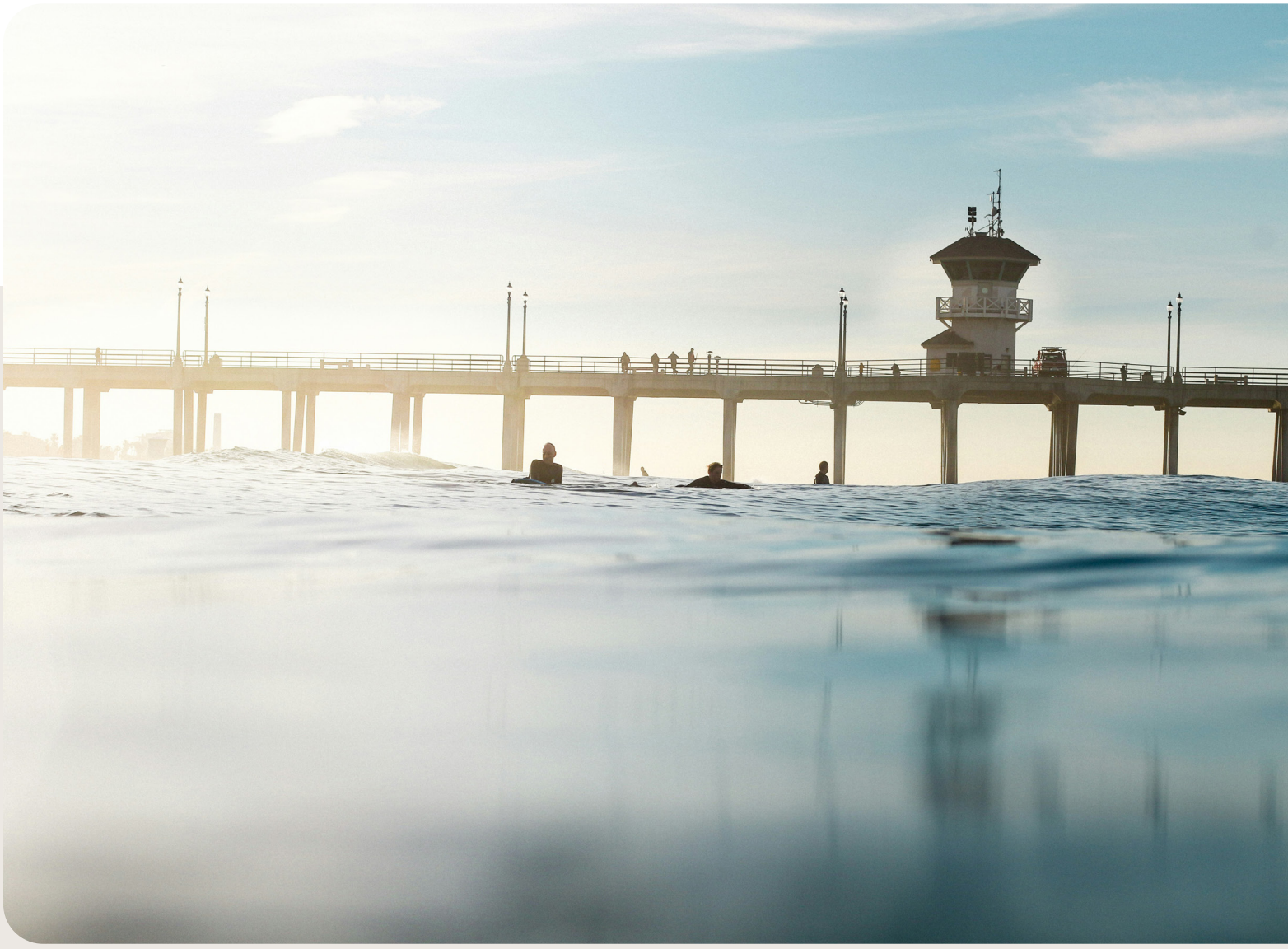
Employee Benefits

September 1, 2026 through August 31, 2027

Benefits Advocacy Team

Phone: 844-852-5769
Email: waterfrontbenefits@sullicurt.com
7:30am - 5:00pm PST M-F (excluding holidays)



The Waterfront Beach Resort

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Contact Information

Member Services

Aetna ..... (888) 982-3862
Guardian
Dental Customer Service ..... (800) 273-3330
Dental PPO Claims Help ..... (800) 541-7846
VSP Vision ..... (800) 877-7195
ComPsych EAP ..... (855) 239-0743
Fidelity
401(k) ..... (800) 343-3548
Roth IRA ..... (800) 835-5097
AFLAC ..... (800) 462-3522
United Pet Care ..... (888) 781-6622
Nationwide Pet Insurance ..... (888) 899-4874
RULA Mental Health Resource ..... (323) 205-7088
Health Equity ..... (866) 735-8195

Website/Email

Aetna ..... www.aetna.com
Guardian ..... www.guardiananytime.com
Guardian EAP ..... www.guidanceresources.com
(Web ID: Guardian)
Fidelity ..... www.fidelity.com
Net Benefits ..... www.netbenefits.com
AFLAC ..... www.aflac.com
United Pet Care ..... www.unitedpetcare.com
Nationwide Pet Insurance ..... www.petinsurance.com
RULA ..... www.rula.com/waterfront
Health Equity ..... www.healthequity.com

If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 9 for more details.

Please remember to review the CHIP notice within this brochure. It includes information on how employees can contact their state to check if you are eligible for premium assistance under Medicaid or Children's Health Insurance Program (CHIP) and how to apply for the programs.

Welcome to Your Benefits

The Waterfront Beach Resort is committed to providing you with a comprehensive, high-quality, affordable employee benefits program that meets your needs and serves as an integral component of your total compensation package. Designed to provide you with flexibility, choice and peace of mind to choose the plans and coverage that are right for you.

Benefits Website

All enrollment documents are available electronically at www.waterfrontresort.benefitsmap.com (username: waterfrontresort, password: benefits)

Benefits Advocacy Team

Questions? Need help deciding which plan is the best for you? The Benefits Advocacy Team is glad to help answer any questions and provide guidance on the best plan offerings for you and your family! The Benefits Advocacy Team is available from 7:30am - 5:00pm PST, Monday through Friday (excluding Holidays). Spanish speaking representatives are available.

Phone: (844) 852-5769
Email: waterfrontbenefits@sullicurt.com

Eligibility and Enrollment

The Waterfront Beach Resort is pleased to provide you with an opportunity to enroll in our Company benefit plans annually during open enrollment and at hire. Prior to enrolling, you are encouraged to make use of this benefits brochure and carefully read through each of the benefit plan descriptions. The decisions you make will remain in effect until our next open enrollment period.

Who is Eligible?

All regular, full-time employees who work at least thirty hours per week are eligible to participate in The Waterfront Beach Resort benefit plans. For all new employees, your coverage will become effective on the first date of the month following sixty days of employment. You must be actively at work for your coverage to be effective on your eligibility date. You may also enroll your dependents in The Waterfront Beach Resort benefit plans.

Your eligible dependents include your legal spouse, your registered domestic partner and your dependent children, whether natural, adopted, step, foster, or those for whom you have legal custody by court decree up to age 26.

After Enrolling

After you enroll in The Waterfront Beach Resort benefit plans, you cannot change your elections until the next benefits enrollment period, unless you have a change in life status during the year.

Change in Life Status

Once enrolled, you cannot make enrollment changes unless you have an IRS approved “change in life status” during the year. This may include:

- the addition of a dependent through birth, adoption, or marriage;
- the loss of a dependent through divorce or death, or if your child reaches the maximum age limit for coverage;
- a change in your or your spouse’s employment status from full-time to part-time, or vice versa;
- a substantial change in your or your spouse’s benefits coverage

You must adjust your benefits elections within 30 days of the qualified change in life status. It is your responsibility to contact Human Resources to request a change form as soon as you are aware of an event.

If an employee or otherwise eligible dependent loses coverage under a state Medicaid Plan or a state Children’s Health Insurance Plan (CHIP) due to a loss of eligibility of the employee or an otherwise eligible dependent becomes eligible for state funded group health plan premium assistance under a stated Medicaid or CHIP program, the employee must request enrollment within 60 days of the date coverage is lost or the date the employee or dependent is determined to be eligible for premium assistance (whichever is applicable).

Medical Insurance

In choosing your medical plan for 2026-27 plan year, you should consider the following: What are your anticipated medical expenses for the coming year? How much will you have to pay for these expenses in copayments? How much can you afford to pay towards the cost of coverage?

The chart below was developed to highlight the major features of each of our medical insurance plans and is intended to help you make an informed decision. For more information on our medical insurance plans, please see the full plan description and summary of benefits and coverage (SBC).

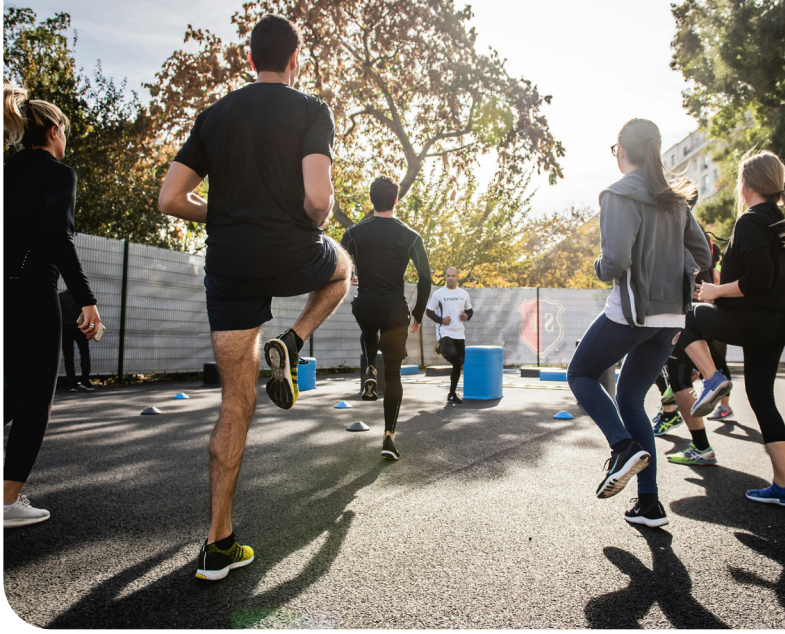
Mental Health

We are pleased to offer "Rula" a mental health resource available to all employees. Rula makes it easy to find a licensed therapist in network with your insurance, who is accepting new clients, and is an expert in caring for your unique needs. Their network of 3000+ therapists includes individuals from diverse backgrounds and a wide range of specialties. Every Rula therapist is fully-licensed and has undergone a thorough background check and clinical review, to ensure you receive the highest standard of care. It's free to sign up. To get started, go to www.rula.com/waterfront.

	Aetna AWH HMO	Aetna AVN HMO	Aetna Full HMO	Aetna OA Managed Choice POS	
	In-Network Only	In-Network Only	In-Network Only	In-Network	Out-of-Network
Deductible	None	None	None	None	$2,500 per person $5,000 per family
Office Visit copay (Primary / Specialist)	$15 / $30 copay	$20 / $30 copay	$15 / $30 copay	$20 / $25 copay	30% after deductible
Urgent Care	$35 copay	$50 copay	$35 copay	$50 copay	30% after deductible
Preventive Care Visit	No charge	No charge	No charge	No charge	30% after deductible
Hospitalization	$250 copay	$500 copay	$250 copay	$250/day for first 3 days; thereafter covered 100%	30% after deductible
Outpatient Surgery	$100 copay	Facility: $100 copay Hospital: $300 copay	$100 copay	10%	30% after deductible
Emergency Room (waived if admitted)	$150 copay	$300 copay	$150 copay	$250 copay	$250 copay
Diagnostic, X-Ray & Lab	No Charge	No Charge	No Charge	10%	30% after deductible
Complex Imaging (MRI, CT , PET Scan)	$100 copay	$100 copay	$100 copay	10%	30% after deductible
Chiropractic/Acupuncture	$15 copay / 20 visits	$15 copay / 20 visits	$15 copay / 20 visits	$25/ $20 copay / 20 visits	30% after deductible
Out-of-Pocket Maximum – Medical & Prescriptions	$2,000 per person $4,000 per family	$2,000 per person $4,000 per family	$2,000 per person $4,000 per family	$2,500 per person $5,000 per family	$12,500 per person $25,000 per family
Prescription copay	(30-day supply)	(30-day supply)	(30-day supply)	(30-day supply)	
Generic	$10 copay	$10 copay	$10 copay	$10 copay	
Brand	$30 copay	$30 copay	$30 copay	$30 copay	Not covered
Formulary	$50 copay	$50 copay	$50 copay	$50 copay	Not covered
Specialty Drugs	30% up to $250	30% up to $250	30% up to $250	30% up to $250	Not covered

SEE COMPLETE PLAN DESCRIPTION OR SUMMARY OF BENEFITS AND COVERAGE (SBC) FOR COMPLETE DETAILS

Dental Insurance



The Waterfront Beach Resort offers two distinct insurance programs through Guardian. After considering your anticipated dental needs for the coming year and evaluating the DHMO and DPPO dental plan provider networks, you can determine which plan will work best for you by reviewing deductibles, copayments and services covered under each plan.

The Guardian DHMO Dental Plan provides dental care through a network of dentists. There are no deductibles, plan maximums, or claim forms. You must select a Primary Care Dentist from Guardian's large network.

The Guardian Dental PPO Plan covers a wide range of dental services. You have the freedom to go in and out of network for care. You may also visit an out of network Dentist, where services will be based on reasonable and customary amounts and you will be responsible for any amount owed, after insurance has paid.

Guardian DHMO		
Type of Service	**ADA**	**Copays**
Calendar Year Maximum		N/A
Calendar Year Deductible		Unlimited
Preventive & Diagnostic		
X-Rays	0270	No Charge
Prophylaxis (Cleaning)	1110	No Charge
Restorative		
Amalgam Filling, one surface	2140	No charge
Crowns and Pontics		
Porcelain Crown-fused to metal	2750	$190
Oral Surgery		
Impacted Tooth—partially bony	7230	$60
Periodontics		
Root Planning - per quadrant	4341	$35
Gingivectomy - per quadrant	4210	$70
Endodontics		
Root Canal Therapy - anterior	3310	$75
Root Canal Therapy - molar	3330	$150
Prosthetics		
Denture - complete upper/lower	5110	$190
Orthodontics		
Child (to age 18) / Adult		$1,895 / $2,195

Guardian DPPO		
Type of Service	**In-Network**	**Out-of-Network**
Calendar Year Maximum	$1,500	$1,000
Calendar Year Deductible		
Individual	$50	
Family	$150	
Deductible waived for preventive	Yes	Yes
Preventive & Diagnostic Services	100%	100% of UCR
Basic Services	90%	80%
Major Services	60%	50%
Orthodontics (Adult & Child)	50%; $1,000 maximum	

Maximum Rollover Feature

Allows each member to roll-over a portion of the unused calendar year maximum into a Maximum Rollover Account (MRA). The MRA can be used for future years in which the members may exceed the normally allocated calendar year maximum.

To qualify, a member must submit at least one claim during the calendar year which cannot exceed $500. Refer to Guardian contract for more details

Vision Insurance

Guardian VSP Vision provides professional vision care and high quality lenses and frames through a broad network of ophthalmologist, optometrists, and opticians.

VSP Vision		
Frequency Exam / Lenses Frames	Every 12 months Every 24 months	
	VSP Provider	**Non-VSP Provider Reimbursement**
Copayments Exam Materials	 $10 Copay $25 Copay	 Up to $39 Up to $64
Frames	$130 allowance then 20% off	Up to $46
Lenses	Covered	From $23-$64
Contact Lenses Standard Medically Necessary	 $130 allowance $0 copay	 Up to $100 Up to $210

401(k) Retirement Plan

Whatever your stage in life, it is important to prepare for your future financial security. With our Fidelity 401(k) retirement savings plan, The Waterfront Beach Resort has established a tax-favored program that will help you save for retirement. Here are some of the highlights of our 401(k) plan.

- You reduce your current taxes. Your contributions are deducted from your paycheck before taxes are taken out of your pay.
- You decide how much to invest. You can save on a pre-tax basis 1% - 60% up to $24,500 in 2026. If you are over the age of 50, or will reach 50 during the plan year, you can contribute an additional amount to your 401 (k) account under the plan's catch-up provision.
- Investment options to help you manage your money. You have a choice of a number of professionally managed investment funds in which to invest your savings.

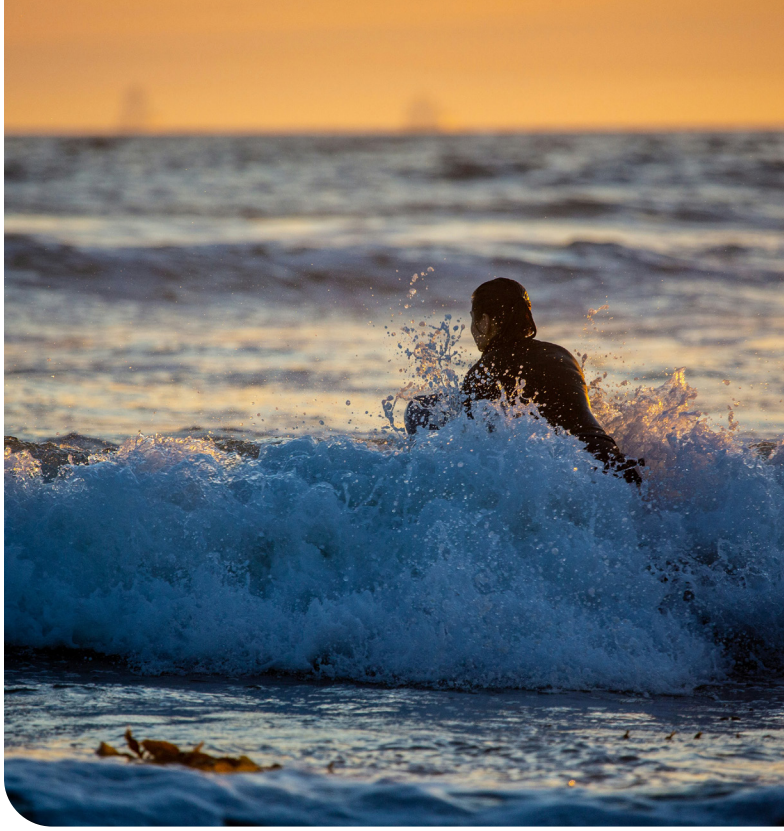
The Waterfront Beach Resort matches 100% of your first 3% of contributions and an additional 50% on the next 2% of your contributions. All employees are eligible after a full 3 months of employment and who are at least 21 years of age.

Roth 401(k)

We are happy to offer a Roth 401(k) feature to the RLM Associates Retirement Plan, so you have another choice on how to save for your retirement.

With a Roth 401(k) feature, you can designate all or a portion of your future deferral contributions as Roth contributions. Traditional 401(k) contributions are made on a pretax basis and are not included in current taxable income. The pretax contributions and any earnings will be subject to income taxes when withdrawn. In contrast, Roth 401(k) contributions are made on an after-tax basis and are included in current taxable income. Earnings are tax-free if they are part of a qualified distribution—a distribution that is taken at least five tax years from the year of your first Roth 401(k) contribution and after you have attained age 59½, or become disabled or deceased.

For more information or to enroll or change your current deferral amount, log on to Fidelity NetBenefits at www.netbenefits.com or call the Fidelity Retirement Benefits Line at 800-835-5097 Monday through Friday (excluding New York Stock Exchange holidays), from 8:30 a.m. to 8 p.m. Eastern time, to speak to a Fidelity representative. To see how a small increase can boost your growth potential, visit NetBenefits and select Planning & Guidance Center under the Planning tab.



Life and AD&D

Basic Life and AD&D

The Waterfront Beach Resort provides full-time employees with $20,000 of Basic Term Life and AD&D insurance through Guardian.

Naming your beneficiary: You may name anyone you wish as the beneficiary who will receive your life and AD&D insurance benefits in the event of your death. You may change your beneficiary as often as you wish through the course of the year.

Voluntary Life

Additional Term Life Insurance is available for you and your family. Your cost for this coverage is paid by convenient payroll deductions.

Full-time employees may enroll for additional Term Life insurance through Guardian. You may purchase in increments of $25,000 up to $300,000 coverage for yourself, with as much as 50% of your amount up to $150,000 for your spouse, and 10% to $10,000 for your dependent children. At initial enrollment you are guaranteed $200,000 and your spouse $25,000 without Evidence of Insurability (EOI). At Open Enrollment, All amounts are subject to approval and you will need to submit evidence of insurability (health questions).

Employee Assistance Program (EAP)

The Employee Assistance Program (EAP) offers you and your family members assistance with balancing the demands of work and home. The EAP provides access to resources and solutions to problems of daily living, designed to enhance your quality of life. In addition to telephonic counseling, up to 3 face-to-face consultations are available at no cost to you. Refer to the EAP flyers on the benefits website or visit guidanceresources.com for further details.

- Family Counseling
- Child / Elder Care Referrals
- Behavioral Health Information
- Substance Abuse Counseling
- Legal Counseling
- Financial Counseling

ComPsych EAP
855-239-0743
guidanceresources.com (Web ID: Guardian)

Flexible Spending Accounts (FSA)

Health Care FSA

The Health Care FSA allows you to use tax-free dollars for eligible health care expenses that are not covered by insurance for you, your legal spouse, and your eligible dependents. You can put up to the 2026 IRS annual maximum of $3,400 into the Health Care FSA each year. Keep in mind that with the Health Care FSA, you may be allowed to roll over your unused funds for use in the next plan year up to IRS maximum.

Dependent Care FSA

The Dependent Care FSA lets you use tax-free dollars to pay for child and elder care costs incurred so you and your spouse may work or attend school full-time. The IRS allows a family maximum contribution of $7,500 per calendar year to the Dependent Care FSA. If your spouse also participates in a Dependent Care FSA, your combined contributions cannot be higher than the family maximum. If you are married and file separate tax returns, the maximum amount you can contribute is $3,750. Special rules apply for determining the earned income of a spouse who is disabled, a full-time student or unemployed. Please contact Health Equity or your tax advisor for more information.

Keep in mind with the Dependent Care FSA, you have a grace period which allows you to get reimbursed for expenses occurring after the 2026-2027 plan year ends. You can incur eligible dependent care expenses until November 15, 2027, as long as you submit all claims no later than November 30, 2027. These claims will be billed against your 2026-2027 account balance.

Aetna Extras

Teladoc – Teladoc gives you access to quality care at your fingertips, through phone, video or mobile app visits:

- Everyday care (flu, sinus infections, sore throats, and more) available 24/7 with a $0 copay
- Mental health care with a therapist at a $0 copay
- Dermatology care (eczema, acne, rashes, and more) with a $0 copay

Set up your account today so when you need care, a Teladoc doctor is just a call or click away:

- Online - Go to teladoc.com/aetna
- Mobile app - Download the Teladoc app
- Phone - Call 855.Teladoc (835.2362)

Aetna Health Your Way Achieve – Aetna's new unified well-being platform will provide members with simplified access via the Aetna Health app, and will include personalized and holistic resources to help you reach your goals. Members earn "hearts" through the completion of various activities which can be redeemed for electronic gift cards. Members can earn $20 in e-gift cards for every 2,000 hearts they earn, up to $100 per covered member including employee, spouse/partner and dependents that are over the age of 18 years by completing well-being activities. Review your progress and redeem gift cards in the Reward Center.

A few ways to earn your rewards:

- Know your risks: Well-being assessment, preventive screenings, or mental health check in.
- Stay active: Verified daily activity and weekly challenges.
- Improve your health: Coaching and goal achievement.

Ready to explore Aetna Health your Way today? Sign in at Aetna.com or get the Aetna Health app.

Aflac Supplemental Insurance

(Employee Paid)

American Family Life Assurance Company of Columbus (Aflac) offers a wide range of supplemental products that give you an extra measure of financial protection if you become sick or hurt. Aflac pays cash benefits to you, that you in turn, direct to help you and your family with unexpected expenses. Benefits are pre-determined and paid regardless of any other insurance that you may have. The options available to you are as follows:

Accident: For a covered accident, Aflac policyholders receive cash benefits for use as they see fit. This plan helps provide a financial cushion if an accident occurs. Coverage is 24 hours a day and 7 days a week.

Cancer/Specified-Disease: Aflac's cancer/specified-disease insurance policies are designed to pay cash benefits that can be used to help offset cancer-related expenses and to help with a variety of daily living expenses.

Hospital Confinement: Helps with non-covered expenses of a hospital stay. Also includes physician visits. This umbrella policy covers and illness and any injury.

Pet Insurance

Nationwide (Employee Paid)

Health insurance for your pets is provided by Nationwide Pet Insurance.

Options include:

- Plan options for dogs and cats
- A medical plan option just for cats
- An injury-only plan option for dogs and cats
- A medical plan for birds, rabbits, reptiles and other exotic pets
- A wellness coverage rider, to add to any dog and cat medical plan

All plans include a deductible, pre-existing conditions and underwriting. You may choose to visit ANY veterinarian you wish. Please visit the benefits website or www.petinsurance.com for more information.

United Pet Care Discount Program

(Employee Paid)

Also available is United Pet Care (UPC), a unique veterinary savings program for your pets. With UPC, You are guaranteed to reduce the cost of escalating veterinary bills by saving 20% - 50% on EVERY visit to the veterinarian. Unlike traditional pet insurance – ALL PETS ARE ELIGIBLE, regardless of their age, pre-existing or breed specific conditions! In order to receive the discounts, you must visit a participating veterinarian. Please visit the benefits website or www.unitedpetcare.com for more information.

2026-27 Per Paycheck Contributions

	Employee Only	Employee + 1 Dependent	Employee + Family
Aetna AWH HMO			
Tobacco Free*	$83.35	$195.10	$272.85
Tobacco Use	$97.19	$208.95	$286.69
Aetna AVN HMO			
Tobacco Free*	$95.67	$221.62	$309.22
Tobacco Use	$109.51	$235.46	$323.07
Aetna Full HMO			
Tobacco Free*	$114.32	$261.72	$364.25
Tobacco Use	$128.17	$275.57	$378.10
Aetna POS			
Tobacco Free*	$173.59	$389.17	$539.11
Tobacco Use	$187.44	$403.02	$552.96
Dental DHMO	$1.95	$3.59	$5.35
Dental PPO	$7.05	$13.08	$22.37
Vision PPO	$3.89	$5.90	$10.38

Tobacco Free Discount

The Waterfront Beach Resort will be giving a tobacco free credit of $15 per paycheck towards your medical contributions. In order to receive the credit, you must be tobacco free or a tobacco user that participates and completes a company-approved tobacco cessation program. You must also complete the Tobacco Free Discount Affidavit and return in to Human Resources. A tobacco user is defined as a person who has smoked or used any tobacco products, such as cigarettes (including but not limited to electronic or e-cigarettes), cigars, pipes, or smokeless tobacco products.

Smoking Cessation Program Resources

- www.aetna.com/health-guide/secrets-of-nonsmokers.html

Free Government Programs and Resources

- 800-QUIT-NOW
- www.smokefree.gov

Important: Medical, Dental, and Vision contributions are payroll deducted before taxes through the Section 125 plan. If you do not wish for these deductions to be taken out on a pre-tax basis, please reach out to Human Resources. Pre-tax contributions may affect your Social Security benefits since these deductions are not counted when determining FICA earnings; consult with your tax advisor.

Also keep in mind that the decisions you make will stay in force until Open Enrollment for 2027 unless you experience an IRS Qualified change in Life Status. If you experience an IRS Qualified change in Life Status you will have a 30-day time frame to request the change. Please make sure to contact Human Resources as soon as you become aware of the change.

How to Find an In-Network Provider

- Go to www.aetna.com
- Click Find a doctor
- Under Guests, choose Plan from an employer
- Continue as a guest and enter your location
- Under “Select a Plan,” choose from the following options:
    - **AWH HMO:** scroll down to Aetna Whole Health Plans and select: AWH Southern CA HMO
    - **AVN HMO:** scroll down to State Based Plans and select: Aetna Value Network HMO
    - **Full HMO:** scroll down to Aetna Standard Plans and select: HMO
    - **PPO:** scroll down to Aetna Open Access Plans and select: Managed Choice POS (Open Access)

Find what you need by category

- For PCP’s, click Medical Doctors & Specialists, then click All Primary Care Physicians IMPORTANT: Use the 6-digit Primary Care ID on your Aetna Enrollment Form

Annual Notices & Disclosures

The Women's Health and Cancer Rights Act of 1998—Important Notice

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a mastectomy is also entitled to the following benefits:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications in all stages of mastectomy, including lymphedemas.

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

HIPAA Privacy Notice—Important Notice about Your Health Information

The HIPAA Notice of Privacy Practices applies to Protected Health Information associated with the Group Health plan provided to our employees, employee's dependents and, as applicable, retired employees. The Notice describes that The Waterfront Beach Resort may use and disclose Protected Health Information to carry out payment and health care operations, and for other purposes that are permitted or required by law.

We are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of Protected Health Information and to provide individuals covered under our group health plan with notice of our legal duties and privacy practices concerning Protected Health Information. We are required to abide by the terms of the Notice so long as it remains in effect. We reserve the right to change the terms of the Notice as necessary and to make the new Notice effective for all Protected Health Information maintained by us. If we make material changes to our privacy practices, copies of revised notices will be mailed to all policyholders then covered by the Group Health plan. Copies of our current Notice may be obtained by contacting Human Resources

Newborns' and Mothers Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

Patient Protection Disclosure

The Aetna HMO health plan generally requires/allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Aetna designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Aetna HMO at (888) 982-3862.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Aetna HMO at (888) 982-3862.

HIPAA Special Enrollment Rights

If you are declining for yourself or your dependent (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards you or your dependent's other coverage). However, you must request enrollment within 30 days after your or your dependent's other coverage ends (or after the employer stops contributing towards the other coverage). Note: if the change is due to Medicaid/CHIP eligibility, there is a 60 day window for Medicaid/CHIP eligibility changes only.

Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

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

You're protected from balance billing for:

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

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

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

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

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

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:

  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact 1-800-985-3059. Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

Medicare Notice of Creditable Coverage

Important Notice from The Waterfront Beach Resort 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 The Waterfront Beach Resort and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

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

2. The Waterfront Beach Resort has determined that the prescription drug coverage offered by the Aetna plans 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 to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

- If you decide to join a Medicare drug plan, your current The Waterfront Beach Resort coverage may be affected.
- If you do decide to join a Medicare drug plan and drop your current The Waterfront Beach Resort coverage, be aware that you and your dependents may not be able to get this coverage back.

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 The Waterfront Beach Resort 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 Human Resources 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 Waterfront Beach Resort changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

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

For more information about Medicare prescription drug coverage:

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

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

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

Human Resources
Address: 21100 Pacific Coast Highway
Huntington Beach, CA 92648
Phone: 714-845-8430 or 714-845-8449

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
ARKANSAS – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecover y.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health- insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization- act-2009-chipra Phone: 678-564-1162, Press 2
INDIANA – Medicaid
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338 8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid
Website:https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 / Lincoln: 402-473-7000 / Omaha: 402-595-1178
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742

PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program- hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820
TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
VERMONT– Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs- services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059
UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium- assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium- assistance/health-insurance- premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website:https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2026, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 4/30/2026)

Notes

This summary provides an overview of some of your benefit plan choices. It is for informational purposes only. It is not intended to be an agreement for continued employment. Neither is it a legal plan document. If there is a disagreement between this summary and the plan documents, the documents will govern. In addition, the plans described in this summary are subject to change without notice. Continuation of any benefit plan or coverage is at the company's discretion and in accordance with federal and state laws. If you need additional information or have any questions about the benefit program, please contact Human Resources at The Waterfront Beach Resort.