Hard Rock HOTEL & CASINO

LAS VEGAS

2016 TEAM MEMBER BENEFIT GUIDE

HARD ROCK HOTEL & CASINO LAS VEGAS

Introduction

Hard Rock Hotel & Casino offers a competitive benefits package, including a variety of programs you can choose from to meet your needs and those of your family. Your Guide to Benefits is an overview of the benefit plans and programs Hard Rock Hotel & Casino offers to eligible Team Members.

We know that making benefit choices can be a bit overwhelming. Please read this guide carefully to help you make the right choices for you and your family. Then keep this guide for future reference when you have questions about your benefits or want to make changes.

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Benefits highlighted in this guide are governed by Hard Rock Hotel & Casino plan contracts and policies, applicable state and federal law and company policy. If there is a conflict between the wording of this guide and the group policies and contracts, the policies, contracts and applicable laws govern. Hard Rock Hotel & Casino reserves the right to alter, amend or terminate any of the benefits described in this guide at any time.

Eligibility

TEAM MEMBERS

You are eligible to participate if you are:

- A Full Time Hourly or Salaried Team Member scheduled to work at least 30 hours per week.

WHEN COVERAGE BEGINS

If you are a new Team Member, you must elect benefits within your eligibility period. The elections you make for yourself and eligible dependents are effective on the first of the month following the waiting period.

Coverage Waiting Periods	
Full Time Hourly	60 days following your Date of Hire
Salaried	First of the month following your Date of Hire

FAMILY MEMBERS

If you are an eligible Team Member, you may enroll the following dependents:

- Legally married spouse
- Registered domestic partner
- Children up to age 26 (natural children, stepchildren, legally adopted children, children for whom you are the legal guardian, foster children, children for whom you are legally responsible to provide health coverage under a Qualified Medical Child Support Order (QMSCO))
- Disabled children over age 26 if unmarried, incapable of self-support, dependent on you for primary support and the disability occurred before the age of 26

Please note: Hard Rock Hotel & Casino will comply with The Affordable Care Act (ACA) requirements for Team Members who are not classified as Full Time Hourly or Salaried, but meet the ACA eligibility requirements.

IF YOU COVER A DEPENDENT

To control health care costs and meet health plan contract obligations, Hard Rock Hotel & Casino performs periodic reviews to verify family members' eligibility for enrollment in the benefit plans. Hard Rock Hotel & Casino and the insurance carriers reserve the right to request documentation (for example: marriage certificates, birth certificates, and Certificates of Domestic Partnership issued by a government entity) to verify eligibility.

SPOUSAL SURCHARGE

If you are electing medical coverage for your working spouse and he/she is eligible for coverage through their employer, you will be assessed a $150/month Spousal Surcharge. The surcharge may be waived, if you submit an annual certification to Human Resources upon enrollment.

MAKING CHANGES TO YOUR BENEFITS

Every year you will have an opportunity to make changes to your benefits and covered dependents during Open Enrollment. When it is not Open Enrollment, you must have a qualifying event that satisfies federal regulations.

Examples of Qualifying Events

If one of the following qualifying events below occurs, you may make adjustments to your benefits that are consistent with the event.

- Marriage, legal separation or divorce
- Birth or adoption of a child
- Change in eligibility of a child
- Death of a dependent family member
- Change in your or your spouse's/registered domestic partner's employment status
- Your spouse or registered domestic partner reaches age 65 and is covered by Medicare
- FMLA special requirements
- HIPAA special enrollment rights
- Increase or reduction of hours that changes employment status
- Transfer to or from benefits-eligible position
- Transfer to or from non-benefits eligible position

Remember: You must report any Qualifying Events to Human Resources within 31 days of the Event.

Life Assistance Program

Just when you think you have it figured out, along comes a challenge. But whether those challenges are big or small, your Life Assistance & Work/Life Support Program is available to help you and your family find a solution and restore your peace of mind.

CALL ANY TIME, ANY DAY

A Cigna advocate is just a phone call away whenever you need them — at no cost to you. An advocate is ready to help assess your needs and develop a solution to help resolve your concerns. He or she can also direct you to an array of resources in your community and online tools.

VISIT A SPECIALIST

For face-to-face assistance, you have three sessions available to you and your household members. Call Cigna at 800-538-3543 to request a referral.

REWARD YOURSELF

Visit **www.CignaBehavioral.com/CGI** to access your Healthy Rewards®[1] amenities program for discounts on a range of health and wellness services and products from participating providers. Click on the Healthy Rewards link to access discount information.

ACHIEVE WORK/LIFE BALANCE

Get extra support for handling life's demands. Call for a referral to a service in your community or advice on topics such as:

- **Legal consultation.** Receive a 30-minute free consultation and up to a 25% discount on select fees.
- **Parenting.** Receive guidance on child development, sibling rivalry, separation anxiety and much more.
- **Senior care.** Learn about challenges and solutions associated with caring for an aging loved one.
- **Child care.** Whether you need care all day or just after school, find a place that's right for your family.
- **Pet care.** From grooming to boarding to veterinary services, find what you need to care for your pet.
- **Temporary back-up care.** Don't let an unplanned event get the best of you – find back-up child care.

1. Some Healthy Rewards programs are not available in all states. If your Cigna plan includes coverage for any of these services, this program is in addition to, not instead of, your plan benefits. A discount program is NOT insurance, and you must pay the entire discounted charge.

Medical

Hard Rock Hotel & Casino continues to invest in a quality medical plan, wellness and preventive care, which include providing you with a variety of resources to support your health and 100% coverage for routine check-ups and preventive services received in-network. To help you understand the features and coverage available to you, we've provided the following brief summary of benefits. Please refer to plan documents for details, including important coverage exclusions and limitations. If there are any discrepancies between this benefits summary and plan documents, the plan documents will govern.

Anthem Blue Cross and Blue Shield Medical Plans									
	Blue Secure PPO (Low Plan)		Anthem Choice PPO (Middle Plan)			Blue Preferred PPO (High Plan)		Lumenos HSA (Base HSA)	
	In-Network	Out-of-Network	In-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Network	Pathway		Pathway	PPO or National Blue Card PPO		PPO or National Blue Card PPO		PPO or National Blue Card PPO	
Deductible	You pay if applicable		You pay if applicable			You pay if applicable		You Pay	
Individual	$3,000	$6,000	$500	$1,500	$3,000	$0	$1,000	$3,000	$3,000
Family	$6,000	$12,000	$1,000	$3,000	$6,000	$0	$3,000	$6,000	$6,000
Out-of-Pocket Maximum									
Individual	$4,000	$8,000	$4,500		$9,000	$3,000	$7,000	$3,000	$6,000
Family	$8,000	$16,000	$9,000		$18,000	$6,000	$15,000	$6,000	$12,000
Lifetime Maximum	Unlimited		Unlimited			Unlimited			
Coinsurance / Copays									
Preventive Care	$0	40%**	$0	$0	50%**	$0	45%**	$0	30%**
Primary Care Physician	$30 copay	40%**	$15 copay	$45 copay	50%**	$15 copay	45%**	$0*	30%**
Specialist	$60 copay	40%**	$30 copay	$90 copay	50%**	$30 copay	45%**	$0*	30%**
Diagnostics X-Ray and Lab	10%*	40%**	10%*	30%*	50%**	15%	45%**	$0*	30%**
Urgent Care	$60 copay	40%**	$30 copay	$90 copay	50%**	$30 copay	45%**	$0*	30%**
Emergency Room	$150 copay + 10%		10% after deductible			$125 copay + 15%		$0*	30%**
Inpatient Hospital Care	10%*	40%**	10%*	30%*	50%**	$500 copay + 15%	$1,500 copay + 45%**	$0*	30%**
Outpatient Surgery	10%*	40%**	10%*	30%*	50%**	$500 copay + 15%	$1,500 copay + 45%**	$0*	30%**
Teledoc	$30 copay	In-Network Only**	$15 copay	$15 copay	In-Network Only**	$15 copay	In-Network Only**	$0*	In-Network Only**
Pharmacy									
Retail Rx – Up to 30-day supply									
Generic	$15	40%**	$15	$15	50%**	$15	45%**	$0*	30%**
Formulary Brand	$40		$40	$40		$40		$0*	30%**
Non-formulary Brand	$60		$60	$60		$60		$0*	30%**
Self-Injectable	30%		30%	30%		30%		$0*	30%**
Mail Order Rx – Up to 90-day supply									
Generic	$15	40%**	$37.50	$37.50	50%**	$15	45%**	$0*	30%**
Formulary Brand	$80		$100	$100		$80		$0*	30%**
Non-formulary Brand	$120		$150	$150		$120		$0*	30%**

* After deductible

** After deductible of the Reasonable and Customary Fee.

Lumenos HSA

Hard Rock Hotel & Casino offers the Lumenos HDHP (High Deductible Health Plan). When coupled with a Health Savings Account (HSA), it's an innovative health plan that gives you greater choice, flexibility and control over how you spend your health care dollars.

HEALTH PLAN

- The Lumenos HDHP offers 100 percent coverage for in-network preventive and wellness care.
- After satisfying a $3,000 individual, in-network deductible, Team Members will receive 100% coverage (in-network) for the remainder of the plan year.
- All qualified Team Member-paid medical expenses count toward the deductible and out-of-pocket maximum.

UNDERSTANDING THE HSA

When you enroll in the Lumenos HDHP plan, you're eligible to open an HSA. An HSA is a personal savings account, funded by you, that you can use to pay qualified out-of-pocket medical expenses with pre-tax dollars.

WHEN ARE YOU ELIGIBLE TO OPEN AN HSA?

You are eligible to open and fund an HSA if you:

- Are enrolled in the Lumenos HDHP plan.
- Are not covered by other non-qualified high deductible health plans, such as your spouse's non-qualified high deductible health plan or Health Care Flexible Spending.
- Are not eligible to be claimed as a dependent on someone else's tax return.
- Are not enrolled in Medicare or TRICARE.
- Have not received Veterans Administration benefits.

You can use the money in your HSA to pay for qualified medical expenses now or in the future. Your HSA can be used for your expenses and those of your spouse and dependents, even if they are not covered by the HDHP.

YOUR HSA HIGHLIGHTS

- You may contribute to the account through pre-tax payroll deductions. Your total HSA contributions cannot exceed the IRS maximums of $3,350 for an individual and $6,750 for a family for the 2016 calendar year.
- Funds withdrawn from your HSA to pay qualified medical expenses are tax-free.
- Your HSA balance grows with tax-free interest. (Investment opportunities are available that will also grow tax-free.)
- Any unused funds in your HSA roll over from year to year.
- Your HSA is portable. If you leave Hard Rock Hotel & Casino or retire, you take the account and its balance with you.

OPENING AN HSA

Once you enroll in the Lumenos HDHP medical plan, your HSA account will automatically be opened with Health Equity. Your personal information will be provided to Health Equity through your medical plan election on the Plan Source website. Like any other bank account, your HSA account will need to go through the USA Patriot Act before it can be activated. Please note, Health Equity may contact you to verify some of your personal information in order to complete the account set-up. Once the account is set up, you will receive a welcome kit with specific details on activating your account and debit card.

PAYROLL CONTRIBUTIONS

For convenience and tax-savings, you may request that automatic, pre-tax payroll contributions be made to your HSA. The annual amount you choose to contribute is deducted in equal amounts from each paycheck throughout the year. After-tax contributions may also be made to your HSA at any time by check or electronically. If you choose to make after-tax contributions rather than tax-free contributions through payroll deductions, you can deduct those contributions on your tax return at the end of the year.

MAXIMUM CONTRIBUTIONS

Your contributions to your HSA, may not exceed the annual maximum amount established by the Internal Revenue Service.

The annual contribution maximum is based on the coverage option you elect.

2016 IRS Maximum Annual Contributions	
Individual	$3,350
Family (filing jointly)	$6,750

Team Members age 55 and older may contribute an additional $1,000 as a catch-up contribution.

Dental

Hard Rock Hotel & Casino offers Team Members and their families high-quality dental health care. With a range of covered services, the dental plan helps you save money and manage your health. To help you understand the features and coverage available to you, we've provided the following brief summary of benefits. Please refer to plan documents for details, including important coverage exclusions and limitations. If there are any discrepancies between this benefits summary and plan documents, the plan documents will govern.

	UnitedHealthcare Dental			
	Dental HMO Plan	Dental INO Plan	Dental PPO Plan	
	IN-NETWORK (ONLY)	IN-NETWORK (ONLY)	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible				
Individual Family	$0 $0	$25 $75	$25 $75	$50 $150
Calendar Year Maximum Benefit				
	Unlimited	$3,500	$1,500	
Dental Benefits				
Preventive Care (Cleanings, Oral Examinations, Fluoride Treatments, etc.)	(See schedule of benefits)	100%*	100%	80%*
Basic Care (Fillings, Simple Extractions, Root Canals, etc.)	(See schedule of benefits)	80%*	100%	80%*
Major Care (Crowns, Inlays, Bridges, etc.)	(See schedule of benefits)	50%*	80%	50%*
Orthodontia				
Coverage Adult and Child	Yes	Yes	Yes	
Benefit	$3,050	50%*	50%	50%*
Lifetime Maximum	Unlimited	$1,500	$1,500	

*After deductible

**After deductible of the Reasonable and Customary Fee.

Dental coverage is bundled with Vision.

Vision

The Hard Rock Hotel & Casino vision plan is offered to you through EyeMed Vision Care. When you use one of the providers in their extensive network, you receive a higher level of coverage and you are only required to pay a copayment at the time of service. With an out-of-network provider, you must pay the bill in full and file a claim for reimbursement of covered benefits up to the allowance shown. For a list of providers, visit **www.eyemed.com** or call member services at 866-723-0514. Below is a brief summary of benefits. Please refer to plan documents for details, including important coverage exclusions and limitations. If there are any discrepancies between this benefits summary and plan documents, the plan documents will govern.

	EyeMed Vision Care	
	IN-NETWORK	OUT-OF-NETWORK
Costs		
Exam Materials	$10 $25	Up to $21 Allowance Up to $7 Allowance
Benefit Frequency		
Exams **Lenses** **Frames** **Contacts**	Once per 12 months Once per 12 months Once per 24 months Once per 12 months	
Lenses		
Single Lenses	100%	Up to $7 Allowance
Bifocals	100%	Up to $21 Allowance
Trifocals	100%	Up to $46 Allowance
Frames		
	$100 Allowance plus 20% discount	Up to $50 Allowance
Contacts		
Medically Necessary	100%	Up to $200 Allowance
Elective	$115 Allowance plus 15% discount	Up to $92 Allowance

Vision coverage is bundled with Dental.

Disability

An unexpected injury or illness that keeps you out of work for a long time can use up your savings rapidly. Disability insurance can help replace lost wages and can be an important part of personal financial planning. Important: Disability benefits are reduced by other income you receive (e.g., Social Security, state disability benefits, pension benefits and Workers' Compensation).

These benefits are provided through Cigna. Hourly Team Members have the option to purchase voluntary short term and long term disability insurance through payroll deductions. Salaried Team Members are provided with company paid short term and long term disability income benefits.

SHORT TERM DISABILITY

Short term disability (STD) coverage is designed to replace a portion of your earnings if you are unable to work due to a non-work related short term illness or injury.

LONG TERM DISABILITY

Long term disability (LTD) insurance provides financial protection should you experience a serious illness or injury that prevents you from working for an extended time.

	Hourly Team Members		Salaried Team Members	
	Short Term Disability	**Long Term Disability**	**Short Term Disability**	**Long Term Disability**
Benefits Begin	1st day for an injury 15th day for an illness	181st consecutive day of disability	8th day for an injury or an illness	181st consecutive day of disability
Benefits Payable	Up to 26 weeks	Up to 2 years	Up to 26 weeks	Up to Social Security Normal Retirement Age (65 to 67)
Income Replaced	60% of weekly income up to a maximum of $1,385	60% of income up to a maximum benefit of $10,000 per month	66.7% of income up to a maximum benefit of $1,700 per week	66.7% of income up to a maximum benefit of $10,000 per month

Please review the STD and LTD policies for complete information on coverage and exclusions.

Please note: STD and LTD are based on your previous year's W2 Earnings. HRH uploads your W2 Earnings annually and your payroll deductions may change as a result of this update.

Survivor Benefits

BASIC LIFE AND AD&D

Your life and AD&D insurance benefits are some of the most valuable benefits available to you. They are often referred to as "survivor" benefits because they provide financial security to your loved ones if you die or are severely injured in an accident. This benefit is employer paid and provided through Cigna.

If your death or injury is accidental, you or your beneficiaries may be entitled to Accidental Death and Dismemberment (AD&D) benefits. If an accident causes you to lose a limb or partial sight or hearing, a portion of the benefit amount will be paid.

	Hourly Team Members		Salaried Team Members	
	Basic Life	Basic AD&D	Basic Life	Basic AD&D
Who pays?	Hard Rock Hotel & Casino pays.		Hard Rock Hotel & Casino pays.	
Coverage Amount	1 ½ x your annual pay	1 ½ x your annual pay	1 ½ x your annual pay	1 ½ x your annual pay
Maximum Benefit	Up to $500,000	Up to $500,000	Up to $500,000	Up to $500,000

After normal retirement age, the benefit amount will be reduced. Please see the Cigna Benefit Summary for reduction schedule.

Beneficiary Information

To ensure your family's financial security, keep your beneficiary information up-to-date and on file with Human Resources.

VOLUNTARY LIFE AND AD&D

For additional protection, voluntary life and AD&D insurance is available. This voluntary benefit is paid by the Team Member, and is provided through Cigna. Coverage amounts are available as follows:

- **Team Member:** Available to a maximum of 5x the Team Member's basic annual earnings, or $500,000 (rounded to the nearest $10,000), whichever is lesser
- **Spouse:** Available to a maximum of the Team Member's elected coverage, or $25,000 (rounded to the nearest $5,000), whichever is lesser
- **Child:** Available to a maximum of the Team Member's elected coverage, or $10,000 (rounded to the nearest $2,000), whichever is lesser

Evidence of Insurability

If you do not elect voluntary life and AD&D insurance for yourself, your spouse or your child(ren) when you are first eligible, and wish to elect coverage during a subsequent open enrollment, you and/or your dependents will be considered "late entrants" and subject to the insurance company's evidence of insurability requirements before coverage is approved.

Other Benefits

Hard Rock Hotel & Casino Team Members have the option of purchasing valuable voluntary benefits to cover you and your family in the case of accidental injury and critical illness. The plans are supplemental to your regular health insurance plans and can provide cash benefits to help cover expenses that normal insurance does not. These insurance policies are offered through Transamerica Life Insurance Company.

HOSPITAL INDEMNITY - NEW!

This policy pays a specified amount for each day a covered person is confined to the hospital. Benefit payments go straight to the Team Member unless they are assigned to health care providers.

CRITICAL ILLNESS

A critical illness insurance policy pays a lump sum benefit equal to the amount you choose multiplied by the applicable percentage shown in the Schedule of Benefits upon the occurrence of a covered critical illness within each category. If the benefit payment is less than 100% of the selected benefit amount, the policy pays another lump sum benefit amount upon the diagnosis of a different type of critical illness within the same category up to the limit per category. There is a lifetime maximum of three times the benefit amount you choose. Benefits are also available for your spouse and eligible children. Their benefit amount will be 50% of your elected benefit.

The critical illness policy helps pay the costs associated with the initial occurrence of a heart attack, stroke, cancer or other serious illness as defined in the policy.

During this enrollment period with Transamerica, guarantee issue is available for Team Members who enroll in hospital indemnity, critical illness or accident insurance.

ACCIDENT INSURANCE

The accident insurance pays benefits you can use for medical bills and other out-of-pocket expenses — or for any other purpose, including paying your mortgage or other bills. Your medical coverage may not take care of all the added expenses you'll have after an accident.

You'll want your family protected. This policy helps provide protection for you and your insured family every day of the year for covered accidents. These benefits are paid directly to you, not to your doctor or hospital. You can use this money for anything you need. The extra cash can really assist you and your family during a difficult time.

INTEREST SENSITIVE WHOLE LIFE — UNUM

Team Members who currently have this policy will be able to keep it. No new enrollment is allowed.

Paycheck Contributions

Medical				
Tier	**Blue Secure PPO**	**Anthem Choice PPO**	**Blue Preferred PPO**	**Lumenos HDHP**
Team Member Only	$20.78	$42.96	$68.95	$16.85
Team Member & Spouse	$38.37	$87.17	$144.35	$34.27
Team Member & Child(ren)	$34.92	$74.85	$121.64	$29.39
Family	$56.66	$125.43	$206.01	$49.29

Dental and Vision Contributions			
Tier	**Dental HMO Plan with Vision**	**Dental INO Option with Vision**	**Dental PPO Plan with Vision**
Team Member Only	$0.94	$5.52	$9.43
Team Member & Spouse	$2.32	$10.16	$17.33
Team Member & Child(ren)	$2.32	$11.81	$20.18
Family	$5.08	$16.21	$27.66

- Deductions are taken from 26 paychecks per year.
- Team Members who are subject to the working spouse surcharge would add $69.23 to bi-weekly medical contributions.
- By enrolling in Medical, Dental or Vision you are agreeing to have your deductions taken on a pre-tax basis under a Section 125 plan. Failure to timely notify Human Resources of any Qualifying Event (i.e. Divorce) may result in a retroactive termination of coverage without any refund or modification to your paycheck contributions for the remainder of the calendar year.
- Paycheck contributions for the Voluntary Plans (Supplemental Life, AD&D, Disability, Accident, Critical Illness and Hospital Indemnity Insurance) may vary depending on your age and requested coverage amounts. Please consult the plan documents on Plan Source for more information.

On-Call Team Members

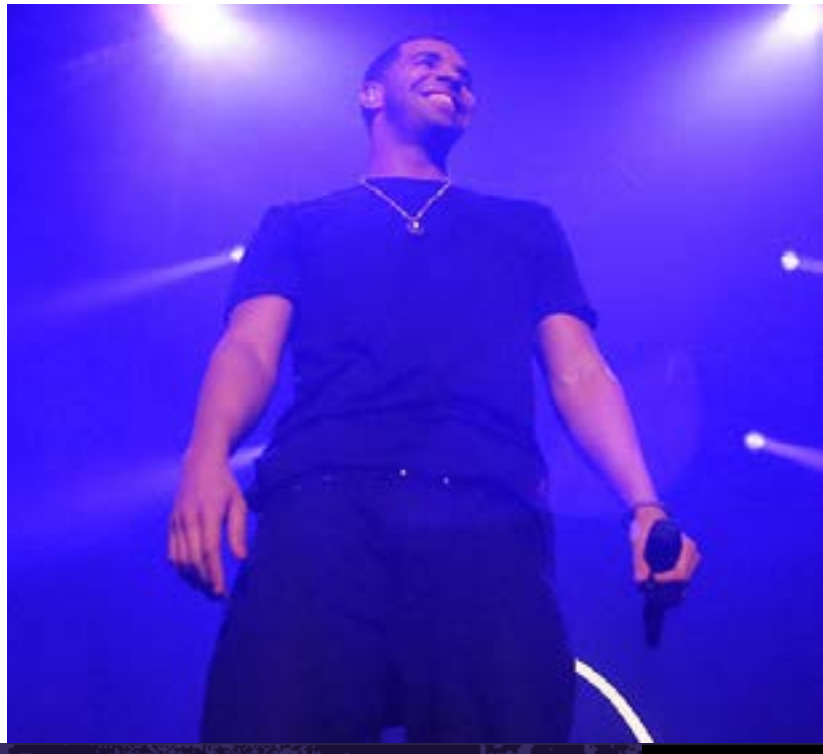
On-Call Team Members working at least 20 hours per week are eligible to enroll in the following Voluntary Benefits:

- Voluntary Dental and Vision (bundled)
- Voluntary Short Term Disability
- Voluntary Long Term Disability
- Voluntary Life and Accidental Death and Dismemberment (AD&D)
- Accident
- Critical Illness
- Hospital Indemnity - New!
- Deductions are taken from 26 paychecks per year
- If you do not work enough hours to cover your deductions, please make other payment arrangements with Human Resources/Payroll to ensure continuous coverage

Dental and Vision Contributions

Tier	Dental HMO Plan with Vision	Dental INO Option with Vision	Dental PPO Plan with Vision
Team Member Only	$7.07	$15.53	$19.18
Team Member & Spouse	$13.81	$28.49	$35.18
Team Member & Child(ren)	$13.80	$33.07	$40.89
Family	$22.26	$45.43	$56.12

On-Call Team Members who are interested in voluntary medical coverage are encouraged to visit the Lockton Marketplace. This program helps individuals find cost effective alternative coverage by navigating both public and private exchanges. For more information, visit **https://choosemylo.com/ca2**.



How To Enroll Or Make Changes In Your Benefits

To enroll in your benefits, review all your information, discuss plan options with your spouse or other family members. The enrollment process can be completed through Plan Source, our online benefits system.

1. Login Enrollment URL: https://benefits.plansource.com

- USERNAME: Your username is the first initial of your first name, up to the first six characters of your last name, and the last four of your SSN. For example: If your name is Jane Anderson and the last four of your SSN is 1234, your username would be janders1234.
- PASSWORD: Your birth date is YYYYMMDD format. For example: If your birth date is August 14, 1962, your password would be 19620814. At initial login, you be will prompted to change your password.

2. Launch Enrollment

- Click on "Make a Change to My Benefits" to begin. If you are a new hire, this link will say "New Hire — Enroll" and during Annual Open Enrollment "Enroll-Annual."

3. Enroll

- Follow the enrollment through each step of the enrollment process form top to bottom.
- In making your elections, choose the plan option of choice or select the "Decline" option and then select "Continue" after each election has been made until you reach the confirm page.

4. Confirm Enrollment Selections

- Once you complete all your coverage elections, you will land on the Confirmation Statement. Click the "Confirm Enrollment" button at the bottom of the page to complete your enrollment process.

5. Print a Copy of Your Enrollment Summary For Your Records

STEPS FOR A SUCCESSFUL ENROLLMENT

Read your enrollment materials

Consider your plan options and discuss your health care needs with your spouse, if applicable

Participate in a new hire or Open Enrollment information session

Attend a benefit meeting during Open Enrollment

Have the following information with you:

- Full names of your dependents
- Dates of birth
- Social Security numbers

Enroll by the applicable deadlines

Health Advocacy Services

Cigna's Health Advocacy Services offers employees and their eligible family members access to expert assistance with a wide range of health care and health insurance challenges. Personal Health Advocates will assist members with Clinical, Senior Care and Special Needs, Administrative and Financial Support services, at no cost.

Health Advocacy can help you with:

- Finding the right health care professional based on your needs
- Answering questions about diagnoses, test results, treatments and medications
- Getting estimated fees for services in your area
- Finding options for non-covered and alternative health services
- Addressing questions and concerns related to your medical bills
- Finding in-home care, adult day care, group homes, assisted living and long-term care
- Clarifying or getting help applying for Medicare, Medicare Supplement Plans and Medicaid

Plan Specific Questions?

If you have specific questions about a certain line of coverage, you should call that carrier's toll-free number, listed on page 18. Those service centers are still your primary resource, and representatives have access to all of your eligibility and claims information.

Help is only a click or call away.
Call **1.866.799.2725** or visit

HealthAdvocate.com/members to:

- Receive 24/7 support
- Learn more about the program features
- Access the health information center for common health topics
- Read educational newsletters
- Print an ID card

Contact Information

Benefit Plan	Carrier	Contact
Hard Rock Health Advocate Services	Cigna	866-799-2725
Medical	Anthem Blue Cross and Blue Shield Blue Secure PPO - Pathway Network Anthem Choice PPO - Pathway and PPO or National BlueCard Network Blue Preferred BlueCard - PPO or National Blue Card PPO Network Lumenos HDHP - PPO or National Blue Card PPO Network	www.anthem.com 1-800-542-9402
Health Savings Account (HSA)		
Dental HMO Plan	UnitedHealthcare Dental	
Dental PPO & INO Plan	DHMO – NV Select Managed Care/NV Pacific Dental Network Dental INO and PPO – PPO National Network	1-877-816-3596 www.myuhcdental.com
Vision	EyeMed Select Network	1-866-723-0514 www.eyemed.com
Disability Insurance Basic Life and AD&D Voluntary Life and AD&D	Cigna	1-800-36-CIGNA (1-800-362-4462) www.cigna.com
Accident Protection Critical Illness Hospital Indemnity Insurance	Transamerica Employee Benefits	1-888-763-7474 www.transamericaemployeebenefits.com
Life Assistance Program	Cigna	1-800-538-3543 www.cignabehavioral.com/CGI
Interest Sensitive Whole Life	Unum	1-800-421-0344 www.unum.com
401(k)	Transamerica	1-888-676-5512 my.trsretire.com

Required Notices

Company Name (the "Company")

HRHH Gaming Senior Mezz, LLC (DBA Hard Rock Hotel and Casino)

Effective Date

01/01/2016

Creditable Plan Name(s)

HRHH Gaming Senior Mezz, LLC Employee Benefits Plan

Plan Administrator

HRHH Gaming Senior Mezz, LLC
(DBA Hard Rock Hotel and Casino)
Human Resources
4455 Paradise Road
Las Vegas, NV 89169
702-693-5088

HIPAA Privacy Official

Doug McCombs
VP of Human Resources
702-693-5088

HIPAA Special Enrollment Deadline

31 days

Members of Organized Health Care Arrangement

HRHH Gaming Senior Mezz, LLC
(DBA Hard Rock Hotel and Casino)
Lockton Insurance Brokers, LLC
Anthem Blue Cross and Blue Shield
United Health Care
EyeMed
Cigna
Plan Source
Igoe & Company
Transamerica
Unum

See page 22 for Important Information concerning your Medicare Part D Coverage.

Women's Health and Cancer Rights Notice

The Company is required by law to provide you with the following notice:

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

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

The Company's plan(s) provide medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

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

HIPAA Notice of Privacy Policy and Procedures

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. This notice is provided to you on behalf of the Company about the Plan. It pertains only to health care coverage provided under the Plan.

The Plan's Duty to Safeguard Your Protected Health Information

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

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

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

How the Plan May Use and Disclose Your Protected Health Information

The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative (e.g., a person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the Plan's uses and disclosures of your PHI.

Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations

- Treatment: Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it's important for your treatment team to know your blood type, the Plan could disclose that PHI to the team in order to allow it to more effectively provide treatment to you.

- Payment: Of course, the Plan's most important function, as far as you are concerned, is that it pays for all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan receives a substantial amount of PHI about you. For example, doctors, hospitals and pharmacies that provide you care send the Plan detailed information about the care they provided, so that they can be paid for their services. The Plan may also share your PHI with other plans, in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this Plan, and your spouse's plan, or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.

- Health care operations: The Plan may use and disclose your PHI in the course of its "health care operations." For example, it may use your PHI in evaluating the quality of services you received, or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverage. However, the Plan will not disclose, for underwriting purposes, PHI that is genetic information.

Other Uses and Disclosures of Your PHI Not Requiring Authorization

The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:

- To the Plan Sponsor: The Plan may disclose PHI to the employers (such as the Company) who sponsor or maintain the Plan for the benefit of employees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and disenrollments, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage and other disputes related to the Plan's provision of benefits.

- To the Plan's Service Providers: The Plan may disclose PHI to its service providers ("business associates") who perform claim payment and plan management services. The Plan requires a written contract that obligates the business associate to safeguard and limit the use of PHI.

- Required by law: The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities that monitor compliance with these privacy requirements.

- For public health activities: The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.

- For health oversight activities: The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.

- Relating to decedents: The Plan may disclose PHI relating to an individual's death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.

- For research purposes: In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research.

- To avert threat to health or safety: In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.

- For specific government functions: The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.

Uses and Disclosures Requiring Authorization

For uses and disclosures beyond treatment, payment and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. For example, uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI would require your authorization. Your authorizations can be revoked at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.

Uses and Disclosures Requiring You to Have an Opportunity to Object

The Plan may share PHI with your family, friend or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

Your Rights Regarding Your Protected Health Information You have the following rights relating to your protected health information:

- To request restrictions on uses and disclosures: You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request, but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.

- To choose how the Plan contacts you: You have the right to ask that the Plan send you information at an alternative address or by an alternative means. To request confidential communications, you must make your request in writing to the Privacy Official. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.

- To inspect and copy your PHI: Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.

- To request amendment of your PHI: If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors, you may request, in writing, that the record be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its vendor and/or not part of the Plan's or vendor's records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.

To find out what disclosures have been made: You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

How to Complain about the Plan's Privacy Practices

If you think the Plan or one of its vendors may have violated your privacy rights, or if you disagree with a decision made by the Plan or a vendor about access to your PHI, you may file a complaint with the person listed on the first page of these notices. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

Notification of a Privacy Breach

Any individual whose unsecured PHI has been, or is reasonably believed to have been used, accessed, acquired or disclosed in an unauthorized manner will receive written notification from the Plan within 60 days of the discovery of the breach.

If the breach involves 500 or more residents of a state, the Plan will notify prominent media outlets in the state. The Plan will maintain a log of security breaches and will report this information to HHS on an annual basis. Immediate reporting from the Plan to HHS is required if a security breach involves 500 or more people.

Contact Person for Information, or to Submit a Complaint

If you have questions about this Notice please contact the Plan's Privacy Official or Deputy Privacy Official(s) (see first page). If you have any complaints about the Plan's privacy practices, handling of your PHI, or breach notification process, please contact the Privacy Official or an authorized Deputy Privacy Official.

Organized Health Care Arrangement Designation

The plan state, in writing, the reason(s) for declining coverage. The Plan participates in what the federal privacy rules call an "Organized Health Care Arrangement." The purpose of that participation is that it allows PHI to be shared between the members of the Arrangement, without authorization by the persons whose PHI is shared, for health care operations. Primarily, the designation is useful to the Plan because it allows the insurers who participate in the Arrangement to share PHI with the Plan for purposes such as shopping for other insurance bids.

HIPAA Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

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

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

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

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

To request special enrollment or obtain more information, contact the Plan Administrator. Note: Additional information may be required if the plan requires that persons declining coverage under

Important Notice from the Company About Your Prescription Drug Coverage and Medicare under the Creditable Plan(s)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Company 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or the dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The Company has determined that the prescription drug coverage offered by the Creditable Plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

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

Enrolling in Medicare—General Rules

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty

If you decide to wait to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15th through December 7th.

But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period, you go 63 continuous days or longer without "creditable" prescription drug coverage (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1% of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go nineteen months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. However, there are some important exceptions to the late enrollment penalty.

Special Enrollment Period Exceptions to the Late Enrollment Penalty

There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage

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. See the Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting us at the telephone number or address listed at the beginning of this document.

Coordinating Other Coverage with Medicare Part D Generally speaking, if you decide to join a Medicare drug plan while covered under the Company Plan due to your employment

(or someone else's employment, such as a spouse or parent), your coverage under the Company Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second.

For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or Web address listed below.

If you do decide to join a Medicare drug plan and drop your prescription drug coverage with , be aware that you and your dependents may not be able to get this coverage back. To regain coverage you would have to re-enroll in the Plan, pursuant to the

Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

For more information about this notice or your current prescription drug coverage...

Contact the Plan Administrator 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 the Company changes. You also may request a copy.

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

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

For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

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Hard Rock
HOTEL & CASINO
LAS VEGAS