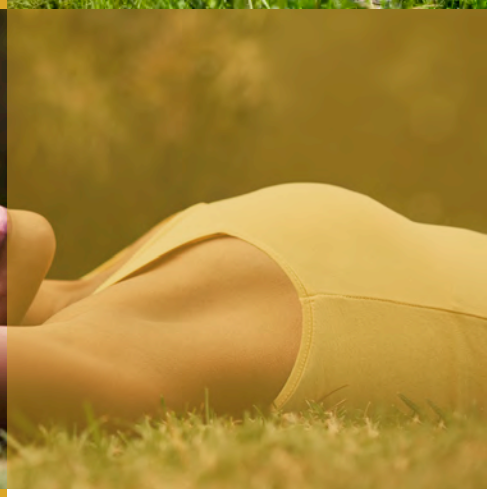
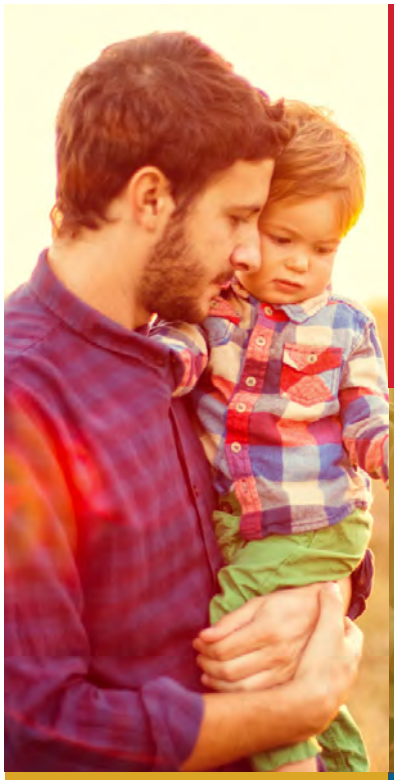
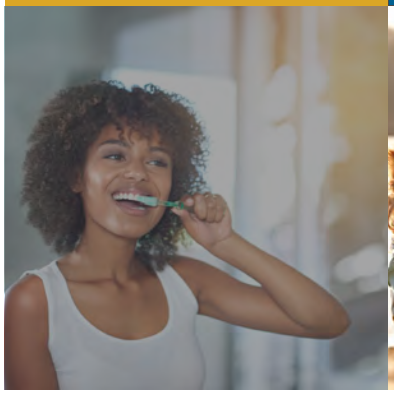


2018
Benefits Guide

ELDORADO RESORTS





What's in this guide?

Keep in mind, this summary of benefits is intended to be a brief outline of your coverage; the entire provisions of benefits and exclusions are contained in your Summary Plan Descriptions (SPDs). In the event of a conflict between the SPD and this guide, the terms of your SPD will prevail.

Welcome to the 2018 Benefit Election Period!

Get ready to make your benefit elections for 2018!

At Eldorado Resorts, we value the dedication and hard work our team members commit each day out to ensure the growth and continued success of our company. Our family of properties has grown and we have never been so excited about the future of our team, their families and our company. Eldorado Resorts has always believed that the foundation of our success is driven by our team and the family-style service you provide our guests.

To support you during times that matter most, Eldorado Resorts offers a comprehensive package of benefits for our team members that include, Medical, Prescription, Dental, Vision and Life Insurance available to both you and your family. In addition, we offer the ability to purchase Short Term and Long-Term disability insurance to protect your income. Other Voluntary programs include a Flexible Spending Account so you can put away tax-free dollars to use on your family's healthcare expenses. We also offer a 401K plan to help you save for your retirement. Lastly, we offer all of our employees the opportunity to purchase additional voluntary products through Colonial Life that are intended to protect your savings and assets during life's unintended or unexpected medical events.

This enrollment guide is provided to educate you on the benefits available to you as an important member of our team. We will also support you with benefit counselors at your property if you have questions about the best options for you and your family such as:

- Which Medical plan works best for you and your family?
- Should I be contributing to a Flexible Spending Account ?
- Should I purchase supplemental Life or Disability Insurance?
- Do I need to cover eligible family members under my health or insurance benefits?

Answers to these questions and more can affect how insurance can work for you to offset life's twists and turns. So take some time to consider your options and if you have questions, take some time to meet with a benefit counselor who can assist you with your personal needs.

NOTE: If you do not want to make any changes to your current benefits you do not need to re-enroll. The benefits you currently have will automatically continue into 2018. There is only one exception: If you would like to participate in a Flexible Spending Account (FSA), you must make a new election for 2018.

If you are enrolled in a medical plan, you must complete the on-line smoking affidavit.

If you are enrolling your spouse in the medical plan, you must verify your spouse is not eligible for other insurance by completing the on-line spousal affidavit.

Your Benefit Choices

Eldorado Resorts offers the following benefit package to active full-time Team Members:

- Medical Plan
- Dental Plan
- Vision Plan
- Company paid Basic Life and Accidental Death & Dismemberment Insurance
- Voluntary Life
- Voluntary Short and Long Term Disability
- Flexible Spending Accounts
- Critical Illness with Cancer
- Accident
- Hospital Indemnity

Choosing Your Coverage

Your benefit choices are "un-bundled" meaning you may elect to enroll in the plans that provide you and your family with the best coverage. There are 4 tiers of coverage for the medical, dental and vision plans:

- Team Member Only
- Team Member and Spouse
- Team Member and Child(ren)
- Team Member and Family

Paying for Your Contributions on a Pre-Tax Basis

If you enroll in the medical, dental and/or vision plans, your contributions will automatically deduct from your paycheck on a pre-tax basis. Pre-tax deductions save you money by not paying Social Security and Federal Income Tax on your contributions.

WHAT DO YOU NEED TO DO?

1. Read this guide and share information with your family members.
2. Consider the options and compare the features of each plan. Consider how you use your current medical plan, then think about your needs for the coming year.
3. Decide if you would like to save money by enrolling in a Flexible Spending Account. This is where you can save money on a pre-tax basis to pay for health and/or qualified dependent care expenses.
4. Compare the costs of the plans. Review key benefits such as the deductible and the cost to see a physician or specialist.
5. Gather any documentation you'll need for adding dependents to your coverage. Be sure your dependents are eligible based on the eligibility rules included in this guide.
6. Complete and submit your enrollment form by the deadline.

Eligibility

Full-time Team Members are classified as Team Members who work 30+ hours per week. Full-time Team Members are eligible to participate in the plan after 90 days of employment with an effective date on the 91st day. **If you do not enroll within 31 days of your initial eligibility period, you will not be able to enroll until the next annual open enrollment period**

Dependent Eligibility—You can enroll the following dependents into the same medical, dental and vision plans you choose for yourself.

- Your legal spouse
- Your under age 26 child, stepchild, legal ward or any child required by a Qualified Medical Child Support Order (QMCSO) or other court or administrative order—even if the child does not reside with you.

Spousal Coverage Rule—If your spouse is eligible for health coverage through his/her employer, the spouse is not eligible for coverage under this plan.

Required Documentation

If you are adding dependents to the medical, dental or vision plans for the first time during your enrollment, you must present the following dependent verification documentation to your Benefits Department. If proper documentation is not provided by you by the end of the open enrollment period, these newly added dependents will not be enrolled for coverage during the new plan year unless you experience a qualifying life event. A valid social security card is required for all spouses and dependents and you must sign an affidavit declaring your spouses eligibility.

DEPENDENT REQUIRED DOCUMENTATION	
Spouse	Marriage License, valid Social Security Card
Natural Children	Birth Certificate, valid Social Security Card
Step-Children	Birth Certificate and Marriage License showing parent's names, valid Social Security Card
Dependent Child(ren)	Legal guardian, adoption Certificate, final court order of legal guardianship, valid Social Security Card

Health Care Reform requirements state we must report valid Social Security Numbers (SSN) for all covered individuals to the IRS. Missing SSN's could later result in you paying a tax penalty.

If my spouse also works for an Eldorado Resorts Property, what coverage level should we select?

If both you and your spouse work full-time for the company and are both eligible for coverage, you may both enroll in either Team Member only coverage or one of you may enroll as Team Member and spouse. If both enroll in Team Member only coverage, only one of you may cover eligible dependent children. Determine which is more advantageous based on your circumstances.

Waiving Medical Coverage

You may choose not to elect medical coverage under the Eldorado Resorts group medical plan. But keep in mind that the individual mandate provision of the Patient Protection and Affordable Care Act (PPACA) requires you, your children and anyone else that you claim as a dependent on your taxes to have health insurance in 2017 or you may be required to pay a penalty when you file your federal income tax return.

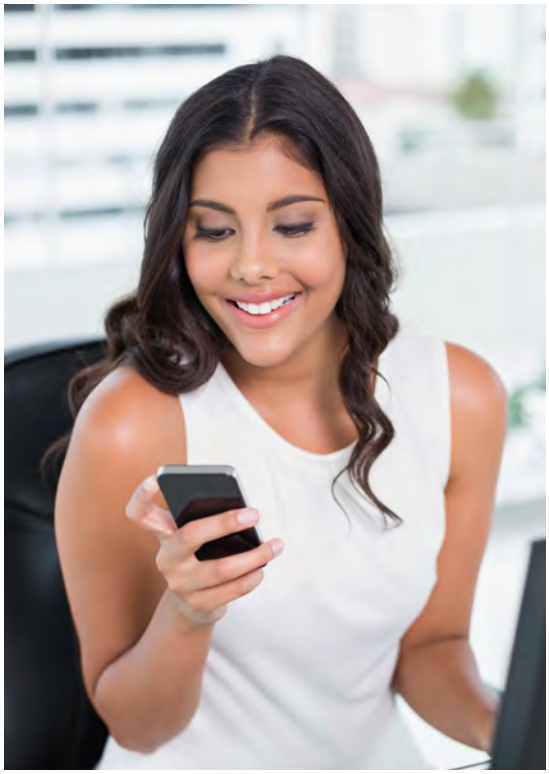
Qualifying Life Event

You cannot change your plans, coverage levels or dependents during the year unless you have a "Qualifying Life Event" (QLE). Qualifying Life Events allow you to make changes to certain benefits during the year. You must submit the required documentation to Human Resources, (e.g., legal marriage certificate, birth certificate or birth confirmation for newborns, etc.) **within 30 days of the event, (60 days for a birth or adoption).**

You may change your medical, dental/vision coverage tier, voluntary life insurance and Flexible Spending Account elections during the year for the following QLE's:

- Legal marriage
- Divorce, legal separation or death
- Birth or adoption of a child
- Change in your employment status and corresponding change in eligibility for benefits
- Changes in your spouse's employment status in which available health coverage is gained or lost.

If you have questions regarding Qualifying Life Events, call Health Advocate at: 866-799-2731.



Basic Medical Insurance Terms

IN-NETWORK VERSUS OUT-OF-NETWORK—Networks request providers to participate in its network, and in return, providers agree to offer discounted services to their patients. If you pick an out-of-network provider, your claims could cost more because you will not receive the discounts that an in-network provider offers.

PREVENTIVE CARE—You and your family may be eligible for some important preventive services which can help you avoid illness and improve your health—at no additional cost to you. Examples of Preventive Care Services include: physical, flu vaccine, diabetes and cholesterol tests, cancer screenings such as mammograms and colonoscopies. **For a full list of covered preventive services, visit www.HHS.gov or see page 25-26 of this guide.**

DEDUCTIBLE—The amount you owe for covered healthcare services before your plan begins to pay benefits. Some services are subject to the deductible and other services may either be free (preventive care) or require just a co-pay (office visit). For example, if you have a service that is subject to the deductible and the deductible is $1,000, the plan won't pay anything until you've paid the first $1,000 of the bill.

COINSURANCE—The percentage of covered expenses that are paid by the plan each calendar year after you have paid the deductible. This is your cost share.

COPAY—A copay is a fixed-dollar amount you pay for a healthcare service. The amount can vary by the type of service. Your copays will not count towards your deductible but will count towards your out-of-pocket maximum.

OUT-OF-POCKET MAXIMUM—The out-of-pocket maximum is designed to protect you in the event of a catastrophic illness or injury. Your out-of-pocket maximum includes your deductible, coinsurance, and copays that you pay for out of your own pocket. After you have paid the specified out-of-pocket amount during a policy year, your health insurance pays the remaining in-network covered services at 100%.

EXPLANATION OF BENEFITS (EOB)—This is a statement from the insurance company showing how claims were processed. The EOB tells you what portions of the claim were paid to the doctor or hospital and what portion of the payment, if any, you are responsible for paying.

If you have questions regarding these definitions or any other medical terms, call Health Advocate at: 866-799-2731

Medical Benefits

Medical/Prescription Drugs

You have two plans to choose from; the Core Plan or the Buy-up Plan.

Both Plans offer:

- 100% coverage for in-network preventive care, such as annual physicals, immunizations, age-appropriate lab tests and screenings.
- A higher level of benefits when you use in-network providers, specialists and hospitals. Contracted in-network providers offer discounted rates so you pay less out-of-pocket for care.
- The flexibility to choose an out-of-network doctor or hospital. Please note that the plan pays less for services received from out-of-network providers, so you will end up paying more, including any charges above the plan's allowable charges.

The Core and Buy-up Plans are traditional "co-pay" based plans. These plans have a set co-pay for each visit to an in-network doctor. Other types of medical services received outside of the normal doctor office visit may require the annual deductible to be met before the plan will pay. Once you meet the plan's deductible, the Core Plan pays 75% and the Buy-up Plan pays 80% of your covered medical expenses.

Which Plan is Best for You?

FEATURE	CORE PLAN	BUY-UP PLAN
Contribution: This is the amount you pay from your paycheck for coverage.	Offers lower Team Member contributions. This plan might be right for you if you expect low (or no) medical costs beyond preventive care (covered at 100%)	Costs more in Team Member contributions and gives you higher co-insurance coverage.
In-network Deductible: This is the amount you have to pay before co-insurance applies.	$1,000 Team Member only coverage $2,000 family coverages	$750 Team Member only coverage $1,500 family coverage
Co-insurance: This is the percentage of in-network services that you and the plan pay (after the total deductible is met).	The plan pays 75% of the cost, you pay 25%.	The plan pays 80% of the cost, you pay 20%.
Out-of-Pocket Maximum: The plan pays 100% of in-network expenses over the out-of-pocket maximum for the rest of the year.	$6,000 Team Member only coverage $12,000 family coverage	$4,000 Team Member only coverage $8,000 family coverage

Out of Network Area Coverage

For Team Members, spouses or other dependents who reside in an area outside of the network, access to additional providers and hospitals is provided through the Multiplan/PHCS network. More information can be found at http://www.multiplan.com/.

For those traveling outside of the network area, non-emergent services may require prior-authorization.

Medical and Prescription Drugs Plan Design

MEDICAL AND PRESCRIPTION BENEFIT COMPARISON				
	Core Plan		Buy-Up Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Medical				
Preventive Care	Plan pays 100%	50%	Plan pays 100%	50%
Primary Care Office Visit	$40 copay	50% after deductible	$25 copay	50% after deductible
Specialist Office Visit	$80 copay		$50 copay	
Urgent Care	$50 copay		$50 copay	
Emergency Room	$750 copay		$750 copay	
Radiology (X-Rays)	25% after $1,000 Team Member or $2,000 family deductible is met		20% after $750 Team Member or $1,500 family deductible is met	
Routine Lab				
Calendar Year Deductible (individual/family)	$1,000/$2,000	$2,000/$4,000	$750/$1,500	$1,500/$3,000
Coinsurance *	25%	50%	20%	50%
Out-of-Pocket Maximum (individual/family)	$6,000/$12,000	$12,000/$24,000	$4,000/$8,000	$8,000/$16,000
Inpatient Hospital Services	25% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient Hospital Services				

MEDICAL AND Rx BENEFIT COMPARISON		
	Core Plan	Buy-Up Plan
	In-Network	In-Network
Prescription Drugs		
Generic	$15	$10
Preferred Brand	$40	$35
Non-Preferred Brand	$75	$50
Mail Order	2.5x retail copay	2.5x retail copay
Specialty	$100	$100

* Coinsurance is the percentage of expenses paid by you after you have paid the deductible. Co-pays do not count toward the plan deductible.

Mental Health/Substance Abuse

In addition to the importance of your major medical needs, the mental and behavioral health of Eldorado Team Members is of the utmost importance. Both plan options provide coverage of mental health and substance use disorders. The plans also cover rehabilitative and habilitative services that can help support people with behavioral health challenges. See your plan documents for more details.

Mail Order: Home Delivery for Prescriptions

Home delivery is a convenient and cost-effective way for you to order up to a 90-day supply of maintenance or long-term medication for delivery to your home.

For new prescriptions, the easiest way to start home delivery is to ask your doctor to write your prescription for 90 days. Your doctor may call or fax the prescription to OptumRx for you.

You should receive your order within 14 days from the time OptumRx receives your order. You can track your order on the OptumRx website or you can call member services.

Medical Plan Contributions

SALARY BAND/ ENROLLMENT TIER	CORE PLAN	BUY UP PLAN
	Paycheck Contribution Amount (from the paychecks each month, 26 x per year)	
Less than $35k		
Team Member Only	$44.39	$57.91
Team Member + Spouse	$121.23	$146.46
Team Member + Child(ren)	$98.81	$119.82
Family	$164.65	$202.93
$35k–$60k		
Team Member Only	$74.54	$89.45
Team Member + Spouse	$139.88	$166.49
Team Member + Child(ren)	$116.96	$139.36
Family	$185.81	$225.47
Greater than $60k		
Team Member Only	$111.31	$127.60
Team Member + Spouse	$181.15	$209.15
Team Member + Child(ren)	$157.23	$185.63
Family	$230.08	$271.13

Contact Info

MEDICAL AND PRESCRIPTION DRUGS PLAN	
Hometown Health	
Website	www hometownhealth com
Telephone	800.336.0123 or 775.982.3024
Hometown Health E-Card:	Available on the iTunes and Google Play stores. Once loaded, swipe to see the front and back of card. You may fax or e-mail the card to your providers office.

Tobacco Surcharge

$65 per month ($30 — 26 times/year)

For Team Members who use tobacco products, there will be a $65 per month surcharge added to your monthly rates.

This surcharge is intended to discourage the use of tobacco products, which are harmful to your health even when used in moderation. Tobacco cessation programs and tobacco cessation drug coverage are offered to support your health.

ALL Team Members covered under Eldorado's medical plan will certify annually during Open Enrollment whether or not they are tobacco users. If you participate and complete an approved tobacco cessation program, contact your Human Resources department to have the surcharge removed.

We expect Team Members in our company to have integrity and to complete this processes honestly. Any false statement could lead to disciplinary action up to and including termination of employment. You may also lose all company contributions to your health premium. We reserve the right to randomly test for nicotine.

HealthAdvocate™

ONE CALL for ALL of your healthcare and benefits questions! (medical, dental, vision, etc.)

Personal assistance from registered nurses supported by medical directors and benefits specialists who will:

- Help find the right doctor, specialist, and hospital
- Help scheduling appointments, especially with hard-to-reach specialists
- Help with insurance claims and billing issues; research and uncover claims or billing errors
- Negotiate payment arrangements
- Explain complex medical conditions and procedures; research treatment options
- Review options and arrange second opinions; transfer medical records
- Assist with benefit issues for you and your family including family covered under Medicare or another plan
- Help obtaining services for your elderly parents and parents-in-law
- Help with transportation
- Help when faced with serious illness or injury
- Help is available in Spanish

Health Advocate provides unlimited access to a team of experienced Personal Health Advocates. Personal Health Advocates are familiar with your entire employee benefits package. They can explain your coverage, answer your questions, and when you need to reach a specific benefit (such as medical, pharmacy or dental), **they can connect you right away!** Personal Health Advocates are experts at navigating the complicated healthcare and insurance systems. They will do the paperwork, make the calls and cut through the red tape to resolve a wide range of issues. **All to save you time, money and worry!**

Personalized Health Information at your fingertips! You also have 24/7 access to your own, password-protected member website.

Register and log-in to find:

- Up-to-Date benefits, insurance and other information
- Tools to track your health and develop a personal health action plan
- Important alerts about recommended preventive care and other screenings

Employee Assistance Program (EAP)

As an Eldorado Team Member, you have access to Hartford's EAP, known as "Ability Assist"

This program is a valuable resource for both you and your family, to receive professional support for everyday issues like job pressures, relationships, retirement planning or personal impact of grief, loss, or a disability.

The service includes up to three face-to-face emotional or work-life counseling sessions per occurrence per year. This means you and your family members won't have to share visits. Each individual can get counseling help for his/her own unique needs. Legal and financial counseling are also available by telephone during business hours.

Contact Info

TEAM MEMBERS ASSISTANCE PROGRAM (EAP)	
The Hartford	
Website	www.guidanceresources.com In the Company/Organization field, use: HLF902; Then, create your own confidential user name and password. Company Name: "abili"
Telephone	800.964.3577

Flexible Spending Account

Flexible Spending Accounts (FSA's) offer a convenient way to save money on a pre-tax basis through payroll deductions for your estimated out-of-pocket Health Care and Dependent Care expenses. Pre-tax means the dollars you use for eligible expenses are not subject to Social Security Tax, Federal Income Tax, and in most cases, state and local income taxes. Your FSA contributions are then reimbursed to you for expenses incurred during the plan year.

Note: If you enroll in an FSA, you must re-enroll every year and elect your annual contribution amount. Annual re-enrollment is not automatic!

Healthcare FSA

In 2018, you may elect to contribute between $130 and $2,650 per year.

With a Healthcare FSA, you get a tax break on you or your eligible dependents' (regardless if they are enrolled in a the Eldorado Resorts Health Plan) out-of-pocket healthcare expenses. The funds can be used for expenses such as:

- Deductible and Copays
- Medical and dental coinsurance (the portion of covered expenses that you pay)
- Prescription Copays

Your entire 2018 health care election amount is available for immediate use. This is especially helpful for unexpected expenses. You may pay for your FSA claims as you incur them by using your FSA debit card. You can also submit claims for payment using an FSA claim form on-line.

Example;

Your child needs braces and you know you will use the maximum $1,000 allowed under the dental plan.

	HEALTHCARE	
	No FSA	FSA
Annual Pay	$30,000	$30,000
Pre-tax FSA (cost of braces)	$0	$1,000
Taxable wages	$30,000	$29,000
Estimated tax (28%)	$8,400	$8,120
After tax cost of braces	$1,000	$0
Take home	$20,600	$20,880
Your cost of braces	$1,000	$720

Some ways to use your FSA...

Health Plan Related Expenses

- Prescription Drugs
- Co-payments
- Doctor Visits
- Hospital Charges

Vision Care Related Expenses

- Eyeglasses
- Contact Lenses
- Contact Lens Solution
- Laser Vision Correction

Dental Care Related Expenses

- Dental Exams and Cleanings
- Fillings
- Root Canals and Crowns
- Dentures and Bridges
- Orthodontia

Dependent Care Expenses

- Qualified Day Care Centers
- Preschool Charges
- Before- and After-School Care
- Summer Day Camp
- In- and Out-of-Home Care for Children or the Elderly

Contact Info

FLEXIBLE SPENDING ACCOUNTS

Ameriflex

Website www. myameriflex.com

Telephone 844-423-4636

Dependent Day Care FSA

In addition, you can participate in the Dependent Day Care FSA and contribute between $130 and $5,000 per year. You can use pre-tax dollars to pay for qualified day care expenses for your children under age 13 or a dependent adult so you and your spouse can work. Eligible expenses include day care, preschool, before and after school care, summer day camp and elder/handicapped dependent care. Must be a qualified and licensed day care provider. Your dependent care funds can only be reimbursed up to the amount you have contributed at the time the claim is submitted (less any previous claims paid that year).

Note: The Dependent Care FSA does not cover Health Care expenses for dependents. Unused Dependent Care Funds do not rollover from year to year.

Four things to remember about the Flexible Spending Accounts

1. The Health Care and Dependent Care Flexible Spending Accounts are two separate accounts. Money in the Health Care account cannot be used to pay for Dependent Care expenses and vice versa.
2. If you do not use your entire health care contribution during the plan year, up to $500 of unused funds may be rolled over to the following year. You will have up to December 31st to use the roll-over.
3. Plan carefully! Unused amounts above $500 will be forfeited (per IRS guidelines). Remember to set aside only what you expect to use during the plan year.
4. Flexible Spending Account cannot be used to pay for the company medical plan contributions.

Dental Benefits

Delta Dental is our new dental insurance partner. This network includes the Premier Dentist Network with no balance billing. This means that you can use any Delta Dental provider and the the benefits will be paid based on the schedule below.

This network includes the Premier Dentist Network no balance billing. This means that you can use any Delta Dental provider and the benefits will be paid based on the scheudule below.

Dental Plan Design

BENEFITS	DELTA DENTAL PPO DENTIST	DELTA DENTAL PREMIERE DENTIST	NON-DELTA DENTAL DENTIST
Diagnostic & Preventive	100%	100%	80%
Sealants	100%	100%	80%
Space Maintainers	100%	100%	80%
Basic Restorative	80%	80%	60%
Oral Surgery	80%	80%	60%
Simple Extractions	80%	80%	60%
Endodontics	80%	80%	60%
Surgical Periodontics	80%	80%	60%
Non-Surgical Periodontics	80%	80%	60%
Stainless Steel Crown	80%	80%	60%
Denture Repair and Relining	80%	80%	60%
Major Restorative	50%	50%	50%
Prosthodontics—Fixed & removable	50%	50%	50%
Implants	50%	50%	50%
Orthodontics—Child	50%	50%	50%
Orthodontics—Adult	Not Covered	Not Covered	Not Covered
Deductible (Does not apply to Diagnostic, Preventive, and Orthodontic Services)			
Per Patient/Calendar year	$ 50	$ 50	$ 50
Per Family/Calendar year	$150	$150	$150
Maximums			
Per Patient/Calendar year	$1500	$1500	$1500
Lifetime Ortho maximum/Patient	$1000	$1000	$1000

Dental Plan Contributions

TEAM MEMBER CONTRIBUTIONS	
	Paycheck Contribution Amount (deducted from the first two paychecks each month —26 x per year)
Team Member Only	$5.52
Team Member + Spouse	$11.04
Team Member + Child(ren)	$11.04
Family	$16.56

Contact Info

DENTAL CARE	
Delta Dental	
Website	www.deltadentalins.com
Telephone	800.521.2651
Mobile App	Delta Dental's Mobile App available on the iTunes and Google Play stores

Vision Benefits

100% Team Member Paid Benefit

VSP is our new vision partner. Coverage with VSP offers you a nationwide network of premier providers as well as the option to select an out-of-network provider.

Regular eye examinations can not only determine your need for corrective eye wear but also may detect general health problems in their earliest stages.

Vision Plan Design

VISION PLAN COMPARISON				
	Vision 1		Vision 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
WellVision Exam	$10 co-pay	Covers up to $45	$10 co-pay	Covers up to $45
Prescription Glasses	$20 co-pay	N/A	$20 co-pay	N/A
Frame	Included w prescrip. glasses	Covers up to $70	Included w prescrip. glasses	Covers up to $70
Lens Allowance	Included w prescrip. glasses	Covers up to $30	Included w prescrip. glasses	Covers up to $30
Lined Bifocal Allowance	Included w prescrip. glasses	Covers up to $50	100%	Covers up to $50
Lined Trifocal Allowance	Included w prescrip. glasses	Covers up to $65	100%	Covers up to $65
Standard Progressive Lens	$55 co-pay	Covers up to $50	$55 co-pay	Covers up to $120
Contacts (**instead** of glasses)	Up to $40 co-pay	Covers up to $120	N/A	N/A
Contacts (**in addition** to glasses)	N/A	N/A	Up to $40 co-pay	Covers up to $120
Laser Vision Correction	Avg 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities			

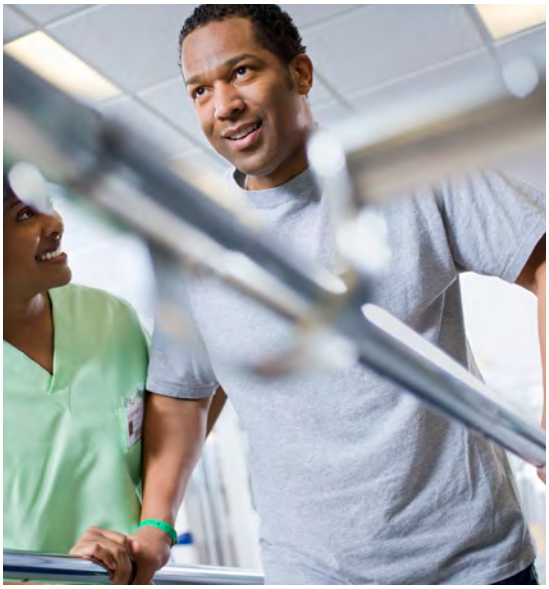
Vision Plan Contributions—100% Voluntary

TEAM MEMBERS CONTRIBUTIONS	Vision 1	Vision 2
	Paycheck Contribution Amount (deducted from paychecks each month—26 x per year)	
Team Member Only	$1.77	$4.07
Team Member + Spouse	$3.78	$8.67
Team Member + Child(ren)	$3.53	$8.10
Family	$6.02	$13.84

Contact Info

VISION	
VSP - Vision Services Plan	
Website	www.vsp.com
Telephone	800-877-7195

Life/AD&D Insurance



Company Paid

Eldorado Resorts pays for Basic Life and Accidental Death and Dismemberment insurance for all benefit eligible Team Members. This insurance is provided to you through The Hartford.

In the event of your death, our life insurance policy helps provide a safety net for your beneficiaries.

If your death is the result of an accident, or if an accident leaves you with certain debilitating injuries, you'll be covered under our Accidental Death and Dismemberment (AD&D) insurance for the same amount. We hope this company-paid policy helps you feel more secure and prepared to manage your financial obligations.

If you die while covered by this plan, the benefit is paid to the beneficiary (or beneficiaries) you designate, in writing. If you do not have a beneficiary on file, Hartford will follow guidelines (outlined in the contract) to determine to whom your benefit will be paid.

CLASS	BENEFIT
Salaried Team Members	1x your annual salary
Hourly Team Members	$40,000

Voluntary Life Insurance

We recognize you and your family have specific needs, and our company-paid life insurance policy may not be enough to ensure your financial security if your income was suddenly lost. We offer a voluntary life insurance option with competitive group rates so you can purchase the financial protection you need. Voluntary Life Insurance is offered through The Hartford.

Evidence of Insurability (EOI) or proof of good health is required under the following circumstances:

- **Late entrant:** You previously waived the opportunity to elect this coverage and are now electing for the first time.
- **Current participant:** You currently have this coverage and are requesting an increase to your current coverage amount.
- **Newly eligible:** You have never been offered this coverage or previously waived this coverage and are requesting more than $200,000.

CURRENT RENO VOLUNTARY LIFE BENEFITS (NO AD&D)	
Team Members Benefit	Increments of $10,000 up to $500,000 Maximum—No Salary Cap
Team Members Guarantee Issue	$200,000
Spouse Benefit	50% of spouse benefit to a maximum of $100,000
Spouse Guarantee Issue	$50,000
Child Benefit	50% of Team Member benefit to a maximum of $10,000
Accelerated Death Benefit	80% of benefit
Age Reduction	Reduces to: 65% age 70, 45% age 75, 30% age 80, 25% age 85, 15% age 90
Portability	Portable

Voluntary Life Insurance—Monthly Plan Contributions

AGE BANDS	RATES PER $1,000 IN BENEFIT:
<29	$0.08
30-34	$0.09
35-39	$0.11
40-44	$0.18
45-49	$0.29
50-54	$0.49
55-59	$0.76
60-64	$1.19
65-69	$2.12
70-74	$3.80
75-79	$6.27

How to Calculate your Cost—Voluntary Life

AMOUNT OF COVERAGE	DIVIDED BY 1000	MULTIPLIED BY RATE FOR YOUR AGE ON JAN 1, 2018	MULTIPLIED BY 12	DIVIDED BY 26
$	/1000	X $ _____ =	X 12 =	/26 =

Example

If you are 35 and you want to purchase $50,000 in optional Team Members-paid life insurance, your premium would be

AMOUNT OF COVERAGE	DIVIDED BY 1000	MULTIPLIED BY RATE FOR YOUR AGE ON JAN 1, 2018	MULTIPLIED BY 12	DIVIDED BY 26
$50,000	/1000 = $50	X $ 0.11 = $5.50	X 12 = $66	/26 = $2.54

Short-Term Disability

A short-term disability plan ensures you have financial protection in the event of a short term injury or illness. Our policy, through The Hartford, provides you with a percentage of your weekly income while you are out of work following a non-work-related accident or illness.

VOLUNTARY STD—THE HARTFORD	
Benefit %	60%
Maximum Weekly Benefit	$1,000
Maximum Benefit Period	24 weeks
Pre-existing Limitation	12/12
Elimination Period	14 Day Accident/14 Day Sickness (waived if hospitalized)

Short-Term Disability Plan Contributions

	MONTHLY PREMIUM
Rates per $10 of covered benefit	$0.67

How to Calculate your Cost—Voluntary STD

WEEKLY EARNINGS	TIMES 60% (EQUALS COVERED WEEKLY BENEFIT AMOUNT)	DIVIDED BY 10	MULTIPLIED BY RATE	MULTIPLIED BY 12	DIVIDED BY 26
$	x .60	/10	X $ .67 =	X 12 =	/26 =

Example

WEEKLY EARNINGS	TIMES 60% (EQUALS COVERED WEEKLY BENEFIT AMOUNT)	DIVIDED BY 10	MULTIPLIED BY RATE	MULTIPLIED BY 12	DIVIDED BY 26
$400	x .60 = $240	/10 = $24	X $ .67 = $16.08	X 12 = $192.96	/26= $7.42

Long-Term Disability

Long Term Disability (LTD) protects your family by providing you with a percentage of your income while you are disabled for a longer period than Short Term Disability would otherwise cover. Eldorado offers a Voluntary LTD plan through The Hartford.

	STANDARD LTD	5 YEAR DURATION
Benefit %	60%	60%
Maximum Monthly Benefit	$10,000	$10,000
Maximum Benefit Duration	Social Security Normal Retirement Age (SSNRA)	5 years
Pre-existing Limitation	12/12	12/12
Own Occupation*	2 years	2 years
Elimination Period	180 days	180 days

*Own occupation means you are unable to perform your own occupation (that which you were engaged when you became unable to work).

Long-Term Disability Plan Contributions

	HARTFORD 2 LTD OPTIONS	
	Rates—Standard LTD	Rates—5 Year Duration
Age Bands	Rates per $100 of covered payroll	Rates per $100 of covered payroll
<25	$0.261	$0.149
25-29	$0.261	$0.149
30-34	$0.387	$0.221
35-39	$0.549	$0.314
40-44	$0.756	$0.432
45-49	$1.368	$0.781
50-54	$1.800	$1.028
55-59	$2.529	$1.444
60-64	$2.529	$1.290
65-69	$1.467	$0.838

How to Calculate your Cost—Voluntary LTD

MONTHLY EARNINGS	DIVIDED BY 100	MULTIPLIED BY RATE FOR YOUR AGE ON JAN. 1, 2017	MULTIPLIED BY 12	DIVIDED BY 26
$	/100	X $ _____=	X 12 =	/26 =

Example

35 year old electing Standard LTD option.

MONTHLY EARNINGS	DIVIDED BY 100	MULTIPLIED BY RATE FOR YOUR AGE ON JAN. 1, 2017	MULTIPLIED BY 12	DIVIDED BY 26
$1,700	/100 = $17	X $0.549 = $9.33	X 12 = $112.00	/26 = $4.31

Contact Info

LIFE AND DISABILITY INSURANCE	
The Hartford	
Website	www.thehartford.com
Telephone	800.303.9744

Colonial Life
The benefits of good hard work.®

Group Critical Illness Insurance
Plan 2 Basic

For more information, talk with your benefits counselor.

ColonialLife.com

If you're diagnosed with a covered critical illness or cancer, group critical illness insurance* from Colonial Life can help with your expenses, so you can concentrate on what's most important – your treatment, care and recovery.

*The policy name is Critical Illness and Cancer Group Specified Disease Insurance.

Face amount: $ Up to $30,000 in Guaranteed Issue Coverage

Critical illness benefit

For the diagnosis of this covered critical illness condition:[1]	This percentage of the face amount is payable:
Heart attack (myocardial infarction)	100%
Stroke	100%
End-stage renal (kidney) failure	100%
Major organ failure	100%
Coronary artery bypass graft surgery/disease[2]	25%

Subsequent diagnosis of a different critical illness[3]

If you receive a benefit for a critical illness, and later you are diagnosed with a different critical illness, the original percentage of the face amount is payable for that particular critical illness.

Subsequent diagnosis of the same critical illness[3]

If you receive a benefit for a critical illness, and later you are diagnosed with the same critical illness, 25% of the original face amount is payable. Critical illness conditions that do not qualify are: coronary artery bypass graft surgery/coronary artery disease[2].

Diagnosis of cancer benefit

Covered cancer benefits	
For this condition:[1]	**The amount payable is:**
Diagnosis of cancer (internal or invasive)	100% of the face amount
Diagnosis of carcinoma in situ	25% of the face amount
Skin cancer	$500

Cancer vaccine benefit: $50

This benefit is payable if you or your covered family members incur a charge for any FDA-approved cancer vaccine while your certificate is inforce.

UNI-TOBACCO RATES
GROUP SPECIFIED DISEASE

	EE Only	EE plus Spouse	1-Parent Family	2- Parent Family
$10,000	$12.32	$18.78	$12.55	$19.02
$20,000	$24.65	$37.57	$25.11	$38.03
$30,000	$36.97	$56.35	$37.66	$57.05

Bi-Weekly Premiums shown and will be paid Post Tax

Colonial Life
The benefits of good hard work.

ColonialLife.com

1 Please refer to the certificate for complete definitions of covered conditions.

2 Benefit for coronary artery disease applicable in lieu of benefit for coronary artery bypass graft surgery when health savings account (HSA) compliant plan is selected.

3 Dates of diagnoses of a covered critical illness must be separated by at least 180 days.

THIS POLICY PROVIDES LIMITED BENEFITS.

Insureds in MA must be covered by comprehensive health insurance before applying for this coverage.

EXCLUSIONS AND LIMITATIONS FOR CRITICAL ILLNESS

We will not pay the Critical Illness Benefit or Benefit Payable Upon Subsequent Diagnosis of a Critical Illness that occurs as a result of a covered person's: alcoholism or drug addiction; felonies or illegal occupations; intoxicants and narcotics; psychiatric or psychological conditions; suicide or injuries which any covered person intentionally does to himself; war or armed conflict; or pre-existing condition, unless the covered person has satisfied the pre-existing condition limitation period shown on the Certificate Schedule on the date the covered person is diagnosed with a critical illness.

EXCLUSIONS AND LIMITATIONS FOR CANCER

We will not pay the Diagnosis of Cancer Benefit, Diagnosis of Carcinoma in Situ Benefit, the Cancer Treatment and Care Benefit or the Skin Cancer Benefit for a covered person's cancer (internal or invasive), carcinoma in situ or skin cancer that: is diagnosed or treated outside the territorial limits of the United States, its possessions, or the countries of Canada and Mexico; is a pre-existing condition, unless the covered person has satisfied the pre-existing condition limitation period shown on the Certificate Schedule on the date the covered person is initially diagnosed as having cancer (internal or invasive), carcinoma in situ or skin cancer. No pre-existing condition limitation will be applied for dependent children who are born or adopted while you are covered under the policy, and who are continuously covered from the date of birth or adoption.

This is not an insurance contract and only the actual certificate provisions will control. Applicable to certificate form GCC1.0-C (including state abbreviations where used, for example: GCC1.0-C-TX). The certificate or its provisions may vary or be unavailable in some states. Please see your Colonial Life benefits counselor for details.

Underwritten by Colonial Life & Accident Insurance Company, Columbia, SC

Accident

Starting in 2017, we are introducing a voluntary Group Accident policy through Colonial Life. Group Accident insurance is an indemnity plan that provides Team Members and their families with hospital, doctor, accidental death and catastrophic accident benefits in the event of a covered accident. These benefits can help with the out-of-pocket medical and non-medical expenses associated with an accident.

Colonial Life pays these benefits once per covered person for each covered accident unless otherwise noted. You may elect either "Plan 2" or "Plan 3" depending on the level of coverage you need:

ACCIDENT BENEFITS	PLAN 2	PLAN 3
Accident Emergency Treatment—4 visits per person per calendar year (Doctor's office, urgent care facility or emergency room)	$125 per visit	$125 per visit
Accident Follow-Up Doctor Visit (Doctor's office, urgent care facility or emergency room)	$50/visit 3 visits per covered accident; 12 visits per calendar year	$50/visit 4 visits per covered accident; 16 visits per calendar year
Accidental Death	$25,000 Team Member/SP;$5,000 CH	$50,000 Team Member/SP;$10,000 CH
Accidental Death—Common Carrier	$100,000 Team Member/SP;$20,000 CH	$200,000 Team Member/SP;$40,000 CH
Accidental Dismemberment: Loss of Finger/Toe Loss of Hand/Foot/Sight	(1) $750; (2+) $1,500 (1) $7,500; (2+) $15,000	(1) $1,500; (2+) $3,000 (1) $15,000; (2+) $30,000
Ambulance—Air	$1,500	$2,000
Ambulance—Ground	$200	$400
Appliances (such as wheelchair, crutches)	$100	$200
Blood/Plasma/Platelets	$300	$500
Burns(based on size and degree)	2nd Degree 36% of body: $1,000 3rd Degree 9sq"–18sq": $2,000 >18sq"–35sq": $4,000 Over 35 sq": $12,000	2nd Degree 36% of body: $1,500 3rd Degree 9sq"–18sq": $3,000 >18sq"–35sq":$6,000 Over 35 sq":$18,000
Burns—Skin Graft	50% of burn benefit	50% of burn benefit
Catastrophic Accident (For severe injuries that result in the total and irrevocable: loss of one hand and one foot; loss of both hands or both feet; loss or loss of use of one arm and one leg; loss or loss of use of both arms or both legs; loss of sight of both eyes; loss of hearing of both ears; loss of the ability to speak.)365-day elimination period	$50,000 Team Member/SP;$25,000 CH	$75,000 Team Member/SP;$37,500 CH
Coma (duration of at least 14 consecutive days)	$10,000	$20,000
Concussion	$150	$200
Dislocation (Based on joint and if repaired by open or closed reduction)	$150—$6,000	$200—$8,000
Emergency Dental Work	$300 (crown, implant or denture) or $100 (extraction)	$600 (crown, implant or denture) or $200 (extraction)
Eye Injury	$300	$400
Fracture (Based on bone and if repaired by open or closed reduction)	$150—$7,500	$200—$10,000
Hospital Admission[1]	$1,000	$1,500
Hospital Confinement[2]	$200/day, up to 365 days	$300/day, up to 365 days

ACCIDENT BENEFITS	PLAN 2	PLAN 3
Hospital Confinement Due to Covered Sickness benefit (Optional Benefit)	$100/day, max 30 days	$100/day, max 30 days
Hospital ICU Admission[1]	$1,500	$2,500
Hospital ICU Confinement[2]	$400/day, up to 15 days	$600/day, up to 15 days
Rehabilitation Unit Confinement[3]	$100/day, up to 15 days per covered accident, and up to 30 days per calendar year	$150/day, up to 15 days per covered accident, and up to 30 days per calendar year
Knee Cartilage—Torn	$500	$1,250
Laceration(based on size and repair)	No Stitches: $25 With stitches less than 2": $75 2'-6": $300 greater than 6": $600	No Stitches: $50 With stitches less than 2": $1502'-6": $600 greater than 6": $1,200
Lodging (Companion) (per day up to 30 days)	$150	$200
Medical Imaging Study (Limit one per covered person per calendar year)	$150	$400
Pain Management (Epidural Anesthesia)	$100	$150
Prosthetic Device/Artificial	$500 (1);	$1,000 (1);
Limb	$1,000 (2+)	$2,000 (2+)
Ruptured Disc with Surgical Repair	$500	$1,200
Surgery—Cranial, Open Abdominal, Thoracic	$1,500	$2,000
Surgery—Hernia	$200	$250
Surgery—Exploratory and Arthroscopic	$150	$250
Tendon/Ligament/Rotator	$500(1);	$1,200(1);
Cuff	$750(2+)	$1,800(2+)
Therapy—Occupational and Physical Therapy(per day, up to 10 days)	$25	$40
Transportation(per trip, up to 3 trips per accident)	$500	$600
X-Ray Benefit	$30	$50

[1] Colonial will not pay the hospital admission benefit and the hospital ICU admission benefit for the same covered accident simultaneously.
[2] Colonial will not pay the hospital confinement benefit and the hospital ICU confinement benefit simultaneously.
[3] Colonial will not pay the hospital confinement benefit and the rehabilitation unit confinement benefit simultaneously.

Bi-Weekly Premium Rates—"Plan 2"

	TEAM MEMBERS	TEAM MEMBERS & SPOUSE	1-PARENT FAMILY	2-PARENT FAMILY
Bi-Weekly Premium	$6.89	$11.37	$13.18	$17.66

Bi-Weekly Premium Rates—"Plan 3"

	TEAM MEMBERS	TEAM MEMBERS & SPOUSE	1-PARENT FAMILY	2-PARENT FAMILY
Bi-Weekly Premium	$10.93	$17.91	$19.74	$26.72

Colonial Life
The benefits of good hard work.®

Group Hospital Confinement Indemnity Insurance

Plan 1 with Accident Only Emergency Room Visit Benefit

For more information, talk with your benefits counselor.

ColonialLife.com

Group Medical Bridge℠ insurance can help with medical costs that your health insurance may not cover. These benefits are available for you, your spouse and eligible dependent children.

Hospital confinement benefit ..... **$500 and $1500 per day options**
Maximum of one day per covered person per calendar year

Accident only emergency room visit benefit ..... **$150 per day**
Maximum of one day per covered person per calendar year

Health savings account (HSA) compatible

This plan is compatible with HSA guidelines. This plan may also be offered to employees who do not have HSAs.

Colonial Life & Accident Insurance Company's Group Medical Bridge offers an HSA compatible plan in most states.

EXCLUSIONS

We will not pay benefits for losses which are caused by: dental procedures, elective procedures, cosmetic surgery, felonies or illegal occupations, pregnancy of a dependent child, psychiatric or psychological conditions, suicide, intentional injuries, war, armed forces service or giving birth within the first nine months after the certificate effective date. We will not pay benefits for hospital confinement of a newborn who is neither injured nor sick. We will not pay benefits for loss during the first 12 months after the effective date due to a pre-existing condition, which means a sickness or physical condition for which a covered person was treated, had medical testing, received medical advice or had taken medication within the six months before the certificate effective date.

For cost and complete details, see your Colonial Life benefits counselor. Applicable to certificate number GMB1.0-C-NV-R. This is not an insurance contract and only the actual certificate provisions will control.

Deductions per year: 26

Group Medical Bridge for NV Composite

Applicable to Policy Forms GMB1.0-P & GMB1.0-C

- Hospital Confinement: $500, Accident Only Emergency Room: $150

ISSUE AGE	NAMED INSURED	EMPLOYEE & SPOUSE	ONE-PARENT FAMILY	TWO-PARENT FAMILY
17-99	$2.96	$5.91	$4.81	$7.77

Group Medical Bridge for NV Composite

Applicable to Policy Forms GMB1.0-P & GMB1.0-C

- Hospital Confinement: $1500, Accident Only Emergency Room: $150

ISSUE AGE	NAMED INSURED	EMPLOYEE & SPOUSE	ONE-PARENT FAMILY	TWO-PARENT FAMILY
17-99	$8.35	$16.70	$12.16	$20.51

Preventive Services Covered Under the Affordable Care Act

The following preventive services must be covered without your having to pay a copayment or co-insurance or meet your deductible. This applies only when these services are delivered by a network provider. **For more information, visit www.hhs.gov**

Covered Preventive Services for Adults

- Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
- Alcohol Misuse screening and counseling
- Aspirin use for men and women of certain ages
- Blood Pressure screening for all adults
- Cholesterol screening for adults of certain ages or at higher risk
- Colorectal Cancer screening for adults over 50
- Depression screening for adults
- Type 2 Diabetes screening for adults with high blood pressure
- Diet counseling for adults at higher risk for chronic disease
- HIV screening for all adults at higher risk
- Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
- Hepatitis A
- Hepatitis B
- Herpes Zoster
- Human Papillomavirus
- Influenza (Flu Shot)
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Tetanus, Diphtheria, Pertussis
- Varicella
- Learn more about immunizations and see the latest vaccine schedules.
- Obesity screening and counseling for all adults
- Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
- Tobacco Use screening for all adults and cessation interventions for tobacco users
- Syphilis screening for all adults at higher risk

22 Covered Preventive Services for Women, Including Pregnant Women

- Anemia screening on a routine basis for pregnant women
- Bacteriuria urinary tract or other infection screening for pregnant women
- BRCA counseling about genetic testing for women at higher risk
- Breast Cancer Mammography screenings every 1 to 2 years for women over 40
- Breast Cancer Chemoprevention counseling for women at higher risk
- Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women*
- Cervical Cancer screening for sexually active women
- Chlamydia Infection screening for younger women and other women at higher risk
- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs*
- Domestic and interpersonal violence screening and counseling for all women*
- Folic Acid supplements for women who may become pregnant
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes*
- Gonorrhea screening for all women at higher risk
- Hepatitis B screening for pregnant women at their first prenatal visit
- Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women*
- Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older*
- Osteoporosis screening for women over age 60 depending on risk factors
- Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users
- Sexually Transmitted Infections (STI) counseling for sexually active women*
- Syphilis screening for all pregnant women or other women at increased risk
- Well-woman visits to obtain recommended preventive services*

26 Covered Preventive Services for Children

- Alcohol and Drug Use assessments for adolescents
- Autism screening for children at 18 and 24 months
- Behavioral assessments for children of all ages
  - Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- Blood Pressure screening for children
  - Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- Cervical Dysplasia screening for sexually active females
- Congenital Hypothyroidism screening for newborns
- Depression screening for adolescents
- Developmental screening for children under age 3, and surveillance throughout childhood
- Dyslipidemia screening for children at higher risk of lipid disorders
  - Ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- Fluoride Chemoprevention supplements for children without fluoride in their water source
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screening for all newborns
- Height, Weight and Body Mass Index measurements for children
  - Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- Hematocrit or Hemoglobin screening for children
- Hemoglobinopathies or sickle cell screening for newborns
- HIV screening for adolescents at higher risk
- Immunization vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
- Diphtheria, Tetanus, Pertussis
- Haemophilus influenzae type b
- Hepatitis A
- Hepatitis B
- Human Papillomavirus
- Inactivated Poliovirus
- Influenza (Flu Shot)
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Rotavirus
- Varicella

Learn more about immunizations and see the latest vaccine schedules.

- Iron supplements for children ages 6 to 12 months at risk for anemia
- Lead screening for children at risk of exposure
- Medical History for all children throughout development
  - Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- Obesity screening and counseling
- Oral Health risk assessment for young children
  - Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years.
- Phenylketonuria (PKU) screening for this genetic disorder in newborns
- Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk
- Tuberculin testing for children at higher risk of tuberculosis
  - Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- Vision screening for all children

Required Notices

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 August 10, 2017. 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: **http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx**

ARKANSAS—MEDICAID

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

COLORADO—MEDICAID

Medicaid Website: **http://www.colorado.gov/hcpf**
Medicaid Customer Contact Center: 1-800-221-3943

FLORIDA—MEDICAID

Website: **http://flmedicaidtplrecovery.com/hipp/**
Phone: 1-877-357-3268

GEORGIA—MEDICAID

Website: **http://dch.georgia.gov/medicaid**
Click on Health Insurance Premium Payment (HIPP)
Phone: 404-656-4507

INDIANA—MEDICAID

Healthy Indiana Plan for low-income adults 19–64
Website: **http://www.hip.in.gov**
Phone: 1-877-438-4479
All other Medicaid
Website: **http://www.indianamedicaid.com**
Phone: 1-800-403-0864

IOWA—MEDICAID

Website: **http://www.dhs.state.ia.us/hipp/**
Phone: 1-888-346-9562

KANSAS—MEDICAID

Website: **http://www.kdheks.gov/hcf/**
Phone: 1-785-296-3512

KENTUCKY—MEDICAID

Website: **http://chfs.ky.gov/dms/default.htm**
Phone: 1-800-635-2570

LOUISIANA—MEDICAID

Website: **http://dhh.louisiana.gov/index.cfm/subhome/1/n/331**
Phone: 1-888-695-2447

MAINE—MEDICAID

Website: **http://www.maine.gov/dhhs/ofi/public-assistance/index.html**
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS—MEDICAID AND CHIP

Website: **http://www.mass.gov/MassHealth**
Phone: 1-800-462-1120

MINNESOTA—MEDICAID

Website: **http://mn.gov/dhs/ma/**
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

NEBRASKA—MEDICAID

Website: **http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx**
Phone: 1-855-632-7633

NEVADA—MEDICAID

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

NEW HAMPSHIRE—MEDICAID

Website: **http://www.dhhs.nh.gov/oii/documents/hippapp.pdf**
Phone: 603-271-5218

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: **http://www.nyhealth.gov/health_care/medicaid/**
Phone: 1-800-541-2831

NORTH CAROLINA—MEDICAID

Website: **http://www.ncdhhs.gov/dma**
Phone: 919-855-4100

NORTH DAKOTA—MEDICAID

Website: **http://www.nd.gov/dhs/services/medicalserv/medicaid/**
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**
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA—MEDICAID

Website: **http://www.dhs.pa.gov/hipp**
Phone: 1-800-692-7462

RHODE ISLAND—MEDICAID

Website: **http://www.eohhs.ri.gov/**
Phone: 401-462-5300

SOUTH CAROLINA—MEDICAID

Website: **http://www.scdhhs.gov**
Phone: 1-888-549-0820

SOUTH DAKOTA—MEDICAID

Website: **http://dss.sd.gov**
Phone: 1-888-828-0059

TEXAS—MEDICAID

Website: **http://gethipptexas.com/**
Phone: 1-800-440-0493

UTAH—MEDICAID AND CHIP

Website:
Medicaid: **http://health.utah.gov/medicaid**
CHIP: **http://health.utah.gov/chip**
Phone: 1-877-543-7669

VERMONT— MEDICAID

Website: **http://www.greenmountaincare.org/**
Phone: **1-800-250-8427**

VIRGINIA—MEDICAID AND CHIP

Medicaid Website: **http://www.coverva.org/programs_premium_assistance.cfm**
Medicaid Phone: 1-800-432-5924
CHIP Website: **http://www.coverva.org/programs_premium_assistance.cfm**
CHIP Phone: 1-855-242-8282

WASHINGTON—MEDICAID

Website: **http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program**
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA—MEDICAID

Website: **http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx**
Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN—MEDICAID AND CHIP

Website: **https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf**
Phone: 1-800-362-3002

WYOMING—MEDICAID

Website: **https://wyequalitycare.acs-inc.com/**
Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Team Members Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 10/31/2016)

Model Women's Health And Cancer Rights Act Notice

Eldorado Resorts, Inc. is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections for individuals receiving mastectomy-related benefits. Coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

The Eldorado Health Plan provides medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan under applicable deductibles and coinsurance of your plan.

If you would like more information on WHCRA benefits, please refer to your Summary Plan Description/Policy booklet or contact your Plan Administrator.

Notice of Special Enrollment Rights

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e., legal separation, divorce, cessation of dependent status, death of a Team Member, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 30 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within **60 days** of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted

premium subsidy towards this plan, you may request enrollment under this plan within **60 days** after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

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

* This notice is relevant for healthcare coverages subject to the HIPAA portability rules.

Your Privacy Is Protected with HIPAA

Federal regulations restrict the use and sharing of confidential health information that can be directly linked to you individually. Protected health information, as outlined in the Health Insurance Portability and Accountability Act (HIPAA), cannot be used or disclosed, except as provided in our group health plans' notices of privacy practices, without your specific authorization, under penalty of law.

Special Note on Maternity and Newborn Infant Coverage

Federal law requires that we inform you each year that Eldorado Resorts, Inc. medical plans cannot restrict or require you to obtain certification for any length of stay in a hospital in connection with childbirth, for mother or newborn, that is 48 hours or less following a standard delivery or 96 hours or less following a cesarean delivery.

Your Rights Under ERISA

As a participant in Eldorado's benefits, you are entitled to certain rights and protections under the Team Members Retirement Income Security Act (ERISA) of 1974, a federal law regarding requirements for Team Members benefit plans. Your rights under ERISA are reviewed in the health care plan Summary Plan Description.

If you have any questions about your rights, you should contact the nearest office of the Team Members Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or:

Division of Technical Assistance and Inquiries
Team Members Benefits Security Administration (EBSA)
U.S. Labor Department
200 Constitution Avenue, N.W.
Washington, DC 20210

The Plan's Duty to Safeguard Your Protected Health Information

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered "Protected Health Information" ("PHI"). The Plan is required to extend certain protections to your PHI, and to give you this Notice about its privacy practices that explains how, when and why the Plan may use or disclose your PHI. Except in specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

The Plan is required to follow the privacy practices described in this Notice, though it reserves the right to change those practices and the terms of this Notice at any time. If it does so, and the change is material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other fashion. This Notice, and any material revisions of it, will also be provided to you in writing upon your request (ask your Human Resources representative, or contact the Plan's Privacy Official, described below), and will be posted on any website maintained by Eldorado Resorts, Inc. that describes benefits available to Team Members and dependents.

You may also receive one or more other privacy notices, from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI, and your rights with respect to the PHI they maintain.

Important Notice About
Your Prescription Drug Coverage and Medicare

If neither you nor any of your dependents are eligible for Medicare, please disregard this notice.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage and about your options under Medicare's prescription drug coverage. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage. 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 through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The prescription plan offered by your employer is on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay A higher premium (a penalty) if you later decide to enroll in Medicare drug plan.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from October 15 to December 7th. Individuals losing creditable prescription drug coverage through no fault of their own may be eligible for a two-month Special Enrollment Period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in a Medicare prescription drug plan and drop your current prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

Your current coverage may pay for other health expenses, in addition to prescription drugs. You may still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan. Please refer to your Plan's plan document for more information.

You should also know that if you drop or lose your current coverage and don't enroll in Medicare prescription drug coverage, and your current coverage ends, you may pay a higher premium (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 continuous days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premiums will always be at least 19% higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll.

For more information about your options under Medicare prescription drug coverage….

NOTE: You'll get this notice each year. You will also get it if this coverage through Eldorado Resorts, Inc. changes. You also may request a copy.
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 prescription drug plans. For more information about Medicare prescription drug plans:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see 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.

For people with limited income and resources, extra help paying for Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online 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).