Caesars Entertainment Health & Welfare Summary Plan Description

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Have Questions?

WHO TO CALL AND WHERE TO LOOK

For more information about any of the benefit plans in this Summary Plan Description or about your claims, contact:

CONTACT	PHONE	WEBSITE
Caesars Benefit Service Center (for questions on all benefits listed below or to enroll)	(866) BEN-FITS or (866) 236-3487 (Interpreters are available for non-English-speaking employees.)	www.caesars.benefitsnow.com
Benefits Concierge	(800) 423-9920	
Medical insurance:		
Cigna (all properties excluding Atlantic City properties, Horseshoe Cincinnati, Turfway Park, and Horseshoe Indiana)	(800) 423-9920	www.cigna.com (before benefit enrollment) www.mycigna.com (after benefit enrollment)
Horizon BCBS (Atlantic City properties only)	(800) 355-BLUE or (800) 355-2583	www.horizonblue.com
Humana (Horseshoe Cincinnati, Turfway Park, and Horseshoe Indiana only**)**	(855) 634-8486	www.humana.com (before benefit enrollment) www.myhumana.com (after benefit enrollment)
Employee Assistance Program (EAP): Cigna Behavioral Health	(888) 886-2404	www.cignabehavioral.com Employer ID: caesars
Prescriptions: Express Scripts	(866) 578-5001	www.express-scripts.com
Dental insurance: MetLife	(800) 942-0854	www.metlife.com/mybenefits Company Name: Caesars Entertainment
Vision insurance: EyeMed Vision Care	(855) 400-3639	www.eyemedvisioncare.com
Health Savings Accounts (HSAs) and Flexible Spending Accounts (FSAs):		
Bank of America (for questions about HSAs and FSAs in the Caesars plans)	(800) 297-0827	www.bankofamerica.com/benefitslogin
Internal Revenue Service (for questions about	(800) 829-3676	www.irs.gov

CONTACT	PHONE	WEBSITE
eligible expenses)		

Health Reimbursement Accounts (HRAs): **Cigna** (all properties excluding Atlantic City properties, Horseshoe Cincinnati, Turfway Park, and Horseshoe Indiana) **Horizon BCBS** (Atlantic City properties) **Humana** (Horseshoe Cincinnati, Turfway Park, and Horseshoe Indiana only)	(800) 423-9920 (800) 355-BLUE or (800) 355-2583 (855) 634-8486	www.mycigna.com www.horizonblue.com www.myhumana.com
Life and AD&D insurance: **Aetna** **Minnesota Life**	(800) 523-5065 (866) 296-6047	www.aetnalifeessentials.com www.lifebenefits.com
Disability (STD or LTD): Cigna	(800) 423-9920	www.mycigna.com
Expert Second Opinion: **Best Doctors**	(888) 237-3073	www.bestdoctors.com
Surgery Assist: **Surgery Plus** (Tahoe & Reno only)	(855) 200-2116	www.mysurgeryplus.com/Caesars
401(k): Aon Hewitt	(866) BEN-FITS or (866) 236-3487	www.caesars.benefitsnow.com
Travel Assistance: **Aetna**	877.935.3704 (U.S.) 312.935.3704 (all other countries)	
24-hour Health Information Line **Cigna** (all properties excluding Atlantic City properties, Horseshoe Cincinnati, Turfway Park, and Horseshoe Indiana) **Horizon BCBS** (Atlantic City properties)	(800) 564-9286 (800) 355-BLUE or (800) 355-2583	
Cigna Health Pregnancy, Healthy Babies Program **Cigna** (all properties excluding Atlantic City properties, Horseshoe Cincinnati, Turfway Park, and Horseshoe Indiana)	(800) 423-9920	

Telehealth Services: MDLIVE	(888) 632-2738	www.mdlive.com/caesars
Cost Transparency Tool (medical and pharmacy costs): **ClearCost Health** (available to Cigna and Horizon plan members; available to Horseshoe Cincinnati, Turfway Park, and Horseshoe Indiana in 2015)	(800) 318-4168	www.clearcosthealth.com/caesars
Wellness Rewards	(800) 591-9220	www.wellnessrewardsnow.com

CHOOSING WELLNESS

At Caesars, we know when you're at your best you bring your best to your life – to your family, your friends, our customers and our business. That's why we're committed to Choosing Wellness as a company, and why we're committed to providing a complete benefit package that supports the overall wellness of you and your loved ones.

Choosing Wellness means different things to different people. For some, it means exercising more, or managing an existing health condition. For others, it means saving for retirement or increasing life insurance. But for everyone, it's about understanding your benefits and the choices you have, so you can make the best decisions for your personal situation.

Choosing Wellness includes three areas, detailed in this booklet:

- Health Plans include medical, dental and vision coverage
- Wellness & Health Management programs include no- or low-cost preventive care and disease management
- Financial Benefits & Education includes life, AD&D and disability

The goal is to help you be at your best, bringing together a complete vision of Choosing Wellness for yourself and for your career.

ABOUT THIS BOOKLET

The purpose of this Summary Plan Description (SPD) booklet is to familiarize you with the health and welfare benefit programs offered by Caesars Enterprise Services, LLC (Caesars) under the Caesars Enterprise Services, LLC Welfare Benefit Plan (Plan). For a list of all of the Caesars entities participating in the Plan, please refer to the Administrative Information Section of this SPD.

While the summary in this booklet describes the principal features of Plan benefits in general, in some instances, it is still only summary and not intended to explain each and every detail of the benefits. For those summarized benefits, you will be directed to links containing individual summaries or insurance certificates that further describe your rights and benefits. Caesars has available the underlying master Plan documents and group insurance contracts, where applicable, for your examination.

Our goal is to help you make well-informed decisions about your benefits. Read this SPD to learn:

- how the plans work,
- key plan features,
- your benefit options,
- what services are covered,
- how benefits are paid and
- special rights and protections.

Although comprehensive, this booklet is designed to make it easy for you to find and understand the information about your benefit plans.

Benefits for **union-represented employees** are subject to collective bargaining. Some, or all, of the benefits and/or features outlined in this Summary Plan Description may not apply. If you are a union-represented employee, your local Human Resources department can explain how these benefits apply to you.

La Descripción del Plan del Resumen

Este folleto, llamado una Descripción del Plan del Resumen, describe los Beneficios del Programa de Caesars para empleados que trabajan el tiempo completo son elegibles de Caesars Entretenimiento Inc. Lea este Resumen para aprender: sobre las características del plan/cómo sus beneficos trabajan/sus opciones del beneficio/qué servicios son cubiertos/cómo beneficios son pagados/los derechos y las protecciones especiales.

Si usted quisiera leer su Resumen en Español por favor de contactar el Centro de Servicio de Beneficios de Caesars al (866) BEN-FITS.

Please keep this booklet to refer to in the future.

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Your Benefits Program

WHO IS ELIGIBLE?

Generally, you are eligible to participate in Caesars' Benefits Program if you:

- are an active non-union full-time employee of Caesars Entertainment Corporation working a minimum of 30 hours a week; an employee shall be deemed at work on each day of a regular paid vacation day or a regular non-working holiday,
- are a United States citizen or legal resident alien and
- complete the eligibility waiting period, as explained below.

You are not eligible to participate in the benefit plans if you are:

- A temporary agency employee, leased employee, independent contractor or other non-employee service provider to the company (regardless of the number of hours worked).
- An employee covered by a union contract (unless coverage in the plans is specified in the contract).

WHEN COVERAGE BEGINS

Eligibility Waiting Period

For certain benefits you may need to wait a certain amount of time before you are eligible for coverage. This is called a "waiting period." The length of your waiting period depends on where you work and whether you are a salaried or hourly employee, as shown in the chart below:

If You Work For...	If You Are A Full-Time Hourly Employee You Are Eligible For:	If You Are a Full-Time Salaried Employee You Are Eligible For:
All Properties	All plans: After working 90 days	All plans except disability: Upon your date of hire Short- and long-term disability: After 90 days of service

If You Work For…	If You Are Salary Grade 11 Or Below, You Are Eligible For:	If You Are Salary Grade 12 Or Above, You Are Eligible For:
Corporate & Marketing Services	All plans: After 90 days	All plans except disability: Upon your date of hire Short- and long-term disability: After 90 days of service

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DEPENDENTS WHO ARE ELIGIBLE

Caesars Benefits Program is also available to your eligible dependents. Your eligible dependents include:

- **Your legal spouse** — Your lawfully married spouse recognized under federal law. This includes lawfully married same-sex spouses. A common law spouse may be covered if recognized under the laws of the state in which you live. To be eligible for benefit coverage, the spouse must be a United States citizen or legal resident alien.
- **Your domestic partner** (see *Domestic Partner Coverage* in this SPD for more information)
- **Your children and adult dependents** — Natural children, legally adopted children or those placed with you for adoption, stepchildren or any other child for whom you are a legal guardian. To be eligible for benefit coverage, a child must be a United States citizen or legal resident alien and also must be considered one of the following:
  - For medical, dental and vision coverage, your children up to age 26; or
  - for other coverage available to your dependent children, your children under age 19 who are either dependent on you for support, or for whom coverage must be provided because of a separation, divorce or Qualified Medical Child Support Order; or
  - your children of any age, who are incapable of caring for themselves due to mental or physical handicap and who are primarily dependent upon you for support (For life insurance, child must be incapable of self-support prior to age 19, or 24 if a full-time student).
  - Your domestic partner's dependents may also be eligible for coverage (see *Your Domestic Partner's Eligible Dependents* in this SPD for more information).

For medical insurance, you may be asked to submit proof of disability initially and on an annual basis.

Verifying Eligibility

You will be required to submit proof of eligibility for any dependent you cover on the Caesars Benefit Programs. Information about the required documentation will be mailed to your home address along with your Benefits Confirmation Statement showing the covered dependents. If you do not submit the required documentation on or before the date indicated on the initial request your dependents may be disenrolled retroactively from the plan.

You will be charged a spouse/domestic partner surcharge if your spouse or domestic partner has access to medical coverage through his or her employer and your spouse or domestic partner declines that coverage. The surcharge does not apply if your spouse or domestic partner is a Caesars employee eligible for the Caesars plan; employed part-time, self-employed or unemployed; or enrolled in Medicare or any other retiree medical plan (sponsored by the government or a former employer).

Special Eligibility for Newborns

Your newborn is eligible for medical and life insurance coverage. He or she is covered automatically under the medical plan for the first 31 days after birth. **To have this coverage continue beyond 31 days, you must enroll your newborn within this first 31 days.**

Your newborn is also eligible for dependent life insurance. Coverage is effective the date application is made. You must enroll him or her within 31 days of the birth. If you have children who are already enrolled in dependent life insurance, then your newborn is enrolled automatically for life insurance coverage.

Qualified Medical Child Support Orders

If a judgment, decree or order from divorce, separation, annulment or custody change requires your dependent child (including a foster child who is your tax dependent) to be covered for medical, dental or vision coverage, you may add coverage for the dependent child provided you cover yourself. If the order requires that another individual (such as a former spouse) cover the dependent child, you may change your election to drop medical, dental or vision coverage for the child if the coverage is, in fact, provided by such other individual.

A free copy of the company's Qualified Medical Child Support Orders procedures may be obtained by contacting the Caesars Benefit Service Center.

Domestic Partner Coverage

You can enroll your same-sex domestic partner and his or her dependents for medical, dental and vision coverage. A same-sex domestic partner is someone with whom you share a long-standing, mutually committed relationship. To be eligible to enroll your domestic partner and his or her dependents for benefits, your domestic partner relationship must meet all of the following criteria:

- You and your partner are 18 years of age or older.
- You and your partner have the same regular and permanent residence and have been living together as a couple in the same household for at least 12 months with the current intent to continue doing so indefinitely.
- You and your partner are not so closely related by blood that you would not be eligible to marry under existing state law.
- You and your partner have agreed to be jointly responsible for basic living expenses, such as food, clothing and shelter.
- You and your partner are financially interdependent evidenced by at least four of the following — joint bank accounts, joint credit cards, joint ownership of a residence, household expenses, granting power of attorney, designating each other as sole beneficiary/executor. You may also provide evidence of other joint financial responsibilities.
- You and your partner must complete and submit a Declaration of Domestic Partnership.

Declaration of Domestic Partnership

By signing a Declaration of Domestic Partnership, you and your domestic partner attest to the domestic partnership eligibility criteria that establish your relationship and that you both accept the terms.

What the Declaration *Does*:

Makes you eligible to enroll your domestic partner and your domestic partner's dependent child(ren) for medical, dental and vision benefits.

What the Declaration *Doesn't Do*:

- Automatically enroll your domestic partner in benefits.
- Automatically name your domestic partner as beneficiary of your life insurance coverage, 401(k) Plan or any other Caesars benefit plans.

Once you enroll your Domestic Partner, you will receive a Declaration of Domestic Partnership. After carefully reading the Declaration of Domestic Partnership, you and your domestic partner will need to sign it and send the original to the Caesars Benefits Service Center within 31 days of the election window. Otherwise, your benefit elections for your domestic partner (and domestic partner's child(ren)) will not be valid and you will need to wait until the next annual enrollment period or qualified status change to enroll for this coverage.

Your Domestic Partner's Eligible Dependents

You may also cover an eligible domestic partner's dependent children if they meet the definition of eligible dependents and you and your domestic partner have filed a Declaration of Domestic Partnership. Eligible dependents of your domestic partner include:

- Child(ren) (including stepchild(ren), foster children, and legally adopted children and children for whom you have legal guardianship) who are:
  - for medical coverage, up to age 26; or for dental and vision coverage, children who are unmarried and under age 26, if they are full-time students (eligible full-time students on a medically necessary leave of absence from school remain eligible for up to one year, but not beyond age 26);
  - for other coverage available to dependent children, children who are under age 19;
  - Children of any age, who are incapable of caring for themselves due to mental or physical handicap and who are primarily dependent upon you and/or your domestic partner for support.

When You Can Enroll In Domestic Partner Coverage

You can enroll your domestic partner and his or her dependent child(ren):

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- any time during the year after you meet the eligibility requirements;
- under certain limited circumstances as a result of an eligible family status change; or
- during annual benefits enrollment.

Keep in mind that coverage for your domestic partner and his or her dependent child(ren) is effective on the benefit effective date or the date the Declaration is approved, whichever is later. For information on how to enroll your domestic partner or domestic partner's dependent child(ren), please contact the Caesars Benefit Service Center at 1-866-BEN-FITS (1-866-236-3487).

After-Tax Considerations

Your cost for covering a domestic partner and his or her dependent children is the same as for a spouse and your dependent child(ren). However, there are tax consequences that go along with choosing domestic partner and domestic partner's dependent child(ren) coverage if they do not qualify as your federal tax dependents. The medical, dental and vision costs for your domestic partner and domestic partner's dependent child(ren) are deducted from your pay on an after-tax basis versus on a before-tax basis for a spouse and your dependent child(ren).

Imputed Income

In addition to paying part of the coverage cost on an after-tax basis, the IRS requires you to be taxed on the value of the coverage the company provides to a domestic partner and the domestic partner's dependent child(ren). This amount is referred to as imputed income. The amount of imputed income is calculated by taking the Fair Market Value (FMV) of your domestic partner's coverage and subtracting any after-tax cost you've paid. The remaining amount is what Caesars pays for your domestic partner coverage. This amount is taxed as imputed income.

Keep in mind that your imputed income will be taxed at your current tax rate and paid through normal payroll income tax deductions.

Be sure you understand the financial implications of electing domestic partner coverage so you can make the decision that is best for you and your family. The rules are complex and we recommend we consult with a tax advisor if you have any questions.

How Imputed Income Impacts Your Take-Home Pay

Let's take a look at the following scenario for Pat. She would like to add coverage for a domestic partner but does not understand how imputed income would affect take-home pay. Below is an example of how imputed income on domestic partner coverage may affect Pat's take-home pay.

Example #1:

- Pat has elected the coverage level of Employee Only.
- For this example, benefit deductions include medical, dental, and vision only. This example does not include additional deductions for benefits such as FSA or 401(k), etc. Keep in mind that differences in filing status, number of exemptions, and other benefit deductions would impact the calculations shown below.

Example #2:

- Pat has elected the coverage level of Employee plus Domestic Partner.
- For this example, benefit deductions include medical, dental, and vision only. This example does not include additional deductions for benefits such as FSA or 401(k), etc. Keep in mind that differences in filing status, number of exemptions, and other benefit deductions would impact the calculations shown below.

Calculating Pat's Take-Home Pay

	Example 1 (Employee Only)	Example 2 (Employee + Domestic Partner)
Gross Pay (base pay per-pay-period+ tips: before pre-tax deductions)	$1,500.00	$1,500.00
Pre-tax deductions (The cost of coverage you pay on a pre-tax basis)	– 27.99	– 27.99
Value of company contribution for domestic partner coverage (imputed income) this amount is taxable to you	+ 0.00	+ 235.25
Gross Taxable Pay	$1,472.01	$1,707.26
Social Security & Medicare taxes (7.65%)	$1,472.01	– 130.61*
Federal income withholding (Single – 1 Exemption)	– 182.85	– 241.66*
State Withholding (Single)	– 63.00	– 75.00*
Value of company contribution for domestic partner coverage (imputed income) – you do not receive this amount as part of your pay	– 0.00	– 235.25
After-tax deduction (IRS regulations state that deductions for domestic partner coverage must be taken on after-tax basis)	– 0.00	– 48.17
Net Take-Home Pay (Gross Taxable Pay less deductions, taxes, withholding, and imputed income)	$1,113.55 (without Domestic partner coverage)	$ 976.57 (with Domestic partner coverage)

**In Example #2, the deduction amounts for Social Security & Medicare taxes and federal and state withholding taxes increase as a result of the imputed income.*

If Your Relationship Ends

Should your relationship with your domestic partner end, or you no longer meet the domestic partnership eligibility requirements (such as sharing the same permanent residence), you're no longer considered to be domestic partners. Your former domestic partner and your domestic partner's dependent child(ren), if any, are no longer eligible for benefits. Their benefits will cease as of the date you no longer meet all the criteria for a domestic partnership. When you file the Declaration of Domestic Partnership, you and your partner agree to immediately notify Caesars if you no longer meet the domestic partner criteria.

To report the termination of your domestic partnership, you must complete the "Statement of Discontinuance of Domestic Partner Coverage." Contact the Caesars Benefits Service Center for details on how to obtain the form and where to send it. Benefits for your former domestic partner (and domestic partner's dependent children, if applicable) will cease as of the effective date of the termination of your domestic partnership. Your domestic partner and your domestic partner's dependent child(ren) may be eligible for continuation of coverage. Please contact the Caesars Benefits Service Center for more information on benefits continuation.

The termination of a domestic partnership cannot be revoked once reported to the Caesars Benefits Service Center. After 12 months from the time you report a termination of your domestic partnership, a different domestic partner may

be added to your coverage as long as the domestic partnership criteria has been met and a new Declaration of Domestic Partnership is filed within 31 days of the family status change criteria being met.

For More Information

If you have questions or would like to enroll your same-sex domestic partner and his or her dependents for medical, dental or vision coverage, you must contact the Caesars Benefits Service Center at 1-866-BEN-FITS (236-3487) for more information.

DEPENDENTS WHO ARE NOT ELIGIBLE

Certain dependents are not eligible for coverage under the plans of Caesars Benefits Program:

- Any spouse from whom you are legally divorced
- Your parents and the parents of your spouse, even if you have legal guardianship
- Grandchildren for whom you are not a legal guardian

What to Do When Your Dependents Are No Longer Eligible

If your spouse or dependent child(ren) no longer is eligible, you must contact Caesars Benefit Service Center within 31 days from the date he or she becomes ineligible. You may be able to continue health coverage for these dependents if they qualify for continuation of coverage under COBRA. To learn more about COBRA coverage see *Continuing Your Coverage Under COBRA.*

Although your dependent's coverage will end on the date he or she becomes ineligible, payroll deductions for this dependent will not stop until you notify the Caesars Benefit Service Center of your dependent's change in status. You may need to repay the cost of any benefits provided to your dependent while he or she is ineligible.

(For Dental and Vision coverage, if your child age 19 through 23 ceases to be a full-time student and later resumes as a full-time student while still under age 24, you can re-enroll the dependent child within 31 days under Caesars' Dental and Vision plans).

When Your Coverage Ends

Benefits will terminate effective 11:59 PM on the date you are terminated from the company. You may be able to continue coverage through COBRA; please see *Continuing Your Coverage Under COBRA.* For information about Flexible Spending Accounts and Life Insurance when your coverage ends, please see Additional Flexible Spending Account Rules and Additional Information About Your Life Insurance Coverage.

Participating in the Benefits Program

WHEN YOU CAN ENROLL

You must enroll to be covered under the medical, dental, vision, disability or life insurance plans or to participate in one or both of the flexible spending accounts. Generally, there are two primary circumstances in which you may enroll yourself and your eligible dependents:

- When you are first hired, or
- During annual enrollment

When First Hired

Depending on your required eligibility period (described in *Eligibility Waiting Period*), you will be allowed to enroll yourself and eligible dependents in the Caesars Benefits Program as follows:

Plan	You Must Enroll	Your Benefit Coverage Begins
Medical, Dental, Vision, Life Insurance* and FSA s		
If you are eligible after working 90 days…	Any time after you receive your enrollment packet (arriving typically 30-40 days before you become eligible), but before your actual eligibility date	On your 91st day
If you are eligible on the date you were hired or become benefits eligible due to a status change…	Within 31 days after your eligibility date	Retroactively to your date of hire, except disability, which is effective on your 91st day, and supplemental life insurance, which is effective on the date of application*

** **Note:** Depending on your elections, you may be required to submit an Evidence of Insurability (EOI) form when buying additional life insurance and disability coverage. In these instances, coverage will begin after the EOI is approved by the insurance company, provided you are actively at work.*

The Caesars Benefit Service Center will send you a notification and enrollment information before your eligibility period ends. You will be enrolled automatically in basic life insurance, basic Accidental Death & Dismemberment (AD&D) coverage and basic disability. If you choose to enroll in the medical, dental, vision, supplemental disability, supplemental life insurance or supplemental AD&D plans and the flexible spending accounts, you must enroll during the enrollment period listed on your personalized enrollment worksheet and before your eligibility period ends, if applicable.

DURING ANNUAL ENROLLMENT

Each year, you have an opportunity to go over your benefit coverage needs and re-enroll or make changes for the coming year. Annual enrollment typically is held in the fall. You'll receive a packet of enrollment materials to help you make informed decisions about your benefit choices. As part of the packet, you'll receive a personalized enrollment worksheet, which includes updated information about the cost of coverage.

During annual enrollment you may:

- join the benefit plans,
- change plan options,
- cancel coverage under a plan,
- add or remove a dependent, and
- select or change your beneficiary.

Elections made during annual enrollment are effective on January 1 of the next calendar year, unless Evidence of Insurability (EOI) is required, in which case any increase for supplemental disability and/or supplemental life insurance will become effective the latter of January 1 or the date EOI is approved by Cigna and/or Aetna, provided you are actively at work on the effective date, elections will remain in effect through December 31 of that year. If you are absent from work as a result of a medical leave on the date an increase in coverage would otherwise become effective, the increase will be delayed until you return to active work.

IF YOU LOSE OTHER HEALTH CARE COVERAGE

If you or your dependents have other medical coverage, and then lose that coverage, you have the opportunity to enroll in the Caesars plan. The following are circumstances under which you and your dependent(s) may elect coverage mid-year:

- You were covered by the other medical plan at the time you previously waived coverage under Caesars' medical plan.
- You lost coverage for one of the following reasons:
  - loss of COBRA continuation under another employer's plan because the maximum time period allowed by law has ended.
  - loss of other non-COBRA coverage because:
  - you lose eligibility for coverage due to divorce (or legal separation), death, loss of employment or reduction in work hours;
  - you do not elect COBRA when first eligible;
  - the employer stopped contributions toward the other coverage; or
  - you became ineligible for the other coverage (for example, through legal separation or loss of dependent status).

If you don't enroll after losing other health care coverage **within 31 days** after becoming eligible, you'll have to wait until the next annual enrollment period, and coverage will take effect on the next January 1, unless you have a lifestyle change described under *Making Changes to Your Elections* in this SPD.

IF YOU GAIN A NEW DEPENDENT

You also may be eligible for the special enrollment period if you gain a new dependent.

- **Spouse** – if you marry and want to add your spouse to your coverage, you must enroll your spouse within 31 days after the marriage. Coverage for a new spouse begins on the event date, except for life insurance, which begins on the date application for coverage is made. An eligible spouse must be living at the time application for life insurance benefits.
- **Child** – if you add a dependent child (for example, a newborn, foster child, stepchild or newly adopted child) and you want to enroll the child in the plan, you must enroll within 31 days after the child is born or acquired. If you enroll your eligible dependent within 31 days, coverage will begin on the event date, except for life insurance, which begins on the date application for coverage is made. An eligible child must be living at the time application for life insurance benefits.

If you don't enroll a newly eligible dependent **within 31 days** after becoming eligible, you'll have to wait until the next annual enrollment period, and coverage will take effect on the next January 1, unless you have a lifestyle change described under *Making Changes to Your Elections* in this SPD.

IF YOU EXPERIENCE A MEDICAID OR CHIP EVENT

If you or your dependent are eligible for, but not enrolled in, medical coverage, you and your dependent may enroll in medical coverage or switch your medical coverage, if either of the following conditions is met:

- You or your dependent is covered under a state Children's Health Insurance Plan (CHIP) or Medicaid and such coverage is terminated as a result of loss of eligibility, and you request coverage under the medical plan not later than 60 days after the date of termination of such CHIP or Medicaid coverage; or
- You or your dependent becomes eligible for CHIP or Medicaid premium assistance subsidy assistance with respect to coverage under the medical plan, if you request coverage under the medical plan not later than 60 days after the date you or your dependent is determined to be eligible for such premium assistance subsidy.

If you don't enroll yourself or your newly eligible dependent within 60 days after becoming eligible, you'll have to wait until the next annual enrollment period, and coverage will take effect on the next January 1, unless you have a lifestyle change described under *Making Changes to Your Elections* in this SPD.

Please note that certain states do not maintain CHIP and/or Medicaid programs, so this provision may not apply to all participants. Please contact the Caesars Benefit Center for more information.

WHO YOU CAN COVER

For the medical, dental and vision plans, you must decide if you want to cover your dependents. Keep in mind that as the employee, you must enroll in a given plan in order for your dependents to be enrolled in the plan. In other words, you cannot decline coverage for yourself and elect coverage for your dependents.

There are four coverage categories from which to choose:

Category	Coverage
Employee Only	Yourself only
Employee + Child	Yourself and one eligible child
Employee + Spouse or Domestic Partner	Yourself and your husband, wife or your domestic partner
Employee + Family or Domestic Partner Family **Employee + Children**	Yourself and two or more eligible dependents

You may select a different category for each of the plans. For example, you may elect **Employee and Family** for your medical coverage and **Employee and Child** for your dental coverage.

IF YOU WAIVE COVERAGE

When you enroll — either when you are first eligible or later, during an annual enrollment period — you may choose to decline (or waive) coverage for yourself and/or your dependents. As a result, you and/or your dependents will not be covered for an entire plan year (from January through December), unless you have a lifestyle change described under *Making Changes to Your Elections* in this SPD.

The option to waive coverage is meant for employees who have coverage elsewhere, such as under a spouse's benefits program. If you lose this coverage, you may be able to enroll in the Caesars plans.

Call the Caesars Benefit Service Center for more information.

IF YOU DON'T ACTIVELY ENROLL

If you do not go through the enrollment process during your enrollment period, you and any elected dependents may not have the type and level of coverage you need for the coming year. Your next opportunity to enroll will be during the annual enrollment period or during the year if you have a qualifying lifestyle change.

Here is what happens to your benefits if you do not enroll:

Plan	Impact of Not Enrolling
Medical and Prescription Drug	No coverage
Dental	No coverage
Vision	No coverage
Flexible Spending Accounts	No participation
Short-Term Disability	Basic Coverage only (provided by Caesars)

Plan	Impact of Not Enrolling
Long-Term Disability	Basic Coverage only (provided by Caesars)
Employee Life Insurance & AD&D	Basic Coverage only (provided by Caesars)
Dependent Life Insurance	No coverage for your dependents

MAKING CHANGES TO YOUR ELECTIONS

Once you make your elections during annual enrollment, you generally may not make changes until the next enrollment period. However, if you have a qualified lifestyle change (family status change) during the year, you may be able to make certain changes to your benefits coverage within 31 days of the lifestyle change.

The Internal Revenue Service (IRS) makes the rules about what type of event qualifies as a "lifestyle change" (see below). The IRS can modify these rules at any time, in which case you would be notified.

To be considered a qualified "lifestyle change," the event must directly affect your or your dependent's plan eligibility. You experience a qualifying lifestyle change when:

- You marry, legally separate or divorce.
- You gain a dependent through birth, adoption or placement of adoption.
- Your previously ineligible dependent becomes eligible. (If the dependent experiences a change in status — for example, to a full-time student — you may elect dental and vision coverage for the dependent.)
- Your eligible dependent becomes ineligible (for example, reaches the age limit, marries or dies).
- You receive an approved Qualified Medical Child Support Order.
- Your spouse or dependent starts or stops working, or reduces or increases work hours to the extent that the change affects your dependent's plan eligibility (either Caesars or another employer's plan).
- You, your spouse or your dependent gain or lose group health plan coverage sponsored by:
  - a governmental agency,
  - educational institutions including state children's health insurance programs,
  - a state health benefits risk pool, or
  - a foreign governmental group health plan.
- Your spouse's plan offers annual enrollment at a different time during the year.
- You, your spouse or a dependent child become enrolled in Medicare or Medicaid or loses the right to enroll in either.
- If you or your dependent lose other health care coverage as described under *If You Lose Other Health Care Coverage* in this SPD.
- If you or your dependent experience a Medicaid or CHIP event as described under *If You Experience a Medicaid or CHIP Event* in this SPD.
- If you or your dependent becomes eligible for federal-or a state-based insurance exchange or "Marketplace" coverage.

Any coverage change you make must be consistent with your qualifying lifestyle change. For example, in the case of the birth of a child, you may add the child to your coverage, but you may not stop medical coverage for your spouse. Generally, coverage begins on the date you report the change unless it's for a birth, adoption, divorce, death, marriage or your dependent becomes ineligible, in which case, the change takes effect on the date of the event.

Note: A qualified lifestyle change for purposes of life insurance coverage means: (1) marriage, separation or divorce; or (2) birth, adoption, placement of adoption; or (3) death of spouse or dependent child. For life insurance, coverage begins on the date you apply for coverage unless evidence of insurability is required. If Evidence of Insurability (EOI) is required, coverage will become effective when the EOI is approved by Aetna, provided you are actively at work.

Let Us Know…

Because you receive favorable tax treatment by paying for your benefits before taxes, the Internal Revenue Service (IRS) requires strict compliance with requirements that govern when changes are allowed.

If you have a qualified lifestyle change during the year, or are eligible for special enrollment rights, you must notify the Caesars Benefit Service Center within 31 days of the qualified lifestyle change (60 days for a Medicaid or CHIP event).

You must call 1-866-BEN-FITS (1-866-236-3487) to report the change. The Benefit Service Center will explain the types of changes you may make to your benefits coverage. You may be asked to show proof of your lifestyle change, such as a birth certificate or marriage license. Please note that even though you have 31 days to notify us of a status change and that coverage changes are generally effective on the date of the change, payroll changes are not effective on the date of the change. Payroll changes are effective as soon as administratively possible following notification of the change. There will be no retroactive deduction calculations, meaning you will not receive a refund or be charged for the period between the date of the change and the payroll effective date. To ensure your deduction amount changes timely please notify Caesars Benefit Service Center as soon as possible.

Additional Enrollment Rules and Limitations

If Both You and Your Spouse Work for Caesars

If both you and your spouse work for Caesars and are eligible for medical, dental and vision coverage:

- one or both of you may enroll for "employee" coverage or
- one of you can enroll for "employee plus spouse" coverage.
- If you both enroll as employees, neither of you can be covered as a dependent of the other. In addition, only one employee can cover an eligible child as a dependent.

If both you and your spouse work for Caesars and are eligible for life insurance, both of you can elect life insurance for yourselves (as employees). If you are eligible for coverage as an employee you are not eligible to be covered as a spouse. If both parents of a child qualify as eligible employees, the child can only be covered by one parent. If any child qualifies as an eligible employee, he or she is not eligible to be insured as a dependent child.

EVIDENCE OF INSURABILITY (EOI)

If you don't enroll yourself in supplemental life insurance and/or disability coverage when first eligible and you want to enroll during a future annual enrollment period, you'll be required to provide Evidence of Insurability (EOI). This proof must be provided within 31 days of enrollment, otherwise you are not eligible to receive coverage. An EOI form will be sent to your home with your confirmation statement showing your benefit elections.

"Evidence of Insurability" is usually in the form of a health questionnaire that you fill out. You also may be required to take a physical exam, which you pay for at your own expense. Evidence of Insurability must be approved by the insurance company before the coverage you elect becomes effective. If increased coverage is approved by the insurance company, the new deduction amount will be included on the next payroll processed after the approval notification is received by the Caesars Benefit Service Center.

The following outlines the circumstances under which Evidence of Insurability may be required:

- **Supplemental Disability** — You must provide Evidence of Insurability if you decline coverage when you first become eligible and then decide to elect or increase your coverage.
- **Supplemental Life Insurance** — Generally, you must provide Evidence of Insurability if you:
  - elect more than $500,000 of coverage when you are first eligible to enroll,
  - increase coverage by more than one $50,000 increment during an annual enrollment period or a qualified lifestyle change,
  - were previously declined coverage by Aetna due to unsatisfactory evidence of insurability, or
  - waive additional life insurance and/or dependent life insurance when you first become eligible, then later enroll.

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DENTAL COVERAGE ENROLLMENT RULE

If you enroll in the Dental Plus Orthodontia option you must participate in that plan for a minimum of two years. After the two-year minimum, during the next annual enrollment or due to a qualified lifestyle change, you may elect to make a change to your dental coverage.

How to Enroll

There are two ways to enroll:

- Online: www.caesars.benefitsnow.com
- By phone: **1-866-BEN-FITS** (236-3487)

The Website is available 24 hours a day, seven days a week. Customer service representatives are available by phone from 8 a.m. to 8 p.m. EST, Monday through Friday. Regardless of which method of enrollment you choose, you will need your user ID (your Social Security number) and your password (your birth date) to enroll.

Sharing the Cost of Coverage

Caesars pays the majority of your benefit costs, however, you share some of the expense. You pay your share of the benefit coverage through:

- **Employee contributions for all benefits** – this is your share of the cost for benefit coverage for yourself and your dependents.
- **Copays for vision** – this is a preset dollar amount you pay upfront for certain services under the vision plan.
- **Deductibles for medical, prescription drugs and dental benefits** – this is the specified amount of money you must pay each year for health care services before the plan begins paying its portion of your covered expenses.
- **Coinsurance for medical and dental benefits** – this is the percentage of covered expenses you are responsible for paying after you have met your deductible. Under each medical plan option, your coinsurance is lower when you use an in-network provider.
- **Annual out-of-pocket maximum for medical and prescription drug benefits** – this is the most you will pay for covered expenses in a year, equal to your deductible plus your coinsurance. Once you reach this amount, Caesars pays 100 percent of these expenses for the remainder of the year.

EMPLOYEE CONTRIBUTIONS

Every employee who participates in the Caesars Benefits Program shares in the cost of coverage by electing and paying with pre-tax dollars (discussed below) for the employee's share of the cost of coverage. The elected amount is deducted from each paycheck throughout the year. The amount of your "per-pay-period employee contribution" for medical coverage is based on:

- The plan option you elect,
- How many dependents you want to cover and
- Your annual salary
  - $30,000 and under
  - $30,001 - $60,000
  - $60,001 - $90,000
  - over $90,000

Your contribution amount is listed on your personalized enrollment worksheet and confirmation statement.

When you enroll, you agree to pay your share of the cost, through payroll deductions, for medical, prescription drug, dental and vision coverage (sometimes referred to as "health coverage" or "health insurance") with "pre-tax dollars." This means your employee contributions are set aside from your paycheck and are not taxed for federal and, in most cases, state tax purposes. Employee contributions for disability coverage and voluntary life insurance are paid with after-tax dollars.

TIMING OF PAYROLL DEDUCTIONS

Once you enroll for coverage, your contribution amount is deducted from your paycheck as soon as administratively possible. Due to administrative timing, payroll deductions may not begin immediately when your coverage takes effect or end exactly when coverage ends. If payroll deductions do not exactly coincide with the start and end date of coverage there is no effect on eligibility for coverage.

If you make a change in coverage that affects the cost of coverage, the difference will be reflected in the amount of your employee contribution as soon as administratively possible.

Note: If you work one or more days in the pay period, the full bi-weekly benefit deduction amount will be taken out of your paycheck.

STOPPING CONTRIBUTIONS

Unless you leave the company or no longer are eligible, you can't stop your contributions during the year unless you have a qualified lifestyle change, as described previously in *Making Changes to Your Elections*.

You have the opportunity during annual enrollment to stop or change your benefits for the following year. However, there are special enrollment restrictions on changes you can make during annual enrollment if you are enrolled in Dental Plus Orthodontia. See *Dental Coverage Enrollment Rule in this SPD*.

Wellness Rewards Program

Wellness Rewards is a program to guide you on a path to healthy living and improving your health. This onsite program provides you and your family tools and resources to help you achieve your health goals. As a program participant, you will have access to a quality onsite WellNurse/Coach who can help you understand your individual health needs and if necessary take action to improve the quality of your health. By completing the program requirements, you will avoid an increased premium per pay period on your medical health insurance payroll contributions if you and your covered spouse or domestic partner complete the requirements of the program.

The program runs from June 1st- May 31st and must complete a biometric screening by November 30th (newly eligible participants may have a different biometric deadline) and an annual physical by May 31st each year. Should you trigger for condition management, the program provides fun and engaging ways to improve your health and complete the additional program activity requirements. Your Condition Management program must be completed by May 31st of the program year you triggered. All program requirements and deadlines to participate will be posted around your property and communicated in various ways by your Human Resources team and your local onsite WellNurse/Coach. Please be advised, submission of late paperwork may not be eligible to receive the lower premium incentive and refunds may not be provided. Please talk with your onsite WellNurse/Coach immediately if you have any concerns completing the requirements by each deadline. If you have missed the November 30th deadline, you may be eligible for second chance for savings. Please talk with your onsite WellNurse/Coach for eligibility. Additional program information, deadline dates, and timeline on increased premiums due to non-participation can be found online at

www.wellnessrewardsnow.com, or by calling the Wellness Rewards team at (800) 591-9220. You can view your program completion tracker at www.caesars.benefitsnow.com.

Wellness Rewards is intended to help you improve and/or maintain your overall health status. If you think you might be unable to meet the wellness program requirements, you might qualify for an opportunity to receive the incentive by completing an alternative program requirement under the Wellness Rewards program. Please call the Wellness Rewards team at (800) 591-9220 if you have any questions about Wellness Rewards and/or whether you may be eligible to receive an incentive by meeting an alternative requirement.

Your Wellness Rewards information is kept private and confidential. Cigna Onsite Health manages the Wellness Rewards program and does not share your health information with Caesars. Cigna Onsite Health is subject to all of the federal HIPAA privacy and security protections because it is a business associate of the Plan. The program is designed to help you manage your health and wellness by promoting preventive services. Cigna Onsite Health will supply aggregate information to Caesars for program management but does not provide individual information, including an individual's name or personal information.

WHO IS ELIGIBLE FOR WELLNESS REWARDS?

- Employees who enroll in the Caesars medical plan during the plan year.
- Spouse or same-sex domestic partners enrolled as the primary dependent on the Caesars medical plan during the plan year.

YOUR ONSITE WELLNURSE/COACH AND OTHER RESOURCES

A WellNurse or WellCoach is available on property to assist you with matters related to your health and well-being. The primary role of your WellNurse/Coach is to help guide you through the Wellness Rewards program and develop a personalized wellness plan based on your individual priorities and needs. He or she will provide you with face-to-face health coaching related to wellness and risk management on primary health care prevention, lifestyle behavior risks (e.g. hypertension, hypercholesterolemia, weight management and stress), compliance with treatment plans, and closing gaps in your health care. Your WellNurse/Coach also provides onsite educational seminars and health campaigns. Other resources such as telephonic coaching, online tools, and health coaches at participating Wellness Centers are also available to support you and your covered spouse or same-sex domestic partner to reach your health goals.

Additionally, your WellNurse/Coach is also familiar with Caesars' insurance plan and can assist you in finding other available services that are included in your benefits offerings that may help you manage your health. These others services include telephonic and online disease management, lifestyle behavior coaching, health-related educational materials, the Employee Assistance Program (EAP), price transparency tools, and network providers.

Members of the Wellness Rewards team are not Caesars employees. Caesars uses an external provider, Cigna Onsite Health, which specializes in employer solutions for health care. The Wellness Rewards team is a resource for the benefit of employees' health and wellness and by law does not report any individual's personal health information back to Caesars.

NOTE: Caesars reserves the right to modify or terminate the Wellness Rewards Program at any time, for any reason, with or without notice to participants. Nevertheless, Caesars will not modify the program in any way that will give Caesars access to individual information which is developed or used in the program.

WELLNESS PROGRAMS

As part of Choosing Wellness, your Wellness Rewards program provides several health programs to help you get healthy and stay healthy. Among these programs are:

- **No or Low-Cost Preventive Care** – including annual physicals, well woman examinations, well baby examinations and child immunizations.

- **Biometric Screening** –screenings that measure values such as cholesterol, blood pressure, blood sugar, and other important health measures and can be completed at your onsite Wellness Center (where available), with your WellNurse/Coach, through your primary care physician, or at an onsite event (when available). **Health Risk Assessment** – this is available as an online tool to provide a reference point for your current health status. If you have any significant risks you may be contacted by a health coach to participate in a program to help manage your disease or condition.
- **Smoking Cessation** – the medical plan offers help and support to tobacco users who want to quit.
- **Individual Health Coaching -** telephonic and in-person wellness coaching is available to help you manage your health needs
- **Year Round Health Campaigns**- offered through your onsite WellNurse/Coach or with your health coach at your onsite Wellness Center (where available)

Each year, Caesars provides you with a wellness guide describing the following year's program. Please watch for that guide to learn about options and changes. You can always find the wellness guide and more information at on www.caesars.benefitsnow.com and www.wellnessrewardsnow.com**.**

Medical Plan

ABOUT THE MEDICAL PLANS

Caesars' medical coverage is provided to Eligible Employees (and their eligible dependents) through the **Cigna Open Access Choice Plans, Horizon Direct Access Plans, and Humana**. The medical plans combine traditional medical coverage with a Health Reimbursement Account (HRA) funded entirely by Caesars or a Health Savings Account (HSA) funded in part by Caesars to help you pay for qualified health care expenses. Cigna, Horizon, and Humana give you the flexibility and support to actively manage both your health and your health care costs. A brief summary of how the medical plans work as well as a summary of how an HRA or HSA works with those plans is provided below. For a complete description of these benefits, please refer to the Horizon and Humana **plan documents**. The Cigna Open Choice Access Plans summary is provided following this general overview.

How the Plans Work – General Overview

1. Deductible	2. Coinsurance	3. Out-of-Pocket Maximum
Caesars contributes health care dollars to your medical plan account at the beginning of each year. You also have the opportunity to earn additional funds that are deposited quarterly into your medical plan account. When you have eligible medical and prescription drug expenses, they will be paid in full from your HRA either automatically (Cigna) or with your debit card (Horizon/Humana) as long as there is money in your account. If you have an HSA, you may choose to pay using HSA funds with your debit card or pay out of pocket if you wish to save your HSA funds for a later expense. In addition, preventive care (such as physicals, immunizations and health screenings) is free to you if you use in-network physicians. No money is deducted from your HRA or HSA for preventive care. If you use all the money in your HRA or have an HSA and	If you meet your deductible, the plan will begin to pay a portion of the costs. The amount the plan pays depends on the plan option you choose. You continue paying a portion of your expenses until you meet the out-of-pocket maximum.	If you meet the out-of-pocket maximum, you do not have to pay anything for eligible medical and pharmacy expenses.

choose to save your funds for use at a later time, you will pay expenses out of your pocket until you reach your plan's deductible. This is the amount that you must pay before the plan pays any additional benefits. The deductible amount is based on the plan option you choose. If you don't use all the money in your HRA or HSA, it will "roll over" for you to use in the next plan year.		

Note: *For HRA plan members, the $150 Emergency Room copay applies in all phases of the plan. The copay is waived if admitted for a hospital stay.*

Caesars contribution to your HRA or HSA is based on the level of dependent coverage you choose*

Employee Only	$250
Employee + spouse/domestic partner	$375
Employee + child	$375
Employee + children	$500
Employee + family	$500

**HRA and HSA amounts are prorated based on the number of months your benefits are effective in a medical plan year.*

YOUR MEDICAL PLAN OPTIONS

Caesars offers two plan options for you and your eligible family members:

- The Health Savings Account (HSA) Option
- The Health Reimbursement (HRA) Option

Both options cover free in-network preventive care, including annual physicals, well-woman exams, well-baby and well-child exams, immunizations, and a variety of online tools.

There are four differences between the medical plan options:

- The medical plan account type
- The amount of your deductible
- The coinsurance you pay for in-network and out-of-network care
- The amount of your out-of-pocket maximum

The beginning balance in your HRA or HSA will be prorated according to your coverage-effective date. However, your deductible will not be prorated.

Medical Plan Account Proration

Proration is calculated on a monthly basis. For example, if your coverage is effective in July, you will receive 6/12th, or 50 percent of the Caesars' contribution for the remaining plan year.

Month	EE Only	EE + Spouse/ EE + Child	EE + Children/ EE + Family
January	$250.00	$375.00	$500.00
February	$229.17	$342.75	$458.33
March	$208.33	$312.50	$416.67
April	$187.50	$281.25	$375.00
May	$166.67	$250.00	$333.33
June	$145.83	$218.75	$291.67
July	$125.00	$187.50	$250.00
August	$104.17	$156.25	$208.33
September	$83.33	$125	$166.67
October	$62.50	$93.75	$125.00
November	$41.67	$62.50	$83.33
December	$20.83	$31.25	$41.67

Note: *These amounts also apply if you are insuring a qualified same-sex domestic partner or your domestic partner's eligible dependents.*

HOW THE HEALTH REIMBURSEMENT ACCOUNT WORKS

The Health Reimbursement Account (HRA) is a fund established by Caesars on a plan year basis that can be used to pay for qualified health care expenses. The amount of money allocated to your HRA* is determined by Caesars and depends on the coverage category you choose.

The money in your HRA is used first to pay the cost of covered services. This means if all of your medical expenses are covered services and the total cost doesn't exceed the amount in your HRA, you may not have any out-of-pocket costs for the year.

Once you've used all the money in your HRA, you pay 100 percent of your expenses up to the deductible. After your deductible is met, you and Caesars share the cost of your covered services until you reach the out-of-pocket maximum.

You cannot put any of your own money into your HRA, either on a pre-tax or after-tax basis. Your HRA is an "unfunded" account, and benefits are payable solely from the general assets of Caesars. You may use your HRA to cover eligible expenses for all of your family members claimed on your federal tax return as your dependents (which may include your domestic partner and his or her dependents if you can claim them on you federal return as tax dependents) as well as your natural, adopted, step or foster children through the end the year in which they turn age 26

(whether or not you can claim them on your tax return as your dependents), whether they are covered under your medical plan or not.

Please Note: Your HRA benefit dollars are subject to two restrictions: 1) they may only be used for covered expenses as defined in this Summary Plan Description, and 2) you will forfeit your HRA benefit dollars if you: a) terminate employment for any reason or retire, unless you elect COBRA coverage; or b) are no longer enrolled in the HRA plan (whether by moving to a HSA or union medical plan or no coverage at all). If you elect COBRA coverage, any money left in your HRA when your employment ends will assist you in paying your medical expenses while COBRA coverage is in effect

You can keep track of your HRA balance by going to www.mycigna.com or by calling the Cigna customer service number at 1-800-423-9920.

**HRA amounts are prorated based on the number of months your benefits are effective in a medical plan year.*

HOW THE HEALTH SAVINGS ACCOUNT WORKS

An HSA is yours to keep for life. Use your HSA dollars now or save them for the future. You can even use your HSA funds tax-free to pay eligible medical expenses in retirement, a special feature that's not offered by a 401(k). There's no account balance limit or expiration date for using your HSA and unspent funds carry over year after year. If you opt out of the HSA Plan, become ineligible for benefits, leave our company or retire, you'll keep the HSA and all funds already contributed by you and Caesars.

Plus, the federal government never taxes on:

- Money contributed by you or Caesars
- Earnings from interest or investments (an HSA is an interest-bearing account and funds in the account can also be invested once you reach a minimum balance)
- Amounts spent on eligible medical expenses.

If you are a resident of, and/or pay income tax in, Alabama, California, or New Jersey, state tax law requires that any HSA contributions you make through salary deferrals be included in your taxable income for state income tax purposes. In addition, if you are a resident of, and/or pay income tax in, Alabama, California or New Jersey, HSA contributions made on your behalf by Caesars must be included in your taxable income for state income tax purposes. *Please note, that you must open your HSA account before any HSA contributions can be made by you or by Caesars. If you do not open your HSA account* ***within 90 days of the date*** *you were entitled to a contribution, you will forfeit the Caesars contributions. Due to Patriot Act mandates, you will be required to furnish certain information prior to opening the HSA and it may take additional time to open the HSA. Please start the process to open your HSA as soon as possible.*

On top of Caesars' contributions, you can contribute your own money through additional paycheck deductions, up to the combined annual limit set by the IRS ($3,350 or $6,650 in 2015, depending on your medical plan coverage level). Your contributions are made on a pre-tax basis, so your income tax will be lower.

Your HSA funds are your money for the rest of your life, which means you choose when to spend them and how much to spend. When you have enough funds in your account to pay for you, your spouse, and all of your family members claimed on your tax return as your dependents' (which may include your domestic partner and his or her dependent children) eligible expenses, choose from three ways to pay:

- HSA Debit Card: Use your Bank of America HSA debit card (mailed to you when your HSA is opened) to pay on-site when you receive services at an eligible health care facility that accepts VISA cards, or
    - Provider Payment: Pay a provider's invoice online from your HSA account, just like any other online bill payment service, or
    - Reimburse Yourself: If you don't have enough funds in your HSA at the time of service, or you previously forgot to use your HSA to pay for an eligible expense, you can request an electronic or check reimbursement from your HSA to help cover your out-of-pocket costs (only for expenses incurred after

your HSA was originally opened). You can also choose not to reimburse yourself in order to continue saving tax-free interest-bearing, investment-eligible HSA funds for future expenses.

Certain fees may apply. Go to www.bankofamerica.com/benefitslogin to see the Bank of America fee schedule.

Save Your Health Care Receipts! It's a good idea to do this, in case the IRS ever asks you to show proof that you've used HSA funds on eligible expenses.

Manage your HSA account online at www.bankofamerica.com/benefitslogin. Register as a new user today to check your balance, submit claims, order dependent debit cards, and more!

Main Features of the Medical Plans

The following charts show your deductible, coinsurance and out-of-pocket maximum for each medical plan choice and level of family coverage.

Please keep in mind that the medical plan account amounts and deductibles shown in the charts apply to the coverage category and not to each individual family member. For example, if you elect the HSA plan with coverage for yourself and your spouse, the $375 HSA amount is for both of you to use, and your deductible is $2,875 combined. These amounts also apply if you are insuring a qualified same-sex domestic partner and/or your domestic partner's eligible dependents.

	Employee				
		In-Network		**Out-of-Network**	
	Employee Deductible	**Coinsurance**	**Out-of-Pocket Maximum**	**Coinsurance**	**Out-of-Pocket Maximum**
HSA Plan	$1,750 (includes $250 HSA funded by Caesars)	80% Caesars 20% Employee	$3,700 (includes $250 HSA funded by Caesars)	50% Caesars 50% Employee	$11,100 (includes $250 HSA funded by Caesars)
HRA Plan	$1,350 (includes $250 HRA funded by Caesars)	80% Caesars 20% Employee	$3,200 (includes $250 HRA funded by Caesars)	50% Caesars 50% Employee	$9,600 (includes $250 HRA funded by Caesars)
	Employee + Spouse or Domestic Partner				
		In-Network		**Out-of-Network**	
	Employee Deductible	**Coinsurance**	**Out-of-Pocket Maximum**	**Coinsurance**	**Out-of-Pocket Maximum**
HSA Plan	$2,875 (includes $375 HSA funded by	80% Caesars 20% Employee	$6,200 (includes $375 HSA funded by	50% Caesars 50% Employee	$18,600 (includes $375 HSA funded by

	Caesars)		Caesars)		Caesars)
HRA Plan	$2,475 (includes $375 HRA funded by Caesars)	80% Caesars 20% Employee	$5,200 (includes $375 HRA funded by Caesars)	50% Caesars 50% Employee	$15,600 (includes $375 HRA funded by Caesars)
	Employee + Child				
	Employee Deductible	**In-Network**		**Out-of-Network**	
		Coinsurance	**Out-of-Pocket Maximum**	**Coinsurance**	**Out-of-Pocket Maximum**
HSA Plan	$2,600 (includes $375 HSA funded by Caesars)	80% Caesars 20% Employee	$5,700 (includes $375 HSA funded by Caesars)	50% Caesars 50% Employee	$17,100 (includes $375 HSA funded by Caesars)
HRA Plan	$1,825 (includes $375 HRA funded by Caesars)	80% Caesars 20% Employee	$4,700 (includes $375 HRA funded by Caesars)	50% Caesars 50% Employee	$14,100 (includes $375 HRA funded by Caesars)
	Employee + Family				
	Employee Deductible	**In-Network**		**Out-of-Network**	
		Coinsurance	**Out-of-Pocket Maximum**	**Coinsurance**	**Out-of-Pocket Maximum**
HSA Plan A	$3,300 (includes $500 HSA funded by Caesars)	80% Caesars 20% Employee	$7,200 (includes $500 HSA funded by Caesars)	50% Caesars 50% Employee	$21,600 (includes $500 HSA funded by Caesars)
HRA Plan A	$2,800 (includes $500 HRA funded by Caesars)	80% Caesars 20% Employee	$6,200 (includes $500 HRA funded by Caesars)	50% Caesars 50% Employee	$18,600 (includes $500 HRA funded by Caesars)
	Employee + Children				
	Employee Deductible	**In-Network**		**Out-of-Network**	
		Coinsurance	**Out-of-Pocket Maximum**	**Coinsurance**	**Out-of-Pocket Maximum**
HSA Plan A	$2,800 (includes $500 HSA funded by	80% Caesars 20% Employee	$6,700 (includes $500 HSA funded by	50% Caesars 50% Employee	$20,100 (includes $500 HSA funded by

	Caesars)		Caesars)		Caesars)
HRA Plan A	$2,300 (includes $500 HRA funded by Caesars)	80% Caesars 20% Employee	$5,700 (includes $500 HRA funded by Caesars)	50% Caesars 50% Employee	$17,100 (includes $500 HRA funded by Caesars)

Note: *The combined medical/pharmacy expenses of all covered family members count toward the annual deductible and out-of-pocket maximum.*

Expenses applied toward your in-network out-of-pocket maximum also count toward your out-of-network out-of-pocket maximum, and vice versa.

HRA Plan: Embedded deductible and OOPM– once one covered individual meets the Individual deductible, or OOPM that individual's deductible or OOPM has been met

HSA Plan: Aggregate deductible and OOPM – Once any combination of covered individuals meet the Family deductible or OOPM, the deductible or OOPM has been satisfied for all covered family members

HOW YOUR MEDICAL PLAN ACCOUNT WORKS WITH A FLEXIBLE SPENDING ACCOUNT

Health Reimbursement Account (HRA) and the Flexible Spending Account (FSA)

Flexible Spending Accounts (FSAs) use tax-free dollars to help save you money. If elected, FSA amounts are taken out of your paycheck automatically before taxes, in equal amounts spread over the whole year. There are two kinds of FSAs: Health Care and Dependent Day Care. Dependent Day Care FSAs are discussed later in this SPD under *Dependent Care Flexible Spending Account*.

Health Care FSA – If you think you will meet your employee deductible, you should consider participating in the Health Care FSA, especially if you have ongoing or high-cost prescriptions.

You may use your Health Care FSA to pay for out-of-pocket medical, prescription, dental, vision, or other miscellaneous health care expenses, as well as copays, or deductibles that are not covered by your Health Reimbursement Account (HRA). Ineligible expenses include payroll contributions, medically unnecessary cosmetic surgery, and over-the-counter medications, vitamins and supplements without a prescription.

You may use your Health Care FSA to cover eligible expenses for all of your family members claimed on your tax return as your dependents (which may include your domestic partner and his or her dependents if you can claim them on you federal return as tax dependents) as well as your natural, adopted, step or foster children through the end the year in which they turn age 26 (whether or not you can claim them on your tax return as your dependents), whether they are covered under your medical plan or not. The full amount you elect during your Enrollment will be available on your effective date. This means that even though you have not contributed the full amount of your election through payroll contributions, your claims will be paid up to your full election. This is a great way to cover out-of-pocket costs and manage your cash flow!

While your HRA is similar to an FSA, they are not the same thing and these accounts are used for different purposes. Keep in mind:

- The HRA is available only if you enroll in the HRA medical plan. However, you do not have to sign up for medical coverage to participate in an FSA.
- While the HRA and FSA may cover some of the same types of expenses, the FSA is funded with pre-tax contributions that you make under a salary reduction arrangement. You are not permitted to contribute any amount of your income to the HRA.
- Expenses reimbursed through the HRA cannot also be reimbursed through the FSA.

- Unused FSA dollars are forfeited if not used by the claim submission date, but unused HRA funds roll over to the next plan year.
- Refer to About the Health Care Flexible Spending Account for more information.

Health Savings Account (HSA) and the Limited Purpose Flexible Spending Account

If you have an HSA, you are not eligible for a standard FSA. Instead, you may elect to contribute (pre-tax) to a Limited Purpose FSA which can be used for dental and vision expenses. You will receive one debit card for both your HSA and your Limited Purpose FSA.

- Medical and pharmacy expenses will be deducted from your HSA.
- Dental and vision expenses will automatically be deducted from your FSA.

IN-NETWORK VERSUS OUT-OF-NETWORK PROVIDERS (CIGNA – FOR INFORMATION ABOUT THE HUMANA AND HORIZON NETWORKS, PLEASE ACCESS THE PLAN SUMMARIES POSTED SEPARATELY).

The medical plans offer medical benefits through a network of providers referred to as "in-network" doctors and health care facilities have agreed to provide services to Caesars employees at special negotiated rates. You may go to any provider you wish; however, you will enjoy greater savings when you go to an in-network provider.

In-Network Providers. When you receive health care services from a Choice Fund Open Access Plus network provider, your coinsurance and out-of-pocket maximum will be lower and you can save money by taking advantage of the provider's negotiated rates. Also, there are no claim forms to complete when you go to an in-network provider.

Out-of-Network Providers. If you choose to go to an out-of-network provider, your coinsurance and out-of-pocket maximum will be higher — and the plan will pay benefits based on Cigna's "maximum reimbursable charge." This charge is determined based on the lesser of the provider's normal charge for a similar service or supply, or a percentage of a schedule that Cigna has developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for similar services within the geographic market. If your out-of-network provider charges more than the maximum reimbursable charge covered by the plan, you will have to pay the difference. Also, when you go to an out-of-network provider, you may have to pay the full cost of your medical services up front. You will then file a claim with Cigna to be reimbursed for the covered amount of your bill.

If you can't find an in-network provider in your area who can provide the covered service or supply you need, you must call the number on the back of your ID card to request authorization for out-of-network coverage. If you get authorization for services provided by an out-of-network provider, benefits for those services will be covered at the in-network benefit level.

Please refer to the following for more information about the "maximum reimbursable charge."

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Maximum Reimbursable Charge Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or supply; or A percentage of a schedule that we have developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for similar services within the geographic market. In some cases, a	Not Applicable	110%

Medicare based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of: • the provider's normal charge for a similar service or supply; or • the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by the Insurance Company. **Note:** The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable deductibles, copayments and coinsurance.		

Schedule of Benefits and Additional Plan Details - Cigna (For information about the Horizon and Humana additional plan details, please access the linked summaries on page 18.)

Important note regarding the HRA:
For all benefits listed below, the HRA pays first — 100% of the Covered Expense. Once the HRA is depleted and the Deductible is satisfied, the plan will pay as shown unless otherwise noted.

Covered Expenses	Plan Pays		Plan Pays (Up To Maximum Reimbursable Charge)	
	In-Network		Out-of-Network	
	HSA Plan	HRA Plan	HSA Plan	HRA Plan
Abortion (non-elective procedures only) **Includes:** • Inpatient facility • Outpatient surgical facility • Physician's office • Outpatient professional services • Inpatient professional services	80%	80%	50%	
Acupuncture (includes acupuncture for pain management, nausea for pregnancy and chemotherapy) • Unlimited visits per calendar year	80%	80%	50%	
Bariatric Surgery **Includes:** • Doctor's office • Inpatient facility • Outpatient surgical facility • Physician's services • Excess skin removal, including outpatient physician services, facility and ancillary services related to the surgery (such as anesthesia and preadmission testing), limited to $5,000 maximum per lifetime. See	80%	80%	In-network coverage only	

Important note regarding the HRA:
For all benefits listed below, the HRA pays first — 100% of the Covered Expense. Once the HRA is depleted and the Deductible is satisfied, the plan will pay as shown unless otherwise noted.

Covered Expenses	Plan Pays		Plan Pays (Up To Maximum Reimbursable Charge)	
	In-Network		Out-of-Network	
	HSA Plan	HRA Plan	HSA Plan	HRA Plan
"What the Medical Plan Covers" for more information				
Bereavement Counseling • Inpatient and outpatient services provided as part of hospice care • Services provided by mental health professional	80%	80%	50%	
Breast Feeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician. • Includes related supplies.	100%; no deductible	100%; no deductible	50%	
Cancer Travel Services • See "What the Medical Plan Covers" for more information	$10,000 lifetime maximum per person; combined with organ transplant travel services benefit		In-network coverage only	
Cardiac Rehabilitation • Maximum of 36 days per calendar year	80%	80%	50%	
Chiropractic Services (includes ART services) • Maximum of 30 days per calendar year	80%	80%	50%	
Dental Care **Includes:** • Doctor's office • Inpatient facility • Outpatient surgical facility • Physician's services Limited to charges made for a	80%	80%	50%	

Important note regarding the HRA:
For all benefits listed below, the HRA pays first — 100% of the Covered Expense. Once the HRA is depleted and the Deductible is satisfied, the plan will pay as shown unless otherwise noted.

Covered Expenses	Plan Pays		Plan Pays (Up To Maximum Reimbursable Charge)	
	In-Network		Out-of-Network	
	HSA Plan	HRA Plan	HSA Plan	HRA Plan
continuous course of dental treatment started within 6 months of an injury to sound, natural teeth				
Durable Medical Equipment • Unlimited maximum per calendar year	80%	80%	50%	
Emergency and Urgent Care Services **Includes:** • Hospital emergency room Physician's office • Outpatient professional • services (includes radiology, • pathology and ER physician) • Urgent care facility or • outpatient facility • Ambulance	80%	80%	80%	80%
	Note: When using an emergency room you will be asked to pay $150 upfront. The upfront charge is paid to the facility in advance of any services rendered and does not count towards your calendar year deductible. You will be billed directly for any additional covered services. If you have not met your calendar year deductible, you must pay for the additional charges for covered services up to you deductible. Charges that exceed your deductible will be paid by the plan, pursuant to the terms of the plan. The $150 upfront charge will be applied to your out-of-pocket maximum. This charge is waived if you are admitted to the hospital.			
External Prosthetic Appliances • Unlimited maximum per calendar year	80%	80%	50%	
Family Planning – Men's Services **Includes:** • Office visits • Tests • Counseling • Inpatient or outpatient surgical sterilization procedure for	80%	80%	50%	

Important note regarding the HRA:
For all benefits listed below, the HRA pays first — 100% of the Covered Expense. Once the HRA is depleted and the Deductible is satisfied, the plan will pay as shown unless otherwise noted.

Covered Expenses	Plan Pays		Plan Pays (Up To Maximum Reimbursable Charge)	
	In-Network		Out-of-Network	
	HSA Plan	HRA Plan	HSA Plan	HRA Plan
vasectomy (excludes reversals)				
Family Planning –Women's Services **Includes:** • Office visits • Tests • Counseling • Contraceptive devices as ordered or prescribed by a physician. • Inpatient or outpatient surgical sterilization procedure for tubal ligation (excludes reversals)	100%; no deductible		50%	
Flu Vaccine	100%; no plan deductible		100%; no plan deductible	
Gambling Addiction • Inpatient • Outpatient	100% (first 5 visits through EAP), then 80%	100% (first 5 visits through EAP), then 80%	In-network coverage only	
Gender Reassignment • Benefits follow the World Professional Association for Transgender Health (WPATH) Standards of Care. See "What the Medical Plan Covers" for more information	80%	80%	50%	
High Tech Radiology (MRIs, MRAs, CAT scans, PET scans, etc.) **Includes:** • Inpatient facility	80%	80%	50%	

Important note regarding the HRA:
For all benefits listed below, the HRA pays first — 100% of the Covered Expense. Once the HRA is depleted and the Deductible is satisfied, the plan will pay as shown unless otherwise noted.

Covered Expenses	Plan Pays		Plan Pays (Up To Maximum Reimbursable Charge)	
	In-Network		Out-of-Network	
	HSA Plan	HRA Plan	HSA Plan	HRA Plan
• Outpatient facility • Physician's office Emergency Room/urgent care facility (billed by the facility as part of the ER/UC visit)				
Hearing Aids • Maximum lifetime benefit of $1,000	80%	80%	50%	
Home Health Care • Maximum of 90 days per calendar year	80%	80%	50%	
Hospice Includes: • Inpatient services • Outpatient services	80%	80%	50%	
Infertility Treatment **Includes:** • Testing and treatment services performed in connection with an underlying medical condition • Testing performed specifically to determine the cause of infertility • Treatment and/or procedures performed specifically to restore fertility (procedures to correct an infertility condition) • Artificial insemination • Maximum lifetime benefit of $10,000 Excludes in-vitro, GIFT, ZIFT, etc.	80%	80%	50%	

Important note regarding the HRA:
For all benefits listed below, the HRA pays first — 100% of the Covered Expense. Once the HRA is depleted and the Deductible is satisfied, the plan will pay as shown unless otherwise noted.

Covered Expenses	Plan Pays		Plan Pays (Up To Maximum Reimbursable Charge)	
	In-Network		Out-of-Network	
	HSA Plan	HRA Plan	HSA Plan	HRA Plan
Inpatient Hospital – Facility Services **Includes:**	80%	80%	50%	
• Semi-private room and board/Private room	Limited to semi-private room negotiated rate			
• Special care units (ICU/CCU)	Limited to negotiated rate		Limited to ICU/CCU daily room rate	
Inpatient Hospital Physician's Visits/ Consultations	80%	80%	50%	
Inpatient Hospital – Professional Services (includes surgeons, radiologists, pathologists and anesthesiologists)	80%	80%	50%	
Inpatient Services at Other Health Care Facilities (includes skilled nursing facilities, rehabilitation hospitals, and sub-acute facilities) • Maximum of unlimited days combined per calendar year	80%	80%	50%	
Laboratory and Radiology Services Includes:				
• Pre-admission testing • Physician's office • Outpatient hospital facility	80%	80%	50%	
• Emergency Room/urgent care facility (billed by the facility as part of the ER/UC visit)	80%	80%	80%	80%
• Independent X-ray and/or lab	80%	80%	50%	

Important note regarding the HRA:
For all benefits listed below, the HRA pays first — 100% of the Covered Expense. Once the HRA is depleted and the Deductible is satisfied, the plan will pay as shown unless otherwise noted.

Covered Expenses	Plan Pays		Plan Pays (Up To Maximum Reimbursable Charge)	
	In-Network		Out-of-Network	
	HSA Plan	HRA Plan	HSA Plan	HRA Plan
facility				
• Independent X-ray and/or lab facility (in conjunction with an ER visit)	80%	80%	80%	80%
Mammogram, PSA , Pap Smear – Routine Only	100%; no plan deductible		50%	
Maternity Care Services **Includes:** • Initial visit to confirm pregnancy • All subsequent prenatal visits, postnatal visits and physician's delivery charges (i.e., global maternity fee) • Office visits in addition to the global maternity fee when performed by an Obstetrician or specialist • Delivery – facility (inpatient hospital, birthing center)	80%	80%	50%	
Nutritional Evaluation	80%	80%	50%	
Outpatient Facility Services (includes operating room, recovery room, procedures room, treatment room, and observation room)	80%	80%	50%	
Outpatient Mental Health Care and Substance Abuse	80%	80%	50%	
Outpatient Professional Services (includes surgeons, radiologists, pathologists and anesthesiologists)	80%	80%	50%	

Important note regarding the HRA:
For all benefits listed below, the HRA pays first — 100% of the Covered Expense. Once the HRA is depleted and the Deductible is satisfied, the plan will pay as shown unless otherwise noted.

Covered Expenses	Plan Pays		Plan Pays (Up To Maximum Reimbursable Charge)	
	In-Network		Out-of-Network	
	HSA Plan	HRA Plan	HSA Plan	HRA Plan
Outpatient Short-Term Rehabilitative Therapy **Maximum of 30 days per Calendar Year** **Includes:** • Physical therapy • Speech therapy • Occupational therapy • Pulmonary rehab • Cognitive therapy	80%	80%	50%	
Physician's Services **Includes:** • Office visits • Specialist visits • Consultant and Referral services • Surgery performed in the physician's office • Second opinion consultations (services will be provided on a voluntary basis) • Allergy treatment injections • Allergy serum (dispensed by the physician in the office)	80%	80%	50%	

Important note regarding the HRA:
For all benefits listed below, the HRA pays first — 100% of the Covered Expense. Once the HRA is depleted and the Deductible is satisfied, the plan will pay as shown unless otherwise noted.

Covered Expenses	Plan Pays		Plan Pays (Up To Maximum Reimbursable Charge)	
	In-Network		Out-of-Network	
	HSA Plan	HRA Plan	HSA Plan	HRA Plan
Prescription Drugs* Participating Retail Pharmacy (Your coinsurance) Up to a 30-day supply				
"Affordable Care Act"; HealthCare Reform Preventive Care Offering	0%		In-network coverage only	
Generic Medication	10%			
Preferred-Brand Medication	25% ($25 minimum; $200 maximum)			
Nonpreferred-Brand Medication	50% ($50 minimum; $200 maximum)			
Prescription Drug Home Delivery Service (Your Coinsurance) Up to a 90-day supply				
"Affordable Care Act"; HealthCare Reform Preventive Care Offering	0%		In-network coverage only	
Generic Medication	10%			
Preferred-Brand Medication	25% ($50 minimum; $500 maximum)			
Nonpreferred-Brand Medication	50% ($100 minimum; $500 maximum)			
**If you choose to have your prescription filled with a brand-name drug when a generic equivalent is available, you will pay more for your drugs. If you have not yet met your deductible, you will pay the full cost of the brand-name drug at*				

Important note regarding the HRA:
For all benefits listed below, the HRA pays first — 100% of the Covered Expense. Once the HRA is depleted and the Deductible is satisfied, the plan will pay as shown unless otherwise noted.

Covered Expenses	Plan Pays		Plan Pays (Up To Maximum Reimbursable Charge)	
	In-Network		Out-of-Network	
	HSA Plan	HRA Plan	HSA Plan	HRA Plan
the Express Scripts discounted rate. If you have met your deductible, your coinsurance will be based on the cost of the brand-name drug; you will also pay the difference between the cost of the two drugs. The difference between the cost of the brand name drug and the generic will not apply toward your out of pocket maximum. For more information, see the Prescription Drug section.				
Preventive Care (includes routine preventive care, well-woman care, well-baby care, well-child care and immunizations)	100%; no deductible ***Note:*** X-ray and laboratory services related to preventive care that are billed by a separate outpatient diagnostic facility (such as an outpatient hospital facility or independent facility) will be covered at 100% with no deductible.		50% Note: Out-of-network preventive care services are subject to the deductible and coinsurance.	
Private Duty Nursing • Maximum of 90 days per calendar year	80%	80%	50%	
Routine Foot Disorders	Not covered, except for services associated with foot care for diabetes and peripheral vascular disease, when medically necessary.			
TMJ – Surgical and Non-Surgical **Includes:** • Doctor's office • Inpatient facility • Outpatient surgical facility • Physician's services • Provided on a limited, case-by-case basis. Always excludes appliances and orthodontic treatment. Subject to medical necessity. Non-surgical services subject to a maximum lifetime benefit of $5,000	80%	80%	50%	
Transplant Services **Includes:**				

Important note regarding the HRA:
For all benefits listed below, the HRA pays first — 100% of the Covered Expense. Once the HRA is depleted and the Deductible is satisfied, the plan will pay as shown unless otherwise noted.

Covered Expenses	Plan Pays		Plan Pays (Up To Maximum Reimbursable Charge)	
	In-Network		Out-of-Network	
	HSA Plan	HRA Plan	HSA Plan	HRA Plan
• Inpatient facility charges and physician's services for all medically appropriate, non-experimental transplants	100% after deductible at Lifesource center; otherwise not covered		In-network coverage only	
• Travel services benefit — only available for Lifesource facilities	$10,000 lifetime maximum per person; combined with cancer travel services benefit		In-network coverage only	
Wigs/Cranial Prosthesis • When required for hair loss due to cancer or alopecia areata • Up to $1,000 every 36 months	80%	80%	80%	80%

NOTE : *Maximum dollar/day limits under the Open Access Choice plans cross apply between in- and out-of-network.*

WHAT THE MEDICAL PLAN COVERS

Preventive Care

Preventive services are recommended screenings for proactive wellness management. These services help identify health risks before they become greater health issues. By identifying risks early, you can avoid greater health complications as well as save on the costs of managing more complicated health issues.

The Cigna Choice Fund Open Access Plus Plan covers preventive care at 100 percent when you receive it from an in-network provider. That means no cost to you, no cost to your HRA or HSA, and no plan deductible to meet.

The plan covers charges made for routine preventive care, including immunizations of a dependent for the first two years of life. Routine preventive care means health care assessments, wellness visits and any related services.

While your doctor will determine the tests that are right for you based on your age, gender and family history, here's a list of many items covered by your preventive health benefits. This list is not all-inclusive. Please contact Caesars Benefit Center for more information.

- Periodic well-baby and well-child visits, depending on age.
- Immunizations (as appropriate by age), such as:
  - Diphtheria, tetanus and acellular pertussis (DTAP)
  - Haemophilus influenzae b (Hib)
  - Hepatitis A & B
  - HPV in girls and women ages 9-26
  - Influenza: ages 19 to 49, as your doctor advises, and annually after age 50
  - Measles-mumps-rubella (MMR)
  - Meningococcal (MCV4)

  - Pneumonia: once for those age 65 or older (or younger for those with risk factors)
  - Poliovirus (IPV)
  - Rotavirus
  - Varicella (chickenpox)
- Screenings (as appropriate by age):
  - Blood pressure
  - Cholesterol
  - Hearing and vision
  - Height and weight
  - Hemoglobin or hematocrit
  - Chlamydia for sexually active females under age 25
  - Mammogram once a year for women age 35 to 69, or at any age for women at risk as recommended by a physician
  - Osteoporosis screening for women ages 65+, 60 for women at high risk
  - Pap smear and pelvic exam once a year
  - Prostate screening (PSA) once per year for men age 50 and older
  - Colorectal cancer screenings at age 50 and older
    - Sigmoidoscopy once every 5 years
    - Fecal occult blood test annually
    - Colonoscopy once every 10 years
    - Barium enema once every 5 years

Women's Preventive Care

Beginning January 1, 2013 as part of health care reform and Caesars commitment to your health, the following women's preventive care services will be covered at 100% in addition to women's services already covered in full:

- Annual well-woman visits
- Screening for gestational diabetes
- HPV DNA testing for women 30 years and older
- Sexually-transmitted infection counseling
- HIV screening and counseling
- FDA-approved contraception methods and contraceptive counseling
- Breastfeeding support, supplies, and counseling
- Screening and Counseling for Interpersonal & Domestic Violence

Covered Expenses

The plan covers the following "Covered Expenses," which are expenses that 1) are incurred after the person becomes insured for these benefits, and 2) are recommended by a physician and are Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by Cigna. Any applicable deductibles, HRA amounts, coinsurance, and limits are shown in the Schedule of Benefits. Many of the health care terms that are capitalized in this section have a special meaning that is explained in the *Definitions* section.

Acupuncture

- Charges made for acupuncture for the treatment of pain management, nausea due to pregnancy, and chemotherapy.

Assistant Surgeons

- The maximum amount payable for assistant surgeons will not exceed 20 percent of the surgeon's allowable charge. In this case, allowable charge means the amount payable to the surgeon before any reductions due to coinsurance or deductible amounts.

Bariatric Surgery

The plan covers charges made for medical and surgical services for the treatment or control of clinically severe (morbid) obesity as defined below and if the services are demonstrated, through existing peer reviewed, evidence based scientific literature and scientifically based guidelines, to be safe and effective for the treatment or control of the condition. Clinically severe (morbid) obesity is defined by the National Heart, Lung and Blood Institute (NHLBI) as a Body Mass Index (BMI) of 40 or greater without comorbidities, or a BMI of 35-39 with comorbidities. The following items are specifically excluded:

- medical and surgical services to alter appearances or physical changes that are the result of any medical or surgical services performed for the treatment or control of obesity or clinically severe (morbid) obesity; and
- weight loss programs or treatments, whether or not they are prescribed or recommended by a Physician or under medical supervision.

In addition:

- All surgeries must be authorized by Cigna in advance and must be performed at a Cigna participating provider.
- Services are limited to one surgery per lifetime.
- Removal of excess skin following a covered bariatric surgery is available, up to a lifetime maximum of $5,000. Procedures must occur within 12 – 60 months after the bariatric surgery, and coverage includes physician, facility and ancillary services related to the surgery (e.g., anesthesia and preadmission testing). Prior authorization is required, and medical documentation of at least a 70 percent loss of excess weight (defined by the difference between the weight of member on day of surgery and weight required to reach <25 BMI) must be provided.

Bariatric Surgery Travel Services

Expenses for travel, lodging and meals for the individual receiving bariatric surgery services at a Cigna participating provider and a companion are covered under this Plan as follows:

- The term "companion" includes your spouse, domestic partner, a member of your family, your legal guardian and any person who is not related to you but is actively involved as your caregiver.
- Reasonable and necessary expenses for lodging and meals for the patient (while not confined) and one companion. Lodging and meals are paid at a per diem rate of up to $50 for one person or up to $100 for two people.
- The following are specifically excluded travel expenses:
  - travel costs incurred due to travel within 50 miles of your home;
  - laundry bills;
  - telephone bills;
  - alcohol and tobacco products;
  - and charge for transportation that exceed coach class rates.
- Travel and lodging expenses are only available if the patient resides more than 50 miles from a Cigna participating provider.
- There is a combined overall lifetime maximum benefit of $1,000 per patient for all transportation, lodging and meal expenses incurred by the patient and companion and reimbursed under this Plan in connection with all bariatric procedures.

Breast Reconstruction and Breast Prostheses

- Charges made for reconstructive surgery following a mastectomy, including:
  - surgical services for reconstruction of the breast on which surgery was performed;
  - surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance;
  - postoperative breast prostheses; and
  - mastectomy bras and external prosthetics, limited to the lowest-cost alternative available that meets external prosthetic placement needs.

- During all stages of mastectomy, treatment of physical complications, including lymphedema therapy are covered.

Cancer Screening

- Charges made for a mammogram for women ages 35 to 69, every one to two years.
- Charges made for an annual Pap screening test.
- Charges made for an annual prostate-specific antigen test (PSA).

Cancer Travel Services

Expenses for travel, lodging and meals for the individual receiving cancer-related treatment and a companion are covered under this plan as follows:

- Transportation of the patient and one companion who is traveling the same day(s) to and/or from the site where services are given for the purposes of the evaluation, the procedure or other treatment, or necessary post-discharge follow-up.
- The term companion includes your spouse, a member of your family, your legal guardian and any person who is not related to you but is actively involved as your caregiver.
- Reasonable and necessary expenses for lodging and meals for the patient (while not confined) and one companion.
- Lodging and meals are paid at a per diem rate of up to $50 for one person or up to $100 for two people.
- Travel and lodging expenses are only available when the patient resides more than 50 miles from the facility.
- If the patient is a covered dependent minor child, the transportation expenses of two companions will be covered, and lodging and meal expenses will be reimbursed up to $100 per day.
- There is a combined overall lifetime maximum of $10,000 for you and your covered family member for all transportation, lodging and meal expenses incurred by the patient and companion(s) and reimbursed under this plan in connection with all transplant procedures or cancer-related services.
- The following are specifically excluded travel expenses:
  - travel costs incurred due to travel within 50 miles of your home;
  - laundry bills;
  - telephone bills;
  - alcohol or tobacco products; and
  - charges for transportation that exceed coach class rates.

Chiropractic Care Services

- Charges made for diagnostic and treatment services in an office setting by chiropractic physicians.
- Chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function. For these services you have direct access to qualified chiropractic physicians.

Clinical Trials

- Charges made for routine patient services associated with clinical trials approved and sponsored by the federal government. In addition, the following criteria must be met:
  - The clinical trial is listed on the NIH web site www.clinicaltrials.gov as being sponsored by the federal government;
  - The trial investigates a treatment a disease and 1) the person has failed standard therapies for the disease, 2) the person cannot tolerate standard therapies for the disease or 3) no effective non-experimental treatment for the disease exists;
  - The person meets all inclusion criteria for the clinical trial and is not treated “off-protocol;”
  - The trial is approved by the Institutional Review Board of the institution administering the treatment; and
  - Coverage will not be extended to clinical trials conducted at non-participating facilities if a person is eligible to participate in a covered clinical trial from a Participating Provider.

- Routine patient services do not include, and reimbursement will not be provided for the investigational service or supply itself; services or supplies listed herein as exclusions; or services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs).
- Services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., a device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant.

Co-Surgeons

- The maximum amount payable for charges made by co-surgeons will be limited to the amount specified in Cigna Reimbursement Policies.

Counseling for Transsexual Surgery

- Counseling expenses, in preparation for or subsequent to, transsexual surgery will be covered based on the plan selected by the participant at the time of enrollment. Payment may also vary by the usage of in- or out-of-network providers. Transsexual surgery is still considered a non-covered expense under the plan.

Cranial Banding and/or Cranial Orthoses

- Cranial banding and/or cranial orthoses, subject to medical necessity. When used for this indication, the cranial orthoses will be subject to the limitations and maximums of the "External Prosthetic Appliances and Devices" benefit.

Durable Medical Equipment

- Charges made for purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician and provided by a vendor approved by Cigna for use outside a Hospital or Other Health Care Facility.
- Coverage for repair, replacement, or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear.
- All maintenance and repairs that result from a person's misuse are the person's responsibility.

External Prosthetic Appliances and Devices

- Charges made or ordered by a Physician for the initial purchase and fitting of external prosthetic appliances and devices available only by prescription that are necessary to alleviate or correct an injury, sickness or congenital defect. This includes prostheses; prosthetic appliances and devices; orthoses and orthotic devices; braces; and splints.

Family Planning

- Charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives, after appropriate counseling, medical services connected with surgical therapies (tubal ligations, vasectomies).

Gender Reassignment

- Charges for gender reassignment surgery (including, but not limited to, related services such as medical counseling, psychological clearance for surgery in the absence of a need for behavioral health therapeutic services, and hormonal therapy). In addition, procedures associated with gender reassignment surgery that are performed solely for the purpose of improving or altering appearance or self-esteem, or to treat psychological symptomatology or psychosocial complaints related to one's appearance are also covered. Benefits follow the World Professional Association for Transgender Health (WPATH) Standards of Care.
- Gender reassignment surgery is covered as medically necessary when ALL of the following criteria are met:
  - age 18 or older.
  - diagnosis of gender identity disorder (GID), including a diagnosis of transsexualism with ALL of the following criteria:

  - demonstrated desire to live and be accepted as a member of the opposite sex.
  - expressed desire to make his/her body as congruent as possible with the preferred sex through surgery and hormone replacement.
  - transsexual identity has been present consistently for at least two years.
  - GID is not secondary to another mental disorder or chromosome abnormality.
- The individual is an active participant in a recognized gender identity treatment program and demonstrates ALL of the following conditions:
  - the individual has successfully lived and worked within the desired gender role full-time for at least 12 months (real life experience) without returning to the original gender
  - initiation of hormonal therapy or breast surgery recommended by a qualified health professional with written documentation submitted to the physician responsible for the medical treatment
  - documentation of at least 12 months of continuous hormonal sex reassignment therapy, unless medically contraindicated (May be simultaneous with real life experience.)
  - recommendation for sex reassignment surgery by two qualified mental health professionals recommend sex reassignment surgery with written documentation submitted to the physician performing the genital surgery (At least one letter should be a comprehensive report. Two separate letters or one letter with two signatures is acceptable. One letter from a Master's degree mental health professional is acceptable if the second letter is from a psychiatrist or Ph.D. clinical psychologist.)
  - separate evaluation by the physician performing the genital surgery.

- ANY of the following surgeries are covered when performed as part of a medically necessary gender reassignment surgery:
  - male to female reassignment:
  - vaginoplasty
  - colovaginoplasty
  - orchiectomy
  - penectomy
  - clitoroplasty
  - labiaplasty
  - female to male reassignment:
  - initial mastectomy/breast reduction
  - hysterectomy
  - salpingo-oophorectomy
  - colpectomy/vaginectomy
  - urethroplasty
  - urethroplasty combined with initial phalloplasty
- The following associated gender reassignment surgeries are considered cosmetic in nature and not medically necessary; however, these services will be covered when performed in conjunction with gender reassignment surgery (this list may not be all-inclusive):
  - breast enlargement procedures, including augmentation mammoplasty, implants, and silicone injections of the breast
  - nipple/areola reconstruction
  - mastopexy
  - blepharoplasty
  - facial feminization surgery
  - rhinoplasty
  - lip reduction/enhancement
  - face/forehead lift
  - chin/nose implants
  - trachea shave/reduction thyroid chondroplasty
  - laryngoplasty
  - liposuction

- electrolysis
- jaw shortening/sculpturing/facial bone reduction
- collagen injections
- removal of redundant skin
- voice modification surgery
- hair removal/hair transplantation
- testicular prostheses

Genetic Testing

- Charges made for genetic testing that uses a proven testing method for the identification of genetically linked inheritable disease. Genetic testing is covered only if:
  - A person has symptoms or signs of a genetically linked inheritable disease;
  - It has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically linked inheritable disease when the results will impact clinical outcome; or
    - The therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.
- Pre-implantation genetic testing, genetic diagnosis prior to embryo transfer, is covered when either parent has an inherited disease or is a documented carrier of a genetically linked inheritable disease.
- Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 3 visits per contract year for both pre-and post-genetic testing.

Hearing Aids

- Hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.

Home Health Care Services

- Charges made for Home Health Care Services are covered when you require skilled care, are unable to obtain the required care as an ambulatory outpatient and do not require confinement in a hospital or other health care facility.
- If you are a minor or an adult who is dependent upon others for non-skilled care (e.g., bathing, eating and toileting), Home Health Care Services will only be provided for you during times when there is not a family member or caregiver present in the home to meet your non-skilled care needs.
- Home Health Care Services are:
  - Those skilled health care services that can be provided during intermittent visits of two hours or less by Other Health Care Professionals.
  - Necessary consumable medical supplies, home infusion therapy and durable medical equipment administered or used by other health care professionals in providing home health care services are covered.
  - Home Health Care Services do not include services of a person who is a member of your family or your dependent's family or who normally resides in your house or your dependent's house.
  - Physical, occupational, and speech therapy provided in the home are subject to the benefit limitations described under "*Short-Term Rehabilitative Therapy*."

Hospice Care Services

- Charges made for a person who has been diagnosed as having six months or less to live, due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program:
  - by a Hospice Facility for Bed and Board and Services and Supplies, but only up to the Hospice Bed and Board Daily Limit shown in the *Schedule of Benefits*;
  - by a Hospice Facility for services provided on an outpatient basis;
  - by a Physician for professional services;
  - by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling;

- for pain relief treatment, including drugs, medicines and medical supplies;
- by an Other Health Care Facility for part-time or intermittent nursing care by or under the supervision of a Nurse; part-time or intermittent services of Other Health Care Professionals; physical, occupational, and speech therapy; medical supplies, drugs, and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services — but only to the extent such charges would have been payable under the policy if the person had remained or been confined in a Hospital or Hospice Facility.

Hospital and Facility Expenses

- Charges made by a Hospital for bed and board and other necessary services and supplies, but only up to the Bed and Board limit shown in the *Schedule of Benefits.*
- Charges for licensed ambulance service to or from the nearest hospital where the needed medical care and treatment can be provided.
- Charges made by a Hospital for medical care and treatment received as an outpatient.
- Charges made by a Free-Standing Surgical Facility for medical care and treatment.
- Charges made by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital, or a sub-acute facility for medical care and treatment, but only up to the daily limit shown in the *Schedule of Benefits*.
- Charges made for Emergency Services and Urgent Care.
- Charges made by a Physician or a Psychologist for professional services.
- Charges made by a Nurse, other than a member of your family or your dependent's family, for professional nursing service.
- Charges made for anesthetics and their administration; diagnostic X-ray and laboratory examinations; X-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; and oxygen and other gases and their administration.

Infertility Services

- Charges made for services related to diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed. Services include, but are not limited to, approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy; laboratory tests; sperm washing or preparation; artificial insemination; and diagnostic evaluations.

Internal Prosthetic/Medical Appliances

- Charges made for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.

Nutritional Evaluation

- Charges made for nutritional evaluation and counseling when diet is a part of the medical management of a documented organic disease.

Orthognathic Surgery

- Orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone cannot correct, provided:
  - the deformity or disfigurement is accompanied by a documented clinically significant functional
  - impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement; or
  - the orthognathic surgery is Medically Necessary as a result of tumor, trauma, or disease; or
  - the orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.

- Repeat or subsequent orthognathic surgeries for the same condition are covered only when the previous orthognathic surgery met the above requirements, and there is a high probability of significant additional improvement as determined by the utilization review Physician.

Prostheses/Prosthetic Appliances and Devices

- Prostheses/prosthetic appliances and devices are defined as fabricated replacements for missing body parts.
- Prostheses/prosthetic appliances and devices include, but are not limited to, basic limb prostheses; terminal devices such as hands or hooks; and speech prostheses.

Orthoses and Orthotic Devices

- Orthoses and orthotic devices are defined as orthopedic appliances or apparatuses used to support, align, prevent or correct deformities. Coverage is provided for custom foot orthoses and other orthoses as follows:
  - **Non-foot orthoses** – only the following non-foot orthoses are covered: rigid and semi-rigid custom fabricated orthoses; semi-rigid prefabricated and flexible orthoses; cranial banding or cranial orthoses, if medically necessary; and rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.
  - **Custom foot orthoses** – covers custom-fitted or custom-fabricated foot orthotics, orthotic shoes, shoe additions, shoe modifications and transfers, and arch supports for any condition. Also covers shoes and other supportive devices for the feet for job-related foot issues. Excludes orthoses primarily used for cosmetic rather than functional reasons; excludes orthoses primarily for improved athletic performance or sports participation.

Reconstructive Surgery

- Charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; (other than abnormalities of the jaw or conditions related to TMJ disorder) provided that:
  - the surgery or therapy restores or improves function;
  - reconstruction is required as a result of Medically Necessary, non-cosmetic surgery; or the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part; or
  - repeat or subsequent surgeries for the same condition are covered only where there is the probability of significant additional improvement as determined by the utilization review physician.

Sexual Dysfunction

- Any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation, only if the cause of the sexual dysfunction is based on medical necessity, as determined by Cigna HealthCare.

Short-Term Rehabilitative Therapy

- Short-Term Rehabilitative Therapy is covered if it is part of a rehabilitation program, including physical, speech, occupational, cognitive, osteopathic manipulative, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting. Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Illness or Injury or Sickness.

Splints

- A splint is defined as an appliance for preventing movement of a joint or for the fixation of displaced or movable parts. Coverage for replacement of external prosthetic appliances and devices is limited to the following:
  - Replacement due to regular wear.
  - Replacement for damage due to abuse or misuse by the person will not be covered.
  - Replacement will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.

- Coverage for replacement is limited as follows:
  - No more than once every 24 months for persons 19 years of age and older.
  - No more than once every 12 months for persons 18 years of age and under.
  - Replacement due to a surgical alteration or revision of the site.

TMJ Dysfunction

- Surgical or non-surgical treatment of TMJ Dysfunction.

Transplant Services

- Charges made for human organ and tissue transplant services, including solid organ and bone marrow/stem cell procedures at designated facilities throughout the United States or its territories.
- Transplant services include the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human-to-human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine (which includes small bowel), liver or multiple viscera.
- All transplant services, other than cornea, are payable at 100 percent when received at Cigna LIFESOURCE Transplant Network® Facilities.
- Cornea transplants are not covered at Cigna LIFESOURCE Transplant Network® facilities.
- Transplant services received at any other facilities are not covered.
- Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor.
- Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search for, and identification of, a bone marrow or stem cell donor for an allogeneic transplant are also covered.

Transplant Travel Services

- The following benefits are only available when the covered person is the recipient of an organ transplant. No benefits are available when the covered person is a donor.
- Charges made for reasonable travel expenses incurred by you in connection with a pre-approved organ/tissue transplant are covered subject to the following conditions and limitations:
  - Lodging and meals are paid at a per diem rate of up to $50 for one person or up to $100 for two people.
  - Travel and lodging expenses are available only if the patient lives more than 50 miles from the designated Cigna LIFESOURCE Transplant Network® facility.
  - If the recipient is a minor child, the transportation expenses of two companions will be covered and lodging and meal expenses will be reimbursed up to $100 per day.
  - Transplant travel benefits are not available for corneal transplants.
  - Benefits for transportation, lodging and food are available to you only if you are the recipient of a pre-approved organ/tissue transplant from a designated Cigna LIFESOURCE Transplant Network® facility.
  - The term recipient is defined to include a person receiving authorized transplant related services during any of the following: (a) evaluation, (b) candidacy, (c) transplant event or (d) post-transplant care.
- Travel expenses for the person receiving the transplant will include charges for:
  - transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility);
  - lodging while at, or traveling to and from the transplant site; and
  - food while at, traveling to or traveling from, the transplant site.
- The plan will also cover travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian and any person who is not related to you but is actively involved as your caregiver.

- There is a combined overall lifetime maximum of $10,000 for you and your covered family member for all transportation, lodging and meal expenses incurred by the patient and companion(s) and reimbursed under this plan in connection with all transplant procedures or cancer-related services.

Wigs/Cranial Prosthesis

- When required for hair loss due to cancer or alopecia areata.

Resources to Help You Stay Healthy

Caesars encourages you to get to know your medical plan and become a more informed health care consumer. Cigna offers the following tools and resources to help you take control of and manage your health.

CIGNA HEALTHCARE 24-HOUR HEALTH INFORMATION LINE℠

Call 1-800-564-9286 toll-free to speak to a registered nurse for guidance on getting the appropriate care. You can also listen to audio tapes on a variety of health topics.

CIGNA HEALTH COACHES

When you have health concerns or questions, Cigna health coaches are there to listen to you and help you make important decisions. Health coaches are registered nurses who can assess your situation, provide helpful information and resources, find and evaluate treatment options and help you enhance your health. For example, you could call a health coach when:

- You don't understand your doctor's diagnosis.
- You're about to visit a specialist and want to ask the right questions.
- Your doctor recommends surgery and you want to better understand the procedure, associated risks and possible alternatives.
- You have asthma or diabetes and want ideas to better manage your health.
- Your doctor has recommended an MRI and you want to find a facility, compare costs and explore your options.

Health coaches are available Monday through Friday, from 8:00 a.m. to 6:00 p.m. (all local time zones) at 1-800-423-9920.

HEALTHY PREGNANCY PROGRAM

Prenatal care and education can help prevent premature births and low birth weight. The Healthy Pregnancy Program is designed to help you learn about risk factors and indicators of possible premature births. Early enrollment into the program is important for your health, as well as the health of your baby. The following benefits are provided for early enrollment:

- Free 24-hour phone access to nurses specifically trained to assist expectant mothers.
- Free support for special health needs.

Call 1-800-423-9920 to enroll.

CERTIFICATION REQUIREMENTS

Certain kinds of medical treatment require authorization and approval from Cigna before services will be covered. The following kinds of certification are performed through a review organization with which Cigna has contracted.

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

Before being admitted for hospital care, you must get pre-admission certification (PAC) from Cigna to certify the medical necessity of the hospitalization. Once you are in the hospital, the continued stay review (CSR) process will be used to certify the length of your confinement. PAC and CSR apply to you or your dependent for:

- Hospitalization as a registered bed patient; and
- Residential treatment services.

When you or your dependents choose to get non-emergency inpatient care from an out-of-network provider, you are responsible for calling Cigna to request PAC.

- In advance of an admission due to pregnancy, you should call the review organization by the end of the third month of pregnancy to get PAC. You may contact the review organization at four months or more of pregnancy, but must get PAC before any services are rendered and to avoid penalties.
- CSR should be requested, prior to the end of the certified length of stay, for continued hospital confinement.

In the case of emergency admission, you should contact the review organization within 48 hours after the admission.

Penalties for Not Getting Pre-Admission Certification/Continued Stay Review for Hospital Confinement

- The first $300 of hospital charges will not be counted as covered expenses in the following circumstances:
  - You do not receive PAC before you are admitted to the hospital — or within 48 hours of admission in the case of an emergency.
  - Your hospitalization exceeds the number of days certified through PAC or CSR; in this case, covered expenses for bed and board for each additional day are denied.
  - You receive hospital treatment that was not certified as Medically Necessary through PAC; in this case, covered expenses will not include the first $300 of charges for bed and board.
  - Any charges excluded from covered expenses for the reasons listed above will not count toward your deductible, out-of-pocket maximum, or any part of this plan, except for "coordination of benefits" (as described on page 166).

In-Network Care — Prior Authorization

Your participating provider must get prior authorization from the review organization in order for certain services to be covered under this policy. Services that require prior authorization include but are not limited to:

- All inpatient admissions and non-obstetric observation stays
- Inpatient services at any participating other health care facility
- Potentially experimental and investigational procedures
- Potentially cosmetic procedures
- Maternity stays longer than 48 hours (vaginal delivery) or 96 hours (Cesarean section)
- Hysterectomies
- Back surgery
- Outpatient procedures
- Transplants (Payments made under this program are taxable and will be grossed up at the time paid)
- Durable medical equipment
- Orthotics and prosthetics
- Outpatient rehabilitation
- Potential experimental/investigational/unproven procedures
- Diagnostic radiology
- Therapeutic radiology
- Non-emergency ambulance services
- Residential treatment

Out-of-Network Care — Outpatient Certification Requirements

Outpatient certification is required to certify the medical necessity of certain outpatient diagnostic testing and procedures, including but not limited to high-tech radiology also known as advanced radiological imaging (CT scans, MRIs, MRAs, or PET scans) and hysterectomies when performed in a free-standing surgical facility, other health care facility or a physician's office.

You or your dependent should call the toll-free number on the back of your ID card to determine if Outpatient certification is required prior to any non-emergency outpatient diagnostic testing or procedures. You must call at least four working days (Monday through Friday) prior to having the procedure performed or the service rendered.

Penalties for Not Getting Outpatient Certification

Covered expenses for outpatient diagnostic testing or procedures will be reduced by $300 in the following circumstances:

- You do not receive outpatient certification before the date on which the testing or procedure is performed.
- You have an outpatient diagnostic test or procedure performed that was not certified as Medically Necessary through outpatient certification.

Any charges excluded from covered expenses for the reasons listed above will not count toward your deductible, out-of-pocket maximum, or any part of this plan, except for "coordination of benefits" (as described on page 166).

Case Management

Cigna provides case management services through a review organization, to assist patients whose treatment needs extend beyond the acute care setting. The goal of case management is to ensure that patients receive appropriate care in the most effective setting possible — whether at home, as an outpatient, or an inpatient in a hospital or specialized facility. Should the need for case management arise, a case management professional will work closely with the patient, his or her family, and the attending physician to determine the treatment options that will best meet the patient's needs and keep costs manageable. The case manager will help coordinate the treatment program and arrange for necessary resources. Case managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Case managers are registered nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high-risk pregnancy and neonates, oncology, mental health, rehabilitation, or general medicine and surgery. A case manager trained in the appropriate clinical specialty area will be assigned to you or your dependent. In addition, case managers are supported by a panel of physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the case manager recommends alternative treatment programs and helps coordinate needed resources, the patient's attending physician remains responsible for the actual medical care.

- You, your dependent or an attending physician can request case management services by calling the toll-free number shown on your ID card during normal business hours, Monday through Friday. In addition, your employer, a claim office, or a utilization review program may refer an individual for case management.
- The review organization assesses each case to determine whether case management is appropriate.
- The assigned case manager contacts you or your dependent and explains in detail how the program works. Participation in the program is voluntary — no penalty or benefit reduction is imposed if you do not wish to participate in case management.
- Following an initial assessment, the case manager works with you, your family, and your physician to determine the needs of the patient and to identify what alternative treatment programs are available (for example, in-home medical care in lieu of an extended hospital convalescence). You are not penalized if the alternative treatment program is not followed.
- The case manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a hospital bed and other durable medical equipment for the home).

- The case manager also acts as a liaison between the insurer, the patient, his or her family, and the physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan).
- Once the alternate treatment program is in place, the case manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

While participation in case management is strictly voluntary, case management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

What the Medical Plan Does Not Cover

Payment for the following is specifically excluded from this plan. Additional coverage limitations determined by plan or provider type are shown in the *Schedule of Benefits*. See the *Pharmacy* section of this SPD for expenses not covered by the pharmacy benefit.

- Expenses for supplies, care, treatment, or surgeries not Medically Necessary.
- Expenses for which you or any one of your dependents is in any way paid or entitled to payment by or through a public program, other than Medicaid.
- Expenses for which payment is unlawful where the person was living when the expenses were incurred.
- Charges made by a Hospital that is owned or operated by, or which provides care or performs services for, the United States government, if such charges are directly related to a military-service-connected Injury or Sickness.
- Expenses for or in connection with an Injury or Sickness that is due to war, declared or undeclared.
- Charges that you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary, or convalescent care.
- Charges excluded under the plan's mental health and substance abuse benefits, as listed in the *EAP* section of this document.
- Expenses for or in connection with experimental, investigational or unproven services. These are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:
  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
  - the subject of review or approval by an Institutional Review Board for the proposed use except as
  - provided in the *Clinical Trials* section of this plan; or
  - the subject of an ongoing phase I, II or III clinical trial, except as provided in the *Clinical Trials* section of this plan.
- Regardless of clinical indication for rhinoplasty (except in conjunction with Gender Reassignment Surgery); blepharoplasty (except in conjunction with Gender Reassignment Surgery); acupressure; craniosacral/cranial therapy; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- For or in connection with treatment of the teeth or periodontium unless such expenses are incurred for:
  - charges made for a continuous course of dental treatment started within six months of an Injury to sound natural teeth;
  - charges made by a Physician for any of the following Surgical Procedures: excision of epulis; excision of unerupted impacted tooth, including removal of alveolar bone and sectioning of tooth; removal of residual root (when performed by a Dentist other than the one who extracted the tooth); intraoral drainage of acute alveolar abscess with cellulitis; alveolectomy; gingivectomy, for gingivitis or periodontitis;
  - charges made by a Hospital for Bed and Board or Necessary Services and Supplies;
  - charges made by a Free-Standing Surgical Facility or the outpatient department of a Hospital in connection with surgery.
- Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.

- Transsexual surgery including hormonal therapy in preparation for, or subsequent to, any such surgery.
- Any non-medically necessary services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy and premature ejaculation.
- Charges under the Infertility Services benefit for:
  - infertility drugs (see the section on prescription drug benefits);
  - in-vitro fertilization (IVF); gamete intrafallopian transfer (GIFT); zygote intrafallopian transfer (ZIFT) and variations of these procedures;
  - reversal of male and female voluntary sterilization;
  - infertility services when the infertility is caused by or related to voluntary sterilization;
  - donor charges and services;
  - cryopreservation of donor sperm and eggs; and
  - any experimental, investigational or unproven infertility procedures or therapies.
- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- Charges under the Cancer Travel Services benefit or the Transplant Travel Services benefit for the following travel expenses:
  - travel costs incurred due to travel within 50 miles of your home;
  - laundry bills;
  - telephone bills;
  - alcohol or tobacco products; and
  - charges for transportation that exceed coach class rates.
- Charges under the Hospice Care Services benefit:
  - for the services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;
  - for any period when you or your Dependent is not under the care of a Physician;
  - for services or supplies not listed in the Hospice Care Program;
  - for any curative or life-prolonging procedures;
  - to the extent that any other benefits are payable for those expenses under the policy; or
  - for services or supplies that are primarily to aid you or your Dependent in daily living.
- Charges made by a Physician for any of the following Surgical Procedures: excision of epulis; excision of unerupted impacted tooth, including removal of alveolar bone and sectioning of tooth; removal of residual root (when performed by a Dentist other than the one who extracted the tooth).
- Charges under the Durable Medical Equipment benefit for the following items:
  - bed-related items: bed trays, over-the-bed tables, bed wedges, pillows, custom bedroom equipment, and mattresses, including non-power mattresses, custom mattresses and posturepedic mattresses;
  - bath-related items: bath lifts, non-portable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand-held showers, paraffin baths, bath mats and spas;
  - chairs, lifts, and standing devices: computerized or gyroscopic mobility systems, roll-about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized — manual hydraulic lifts are covered if the patient requires two-person transfer) and auto tilt chairs;
  - fixtures to real property: ceiling lifts and wheelchair ramps;
  - car/van modifications;
  - air quality items: room humidifiers, vaporizers, air purifiers and electrostatic machines;
  - blood/injection related items: blood pressure cuffs, centrifuges, nova pens and needleless injectors;
  - other equipment: heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment and diathermy machines.
- Charges under the Short-Term Rehabilitative Therapy benefit for:

  - sensory integration therapy; group therapy; treatment of dyslexia; or behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions without evidence of an underlying medical condition or neurological disorder;
  - treatment for functional articulation disorder such as correction of tongue thrust, lisp, verbal apraxia, or swallowing dysfunction that is not based on an underlying diagnosed medical condition or injury; and
  - maintenance or preventive treatment consisting of routine, long-term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status.
- Charges under the Chiropractic Care Services benefit for:
  - services of a chiropractor which are not within his scope of practice, as defined by state law;
  - charges for care not provided in an office setting;
  - maintenance or preventive treatment consisting of routine, long-term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status, which could include short-term rehabilitation; and
  - vitamin therapy.
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long-term or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- Weight loss programs or treatments (except treatment related to covered bariatric surgery services), whether prescribed or recommended by a physician or under medical supervision.
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the *Covered Expenses* section.
- Private Hospital rooms and/or private duty nursing except as specified in the *Covered Expenses* section.
- Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements and other articles that are not for the specific treatment of an Injury or Sickness.
- Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports (unless covered under the Custom Foot Orthotics benefit), elastic stockings, garter belts, corsets and dentures.
- Aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, personal digital assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Massage therapy.
- Aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, personal digital assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Charges under the Orthoses and Orthotic Devices benefit for:
  - prefabricated foot orthoses;
  - orthoses primarily used for cosmetic rather than functional reasons; and
  - orthoses primarily for improved athletic performance or sports participation.
  - Copes scoliosis braces.
- Charges under the External Prosthetic Appliances and Devices benefit for:
  - external and internal power enhancements or power controls for prosthetic limbs and terminal devices; and
  - myoelectric prostheses peripheral nerve stimulators.
- Medical benefits for eyeglasses, contact lenses or examinations for prescription or fitting thereof, except that Covered Expenses will include the purchase of the first pair of eyeglasses, lenses, frames or contact lenses that follows keratoconus or cataract surgery.
- Charges made for or in connection with routine refractions, eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn.

- Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- Membership costs or fees associated with health clubs, weight-loss programs and smoking cessation programs. (These services may be covered under the Wellness Program. Please review that section for more information.)
- Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Dental implants for any condition.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- Nutritional supplements and formulas, except for infant formula, needed for the treatment of inborn errors of metabolism.
- Medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.
- Medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Telephone, e-mail, and Internet consultations and telemedicine.
- Charges that would not have been made if the person had no insurance.
- Amounts that are more than Maximum Reimbursable Charges.
- Expenses incurred outside the United States, unless you or your dependent is a U.S. resident and the charges are incurred while traveling on business or for pleasure, unless on a temporary work assignment.
- Charges made by any covered provider who is a member of your family or your dependent's family.

Resources to Help You Stay Healthy

Caesars encourages you to get to know your medical plan and become a more informed health care consumer. Caesars offers the following tools and resources to help you take control of and manage your health.

Expert Second Opinions

Expert Second Opinions are provided by Best Doctors, which is an independent resource, separate from your health coverage or benefits. Participation will not affect your health coverage or benefits. The service is completely confidential. It is designed to provide you and your treating physician access to leading medical experts who will review your diagnosis and treatment. The expert will review your diagnosis, suggest best treatment options for your condition, and provide you with a written report. With your permission, the Expert will also provide a report for your treating physician. Services offered include:

- Find an expert second opinion: Matching members to the right physician.
- Ask the Expert: Quick answers to basic questions.
- InterConsultation: In-Depth medical review – better than a second opinion.
- Critical Care: Help during times of critical medical crisis.

Eligibility: All employees enrolled in the Caesars benefits and their eligible dependents – spouse/domestic partner, children, parents and parents-in-laws.

Incentive: $100 to be deposited directly into the employee's HSA or HRA account.

MDLive

MDLive allows you to visit with board-certified doctors and licensed therapists by online video or phone at any time, from practically anywhere. MDLive's national network is available 24/7, including holidays to provide affordable quality care. MDLive physicians can diagnose, treat, and write prescriptions for routine medical conditions.

Surgery Assistant *(available in Reno / Tahoe areas ONLY)*

Surgery Assistant, provided by Surgery Plus is a NEW supplemental surgery benefit available for Reno / Tahoe employees enrolled in the Plan beginning March 1, 2015. This service gives direct access to surgeons of excellence nationwide for orthopedic, spine, heart, bariatric and general outpatient. Personal concierge service to help participants access better quality care with a surgeon of excellence. They will also manage all appointment scheduling, travel, transfer of medical records, and no more medical bills for members. Surgery Assistant negotiates all costs into a bundle BEFORE surgery. Bundled case rates save 25% - 30% more than traditional insurance.

Eligibility: All employees enrolled in the Caesars benefits (Reno / Tahoe ONLY) and their eligible dependents – spouse/domestic partner and children.

Incentive: $500 to be deposited directly into the employee's HSA or HRA account.

Prescription Drug Benefits

You do not need to enroll to participate in the Express Scripts prescription benefit; enrollment is automatic when you enroll in a medical plan.

Caesars Plan pays benefits for prescription drugs the same way it would for any other medical expense, depending on where you are in the plan. If you have the HRA plan, prescription drug costs are paid first by your HRA, then entirely by you (while you're meeting your deductible) and then by both you and Caesars (coinsurance) until you meet your out-of-pocket maximum. If you have the HSA plan, you can choose to use your HSA to pay for prescription drug costs

or decide to pay out-of-pocket if you are saving your HSA for a future expense. After your deductible is met, you will only be responsible for your coinsurance amount.

When you have a prescription filled at one of the plan's participating pharmacies, you will pay the full amount of Express Scripts' discounted rate for your medication until you have met your deductible. After that, you will pay coinsurance.

Unlike some pharmacy plans, Caesars' pharmacy plan does not charge a copay for prescription drugs. Instead, you pay coinsurance after the deductible has been met.

Each prescription order and refill covers the following quantities:

- up to a consecutive 30-day supply at a retail pharmacy, unless limited by the drug manufacturer's packaging or your doctor's written prescription directions;
- up to a consecutive 90-day supply through the mail-order drug program, unless limited by the drug;
- manufacturer's packaging or your doctor's written prescription directions; or
- up to the dosage and/or dispensing limits determined by Express Scripts.

When you have your prescriptions filled at a participating in-network pharmacy, you do not need to file a claim form.

The plan does not cover prescription drugs purchased at an out-of-network pharmacy. However, if you or your dependent is prescribed medically necessary prescriptions drugs or related supplies while receiving emergency services, and the prescription cannot reasonably be filled at a participating in-network pharmacy, the Pharmacy Plan may cover the prescription at the in-network benefit level. You will need to pay for the services and file a paper claim with Express Scripts for reimbursement. Claim forms may be obtained by calling Express Scripts customer service.

Please see What the Pharmacy Plan Does Not Cover for a detailed list of pharmacy charges that the plan will not pay.

If you are using the mail-order drug program, be sure your physician writes your maintenance prescription(s) for a supply of 90 days with 3 refills.

Cost of Prescriptions*

Purchases at In-Network	
Retail Pharmacies	
"Affordable Care Act"; HealthCare Reform Preventive Care Offering	0% of prescription cost
Generic medication	10% of prescription cost
Preferred-brand medication	25% ($25 minimum; $200 maximum)
Nonpreferred-brand medication	50% ($50 minimum; $200 maximum)
Home Delivery Service	
"Affordable Care Act"; HealthCare Reform Preventive Care Offering	0% of prescription cost
Generic medication	10% of prescription cost
Preferred-brand medication	25% ($50 minimum; $500 maximum)
Nonpreferred-brand medication	50% ($100 minimum; $500 maximum)

**After HRA is used and the deductible is met.*

Note: The "Affordable Care Act"; HealthCare Reform Preventive Care Offering includes standard lists of Aspirin (to prevent cardiovascular events), Fluoride, Folic Acid, Iron Supplements, Immunizations, and preventive contraceptives (mostly generics). Please contact Express Scripts for more details.

SAVING MONEY WITH GENERIC DRUGS

Generic drugs cost less than brand-name drugs and work just as well. Although a generic drug may have a different color or shape than the brand-name version, it has the same active ingredients and effect on clinical outcome.

The plan will automatically substitute a generic drug for its brand-name equivalent when available. If a generic is available but you choose to purchase the brand-name drug, you will have to pay the difference in cost, referred to as the ancillary fee. Here's how you would pay for your brand-name drug in this case:

- **If you are still in the deductible phase…** You will be charged the plan's discounted rate for the brand-name drug.
- **If you have met your deductible…** You will pay your coinsurance amount for the brand-name drug, plus the difference between the cost of the generic and brand-name drugs.

ORDERING YOUR DRUGS THROUGH THE MAIL

If you take certain "maintenance" medications (that is, drugs you must take regularly, such as blood pressure medication or birth control pills), you can save time and money by filling your prescriptions through Express Scripts Home Delivery Program or you may opt out of the Home Delivery Program and continue all maintenance medications at a participating retail pharmacy. The mail-order drug benefit allows you to order up to a 90-day supply of maintenance medication at discounted prices, as low as $10. For questions about this service, call Express Scripts at 1-866-578-5001.

Home Delivery Program

- The Caesars Pharmacy Plan covers up to two fills of certain maintenance medications at participating retail pharmacies.
- After two fills, the plan will no longer pay for your prescription and your cost will increase to 100% of the discounted price.
- If you wish to use the prescription plan after two fills at a retail pharmacy you **must** take action!
  - Contact Express Scripts to opt out of the Home Delivery Program and keep getting prescriptions at your retail pharmacy
  - If you choose to opt out of using home delivery, Express Scripts will apply a special override so that you can continue getting your fills at retail

  Note: This is a letter based program. You will receive a reminder after your first two fills to contact Express Scripts. If you have chosen to opt out, the override is good for one year. When your override is nearing expiration, you will receive a reminder to contact Express Scripts again.

- If you wish to transition your prescription to the Express Scripts Home Delivery pharmacy
  - Contact Express Scripts to set up your mail-order account
  - A 90-day supply filled through home delivery may cost less over time than going to the pharmacy every month.

- If you are using the mail-order drug program, be sure your physician writes your maintenance prescription(s) for a supply of 90 days with 3 refills.

How to Opt Out of Using Home Delivery

- Call the Express Scripts Member Choice Center immediately at 1-877-603-1032 and tell them you want to Opt out of the Home Delivery Program

How to Get Started Using Home Delivery

1. You can set up your mail-order account by logging on to www.express-scripts.com, www.starthomedelivery.com or by calling the Express Scripts Member Choice Center at 1-877-603-1032. Express Scripts will contact your doctor for a new prescription and will start processing your order when the prescription is received.
2. Or, if you have prescriptions in hand already, mail your prescriptions to:
   Express Scripts Inc.
   P.O. Box 52069
   Phoenix, AZ 85072-2069

Write the following information on the back of your prescription:

- your employee ID number or Social Security number
- patient's name
- patient's date of birth
- address

To Order Refills

Call Express Scripts toll free at 1-866-578-5001 or visit www.express-scripts.com to utilize the auto-refill function.

Payment Options

- You can maintain a credit or debit card number on your account profile. The pharmacy will automatically charge your card when the order processes. It is important to note that if you maintain a credit card on file with the pharmacy, the pharmacy may place up to a $500 charge on the card. If an order exceeds that limit, Express Scripts will ask you for confirmation.
- You can also keep multiple credit or debit cards stored on the member website, instead of the pharmacy. The website allows you to make payments online at your convenience and with the dollar amount you choose to pay.
- If you do not have a credit card on file with the pharmacy, it is important to note that the pharmacy extends a credit limit of $150 on orders. If your account balance is paid, the pharmacy will release your order automatically. However, if you have an outstanding balance, you will be requested to make a payment for the pharmacy to release an order for shipment.
- You will receive an invoice with your medication shipment and can mail a check or money order to the pharmacy in the envelope provided.
- You can make a payment online toward any balance you have using a credit or debit card. Visit www.express-scripts.com.
- You can use the "Bill Me Later" credit-line option to pay monthly on your mail-order balance. For more information, contact Express Scripts at 1-866-578-5001.

WHAT DOES THE MANDATORY GENERIC DRUG PROVISION MEAN?

Mandatory generic for prescription drugs applies during the coinsurance phase of the plan. The cost of brands when generics are available is calculated at 10 percent of the brand-name drug price PLUS the difference in cost between the brand and the generic. The Express Scripts discounted cost of the drug always applies whether you're in the Health Reimbursement Account (HRA), deductible or coinsurance phase. Here's an example.

Express Scripts Discount Prescription Rates for a Specific Drug:

- Brand Name Drug = $40
- Generic Equivalent = $10

In the HRA phase of the plan, the $40 discounted cost of the brand-name drug will be deducted from the HRA account.

In the deductible phase of the plan, the cost will be $40 if the brand is chosen instead of the generic. You must pay this amount at the pharmacy.

In the coinsurance phase, the cost will be your share of the brand name drug, plus the difference between the brand and generic drugs.

In this example, you would pay 10 percent of $40 ($4) for a brand name drug, plus the $30 difference, for a total cost of $34.

The cost to you is no greater than the discounted rate for the brand-name drug. The difference between the cost of the brand-name drug and the generic will not apply toward your out-of-pocket maximum. The mandatory generic prescription drug benefit applies even if the physician has written “dispense as written” or “do not substitute” on the prescription.

Prior Authorization for Certain Drugs

The plan requires your physician to secure authorization from Express Scripts before certain drugs or related supplies will be allowed for coverage. If your pharmacy tells you that your prescription is denied for Prior Authorization, have your physician call Express Scripts (or fax a letter requesting Prior Authorization with supporting documentation). Once the authorization has been secured, your pharmacy can rerun the claim for payment. If the authorization request is denied, you and your doctor will receive notification from Express Scripts. The authorization process may include Step Therapy, in which you would begin with a proven, cost-effective alternative, such as a generic equivalent before moving to the more expensive brand-name medications (A therapeutic equivalent is a generic option for another brand name in the same category of drugs. For example, the ulcer medication Aciphex does not have a generic, but another ulcer medication, Prilosec, does. The plan would see a treatment course with generic Prilosec first, omeprazole, as a therapeutic equivalent.).

If the request for prior authorization is approved, your physician will receive confirmation. The length of the authorization will depend on the diagnosis and the prescription. When your physician advises you that coverage has been approved, you should go ahead and fill the prescription. If you disagree with a coverage decision, you may appeal that decision by submitting a written request stating why the prescription drugs or related supplies should be covered.

If you have questions about a specific prior authorization request, please call Express Scripts at 1-866-578-5001.

CuraScript Specialty Pharmacy

CuraScript is your provider for specialty medications. Specialty medications include high cost injectables used to treat such conditions as cancer, multiple sclerosis, hepatitis-C, rheumatoid arthritis and hemophilia. Patients enrolled under the Choice plans will be required to use the CuraScript mail service. CuraScript will obtain your prescription from your doctor and ship your medicine to you via overnight delivery free of charge. CuraScript will remind you when it is time for renewal and will arrange for your next delivery. Fills through this service have been limited to a maximum of 30 days, just like a retail pharmacy. To learn more, call CuraScript toll free at 1-866-848-9870.

Step Therapy

Your plan includes step therapy to ensure that when a new treatment is started, the most cost-effective medications are used first. Here is how it works:

- First-line drugs are automatically allowed and include generic or preferred-brand drugs.
- Second-line products would include higher-cost products, or non-preferred brands.
- To start a second-line drug as your first treatment, your physician would need to establish a medical necessity for that product, as well as offer documentation that he or she had already attempted a course of treatment with a generic to secure prior authorization through Express Scripts. The step therapy program looks back 130 days to check for history of first-line drug use.
- If a first-line drug has been used within the 130-day look back period,, the plan will allow a second-line drug to pay.

WHAT THE PHARMACY PLAN DOES NOT COVER

Payment for the following is specifically excluded from this plan. Additional coverage limitations determined by plan or provider type are shown in the *Schedule of Benefits*.

- Charges under the Express Scripts Prescription Drug Program are excluded for:
  - drugs available over the counter that do not require a prescription by federal or state law;
  - any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
  - a drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee;
  - all prescription drugs that are typically considered investigational and/or experimental drugs, except as provided in this plan;
  - Food and Drug Administration (FDA) approved drugs used for indications other than those approved by the FDA, unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, The American Medical Association Drug Evaluations; or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal;
  - prescription and non-prescription supplies or durable medical equipment (such as ostomy supplies or peak flow meters), devices, and appliances other than Related Supplies;
  - implantable contraceptive products and diaphragms;
  - legend diagnostic and/or testing supplies (such as Tubersol used for TB skin test, Radiopaque dye for outpatient testing). The exception would be blood or urine glucose testing products for diabetes;
  - injectable infertility agents;
  - drugs used for the treatment of sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasmy and decreased libido;
  - unit dose medications, or those medications packaged as single unit doses in blister packaging;
  - prescription vitamins (other than prenatal vitamins), dietary supplements, medical foods and fluoride products;
  - drugs used for cosmetic purposes such as drugs used to reduce wrinkles (such as Botox) or promote hair growth, as well as drugs used to control perspiration and fade cream products;
  - diet pills or appetite suppressants (anorectics);
  - vaccines or immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis (only the oral typhoid vaccine, Vivotif Berna capsules, are allowed for coverage);
  - replacement of Prescription Drugs and Related Supplies due to loss or theft;
  - drugs used to enhance athletic performance, or increase musculature;
  - drugs which are to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows a facility for dispensing pharmaceuticals to be operated on its premises a;
  - prescriptions more than one year from the original date of issue.

Wellness Centers

Wellness Centers are available to eligible employees at various locations. The third-party providers that staff and manage the Wellness Centers, the services provided, and eligibility vary by location.

OVERVIEW OF WELLNESS CENTERS IN ATLANTIC CITY, LAKE TAHOE, LAS VEGAS, NEW ORLEANS, AND TUNICA

Wellness Centers are a benefit provided under the Caesars Medical Plan and offers Eligible Employees and Eligible Dependents with Covered Services, which may change from time to time, that are similar to certain services provided by a Physician.

Eligible Employees or Eligible Dependents either make a copayment for each visit, certain lab work, vaccination procedures and other injections (such as allergy shots) or pay a fee based on a fee schedule if they participate in an HSA plan. Up to a 30-day supply of certain prescription drugs prescribed is available through the Wellness Center providers, with applicable copayments.

The Wellness Centers have full-time staff physicians, advanced practitioners, registered nurses and other clinical staff to serve your needs. If needed and as appropriate, the Wellness Centers will provide employees with referrals to providers within Caesars' Medical Plan options.

The services provided by the Wellness Centers may, but are not required to, take the place of services provided through your primary care physician or any other physician you currently use.

The Wellness Centers are managed and staffed by PremiseHealth, a third-party provider.

For urgent care, no appointment is necessary. However, appointments will be necessary for non-urgent care. Refer to the *How to Access the Wellness Center* section for additional information.

Terms You Should Know

Benefits Administrator: The daily administrator of benefits available at the Wellness Centers is PremiseHealth, 5500 Maryland Way, Suite 400, Brentwood, TN 37027.

Covered Services: Specific services related to a non-occupational illness, injury or disease, which are available through the Wellness Centers. A list of Covered Services is located in the Covered Services section in this summary.

Eligible Employee: Generally, you are eligible for Wellness Center services if you are eligible for coverage under the Caesars Medical Plan. The terms "you" and "your" as used in this document refer to any Eligible Employee.

Eligible Dependent: Your Eligible Dependents are those identified as eligible under the Caesars Medical Plan and who are age two or older.

Emergency Response and Care: Initial stabilization for all emergencies. Scope of care may include basic life support measures with the use of an automated external defibrillator and/or appropriate treatment within the skill set of Wellness Center medical staff as appropriate.

Urgent Care: Non-work-related urgent care including infections, such as upper respiratory and urinary tract, sprains, strains, GI disorders, rashes, and insect bites, etc. Components of urgent care may include wound care, suturing, radiology services and throat cultures.

Eligibility and Enrollment

Covered Services at the Wellness Centers are available to Eligible Employees and Eligible Dependents. (See above, for the definitions of these terms.) In addition, Eligible Employees whose employment has terminated and their Eligible Dependents may be eligible for continued coverage if electing COBRA Continuation of Coverage under the Caesars Medical Plan.

There are no enrollment forms to complete or enrollment procedures to follow outside of the enrollment for Caesars Medical Plan. However, you and your Eligible Dependents will each be required to complete a HIPAA Notice of Privacy and Acknowledgement, General Consent for Treatment and Authorization for Release of Medical Records, Patient Demographics Form and a Health Care Summary the time you first utilize a Wellness Center.

If you are employed at a Louisiana property, please contact the Property Human Resources Department for more information about eligibility and enrollment.

Cost of Coverage

As an Eligible Employee, coverage for services at a Wellness Center for you and your Eligible Dependents is provided subject to a flat dollar copayment (HRA plan) or fee schedule (HSA plan) that varies by type of service. Eligible Employees or Eligible Dependents enrolled in an HRA plan make a copayment for each visit via payroll deduction. Eligible Employees or Eligible Dependents enrolled in an HSA plan may pay with their HSA debit card. There is no

cost for preventive care. Up to a 30-day supply of certain prescription drugs prescribed is available through the Wellness Centers, with applicable copayments or fees.

How to Access the Wellness Centers

The Wellness Center Patient Portal

You may access more information about the Wellness Centers, make appointments, and view fee schedules online at Wellness Center Patient Portal (https://myhealthcenterhome.com/sites/caesars). You and your dependents can register and use the site. The employee account will have access to the dependent accounts.

Making an Appointment

If you or your Eligible Dependents wish to receive services at a Wellness Center, it is recommended that you call or go online to make an appointment. Walk-in visits are accepted and staff will do their best to work your visit in around previously scheduled appointments that day.

For urgent care, the staff will make every effort to accommodate patient needs based on visit volume. You are encouraged to schedule a same-day appointment for urgent care, if possible, to reduce wait time. Urgent care is available during the Wellness Center's Hours of Operations.

Hours of Operation

The Wellness Centers are open Monday through Friday and some sites are open on Saturdays as well. Hours vary by site. Please go online or contact your local Wellness Center for its scheduled hours. The Wellness Centers will follow Caesars corporate holiday schedule and be closed on those days.

These locations have Wellness Centers providing coverage under this Program.

Atlantic City, NJ **Showboat Casino & Hotel** **801 Boardwalk** **Atlantic City, NJ 08401** **(609) 343-4003**	This location provides x-ray, physical therapy, Registered Dietician and Health Risk Disease Management services.
Lake Tahoe, NV **Caesars Lake Tahoe** **Hwy 50 & Stateline St.** **Stateline, NV 89449** **(775) 586-5000**	This location provides physical therapy and Registered Dietician services.
Las Vegas, NV **4100 W. Flamingo Road, Ste. 2100** **Las Vegas, NV 89103** **(702) 822-5000**	This location provides physical therapy, Registered Dietician and Health Risk Disease Management services.
New Orleans, LA **Caesars New Orleans** **555 Convention Center Boulevard** **New Orleans, LA 70130** **(504) 533-6624**	
Tunica, MS **Caesars Tunica** **13615 Old Highway 61 North** **Robinsonville, MS 38664** **(662)357-3264**	This location provides physical therapy and Health Risk Disease Management services.

Covered Services

This section contains information about Covered Services at the Wellness Centers.

Emergency Response and Care

Initial stabilization for all emergencies. Scope of care may include basic life support measures with the use of an automated external defibrillator and/or appropriate treatment within the skill set of Wellness Center medical staff as appropriate. If you have an emergency situation, proceed to the nearest emergency room.

Urgent Care

Non-work-related urgent care including infections, such as upper respiratory and urinary tract, sprains, strains, GI disorders, rashes, and insect bites, etc. Components of urgent care may include:

- Wound care
- Suturing
- Radiology services
- Throat cultures

Immunizations

Immunizations including tetanus, influenza and hepatitis A and B are offered at the Wellness Centers.

Injections

Vitamin B-12 and allergy desensitization injections are offered.

Laboratory Testing

Screening and urgent, related laboratory testing.

Preventive Physical Exams

Preventive physical exams, including both a physical examination and a clinical consultation with a qualified practitioner who will review the Eligible Employee's risk factors for disease, physical findings and the results of all laboratory work, and will assist in designing a health care and wellness plan for that individual. Components of the physical exam may include:

- Comprehensive medical history
- Preventive physical examinations (including well-adult exams and well-child exams for children over 2 years old)
- Basic hearing and vision tests
- Laboratory testing (as appropriate)
- Blood pressure and cholesterol screenings
- Skin/Dermatological examination
- EKG (where medically indicated or if Eligible Employee is over age 40)
- Urinalysis

Primary Care

Health care provided where a patient is evaluated and treated by a family doctor or nurse, or, if necessary, is referred to a specialist. Components of primary care may include treatment of:

- Diabetes
- Depression
- Hypertension
- Thyroid disease
- Back pain
- Heart disease
- Other high-risk diseases

Evaluation and Treatment of Injuries and Illnesses

Evaluation and treatment of episodic, non-occupational injuries and illnesses, including ongoing follow-up care to evaluate progress. The Wellness Center will make referrals to primary care physicians or specialists within the Caesars health plans if needed.

Pharmacy

Eligible employees and eligible dependents can receive most prescribed medications as part of a visit to a Wellness Center. Up to a 30-day supply of certain prescriptions is available, subject to applicable copayments.

Just as with any prescription, the pharmacy benefit requires your physician to get authorization from the Caesars Medical Plan administrator before prescribing certain drugs or related supplies. In this case, your physician should call (or fax the appropriate form) before writing the prescription. If the request for prior authorization is approved, your physician will receive confirmation. The length of the authorization will depend on the diagnosis and the prescription. When your physician advises you that coverage has been approved, you should go ahead and fill the prescription. If the request is denied, both you and your physician will be notified. If you disagree with a coverage decision, you may appeal that decision by submitting a written request to the Caesars Medical Plan Claims Administrator stating why the prescription drugs or related supplies should be covered. If you have questions about a specific prior authorization request, please contact the Claims Administrator.

Limited Screening Programs/Health Fairs (available at certain locations)

Health screening programs may include blood pressure and other biometric measurements.

Registered Dietician

Components of Registered Dietician may include:
- Weight management services
- Nutrition counseling and education
- Smoking cessation
- Stress management
- Education material distribution
- Health risk screening and assessments

Physical Therapy

Select Wellness Centers will offer physical therapy. A licensed physical therapist will provide one-on-one personalized treatment for conditions including:
- back, neck and foot pain
- spinal and joint injuries
- muscle aches, strains and sprains
- pre- and post-surgical rehabilitation
- sport-related injuries
- headaches
- neurological conditions (carpal tunnel and sciatica)
- exercise program development

Health Risk Condition Management

Select Wellness Centers will offer personal condition management services in conjunction with PremiseHealth provider staff through one-on-one consultations and ongoing counseling to help employees treat and manage specific conditions.
- Diabetes
- Depression
- Hypertension

- Thyroid disease
- Back pain
- Heart disease
- Other high-risk diseases

X-Ray

Select Wellness Centers will offer Radiology services.

Medical/Specialist Referrals

Eligible Employees and Eligible Dependents may receive medical and specialist referrals to providers within the Caesars Medical Plan.

EAP Referrals

Eligible Employees and Eligible Dependents may be provided appropriate referrals to Caesars Employee Assistance Program.

OVERVIEW OF WELLNESS CENTERS IN BOSSIER CITY, CINCINNATI, COUNCIL BLUFFS, HAMMOND, NORTH KANSAS CITY AND SOUTHERN INDIANA

The Wellness Centers in Bossier City, Cincinnati, Council, Bluffs, Hammond, North Kansas City and Southern Indiana are managed and staffed by Cigna Onsite Health Nurse Practitioners.

Eligibility and Enrollment

Employees enrolled in the Caesars medical plan can visit the Health and Wellness Center.

Cost of Coverage

As an Eligible Employee, coverage for services at a Wellness Center is provided subject to a flat dollar fee that varies by type of service or subject to HSA fee schedule. Eligible Employees make a copayment for each visit via payroll deduction, such as required lab work, vaccination procedures and other injections (such as allergy shots). There is either a no- or low-cost for preventive care.

How to Access the Wellness Centers

Making an Appointment

If you wish to receive services at a Wellness Center, it is recommended that you call to make an appointment. Walk-in visits are accepted and staff will do their best to work your visit in around previously scheduled appointments that day.

When you need urgent care for minor illnesses or injuries, the staff will make every effort to accommodate patient needs based on visit volume. You are encouraged to schedule a same-day appointment for urgent care, if possible, to reduce wait time. Urgent care is available during the Wellness Center's Hours of Operations.

Hours of Operation

The Wellness Centers are open Monday through Friday. Hours vary by site. Please contact your local Wellness Center for its scheduled hours. The Wellness Centers will follow Caesars corporate holiday schedule and be closed on those days.

North Kansas City, MO **Harrah's North Kansas City** **1 Riverboat Drive** **North Kansas City, MO 64116** **816-460-5055**	
Hammond, IN **Horseshoe Hammond** **777 Casino Drive** **Hammond, IN 46320** **219-473-6100**	
Cincinnati, OH 45202 **Horseshoe Cincinnati** **1000 Broadway** **Cincinnati, OH 45202** **513-250-3405**	
Bossier City, LA **Horseshoe Bossier City** **711 Horseshoe Blvd.** **Bossier City, LA 71111** **(318) 741-7894**	The Bossier City Health and Wellness Center is located on the second floor close to the entrance from the 2nd floor parking garage.
Council Bluffs, IA **Horseshoe Council Bluffs** **2701 23rd Ave.** **Council Bluffs, IA 51501** **(712) 396-3722**	The Council Bluffs Health and Wellness center is located inside the employee entrance at Horseshoe Casino.
Elizabeth, IN **Horseshoe Southern Indiana** **11999 Casino Center Dr. SE** **Elizabeth, IN 47117** **(812) 969-6741**	The Horseshoe Southern Indiana Health and Wellness Center is located at the entry to employee hallway at the end of the moving sidewalks from the hotel.

Covered Services

This section contains information about Covered Services at the Wellness Centers.

Primary, Urgent, and Preventive Care

- Preventive health exams (including Wellness Rewards requirements)
- Blood pressure checks and body measurements
- Colds, sore throats, infections
- Routine laboratory services
- Respiratory and stomach disorders
- Rashes, insect bites, and other skin conditions
- Eye/ear irritation
- Flu vaccinations
- Care coordination with your Primary Care Physician or other specialists

OVERVIEW OF WELLNESS CENTER IN LAUGHLIN

The Wellness Center in Laughlin is managed and staffed by Western Arizona Regional Medical Center (WARMC). It is a private practice available to Harrah's Laughlin, Riverside Casino, and Avi Casino.

Eligibility and Enrollment

Employees and their dependents enrolled in the Caesars medical plan can visit the Wellness Center.

Cost of Coverage

As an Eligible Employee, coverage for services at a Wellness Center for you and your Eligible Dependents is provided subject to a flat dollar fee.

How to Access the Wellness Center

Making an Appointment

If you wish to receive services at the Wellness Center, it is recommended that you call to make an appointment. Walk-in visits are accepted and staff will do their best to work your visit in around previously scheduled appointments that day.

When you need urgent care for minor illnesses or injuries, the staff will make every effort to accommodate patient needs based on visit volume. You are encouraged to schedule a same-day appointment for urgent care, if possible, to reduce wait time. Urgent care is available during the Wellness Center's Hours of Operations.

Hours of Operation

The Wellness Centers are open Monday through Friday. Hours may vary. Please contact your local Wellness Center for its scheduled hours. The Wellness Centers will follow Caesars corporate holiday schedule and be closed on those days.

Riverview Wellness Clinic
2724 Silver Creek Road
Bullhead City, AZ 86442
Telephone: (928) 444-1823
Fax : (928) 444-1824

About the Employee Assistance Program

Caesars has partnered with Cigna Behavioral Health to provide the Employee Assistance Program (EAP) to employees and their families.

The EAP is a confidential, short-term, professional service to help you manage problems that may be affecting your daily life — from a difficult situation at home to stress on the job. Just as the medical plan is designed to address your physical health needs, your EAP is designed to address your emotional and mental well-being.

EAP services are provided by Caesars at no cost to you.

WHO'S ELIGIBLE

The EAP is available to all employees, your dependents, and all members of your household. The EAP is integrated with your behavioral health benefits, which makes seeking help for emotional or personal concerns easy and seamless.

IN AN EMERGENCY

If your situation is life-threatening, you should go directly to a hospital emergency room or call 911 for assistance. If you have a question and don't know what to do, you can always call Cigna's 24-Hour Health Information Line at 1-800-423-9920 or the EAP for help at 1-888-886-2404.

HOW THE EAP CAN HELP

The EAP helps you get the guidance, support and resources you need during difficult times. It provides professional counseling and referral services to help with a wide variety of work-related and personal issues, including:

- Alcohol and drug dependency or abuse
- Child care and parenting
- Chronic condition support services
- Depression and anxiety
- Domestic relocation
- Eating disorders
- Legal resources and advice
- Life learning education support services
- Marital and relationship issues
- Mental health
- Problem gambling
- Stress Work/life balance

Your behavioral health care is provided by a national network of independent psychologists and clinical social workers who have contracted with Cigna Behavioral Health. Other services are provided by networks of screened vendors and experts who are here to help you find the answers you need.

The EAP also gives you discounts on health and wellness products and services, as well as an online savings center that offers discounts at leading retailers.

HOW THE EAP WORKS

Getting help is simple with the EAP. If you have a concern or problem that is interfering with your home or work life, just:

- Call the toll-free hotline at 1-888-886-2404 — 24 hours a day, 7 days a week.
- You will be connected to an EAP counselor who will talk with you about your problem or concern.

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- The counselor may refer you to a qualified EAP network professional in your area so you can talk through your problem in person.

In addition to unlimited telephone assistance, the EAP will cover up to five face-to-face counseling visits per person per year for each issue that may arise.

- The EAP can also help you access your mental health and substance abuse treatment benefits under the medical plan. Please see the *Medical Plan* section of this SPD for more information about those benefits.

Check it Out: Cignabehavioral.com

You can access your EAP online whenever you want. Simply log on to www.cignabehavioral.com. The Employer ID is Caesars.

Use this secure web site any time to:

- Check your EAP benefits information;
- Take a behavioral assessment or stress assessment;
- Search the Resource Center for information on health and wellness tools, family and care-giving matters, and career issues;
- Access online coaching and health management programs;
- RSVP for telephone seminars on a variety of topics or listen to replays available in the Resource Center; and
- Look up articles on a range of behavioral topics.

WHAT THE EAP BENEFITS DO NOT COVER

- Treatment that is experimental, investigational, primarily for research or not in keeping with national standards of practice and not demonstrated through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed
- Sexual addiction counseling
- Co-dependency counseling
- Regressive therapy
- Educational, vocational or employment testing, training or services
- Educational therapy or services for learning disabilities or mental retardation
- Treatment for autism, except for behavioral therapy provided by eligible providers as listed in the medical plan SPD
- Treatment for pervasive developmental disorders, except for behavioral therapy provided by eligible providers
- Treatment for personal growth and development
- Services required by state or federal law to be provided to a child by the school system or school district
- Aversion therapy
- Bio-feedback, neuro-bio-feedback or hypnotherapy
- Acupuncture, acupressure, aroma therapy, massage therapy or reiki
- Thought field, energy, art or dance therapy
- Custodial treatment that is not expected to reduce the disability to the extent necessary to enable the individual to function outside a protected, monitored or controlled environment
- Therapeutic foster care
- Group homes
- Three-quarter houses
- Wilderness programs
- Residential/therapeutic schools
- Camps
- Court-ordered, forensic or custodial evaluations
- Court-ordered treatment, unless deemed to be medically necessary
- Weight-loss programs
- Smoking cessation programs

- E-mail or internet consultations, therapy or telemedicine
- Ongoing telephonic consultations or therapy as a substitution or in lieu of direct member-provider interaction

About the Dental Plan

Caesars' dental coverage is offered through MetLife and is available to you and your eligible family members to help pay for dental care and, in some cases, orthodontia.

YOUR DENTAL PLAN OPTIONS

You can choose between two dental options:

- The Dental Plan
- The Dental Plus Orthodontia Plan

Both options cover the same preventive, basic and major dental services. The only difference is that the Dental Plus Orthodontia Plan also covers orthodontic services. Employees in Atlantic City and Las Vegas will have the use of a PPO network which has in-network and out-of-network benefits. Utilizing in-network providers will provide a higher level of dental coverage.

How the Plan Works

Caesars offers dental benefits through the Preferred Dental Network — a network of dental care providers who have agreed to provide quality dental services at negotiated rates for Caesars employees.

Each time you seek dental care you are able to select any licensed dental provider, whether they are a network provider or not. However, if you use a network provider your costs are less because fees are based on reduced negotiated fees instead of standard fees.

You do not need a primary dental provider, so you and your dependents have the freedom to choose a provider without needing referrals.

Preventive care services (such as cleanings and oral exams) are covered at 100 percent. For other services, you must pay an annual deductible and a portion of the costs (called coinsurance), depending on the type of service provided.

For a list of dental network providers, or to find out more about the dental plan, call MetLife at 1-800-942-0854 or visit the Metlife web site at www.metlife.com/mybenefits.

All dental and orthodontia care must be administered in the United States. The plan will pay for care outside the United States only if there is an emergency.

Using an In-Network Provider

You will not get a dental ID card. Simply tell your provider you are covered under Metlife. To confirm your eligibility and benefit coverage, have your dentist call MetLife directly at 1-800-942-0854.

Out-of-Network Coverage If a Network Provider Isn't Available (or you decide not to use a Network Provider)

If a Network Provider isn't available (or you decide not to use a Network Provider), you still have coverage under the plan at the same coinsurance levels as those with a network available. However, you may be required to pay amounts above your coinsurance if your dentist charges more than the standard charge.

Dental Plus Orthodontia Lock-In Period

If you enroll in the Dental Plus Orthodontia option you must participate in that plan for a minimum of 24 months before you can elect to make a change. For example, if you experience a qualified lifestyle change during the first 24 months you may not make a change to your dental coverage.

After the 24 month minimum, you may elect to make a change to your dental coverage during the next annual enrollment or due to a qualified lifestyle change.

This standard charge is based on what other dental providers charge for the same service in the same geographic area. So, as long as your dentist's charges for his or her services are within the "reasonable and customary" charge, your services will be covered the same as they would had you received in-network dental care. However, if your dentist's charge is above the standard charge, you must pay the cost difference plus any applicable coinsurance.

For example, let's say you lived outside the network area and had an out-of-network provider put in a filling. If the reasonable and customary fee was set at $100 and your dentist charged $150, you would have to pay coinsurance on the $100 plus the $50 difference ($150 - $100).

SHARING THE COST OF COVERAGE

While Caesars pays the majority of your dental costs, you share some of the expense. Under both dental plan options, you contribute through deductibles, copays and coinsurance.

Annual Deductible

Both dental plan options begin to pay benefits for covered services after you meet the $50 per person annual deductible. There is a maximum amount that your family has to pay in deductibles — $150 — meaning once the amount your family members pay out in coinsurance reaches a combined total of $150, you all are considered to have met your annual deductible.

You can satisfy the family maximum deductible with any combination of individual deductibles. An individual can contribute up to $50 to the family maximum to achieve the $150 family maximum. No expenses over an individual deductible amount count toward the family maximum.

Coinsurance

Under both dental plan options the company pays 100 percent of the costs for eligible preventive care services received from in-network providers. If you receive preventive care services from an out-of-network provider the plan will pay up to the reasonable and customary cost for these services. If your out-of-network dentist's usual charge is higher than the reasonable and customary cost, then the difference will be out of pocket. For basic and major care services, you pay an upfront deductible plus a percentage of the remaining cost (coinsurance). See the Dental Plan Comparison Chart for specific amounts.

Maximum Annual Dental Benefit

The most the dental plan will pay for each covered participant in a year is called the maximum annual dental benefit. Once the $2,000 maximum is met, you must pay any future dental costs for the rest of the year.

Amounts paid for orthodontics do not count toward this maximum.

Maximum Lifetime Orthodontia

Under the Dental Plus Orthodontia Plan, the most the plan will pay over the course of a covered member's lifetime is $2,000. (This maximum is separate from the maximum annual dental benefit noted above.)

Before You Have Dental Work Done

If you plan to have dental work costing more than $300, you have the option of asking for a "predetermination of benefits." This lets you know — ahead of time — what your treatment will cost and how much the plan will pay.

To complete this process, take a claim form available at www.metlife.com/mybenefits (company name Caesars Entertainment) with you to your dentist's office, ask your dentist to describe the treatment on the claim form and attach x-rays or other supporting information. After the insurance company reviews the treatment plan, you and your dentist will be notified of the benefits the plan will pay.

Your dental benefits will not be affected if you choose not to request a predetermination of benefits.

WHAT'S COVERED AT AN IN-NETWORK PROVIDER

The dental services are grouped into four categories: preventive care, basic care, major care and orthodontia. The chart below compares the services covered and costs for coverage.

Dental Plan Comparison Chart

LAS VEGAS AND ATLANTIC CITY PROPERTIES				
	Dental Plan		Dental Plus Orthodontia	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible				
Single	$50	$75	$50	$75
Family	$150	$225	$150	$225
Preventive Care				
• Routine dental exams and cleanings — up to two per calendar year. • Fluoride treatment for children under age 14 once per year. • Bitewing x-rays — twice per year for children (separated by 6 months) and once per year for adults. • Full mouth series of x-rays and panorex x-rays — once per 60 consecutive months • Sealants — (Dependent Child to age 19, permanent	You do not pay a deductible or copays — the company covers the full cost of these services.	You pay 20%	You do not pay a deductible or copays — the company covers the full cost of these services.	You pay 20%

molars only)				
Basic Care				
• Fillings • Extractions • Root canal treatment and pulp therapy • Treatment of gum and mouth tissue diseases • Restorative treatments (including repair or re-cementing of crowns, inlays, bridgework or dentures)	You pay 20% after deductible	You pay 30% after deductible	You pay 20% after deductible	You pay 30% after deductible
Major Care				
• Inlays and crowns once per 84 months • Fixed and removable bridges once per 84 months • Installation of full or partial dentures once per 84 months • Implants — including supported prosthetics, no more than once for same tooth position in a 60-month period (repair of implants and supported prosthetics no more than once in a 12-month period)	You 50% after deductible	You pay 60% after deductible	You pay 50% after deductible	You pay 60% after deductible
Orthodontia	Not covered	Not covered	You pay 50% coinsurance after deductible, up to $2,000 per person during their lifetime	You pay 50% after deductible, up to $1,500 per person during their lifetime

Maximum Annual Benefit	$2,000 per person per year	$1,500 per person per year	$2,000 maximum lifetime per person	$1,500 lifetime maximum per person

NOTE: In Las Vegas and Atlantic City, out-of-network coverage exists because, generally, there are more providers to choose from in Las Vegas and Atlantic City.

ALL OTHER PROPERTIES		
	Dental Plan	**Dental Plus Orthodontia**
	In-Network	In-Network
Annual Deductible		
Single	$50	$50
Family	$150	$150
Preventive Care		
• Routine dental exams and cleanings — up to two per calendar year. • Fluoride treatment for children under age 14 once per year. • Bitewing x-rays — twice per year for children (separated by 6 months) and once per year for adults. • Full mouth series of x-rays and panorex x-rays — once per 60 consecutive months Sealants — (Dependent Child to age 19, permanent molars only)	You do not pay a deductible or coinsurance — the company covers the full cost of these services.	You do not pay a deductible or coinsurance — the company covers the full cost of these services.
Basic Care		
• Fillings • Extractions • Root canal treatment and pulp therapy • Treatment of gum and mouth tissue diseases • Restorative treatments (including repair or re-cementing of crowns, inlays, bridgework or dentures)	You pay 20% after deductible	You pay 20% after deductible
Major Care		

• Inlays and crowns once per 84 months • Fixed and removable bridges once per 84 months • Installation of full or partial dentures once per 84 months • Implants — including supported prosthetics, no more than once for same tooth position in a 60-month period (repair of implants and supported prosthetics no more than once in a 12-month period)	You pay 50% after deductible	You pay 50% after deductible
Orthodontia	Not covered	You pay 50% after deductible, up to $2,000 per person during their lifetime
Maximum Annual Benefit	$2,000 per person per year	$2,000 maximum lifetime per person

Orthodontia Coverage

Only the Dental Plus Orthodontia option provides coverage for orthodontia. Orthodontic treatment includes services and appliances for straightening teeth, such as braces and retainers. After you meet the annual deductible, this option pays 50 percent of:

- negotiated fees if an in-network orthodontist and
- charges up to the reasonable and customary limit if an out-of-network orthodontist provides the care.

Repetitive orthodontia payments are paid in the last month of each three-month period. The three-month periods begin with the initial placement of the orthodontic appliance and are not based on the calendar year. Your orthodontist's estimate of the length of treatment determines the number of payments that will be made; the plan will make no more than eight payments.

Coverage at an Out-Of-Network Provider

If you receive preventative care services from an out-of-network provider, the plan will pay up to the reasonable and customary costs for these services. If your out-of-network dentist's usual charge is higher than the reasonable and customary cost, then the difference will be out of pocket.

WHAT'S NOT COVERED

Specific dental services are not covered by the plan. For questions about covered expenses, contact Metlife at (800) 942-0854. Services not covered include, but are not limited to:

- **General.** Dental treatment before coverage is in effect or after it is canceled or for a person who is not eligible. Dental care not specifically listed as covered expenses.
- **Non-dentist.** Any work not done by a dentist, except x-rays ordered by a dentist and services by a dental hygienist under the dentist's supervision.
- **Pre-coverage preparation.** The following services are not covered if preparation began before the patient was covered:
- Crown, gold restoration or bridge if the tooth was prepared before coverage began
- Root canal therapy if the pulp chamber was prepared before coverage began

- Appliance or alteration of an appliance if the impression was made before the patient was covered by the plan, except as provided under the Dental Plus Orthodontia option
- Denture, implant or fixed bridge if replacing a tooth that was missing before coverage began
- **Retainers.** Replacement retainers.
- **Treatment of TMJ disorders.** Treatment of TMJ disorders or malocclusion involving joints or muscles by methods that may include wiring, surgical alteration or repositioning teeth or the jaw. Treatment of TMJ disorders is covered in part by the medical plan as described under Temporomandibular Joint (TMJ) Disorder.
- **Cosmetic dentistry.** Unless necessary because of an accident that happened while the patient was covered. Note that facings on molar crowns or pontics are always considered cosmetic and are not covered.
- **Bite adjustment.** Appliances or restorations for the purpose of splitting or changing the height of teeth to restore proper bite other than orthodontia services covered under the Dental Plus Orthodontia option.
- **Bridges and dentures.** Replacement of any prosthodontics with a like prosthetic or with an alternate prosthetic is available once in 84 months. Prosthodontics include inlays/onlays, crowns, dentures, partial dentures, bridges and implants.
- **Upgraded treatment.** Extra cost for a more expensive or elaborate course of treatment instead of a less expensive treatment that would produce professionally satisfactory results.
- **Charges in excess of reasonable and customary limits.** Charges that exceed the reasonable and customary levels.
- **Covered by government programs.** Services or supplies furnished by or for a U.S. government program or law under which the individual is or could be covered, unless payment is required by law.
- **Covered by workers' compensation.** Services or supplies received as a result of an accident or sickness that makes you or a covered family member eligible for benefits under workers' compensation or similar laws.
- **Resulting from act of war.** Services or supplies received to treat a condition resulting from an act of war occurring while covered.
- **Non-covered orthodontia.** Orthodontic treatment received before covered under the Dental Plus Orthodontia option or while covered under the Dental Plan option.
- **Lost or stolen appliances.** The cost to replace lost, missing or stolen prosthetic devices or appliances.
- **Third party responsibility.** Charges for conditions for which others are responsible for payment. Charges that are paid by someone else (or their insurance company) as a judgment or settlement because of their responsibility for the condition that causes the charge. If payment is made to you, the company has the right to require repayment of any benefits paid to you in full without deduction for your legal fees or other costs. (See Third Party Liability.)
- **Experimental or unnecessary treatment.** Services not reasonably necessary, not customarily performed or experimental for the dental treatment of a specific condition of a covered person.

About the Vision Plan

Caesars' vision plan is offered through EyeMed Vision Care, giving you and your eligible family members access to a large network of vision care providers, such as optometrists and ophthalmologists, and retailers such as LensCrafters® and most PearleVision locations.

YOUR VISION PLAN OPTIONS

You can choose between three vision plan options:
Vision Plan A
Vision Plan B
Vision Plan C

Vision Plan A premiums are covered by the company and include a free annual eye exam and discounts on your glasses or contacts. Vision Plans B and C offer you buy-up vision coverage that includes improved benefits payable for lenses, frames and contacts, with less out-of-pocket costs.

The EyeMed Network

EyeMed Vision Care's network of providers includes private practitioners, as well as the nation's premier optical retailers, LensCrafters®, Sears Optical, Target Optical, JC Penney Optical and most Pearle Vision locations. To locate EyeMed Vision Care providers near you, visit www.eyemedvisioncare.com and choose the Select Network. You may also call EyeMed's Customer Care Center at 1-855-400-3639. EyeMed's Customer Care Center can be reached Monday through Saturday 7:30 am to 11:00 pm EST and Sunday 11:00 am to 8:00 EST.

Paying Benefits In-Network vs. Out-of-Network

When making an appointment with the provider of your choice, identify yourself as an EyeMed member and provide your name and the name of your organization or Plan Number, located on the front of your ID card. Confirm the provider is an in-network provider for the Select Network. While your ID card is not necessary to receive services, it is helpful to present your EyeMed Vision Care ID card to verify your eligibility.

When you receive services at a participating EyeMed Provider, the provider will file your claim. You will have to pay the cost of any services or eyewear that exceeds any allowances, and any applicable co-payments. You will also owe state tax, if applicable, and the cost of non-covered expenses (for example, vision perception training).

Using Out-of-Network Providers

If you receive services from an out-of-network Provider, you will pay for the full cost at the point of service. You will be reimbursed up to the maximums as outlined in the Summary of Vision Care Services. To receive your out-of-network reimbursement, complete and sign an out-of-network claim form, attach your itemized receipts and send to:

FAA/EyeMed Vision Care
Attn: OON Claims
P.O. Box 8504
Mason, Oh 45040-7111

For your convenience, a FAA/EyeMed out-of-network claim form is available at www.eyemedvisioncare.com or by calling EyeMed's Customer Care Center at 1-855-400-3639.

WHAT'S COVERED

	Plan A Standard Use		Plan B Moderate Use		Plan C High Use	
Network • **In-Network Copays** • **Out-of-network Reimbursement**	**In**	**Out**	**In**	**Out**	**In**	**Out**
Payroll Deduction	None		$$		$$$	
Vision Exams (every 12 months)	No copay	Up to $46	$10 copay	Up to $46	No copay	Up to $46
Contact Lens Fit and	N/A	N/A	$40 copay	N/A	No copay	Up to $40

Follow-up						
Retinal Imaging	$39 copay	N/A	$39 copay	N/A	$39 copay	N/A
Standard Plastic Lenses • Single • Bifocal • Trifocal • Standard Progressive	• $50 • $70 • $105 • $135 copays for unlimited pairs of lenses	N/A	• $0 • $0 • $0 • $65 copays, once a year	• $40 • $60 • $90 • $60	• $0 • $0 • $0 • $0 copays, once a year	• $40 • $60 • $90 • $60
Standard Lens Options • UV coating • Tint (solid and gradient) • Standard scratch resistance • Standard polycarbonate – Adults • Standard polycarbonate – kids under 19 • Standard anti-reflective coating • Premium anti-reflective coating • Polarized • Photochromatic/Transitions Plastic – Adults • Photochromatic/Transitions Plastic – Kids • Other add-ons & services	• $15 • $15 • $15 • $40 • $40 • $45 • 80% of retail • 80% of retail • 80% of retail • 80% of retail copays for unlimited	• N/A • N/A • N/A • N/A • N/A • N/A • N/A • N/A • N/A • N/A	• $15 • $15 • $15 • $40 • $0 • $45 • $57-$68 • 80% of retail • $75 • N/A • 80% of retail	• N/A • N/A • N/A • N/A • $28 • N/A • N/A • N/A • N/A • N/A	• $0 • $0 • $0 • $0 • $0 • $0 • $12-$23 • 80% of retail • $75 • $0 • 80% off retail	• N/A • N/A • N/A • N/A • $28 • N/A • N/A • N/A • N/A • N/A

	pairs of lenses					
Frames	40% discount, unlimited Discounts apply only when purchasing a complete pair of eyeglasses	N/A	$150 allowance, 20% discount off the balance every other year	Up to $75	$200 allowance, 20% discount off balance every other year	Up to $75
Contact Lenses • Disposable • Conventional *in lieu of lenses*	• No discount • 15% discount unlimited	N/A	• $150 allowance • $150 allowance, 15% off remaining balance once a year	Up to $120	• $150 allowance • $150 allowance, 15% off remaining balance once a year	Up to $130
Laser Correction	15% off Retail Price or 5% off promotional price (once per lifetime)	N/A	15% off Retail Price or 5% off promotional price (once per lifetime)	N/A	15% off Retail Price or 5% off promotional price less $500 allowance (once per lifetime) ***Note:*** $500 allowance for employee only; discount applies to all plan members)	$500 allowance (employee only)
KidsEyes - Children under 19	NA	N/A	N/A		Vision exams and lenses covered twice a year, additional lenses available with Rx change	Up to $28 for poly-carbonate lenses; see above for exam and lenses reimburse-ment
Diabetic Care	NA	NA	Exams twice a year at stated copay or reimbursement amount, plus additional testing covered (ask provider for details)			
Additional Pairs	40% discount off complete pair eyeglass purchases, unlimited					

You are responsible to pay the out-of-network provider in full at time of service and then submit an out-of-network claim form for reimbursement. You will be reimbursed up to the amount shown on the chart. Benefit allowances provide no remaining balance for future use within the same Benefit Frequency.

Additional In-Network Discounts

Under the Plan, you may receive benefits for vision examinations. In addition, EyeMed provides an in-network discount on certain products and services as follows:

- 40% off a complete pair of eyeglasses (including prescription sunglasses)
- 15% off conventional contact lenses
- 20% off polarized lenses and certain other add-ons network providers.

These in-network discounts may not be combined with any other discounts or promotional offers. Discounts do not apply to EyeMed Provider's professional services or certain brand name vision materials in which the manufacturer imposes a no-discount policy.

Savings on Laser Vision Correction

EyeMed Vision Care, in conjunction with LCA Vision, offers discounts to you for Lasik under Vision Plans B and C. You receive a discount (15% off retail or 5% off promotional price) when using a network provider in the US Laser Network, owned and operated by LCA Vision. The US Laser Network offers many locations nationwide. For additional information or to locate a network provider, visit www.eyemedlasik.com or call 1-877-5LASER6.

After you have located a U.S. Laser Network provider, you should contact the provider, identify yourself as an EyeMed member and schedule a consultation to determine if you are a good candidate for laser vision correction. If you are a good candidate and schedule treatment, you must call the U.S. Laser Network again at 1-877-5LASER6 to activate the discount.

At the time treatment is scheduled, you will be responsible for an initial refundable deposit to U.S. Laser Network. Upon receipt of the deposit, and prior to treatment, U.S. Laser Network will issue an authorization number to you. Once you receive treatment, the deposit will be applied to the total cost of the treatment. On the day of treatment, you must pay or arrange to pay the balance of the fee. Should you decide against the treatment, the deposit will be refunded.

You are responsible for scheduling any required follow-up visits with the U.S. Laser network provider to ensure the best results from your laser vision correction procedure.

WHAT'S NOT COVERED

Benefits are not provided for services or materials arising from:

- Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
- Medical and/or surgical treatment of the eye, eyes or supporting structures;
- Any eye or vision examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear;
- Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
- Plano (non-prescription) lenses and/or contact lenses;
- Non-prescription sunglasses;
- Two pair of glasses in lieu of bifocals;
- Services rendered after the date an Insured Person ceases to be covered under the Policy, except when vision materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order.
- Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when vision materials would next become available.
- Benefits may not be combined with any discount, promotional offering, or other group benefit plans.
- Certain brand name vision materials in which the manufacturer imposes a no-discount practice, including, but not limited to: Bvlgari, Cartier, Chanel, Gold & Wood, Maui Jim and Pro Design.

- Applicable taxes
- Visual Display Terminal (VDT) Exam

About the Health Care Flexible Spending Account

Health Care Flexible Spending Accounts (Health Care FSAs) let you use your pre-tax dollars to pay for health care expenses that are not otherwise covered, or that are only partially covered, by your health care plans. This money can be used for such expenses as medical and dental plan deductibles and coinsurance, prescription drugs and vision care copays.

Participation is voluntary, and you do not have to be enrolled in any of Caesars health care plans to participate.

WHO'S ELIGIBLE

To participate in the Health Care FSA, you must meet the general eligibility requirements of the Caesars Benefit Program (although you don't actually have to be enrolled in any of the health care plans). HSA participants are ineligible for the Health Care FSA. Please refer the Limited Purpose Flexible spending Account section.

You may use your Health Care FSA to cover eligible expenses for all of your family members claimed on your tax return as your dependents (which may include your domestic partner and his or her dependents if you can claim them on you federal return as tax dependents) as well as your natural, adopted, step or foster children through the end the year in which they turn age 26 (whether or not you can claim them on your tax return as your dependents). Employees with domestic partner coverage cannot use their Health Care FSA to pay for any deductible or employee portion for any services or prescriptions for domestic partners or their children.

HOW THE HEALTH CARE FLEXIBLE SPENDING ACCOUNT WORKS

- Before you enroll, you estimate your health care expenses to decide whether it makes sense for you to participate in the account.
- When you enroll, you decide how much of your pay you want to set aside in the account (up to certain legal limits) for the entire year.
- The amount you decide to contribute is deducted from your paycheck, before taxes are taken out, in equal amounts throughout the plan year.
- The money is then credited to your designated account.
- When you have eligible out-of-pocket expenses, you may use your FSA debit card to pay or you may submit a claim.
- You can choose to be reimbursed by ACH deposit or by a reimbursement check is mailed to your home.
- You also have the option to waive participation, by electing the "no participation" option. If you do so, you will not be able to participate in a Health Care FSA for the entire plan year, unless you experience a qualifying lifestyle change.

How Flexible Spending Accounts Help You Save

The biggest advantage to participating in the Health Care FSA is the tax savings. Every dollar you set aside in your account reduces how much you later pay in income taxes. This means more take-home pay for you.

Making Contributions

If you elect to participate in the Health Care FSA, you need to decide the contribution amount that is right for you.

You may contribute a minimum of $260 to a maximum of $2,500 for 2015, and increased thereafter based on inflation.

The contribution amount you elect is divided among the year's pay periods, with equal payments automatically deducted out of your paycheck before taxes are taken out of it. You do not pay income tax or Social Security on your account contributions. The contributions credited to your account do not represent actual deposits to a separate

account, fund or trust. Your Health Care FSA is an "account" for bookkeeping purposes only. You are not paid interest on any contributions you make to the account.

Contributions for highly compensated employees — as defined by the IRS — are subject to special contribution limits. Highly compensated employees are generally those whose annual earnings exceeded the IRS threshold in the prior year. The IRS threshold changes each year. If you are affected, you will be notified.

Plan Your Contributions Carefully

You should estimate your expenses carefully based on predictable expenses, because the IRS requires that you forfeit (lose) any money left unclaimed in your Health Care FSA by the end of the year.

Changing Your Contribution Amount

Your Health Care FSA election will remain in effect for the entire calendar year. You may change or stop your contributions only during annual enrollment, unless you have a qualifying lifestyle change. If such a change occurs, you have 31 days from the day of the change event to adjust your contribution amount accordingly.

See the *Making Changes to Your Elections* section or contact the Caesars Benefit Service Center at 1-866-BEN-FITS (1-866-236-3487) for more information on lifestyle changes.

Check It Out

- Bank of America makes it easy to keep track of your Health Care FSA activity.
- Every month in which you use your Health Care FSA, you'll receive a statement in the mail to keep you aware of your account balance, disbursements and other important information.
- www.bBankofamerica.com/benefitslogin gives you 24-hour online access to your account: up-to-date balance information, claim status, option to order additional debit cards for dependents, and answers to general questions.

HOW THE HEALTH CARE FLEXIBLE SPENDING ACCOUNT WORKS WITH THE HEALTH REIMBURSEMENT ACCOUNT

If you enroll in the Caesars medical plan all medical and prescription drug claims that count toward your deductible and out-of-pocket maximum will be paid from your Health Reimbursement Account (HRA) first. That means you will not be reimbursed for medical or prescription drug expenses until you have used all of the money in your HRA.

You can use your Health Care FSA to pay for certain expenses:

- Dental plan deductibles and coinsurance
- Vision plan copays and out-of-pocket costs for contact lenses and glasses
- Prescription medications not covered by the plan

Be sure to take your HRA amount into consideration when deciding how much to put into your Health Care Spending Account.

WHAT'S COVERED UNDER THE HEALTH CARE SPENDING ACCOUNT

Eligible Expenses

There are many federal rules governing eligible expenses for Health Care FSAs.

The following section is an overview of eligible expenses. For a complete list of expenses that qualify for reimbursement from an FSA, please visit www.bankofamerica.com/benefitslogin.

Keep In Mind

- You may use your Health Care FSA funds only for expenses incurred within the plan year and within your plan effective dates. In other words, if you receive a service during the year, and within your plan effective dates, you

can be reimbursed for it — even if you aren't billed for it until the following year. On the other hand, if you are pre-billed, you cannot file a claim until you actually receive the service.
- Because domestic partners are not generally considered eligible dependents, you may not use your FSA to pay for the health care expenses you incur on behalf of a domestic partner and/or a domestic partner's children (unless you can claim your domestic partner and his or her dependents on your federal return as tax dependents).

Generally, you can use the Health Care FSA to reimburse yourself for any expenses not covered, or only partially covered, by your health care plan(s). Expenses can be related to the medical, prescription drug, dental and vision services and must be incurred while you are actually participating in the account. Keep in mind that if you are enrolled in the medical plan, your qualified medical and prescription drug expenses will be paid from your HRA first.

Expenses that can be reimbursed through the Health Care FSA are generally those expenses allowed by the Internal Revenue Service as tax-deductible health care expenses. Expenses not covered by a health care benefits plan are also eligible for reimbursement. Such expenses include, but are not limited to, the following:
- Artificial limbs
- Chiropractors' fees
- Christian scientist practitioners' fees
- Contact lens solution and eye drops
- Crutches
- Dental expenses not reimbursed by a dental plan
- Doctors' fees
- Eyeglasses, contact lenses, and corrective surgery (LK, RK, laser, etc.)
- False teeth
- Insulin
- Medical expenses not reimbursed by a medical plan
- Medical plan deductibles and coinsurance
- Over-the-counter drugs approved for medical care, i.e. Claritin, aspirin, and cough medicines (see chart below), only if the medications are purchased with a doctor's prescription
- Prescribed drugs and programs to stop smoking
- Prescribed medications including birth control pills
- Routine medical exams
- Special equipment (e.g., telephone equipment for the deaf)
- Wheelchairs
- Weight loss programs (must be prescribed by a physician for the treatment of a specific illness or disease)

Over-the-Counter (OTC) Expenses

Beginning January 1, 2011, over-the-counter medications will be reimbursed under the Health Care FSA, HRA, or HSA only if the medications are purchased with a doctor's prescription.

These restrictions do not apply to the purchase of insulin.

Such expenses include, but are not limited to, the following:

- Allergy/irritation medications
- Antacids
- Anti-diarrhea medications
- Anti-fungal medications
- Anti-gas medications
- Anti-itch medications
- Cold medicines
- Cough/flu/fever reliever
- Cough drops/throat lozenges
- Ear infection medications
- Liquid adhesive for small cuts
- Menstrual cramp/pain products
- Motion sickness pills
- Nasal strips
- Nasal decongestants
- Nausea/vomiting medications
- Pain & muscle relievers/fever reducers
- Pinworm treatment
- Poison treatment
- Prenatal vitamins

- Eye redness medications
- First aid creams/ointments
- Head lice treatment
- Heartburn/indigestion medicines
- Hemorrhoid creams/suppositories
- Laxatives
- Rashes: diaper/ fever blisters
- Rashes: poison ivy/oak/sumac
- Sleeping aids for insomnia
- Sinus medications
- Wart removal treatments
- Yeast infection medications

Dual Purpose Over-the-Counter (OTC) Medicines

"Dual Purpose" over-the-counter (OTC) medicines are medicines that are deemed to have both a medical purpose and a personal, cosmetic or general health purpose. OTC medicines listed below will be reimbursed by the Plan upon presentation of a pharmacy receipt and a doctor's note stating that the employee or the employee's eligible dependent has a specific medical condition, that the OTC medicine is recommended to treat the condition, and that the treatment is not for cosmetic purposes.

- Bandages
- Blood pressure monitor and supplies
- Carpal tunnel wrist support
- Cold/hot packs for injuries
- Contact lens solution
- Crutches
- Dentures and denture adhesives
- Diabetic test supplies
- Incontinence supplies
- Nicotine gum/patches
- Pregnancy test kits
- Reading glasses
- Rubbing alcohol
- Smoking cessation treatments
- Thermometers (ear or mouth)
- Herbal medications only if used to treat a specific medical condition
- Homeopathic medications only if used to treat a specific medical condition
- Medicated shampoos/medicated soaps-only if physician diagnosis skin or scalp infection and prescribes special treatment to be applied for a limited period of time
- Naturopathic medications only if used to treat a specific medical condition
- Orthopedic shoes and inserts

Ineligible Expenses

According to the IRS, some expenses are not eligible for reimbursement through the Health Care FSA, including:

- Services the IRS does not allow as federal income tax deductions. For a complete list of eligible expenses, go to www.irs.gov/formspubs. Search for Publication 502.
- Cosmetic surgery
- Dietary supplements and vitamins
- Premiums for health care coverage (whether through Caesars or another source).

Getting Reimbursed

The full amount of your annual contribution is available to you at the start of the year on January 1 (or when you are effective if not on January 1). You do not have to wait for the money to accumulate in your account before you are reimbursed. So, if you submit a reimbursement request for more than the amount currently collected in your account, you are reimbursed up to the full amount you elected to deposit for the year. This advance reimbursement applies only to the Health Care FSA. You must submit a reimbursement request no later than March 31 of the following plan year.

Submitting Claims for Reimbursement or Provider Payment

- If you pay for eligible services or products out of your pocket, you can reimburse yourself from the funds in your Health Care FSA by electronic or check reimbursement. When you receive an invoice from a provider for an eligible expense, you can request they be paid directly from your Health Care FSA, just like an online bill payment service.

Bank of America can accept the following types of documentation:
- an itemized receipt from your provider showing the provider's name and address, the patient's name, itemized charges, type of service, date of service and insurance payment; or
- an explanation of benefits (EOB) from your provider.

Bank of America cannot accept bank card statements, cancelled checks, estimates of charges, balance due statements or illegible documents. For ongoing expenses such as maintenance medications, the IRS requires a claim form for each expense. If your claim information or documentation is incomplete or missing, Bank of America will request it in writing.

After the end of a plan year (January 1 - December 31), you will have until March 31 of the following year to submit expenses for reimbursement. If you terminate during the plan year, you will have 90 days from your date of termination to submit claims.

ADDITIONAL FLEXIBLE SPENDING ACCOUNT RULES

Although Caesars' FSAs offer significant tax advantages, they are governed by a variety of IRS rules. These IRS rules are outlined in the following sections.

Separate Accounts for Separate Expenses

Even if you participate in both the Health Care and Dependent Day Care Flexible Spending Accounts, the two accounts are managed separately. Under this rule:
- You can use these accounts only for eligible expenses.
- If you want to be reimbursed for eligible health care expenses and dependent care expenses, you must open both a Health Care Flexible Spending Account and a Dependent Day Care Spending Account.
- You cannot transfer money from one account to another.
- You cannot use money from one account to reimburse expenses that qualify under another account.

Forfeitures — The Use It or Lose It Rule

Any unused contributions left in your account at the end of the grace period after all claims have been paid for the year cannot be returned to you or carried over into the following year.

This "forfeiture" can be avoided by carefully estimating your expenses in advance of selecting your annual contribution amount. You should contribute just enough to cover those expenses you are certain you will incur during the year. Remember to take your HRA amount into account when deciding on your Health Care FSA contribution.

When Your Participation Ends

Your FSA contributions will stop during the calendar year if any of the following occurs:
- Your employment with Caesars ends.
- You are no longer eligible to participate in the plan.
- Caesars terminates the plan.

If this occurs, you will receive reimbursement for any health care expenses incurred through the date your participation ends, up to the full amount you elected to contribute to your Health Care FSA. You will have 90 days from your date of termination to submit claims.

Continuing Your Contributions

You may continue to contribute to your Health Care FSA on an after-tax basis through COBRA after you leave Caesars.

About the Limited Purpose Flexible Spending Account

This type of FSA is funded like a Health Care FSA, but it cannot be used to pay as many types of expenses (eligible dental and vision expenses only). Participation is voluntary.

WHO'S ELIGIBLE

HSA participants are eligible to contribute to a Limited Purpose FSA.

HOW THE LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT WORKS

With a Limited Purpose FSA, you may access your entire annual amount as soon as your coverage becomes effective, even if you haven't made all the payroll contributions yet. This lets you take care of any immediate health care needs early in the year.

You may use your Limited Purpose FSA to cover eligible expenses for all of your family members claimed on your tax return as your dependents (which may include your domestic partner and his or her dependents if you can claim them on you federal return as tax dependents) as well as your natural, adopted, step or foster children through the end the year in which they turn age 26 (whether or not you can claim them on your tax return as your dependents). Employees with domestic partner coverage cannot use their Limited Purpose FSA to pay for any deductible or employee portion for any eligible expenses for domestic partners or their children.

- Before you enroll, you estimate your health care expenses to decide whether it makes sense for you to participate in the account.
- When you enroll, you decide how much of your pay you want to set aside in the account (up to certain legal limits) for the entire year.
- The amount you decide to contribute is deducted from your paycheck, before taxes are taken out, in equal amounts throughout the plan year.
- The money is then credited to your designated account.
- When you have eligible out-of-pocket expenses, you may use your FSA debit card to pay or you may submit a claim.
- You can choose to be reimbursed by ACH deposit or by a reimbursement check is mailed to your home.

You also have the option to waive participation, by electing the "no participation" option. If you do so, you will not be able to participate in a Health Care FSA for the entire plan year, unless you experience a qualifying lifestyle change.

How Flexible Spending Accounts Help You Save

The biggest advantage to participating in the Health Care FSA is the tax savings. Every dollar you set aside in your account reduces how much you later pay in income taxes. This means more take-home pay for you.

Making Contributions

If you elect to participate in the Health Care FSA, you need to decide the contribution amount that is right for you.

You may contribute a minimum of $260 to a maximum of $2,500 for 2015, and increased thereafter based on inflation.

The contribution amount you elect is divided among the year's pay periods, with equal payments automatically deducted out of your paycheck before taxes are taken out of it. You do not pay income tax or Social Security on your account contributions. The contributions credited to your account do not represent actual deposits to a separate account, fund or trust. Your Limited Purpose FSA is an "account" for bookkeeping purposes only. You are not paid interest on any contributions you make to the account.

Contributions for highly compensated employees — as defined by the IRS — are subject to special contribution limits. Highly compensated employees are generally those whose annual earnings exceeded the IRS threshold in the prior year. The IRS threshold changes each year. If you are affected, you will be notified.

Plan Your Contributions Carefully

You should estimate your expenses carefully based on predictable expenses, because the IRS requires that you forfeit (lose) any money left unclaimed in your Limited Purpose FSA by the end of the year.

Changing Your Contribution Amount

Your Limited Purpose FSA election will remain in effect for the entire calendar year. You may change or stop your contributions only during annual enrollment, unless you have a qualifying lifestyle change. If such a change occurs, you have 31 days from the day of the change event to adjust your contribution amount accordingly.

See the *Making Changes to Your Elections* section or contact the Caesars Benefit Service Center at 1-866-BEN-FITS (1-866-236-3487) for more information on lifestyle changes.

Check It Out

- Bank of America makes it easy to keep track of your Limited Purpose FSA activity.
- Every month in which you use your Limited Purpose FSA, you'll receive a statement in the mail to keep you aware of your account balance, disbursements and other important information.
- www.bankofamerica.com/benefitslogin gives you 24-hour online access to your account: up-to-date balance information, claim status, option to order additional debit cards for dependents, and answers to general questions.

WHAT'S COVERED UNDER THE HEALTH CARE SPENDING ACCOUNT

You may use a Limited Purpose FSA to pay for eligible dental and vision expenses. When you incur eligible dental or vision expenses, any funds in your Limited Purpose FSA, up to the available balance, will automatically be used to pay those costs before your HSA funds are used. Unused HSA funds carry over year after year, so they're yours to keep for life. However, an FSA is an annual "use it or lose it" account, so your Limited Purpose FSA is always used first to help ensure those funds don't go to waste.

Ineligible expenses include medical and pharmacy expenses. A Limited Purpose FSA may not be used to pay for medical expenses, since you can already apply funds in your HSA toward eligible medical expenses.

Getting Reimbursed

The full amount of your annual contribution is available to you at the start of the year on January 1 (or when you are effective if not on January 1). You do not have to wait for the money to accumulate in your account before you are reimbursed. So, if you submit a reimbursement request for more than the amount currently collected in your account, you are reimbursed up to the full amount you elected to deposit for the year. This advance reimbursement applies only to the Limited Purpose FSA. You must submit a reimbursement request no later than March 31 of the following plan year.

Submitting Claims for Reimbursement or Provider Payment

If you pay for eligible services or products out of your pocket, you can reimburse yourself from the funds in your Limited Purpose FSA by electronic or check reimbursement. When you receive an invoice from a provider for an

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eligible expense, you can request they be paid directly from your Limited Purpose FSA, just like an online bill payment service.

Bank of America can accept the following types of documentation:

- an itemized receipt from your provider showing the provider's name and address, the patient's name, itemized charges, type of service, date of service and insurance payment; or
- an explanation of benefits (EOB) from your provider.

Bank of America cannot accept bank card statements, cancelled checks, estimates of charges, balance due statements or illegible documents. For ongoing expenses such as maintenance medications, the IRS requires a claim form for each expense. If your claim information or documentation is incomplete or missing, Bank of America will request it in writing.

After the end of a plan year (January 1 - December 31), you will have until March 31 of the following year to submit expenses for reimbursement. If you terminate during the plan year, you will have 90 days from your date of termination to submit claims.

ADDITIONAL FLEXIBLE SPENDING ACCOUNT RULES

Although Caesars' FSAs offer significant tax advantages, they are governed by a variety of IRS rules. These IRS rules are outlined in the following sections.

Separate Accounts for Separate Expenses

Even if you participate in both the Limited Purpose and Dependent Day Care Flexible Spending Accounts, the two accounts are managed separately. Under this rule:

- You can use these accounts only for eligible expenses.
- If you want to be reimbursed for eligible health care expenses and dependent care expenses, you must open both a Limited Purpose Flexible Spending Account and a Dependent Day Care Flexible Spending Account.
- You cannot transfer money from one account to another.
- You cannot use money from one account to reimburse expenses that qualify under another account.

Forfeitures — The Use It or Lose It Rule

Any unused contributions left in your account at the end of the grace period after all claims have been paid for the year cannot be returned to you or carried over into the following year.

This "forfeiture" can be avoided by carefully estimating your expenses in advance of selecting your annual contribution amount. You should contribute just enough to cover those expenses you are certain you will incur during the year. Remember to take your HSA amount into account when deciding on your Limited Purpose FSA contribution.

When Your Participation Ends

Your FSA contributions will stop during the calendar year if any of the following occurs:

- Your employment with Caesars ends.
- You are no longer eligible to participate in the plan.
- Caesars terminates the plan.

If this occurs, you will receive reimbursement for any health care expenses incurred through the date your participation ends, up to the full amount you elected to contribute to your Limited Purpose FSA. You will have 90 days from your date of termination to submit claims.

Continuing Your Contributions

You may continue to contribute to your Limited Purpose FSA on an after-tax basis through COBRA after you leave Caesars.

About the Dependent Care Flexible Spending Account

The Dependent Care Flexible Spending Accounts (Dependent Care FSA) lets you use your pre-tax dollars to pay for dependent day care expenses that are not otherwise covered. Participation is voluntary.

WHO'S ELIGIBLE

To participate in the Dependent Care FSA, you must meet the general eligibility requirements of the Caesars Benefit Program.

To qualify for the Dependent Care FSA:

- You (and your spouse, if you are married) must have earned income, unless your spouse is either a full-time student or is physically or mentally incapable of self-care.
- The dependent care must enable you to be employed or look for work. If you are married and your spouse is physically and mentally capable of self-care, the dependent care must also enable your spouse to work, look for work or attend school full time.
- The amount to be reimbursed must not exceed your earned income or that of your spouse (whichever is lower) for the plan year.
- You (and your spouse, if you are married), must have paid over half of the expenses of a household that was your main home and the main home of a qualifying individual.
- The payments for care cannot be paid to someone you can claim as your dependent, or to your child who is under age 19 even if he or she is not your dependent.
- If you use a day care center that cares for more than six children, the center must be licensed.

Per IRS regulations, you will generally be unable to use your Dependent Care FSA to reimburse expenses for your domestic partner and their children. Please contact the Caesars Benefit Center if you have any questions.

How the Dependent Care Flexible Spending Account Works

- Before you enroll, you estimate your dependent day care expenses to decide whether it makes sense for you to participate in the account.
- When you enroll, you decide how much of your pay you want to set aside in the account (up to certain legal limits) for the entire year.
- The amount you decide to contribute is deducted from your paycheck, before taxes are taken out, in equal amounts throughout the plan year.
- The money is then credited to your designated account.
- When you have out-of-pocket expenses that qualify for reimbursement, you have two options for paying eligible expenses using funds in your account:
  - Provider Payment: Pay a provider's invoice online, directly from your account, just like any other online bill payment service , or
  - Reimbursement: Reimburse yourself for expenses you paid out of pocket – choose direct deposit or have our FSA administrator, Bank of America, mail a check to you.

You also have the option to waive participation, by electing the "no participation" option. If you do so, you will not be able to participate in a Health Care FSA for the entire plan year, unless you experience a qualifying lifestyle change.

How Flexible Spending Accounts Help You Save

The biggest advantage to participating in the FSAs is the tax savings. Every dollar you set aside in your account reduces how much you later pay in income taxes. This means more take-home pay for you.

Plus, the money you spend out-of-pocket to cover certain qualified expenses is returned to you through reimbursements from the account.

Making Contributions

If you elect to participate in the spending account, you need to decide the contribution amount that is right for you.

You may contribute a minimum of $260 to a maximum of $5,000 annually.

The contribution amount you elect is divided among the year's pay periods, with equal payments automatically deducted out of your paycheck before taxes are taken out of it. You do not pay income tax or Social Security on your account contributions. The contributions credited to your account do not represent actual deposits to a separate account, fund or trust. Your Dependent Care FSA is an "account" for bookkeeping purposes only. You are not paid interest on any contributions you make to the account. Contributions for highly compensated employees — as defined by the IRS — are subject to special contribution limits. Highly compensated employees are generally those whose annual earnings exceeded the IRS threshold in the prior year. The IRS threshold changes each year. If you are affected, you will be notified.

Plan Your Contributions Carefully

You should estimate your expenses carefully based on predictable expenses, because the IRS requires that you forfeit (lose) any money left unclaimed in your FSA by the end of the year.

Changing Your Contributions Amount

Your FSA elections will remain in effect for the entire calendar year. You may change or stop your contributions only during annual enrollment, unless you have a qualifying lifestyle change. If such a change occurs, you have 31 days from the day of the change event to adjust your contribution amount accordingly. See the *Making Changes to Your Elections* section or contact the Caesars Benefit Service Center at 1-866-BEN-FITS (1-866-236-3487) for more information on lifestyle changes.

Dependent Day Care Spending Account Contribution Limits

The Internal Revenue Service (IRS) has guidelines that may affect how much you can contribute to the Dependent Care FSA. The chart below lists IRS contribution limits based on your marital and income status.

Check It Out

- Bank of America makes it easy to keep track of your Dependent Care FSA activity.
- Every month in which you use your Dependent Care FSA, you'll receive a statement in the mail to keep you aware of your account balance, disbursements and other important information.
- www.bankofamerica.com/benefitslogin gives you 24-hour online access to your account: up-to-date balance information, claim status, option to order additional debit cards for dependents, and answers to general questions.

Dependent Day Care Spending Account

IRS Contribution Guidelines	
If you are single, separated or divorced…	You may contribute up to the full $5,000 per year.
If you are married, both participate in a dependent day care FSA and file a joint federal tax return…	You may contribute up to your spouse's annual earnings.
If your spouse files a joint federal tax return and earns less than $5,000 per year…	You may contribute up to your spouse's annual earnings.
If your spouse has no income, but is a full-time student or disabled…	With one dependent: The most you can deposit is $3,000 ($250 per month). With two or more eligible dependents: The most you can deposit is $5,000 ($500 per month until the limit is reached).

What's Reimbursable

There are many federal rules governing eligible expenses for flexible spending accounts. The following section is an overview of eligible expenses. For a complete list of expenses that qualify for reimbursement from an FSA, please visit www.bankofamerica.com/benefitslogin.

Keep In Mind

- You may be reimbursed only for expenses incurred within the plan year and within your plan effective dates.
- In other words, if you receive a service during the year, and within your plan effective dates, you can be reimbursed for it — even if you aren't billed for it until the following year. On the other hand, if you are pre-billed, you cannot file a claim until you actually receive the service.
- The Dependent Day Care FSA is not for the reimbursement of your dependent's health care expenses. If you want to pay for your dependent's health care expenses, you must contribute to the Health Care or Limited Purpose FSA.
- Because domestic partners are not generally considered eligible dependents per IRS guidelines, you may not use your FSA to pay for the dependent care expenses you incur on behalf of a domestic partner and/or a domestic partner's children (unless you can claim your domestic partner and his or her dependents on your federal return as tax dependents).

WHAT'S COVERED UNDER THE DEPENDENT CARE SPENDING ACCOUNT

You may use the Dependent Day Care Spending Account to pay for child or elder care expenses required so that you (and your spouse, if you are married) can work outside your home. Expenses must be incurred while you are participating in the plan.

Eligible expenses include:

- Baby-sitting and day care
- Preschool and nursery school
- Before- and after-school care
- Summer day camp
- Family day camp
- Elder care

What's Not Reimbursable

According to the IRS, some expenses are not eligible for reimbursement through the Dependent Day Care Spending Account, including:

- School tuition
- Placement fees
- Transportation costs
- Registration fees

Getting Reimbursed

Unlike the Health Care FSA, only the amount you have collected in your account as of the date the service was performed and paid for is available to you. If you submit a reimbursement request for more than the amount currently in your Dependent Care FSA, you will be reimbursed only for the amount in your account at that time. Bank of America will note the remaining reimbursement due and will reimburse you as money collects in your account. You must submit a reimbursement request no later than March 31 of the following plan year.

The Dependent Care FSA works differently than a Health Care or Limited Purpose FSA because you won't receive a debit card with your account. Instead, you have two options for paying eligible expenses using funds in your account:

- Provider Payment: Pay a provider's invoice online, directly from your account, just like any other online bill payment service, or

- Reimbursement: Reimburse yourself for expenses you paid out of pocket — choose direct deposit or have a check mailed to you.

Does Your Dependent Qualify?

For your dependent day care expenses to qualify for reimbursement under the FSA, your dependent must be claimed as a dependent on your federal income tax return and be one of the following:

- A child under age 13;
- An elderly parent (who lives in your home at least 8 hours a day); or
- A dependent incapable of self-care.

Special rules apply for children of divorced or separated parents. If you are divorced or separated, provide at least partial support for your child and have custody of your child, your child care expenses may be eligible. For information about your particular situation, you should speak with your tax advisor.

Find complete details about the rules for children of divorced or separated parents in IRS Publication #503, available at your local IRS office, at www.irs.gov (click on the Forms & Publications link) or by calling 1-800-TAX-FORM (1-800-829-3676).

Submitting a Dependent Care Flexible Spending Account Claim

Your two options for paying eligible expenses using funds in your account:

- Provider Payment: Pay a provider's invoice online, directly from your account, just like any other online bill payment service, or
- Reimbursement: Reimburse yourself for expenses you paid out of pocket — choose direct deposit or have a check mailed to you.

Bank of America can accept an itemized receipt from your provider showing the provider's name and address and the dependent's name.

Bank of America cannot accept bank card statements, cancelled checks, estimates of charges, balance due statements or illegible documents. If your claim information or documentation is incomplete or missing, Bank of America will request it in writing.

After the end of a plan year (January 1 - December 31), you will have until March 31 of the following year to submit expenses for reimbursement. If you terminate during the plan year, you will have 90 days from your date of termination to submit claims.

Additional Flexible Spending Account Rules

Although Caesars FSAs offer significant tax advantages, they are governed by a variety of IRS rules. These IRS rules are outlined in the following sections.

Separate Accounts for Separate Expenses

Even if you participate in both the Health Care/Limited Purpose and Dependent Day Care Spending Accounts, the two accounts are managed separately. Under this rule:

- You can use these accounts only for eligible expenses.
- If you want to be reimbursed for eligible health care expenses and dependent care expenses, you must open both a Health Care/Limited Purpose Flexible Spending Account and a Dependent Day Care Flexible Spending Account.
- You cannot transfer money from one account to another.
- You cannot use money from one account to reimburse expenses that qualify under another account.

Forfeitures — The Use It or Lose It Rule

Any unused contributions left in your account at the end of the grace period after all claims have been paid for the year cannot be returned to you or carried over into the following year.

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This “forfeiture” can be avoided by carefully estimating your expenses in advance of selecting your annual contribution amount. You should contribute just enough to cover those expenses you are certain you will incur during the year.

When Your Participation Ends

Your FSA contributions will stop during the calendar year if any of the following occurs:

- Your employment with Caesars ends.
- You are no longer eligible to participate in the plan.
- Caesars terminates the plan.

If this occurs, you will be able to receive reimbursement for any dependent day care expenses incurred during the same calendar year, up to the balance in your Dependent Day Care Spending Account. You will have 90 days from your date of termination to submit claims.

Continuing Your Contributions

IRS regulations do not allow you to continue to contribute to your Dependent Day Care Spending Account after you leave Caesars.

About Your Life and Accidental Death and Dismemberment Insurance Benefits

Insurance needs vary greatly depending on your personal circumstances and the types of family obligations and expenses you may leave behind. Caesars offers several insurance benefits through Aetna (hourly and salaried employees) and Minnesota Life (senior management and above), to help protect your family from financial hardship if you should become terminally ill or die.

A brief summary of how that life and accidental death and dismemberment insurance benefits work is provided below. For a complete description of these benefits please request a copy of the certificate from your benefits administrator.

YOUR INSURANCE OPTIONS

Your insurance benefit options include:
Basic Life & AD&D Insurance
Supplemental Life Insurance
Supplemental Accidental Death and Dismemberment (AD&D)
Dependent Life Insurance

Life and AD&D Insurance		
	Hourly & Salaried (All H & S Grades) and Management (Grades 10-12)	**Senior Management and Above (Grades 13+)**
Basic Life and AD&D Insurance*	Eligible employees are automatically enrolled for basic coverage equal to 1 times base pay (frozen annually) + tips, tokes, and commissions for hourly employees ($20,000 min. - $50,000 max)	Eligible employees are automatically enrolled for basic coverage equal to 1 times base annual earnings ($500,000 max)

Supplemental Life Insurance (requires payroll contribution)	$50,000 increments up to $500,000, then $100,000 increments up to $2 million. Elected amounts not to exceed 10 times annual salary	$50,000 increments up to $500,000, then $100,000 increments up to $2 million. Elected amounts not to exceed 10 times annual salary***
Supplemental AD&D Insurance (requires payroll contribution)	$50,000 increments up to $500,000, then$100,000 increments up to $1 million. Elected amounts not to exceed 10 times annual salary.	$50,000 increments up to $500,000, then $100,000 increments up to $1 million. Elected amounts not to exceed 10 times annual salary.***
Dependent Life Insurance (requires payroll contribution)	$15,000 for a spouse** $10,000 for all dependent children	$15,000 for a spouse** $10,000 for all dependent children

**If you are age 65 or older, your life insurance coverage will be reduced. The amount you are eligible for is printed on your enrollment worksheet.*

***An employee may not cover a spouse who also is a Caesars employee for the Dependent Life benefit.*

**** Not available to Class 1: Senior executives classified by Caesars as I, L, or X grade level 18 or above.*

Note: *Caesars calculates a frozen annual salary that is used to determine the amount of automatically provided life insurance.*

If you are paid hourly, this frozen annual salary is a combination of your base pay for your primary job plus any tips, tokes or commissions captured by the payroll system. For purposes of determining your amount of automatically provided life insurance, earnings will be updated January 1 of each year using your earnings on or around the immediately preceding August 31. Increases over the guaranteed issue amount available for new employees will require evidence of insurability and will not become effective until the later of January 1, or the date any required evidence of insurability is approved by Aetna. The important thing to remember is that the frozen annual salary is a calculated amount and not your actual salary. If your primary job is a dual rate position (i.e. Dual Rate Supervisor), tips, tokes and commissions will not be included in your frozen salary. If you are absent from work due to sickness or injury on the date that coverage would otherwise become effective, the coverage will be delayed until you return to active work.

About Your Disability Plans

Disability benefits protect you and your family from financial hardship due to a serious illness or injury that keeps you from working — whether it's for a short time or for years. Caesars offers you two types of disability benefits:

- Short-Term Disability
- Long-Term Disability

With Caesars' short- and long-term disability plans, a portion of your pay continues if you are unable to work due to a non-work-related illness or injury. Short-term disability coverage is administered by Cigna. Long-term disability is provided through a group insurance contract issued by Cigna. If your injury is work-related it may be covered under workers' compensation, check with your local Human Resources department.

Please note, if there is a discrepancy between this Summary Plan Description and the insurance policy, the insurance policies will govern.

The Short-Term Disability (STD) Plan

The STD Plan provides you with benefits after you've been out of work for 14 days. Benefits continue for up to 24 weeks or until you recover, whichever comes first. The company provides you with a basic amount of STD coverage. The amount of your coverage depends on your job position.

Who's Eligible

You are eligible after working for Caesars for 90 days.

Your enrollment form will show if you are eligible for this benefit.

Employees Living in California or New Jersey

If you live in New Jersey or California and are eligible for disability coverage under the company plan, any benefits you receive are reduced by any benefits payable from the state. You must apply for state benefits on your own.

If you transfer to or from one of these states, you automatically will receive a notification (either a confirmation statement or enrollment worksheet) on any changes to your eligibility. Your enrollment form will show if you are eligible for this benefit. If you have any questions, please contact the Caesars Benefit Service Center.

What Qualifies As a Disability

To be eligible for benefits under the plan, your disability must meet the following conditions:

- A doctor must determine that you have a disability.
- You must be unable to perform the essential duties of your regular occupation because you are sick or injured and you are not working on the job.
- Losing a professional or occupational license or certification does not, in itself, mean you are disabled.

Cigna may require you be examined by doctors or other medical providers. Cigna will pay for this examination if it is required. Cigna also may require you be interviewed by representatives from the insurance company. If you refuse to either of these requirements, your claim could be denied or terminated.

Elimination Period

You are not eligible for STD benefits until you have been out of work for 14 days in a row. This amount of time is called the "elimination period," or benefit waiting period. You may use your sick, vacation or personal time to cover your pay during the 14-day waiting period.

Your Coverage Options

During annual enrollment, or if you have a qualifying lifestyle change, you may elect between two levels of STD coverage:

- Basic STD
- Additional STD*

SHARING THE COST OF SHORT-TERM DISABILITY COVERAGE

The company-provided STD benefit is paid on your behalf by Caesars, therefore any disability benefits you receive will be subject to tax withholding. If you elect additional coverage (15 percent), any employee contribution for this buy-up amount is paid after taxes; therefore if you become eligible for an STD benefit, the additional disability benefit amount (15 percent) you receive will be tax-free. If you live in California or New Jersey and are eligible for STD coverage under the company plan, any benefits you receive are reduced by any benefits you may receive from the state. You must apply for state benefits on your own.

The following chart provides a summary of your options depending on your employment status.

Short-Term Disability	Hourly & Salaried (All H & S Grades)	Management and Above (Grades 10+)
Company Provided Benefit Amount	50% of frozen quarterly salary as calculated the first day of each quarter*	70% of base pay
Option to Supplement Weekly	15% of frozen quarterly salary as calculated the first day of each	Not applicable

Benefit Payment	quarter for a combined benefit amount of 65% of pay*	
Weekly Maximum Benefit	$1,500	$5,000
Benefit Begins	After 14 days of disability	
Benefit Duration	24 weeks	

Note: Caesars calculates a frozen quarterly salary that is used to determine the amounts of both short-term and long-term disability payments.

Note: *Your covered earnings are based on your frozen salary effective the first Sunday of the month prior to your date of disability. For hourly employees, your frozen salary will be based on your wages over the most recent 12 full calendar month periods (including tips, tokes, and commissions). Wages will be annualized if you have been employed for less than 12 months prior to your date of disability. For salaried employees, your frozen salary earnings will be your base pay (does not include tips, tokes, and commissions).*

*Enrollment in the additional STD coverage is subject to Evidence of Insurability during annual enrollment or when you have a qualifying lifestyle change.

Actively at Work Requirement

You must be actively at work for coverage — or any increase in coverage — to take effect. If you are not actively at work on the date coverage is scheduled to take effect, it will take effect on the date you return to active work.

Evidence of Insurability

You must provide Evidence of Insurability if you decline the STD buy-up option (15 percent of your pay) within the first 31 days after you become eligible, but later want to enroll in the buy-up coverage.

When You Are No Longer Eligible for Short-Term Disability

Your STD coverage ends on the earliest of:

- the date the plan is cancelled,
- the date you are no longer an eligible employee,
- the last day of the period for which you made any required contributions,
- the last day you are in active employment except as described below or
- the date you are no longer in active employment due to a disability that is not covered by the plan.

If you are on temporary layoff or a leave of absence, or if your hours are reduced to less than 30 hours a week, you will be covered to the end of the month after the month in which your layoff, leave or reduced hours begin, as long as you pay the required premium (if any).

How Short-Term Disability Benefits Are Determined

STD benefits are based on the schedule on page 139. Your benefit is reduced by any other deductible sources of income or any payments you might receive as a result of any state compulsory benefit act of law. Benefits will be reduced by state disability payments.

Company provided disability benefits are subject to tax withholding. Any pre-disability voluntary payroll deductions such as medical, dental and vision must be paid during your disability to maintain these benefits.

Payments must be sent to Caesars Benefit Service Center. Deductions for 401(k) contributions are discontinued during your disability.

What's Not Covered

STD benefits are not provided for disabilities due to:

- intentionally self-inflicted injuries,
- active participation in a riot,
- commission of a crime for which you have been convicted under state or federal law,
- job-related illnesses or injuries (these may be covered by workers' compensation) and
- war, declared or undeclared, or any act of war
- cosmetic surgeries/procedures. Does not include elective surgeries/procedure such as bariatric surgery and gender reassignment surgeries.

Benefits are not payable for any period of time spent in prison as a result of a conviction.

BENEFIT PAYMENTS

The STD benefit is administered by Cigna. All claims are filed through Cigna. See section on *Filing a Claim* for more information on required documentation and timing.

When the claims administrator approves your claim, you'll receive STD payments every two weeks from the administrator as long as you remain disabled, up to the maximum time allowed by the plan. If you are disabled for less than one week, you will receive 1/7 of your payment for each day of disability.

STD benefits may not be paid on your regular pay cycle and, due to the time required to process your claim, you may have a time lag between the last paycheck you receive as an active employee and payment of STD benefits.

If your claim is approved by mistake or if you receive any payments in error, the claims administrator can require immediate repayment or subtract the repayment from future benefits or pay owed to you.

Disability benefits are paid to you unless you are legally incompetent, in which case the company can pay benefits to any of your relatives.

Returning to Work after Short-Term Disability

When your doctor releases you to return to work, provide your local Human Resources department with a return-to-work release from your doctor, which should include any restrictions or limitations of your duties.

If you also are on leave covered by the Family and Medical Leave Act (FMLA) and your release to return to work occurs before the end of the FMLA leave as allowed by law, you may be entitled to continue on unpaid leave if approved by your supervisor. Check with your local Human Resources department.

If You Work While You Are Disabled

You may work for wage or profit while disabled. In any week in which you work and a Disability Benefit is payable, the Return to Work Incentive Benefit Calculation applies. Your benefit will be determined as follows:

1. Add your Gross Disability Benefit and Disability Earnings
2. Compare the sum from number 1 to your Covered Earnings
3. If the sum from number 1 exceeds 100% of your Covered Earnings, then subtract the Covered Earnings from the sum in number 1
4. Your Gross Disability Benefit will be reduced by the difference from number 3

The Plan will, from time to time, review your status and will require satisfactory proof of earnings and continued Disability.

No Disability Benefits will be paid, and participation will end if the Plan determines you are able to work under a modified work arrangement and you refuse to do so without Good Cause.

Successive Periods of Disability

A separate period of Disability will be considered continuous:

- if it results from the same or related causes as a prior Disability for which weekly benefits were payable; and

- if, after receiving Disability Benefits, you return to work in his Regular Occupation for less than 30 consecutive days; and
- if you earns less than the percentage of Covered Earnings that would still qualify him or her to meet the definition of Disability/Disabled during at least one week.

Any later period of Disability, regardless of cause, that begins when you are eligible for participation under another group disability plan provided by any employer will not be considered a continuous period of Disability.

For any separate period of disability which is not considered continuous, you must satisfy a new Elimination Period.

When Short-Term Disability Benefits End

STD benefits end on the earliest of:

- the date you are able to work in your regular occupation on a part-time basis but choose not to,
- the end of the 26-week maximum benefit period,
- the date you recover,
- the date you fail to submit satisfactory proof of your continued disability,
- the date your disability earnings exceed the amount allowed by the plan,
- the date you die or
- the last day of the period for which you made any required contributions.

THE LONG-TERM DISABILITY (LTD) PLAN

Long-term disability benefits provide you with a portion of your pay if you still are unable to work after 26 weeks of continuous disability. They pick up where the short-term disability benefits leave off.

You must be actively at work for coverage — or any increase in coverage — to take effect. If you are not actively at work on the date coverage is scheduled to take effect, it will take effect on the date you return to active work.

Who's Eligible

You are eligible after working for Caesars for 90 days:

- Your enrollment form will show if you are eligible for this benefit.

Elimination Period

You are not eligible for LTD benefits until you have been out of work for 180 days. This includes your 14-day waiting period and 24 weeks of STD benefits.

Your Coverage Options

During annual enrollment or when you first become eligible, all employees will automatically receive a basic level of coverage. For Hourly and Salaried (all H & S grades) you may also elect to purchase additional coverage:

- LTD benefit of 60 percent for hourly, salaried non-management employees* (additional 10 percent above basic LTD), or
- LTD benefit of 70 percent for Management and above (Grades 10+) employees* (additional 10 percent above basic LTD)

**The election of additional LTD coverage at annual enrollment is subject to Evidence of Insurability.*

Sharing Cost of Long-Term Disability Coverage

The company-provided LTD coverage is paid on your behalf by Caesars, therefore any disability benefits you receive will be subject to tax withholding. If you elect additional coverage (10 percent), any employee contribution for this buy-up amount is paid after taxes; therefore if you become eligible for an LTD benefit, the additional disability benefit amount (10 percent) you receive will be tax-free. If you live in California or New Jersey and are eligible for LTD coverage under the company plan, any benefits you receive are reduced by any benefits you may receive from the state. You must apply for state benefits on your own.

The following chart provides a summary of your options depending on your employment status.

	Hourly & Salaried (All H & S Grades)	Management (Grades 10-12)	Senior Management Band and Above (Grades 13+)
Company Provided Benefit Amount	50% of base pay + tips, tokes and commissions	60% of base pay	

Option to Supplement Income Protection	10% of base pay + tips, tokes and commissions for a combined coverage amount of 60% of pay	10% of base pay for a combined coverage amount of 70% of pay	Will be allowed to cover up to 70% of base and incentive compensation through separate plan not provided by Cigna. Details provided in a separate communication.
Monthly Maximum Benefit	$10,000 per month	$25,000 per month	
Benefit Begins	After the 180 day elimination period		

Note: *Caesars calculates a frozen quarterly salary that is used to determine the amounts of both short-term and long-term disability payments.*

Note: *Your covered earnings are based on your frozen salary effective the first Sunday of the month prior to your date of disability. For hourly employees, your frozen salary will be based on your wages over the most recent 12 full calendar month periods (including tips, tokes, and commissions). Wages will be annualized if you have been employed for less than 12 months prior to your date of disability. For salaried employees, your frozen salary earnings will be your base pay (does not include tips, tokes, and commissions).*

Enrollment in the additional STD coverage is subject to Evidence of Insurability during annual enrollment or when you have a qualifying lifestyle change.

Actively at Work Requirement

You must be actively at work for coverage — or any increase in coverage — to take effect. If you are not actively at work on the date coverage is scheduled to take effect, it will take effect on the date you return to active work.

Evidence of Insurability

You must provide Evidence of Insurability (EOI) if you decline supplemental LTD coverage within the first 31 days after you become eligible but later want to elect or increase coverage.

When You Are No Longer Eligible for Long-Term Disability

Your LTD coverage ends on the earliest of:

- the date the plan is cancelled,
- the date you are no longer an eligible employee,
- the last day of the period for which you made any required contributions,
- the last day you are in active employment except as described below or
- the date you are no longer in active employment due to a disability that is not covered by the plan.

If you are on temporary layoff or a leave of absence, or if your hours are reduced to less than 30 hours a week, you will be covered to the end of the month after the month in which your layoff, leave or reduced hours begin, as long as you pay the required premium (if any).

How Benefits Are Determined

After you have been disabled for 26 consecutive weeks and are otherwise eligible, you will receive monthly LTD benefits as described above. (***Note:*** Cigna is responsible for determining if you continue to be eligible.) However, your LTD benefit is reduced by any other sources of income. If subtracting other sources of income would result in a zero benefit, then the minimum monthly payment is $100.

Social Security Disability Benefits

If you are entitled to Social Security benefits, Cigna will subtract them when calculating your LTD payment. If the exact amount of your Social Security benefit hasn't been determined, the insurance company will use an estimate and

then make any adjustments when it has been determined. You will be required to repay any excess benefits you receive. If you don't want to have any Social Security amount subtracted until the actual amount is known, you must agree in advance to repay any overpayment by signing an Agreement Concerning Benefits.

What's Not Covered

LTD benefits are not provided for disabilities due to:

- intentionally self-inflicted injuries,
- active participation in a riot,
- commission of a crime for which you have been convicted under state or federal law or
- war or act of war whether declared or undeclared.

A benefit will not be paid for any period of disability during which you are incarcerated as a result of a conviction.

LTD benefits will not be paid for a disability that begins during the first 12 months of coverage and is due to a pre-existing condition as defined on page 145.

Benefit Payments

The insurance company providing the benefit payments and processing claims is:

CIGNA Group Insurance
Disability Management Solutions
2000 Park Lane Drive
North Fayette, PA 15275
Phone: 800.238.2125

See the section on *Filing a Claim* for more information on required documentation and timing. Once Cigna has subtracted any other sources of income from your gross disability payment, the insurance company will not reduce your payment due to future cost-of-living increases in those sources.

You will begin to receive monthly payments once Cigna approves your claim after the 180 day elimination period.

You do not have to pay any premiums for LTD while you are collecting LTD benefits. A notification of any premium requirements for other plan coverages (e.g., medical) will be sent to you by the Caesars Benefit Service Center.

What Happens If Cigna Overpays Your Claim

Cigna has the right to recover any overpayments due to:

- fraud;
- any error Cigna makes in processing a claim; and
- your receipt of deductible sources of income.

You must reimburse Cigna in full. Cigna will determine the method by which the repayment is to be made.

Rehabilitation During a Period of Disability

If we determine that you are a suitable candidate for rehabilitation, we may require you to participate in a

Rehabilitation Plan and assessment at our expense. We have the sole discretion to approve your participation in a Rehabilitation Plan and to approve a program as a Rehabilitation Plan. We will work with you, the Employer and your Physician and others, as appropriate, to perform the assessment, develop a Rehabilitation Plan, and discuss return to work opportunities. The Rehabilitation Plan may, at our discretion, allow for payment of your medical expense, education expense, moving expense, accommodation expense or family care expense while you participate in the program. If you fail to fully cooperate in all required phases of the Rehabilitation Plan and assessment without Good Cause, no Disability Benefits will be paid, and insurance will end.

Benefit Payment Period for Age 60 and Above

If you become disabled at or after age 60, benefits are payable according to the table below.

Age When Disabled	Disability Period
Less than age 60	To normal retirement age, but not less than 60 months
60	To normal retirement age, but not less than 60 months
61	To normal retirement age, but not less than 48 months
62	To normal retirement age, but not less than 42 months
63	To normal retirement age, but not less than 36 months
64	To normal retirement age, but not less than 30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

Disabilities Due to Mental Illness

LTD benefits for disabilities due to mental illness are limited to 24 months in your lifetime. Mental illness includes, but is not limited to, schizophrenia, depression, manic depression or bipolar illness, anxiety, somatization, substance abuse disorders and/or adjustment disorders. These conditions usually are treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs or similar treatment methods.

You will continue to receive benefits beyond the 24-month period as follows:

- If you are confined to a hospital or institution at the end of the 24-month period, benefits will continue during your confinement. If you are still disabled when you are discharged, benefits will continue for a recovery period of up to 90 days. If you are re-confined at any time during the recovery period and remain confined for at least 14 days in a row, benefits will be paid during that additional confinement and for an additional recovery period up to 90 more days.
- If, after the 24-month period for which you have received payments, you continue to be disabled and subsequently become confined to a hospital or institution for at least 14 days in a row, benefits will be paid during your confinement.

Survivor Benefit

We will pay a Survivor Benefit if you die while Disability Benefits are payable to you for a continuous period of Disability. The Survivor Benefit will equal 100% of the sum of the last full Disability Benefit payable to you plus the amount of any Disability Earnings by which the benefit had been reduced for that month. A single lump sum payment equal to 3 monthly Survivor Benefits will be payable. We will pay the Survivor Benefit to your Spouse. If you do not have a Spouse, we will pay your surviving Children in equal shares. If you do not have a Spouse or any Children, we will pay your estate.

"Spouse" means your lawful spouse. "Children" means your unmarried children under age 21 who are chiefly dependent upon you for support and maintenance. The term includes a stepchild living with you at the time of your death.

If You Work While You Are Disabled

The Disability Benefit payable to you is figured using the Gross Disability Benefit, Other Income Benefits and the Return to Work Incentive. Monthly Benefits are based on a 30-day month. The Disability Benefit will be prorated if payable for any period less than a month. During any month you have no Disability Earnings, the monthly benefit payable is the Gross Disability Benefit less Other Income Benefits. During any month you have Disability Earnings, benefits are determined under the Return to Work Incentive. Benefits will not be less than the minimum benefit shown in the Schedule of Benefits except as provided under the section Minimum Benefit.

"Other Income Benefits" means any benefits listed in the Other Income Benefits provision that an Employee receives on his or her own behalf or for dependents, or which the Employee's dependents receive because of the Employee's entitlement to Other Income Benefits.

Return to Work Incentive

During any month the Employee has Disability Earnings, his or her benefits will be calculated as follows. The Employee's monthly benefit payable will be calculated as follows during the first 24 months disability benefits are payable and the Employee has Disability Earnings:

1. Add your Gross Disability Benefit and Disability Earnings.
2. Compare the sum from number 1 to your Indexed Earnings.
3. If the sum from number 1 exceeds 100% of your Indexed Earnings, then subtract the Indexed Earnings from the sum in number 1.
4. Your Gross Disability Benefit will be reduced by the difference from number 3, as well as by Other Income Benefits.
5. If the sum from number 1 does not exceed 100% of the Employee's Indexed Earnings, the Employee's Gross Disability Benefit will be reduced by Other Income Benefits.

After disability benefits are payable for 24 months, the monthly benefit payable is the Gross Disability Benefit reduced by Other Income Benefits and 50% of Disability Earnings. No Disability Benefits will be paid, and insurance will end if the Insurance Company determines the Employee is able to work under a modified work arrangement and he or she refuses to do so without Good Cause.

Recurring Disabilities

If you recover and return to work, and then are again disabled within six months due to:

- the same or a related cause, it will be considered a continuation of the same disability.
- a different and unrelated cause, it will be considered a separate disability.

If you recover and return to work, and then are disabled again after six months for any cause, it will be considered a separate disability.

The insurance company will treat your disability as continuous if your disability stops for 30 days or less during the 80 day elimination period.

When Long-Term Disability Coverage Ends

Your benefits will stop on the first to occur of the following:

- You are no longer disabled.
- You are able to work in your regular occupation on a part-time basis during the first 24 months of payments but you choose not to; after 24 months of payments, when you are able to work in any gainful occupation on a part-time basis but you choose not to.
- Your death occurs.
- You reach the end of the maximum benefit period.
- Your current pay exceeds 80 percent of your indexed pre-disability earnings.
- You fail to submit proof of continuing disability satisfactory to the plan.
- You decline to participate in a rehabilitation program approved by your doctor.

Pre-Existing Conditions (Disability)

We will not pay benefits for any period of Disability caused or contributed to by, or resulting from, a Preexisting Condition. A "Pre-existing Condition" means any Injury or Sickness for which you incurred expenses, received medical treatment, care or services including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a Physician within 3 months before your most recent effective date of insurance. The Pre-existing Condition Limitation will apply to any added benefits or increases in benefits. This limitation will not apply to a period of Disability that begins after you are covered for at least 12 months after your most recent effective date of insurance, or the effective date of any added or increased benefits.

IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES: There are state-specific requirements that may change the provisions under the Coverage(s) described in this Group Insurance Certificate. If you live in a state that has such requirements, those requirements will apply to your Coverage(s) and are made a part of your Group Insurance Certificate.

Additional Benefits Program Information

This section of the Summary Plan Description includes the following resources:

- Information About Filing and Appealing Claims
- Coordination of Benefits
- Special Situations That Affect Your Coverage
- Continuing Your Coverage Under Cobra
- Rights And Authorities
- Health Insurance Portability And Accountability Act Of 1996
- Medicare D Notice Specific To Plan A, B, and C of Caesars Medical Plan
- Definitions
- Administrative Information

Claims Procedures

Information about Filing and Appealing Cigna Medical Claims and Prescription Drug Claims (for Horizon and Humana Medical Claims, please see plan summaries posted separately)

FILING A MEDICAL (CIGNA PLAN MEMBERS)

Filing claims depends on the type of care and if it is received in-network or out-of-network.

Hospital Confinement

Present your ID card at the time of your admission. The card tells the hospital to send its bills directly to Cigna.

Doctor's Bills and Other Medical Expenses

The first medical claim should be filed as soon as you have incurred covered expenses. Itemized copies of your bills should be sent with the claim form(s). If you have any additional bills after the first treatment, file them periodically and timely.

Tips on Filing Your Medical Claims

Be sure to use your member ID and account number when you file Cigna's claim forms or when you call your Cigna claim office at 1-800-423-9920.

Your member ID is shown on your medical plan ID card. Your account number is the 7-digit policy number shown on your medical plan ID card (2466166).

Filing your claim forms promptly will result in faster payment of your claims.

Submit the claim form(s) to the address on the back of your Cigna ID card:

Cigna
P.O. Box 182223
Chattanooga, TN 37422-7223

Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

Deadlines for Filing Medical Claims - Cigna

Cigna medical claims must be filed within 180 days from the date of treatment. If additional claim information is required, it must also be filed within the stated time limit. Completion of all subrogation inquiries requires completion within the 12-month period. The claims and appeals procedures for Horizon and Humana are included in the plan summaries **posted separately**

In most cases, claim forms are available online through the carrier website, or by calling the carrier direct. Each website has complete claims instructions as well.

Notice of claim is given by filing a claim form or by having a claim form submitted on your behalf by a provider. Benefits will be paid within a reasonable timeframe after all claim requirements are completed. Claims procedures and corresponding timeframes are generally based on the type of benefit.

If a claim is denied or disputed, in whole or in part, Cigna will notify the claimant (or his/her agent or designee) of it within 30 days after receipt of the claim for most claims (other claims have shorter timeframes and are followed by Cigna).

The denial notice will set forth:

- the reason(s) the claim is denied;
- specific references to the main Plan provision(s) on which the denial is based;
- a specific description of any further material or information needed to complete the claim, and why it is needed;
- a statement that the claim is disputed, if this is so. If the dispute is about the amount of the claim, Cigna will explain why and also explain why any coding changes were made.
- a statement of the special needs to which the claim is subject, if this is the case;
- an explanation of the Plan's claim review procedure, including any rights to pursue civil action;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision, either the specific rule or a statement that such a rule was relied upon in making the decision, and that a copy of such rule will be provided free of charge upon request;
- if the decision is based on Medical Necessity and Appropriateness or an Experimental or Investigational (or similar) exclusion or limitation, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Plan to the medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- if the decision involves a Medical Emergency or Urgent Care, a description of the expedited review process applicable to such claims; and
- the toll free number that the Covered Person or his/her Provider can call to discuss the claim.
- This applies if you are the non-custodial parent of a Child Dependent. In this case, Cigna will give the custodial parent the information needed for the Child Dependent to obtain benefits under the Plan. Cigna will also permit the custodial parent, or the Provider with the authorization of the custodial parent, to submit claims for Covered Services and Supplies without your approval.
- Sufficient information to identify the claim, including the date of service, the provider, the claim amount (if applicable, and the standard, if any, used for deciding the claim are available upon request; and
- The availability of health insurance consumer assistance or a Public Health Service ombudsman, including contact information, to assist you in seeking plan benefits.

APPEALING A MEDICAL CLAIM

If you have a concern regarding a person, a service, the quality of care you receive or contractual benefits, you may call 1-800-423-9920 the toll-free number on your medical plan ID card, explanation of benefits or claim form and explain your concern to one of Cigna's Customer Service Representatives. You may also express that concern in writing.

Cigna will do their best to resolve the matter on your initial contact. If Cigna needs more time to review or investigate your concern, they will get back to you as soon as possible, but in any case within 30 days. If you are not satisfied with the results of a coverage decision, you may start the appeals procedure.

How the Appeals Procedure Works

Cigna has a two-step appeals procedure for coverage decisions.

- To initiate an appeal, you must submit a request for an appeal in writing to Cigna within 365 days of receipt of a denial notice.
- You should state the reason why you feel your appeal should be approved and include any information supporting your appeal.

- If you are unable or choose not to write, you may ask Cigna to register your appeal by telephone.

Call Cigna at 1-800-423-9920at the toll-free number on your medical plan ID card, explanation of benefits or claim form. You may appeal an adverse claim determination, which includes a complete or partial denial of your claim, or you may appeal a rescission of coverage (please see *Rescission of Coverage in this* SPD).

Level-One Appeal

Your appeal will be reviewed and the decision will be made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level-one appeals, Cigna will respond in writing with a decision within 15 calendar days after receiving an appeal for a required pre-service or concurrent care coverage determination, and within 30 calendar days after receiving an appeal for a post-service coverage determination. If more time or information is needed to make the determination, Cigna will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Physician would cause you severe pain that cannot be managed without the requested services; or (b) your appeal involves non-authorization of an admission or continuing inpatient Hospital stay. Cigna's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, Cigna will respond orally with a decision within 72 hours, followed up with a response in writing.

If Cigna upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial. Your written explanation will include information about your right to file a Level-Two Appeal.

Level-Two Appeal

If you are dissatisfied with Cigna's level-one appeal decision, you may request a second review. To initiate a level-two appeal, follow the same process required for a level-one appeal.

Most requests for a second review will be conducted by the Committee, which consists of a minimum of three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness, the Committee will consult with at least one Physician in the same or similar specialty as the care under consideration, as determined by Cigna's Physician reviewer. You may present your situation to the Committee in person or by conference call.

For level-two appeals, Cigna will acknowledge in writing that they have received your request and schedule a Committee review. For required pre-service and concurrent care coverage determinations, the Committee review will be completed within 15 calendar days; for post-service coverage determinations, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, Cigna will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within 5 business days after the Committee meeting, and within the Committee review time frames above.

You may request that the appeal process be expedited if (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Physician, would cause you severe pain that cannot be managed without the requested services; or (b) your appeal involves non-authorization of an admission or continuing inpatient Hospital stay. Cigna's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, Cigna will respond orally with a decision within 72 hours, followed up with a response in writing.

Once a Level-Two Appeal is complete, if Cigna upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial. Your written explanation will include information about whether you have a right to pursue an external review through an Independent Review Organization as well as any right you may have to file suit in federal court or pursue alternative dispute resolution.

Independent Review Procedure – Medical Coverage

If you are not fully satisfied with the decision of Cigna's Level-Two appeal review, you may request that your appeal be referred to an Independent Review Organization (or "IRO"). The Independent Review Organization is composed of persons who are not employed by Cigna HealthCare, or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this Independent Review Process. Cigna will abide by the decision of the Independent Review Organization.

In order to request a referral to an Independent Review Organization, the reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by Cigna. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

The IRO's decision will be communicated to you in writing within 45 calendar days after its receipt of the appeal, or, if your external appeal request was handled on an expedited basis due to your medical circumstances, within 72 hours. The written decision issued by the IRO will include complete information regarding your appeal and the rationale for the decision. The decision will also include a statement that the IRO's decision is binding except to the extent that other remedies may be available to you or the Plan pursuant to state or federal law. If the decision is favorable to you, the Plan must pay benefits without delay even if it intends to seek other judicial remedies. The decision will also advise you about other resources that may be available to you for additional assistance.

Please contact the Caesars Benefit Center if you have additional questions about external review and whether external review may be available to you.

FILING PRESCRIPTION CLAIMS

Employees can obtain a copy of a claim form on www.express-scripts.com. Send the claim form to:

Express Scripts, Inc.
Member Reimbursements
PO Box 66583
St. Louis, MO 63166

Mail VA claims to:
VA Health Administration Center
CHAMPVA
PO Box 469064
Denver, CO 80246-9064

APPEALING A DENIED PRESCRIPTION CLAIM

Send your Explanation of Benefits statement and the reason for the appeal to the following address:

Express Scripts, Inc.
Attn: Pharmacy Appeals – JQX
Mail Route BL 0390
6625 West 78th Street
Bloomington, MN 55439
Fax (877) 852-4070

You may appeal an adverse claim determination, which includes a complete or partial denial of your claim, or you may appeal a rescission of coverage (please see *Rescission of Coverage in this* SPD).

Deadlines for Appealing a Claim

It is recommended that appeals are filed within 6 months of a Prior Authorization denial, or rejected claim decision.

Level-One Appeal

If a Prior Authorization request from the doctor is denied, you and your Physician will receive a letter from Express Scripts providing the next level of appeal rights. Similarly, a member-submitted or electronic claim that has been processed or denied or in which the reimbursement has been reduced can also be appealed.

Appeal coordinators will review the information received and verify that a Prior Authorization denial or rejected claim is on file. The clinical pharmacist will then review the case. Once a decision has been reached, Express Scripts will send you and your Physician a determination letter within 30 days of your appeal.

Level-Two Appeal

If you are dissatisfied with Express Scripts' level-one appeal decision, you and your Physician may submit a second letter of appeal. The appeals coordinator will prepare and submit your case to a third party reviewer, MCMC, LLC. MCMC, LLC will review the case. Once a decision has been reached, MCMC, LLC will notify Express Scripts and send you a determination letter within 30 days of your appeal.

Independent Review Procedure — Prescription Drug Coverage

If you are not fully satisfied with the Level-Two decision, you may request that your appeal be referred to an Independent Review Organization (IRO). If you choose to have your claim reviewed by an IRO, it will be provided to you at no additional charge. To exercise this right, you must request external review in writing within four months after receiving our final internal appeal decision. External review is not available for a denial, reduction, termination or failure to provide payment for a benefit based solely on a determination that a participant is not eligible to participate in the plan. You will receive information about any external review rights that may be available to you in the notices of adverse determinations provided to you.

The IRO's decision will be communicated to you in writing within 45 calendar days after its receipt of the appeal, or, if your external appeal request was handled on an expedited basis due to your medical circumstances, within 72 hours. The written decision issued by the IRO will include complete information regarding your appeal and the rationale for the decision. The decision will also include a statement that the IRO's decision is binding except to the extent that other remedies may be available to you or the Plan pursuant to state or federal law. If the decision is favorable to you, the Plan must pay benefits without delay even if it intends to seek other judicial remedies. The decision will also advise you about other resources that may be available to you for additional assistance.

Please contact the Caesars Benefit Center if you have additional questions about external review and whether external review may be available to you.

Notice of Benefit Determination on Appeal

Level-One Appeal for Medical and Prescription Drug Coverage

Every notice of a determination on Level-One appeal will be provided in writing or electronically, and if it is an adverse determination, the notice will include:

- The specific reason(s) for the adverse benefit determination;
- References to the specific plan and/or summary plan description provisions on which the benefit determination is based;
- A description of any additional material or information needed to process the claim and an explanation of why that material or information is necessary;
- A description of the plan's internal appeal and external review procedures that may be available to you and the time limits applicable to those procedures, including a statement of your right to bring a civil action under ERISA after an appeal of an adverse benefit determination;
- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request;
- If the adverse benefit determination was based on whether a treatment is medically necessary or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;

- If the adverse benefit determination concerns a claim involving urgent care, a description of the expedited review process applicable to the claim;
- Sufficient information to identify the claim, including the date of service, the provider, the claim amount (if applicable, and the standard, if any, used for deciding the claim are available upon request; and
- The availability of health insurance consumer assistance or a Public Health Service ombudsman, including contact information, to assist you in seeking plan benefits.

Level-Two Appeal for Medical and Prescription Drug Coverage

Every notice of a determination on Level-Two appeal will be provided in writing or electronically, and if it is an adverse determination, the notice will include:

- The specific reason(s) for the adverse benefit determination;
- References to the specific plan provisions on which the benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other Relevant Information to your claim;
- A statement describing the external review procedures that may be available to you or any voluntary appeal procedures offered by the plan and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA;
- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination or a statement that a copy of this information will be provided free of charge to you upon request;
- If the adverse benefit determination was based on whether a treatment is medically necessary or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- Sufficient information to identify the claim, including the date of service, the provider, the claim amount (if applicable, and the standard, if any, used for deciding the claim are available upon request; and
- The availability of health insurance consumer assistance or a Public Health Service ombudsman, including contact information, to assist you in seeking plan benefits.

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant Information is any document, record or other information which: (a) was relied upon in making the benefit determination; (b) was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Information about Filing and Appealing Dental Claims

FILING A DENTAL CLAIM

Filing claims depends on the type of care and if it is received in-network or out-of-network.

For In-Network Dental Services

If you use an in-network dentist, you generally do not need to file a claim. You might receive a statement from your dentist's office showing that the claim has been filed with MetLife. If you receive an actual bill in error or other collection notices from a provider, contact MetLife at 1-800-942-0854.

How to File an Out-of-Network Claim for Dental Services

File all claims as follows:

Step 1: Tell the dentist's office you are covered by MetLife. The dentist's office can submit the claim for you. If your provider doesn't file the claim, you will have to do so yourself.

Step 2: Pay the charges at the time of service as requested by your dentist.

Step 3: Check the bill to be sure it includes patient's name, date and type of service or supply, nature of illness or injury and itemized charges.

Step 4: Save all bills, even those that are used to satisfy your annual deductible (you'll need them as proof of the expense).

Step 5: Keep a separate record of the dental expenses for yourself and each family member.

Step 6: Fill out a claim form — available by going online to www.metlife.com/mybenefits

Include the name and Social Security number of the covered person incurring the expenses.

Indicate whether you want benefits paid directly to you or "assigned," meaning paid directly to your dentist.

Attach the bills to the form, even those that cover expenses that are used to satisfy your deductible.

Remember, your eligible dependents age 19 through age 23 who are full-time students must verify full-time status. Attaching proof of student status to the first claim filed for the semester or quarter can help expedite the claims processing.

Step 7: Submit the claim form to the provider:
MetLife Dental Claims
P.O. Box 981282
El Paso, TX 79998-1282

DEADLINES FOR FILING DENTAL CLAIMS

Dental claims must be filed within 12 months from the date of treatment.

APPEALING A DENTAL CLAIM

Initial Determination

After you submit a claim for dental expense benefits to MetLife, MetLife will review your claim and notify you of its decision to approve or deny your claim.

Such notification will be provided to you within a 30 day period from the date you submitted your claim; except for situations requiring an extension of time of up to 15 days because of matters beyond the control of the Plan. If MetLife needs such an extension, MetLife will notify you prior to the expiration of the initial 30 day period, state the reason(s) why the extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of MetLife's notice requesting further information and an extension until MetLife receives the requested information does not count toward the time period MetLife is allowed to notify you as to its claims decision.

You will have 45 days to provide the requested information from the date you receive the notice requesting further information from MetLife.

If MetLife denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. Further, if an internal rule, protocol, guideline or other criterion was relied upon in making the denial, the claims decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge.

Appealing the Initial Determination

If MetLife denies your claim, you may take two appeals of the initial determination. Upon your written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim. You must submit your appeal to MetLife at the address indicated on the claim form within 180 days of receiving MetLife's decision. Appeals must be in writing and must include at least the following information:

- Name of Employee
- Name of the Plan
- Reference to the initial decision
- Whether the appeal is the first or second appeal of the initial determination
- An explanation why you are appealing the initial determination

As part of each appeal, you may submit any written comments, documents, records, or other information relating to your claim.

After MetLife receives your written request appealing the initial determination or determination on the first appeal, MetLife will conduct a full and fair review of your claim. Deference will not be given to initial denials, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim. If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of dentistry involved in the judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

MetLife will notify you in writing of its final decision within 30 days after MetLife's receipt of your written request for review, except that under special circumstances MetLife may have up to an additional 30 days to provide written notification of the final decision. If such an extension is required, MetLife will notify you prior to the expiration of the initial 30 day period, state the reason(s) why such an extension is needed, and state when it will make its determination.

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied and references any specific Plan provision(s) on which the denial is based. If an internal rule, protocol, guideline or other criterion was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other

criteria was relied upon and that you may request a copy free of charge. Upon written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim. Your written explanation will include information about any right you may have to file suit in federal court or pursue alternative dispute resolution.

When the claim has been processed, you will be notified of the benefits paid. If any benefits have been denied, you will receive a written explanation.

URGENT CARE CLAIM SUBMISSION

A small number of claims for dental expense benefits may be urgent care claims. Urgent Care Claims for dental expense benefits are claims for reimbursement of dental expenses for services which a dentist familiar with the dental condition determines the patient would subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Of course any such claim may always be submitted in accordance with the normal claim procedures. However, your dentist may also submit such a claim to MetLife by telephoning MetLife and informing MetLife that the claim is an Urgent Care Claim. Urgent Care Claims are processed according to the procedures set out above, however once a claim for urgent care is submitted, MetLife will notify you of the determination on the claim as soon as possible, but no later than 72 hours after the claim was filed. If you or your covered dependent does not provide the claims administrator with enough information to decide the claim, MetLife will notify you within 24 hours after it receives the claim of the further information that is needed. You will have 48 hours to provide the information. If the needed information is provided, MetLife will then notify you of the claim decision within 48 hours after MetLife received the information. If the needed information is not provided, MetLife will notify you or your covered dependent of its decision within 120 hours after the claim was received.

If your urgent care claim is denied but you receive the care, you may appeal the denial using the normal claim procedures. If your urgent care claim is denied and you do not receive the care, you can request an expedited appeal of your claim denial by phone or in writing. MetLife will notify you of any necessary information that will need to be submitted in order to make a decision on your appeal. MetLife will then notify you of its decision within 72 hours of your request in writing. However, MetLife may notify you by phone within the time frames above and then will mail you a written notice.

Information about Filing and Appealing Vision Claims

FILING A VISION CLAIM

Filing claims depends on the type of care and if it is received in-network or out-of-network.

For In-Network Vision Services

If you use an in-network doctor, you generally do not need to file a claim. You might receive a statement from your doctor's office showing that the claim has been filed with the Claims Administrator. If you receive an actual bill in error or other collection notices from a provider, contact EyeMed at 1-800-400-3639.

How to File an Out-of-Network Claim for Vision Services

File all claims as follows:

Step 1: Pay all charges at the time of service as requested by your doctor.

Step 2: Complete and sign an out-of-network claim form available on www.eyemedvisioncare.com or by calling 1-855-400-3639.

Step 3: Attach itemized receipts.

Step 4: Send to:
FAA/EyeMed Vision Care
ATTN: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

Deadlines for Filing Claims

Vision claims must be filed within 180 days from the date of treatment.

Appealing a Vision Claim

If your claim is denied, in whole or in part, you may appeal. The appeal must be in writing and received by FAA within 180 days after your receipt of the Explanation of Benefits. If you do not receive this notice within 30 days of submission of your claim, you may submit an appeal within 180 days after this 30-day period has expired. Your appeal will be decided within 60 days after receipt. Your written letter of appeal should include the following:

- The applicable claim number or a copy of the FAA denial information or Explanation of Benefits, if applicable.
- The item of your vision coverage that the member feels was misinterpreted or inaccurately applied.
- Additional information from the member's eye care provider that will assist FAA in completing its review of the member's appeal, such as documents, records, questions or comments.

You may authorize someone else to file and pursue a complaint or appeal on your behalf. If you do so, you must notify FAA/EyeMed Vision Care in writing of your choice of an authorized representative. Your notice must include the representative's name, address, phone number, and a statement indicating the extent to which he or she is authorized to pursue the complaint and/or appeal on your behalf. A consent form that you may use for this purpose will be provided to you upon request.

The appeal should be mailed or faxed to the following address:

FAA/EyeMed Vision Care, LLC
Attn: Quality Assurance Dept.
4000 Luxottica Place
Mason, Ohio 45040
Fax: 1-513-492-4999

FAA/EyeMed will review your appeal for benefits and notify you in writing of its decision. Your written explanation will include information about any right you may have to file suit in federal court or pursue alternative dispute resolution.

Information about Appealing Life Insurance Claims

APPEALING THE DENIAL OF A CLAIM

If you have any additional information, not previously submitted, which you believe will assist us in evaluating your claim for benefits, please forward that to us for our consideration within sixty (60) days from the date of your receipt of your denial letter.

Minnesota Life Insurance Company will review any other claim information or documentation you believe would assist us in reviewing your claim.

Please see the Certificate of Life Insurance Coverage, **available through your plan administrator,** for more information about claims and appeals.

Information about Filing and Appealing Disability Claims

FILING SHORT AND LONG-TERM DISABILITY CLAIMS

File all disability benefit claims as follows:

Step 1: Call the Employee Service Center at 1-877-511-HR4U to request a leave of absence.

Step 2: Call Cigna at 1-800-423-9920 or fill out a claim form online at Cigna.com/customer-forms

Before you call or go online, please have this information handy:

- Your name, address, phone number, birth date, Social Security number and email address.
- Employment information, such as date hired and job title.
- Reason for your claim – illness, injury or pregnancy.
- Description of your illness, symptoms, and/or diagnosis. Include the date the symptoms started and if you've had these symptoms before.
- Workers' compensation claims you've filed or plan to file.
- Details about doctor, hospital or clinic visits, including dates and contact information.

Deadlines for Filing Disability Claims

Written notice, or notice by any other electronic/telephonic means authorized by the Insurance Company, must be given to the Insurance Company within 31 days after a covered loss occurs or begins or as soon as reasonably possible. If written notice, or notice by any other electronic/telephonic means authorized by the Insurance Company, is not given in that time, the claim will not be invalidated or reduced if it is shown that notice was given as soon as was reasonably possible. Notice can be given at our home office in Philadelphia, Pennsylvania or to our agent. Notice should include the Employer's Name, the Policy Number and the claimant's name and address.

Proof of Loss

Written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, must be given to the Insurance Company within 90 days after the date of the loss for which a claim is made. If written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, is not given in that 90 day period, the claim will not be invalidated nor reduced if it is shown that it was given as soon as was reasonably possible. In any case, written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, must be given not more than one year after that 90 day period. If written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, is provided outside of these time limits, the claim will be denied. These time limits will not apply while the person making the claim lacks legal capacity. Written proof or proof by any other electronic/telephonic means authorized by the Insurance Company, that the loss continues must be furnished to the Insurance Company at intervals required by us. Within 30 days of a request, written proof of continued Disability and Appropriate Care by a Physician must be given to the Insurance Company.

Appealing a Disability Claim Determination of Disability Benefits

DETERMINATION OF DISABILITY BENEFITS

The Insurance Company has 45 days from the date it receives a claim for disability benefits, to determine whether or not benefits are payable in accordance with the terms of the Policy. The Insurance Company may require more time to review the claim if necessary due to matters beyond its control. If this should happen, the Insurance Company must provide notice in writing that its review period has been extended for:

- up to two more 30 day periods (in the case of a claim for disability benefits)

If this extension is made because additional information must be furnished, these extension periods will begin when the additional information is received. The requested information must be furnished within 45 days.

During the review period, the Insurance Company may require:

- a medical examination of the Insured, at its own expense; or
- additional information regarding the claim.

If a medical examination is required, the Insurance Company will notify the Insured of the date and time of the examination and the physician's name and location. If additional information is required, the Insurance Company must notify the claimant, in writing, stating what information is needed and why it is needed.

If the claim is approved, the Insurance Company will pay the appropriate benefit.

If the claim is denied, in whole or in part, the Insurance Company will provide written notice within the review period. The Insurance Company's written notice will include the following information:

1. The specific reason(s) the claim was denied.

2. Specific reference to the Policy provision(s) on which the denial was based.

3. Any additional information required for the claim to be reconsidered, and the reason this information is necessary.

4. In the case of any claim for a disability benefit: identification of any internal rule, guideline or protocol relied on in making the claim decision, and an explanation of any medically-related exclusion or limitation involved in the decision.

5. A statement regarding the right to appeal the decision, and an explanation of the appeal procedure, including a statement of the right to bring a civil action under Section 502(a) of ERISA if the appeal is denied.

Appeal Procedure for Denied Claims

Whenever a claim is denied, there is the right to appeal the decision. A written request for appeal must be made to the Insurance Company within 60 days (180 days in the case of any claim for disability benefits) from the date the denial was received. If a request is not made within that time, the right to appeal will have been waived.

Once a request has been received by the Insurance Company, a prompt and complete review of the claim will take place. This review will give no deference to the original claim decision. It will not be made by the person who made the initial claim decision, or a subordinate of that person. During the review, the claimant (or the claimant's duly authorized representative) has the right to review any documents that have a bearing on the claim, including the documents which establish and control the Plan. Any medical or vocational experts consulted by the Insurance Company will be identified. Issues and comments that might affect the outcome of the review may also be submitted.

The Insurance Company has 60 days (45 days, in the case of any disability benefit) from the date it receives a request to review the claim and provide its decision. Under special circumstances, the Insurance Company may require more

time to review the claim. If this should happen, the Insurance Company must provide notice, in writing, that its review period has been extended for an additional 60 days (45 days in the case of any disability benefit). Once its review is complete, the Insurance Company must state, in writing, the results of the review and indicate the Plan provisions upon which it based its decision. If the denial is upheld, you will receive a written explanation including information about any right you may have to file suit in federal court or pursue alternative dispute resolution.

Legal Action Following an Appeal

You have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the appeals procedures. In most instances, you may not initiate a legal action against your carrier until you have completed the appeals process. If your appeal is expedited, you may not need to complete the entire appeals prior to bringing legal action. No action at law or in equity may be brought for recovery under this plan if you do not timely file a claim for benefits and complete the applicable appeals procedures. Under no circumstances may a claim for recovery under this plan be made later than two (2) years from the time the Appeals Procedure is completed or deemed completed.

Coordination of Benefits for Your Medical and Dental Benefits

The following provisions apply to the Caesars Medical and Dental benefit plans.

COORDINATION OF MEDICAL BENEFITS (CIGNA PLAN MEMBERS)

If you have health care coverage available through another employer, this section is for you. For example, you may be covered as a dependent under your spouse's medical plan. This "coordination of benefits" provision prevents duplicating benefit payments when you or your dependents also have coverage through another group plan. Coordination of benefits also determines which plan pays first.

How Coordination of Benefits Works

The first step is to determine which plan is "primary" and which is "secondary." The primary plan is the one that pays benefits first, without taking the existence of another plan into consideration. The secondary plan may reduce its benefits after taking into consideration the benefits paid by the primary plan. A secondary plan may also recover from the primary plan the reasonable cash value of any services it provided to you.

Note: Coverage under this plan plus another plan does not guarantee 100 percent total reimbursement.

Order of Benefit Determination Rules

If one of the plans does not have a coordination of benefits provision, that plan will pay first. If the plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

- The plan that covers a person as an employee will be the primary plan, and the plan that covers that person as a dependent will be the secondary plan.
- For a dependent child whose parents are not divorced or legally separated, the primary plan will be the one that covers the parent whose birthday falls first in the calendar year.
- For the dependent child of divorced or separated parents, benefits will be determined in the following order:

  - first, if a court decree states that one parent is responsible for the child's health care expenses or health coverage and the plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - then, the plan of the parent with custody of the child;
  - then, the plan of the spouse of the parent with custody of the child;
  - then, the plan of the non-custodial parent of the child; and
  - finally, the plan of the spouse of the parent not having custody of the child.
- The plan that covers you as an active employee (or as that employee's dependent) will be the primary plan, and the plan that covers you as laid-off or retired employee (or as that employee's dependent) will be the secondary plan. If the other plan does not have a similar provision and, as a result, the plans cannot agree on the order of benefit determination, this paragraph will not apply.
- The plan that covers you under a right of continuation provided by federal or state law will be the secondary plan, and the plan that covers you as an active employee or retiree (or as that employee's dependent) will be the primary plan. If the other plan does not have a similar provision and, as a result, the plans cannot agree on the order of benefit determination, this paragraph will not apply.
- If one of the plans covering you is issued out of the state whose laws govern this policy, and determines the order of benefits based upon the gender of a parent, and as a result, the plans do not agree on the order of benefit determination, the plan with the gender rules will determine the order of benefits.

If none of the above rules determines the order of benefits, the plan that has covered you for the longer period of time will be primary.

When coordinating benefits with Medicare, this plan will be the secondary plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. However, when more than one plan is secondary to Medicare, the benefit determination rules identified above will be used to determine how benefits will be coordinated.

Effect on the Benefits of This Plan

If this plan is the secondary plan, the benefits that would be payable without coordination of benefits will be reduced by the benefits payable under all other plans. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an expense incurred and a benefit payable.

Recovery of Excess Benefits

If Cigna pays charges for services and supplies that should have been paid by the primary plan, Cigna will have the right to recover such payments from any person to, or for whom, such payments were made by any insurance company, health care plan, or other organization. You must produce any documents that Cigna determines are necessary to secure the right of recovery.

Right to Receive and Release Information

Cigna, without consent or notice to you, may obtain information from and release information to any other plan with respect to you in order to coordinate your benefits. You must provide Cigna with any requested information in order to coordinate your benefits. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information (including an explanation of benefits paid under the primary plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, Cigna reserves the right to determine if the claim will be processed.

If You Are Covered by Medicare

If you or your spouse has medical coverage under this plan and is also eligible for Medicare coverage, Medicare will be the secondary plan. This means that benefits will be provided first from the Caesars plan, then Medicare may provide additional benefits, based on the Medicare coverage rules. For example, if an expense is not covered by the plan but is covered by Medicare, Medicare will provide benefits for the expense subject to Medicare's rules.

Note: If you are on Medicare due to End Stage Renal Disease (ESRD), then the Caesars plan will be primary for the first 30 months. After that, Medicare will be primary and the Caesars plan will be secondary.

Expenses for Which a Third Party May Be Responsible

This plan does not cover:

- Expenses incurred by you or your Dependent (hereinafter individually and collectively referred to as a "Participant,") for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.
- Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage.

Subrogation/Right of Reimbursement

If a Participant incurs a Covered Expense for which, in the opinion of the plan or its claim administrator, another party may be responsible or for which the Participant may receive payment as described above:

- Subrogation: The plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a Participant may have against such party and shall automatically have a lien upon the proceeds of any recovery by a Participant from such party to the extent of any benefits paid under the plan. A Participant or his/her representative shall execute such documents as may be required to secure the plan's subrogation rights.
- Right of Reimbursement: The plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the plan.

Lien of the Plan

By accepting benefits under this plan, a Participant:

- grants a lien and assigns to the plan an amount equal to the benefits paid under the plan against any recovery made by or on behalf of the Participant which is binding on any attorney or other party who represents the Participant whether or not an agent of the Participant or of any insurance company or other financially responsible party against whom a Participant may have a claim provided said attorney, insurance carrier or other party has been notified by the plan or its agents;
- agrees that this lien shall constitute a charge against the proceeds of any recovery and the plan shall be entitled to assert a security interest thereon;
- agrees to hold the proceeds of any recovery in trust for the benefit of the plan to the extent of any payment made by the plan.

Additional Terms

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- The plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan's recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".

- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

Payment of Benefits

To Whom Payable

All Medical Benefits are payable to you. However, at the option of Cigna, all or any part of them may be paid directly to the person or institution on whose charge claim is based.

Medical Benefits are not assignable unless agreed to by Cigna. Cigna may, at its option, make payment to you for the cost of any Covered Expenses received by you or your Dependent from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to you or your Dependent, you or your Dependent is responsible for reimbursing the Provider. If any person to whom benefits are payable is a minor or, in the opinion of Cigna, is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, Cigna may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

If you die while any of these benefits remain unpaid, Cigna may choose to make direct payment to any of your following living relatives: spouse, mother, father, child or children, brothers or sisters; or to the executors or administrators of your estate.

Payment as described above will release Cigna from all liability to the extent of any payment made.

Time of Payment

Benefits will be paid by Cigna when it receives due proof of loss.

Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna will have the right at any time to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment.

Calculation of Covered Expenses

Cigna, in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with:

- the methodologies in the most recent edition of the Current Procedural terminology.
- the methodologies as reported by generally recognized professionals or publications.

Subrogation and Reimbursement

In the event that benefits are provided under this Plan to or on behalf of any participant, beneficiary (including all dependents), hereinafter individually and collectively referred to as "Covered Person", as the result of an injury or illness caused by a third party or organization, the Plan shall be subrogated to all of the Covered Person's rights of recovery against any such person or organization causing the injury or illness to the extent of the benefits provided.

The Covered Person shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights.

The Plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise.

The Plan, by providing benefits hereunder, is hereby granted a lien on the proceeds of any settlement, judgment or other payment intended for, payable to, or received by the Covered Person or his/her representatives, and the Covered Person hereby consents to said lien and agrees to take whatever steps are necessary to help the company secure said lien. By the acceptance of benefits under the Plan, the Covered Person and his/her representatives agree to hold the proceeds of any settlement in trust for the benefit of the Plan to the extent of 100% of all benefits paid on behalf of the Covered Person.

The subrogation and reimbursement rights and liens apply to any recoveries made by the Covered Person as a result of the injuries sustained, including but not limited to the following:

- Payments made directly by the third party tortfeasor, or any insurance company on behalf of the third party tortfeasor, or any other payments on behalf of the third party tortfeasor, or payments made from any other source intended to compensate a Covered Person for injuries sustained.
- Any payments or settlements or judgment or arbitration awards paid by any insurance company under an uninsured or underinsured motorist coverage, whether on behalf of a Covered Person or other person.
- Any worker's compensation award or settlement.
- Any recovery made pursuant to no-fault insurance.
- Any medical payments made as a result of such coverage in any automobile or homeowners insurance policy.

The Plan's right of recovery shall be a prior lien against any proceeds recovered by the Covered Person, which right shall not be defeated nor reduced by the application of any doctrine purporting to defeat the Plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.

No Covered Person hereunder shall incur any expenses on behalf of the Plan in pursuit of the Plan's rights hereunder, specifically, no court costs nor attorneys' fees may be deducted from the Plan's recovery without the prior express written consent of the Plan.

The Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the Plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

The Effect of Medicare on Benefits

For the purposes of this Booklet's "Coordination of Benefits and Services" provision, the benefits for a Covered Person may be affected by whether he/she is eligible for Medicare and whether the "Medicare as Secondary Payer" rules apply to the Plan. This section, on "Medicare as Secondary Payer", or parts of it, may not apply to this Plan. The Employee must contact the Employer to find out if the Employer is subject to Medicare as Secondary Payer rules.

For the purpose of this section:

- "Medicare" means Part A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.
- A Covered Person is deemed to be eligible for Medicare by reason of age from the first day of the month during which he/she reaches age 65. But, if the Covered Person is born on the first day of a month, he/she is deemed to be eligible for Medicare from the first day of the month that is immediately prior to his/her 65th birthday. A Covered Person may also be eligible for Medicare by reason of disability or End-Stage Renal Disease (ESRD).
- Under the rules for coordination of benefits and services described earlier, a "Primary Plan" pays benefits for a Covered Person's Covered Charges first, ignoring what the Covered Person's "Secondary Plan(s)" pays. The "Secondary Plan(s)" then pays the remaining unpaid Allowable Expenses in accordance with the provisions of the Covered Person's secondary health plan.

The following rules explain how this Plan's group health benefits interact with the benefits available under Medicare as Secondary Payer rules. A Covered Person may be eligible for Medicare by reason of age, disability or ESRD. Different rules apply to each type of Medicare eligibility as explained below:

In all cases where a person is eligible for Medicare and this Plan is the secondary plan, the Allowable Expenses under this Plan and for the purposes of the Coordination of Benefits and Services rules, will be reduced by what Medicare would have paid if the Covered Person had enrolled for full Medicare coverage. But this will not apply, however, if; (a) the Covered Person is eligible for, but not covered, under Part A of Medicare; and (b) he/she could become covered under Part A only by enrolling and paying the required premium for it.

Medicare Eligibility by Reason of Age

This part applies to a Covered Person who:

- is the Employee or covered Spouse;and
- is eligible for Medicare by reason of age; and
- has coverage under this Plan due to the current employment status of the Employee.

Under this part, such a Covered Person is referred to as a "Medicare eligible".

This part does not apply to:

- a Covered Person, other than an Employee or covered Spouse;
- a Covered Person who is under age 65; or
- a Covered Person who is eligible for Medicare solely on the basis of ESRD.

When a Covered Person becomes eligible for Medicare by reason of age, he/she must choose one of these options:

Option (A) - Choose this Plan as the primary health plan.

When (a) a Medicare eligible person chooses this Plan as the primary health plan; and (b) Incurs a Covered Charge for which benefits are payable under this Plan and Medicare, this Plan is deemed primary. This Plan pays first, ignoring Medicare. Medicare is deemed the secondary health plan.

Option (B) - Choose Medicare as the primary health plan.

When a Medicare eligible person chooses Medicare as the primary health plan, he/she will no longer be covered by this Plan, as required by Medicare's rules. Coverage under this Plan will end on the date the Covered Person elects Medicare as his/her primary health plan.

If the Medicare eligible person fails to choose either option when becoming eligible for Medicare by reason of age, the Plan will pay benefits as if he/she had chosen Option (A).

If the Medicare eligible person chooses Options (B), he/she can subsequently change the election and choose Option (A), subject to the Employer's requirements for enrolling in this Plan.

Medicare Eligibility by Reason of Disability

This part applies to a Covered Person who:

- is under age 65;
- is eligible for Medicare by reason of disability; and
- has coverage under this Plan due to the current employment status of the Employee.

This part does not apply to:

- a Covered Person who is eligible for Medicare by reason of age; or
- a Covered Person who is eligible for Medicare solely on the basis of ESRD.

When a Covered Person becomes eligible for Medicare by reason of disability, this Plan is the primary plan; Medicare is the secondary plan.

Medicare Eligibility by Reason of End Stage Renal Disease

This part applies to a Covered Person who is eligible for Medicare solely on the basis of ESRD.

This part does not apply to a Covered Person who is:

- eligible for Medicare by reason of age; or
- eligible for Medicare by reason of disability.

When (a) a Covered Person becomes eligible for Medicare solely on the basis of ESRD; and (b) Incurs a charge for the treatment of ESRD for which benefits are payable under both this Plan and Medicare, this Plan is deemed the Primary Plan for a specified time, referred to as the "coordination period". This Plan pays first, ignoring Medicare. Medicare is the Secondary Plan. The coordination period is up to 30 consecutive months.

The coordination period starts on the earlier of:

- the first month of a Covered Person's Medicare Part A entitlement based on ESRD; or
- he first month in which he/she could become entitled to Medicare if he/she filed a timely application.

After the 30-month period described above ends, if an ESRD Medicare eligible person Incurs a charge for which benefits are payable under both this Plan and Medicare, Medicare is the Primary Plan and this Plan is the Secondary Plan.

Dual Medicare Eligibility

This part applies to a Covered Person who is eligible for Medicare on the basis of ESRD and either age or disability.

When a Covered Person who is eligible for Medicare due to either age or disability (other than ESRD) has this Plan as the primary payer, then becomes eligible for Medicare based on ESRD, this Plan continues to be the primary payer for the first 30 months of dual eligibility. After the 30-month period, Medicare becomes the primary payer (as long as Medicare dual eligibility still exists).

When a Covered Person who is eligible for Medicare due to either age or disability (other than ESRD) has this Plan as the secondary payer, then becomes eligible for Medicare based on ESRD, this Plan continues to be the secondary payer.

When a Covered Person who is eligible for Medicare based on ESRD also becomes eligible for Medicare based on age or disability (other than ESRD), this Plan continues to be the primary payer for 30 months after the date of Medicare eligibility based on ESRD.

How To File A Claim If You Are Eligible For Medicare

Follow the procedure that applies to you or the Covered Person from the categories listed below when filing a claim.

New Jersey Providers:

- The Covered Person should give the Practitioner or other Provider his/her identification number. This number is shown on the Medicare Request for Payment (claim form) under "Other Health Insurance";
- The Provider will then submit the Medicare Request for Payment to the Medicare Part B carrier;
- After Medicare has taken action, the Covered Person will receive an Explanation of Benefits form from Medicare;
- If the remarks section of the Explanation of Benefits contains this statement, no further action is needed: "This information has been forwarded to Horizon Blue Cross Blue Shield of New Jersey for their consideration in processing supplementary coverage benefits;"
- If the above statement does not appear on the Explanation of Benefits, the Covered Person should include his/her Identification number and the name and address of the Provider in the remarks section of the Explanation of Benefits and send it to Horizon BCBSNJ.

Out-of-State Providers:

- The request for Medicare payment should be submitted to the Medicare Part B carrier in the area where services were performed. Call your local Social Security office for information;
- Upon receipt of the Explanation of Benefits, show the Identification Card number and the name and address of the Provider in the remarks section and send the Explanation of Benefits to Horizon BCBSNJ for processing.

COORDINATION OF DENTAL BENEFITS

The following provisions apply to the Caesars dental benefit plan.

If You Are Covered by Another Plan

If you or one of your dependents is covered by another dental plan, the Caesars dental plan coordinates payments with the other plan(s). "Coordination" means that benefits from both plans are combined to provide coverage. You and your dependents will not receive more than 100 percent reimbursement from the two combined plans for allowable dental expenses. "Another plan" means group insurance plans that cover you or your eligible family members, including student coverage through a school, another employer-sponsored plan or government-sponsored coverage such as Medicare.

How to Determine Primary and Secondary Coverage

When two or more plans provide benefits for the same allowable charge, one plan pays your claim first. This plan is called the primary plan. The other plan, called the secondary plan, will then pay some or all of the difference (if any) between what the primary plan pays and the charged amount.

Here are some general guidelines to help you know whether a plan is primary or secondary:

- The plan that covers the person as an employee is primary.
- If no plan covers the person as an employee, then the plan without a coordination of benefits provision will be primary.
- If a child is covered under both parents' plans, the plan of the parent whose birthday falls earlier in the year is primary. If both parents have the same birthday, the plan that has covered a parent longer is primary.
- When the parents are separated or divorced, benefits for a child are paid in this order:
- First, the plan of the parent who has been assigned financial responsibility for the child's health expenses by a court decree.
- Next, the plan of the parent who has custody of the child.
- Then, the plan of the stepparent married to the parent with custody.
- Then, the plan of the parent without custody.
- Finally, the stepparent married to the parent without custody.

Coordinating Your Benefits

Here's how coordination works for dental coverage:

- You should first seek benefits coverage under the primary plan.

- Then file a claim with the secondary plan to see whether any of the expenses that were not covered by the primary plan will be reimbursed.
- Be sure to include a copy of the primary plan payment statements or your explanation of benefits (EOB) when submitting the claim to the secondary plan.

IMPORTANT! Neither plan pays more than it would without this coordination provision.

Special Situations that Affect Your Coverage

IF YOU ARE TEMPORARILY LAID OFF DUE TO SHORT-TERM BUSINESS CONDITION

You can continue medical, dental, vision and life insurance coverage for up to six months during layoff as approved by the company. You are responsible for your regular employee contributions. If you fail to pay a contribution within 30 days after it is due, coverage will be cancelled. Failure to pay premiums is not a qualifying event, and COBRA will not be offered.

If your coverage ends voluntarily or because of non-payment of contributions, and then you are rehired within a year after leaving the company and you had at least one year of continuous service before leaving, you have 31 days to enroll for medical, dental or vision coverage and life and disability insurance.

Evidence of Insurability may be required for life and disability insurance. Prior service will be credited toward the disability benefit eligibility waiting period.

If you are totally disabled and eligible for benefits under the company's Long-Term Disability (LTD) Plan, you are eligible to continue medical, dental and vision coverage for a limited time (currently up to 29 months provided you meet the requirements established under COBRA with approval by the Social Security Administration for a qualified disability) at the current COBRA rates after you terminate employment. You may also continue your life insurance provided you pay the premiums while on leave of absence. Coverage will continue without payment if you apply and are approved for Waiver of Premium by Aetna. If Waiver of Premium is approved, life insurance will end on the earliest of:

- your 65th birthday; or
- the date you recover so that you are no longer totally and permanently disabled; or
- the date you fail to furnish proof of continued disability when requested; or
- medical examination.

For more information about Waiver of Premium contact Minnesota Life at 866-296-6047.

IF YOU TAKE VACATION AND OR PAID TIME OFF (PTO)

Your medical, dental, vision, life insurance, STD and LTD coverage will continue while you are using any vacation and/or PTO days. Your contributions continue to be deducted from your vacation and/or PTO payments.

IF YOUR EMPLOYMENT STATUS CHANGES

If you become eligible for coverage due to a change in your employment status, an enrollment package is sent to you. Coverage, with the exception of life insurance, begins on the day of eligibility, even though you will be enrolling after you become eligible.

Deductions for benefit election changes will be included on the next payroll process after the later of when your benefits are effective or when you complete elections with the Caesars Benefit Service Center.

IF YOU CHANGE TO FULL-TIME STATUS

If you switch from non-full-time to full-time status your continuous employment as non-full-time will count towards your eligibility period.

IF YOU CHANGE TO A SALARIED POSITION

If you are hourly and are moved to a salaried position during your eligibility wait period, you are eligible to enroll immediately.

IF YOU LEAVE THE COMPANY AND ARE REHIRED

If you leave the company after at least one year of continuous full-time service and are rehired as a full-time employee within a year, you are eligible to enroll immediately without any waiting period. If you are rehired within 31 days of leaving the company, you are enrolled automatically back into the same benefit elections you had when you left. If you are hired after 31 days, but within a year, you have the option to re-elect new benefits. If you worked less than a year in full-time or part-time status you are eligible to enroll immediately without any waiting period if you meet the following conditions:

- you satisfied your original eligibility waiting period while previously employed, and
- your position was eliminated due to a reduction in force and coded in the Human Resources system with a term code of USR (Uncontrollable - Staff Reductions), and
- you are rehired as a full-time employee within one year of your departure.

For all other plan purposes, you are considered a newly hired employee. If you have the option to re-elect benefits, you must elect them by the date noted on your enrollment package or you will receive only company provided benefits. If your salary changes, there is no change to your basic life insurance coverage until the next annual enrollment. If your salary adjustment results in a change in your salary tier (medical), it is also frozen.

IF YOU TRANSFER INTERNALLY

If you have coverage under the plan, then transfer to another property and remain eligible, you keep the same benefit elections. However, as a result of the transfer your medical, dental and vision deductions could change.

IF YOU ARE ON SALARY CONTINUATION

If you are receiving salary continuation payments, your medical, dental and vision coverage continue, as does your Health Care Flexible Spending Account. Your contributions are deducted from your salary continuation payments.

When salary continuation ends, continuation of medical, dental and vision coverage and participation in your Health Care Flexible Spending Account are available through COBRA. (See *Continuing Your Coverage Under COBRA*.) Life insurance may be continued as outlined in the *Additional Information About Your Life Insurance Coverage* section.

Regardless of whether you receive salary continuation payments as a lump sum or in installments, the 18-month COBRA continuation period begins on the initial effective date of your salary continuation.

IF YOU ARE RECEIVING SHORT-TERM DISABILITY

If you are receiving Short-Term Disability (STD) benefits from the plan and remain on a leave of absence and you wish to continue your coverage, you are required to pay for continued coverage of medical, dental, vision, additional LTD and STD and voluntary life insurance, as well as your Health Care Flexible Spending Account, if applicable, through a payment process coordinated by the Caesars Benefit Service Center.

IF YOU ARE ELIGIBLE FOR LONG-TERM DISABILITY

If you are totally disabled and eligible for benefits under the company's Long-Term Disability (LTD) Plan, you are eligible to continue medical, dental and vision coverage for a limited time (currently up to 29 months provided you meet the requirements established under COBRA with approval by the Social Security Administration for a qualified disability) at the normal employee contribution rate, but not later than the date you terminate employment at which

point COBRA rates apply. You may also continue your life insurance provided you pay the premiums while on leave of absence. Coverage will continue without payment if you apply and are approved for Waiver of Premium by Aetna. If Waiver of Premium is approved, life insurance will end on the earliest of:

- your 65th birthday; or
- the date you recover so that you are no longer totally and permanently disabled; or
- the date you fail to furnish proof of continued disability when requested; or
- you refuse to submit to a required medical examination.

For more information about Waiver of Premium contact Aetna at 1-800-523-5065.

IF YOUR SALARY CHANGES

If your salary changes as a result of a job change within your property, your deductions for Medical, STD and LTD will remain the same. Your deductions are determined by the salary calculated on the day of eligibility or at annual enrollment. Once the salary is determined, it is frozen so that your contributions for these benefits remain the same throughout the plan year.

IF YOU TAKE FAMILY AND MEDICAL LEAVE UNDER FMLA

If you are on leave under the Family and Medical Leave Act (FMLA), you may have your medical, dental, vision, Health Care Flexible Spending Account, voluntary life insurance and additional STD and LTD coverage continued, provided you pay the required employee contributions during the leave.

Paying Your Premiums During FMLA Leave

If you choose to continue coverage while on leave, Caesars Benefit Service Center will send a payment notice with the amount you owe to your home. If you fail to pay the premium within 15 days, you'll receive another notice indicating that payment is due within 15 days or all coverage will be cancelled. You will be responsible to reimburse the plan immediately if any benefits are paid within a period you did not have active coverage.

Returning To Work After FMLA Leave

If you did not choose to continue your medical, dental, vision, Health Care Flexible Spending Account, voluntary life insurance, and additional STD and LTD coverage while on leave, your coverage will be reinstated automatically upon your return to work. If you do not want the coverage to be reinstated, you must contact the Caesars Benefit Service Center at 1-866-BEN-FITS (236-3487) within 10 days of returning to work.

If You Don't Return To Work After FMLA Leave

If you don't return to work at the end of the FMLA leave — or if you notify the company that you don't intend to return to work — you are eligible for COBRA as described later in this booklet under *Continuing Your Coverage Under COBRA*.

The qualifying event for COBRA eligibility occurs at the earlier of:

- the date you notify the company that you do not intend to return or
- the date your FMLA leave expires if your coverage was cancelled during the leave due to non-payment of premiums or you fail to return after the leave ends.

IF YOU ARE RECEIVING WORKERS' COMPENSATION

If you are receiving workers' compensation benefits while you're not working (other than FMLA leave), you'll be considered on unpaid leave as described below.

IF YOU ARE ON UNPAID LEAVE (OTHER THAN FMLA)

If you are on an unpaid leave that does not qualify as an FMLA leave, your coverage may continue and you will receive notification from the Caesars Benefit Service Center of the amount you owe for continued coverage.

IF YOU ELECT TO CONTINUE COVERAGE

If you choose to continue coverage while on leave, Caesars Benefit Service Center will send a payment notice with the amount you owe to your address on file. If you fail to pay the premium within 15 days, you'll receive another notice indicating that payment is due within 15 days or all coverage will be cancelled. Coverage will be cancelled if you don't pay the required premiums. You will be responsible to reimburse the plan immediately if any benefits are paid within a period you did not have active coverage.

It is your responsibility to notify the Caesars Benefit Service Center if you want to continue or discontinue your coverage and to pay premiums. The company will attempt to provide you with information about your benefits and premiums when you take unpaid leave but has no liability if coverage is cancelled or not provided due to your failure to pay premiums.

IF YOU RETURN TO WORK AFTER UNPAID LEAVE (OTHER THAN FMLA)

If you had cancelled all your coverage and later return to work as a benefits-eligible employee, you'll be eligible to re-enroll during the next annual enrollment period, subject to the late enrollment restrictions described earlier in this SPD under *Changing Your Medical, Dental, Vision and Life Insurance Coverage.*

IF YOU ARE ON MILITARY LEAVE

If you are called up for military duty, you may drop your coverage as soon as you are called up. If you are called for military duty for up to 31 days, your coverage may continue as long as you pay the required premium. If you are on military duty for 31 days or more, benefits for you and your dependents may continue as described below:

- Medical, Dental, Vision and the Health Care Flexible Spending Account: continuation through COBRA is available.
- Life insurance and AD&D: continued coverage is available provided you pay the premium. The Caesars Benefit Service Center will provide you with notification of the amount you owe to continue coverage.
- Disability coverage (Short- and Long-term) and the Dependent Day Care Flexible Spending Account: coverage is terminated when your military leave begins.

IF YOU ARE REHIRED AFTER YOUR MILITARY LEAVE

If you return to active employment with the company according to the provisions of the Uniformed Services Employment and Re-employment Rights Act (USERRA) of 1994, any medical, dental, vision, Health Care Flexible Spending Account, life and disability insurance you had on the date of your call to military service will be reinstated; however, you must re-enroll to obtain this coverage. There will be no eligibility period, and pre-existing conditions will not apply other than to conditions related to your military service. You will have 31 days to enroll if you want benefits. Evidence of Insurability is not required to reinstate life insurance.

"Uniformed services" means the United States Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training or full-time National Guard duty, the commission corps of the Public Health Service and any other category of persons designated by the president in time of war or emergency.

QUESTIONS ABOUT SPECIAL SITUATIONS THAT AFFECT YOUR COVERAGE

If you have any questions about how your benefits may be affected while you are on a leave of absence, including your ability to suspend or continue benefits while on leave and any responsibility you may have for payment, please contact the Caesars Benefit Service Center at (866) BEN-FITS or (866) 236-3487.

Continuing Your Coverage Under COBRA

In certain instances, federal law allows you and your dependents to continue medical, dental and vision coverage and participation in the Health Care Flexible Spending Account for up to 18 months (or in some cases up to 29 or 36 months) after the coverage would otherwise end. These certain instances are called "qualifying events." The federal law is called the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). While you are eligible to continue participation in the Wellness Program, you are not eligible for wellness rewards under COBRA.

HOW COBRA AFFECTS YOU AND YOUR DEPENDENTS

Under COBRA, medical, dental and vision coverage (as well as participation in the Health Care Flexible Spending Account) may be extended for you and your dependents if one of the qualifying events listed in the table below occurs.

Qualifying Event Resulting In Loss Of Coverage	Maximum Continued Coverage	Cost
Voluntary termination • **Involuntary termination** (other than for gross misconduct) • **Reduction of hours** (through job status change)	18 months for you and all qualifying family members, including any period of time while you are on salary continuation.	You pay 102% of the full monthly premium.
Termination due to disability (Refer to "Paying Your Cost For COBRA Coverage" on page 181)	29 months for you and all qualifying family members.	If you are totally disabled and eligible for benefits under the company's Long-Term Disability (LTD) Plan, you are eligible to continue medical, dental and vision coverage for a limited time (currently up to 29 months provided you meet the requirements established under COBRA with approval by the Social Security Administration for a qualified disability) at the current COBRA rates after you terminate employment.
Death of Employee Divorce Legal Separation	36 months for family members.	Qualifying family member pays 102% of the full monthly premium.
Dependent loses eligibility under the plan	36 months for the affected dependent.	Dependent pays 102% of the full monthly premium.
Military Leave	24 months	Qualifying family member pays 102% of the full monthly premium.

With COBRA coverage, you also have the right to enroll newly eligible dependents in the same way and at the same time as covered employees. And anyone covered by COBRA has the same rights to make benefits changes based on qualified lifestyle changes or during annual enrollment periods.

Second Qualifying Events

If your spouse or dependent elects continuation coverage following your termination of employment or reduction in hours and during the 18 months of continuation coverage your spouse or dependent experiences a second qualifying event, your spouse or dependent will be entitled to elect a total of 36 months of continuation coverage beginning from the date the initial 18-month continuation coverage period began. To receive this additional continuation coverage, you or your family members must notify the COBRA Administrator through the Caesars Benefit Service Center of the second qualifying event within 60 days of the event. An event is a second qualifying event only if only if the event would have caused your spouse or dependent child to lose coverage under the plan had the first qualifying event not occurred.

Continued Coverage for Covered Domestic Partners

COBRA continuation coverage is generally not available to domestic partners due to COBRA's eligibility rules. Due to Caesars Entertainment Corporation's commitment to its employees, the Company will make continuation coverage available to covered domestic partners and their covered dependent children on substantially the same terms as the COBRA continuation coverage described in this section. The continuation coverage offered to covered domestic partners and their covered dependent children is generally not governed by COBRA but may be governed by other applicable federal or state law.

If you have any questions regarding continuation coverage for covered domestic partners and their covered dependent children, you should call the Caesars Benefits Center.

Medicare

If you become entitled to Medicare and coverage under the plan is lost due to your termination of employment or reduction in hours of employment, your spouse or dependent will be entitled to continuation coverage until the later of the date which is (1) 36 months from the date you became entitled to Medicare, or (2) 18 months from the date of your termination of employment or reduction in hours of employment.

Disability

An 11-month extension of continuation coverage may be purchased if any qualified beneficiary (i.e., you, your spouse or your dependent child) who elected continuation coverage is disabled according to the following guidelines. The Social Security Administration (SSA) must determine that the qualified beneficiary was disabled at the time of the qualifying event date or became disabled within 60 days of that date. You must notify the Caesars Benefit Service Center of that fact within 60 days of the SSA's determination and before the end of the first 18 months of continuation coverage. All qualified beneficiaries who elected continuation coverage will be entitled to the 11-month extension if one of them qualifies.

If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Caesars Benefit Service Center of that fact within 30 days of SSA's determination.

Continuation of Your Health Care Flexible Spending Account

If you lose coverage under the Health Care Flexible Spending Account as a result of a qualifying event as described in the chart on page 179 (the maximum coverage periods do not apply), you, your spouse or your dependent may be eligible to continue the coverage for the rest of the plan year under certain circumstances.

Electing to continue coverage under this plan through COBRA gives you or your covered dependent(s) the opportunity to continue to submit for reimbursement any eligible health care expenses incurred after termination. Continued Health Care Spending Account participation means you can avoid having to forfeit funds in your Health Care Spending Account due to loss of eligibility.

Generally, you may continue coverage under the Health Care Spending Account for the remainder of the plan year following a life change only if you have a positive account balance on the date of the life change. This means that if the maximum benefit available under the Health Care Spending Account for the remainder of the plan year is less than

the maximum the plan could require as payment for the remainder of that year to maintain coverage under the Health Care Spending Account, you will not be offered COBRA continuation coverage.

Newborn Child, Adopted Child or Child Placed for Adoption

If, during the period of continuation coverage, a child is born to you, adopted by you or placed for adoption with you, the child is considered a qualified beneficiary. You have the right to elect continuation coverage for that child, provided the child satisfies the otherwise applicable eligibility requirements. To enroll the child in COBRA, you must notify the Caesars Benefit Service Center within 31 days of the date of the birth, adoption or placement for adoption and pay the required cost, at which time coverage will be effective back to the date of the birth, adoption or placement. If you fail to do so, you will not be offered the option to elect COBRA coverage for the newborn or adopted child until the next annual enrollment period.

NOTIFICATION AND RESPONSIBILITIES

The COBRA administrator will send a COBRA election notice to your last known address. You must enroll by the date specified in the notice.

If you don't receive the notice because you have not updated your address with the company and fail to elect COBRA by the deadline, you will not be eligible for COBRA coverage.

You or your dependents must contact the Caesars Benefit Service Center within 31 days of the qualifying event date (or after the date coverage would be lost due to the qualifying event, if later) if you divorce, legally separate or your dependent becomes ineligible due to marriage or age. COBRA will not be available if you fail to meet this 31-day notification deadline.

In order to qualify for the 11-month extension due to disability, you must notify the Caesars Benefit Service Center within 60 days of determination by SSA that you are disabled. Notification must be provided before the end of the initial 18-month coverage period.

ELECTING COBRA COVERAGE

Caesars Benefit Service Center will mail election notices to members when eligible for COBRA coverage. Anyone who wants to continue the coverage must complete and return the election notice to Caesars Benefit Service Center within 60 days from the date the coverage would have ended or the date of the election notice, whichever is later. The date of election is based on its postmark. If the election is not made within the 60-day period, you will not have continuation coverage and will have no further rights to elect such coverage.

COBRA continuation coverage mirrors the same medical, dental, vision and Health Care Flexible Spending Account elections you had as an active employee. So, for example, if you were enrolled in medical but not in dental when you qualify to continue coverage through COBRA, you will be offered continued coverage only under medical initially. However, each qualified beneficiary who elects continuation coverage has the same rights under the plan as other participants. Therefore, you will have an opportunity to change your elections once a year during annual enrollment and for any qualified lifestyle changes.

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

Coverage during the Election Period

As of the date coverage is terminated, you and your family members will not have any coverage until continuation coverage is properly elected and the required premiums have been paid. This means no benefits or expenses will be paid during the election period. To receive uninterrupted coverage, it is important to elect continuation coverage and make the required premium payments as soon as possible after receiving this notice of the opportunity to continue

coverage. Once a completed election form is received and all required premiums are paid, coverage becomes retroactive to the date coverage was terminated.

Paying Your Cost for COBRA Coverage

You or your dependents pay 102 percent of the full monthly premium. The company does not share any of the cost with you. For disabled qualified beneficiaries, this cost is 150 percent of the full monthly premium. If the disabled qualified beneficiary does not continue coverage during the additional 11 months, the cost remains at 102 percent of the full monthly premium.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (eligible individuals). Under the new tax provision, eligible individuals can either take a tax credit or get advance payment of 65 percent of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll free at 1-866-628-4282. TTD/TTY callers may call toll free at 1-866-626-4282.

You must make your first premium payment for continuation coverage within 45 days after the date of your election. (This is the date the returned Election Forms are postmarked.) If you do not make your first payment for continuation coverage within the 45 days, you will lose all continuation coverage rights under the plan. Your first payment must cover the cost of continuation coverage from the time your coverage under the plan would have otherwise terminated up to the time you make the first payment.

As reflected on your COBRA Election Notice, you are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact Caesars Benefit Service Center to confirm the correct amount of your first payment. Premium payment coupons reflecting the periodic monthly amounts and due dates will be mailed to you upon receipt of your first payment.

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the plan, these periodic payments for continuation coverage are due on the first of each month for which coverage is requested. If these subsequent payments are not postmarked on or before 30 days after they are due, coverage will be discontinued and you will have no further rights to elect continuation coverage. The Plan Administrator retains the right to wait for a check to clear before crediting payment. If a check is received before the deadline and is declined by your bank, it will be considered late and coverage will be discontinued unless you submit a check that clears before the deadline.

Should you decide to terminate COBRA coverage prior to the scheduled end of your continuation period, please notify the Caesars Benefit Service Center to confirm the correct amount of your final payment. Timely retroactive coverage termination for a partial month is subject to the contract governing each specific insurance plan. Approval for a partial month’s coverage could generate a pro-rated daily premium amount based upon specific plan coverage. Please contact the Caesars Benefit Service Center to place your specific request for early termination resulting in possible monthly premium proration.

When COBRA Continuation Ends

COBRA coverage may be terminated before the 18-, 29- or 36-month period if you or a covered dependent:

- Fails to pay the required premiums within 30 days after they are due. In this case, coverage will end retroactively to the date last covered by payments.
- Becomes entitled to coverage under another group health plan, including Medicare.
- Becomes covered under another group health plan (as an employee or otherwise) that does not limit or exclude coverage of pre-existing conditions, after the date COBRA coverage is elected. (This rule applies only to the individual who becomes covered by the other plan.)

Continuation coverage under COBRA also will end if the company terminates all health plans for employees.

Additionally, the 11-month extension of continuation coverage due to disability will end on the first day of the month beginning 30 days after the Social Security Administration determines that the disabled individual no longer is disabled. You must notify the company within 30 days of such a determination.

When the normal COBRA coverage period ends, private medical insurance companies are required under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to make health coverage available without restrictions for pre-existing conditions if there has not been a gap in coverage of 63 or more consecutive days. If you expect your COBRA coverage to end soon, you or a covered dependent should check with the state department of insurance or private insurance companies for more information about this coverage.

Rights and Authorities

STATEMENT OF PARTICIPANT RIGHTS

Caesars Entertainment Corporation has established the plan described here for the exclusive benefit of its employees and employees of certain affiliates. As a participant in the plan, you have certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that, as a plan participant, you will be entitled to the following:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office or your work location, during normal working hours, all plan documents, including insurance contracts, and a copy of the latest annual report (Form 5500 series) filed by the plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of all plan documents governing the operation of the plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The Plan Administrator may request a reasonable charge for the copies.
- Obtain, upon written request to the Plan Administrator, information as to whether a particular employer or employer organization is a sponsor of the plan and the address of any employer or employer organization that is a plan sponsor. Your beneficiaries also have the right to obtain this information upon written request to the Plan Administrator.
- Receive a summary of the plans' annual financial reports. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, your spouse or dependents if coverage is lost under the plan as a result of a lifestyle change. You, your spouse or other dependents may have to pay for such coverage. Refer to the section of this SPD entitled *Continuing Your Coverage Under COBRA* and other plan documents for more information on continued coverage.
- Reduce or eliminate any waiting period for health care coverage under the plan due to pre-existing conditions if you have creditable coverage from another plan. You will be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance provider when:
  - You lose coverage under the plan.
  - You become entitled to COBRA.
  - Your COBRA coverage ends.
  - You request a certificate before losing coverage or within 24 months after losing coverage.

If you don't provide proof of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months after your enrollment date for coverage.

Require Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon those who are responsible for the operation of your employee benefit plan.

The people who supervise the operation of your plans, called "fiduciaries," have a duty to do so prudently and solely in the interest of you and other plan participants and beneficiaries. Fiduciaries who violate ERISA may be removed and required to make good any losses they have caused the plans.

ENFORCE YOUR RIGHTS

No one, including your employer or any other person, may fire you or discriminate against you in any way to prevent you from obtaining a benefit from the plan or exercising your rights under ERISA.

If your claim for a benefit under the plan is denied in whole or in part, you have a right to know why this was done, to obtain copies of documents relative to the decision (with no charge) and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials — unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack of one concerning the qualified status of a Domestic Relations Order or a Medical Child Support Order, you may file suit in federal court.

If the plan's fiduciaries should misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person(s) you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim frivolous).

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your benefits, contact the Caesars Benefit Service Center. If you have any questions or need assistance regarding this statement or about your rights under ERISA or HIPAA with respect to health benefits that are offered under a group health plan, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.

You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or by using this email address: www.askebsa.dol.gov.

RIGHTS AND AUTHORITY OF THE COMPANY

The company, the Plan Administrator and organizations or persons authorized by them have the right and authority, in their discretion, to:

- Make final decisions regarding questions or disputes about eligibility for benefits including deciding facts and interpreting the plan.
- Disqualify an applicant for eligibility (including retroactive disqualification) due to a false or incorrect statement or omission on an application or claim form and require reimbursement of any benefits paid plus any expenses incurred by the company.
- Disqualify a participant and revoke coverage retroactively if coverage was granted through an administrative mistake. In this case, if any employee premiums have been paid, the company may refund them, and if any claims or benefits have been paid, the company is entitled to reimbursement from the employee.
- Administer the plans, including determine all questions of interpretation, eligibility dates and other matters concerning participation and benefits.

- Require proof of the legal status of any child or spouse listed as a dependent when first enrolling or any child or spouse currently covered as a dependent.
- Delegate any decisions regarding benefits to a third-party Claims Administrator or insurer to resolve questions, problems or disputes, subject to the employee's or dependent's rights of claims appeals according to their respective insurance contracts and administrative guidelines and as required by ERISA. This includes making a decision in an employee's favor if the problem was not under the employee's control or due to a legitimate mistake or misunderstanding as determined by the company. A company's decision in any particular situation does not imply that the same decision will be reached in future similar situations. Failure of the employee to read this Summary Plan Description or other materials given to employees is generally not a reason for the company to decide in the employee's favor.

Any plan information or any materials sent to employees via U.S. mail will be considered delivered if they are mailed to a last known address, or if mailed and not returned by the post office.

If any benefits are paid in error, the company, Plan Administrator or Claims Administrator is entitled to recover them from a provider, the employee or the employee's dependent or beneficiary.

Any payment of benefits or a written or spoken statement by an employee, a representative of the company, the Plan Administrator or Claims Administrator that a claim will be covered is not binding if in error and can be reversed if it is not, in fact, covered by the plan.

The company reserves the right to terminate or modify the plan and cancel any related plans, insurance policy or policies at any time or under such circumstances it deems, in its sole discretion, appropriate including termination or modification as to any division, subsidiary or operating unit. The company or its designated agents will approve plan amendments or plan termination pursuant to a written instrument. Termination or modification of this plan will not affect coverage as to benefits or claims that were incurred before the termination or modification.

RELATIONSHIP OF PARTIES (COMPANY-PLAN ADMINISTRATOR-PARTICIPANT-CLAIMS ADMINISTRATOR)

The Company, the Plan Administrator and covered Participants are not agents or representatives of a Claims Administrator.

The Plan Administrator is the named fiduciary under the Plan for the purposes of ERISA and has delegated the authority to the Claims Administrators to determine claims eligible for payment under the Plan, including the claims and appeals processes, in their sole and absolute discretion. The Claims Administrators are also named fiduciaries under the Plan for this purpose.

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries

In carrying out their respective responsibilities under the Plan, the Plan administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan.

Health Insurance Portability and Accountability Act of 1996

HEALTH INFORMATION PRIVACY PROTECTION

In accordance with the HIPAA privacy regulations, effective April 14, 2003, the health information privacy policy and practices of the group health plan benefits under the Plan protect confidential health information that identifies you or

could be used to identify you and relates to a physical or mental health condition or the payment of your health care expenses. This individually identifiable health information is known as "protected health information" (PHI). Your PHI will not be used or disclosed without a written authorization from you, except as described in the HIPAA Privacy Notice or as otherwise permitted by federal and state health information privacy laws. Such instances may include, but are not limited to, disclosure to public health agencies, disclosure in accordance with worker's compensation laws and in response to a court order.

To request a copy of the HIPAA Privacy Notice for the Caesars Medical Plan, please contact the Plan Administrator. The contact information for the Plan Administrator is located in the *Administrative Information* section of this SPD.

Medicare D Notice

IMPORTANT NOTICE FROM CAESARS ENTERTAINMENT CORPORATION

About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Caesars Enterprise Services, LLC. and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- Caesars Enterprise Services, LLC. has determined that the prescription drug coverage offered by Caesars medical plan options are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan and are still an active employee, your current Caesars Enterprise Services, LLC coverage will not be affected. You may keep your Caesars coverage if you enroll in Medicare and your prescription drug benefits under Caesars plan will be coordinated with your Medicare Part D coverage. Eligible prescription drug claims will be paid by the Caesars plan first and Medicare will be the secondary payer. Medicare may pay for your eligible prescription drug claims that are not covered or only partially covered by the Caesars plan.

If you do decide to join a Medicare drug plan and drop your current Caesars Operating Company, Inc. coverage, be aware that you and your dependents will be able to get this coverage back at the next annual enrollment. Please contact the Caesars Benefit Service Center at (866) BEN-FITS (866-236-3487) for more information regarding Medicare Part D coverage coordination.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Caesars Operating Company, Inc. and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Caesars Enterprise Services, LLC changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

Date:	October 2014
Name of Entity/Sender:	Caesars Enterprise Services, LLC
Contact--Position/Office:	Caesars Benefit Service Center
Address:	P.O. Box 785017, Orlando, FL 32878-5017
Phone Number:	1-866-BEN-FITS (236-3487)

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).

Important Definitions

Accident	An unexpected, external, violent and sudden event.
Actively at Work (Disability Insurance)	Active employment means you are working for your Employer for earnings that are paid regularly and that you are performing the material and substantial duties of your regular occupation. You must be working at least the number of hours in the Employer's normal work week. Normal vacation is considered active employment. Individuals whose employment status is being continued under a severance or termination agreement will not be considered in active employment.
Actively at Work (Life Insurance)	To be eligible to become insured or to receive an increase to the amount of insurance, you must be working for your employer for pay with the intent and ability of working the schedule hours (the full-time hours as required by the participating employer, but not less than 30 hours per week) and doing the normal duties of your job, whether you are working at your usual Caesars location, a location to which Caesars requires you to travel or at an alternative worksite. Normal vacation and PTO time are considered active employment.
Adopted Child	A legally adopted child, including a child who is officially placed with you for adoption.
Annual Frozen Salary	Your salary as calculated on the day of eligibility or at annual enrollment. Once the salary is determined, it is frozen so that your contributions for these benefits remain the same throughout the plan year.
Basic Yearly Earnings	The current yearly salary or wage you receive for work done for Caesars Entertainment Corporation It does not include bonuses
Bed and Board	All charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.
Calendar Year	January 1–December 31.
Charges	The actual billed charges; except when the provider has contracted directly or indirectly with Cigna for a different amount.
Chiropractic Care	The conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain, and improve function.
COBRA	A federal law that says health care plan (medical, dental, vision and Health Care Flexible Spending Account) participants may continue their health care coverage under certain situations for a specific period of time beyond when coverage normally would end. For a complete description, see *Continuing Your Coverage Under COBRA*.
Coinsurance	The percentage of covered medical and dental expenses you are responsible for paying after you have met your deductible. Under each medical plan option, your coinsurance is lower when you use an in-network provider.
Company	Caesars Entertainment Corporation
Company Business	Any assignment Caesars requires you to do to advance company business. Traveling while on "company business" begins when you leave your home or work place to go on a trip and continues until you return to your home or work place. Everyday travel to and

	from work or while on leave of absence or vacation is not considered traveling for "company business."
Contribution	Your share of the cost (or premiums) for benefits coverage for yourself and your dependents. Your contributions will be automatically deducted from each paycheck throughout the year. You will pay your contributions for medical, dental and vision coverage on a pre-tax basis; you will pay your contributions for disability coverage and voluntary life insurance on an after-tax basis.
Copayment	A preset dollar amount you pay upfront for certain services under the vision plan.
Covered Health Service(s)	Health services which prevent, diagnose or treat a sickness, injury, mental illness or substance abuse or the symptoms thereof. Covered services include the health care services or supplies described in the *What's Covered* section for each plan. They do not include any services or supplies listed in the *What's Not Covered* sections, including experimental or investigational services. Covered health services must be provided: when the plan is in effect; before a participant loses coverage, based on the guidelines stated in this Summary Plan Description and only when the person who receives services is covered and meets all eligibility requirements specified in the plan. The decision to add new technologies, procedures and treatments as covered services under the plan will be based on generally accepted medical research and findings from clinical trials or group studies.
Creditable Coverage	The period of time you were covered under another health care plan if you were covered by it immediately before you joined the company (or the first date of coverage if you enrolled after you were first eligible or were a special enrollee), unless there was a break in coverage of more than 63 consecutive days excluding any waiting period for plan coverage. For this purpose, "health care plan" is defined as most forms of group, individual, private or government-sponsored health plans (including COBRA) and college health plans.
Custodial Care	Any services that are of a sheltering, protective, or safeguarding nature. Such services may include a stay in an institutional setting, at-home care or nursing services to care for someone because of age or mental or physical condition. This service primarily helps the person in daily living. Custodial care also can provide medical services, given mainly to maintain the person's current state of health. These services cannot be intended to greatly improve a medical condition; they are intended to provide care while the patient cannot care for himself or herself. Custodial Services include but are not limited to: services related to watching or protecting a person; services related to performing or assisting a person in performing any activities of daily living, such as (a) walking, (b) grooming, (c) bathing, (d) dressing, (e) getting in or out of bed, (f) toileting, (g) eating, (h) preparing foods or (i) taking medications that can be self-administered; and services not required to be performed by trained or skilled medical or paramedical personnel.
Deductible	The specified amount you must pay each year, after you use your HRA and before Caesars will pay the shared portion of your health care costs.
Deductible Sources of Income (Short-Term Disability)	When Cigna is determining what your short-term disability benefit should be, they take your initial disability benefit amount and subtract any money you receive (or are entitled to receive) from other sources called "deductible sources of income." The remaining amount becomes your actual disability benefit. The money subtracted comes from the following: • State benefit law

Deductible Sources of Income (Long-Term Disability)	When insurance companies are figuring out what your long-term disability benefit should be, they take your initial disability benefit amount and subtract any money you receive (or are entitled to receive) from other sources — called "deductible sources of income." The remaining amount becomes your actual disability benefit. The money subtracted comes from the following: • Workers' compensation, occupational disease or any other law with the same purpose • State benefit law, other group insurance plans or government retirement systems offered through your employer(s), such as a pension plan • Amounts you, your spouse or children receive (or are entitled to receive) for your disability or retirement under the Social Security Act, Railroad Retirement Act, Canada Pension Plan, Quebec Pension Plan or any similar plan or act (or benefits paid under any similar act) • Any eligible amounts you receive under company retirement plans (other than the S&RP) • Any amount you receive, due to your disability, from a third party by judgment, settlement or otherwise If your disability begins after age 65, any Social Security retirement benefits you already are receiving will not be subtracted from your LTD benefit. With the exception of retirement payments, the insurance company will subtract only other sources of income which are payable as a result of the same disability.
Developmental Care	Services or supplies that the Plan Administrator decides are developmental, meaning provided for someone who cannot take care of themselves the way they should considering their age (including intellectual, physical, language, learning, mobility, self-direction, independent living or financial self-sufficiency). Developmental care services help educate people rather than rehabilitate them.
Disability	You are considered disabled if you: • are unable to perform the primary duties of your regular job and • have a 20 percent or more loss in weekly earnings due to your disability. You may be required to be examined by doctors or vocational experts; if so, the insurance company will pay for these exams. After 24 months you'll be considered disabled if: • you are unable to perform any gainful occupation for which you are reasonably well-matched by education, training or experience or • you are working but still have a 20 percent loss in pay because you are sick or injured. The insurance company can require you to have an independent medical exam at its own expense or to be interviewed by an authorized insurance company representative.
Disability Earnings	The earnings which you receive while you are disabled and working, plus the earnings you could receive if you were working to the greatest extent possible. This would be, based on your restrictions and limitation: • during the first 24 months of disability payments, the greatest extent of work you are able to do in your regular occupation, that is reasonably available • beyond 24 months of disability payment, the greatest extent of work you are able to do in any occupation that is reasonably available, for which you are reasonably fitted by

	education, training and experience.
Doctor	A person (other than you or your immediate family members) performing tasks within the limits of his or her medical license. Doctors are licensed to practice medicine, prescribe and administer drugs or perform surgery. Specifically, these licensed practitioners may include the following: • Doctor of medicine (MD), osteopathy (DO), podiatry (DPM) or chiropractic (DC) • Licensed doctoral clinical psychologist • Master's level counselor and licensed or certified social worker who is acting under the supervision of a doctor of medicine or a licensed doctoral clinical psychologist • Licensed physician's assistant (PA) if billed by a doctor • As required by law, any other licensed practitioner acting within the scope of his or her license and • performing a service that would be covered by the plan if performed by an MD • The fact that the company describes a practitioner as a doctor does not mean that benefits for services from that provider are available under the plan.
Domestic Partner	An unmarried person of the same sex with whom you live in a committed relationship. You may enroll your domestic partner for medical, dental and vision coverage if he or she meets all of the criteria listed under Domestic Partner Coverage. ***Note:*** *The plan will recognize same gender marriages by certain states.*
Durable Medical Equipment	Medical equipment that: • can withstand repeated use, • is not disposable, • is used to serve a medical purpose for treatment of a sickness, injury or the patient's • symptoms and • is appropriate for use in the home.
Earnings for Disability Payments	Earnings are defined as annual base salary as determined at the time of the most recent quarterly update before the disability occurred, plus declared tips and tokes and commissions (if any) for the previous four consecutive fiscal quarters prior to the most recent quarterly update.
Eligible Expenses	The amount the plan will pay for covered health services as long as the service was done while the plan is in effect. Depending on whether you get care from an in-network or out-of-network provider, eligible expenses are based on the following: • For in-network care: Eligible expenses are the provider's contracted fee(s). • For out-of-network care: Unless you receive emergency services, eligible expenses are determined by the Claims Administrators based on the lesser of: (1) the provider's normal charge for a similar service or supply, or (2) a policyholder-selected percentile of charged made by providers of such a service or supply in the geographic area where it is received as compiled in a database selected by the Claims Administrator. The percentile used to determine the Maximum Reimbursable Charge is the 80th percentile. • Eligible expenses are determined solely in accordance with the Claims Administrator's

	reimbursement policy guidelines. The reimbursement policy guidelines are developed, in the Claim Administrator's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies: • As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association. • As reported by generally recognized professionals or publications. • As used for Medicare. As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the Claims Administrator accepts.
Elimination Period	This is the period of continuous disability which must be satisfied before you are eligible to receive benefits. For the STD plan, the time period stars with the first day of disability and continues through the 14th day of disability, for which no benefits are provided. A participant may use paid time off for this time frame.
Emergency	A serious medical condition or symptom that comes from an injury, sickness or mental illness which happens suddenly and, in the judgment of a reasonable person, requires immediate care and treatment (generally within 24 hours of the start of the emergency) to avoid hazards to life or health.
Emergency Services	Medical, psychiatric, surgical, Hospital and related health care services and testing, including ambulance service, required to treat a sudden, unexpected onset of a bodily injury or serious sickness which could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts and broken bones. The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the Hospital, or the final diagnosis — whichever reasonably indicated an emergency medical condition — will be the basis for the determination of coverage, provided such symptoms reasonably indicate an emergency.
Employee	A person who is actively employed with Caesars Entertainment Corporation
Evidence of Insurability (EOI)	A statement of your medical history that the insurance company will use to determine if you are approved for coverage. This is usually a health questionnaire you complete and submit to the insurance carrier. A physical exam may be required at your own expense. Evidence of Insurability must be approved by the insurance company before the elected coverage becomes effective. Refer to the life insurance and disability sections of this booklet for information on when evidence of insurability is required.
Exempt	Generally, a salaried employee who is not allowed to earn overtime pay under the requirements of the Fair Labor Standards Act.
Expense Incurred	An expense is incurred when the service or the supply for which it is incurred is provided.
Experimental or Investigational Drug, Device, Treatment or Procedure	A drug, device, treatment or procedure that: • does not have required FDA (Federal Drug Administration) approval; • must be approved by the treating facility's Institutional Review Board; • is used with a patient informed consent document reviewed and approved by the

	treating facility's Institutional Review Board; • is shown by reliable evidence to be the subject of ongoing phase I, II or III clinical trials or is under study to determine maximum dose, toxicity, safety or efficacy as compared with a standard treatment or diagnosis; or • is shown by reliable evidence as needing further studies or clinical trials. • "Reliable evidence" means published reports and articles in the authoritative medical literature, written protocols by treating facilities studying the drug, device, treatment or procedure, or written informed consent of a facility studying substantially the same drug, device, treatment or procedure.
Flexible Spending Account (FSA)	An account where you set aside money on a pre-tax basis to pay for eligible health care or dependent day care expenses.
Free-Standing Surgical Facility	An institution that meets all of the following requirements: • it has a medical staff of Physicians, Nurses, and licensed anesthesiologists; • it maintains at least two operating rooms and one recovery room; • it maintains diagnostic laboratory and X-ray facilities; • it has equipment for emergency care; • it has a blood supply; • it maintains medical records; • it has agreements with Hospitals for immediate acceptance of patients who need Hospital • Confinement on an inpatient basis; and • it is licensed in accordance with the laws of the appropriate legally authorized agency
Full-Time	Employees working at least 30 hours a week. Your supervisor or general manager sets your classification as full-time or part-time. The company has the authority to decide whether any employee is working at least 30 hours a week and will determine which hours are counted. Time taken for jury duty, funeral leave or other time specifically allowed by company policy will be counted as full-time service for LTD plan purposes.
Full-Time Student	A child who physically attends an accredited school, including home school, for the number of credited hours or courses required by the school for full-time status. School vacation, including the period immediately after graduation, until the start of the next semester, will be included. Beginning at age 19, a full-time student is defined as an unmarried child under the age of 24 who is: • a registered student, • attending school on a regular, full-time basis (receiving 12 or more credits), • principally dependent on you for care and support and • not employed on a regular, full-time basis. Acceptable schools include the following: • High schools • Colleges and universities • Technical schools • Trade schools

	• Professional schools • Schools in foreign countries • Remedial education schools A student who drops out of school will immediately lose eligibility on the event date for the dental and vision plans and any dependent life insurance.
Gainful Occupation	Any job, including self-employment that is or can be expected to provide you with pay equal to at least the LTD benefit percentage of your "indexed monthly earnings" (see definition below) within 12 months of your return to work. Your LTD benefit percentage is based on the LTD plan you are enrolled in.
Generic Drug	Lower-cost alternative to a brand name drug that has the same active ingredients and works the same way.
Health Reimbursement Account (HRA)	Benefit dollars provided each year by Caesars to pay for eligible medical and pharmacy expenses.
Hospice Care Program	The term Hospice Care Program means: • a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families; • a program that provides palliative and supportive medical, nursing, and other health services through home or inpatient care during the illness; • a program for persons who have a Terminal Illness and for the families of those persons.
Hospice Care Services	Any services provided by (a) a Hospital, (b) a Skilled Nursing Facility or a similar institution, (c) a Home Health Care Agency, (d) a Hospice Facility or (e) any other licensed facility or agency under a Hospice Care Program.
Hospice Facility	An institution or part of it that primarily provides care for Terminally Ill patients, is accredited by the National Hospice Organization, meets standards established by Cigna, and fulfills any licensing requirements of the state or locality in which it operates
Hospital	The term Hospital means: • an institution licensed as a hospital that (a) maintains, on the premises, all facilities necessary for medical and surgical treatment; (b) provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and (c) provides 24-hour service by Registered Graduate Nurses; • an institution that qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or • an institution that (a) specializes in treatment of Mental Health and Substance Abuse or other related illness; (b) provides residential treatment programs; and (c) is licensed in accordance with the laws of the appropriate legally authorized agency. The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.
Hospital Confinement or	A person will be considered Confined in a Hospital if he is:

Confined in a Hospital	• a registered bed patient in a Hospital upon the recommendation of a Physician; • receiving treatment for Mental Health and Substance Abuse Services in a Partial Hospitalization program; • receiving treatment for Mental Health and Substance Abuse Services in a Mental Health or Substance Abuse Residential Treatment Center.
Illness	Any disorder of your body or mind (but not an injury), including pregnancy, abortion, miscarriage or childbirth.
In-Network	A provider that has agreed to accept contracted rates for service.
Injury	Under the STD plan, any non-work related injury to your body that happened directly from an accident and not related to another cause. The injury must occur and disability must begin while you are covered under this plan. Under LTD, a work-related injury is not excluded; Accidental bodily injury.
Maintenance Treatment	Treatment rendered to keep or maintain the patient's current status.
Material and Substantial Duties	Duties that are normally required for the performance of your regular occupation and cannot be omitted or modified, except that is you are required to work on average in excess of 40 hours per week, Cigna will consider you able to perform that requirement if you are working or have the capacity to work 40 hours per week.
Maximum Reimbursable Charge	The lesser of: • the provider's normal charge for a similar service or supply; or • the policyholder-selected percentile of all charges made by providers of such service or supply in the geographic area where it is received. To determine if a charge exceeds the Maximum Reimbursable Charge, the nature and severity of the Injury or Sickness may be considered. Cigna uses the Ingenix Prevailing Health Care System database to determine the charges made by providers in an area. The database is updated semiannually. For this plan, the Maximum Reimbursable Charge is calculated at the 80th percentile of all charges made by providers in the geographic area. Additional information about the Maximum Reimbursable Charge is available upon request. Effective 09/01/2012, The Maximum Reimbursable Charge for covered services is determined based on the lesser of: • the provider's normal charge for a similar service or supply; or • a policyholder-selected percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by CG. The percentile used to determine the Maximum Reimbursable Charge is listed in The Schedule. The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by CG. Additional information about how CG determines the Maximum Reimbursable Charge is available upon request.
Medicaid	A state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

Medically Necessary/Medical Necessity	Medically Necessary Covered Services and Supplies are those determined by the Medical Director to be: • required to diagnose or treat an illness, injury, disease or its symptoms; • in accordance with generally accepted standards of medical practice; • clinically appropriate in terms of type, frequency, extent, site and duration; • not primarily for the convenience of the patient, Physician or other health care provider; and • rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the Medical Director may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.
Medicare	A state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended
Mental Illness	Psychiatric or psychological condition such as schizophrenia, depression, manic-depressive or bipolar illness, anxiety, somatization, substance-related disorders (including drug and alcohol abuse) and/or adjustment disorders. A mental health provider or other qualified provider using psychotherapy, psychotropic drugs or other similar methods of treatment usually treats those conditions.
Necessary Services and Supplies	The term Necessary Services and Supplies includes: • any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement; • any charges, by whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided; and • any charges, by whomever made, for the administration of anesthetics during Hospital Confinement. The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.
Network	When used to describe a provider of health care services, this means a provider that has an agreement with the Claims Administrator or affiliate to provide covered health services to members. A provider can choose to stop participating in the network or apply to join the network at any time.
Non-exempt	Generally, hourly employees who are allowed to receive overtime pay under the Fair Labor Standards Act (FLSA).
Nurse	A Registered Graduate Nurse, a Licensed Practical Nurse, or a Licensed Vocational Nurse who has the right to use the abbreviation “R.N.,” “L.P.N.” or “L.V.N.”
Office	A location where a doctor, as defined above, primarily performs covered medical services that are provided by scheduling an appointment. Typically, the doctor’s office is the only location of the doctor’s private practice or a group of clinics. A “doctor’s office” may be an urgent care facility if: • the doctor practices only out of the urgent care facility or • the care is received through a scheduled appointment and does not qualify as “urgent

	care" as defined by the plan. Emergency rooms, hospitals or freestanding surgical centers are not considered "doctors' offices."
Other Health Care Facility	A facility other than a Hospital or Hospice Facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation Hospitals and sub-acute facilities.
Other Health Professional	An individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies. Other Health Professionals include, but are not limited to, physical therapists, registered nurses and licensed practical nurses.
Out-of-Network	A provider that has chosen not to participate in a particular network.
Out-of-Pocket Maximum	The most you will pay for covered medical and pharmacy expenses in a year, equal to your deductible plus your employee share amount. Once you reach this amount, Caesars pays 100% of these expenses for the remainder of the year.
Participating Provider	A hospital, a Physician, or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Cigna to provide covered services with regard to a particular plan under which the participant is covered.
Physician	A licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is operating within the scope of his license and performing a service for which benefits are provided under this plan when performed by a Physician.
Preventive Treatment	Treatment rendered to prevent disease or its recurrence.
Psychologist	A person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is operating within the scope of his license and performing a service for which benefits are provided under this plan when performed by a Psychologist.
Qualified Medical Child Support Order (QMCSO)	A judgment, decree or order resulting from a divorce, separation, annulment or custody change that requires your dependent child (including a foster child who is your tax dependent) to be covered for medical, dental or vision coverage.
Qualified Life-Style Change	A life event that would allow you, under Internal Revenue Service rules, to make certain changes to your benefit coverage outside of the annual enrollment period. For a list of qualified lifestyle changes, see Making Changes to Your Elections.
Qualified Medical Practitioner	A licensed doctor or other person (other than you or an immediate family member) qualified by law and who the insurance company approves to treat your condition.
Reasonable and Customary Charge	The maximum amount that MetLife will pay for a particular out-of-network service under the dental plan. These limits are based on what other dental providers in your geographic area charge for the service or supply.

Recurring Disability	Disability caused by a worsening in your condition and due to the same cause(s) as your prior disability for which you received a disability payment.
Regular Occupation (Job)	The job you are routinely performing when your disability begins. Cigna will look at your occupation as it is normally performed instead of how the work tasks are performed for a specific employer or at a specific location.
Rehabilitation Program	This is a program designed to assist you to return to work. The program may include, but is not limited to, the following services: • coordination with your employer to assist you to return to work; • evaluation of adaptive equipment to allow you to work; • vocational evaluation to determine how your disability may impact your employment options; • job placement services; • resume preparation; • job seeking skills training; • retraining for a new occupation; or • assistance with relocation that may be part of an approved rehabilitation program.
Review Organization	The term Review Organization refers to an affiliate of Cigna or another entity to which Cigna has delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians which may include Physicians, Registered Graduate Nurses, licensed mental health and substance abuse professionals, and other trained staff members who perform utilization review services.
Sickness	Any disorder of your body or mind, but not an injury; includes pregnancy, abortion, miscarriage or childbirth. Disability must begin while you are covered under the plan; The term Sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness
Skilled Nursing Facility	A hospital or nursing facility that is licensed and operated as required by law; A licensed institution (other than a Hospital, as defined) which specializes in physical rehabilitation on an inpatient basis or skilled nursing and medical care on an inpatient basis — but only if that institution: (a) maintains on the premises all facilities necessary for medical treatment; (b) provides such treatment, for compensation, under the supervision of Physicians; and (c) provides Nurses' services.
Special Enrollee	An eligible employee or dependent who has declined medical coverage under this plan because it is provided under another plan, but later loses that coverage. Special enrollees also include employees who marry or acquire a new dependent, the new spouse and new dependents. Special enrollees are eligible to elect coverage under this plan if they lose the other coverage under certain circumstances, as described earlier in this booklet.
Stepchild	A child for whom you or your spouse is legally responsible (meaning a natural or adoptive parent of the child) or is the legal guardian (meaning the child lives with you and you have a verifying court order).
Terminal Condition	An injury or sickness which is expected to result in your death within 12 months and from

	which there is no reasonable chance of recovery.
Terminal Illness	A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.
Termination of Employment	The date you leave the company for any reason. Your employment is considered terminated when Paid Time Off (PTO) and any authorized leave of absence expires and you are not actively working. Termination can also occur if you fail to appear for work or are terminated for cause without notice.
Totally Disabled Child	A child who is physically or mentally incapable of self-support and qualifies as your dependent for federal income tax purposes. Proof of disability must be provided and approved by the medical Plan Administrator, Cigna
Unproved Services	Health services that, according to prevailing medical research, do not have a beneficial effect on health outcomes, and are not based on: • well-conducted randomized controlled trials; or • well-conducted cohort studies. In a randomized controlled trial, two or more treatments are compared to each other, and the patients are not allowed to choose which treatments they receive. In a cohort study, patients who receive study treatment are compared to a group of patients who receive standard therapy. In both cases, the comparison group must be nearly identical to the study treatment group. If you have a Sickness or Injury that is likely to cause death within one year of the request for treatment, Cigna and Caesars may, at their discretion, determine that an Unproven Service is a Covered Health Service for that Sickness or Injury. For this to take place, Cigna and Caesars must determine that the procedure or treatment is: • proved to be safe and promising • provided in a clinically controlled research setting; and • using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.
Urgent Care	Urgent Care is medical, surgical, Hospital or related health care services and testing which are not Emergency Services, but which are determined by Cigna, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that the insured should not travel due to any medical condition.

Administrative Information

Plan Name	Caesars Enterprise Services, LLC. Welfare Benefit Plan	
Cost of Plan	Shared by Caesars and employees	
Plan Number	502	
Employer Tax Identification Number	75-1941623	
Plan Effective Date	All plans: January 1, 2015	
Plan Year	Records maintained on a calendar year basis (January 1–December 31)	
Employer/Plan Sponsor	Caesars Enterprise Services, LLC One Caesars Palace Drive, Las Vegas, NV 89109-4312	
Plan Administrator	Caesars Enterprise Services, LLC One Caesars Palace Drive, Las Vegas, NV 89109-4312	
Funding (How Benefits Are Paid For)	**Medical, Dental, Vision and Short-term Disability:** Paid through contributions made by the company and employees. These plan benefits and other plan costs (such as administrative costs) are paid from the general assets of the company. **Life Insurance:** Paid through Aetna Insurance Company or Minnesota Life Insurance Company. Note for Florida participants: Single employer unfunded plans are not regulated by the Department of Insurance, and no guarantee of funds exists to cover claims that a bankrupt or otherwise insolvent employer or association cannot pay. **Long-Term Disability Plans:** Paid through a group insurance contract with Cigna. The company and any covered operating units pay the entire cost of the core plan, but the cost of supplemental LTD is shared by the employee and Caesars. Cigna pays any benefits payment due under the plan. The company and eligible operating units have no obligation to pay benefits under the plan. **Flexible Spending Accounts:** Paid fully through voluntary employee contributions.	
Claims Administrators and Insurers	Medical Cigna Health Care P.O. Box 42005 Phoenix, AZ 85020 www.mycigna.com Horizon Blue Cross Blue Shield of New Jersey P.O. Box 820 Newark, New Jersey 07101-0820 www.horizonblue.com Humana P.O. Box 14601 Lexington, KY 40512-4601	Life Insurance Aetna Life Insurance Company 151 Farmington Avenue Hartford, CT 06156 Aetna Insurance Company www.aetnalifeassentials.com Minnesota Life Insurance Company A Securian Company 400 Robert Street North A St. Paul, Minnesota 55101-2098 Flexible Spending Account and Health Savings Account Administration Bank of America

	www.myhumana.com Prescription Drug Express Scripts, Inc. PO Box 66583 St. Louis, MO 63166 1-866-578-5001 www.express-scripts.com Dental Metropolitan Life Insurance Company MetLife Dental Claims P.O. Box 981282 El Paso, TX 79998-1282 1-800-942-0854 www.metlife.com/mybenefits Vision EyeMed Vision Care ATTN: Managed Care Claims Dept P.O. Box 8504 Mason, OH 45040-7111 1-855-400-3639 www.eyemedvisioncare.com	PO Box 25165 Lehigh Valley, PA 18002-5165 bankofamerica.com/benefitslogin Employee Assistance Program Cigna Behavioral Health 1-888-886-2404 www.cignabehavioral.com COBRA Administration AON Consulting – COBRA Department Caesars Benefit Service Center P.O. Box 1407 Lincolnshire, IL 60069 1-866-236-3487 Short- and Long-Term Disability CIGNA Group Insurance Disability Management Solutions 2000 Park Lane Drive North Fayette, PA 15275 Phone: 800.238.2125 www.mycigna.com
Agent for Services of Legal Process	Secretary Caesars Enterprise Services, LLC One Caesars Palace Drive Las Vegas, NV 89109 Legal process can also be served on the Plan Administrator.	
Participating Employers	• Bally's Atlantic City • Bally's Las Vegas • Bluegrass Downs • Caesars Atlantic City • Caesars Enterprise Services, LLC • Caesars Linq • Caesars Palace • Cascata Golf • Chariot Run Golf Course • Flamingo Las Vegas • Grand Bear Golf Course • Harrah's Ak-Chin • Harrah's Atlantic City • Harrah's Cherokee • Harrah's Council Bluffs • Harrah's Gulf Coast • Harrah's Iowa Arena • Harrah's Joliet • Harrah's Lake Tahoe • Harrah's Las Vegas • Harrah's Laughlin • Harrah's Louisiana Downs • Harrah's Metropolis • Harrah's New Orleans	

	• Harrah's North Kansas City • Harrah's Philadelphia • Harrah's Poydras Hotel • Harrah's Reno • Harrah's Rincon • Harveys Resort & Casino • Horseshoe Baltimore • Horseshoe Bossier City • Horseshoe Cincinnati • Horseshoe Cleveland • Horseshoe Council Bluffs • Horseshoe Hammond • Horseshoe Southern Indiana • Horseshoe Tunica • Paris Las Vegas • Planet Hollywood • Rio All Suite Hotel & Casino • Rio Secco Golf Course • Sequoyah National Golf Club • The Cromwell • The Links At Cottonwoods Golf Course • The Quad Resort & Casino • Thistle Down • Tunica Roadhouse • Turfway Park

Choosing Wellness

BE AT YOUR BEST

The purpose of this booklet is to provide only a summary of Caesars' benefit plans. Complete details are in the formal plan document or group insurance contract that legally governs the operation of the plans. If, in our efforts to make the plans easy to understand, there is a conflict between information in this booklet and the plan documents and/or contracts, the plan documents and/or contracts will govern. For the purposes of this booklet, the term "plan documents" means the Caesars Enterprise Services LLC, Welfare Benefit Plan and the Caesars Enterprise Services, LLC Cafeteria Plan. In the event of an inconsistency between this booklet and the terms of the plan documents for the Flexible Spending Accounts, the provisions of the Caesars Enterprise Services, LLC Cafeteria Plan shall control. For all other inconsistencies, the provisions of the Caesars Enterprise Services, LLC Welfare Benefit Plan shall control.

Although Caesars expects to continue the benefit plans, Caesars Enterprise Services, LLC ("the company") has the right to change benefit insurance carriers or change, amend or discontinue all or part of the plans at any time for any reason, and has the right to make final decisions about the plan provisions and rules and correct any errors, including any in this booklet. Any amendment to the plans may be affected by the Company. If the plans are changed, any claims made before the amendment date are paid based on the plan provisions in effect before the change. Any claims made on or after the date of the change are paid based on the new plan provisions.

Please note that your eligibility for benefits does not guarantee continued employment at Caesars or any of its entities.