JERSEY, NEW YORK, OR RHODE ISLAND?

You're automatically covered under MVW's STD plan. However, your benefits may be reduced by the amount you receive under your state's paid leave program.

If you transfer from one of these states to a state without a paid leave program, your STD eligibility will be determined by the rules of the location in which you work.

IMPORTANT NOTES

- If you're planning on having a baby, remember to enroll before your pregnancy begins. The STD plans will not provide benefits for your pregnancy if your pregnancy starts before you're covered by the plan.
- The Disability plans have limitations on pre-existing conditions—a condition that you had before your coverage began. Also, benefits may be reduced if you receive other income, such as Social Security disability. For details, see the Summary Plan Description (SPD).

Visit **www.ybr.com/benefits/mvwc** for more information and Summary Plan Descriptions (SPDs).

Please note: Supplemental Disability plans may be subject to Evidence of Insurability (EOI), a health questionnaire that helps determine whether you qualify for new coverage.

Long Term Disability (LTD)

Long Term Disability (LTD) provides benefit payments if you get sick or hurt and can't work for a long time. It starts to pay after you've been unable to work for 26 weeks.

- You may elect supplemental LTD from one of the following plans:

MONTHLY BENEFIT OPTIONS

- Option 1: 50% of your monthly pay. Maximum monthly benefit $10,000
- Option 2: 60% of your monthly pay. Maximum monthly benefit $20,000

IMPORTANT NOTE

If you are diagnosed, treated, or received services for a condition within the 12-month period before the coverage's effective date, you must wait 12 months after the effective date for the treated condition to be covered.

Executive LTD (ELTD)

The ELTD Plan is tailored for General Managers, Project Directors, Assistant Vice Presidents, Vice Presidents, Senior Vice Presidents, and Executive Officers provided through Unum. The plan consists of two parts:

- Automatic Group LTD (no election required): An automatic group LTD is a company-paid group long term disability benefit that pays, after a 180-day elimination period, 60% of your annual pay, capped at $10,000 per month.
- Voluntary Individual Disability Insurance (IDI) (must be elected during Annual Enrollment or initial new hire enrollment): An Individual Disability Insurance policy pays 75% of compensation up to $10,000 per month and is portable. MVW will pay the cost of the first $1,000 of coverage for the IDI. The cost of any additional coverage up to the $10,000 per month limit will be the responsibility of the associate.

Financial Benefits

Retirement Plans

MVW 401(k) Retirement Savings Plan includes both the traditional 401(k) and a Roth 401(k).

TRADITIONAL 401(K) PLAN

- Save pre-tax, post-tax, or a combination of both
- Withdraw money while you're employed if you're facing a financial hardship (subject to guidelines)

ROTH 401(K)

- Save post-tax only
- MVW discretionary match with pre-tax dollars in separate account taxed at withdrawal
- The account grows tax-free and withdrawals taken during retirement are not subject to income tax, provided you're at least 59½ and have held the account for five years or more.

MATCHING CONTRIBUTIONS

MVW can make discretionary matching contributions on associates' contributions. The matching contributions made on deferrals to the Roth 401(k) must be deposited into a pre-tax account, the traditional 401(k) plan account.

HIGHLY COMPENSATED EMPLOYEE (HCE)

The IRS defines you as a Highly Compensated Employee if you made more than IRS limit, which was $150,000 in 2023. If you're an HCE, you cannot contribute to the MVW 401(k) Plan on an after-tax basis, though you may contribute to the Roth 401(k). As a HCE, you may be limited on how much you can save on a before-tax basis. The 2023 contribution limit for HCEs is 4.5%.

Visit **www.netbenefits.com** or call **1-800-835-5095.**

Retirement Plan Contribution Limits

You may contribute up to $22,500* per calendar year. For associates age 50 or older, or those who will turn age 50 during the year, the maximum contribution is $30,000*. You may increase, decrease, or discontinue your contributions at any time.

If you choose to contribute to both, maximum contribution amounts apply to combined traditional 401(k) and Roth 401(k) accounts.

*Contribution limits are subject to change each year as determined by the IRS. Contribution limits for 2024 are expected to be released in late October 2023.

MVW Deferred Compensation Plan (DCP)

The MVW DCP is for HCEs who are limited in the amount they can defer into the MVW 401(k) Plan. The DCP is a type of non-qualified employer sponsored plan, which means that it is not subject to the rules, limitations, and regulations of qualified plans like a 401(k) or IRA. It also means that associates cannot transfer funds to qualified plans.

It can be used as an investment for future financial needs like retirement or paying college tuition, and is available to a select group of associates who are highly compensated. The DCP allows highly compensated associates to defer receipt of taxable income (e.g., salary, bonus, etc.). The enrollment period is usually scheduled in the fourth quarter of the year. All eligible associates will be contacted directly to enroll in the program.

Contact the DCP administrator at **1-866-367-9744** if you are an HCE and have any questions. Inform them you are with MVW.

Employee Stock Purchase Plan (ESPP)

The MVW ESPP provides a convenient way to participate in Company ownership. You can purchase shares of MVW stock (VAC) at a five percent (5%) discount using after-tax payroll deductions.

The after-tax deductions during each pay period mean that you'll regularly set aside money to invest in your future. MVW shares are purchased at a five percent (5%) discount on the average of the high and low price on the last day of the offering period.

Enrollment in the ESPP will occur quarterly. Watch for enrollment notifications via email. For information, contact a Fidelity representative at **1-800-544-9354** between 5:00 p.m. ET Sunday and 1:59 p.m. ET on Friday.

BETTER TOGETHER

"Being a part of this team means challenging each other to learn and grow. Our benefit offerings support this notion by allowing you to make selections that will help you and your family reach your goals in the year ahead. We believe in celebrating these achievements as a team, because we know that we are **Better Together**."

Lori Gustafson
EVP, Chief Brand & Digital Officer

Benefits for Your Life

Commuter Benefits

If you take public transportation, ride in a vanpool, or pay to park near public transportation or work, you can use pre-tax dollars to pay for your commuting expenses. You can manage your account online at any time. The maximum tax-free limits for qualified workplace commuting expenses are $300* per month for mass transit and parking.

**Contribution limits are announced by the IRS each year. Information in this guide represents 2023 limits.*

Paid Time Off

You receive Paid Time Off to help you balance work and life. In addition, MVW provides paid holidays and paid leave for jury duty and bereavement.

Tuition Reimbursement

Tuition reimbursement is available to full-time associates and supports your educational and professional goals. Contact the Associate Service Center (ASC) at **associateservicecenter@mvwc.com** or call **1-855-477-2123** for more information.

Employees' Federal Credit Union

Free to all associates. Go to **www.mefcudirect.com** or call **1-800-821-7280**. No fee transactions at 57,000 CO-OP Network and Allpoint ATMs; checking and savings accounts; Visa credit cards and check cards; direct deposit of paychecks; loans for all purposes and needs; and more.

Free Direct Deposit

Avoid check-cashing fees and monthly service fees by depositing your paychecks directly into your bank account. Paychecks can be deposited in up to eight (8) different accounts and/or financial institutions. You may update your accounts via Workday.

Payroll Cards

Payroll cards are a safe way for you to receive your payroll funds electronically. The full amount or a designated amount of your paycheck may be withdrawn at any U.S. bank displaying the Visa logo at no cost or at an authorized ATM (one free withdrawal per pay period). You can also utilize the Visa card to shop and pay bills (in person, by phone or online) everywhere Visa is accepted. The card comes with access to an app to manage the account.

Employee Assistance Program(EAP)

EAP is a free and confidential employee assistance program offering consultation and referral services to you and your covered dependents to help with work-life issues and challenges. These include substance abuse, relationship management, stress, financial planning, legal advice and much more. The EAP services are accessible online and also by phone, 24-hours a day, 7 days a week at **1-800-272-2727**.

Quit for Life

MVW's Smoking Cessation Program, known as Quit for Life, is available for free to all MVW associates, except contractors and their covered dependents. You don't have to be enrolled in a medical plan to participate.

The Quit for Life program tailors a plan based on your individual lifestyle and tobacco use history. Participants receive coaching and unlimited toll-free access to a Quit Coach and an interactive online community that integrates with Quit Coach sessions and offers e-learning tools and support. To enroll, call **1-866-QUIT-4-Life**.

SAVE ON EVERYDAY ITEMS AND SERVICES

BenefitHub Online Discount Website

MVW BenefitHub is an online discount website that provides access to discounts on many everyday items and services at nationwide merchants. You do not have to be enrolled in any MVW benefits in order to take advantage of BenefitHub discounts.

Find discounts on items from cars to cell phones to insurance services. Access MVW BenefitHub through the myMVWBenefit website. Some of the items and services available at a discount include:

HEALTH & WELLNESS

- Fitness centers
- Weight loss providers
- Hearing aids, sunglasses, eyeglasses, contact lenses, fitness watches, and activity trackers
- Diabetic supplies, personal care and wellness items, prescription drug savings

INSURANCE PROTECTION

- Auto and motorcycle insurance
- Pet insurance and veterinary care plans
- Life insurance and long-term care insurance
- Accident, hospitalization, and critical illness insurance
- Travel insurance and legal services

FINANCE SERVICES

- Home loan financing
- Refinancing and consolidated credit counseling
- Tax services
- Identity theft
- Student loan refinancing and loan consolidation
- Credit repair services
- Personal loans and family legal services

EXCELLENCE ALWAYS

“Our commitment to **Excellence Always** is deeply ingrained in our culture. Yes, we achieve excellence by going above and beyond for our customers, but it’s equally important to provide excellent benefits and resources to our associates.”

Jason Marino
EVP and Chief Financial Officer

Key Terms

AFTER-TAX CONTRIBUTIONS
Contributions you make for your coverage after Social Security, federal and most state taxes are taken out of your paycheck. Contributions for disability coverage, life and accidental death & dismemberment insurance are after tax.

ANNUAL PAY
Your annual compensation is used to calculate your benefits contributions and the coverage amount for your Life, Disability (STD and LTD) and Accidental Death & Dismemberment (AD&D) benefits. Currently, the plan's definition of compensation includes wages, prior year tips, and commissions.

COINSURANCE
The percentage of the total medical bill that you and the plan pay once you meet your deductible. For example, if the plan covers 90% (the plan's coinsurance share), you will pay the remaining 10% (your coinsurance) after your deductible up to the out-of-pocket maximum.

COPAY (OR COPAYMENT)
The flat dollar amount that you pay for an office visit to an in-network provider or for a prescription drug.

DEDUCTIBLE
The deductible is the amount you need to pay out of your pocket for covered health expenses before your plan begins paying a percentage of your costs.

DEPENDENT
Your lawful spouse or domestic partner and a child who meets the plan's eligibility criteria. See your plan summary for details on who meets the dependent definition. Highlights of the rules include:

Spouse: Your spouse must be legally married to you for federal tax purposes and must live in the United States.

Domestic Partner: Your domestic partner (same- or opposite-sex partner) must live in the same household as you and cannot be legally married, separated or involved in another domestic partnership.

Children: Your child(ren) must be under age 26, unless disabled and you provide financial support.

FORMULARY
Each medical plan has its own list of brand-name drugs called a "formulary." Your costs for these drugs are typically lower.

GENERIC DRUG
Generic drugs contain the same active ingredients as brand-name drugs, but they cost much less. (Not all drugs are available as a generic.)

NON-FORMULARY
These are brand-name drugs that are not on the formulary list. These drugs could cost you more.

IN-NETWORK
A group of health care providers that offer services to participants in a medical plan at a negotiated cost.

OUT-OF-NETWORK
Health care providers that do not participate in your health plan. If you visit a provider out-of-network, your cost will be higher.

OUT-OF-POCKET MAXIMUM
The most you will pay each year in deductibles and your share of coinsurance before your plan begins paying most of your covered expenses at 100% for the rest of the year. Copays apply toward the out-of-pocket maximum.

PRESCRIPTION DRUGS
Those medicinal drugs, including insulin, which must be dispensed by a licensed pharmacist or physician and require a physician's written prescription.

PRE-TAX CONTRIBUTIONS
Contributions you make for your coverage before Social Security, federal, and most state taxes are taken out of your paycheck. Your medical, dental and/or vision coverage consists of pre-tax contributions. Contributions for the Health Care Spending Account, Dependent Care Spending Account and Health Savings Account are before tax.

PREVENTIVE CARE
Health provider visits when you're not sick such as annual physicals, immunizations, certain screening laboratory and X-ray tests and procedures that can detect things like cancer and high blood pressure, or which can prevent the development of diseases.

PRIMARY CARE PHYSICIAN/ PROVIDER (PCP)
A provider of Internal Medicine, family practitioner, pediatrician or general practitioner who attends to your common medical problems and provides preventive care and health maintenance. Note: female participants do not need a referral for OB/GYN care provided by an in-network health care professional who specializes in OB/GYN.

YOUR BENEFITS RESOURCES (YBR)
The Your Benefits Resources (YBR) section via myMVWBenefits website provides you with up-to-date, personalized information on all your benefits. Log on at **www.ybr.com/benefits/mvwc**.

Plan Contacts

Benefit	Administrator	Contact Information	Policy/Group Number
myMVW Benefits Service Center	MVW	www.ybr.com/benefits/mvwc 1-855-252-6947	
Medical Benefits			
U.S. Mainland Associates	Aetna	www.aetna.com 1-888-251-4591	326404
U.S.V.I. Associates	Cigna	www.cigna.com 1-800-244-6224	3335085
Hawaii Associates	HMSA	www.hmsa.com 1-800-776-4672	231159
So. California, Hawaii Associates	Kaiser	https://healthy.kaiserpermanente.org 1-800-464-4000	Southern CA: 231159 and 232790 Hawaii: 6841
Arizona, So. California, Mexico Associates	SIMNSA	www.simnsa.com 1-800-424-4652	673
Dental Benefits			
U.S.V.I. Associates	Cigna	www.cigna.com 1-800-244-6224	3335085
Hawaii Associates	Hawaii Dental Services (HDS)	www.hawaiidentalservice.com 1-800-232-2533 ext.228	
U.S. Mainland	MetLife	www.metlife/mybenefits 1-800-942-0854	305254-2-G
Vision Benefits			
U.S.V.I. Associates	Cigna	www.cigna.com 1-800-244-6224	3335085
Hawaii Associates	HMSA	www.hmsa.com 1-800-776-4672	
U.S. Mainland Associates	VSP	www.vsp.com 1-800-877-7195	30093159
Other Benefits			
BenefitHub Online	MVW	www.myMVW.com	
Commuter Benefits	myMVW Benefits Service Center	www.ybr.com/benefits/mvwc 1-855-252-6947	
Deferred Compensation Plan (DCP)	Mezrah Consulting	1-866-367-9744	
Employee Stock Purchase Plan (ESPP)	Fidelity	www.fidelity.com 1-800-544-9354	
Federal Credit Union	MEFCU	www.mefcudirect.com 1-800-821-7208	
Flexible Spending Accounts and Health Savings Account	myMVW Benefits Service Center	www.ybr.com/benefits/mvwc 1-855-252-6947	
Executive LTD	UNUM	1-800-858-6843	
Life & Disability	MetLife	www.metlife.com	305254-2-G
Employee Assistance Program (EAP)		1-800-272-2727	
MVW's Smoking Cessation Program	Quit for Life	myquitforlife.com/mvw 1-866-QUIT-4-Life	
401(k) Plan	Fidelity	www.netbenefits.com 1-800-835-5095	

Legal Information

This Annual Enrollment package is considered a summary of material modifications (SMM) to the Marriott Vacations Worldwide Corporation Medical Plan (Plan). It contains a summary of important changes to the Plan's Summary Plan Description. Please keep it with your Summary Plan Description, SMMs and other important Plan documents. If there is any discrepancy between the terms of the Plan as amended, and this SMM, the provisions of the Plan, as amended, will control.

The benefits shown in this brochure may not apply to you if you are represented by unions and/or collective bargaining agreements, depending on the terms of those agreements. In addition, the information in this brochure provides only an overview of the Company's benefits. Where applicable, always refer to the appropriate Benefits Summary on the Your Benefits Resources section of **www.ybr.com/benefits/mvwc** for actual details of the Plans. Moreover, the information in this brochure is not intended to provide you with legal or investment advice. To the extent you need those professional services, please contact an attorney or investment advisor. MVW reserves the right to terminate, amend, or modify the provisions of any MVW-sponsored Plan or benefit at any time.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage); however, generally, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, or adoption, you may be able to enroll yourself and your dependents; however, generally, you must request enrollment within 31 days after the marriage, or within 60 days after birth, or adoption.

Finally, the Children's Health Insurance Program (CHIP) Reauthorization Act of 2010 contains special enrollment rights that apply to all medical plans. You and your eligible dependents may enroll if Medicaid or CHIP coverage is terminated as a result of loss of eligibility. You must contact the myMVWBenefits Service Center within 60 days of the date Medicaid or CHIP coverage is lost to enroll. You and your eligible dependents may also enroll if you or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP, and you request coverage within 60 days after eligibility for the subsidy is determined.

To request special enrollment or obtain more information, contact the myMVWBenefits Service Center at **1-855-252-6947**.

Benefit Eligibility

This is a brief description of benefits offered to eligible associates of MVW and its subsidiaries and/or affiliates. Your receipt of this brochure does not guarantee that you are entitled to the benefits described within. Enrollment and/or contributions are required for some benefits. In addition, some benefits have waiting periods for eligibility and other requirements.

Nota

Para obtener una version en Español de ésta información, llame al **1-855-252-6947**.

Your Benefits Resources™ is a trademark of Alight Solutions.

HIPAA Privacy Notice

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) PRIVACY PROVISIONS

The Plan will use Protected Health Information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended. The Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations. The Plan Sponsor hereby certifies that in accordance with HIPAA, access to PHI may be given only to the Plan Sponsor and staff of the Plan Sponsor who receive PHI related to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business in carrying out Plan administration functions that the Plan Sponsor performs for the Plan. If the Plan Sponsor and said staff do not comply with this Plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions. With authorization, the Plan will disclose PHI for the purposes granted, and to the parties specified in the authorization.

THE PLAN SPONSOR AGREES:

Not to use or further disclose PHI other than as permitted or required by the Plan document or as required by law; and ensure that the separation between the Plan and Plan Sponsor required under the privacy rules is supported by reasonable and appropriate security measures;

Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI; and to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

Not to use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit Plan of the Plan Sponsor unless authorized by an individual;

To report to the Plan any security incident or any PHI use or disclosure that it becomes aware is inconsistent with the uses or disclosures for which provision is made;

To report to individuals the event of any acquisition, access, use, or disclosure of the individual's PHI in a manner not permitted under HIPAA and its implementing regulations;

To report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;

To make PHI available to an individual in accordance with HIPAA's access requirements;

To make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

To make available the information required to provide an accounting of disclosures;

To make internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA;

If feasible, to return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or, if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and

That the health Plan is prohibited from using or disclosing genetic information for underwriting purposes.

Women's Health and Cancer Rights Act (WHCRA)

As required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, this Plan provides coverage for:

1. All stages of reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the Plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter. For more information, contact: the myMVWBenefits Service Center at **1-855-252-6947**.

Michelle's Law Notice

ELIGIBILITY FOR CONTINUED COVERAGE FOR DEPENDENT STUDENTS ON MEDICALLY NECESSARY LEAVE OF ABSENCE

Michelle's Law applies to group health plans for plan years beginning on or after October 9, 2009 (for calendar year plans, the law is effective beginning January 1, 2010). Michelle's Law provides continued coverage under group health plans for dependent children who are covered under the group health plan as a student but lose their student status because they take a medically necessary leave of absence from school.

As a result, if your child is no longer a student, as defined in the plan, because he/she is on a medically necessary leave of absence, your child may continue to be covered under the plan for up to one year from the beginning of the leave of absence. This continued coverage applies if, immediately before the first day of the leave of absence, your child was (1) covered under the plan and (2) enrolled as a student at a post-secondary educational institution (includes colleges and universities).

For purposes of this continued coverage, a "medically necessary leave of absence" means a leave of absence from a post-secondary educational institution, or any change in enrollment of the child at the institution, that:

1. Begins while the child is suffering from a serious illness or injury,
2. Is medically necessary, and
3. Causes the child to lose student status for purposes of coverage under the plan.

The coverage provided to dependent children during any period of continued coverage:

1. Is available for up to one year after the first day of the medically necessary leave of absence, but ends earlier if coverage under the plan would otherwise terminate, and
2. Stays the same as if your child had continued to be a covered student and had not taken a medically necessary leave of absence.

If the coverage provided by the plan is changed during this one-year period, the plan must provide the changed coverage for the dependent child for the remainder of the medically necessary leave of absence unless, as a result of the change, the plan no longer provides coverage for dependent children.

If you believe your child is eligible for this continued coverage, the child's treating physician must provide a written certification to the plan stating that your child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

COORDINATION WITH COBRA CONTINUATION COVERAGE

If your child is eligible for Michelle's Law's continued coverage and loses coverage under the plan at the end of the continued coverage period, continuation coverage under COBRA will be available at the end of Michelle's Law's coverage period and a COBRA notice will be provided at that time.

Questions?

If you have any questions regarding the information in this notice or your child's right to Michelle's Law's continued coverage, or if you would like a copy of your Summary Plan Description (which contains important information about plan benefits, eligibility, exclusions, and limitations), you should contact: the myMVWBenefits Service Center at **1-855-252-6947**.

Important Notice 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 MVW 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. MVW has determined that the prescription drug coverage offered by MVW 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.

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 MVW coverage will not be affected. You can keep your MVW coverage if you elect Part D, but this plan will NOT coordinate with your Part D coverage if this plan is not the primary payer.

If you do decide to join a Medicare drug plan and drop your current MVW coverage, you and your dependents will be able to get this coverage back during the next annual enrollment period.

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

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

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE

Contact the myMVWBenefits Service Center at **1-855-252-6947** 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 MVW changes. You also may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

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

FOR MORE INFORMATION ABOUT MEDICARE PRESCRIPTION DRUG COVERAGE:

Visit **www.medicare.gov**

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.

Call **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**.

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

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

Name of Entity/Sender: Marriott Vacations Worldwide Corporation

Address: 9002 San Marco Court, Orlando, FL 32819

Phone Number: **1-407-206-6000**

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
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
Website: http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – HEALTH FIRST COLORADO (COLORADO'S MEDICAID PROGRAM) & CHILD HEALTH PLAN PLUS (CHP+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+: https://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-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

INDIANA – MEDICAID
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone: 1-800-457-4584

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://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – MEDICAID
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or
1-855-618-5488 (LaHIPP)

MAINE – MEDICAID
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=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

MASSACHUSETTS – MEDICAID AND CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840, TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – MEDICAID
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

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

MONTANA – MEDICAID
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

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

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

NEW HAMPSHIRE – MEDICAID
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 5218

NEW JERSEY – MEDICAID AND CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

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

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

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

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

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

PENNSYLVANIA – MEDICAID AND CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – MEDICAID AND CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or
401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – MEDICAID
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - MEDICAID
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – MEDICAID
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

UTAH – MEDICAID AND CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– MEDICAID
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

VIRGINIA – MEDICAID AND CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

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

WEST VIRGINIA – MEDICAID AND CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – MEDICAID AND CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – MEDICAID
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

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

U.S. DEPARTMENT OF LABOR
Employee Benefits Security Administration
Website: www.dol.gov/agencies/ebsa
Phone: 1-866-444-EBSA (3272)

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES
Website: www.cms.hhs.gov
Phone: 1-877-267-2323, Menu Option 4, Ext. 61565

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

When key parts of the health care law took effect in 2014, there is a new way 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 new 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. Annual enrollment for health insurance coverage through the Marketplace began in October 2013 for coverage starting as of January 1, 2014.

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 9.5% 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 the myMVWBenefits Service Center at **1-855-252-6947**.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **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.

[1]An 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.