2026 EMPLOYEE BENEFITS GUIDE

RESORTS
Casino · Hotel
SINCE 1978

Resorts Casino Hotel strives to offer you and your dependents a competitive and comprehensive benefits package. We offer medical, prescription drug, vision and dental benefits and encourage you to take the time to educate yourself about the benefit options available to you.

INSIDE THIS GUIDE

Who is eligible to enroll in benefits?

Full time non-union employees are eligible to enroll in the benefits described in this guide.

Please remember that only eligible dependents can be enrolled. For details on what constitutes an eligible dependent, please refer to the plan documents.

If you are enrolling a dependent(s) for the first time, you will need to provide proof of your dependent's eligibility to Human Resources (e.g. birth certificate, marriage certificate, social security card, etc.).

New Hires are eligible for benefits the 1st of the month following 60 days.

ENROLLING & MAKING PLAN CHANGES

How to Enroll

If you wish to enroll in any of the Resorts Casino Hotel benefits, you must **complete an enrollment form and return it to Human Resources.**

Don't Forget!

Once you have made your elections, you will not be able to change them until the next Open Enrollment period, unless you experience a qualified change in status.

Open Enrollment is held annually in November for the January effective date.

Important!

Unless you experience a qualified change in status, you cannot make changes to the benefits you elect until the next Open Enrollment period. Qualified status changes include:

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

If an eligible dependent had other coverage and such coverage is lost, the eligible dependent may be eligible for enrollment during a "special enrollment period," which is usually the 30-day period following the date that other coverage was lost, due to a qualified change in status.

You must notify HR within 30 days of experiencing a qualified status change.

MEDICAL PLANS

Aetna

Below is a summary of the medical plan options available to you. A detailed plan summary is available online. Please visit the Resorts BenePortal at **resortsacbenefits.com**.

	HDHP	CORE PLAN	BUY-UP PLAN
BENEFIT	**IN-NETWORK**	**IN-NETWORK**	**IN-NETWORK**
Calendar Year Deductible* Individual/Family	$2,000 / $4,000	$1,800 / $3,600	$1,200 / $2,400
Coinsurance	80%	80%	90%
Out-of-Pocket Maximum Individual/Family	$8,500 / $17,000	$4,600 / $9,200	$4,000 / $8,000
PCP Copay	Plan pays 80% after deductible	$40 copay	$25 copay
Specialist Copay	Plan pays 80% after deductible	$80 copay	$50 copay
Preventive Care	100%	100%	100%
Inpatient Hospital	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 90% after deductible
Outpatient Surgery	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 90% after deductible
Urgent Care	Plan pays 80% after deductible	$80 copay	$50 copay
Emergency Room	Plan pays 80% after deductible	$200 copay, then plan pays 80% after deductible	$200 copay, then plan pays 90% after deductible

* AGGREGATE DEDUCTIBLE: The entire family deductible must be met before plan pays any benefits. If you cover any dependents under the plan, the full family deductible must be met before the plan pays any benefits. However, once any individual meets the individual out-of-pocket maximum, the plan will begin to pay benefits and that individual has no further liability for the balance of the year. Other members of the family will continue to pay toward the family deductible and out-of-pocket maximum.

AETNA ONLINE RESOURCES

Go to **www.aetna.com** or download the Aetna Health app by texting "**GETAPP**" to **90156** to:

- Find an in-network provider
- Access your medical ID card
- View your benefits and get information about what is covered
- Track how much you've spent towards your deductible
- View and pay claims
- And more!

TELEMEDICINE

CVS Health Virtual Care

With CVS Health Virtual Care, you have access to primary care doctors anytime, anywhere.

If you are enrolled in the Aetna medical plan, through CVS Health Virtual Care you can access doctors by phone or video 24/7, from wherever you are.

CVS Health Virtual Care Benefits

- You can talk to a doctor from wherever you are—day or night.
- Skip the trip to the ER or urgent care.

What can be treated with CVS Health Virtual Care?

- Cold & flu symptoms
- Allergies & Sinus problems
- Asthma
- Acne
- Pink eye
- Ear infection
- Respiratory infection
- Mental health services
- Preventive Care

Visit **www.CVS.com/virtual-care** to learn more. You can also call the number on the back of your Aetna ID card if you have questions.

HEALTH SAVINGS ACCOUNT (HSA)

Inspira

HSA Overview

If you participate in the qualified High Deductible Health Plan (HDHP) through Resorts you may be eligible to participate in an HSA. An HSA is a great way to save money by allowing you to set aside pre-tax dollars, via payroll deductions, to efficiently pay for qualified healthcare, dental and vision expenses. The funds in your HSA never expire; you may utilize the money you accumulate in your account for future healthcare expenses, even if you change jobs or retire.

HSA Eligibility

In order to qualify for the HSA, you must meet the following qualifications:

- You are enrolled in the HDHP
- You (or your spouse, if applicable) have no other health coverage (excluding other types of insurance, such as dental, vision, disability or long-term care coverage)
- Are not enrolled in Medicare
- You cannot be claimed as a dependent on someone else's tax return

HSA Contributions

The maximum amount that can be contributed to the HSA in a tax year is established by the IRS and is dependent on whether you have individual or family coverage in the HDHP plan. For 2026, the contribution limits are:

- $4,400 for individual coverage
- $8,750 for family coverage
- The annual catch-up contribution for age 55 and older is $1,000.

HSA TRIPLE-TAX ADVANTAGES

HSA contributions are tax deductible, you can spend the money tax-free, and any growth is tax free.

HSA-Qualified Healthcare Expenses

You can use the funds in your HSA to pay for qualified healthcare expenses such as:

- Doctor visits
- Dental care, including extractions and braces
- Vision care, including contact lenses, prescription sunglasses and LASIK surgery
- Prescription medications
- Chiropractic services
- Acupuncture
- Hearing aids and batteries
- Over-the-counter (OTC) medications
- And more!

PRESCRIPTION PLANS

RxBenefits/Express Scripts

If you enroll in one of the Aetna medical plans, you are automatically enrolled in the corresponding prescription drug coverage, outlined below.

	HDHP*	CORE AND BUY-UP PLANS
PRESCRIPTION DRUG: RETAIL/MAIL-ORDER		
Preventive - Generic Drugs	$0 copay	$0 copay
Generic - Tier 1	Plan pays 80% after deductible	Retail: $10 copay / Mail-Order: $20 copay
Preferred Brand - Tier 2	Plan pays 80% after deductible	Plan pays 80% (Min: $35, Max: $50)
Non-Preferred Brand - Tier 3	Plan pays 80% after deductible	Plan pays 70% (Min: $60, Max: $90)
Specialty	Plan pays 80% after deductible	Preferred Brand: 80% coinsurance (Min: $50, Max: $100) Non-Preferred Brand: 70% coinsurance (Min: $75, Max: $150)

* The HDHP deductible applies to both medical services and prescription drug coverage combined

Smart90 Program

Use the Smart90 program for your maintenance medications. Smart90 is a feature of your prescription benefit, managed by Express Scripts.

With Smart90, you and your family members have two ways to get up to a 90-day supply of long-term maintenance medication (those drugs you take regularly for ongoing conditions).

You can conveniently fill those prescriptions either through home delivery from Express Scripts Pharmacy or at CVS.

Express Scripts has partnered with GoodRx to ensure that Resorts members are receiving prescription drug discounts automatically, eliminating the need for price shopping. Any out-of-pocket costs after the discount is taken at the pharmacy will count towards your deductible. No action is needed from you to receive the GoodRx discount!

Preventive Medications

To encourage preventive care and reduce out-of-pocket costs, the prescription plan now covers the full cost of certain preventive medications that are dispensed in the generic drug form.

This will include no cost for certain medications to manage diabetes, high-blood pressure, high cholesterol, heart disease, asthma and some other conditions.

Questions? Contact Rx Benefits' Member Concierge Team for assistance at **800.334.8134** or **customercare@rxbenefits.com**.

COMPARE YOUR SAVINGS WITH MAIL ORDER!*

RETAIL PHARMACY	MAIL ORDER	ANNUAL SAVINGS
Generic Copay **$10**	Generic Copay **$20**	**$40**
Annual cost ($10 per month x 12 fills) **$120**	Annual cost ($20 per order x 4 fills per year) **$80**	

* Based on the Core and Buy-Up Plans

DENTAL PLAN

Delta Dental

Below is a summary of the dental plan available to you. A detailed plan summary is available online. Please visit the Resorts BenePortal at **resortsacbenefits.com**.

DENTAL PLAN

BENEFIT	IN-NETWORK		OUT-OF-NETWORK*
	PPO DENTIST	PREMIER DENTIST	NON-DELTA DENTAL DENTIST
Annual Deductible (Individual/Family)	$50/$150	$50/$150	$50/$150
Deductible Waived for Preventive Services	Yes	Yes	Yes
Annual Plan Maximum**	$1,500	$1,500	$1,500
Out-of-Network Reimbursement	N/A	N/A	80th percentile
Diagnostic and Preventive Services	Plan pays 100%	Plan pays 100%	Plan pays 100%
Basic Services Fillings, Extractions, Endodontics (root canal), Periodontics, Oral Surgery, Sealants	Plan pays 80%***	Plan pays 80%***	Plan pays 80%***
Major Services Crowns, Gold Restorations, Bridgework, Full and Partial Dentures	Plan pays 50%***	Plan pays 50%***	Plan pays 50%***
Endodontic/Periodontic Treatment	Plan pays 80%***	Plan pays 80%***	Plan pays 80%***
Orthodontia Services (Adults/Children) Orthodontia Services Orthodontia Maximum		50% $1,500	

* If you utilize an out-of-network provider, Delta Dental will pay the maximum allowable charge (MAC) previously set for a particular service. The member may be balanced billed for the amount over the MAC.

** **Carryover Maximum:** If you get your annual preventive exam and use less than half of your plan's calendar year maximum, the difference between your calendar year maximum and what you actually used multiplied by 25% will be carried over to the following plan year. You may carryover up to $500 towards your calendar year maximum annually.

*** After deductible

The PPO and Premier networks are the same, however, you may pay less utilizing a PPO provider.

DELTA DENTAL ONLINE RESOURCES

Go to **www.deltadentalnj.com** to:

- Find an in-network provider
- Download your ID card
- View your benefits and coverage information
- Compare potential costs by treatment and provider
- Download important forms
- And more!

VISION PLAN

EyeMed

Below is a summary of the EyeMed medical plan option available to you. A detailed plan summary is available online. Please visit the Resorts BenePortal at **resortsacbenefits.com**.

EYEMED VISION PLAN

BENEFIT	IN-NETWORK	OUT-OF-NETWORK*
Routine Eye Exam	Covered in full after $10 copay Includes dilation when professionally indicated	$40 Allowance
Lenses Single Bifocal Trifocal	 $25 copay $25 copay $25 copay	 $30 Allowance $50 Allowance $70 Allowance
Frames*	$0 copay; 20% off balance over $130 allowance	$91 Allowance
Contact Lenses Elective lenses Elective disposable lenses Non-elective contact lenses	$0 copay; 15% off balance over $130 allowance	 $91 Allowance $91 Allowance $300 Allowance
Frequency Exams Lenses Frames	 Once every calendar year Once every calendar year Once every two calendar years	

Enjoy even more savings!

EyeMed also offers 40% off additional complete pairs of prescription eyeglasses and 20% off non-covered items, including non-prescription sunglasses.

To find an in-network (Insight Network) eye doctor, go to **www.eyemed.com**, use the EyeMed members app or call **866.800.5457**. For information on LASIK, call **800.988.4221**.

To view all benefits included in your plan, log into **www.eyemed.com/member**.

HELP WITH MANAGING COMPLEX HEALTH CONDITIONS

Goldfinch Health Surgical Benefit

Having surgery can be frightening and complex and often times patients have little to no help navigating the health are system. To assist, Resorts has set up a no-cost surgical management program called Goldfinch.

Managed by nurses, Goldfinch helps manage you or your covered dependent through all aspect of planned surgery. They will review the pre and post procedures, help with follow up care and assist you in managing all aspects of your surgical care needs with you and your physician. Simply call Goldfinch once you know you need surgery, and they will take it from there.

Connect with your Goldfinch Nurse Navigator today!

Email **Hello@GoldfinchHealth.com** or call **833.453.3624** to get started.

Guardian Nurses

Guardian Nurses provides access to a personal, one-on-one nurse to help employees, and their benefit enrolled dependents deal with a chronic, highly complex or catastrophic condition. You are assigned your own private nurse advocate that will work with you and your family to help in managing the complicated health care maze. The Guardian Nurse is available to you and will assist with:

- Ensuring you get access to the right providers at the right time and setting based on your personal condition
- Explaining complex medical issues
- Helping in making appointments
- Working with your providers on treatment plans
- Answering questions about your health care program
- Serving as your central point of contact around care management and navigation

The service is highly confidential, and your information is shared with no one.

If you are dealing with a chronic, complex, or catastrophic issue and want to be assigned your own Guardian Nurse, simply contact Guardian Nurses at **888.836.0260** and identify yourself as a Resorts employee. You can also call Human Resources for assistance.

COST SAVINGS AND WELLNESS SERVICES

Conner Strong & Buckelew

BenefitPerks

With CSB Benefit Perks, members gain access to premium discounts on valuable services and items.

CSB Benefit Perks is a discount and rewards program provided by Conner Strong & Buckelew (CSB) that is available to all employees at no additional cost.

The program allows employees to receive discounts and cash back for hand-selected shopping online at major retailers.

Use the Benefit Perks website to browse through categories such as: Automotive, Beauty, Computer & Electronics, Gifts & Flowers, Health & Wellness and much more! Employees can also print coupons to present at local retailers and merchants for in-person savings, including movie theatres and other services.

Start saving today by registering online at **connerstrong.corestream.com**.

HealthyLearn

Resorts employees and all your family members have access to a Wellness Portal that offers access to healthcare and wellness information and support across a variety of areas:

- Ask a Coach about common medical issues or conditions
- Look up information about symptoms or illness
- Prepare questions to ask your physician about your condition
- Access wellness support around mental health care and financial wellness

You can access this special portal, Healthy Learn, here or on your phone at **healthylearn.com/connerstrong**.

HUSK Marketplace

Get active with the HUSK Gym Membership Program. HUSK offers steep membership discounts at more than 10,000 gyms and fitness clubs nationwide. Members also get exclusive savings on home health and fitness products including Zumba, Total Gym, Schwinn, Stair Master and more. It is free to get access to this program. You only pay any discounted membership or equipment fees.

You can learn more by calling HUSK at **800-294-1500** or visit their web site at **marketplace.huskwellness.com**.

BENEFITS MAC & BENEPORTAL

Conner Strong & Buckelew

Benefits Member Advocacy Center (Benefits MAC)

When you or your family members are ill, you don't want to spend time and energy stressing about claims, networks, referrals or deductibles. You want an easy and accessible health insurance system that allows you to focus on returning to full health.

The Benefits MAC allows you to speak to a specially trained and licensed Member Advocate who can assist with benefit claims issues, coverage questions, and enrollment inquiries.

If you or your family members are enrolled in the employee benefits plans, you can take advantage of this great service.

To contact the Benefits MAC:

- Call **800.563.9929** (Monday through Friday, 8:30 am to 5:00 pm EST)
- Submit a request online at: **www.connerstrong.com/memberadvocacy**

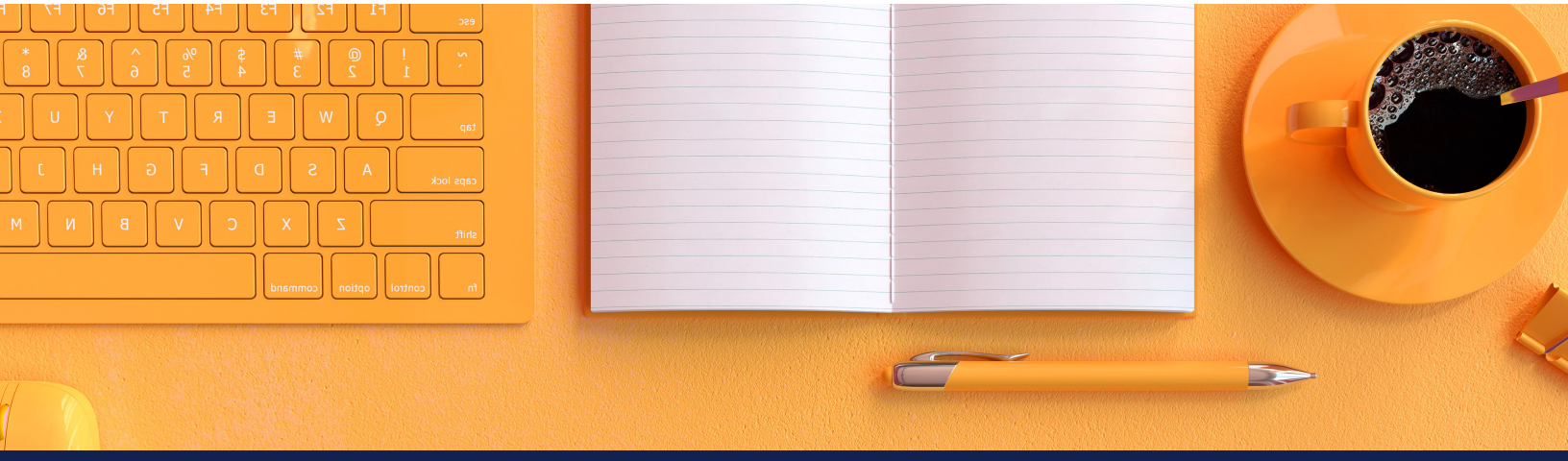
BenePortal

At Resorts Casino Hotel, you have access to a full-range of valuable employee benefit programs. With BenePortal, you and your dependents can review your current employee benefit plan options online, 24/7!

Use BenePortal to access benefit plan documents, insurance carrier contacts, forms, guides, links and other applicable benefit materials. BenePortal is mobile-optimized, making it easy to view your benefits on-the-go. Simply bookmark the site in your phone's browser or save it to your home screen for quick access.

Simply go to **www.resortsacbenefits.com** to access your benefits information today!

If you are over age 65 and want to learn more about your medical plan options and Medicare, contact our Human Resources Department who can connect you with an expert.



BI-WEEKLY EMPLOYEE CONTRIBUTIONS

Medical/Rx, Dental, and Vision Plans

	HDHP		CORE PLAN		BUY-UP PLAN	
COVERAGE TIER	**NON-TOBACCO USER**	**TOBACCO USER**	**NON-TOBACCO USER**	**TOBACCO USER**	**NON-TOBACCO USER**	**TOBACCO USER**
Employee Only	$90	$130	$120	$160	$183	$223
Employee + Spouse	$176	$216	$290	$330	$385	$425
Employee Child(ren)	$160	$200	$215	$255	$327	$367
Family	$209	$249	$335	$375	$470	$510

DENTAL PLAN

COVERAGE TIER	
Employee Only	$6
Employee + Spouse	$17
Employee Child(ren)	$19
Family	$25

VISION PLAN

COVERAGE TIER	
Employee Only	$1.15
Employee + 1	$2.18
Employee + Family	$3.21

CARRIER CONTACTS

Who to contact with questions

CARRIER/VENDOR	PHONE NUMBER	WEBSITE/EMAIL
Aetna Medical Benefits	800.962.6842	www.aetna.com
Inspira Health Savings Account (HSA)	844.729.3539	www.inspirafinancial.com
RxBenefits/Express Scripts Prescription Benefits	800.334.8134	customercare@rxbenefits.com
EyeMed Vision Benefits	866.800.5457	www.eyemed.com
Delta Dental Dental Benefits	800.452.9310	www.deltadentalnj.com
Goldfinch Surgical Benefit	833.453.3624	Hello@GoldfinchHealth.com
Guardian Nurses Complex Health Conditions	888.836.0260	N/A
Conner Strong & Buckelew Benefits MAC	800.563.9929	www.connerstrong.com/memberadvocacy
Conner Strong & Buckelew BenePortal	N/A	www.resortsacbenefits.com

The information in this guide is not intended to be a comprehensive list of benefits and participants should contact Human Resources for a copy of the official plan documents.

LEGAL NOTICES

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 canwnot 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.

Notice Regarding Special Enrollment

Loss of other Coverage (excluding Medicaid or a State Children's Health Insurance Program) If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the Company stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of coverage for Medicaid or a State Children's Health Insurance Program If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program (CHIP).

New dependent by marriage, birth, adoption, or placement for adoption
If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If you request a change due to a special enrollment event within the applicable timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment.

Eligibility for Medicaid or a State Children's Health Insurance Program
If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program (CHIP) with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

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

Newborns' and Mothers' Health Protection Act

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

Notice to Enrollees in a Self-Funded Nonfederal Governmental Group HealthPlan For Plan Years Beginning On or After September 23, 2010

This notice is appropriate in the case of a collectively bargained plan ratified on or after March 23, 2010.
Group health plans sponsored by State and local governmental employers must generally comply with Federal law requirements in title XXVII of the Public Health Service Act. However, these employers are permitted to elect to exempt a plan from the requirements listed below for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. Resorts Casino Hotel has elected to exempt the medical plan from all of the following requirements:

1. Protection against limiting hospital stays in connection with the birth of a child to less than 48 hours for a vaginal delivery, and 96 hours for a cesarean section.
2. Protections against having benefits for mental health and substance use disorders be subject to more restrictions than apply to medical and surgical benefits covered by the plan.
3. Certain requirements to provide benefits for breast reconstruction after a mastectomy.
4. Continued coverage for up to one year for a dependent child who is covered as a dependent under the plan solely based on student status, who takes a medically necessary leave of absence from a postsecondary educational institution.

The exemption from these Federal requirements will be in effect for the 2026 plan year beginning January 1, 2026 and ending December 31, 2026. The election may be renewed for subsequent plan years.

If the Plan provides protections similar to any of the exempted requirements, either voluntarily or in accordance with State law, those protections may be identified.

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other benefits. If you have any questions, please speak with Human Resources.

Availability of Summary Health Information

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

Resorts Casino Hotel offers a series of health coverage options. You should receive a Summary of Benefits and Coverage (SBC) during Open Enrollment. These documents summarize important information about all health coverage options in a standard format. Please contact Human Resources if you have any questions or did not receive your SBC.

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.

LEGAL NOTICES

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, 2025. 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: 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
Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid/
http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website:
Iowa Medicaid | Health & Human Services
Medicaid Phone: 1-800-338-8366
Hawki Website:
Hawki - Healthy and Well Kids in Iowa | Health & Human Services
Hawki Phone: 1-800-257-8563
HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)
HIPP Phone: 1-888-346-9562

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

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

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

MAINE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=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/health-care-coverage/
Phone: 1-800-657-3672

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

LEGAL NOTICES

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. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

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

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

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

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

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

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

PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

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

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

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

TEXAS – Medicaid
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

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

VERMONT– Medicaid
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

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, 2025, or for more information on special enrollment rights, contact either:

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

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

LEGAL NOTICES

Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

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

You're protected from balance billing for:

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

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

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

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

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

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

If you think you've been wrongly billed, the federal phone number for information and complaints: 1-800-985-3059.

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

INSURANCE MARKETPLACE NOTICE

PART A: General Information

When key parts of the health care law took effect in 2014, there was 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 our needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace began in October 2013 for coverage starting as early as 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 insurance carrier's customer service number located on your ID card. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area. To get information about the Marketplace coverage, you can call the government's 24/7 Help-Line at 1.800.318.2596 or go to https://www.healthcare.gov/marketplace/individual/.

PART B: Information about Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

[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.*

3. Employer Name DGMB Casino LLC DBA Resorts Casino Hotel	4. Employer Identification Number (EIN) 27-3361929	
5. Employer Address 1133 Boardwalk	6. Employer phone number 800.334.6378	
7. City Atlantic City	8. State NJ	9. Zip Code 08401
10. Who can we contact about employee health coverage at this job? Debbie Martone	11. Phone Number 609-340-6743	12. Email Address dmartone@resortsac.com

This enrollment communication addresses information on changes coming for the new year, and as such this communication constitutes a "Summary of Material Modification" or SMM to the Summary Plan Description (SPD) for the Plan, thereby modifying the information previously presented in the SPD with respect to the Plan. Please keep a copy of this SMM with the SPD previously provided to you. This benefit summary provides selected highlights of the employee benefits program at Resorts Casino Hotel. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment at Resorts Casino Hotel. All benefit plans are governed by master policies, contracts and plan documents. Any discrepancies between any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents. Resorts Casino Hotel reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time. The authority to make such changes rests with the Plan Administrator.