2026 BENEFITS

designed with YOU in mind



New Hire Benefit Guide

HEALTH WEALTH SELF

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ENROLL for *benefits*

Choosing benefits is one of the most important decisions you'll make all year.

Important reminders

- **New employees: Enroll within 30 days from your date of hire.** If you don't enroll within this time period, you will not have benefits coverage, except for plans and programs that are fully paid for by Aristocrat.
- **Spousal Surcharge**: If your spouse/domestic partner is currently enrolled in your medical benefits, a surcharge will automatically appear. If your spouse/domestic partner does not have access to other employer-sponsored coverage, you must attest to this in Workday to avoid the surcharge.
- **Enroll before the enrollment deadline.** If you miss the deadline and don't enroll or make changes to your benefits, you'll have to wait until the next Open Enrollment, unless you experience a qualified life event, to enroll or change benefits. You will however be enrolled in the company paid benefits including basic life/accidental death & dismemberment, disability, Wellthy caregiving support, and EAP.

Use this guide to:

Review your benefit choices, including any new plans and benefit changes.

Understand how the plans work.

Learn about the tools and resources available with each plan.

Select the benefits that work the best for you and your family.

QUESTIONS? We Can Help

Contact TouchCare:

866-486-8242
assist@touchcare.com
www.touchcare.com/ask

Email mypc@aristocrat.com

Visit www.atibenefits.com

Who Can Enroll?

- **Full-time employees (30+ hrs./wk.) –** Eligible upon hire; must choose benefits within 30 days of hire date.
- **Eligible dependents –** Includes your legal spouse/domestic partner and children to age 26, plus disabled dependent children of any age who meet plan criteria.

Your Enrollment Opportunities

1 Upon Hire

You become eligible for most benefits on the first day of employment.

2 Following a Life Event

If you experience a status change or a qualifying life event during the year that affects your eligibility for benefits, you may be able to enroll for coverage in new plans and change existing coverage. You must notify MyP&C (mypc@aristocrat.com) within 30 days of the event to make changes.

TouchCare

Complementary healthcare concierge service!

TouchCare will work on your behalf to:

- Answer any benefit-related questions, simple or complex
- Provide guidance with claim reviews
- And more!

Download the IOS/Android app

Scan me!

Simple Ways to Enroll or Change Your Benefits

1 ONLINE	2 ALEX	3 TouchCare
Log on to review and choose benefits	Receive help from your online benefit counselor	Benefit question help
Go to Workday through the OKTA dashboard	www.start.myalex.com/aristocrat	866-486-8242 assist@touchcare.com www.touchcare.com/ask

Qualifying Life Events

Qualifying life events include, but aren't limited to, marriage, divorce, legal separation, birth or adoption of a child, or a change to your or your spouse/domestic partner's employment status that affects your eligibility for benefits.



NOT Qualifying Life Events



Life Event Key Points

1. **Benefit changes must be CONSISTENT with the life event**

   Example: Your spouse just gave birth.

   You can't remove your spouse from your medical coverage when this happens because that isn't consistent with the event. But you could add dependent coverage for the newborn child.

2. **You have 30 DAYS to request changes to your benefits**

   To request a change in benefits, contact MyP&C (mypc@aristocrat.com) and submit changes within 30 days of when the event occurred.

What Benefits Can Be Changed When						
Benefit that can be changed	**Change in marital status** (marriage, divorce, death of spouse/ DP)	**Change in number of dependents** (birth, adoption, death of dependent)	**Start or end of employment** (by spouse/ DP or dependent)	**Change in your work hours**	**Significant change in health care plan coverage** (through your spouse/ DP's plan)	**Changes allowed anytime during the year** (qualifying life event not necessary)
Medical, Dental, Vision	X	X	X	X	X	
Health Savings Account	X	X	X	X	X	X
Health Care FSA	X	X	X	X	X	
Dependent Care FSA	X	X	X	X		
Employee Voluntary Life/AD&D, Spouse/DP/ Dependent Life	X	X	X	X		
Required Documentation	Marriage certificate, divorce decree, death certificate	Birth certificate, adoption agreement, or death certificate	Letter from employer confirming benefit start or end date, including dependents covered.		Letter from spouse/DP's employer confirming coverage change and effective date	None

HEALTH *benefits*

Health insurance exists to help offset the costs of medical events, whether they're planned or happen unexpectedly. The cost of health insurance will vary based on your individual situation, like your age, where you live, or even lifestyle.

Insurance doesn't pay everything, leaving you with out-of-pocket costs. In addition to your plan premiums, out-of-pocket costs include copayments, deductibles, and coinsurance. Each plan also includes an out-of-pocket maximum. It's important to understand how these costs work before you choose a plan.

Medical

For 2026, you have a choice of medical plans giving you the flexibility to choose what's best for your needs and budget.

- **Aetna PPO (Base and Buy-Up)**, the PPO plans, allow participants to see any doctor or specialist, but they typically pay less when using in-network providers. The PPO plans usually come with higher premiums, but offers co-pays for physician visits and prescription drugs without needing to meet the deductible. Out-of-pocket expenses can be moderate to high, but can be lowered if you use in-network providers.
- **Aetna HDHP**, the HDHP plan, features low premiums in exchange for a high deductible. This plan is designed to work with a tax-advantaged health savings account.
- **Aetna EPO**, the EPO plan, allows you to receive health care services from the plan's network of providers. Out-of-network services are not covered.

Key features

All of Aristocrat's medical plans offer:

- Comprehensive, affordable coverage for a wide range of health care services.
- In-network preventive care, with services covered at 100%, including annual physicals, recommended immunizations, well-woman and well-child exams, flu shots, and routine cancer screenings.
- Prescription drug coverage included with each medical plan. When you enroll in an Aetna medical plan, you will automatically be enrolled in the pharmacy plan with Express Scripts.
- Financial protection through annual out-of-pocket maximums that limit the amount you'll pay each year.

Aetna PPO and HDHP medical plans offer:

- Flexibility to see any provider you want, although you'll save money when you stay in-network.

Spouse/Domestic Partner Surcharge

Our medical plan will include a spousal/domestic partner surcharge. This is an additional monthly fee for employees who choose to cover a spouse/domestic partner that has access to their own employer-sponsored health insurance. If applicable, you'll pay a monthly surcharge of $100. Be sure to read through the Spousal/Domestic Partner Surcharge Agreement in Workday when you submit your enrollment. Medicare participants are excluded.

Summary of Benefits and Coverage

The Health section of this guide provides an overview of your medical plan options. You can find detailed information about each plan, including a breakdown of costs, in each plan's Summary of Benefits and Coverage (SBC). The SBCs summarize important information about your health coverage options in a standard format to help you compare costs and features across plans. The SBCs are available on www.atibenefits.com.

Choosing a health plan

Selecting the right health plan is one of the most important decisions you'll make all year. No two plans are exactly alike, so it's smart to comparison shop before you enroll. (See chart on the next page.) Consider the premium cost and the cost of care when choosing.

Which plan is right for you?

Consider which plan features are most important to you. Do you want to:	Aetna EPO	Aetna PPO Base	Aetna PPO Buy-Up	Aetna HDHP
Have access to a tax-advantaged account, which you can use to help pay for eligible expenses.				✓
Pay the lowest premium cost, which may make it the least expensive option if you expect to have low health care usage?				✓
Balance your out-of-pocket and paycheck costs with a moderate deductible and premium cost?	✓	✓		
Pay the highest premium cost to keep your out-of-pocket costs as low as possible when you need care?			✓	

Medical plan costs

You and Aristocrat share the cost of your medical benefits — Aristocrat pays a generous portion of the total cost and you pay the remainder through payroll deductions. Your specific cost is based on the plan and coverage level you selected.

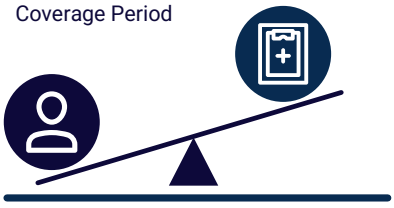
2026 per pay-check deductions (before tax)

Coverage level	Aetna EPO	Aetna PPO Base	Aetna PPO Buy-Up	Aetna HDHP
Employee Only	$17.85	$45.43	$111.84	$12.38
Employee + Spouse/DP	$126.70	$206.71	$399.31	$89.80
Employee + Spouse/DP (Surcharge)	$172.85	$252.87	$445.46	$135.95
Employee + Child(ren)	$79.56	$131.99	$258.17	$70.60
Family	$164.42	$248.57	$451.12	$122.77
Family (Surcharge)	$210.57	$294.72	$497.27	$168.93

You and Your Insurer Share Costs – Example

Jane's Plan Deductible: $2,000 **Coinsurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st
Beginning of Coverage Period



Jane pays **100%** | Her plan pays **0%**

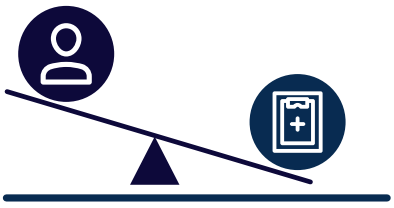
Jane hasn't reached her $2,000 **deductible** yet

Her plan doesn't pay any of the costs.

- **Office visit costs:** $125
- **Jane pays:** $125
- **Her plan pays:** $0

more costs





Jane pays **20%** | Her plan pays **80%**

Jane reaches her $2,000 deductible, **coinsurance** begins

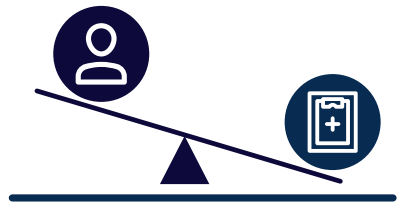
Jane has seen a doctor several times and paid $2,000 in total. Her plan pays some of the costs for her next visit.

- **Office visit costs:** $75
- **Jane pays:** 20% of $75 = $15
- **Her plan pays:** 80% of $75 = $60

more costs



December 31st
End of Coverage Period



Jane pays **0%** | Her plan pays **100%**

Jane reaches her $5,000 **out-of-pocket limit**

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

- **Office visit costs:** $200
- **Jane pays:** $0
- **Her plan pays:** $200

Compare medical plans

The chart below provides a comparison of key coverage features and costs.

Coverage	Aetna EPO	Aetna PPO Base		Aetna PPO Buy-Up		Aetna HDHP	
	In-Network	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Annual deductible							
Per person/per family	$500 / $1,000	$2,000 / $4,000	$4,000 / $8,000	$1,000 / $2,000	$2,000 / $4,000	$2,000 / $4,000	$4,000 / $8,000
Out-of-pocket maximum							
Per person/per family	$3,000 / $6,000	$5,000 / $10,000	$10,000 / $20,000	$4,000 / $8,000	$8,000 / $16,000	$5,000 / $6,900 / $10,000	$10,000 / $10,000 / $20,000
Medical coverage							
Office visits (PCP/SPC)	$20 / $40	$25 / $50	50%*	$15 / $30	40%*	20%*	40%*
Preventive care	No charge	No charge	50%*	No charge	40%*	No charge	40%*
Outpatient surgery	20%*	20%*	50%*	20%*	40%*	20%*	40%*
Inpatient hospital (per stay)	20%*	20%*	50%*	20%*	40%*	20%*	40%*
Emergency room	$300	$350	50%*	$250	40%*	20%*	40%*
Teladoc	No charge	No charge	Not Covered	No charge	Not Covered	Deductible + Copay	Not Covered
Labs and X-rays	No charge / $25	20%*	50%*	20%*	40%*	20%*	40%*
Retail prescription drugs (30-day supply) - Pharmacy Benefit through Express Scripts							
Generic	$10	$15	$15	$10	$10	$10[1]	$10[1]
Brand formulary	$35	$35	$35	$30	$30	$35[1]	$35[1]
Non-formulary	$60	$60	$60 + 20%	$50	$50 + 40%	$60[1]	$60 + 20%[1]
Mail-order prescription drugs (90-day supply) - Pharmacy Benefit through Express Scripts							
Generic	$25	$30	$30	$20	$20	$25[1]	$25[1]
Brand formulary	$87.50	$87.50	$87.50	$75	$75	$87.50[1]	$87.50[1]
Non-formulary	$150	$150	$150 + 20%	$125	$125 + 40%	$150[1]	$150 + 20%[1]

Money-Saving Tips

To stretch your health care dollars, remember to:

- **See in-network providers** who have agreed to accept lower negotiated rates. Visit your plan website to search for in-network providers near you.
- **Use the mail-order pharmacy** to save time and money when refilling long-term prescriptions.

Spousal/domestic partner surcharge

A spousal/domestic partner surcharge is an additional fee or premium you are required to pay if your spouse/domestic partner has an alternative source for health care coverage through their own employer but decides to be added to Aristocrat's plan. If applicable, you'll pay a monthly surcharge of $100. Be sure to read through the Spousal/Domestic Partner Surcharge Agreement in Workday when you submit your enrollment. Medicare participants are excluded.

**Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.*
[1] Medical deductible applies unless Preventative Rx. Deductible must be met before copay applies.

WHERE TO SEEK CARE

When you need help in a hurry, you have choices. Of course, when it's a life-threatening problem, you should call 911 or go straight to the nearest hospital emergency room (ER).

In the ER, true emergencies are treated first, so unless your life is in danger, you'll wait –sometimes for hours. The ER is also the most expensive option for care.

For non-life-threatening problems, call your doctor, access virtual visit services or go to an urgent care center.

	Care Center	Type of Care	Hours Available	Average Wait Time	Average Cost
	**Telemedicine** Speak to a board-certified physician anytime, anywhere	Seasonal allergies, cold, flu, depression	24/7		
	**Doctor's Office** Talk to the person who knows you and your medical history	Fevers, cold, flu, sore throat, stomach ache	Varies		
	**Retail Health Clinic** Access non-emergency care when you can't see your doctor	Infections, minor injuries or pain, strep throat	Based on retail store hours		
	**Urgent Care** Obtain non-emergency care that needs immediate attention	Cuts that need stitches, headaches, back pain, sprains, rashes	Extended hours including evenings, weekends, and holidays		
	**Emergency Room** Receive treatment for life and limb-threatening symptoms	Heart attack, chest pain, stroke, breathing problems, heavy bleeding, broken bones, sudden or severe pain	24/7		

A closer look at the HDHP

The high deductible health plan (HDHP) costs you less from your paycheck, so you keep more of your money. This rewards you for taking an active role as a health care consumer, as a result you could save on your health care costs.

Features of a low-cost, high-deductible plan

1

Managing costs

Your per-paycheck costs are lower compared to Aristocrat's other health plans, giving you the opportunity to budget the extra money saved in a way that works best for you and your family.

2

Tax-advantaged accounts

When you select a qualified health plan, you may be eligible to participate in programs to help you pay for certain medical expenses tax-free. You may also be able to use these programs to pay for dental, vision, or other services.

Note: Programs may have eligibility requirements you must meet before you can enroll.

You won't pay income taxes on withdrawals from a tax-advantaged account. Consult your tax advisor to learn more on how a tax-advantaged account may affect your state or federal taxes.

3

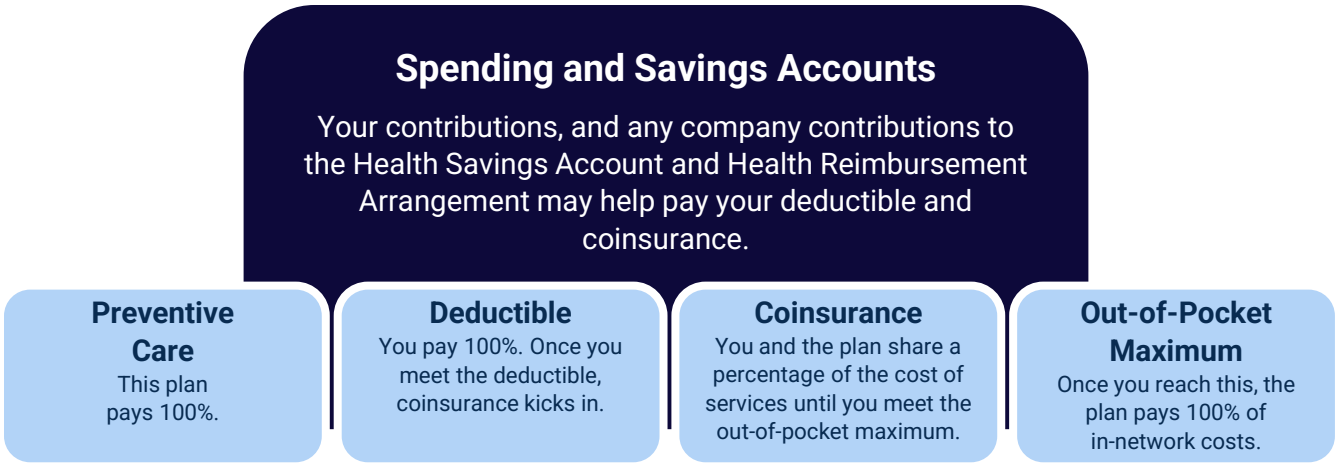
Free in-network preventive care

As with all Aristocrat health plans, preventive care is fully covered — you pay nothing toward your deductible and no copays when you receive care from in-network providers. Preventive care includes annual physicals, well-child and well-woman exams, immunizations, flu shots, and cancer screenings.

4

Extensive provider network

You can receive care from Aetna's large network of doctors and other health care providers.



Health Savings Account (HSA)

If you enroll in the HDHP, you may be eligible to open an HSA. An HSA is a tax-free savings account you can use to pay for eligible health expenses anytime, even in retirement.

How does an HSA work?

Build tax-free savings. You can make before-tax deductions from your paycheck into your HSA, allowing you to save money by using tax-free dollars to pay for eligible medical and Rx, dental, and vision expenses. The total amount that can be contributed to your HSA each year is limited by the IRS: (https://hsabank.com/HSABank/Learning-Center/IRS-contribution-limits-and-guidelines)

Note: Aristocrat may set a different limit. The following limits for 2026 include any Company contributions you receive:

- Up to $4,400 for employee-only coverage.
- Up to $8,750 if you cover dependents.
- Add $1,000 to these limits if you're age 55 or older.

Receive Company contributions. For 2026, Aristocrat may make the following contribution to your account:

- $1,000 ($38.46 bi-weekly) for employee-only coverage.
- $2,000 ($76.92 bi-weekly) if you cover dependents.

- **Important:** During your initial enrollment, you have to actively select an HSA contribution amount for 2026 to receive Aristocrat's HSA contribution to your account. The maximum amount you may contribute for 2026, along with any Company contributions, will be prorated based on your actual hire date on a bi-weekly basis.

Keep your money. Unlike an FSA, the money in your HSA is always yours to keep and can be rolled over from year to year. You can take your unused balance with you when you retire or leave Aristocrat.

Use it like a bank account. Pay for eligible expenses for yourself and your family by swiping your HSA debit card or reimburse yourself for payments you've made (up to the available account balance). Remember, you may only access money that is actually in your HSA when making a purchase or withdrawal. Be sure to keep receipts for your records.

Earn interest and invest for the future. Once your interest-bearing HSA reaches a minimum balance of $1,000, you can invest in a variety of stocks, mutual funds, ETFs and more. (https://hsabank.com/HSABank/Members/HSA-Investment-Options)

Never pay taxes. Contributions are made on a before-tax basis, and your withdrawals will never be subject to federal income taxes when used for eligible expenses. Any interest or earnings on your HSA balance build tax-free, too.*

** Money in an HSA grows tax-free and can be withdrawn tax-free if it is used to pay for qualified health care expenses (for a list of eligible expenses, see IRS Publication 502, available at **www.irs.gov**). If money is used for ineligible expenses, you will pay ordinary income tax on the amount withdrawn plus a 20% penalty tax before age 65. After age 65, withdrawals for ineligible expenses are not penalized. Please review your state regulations and talk with a tax advisor as you may have to pay state taxes depending on your residency.*

HSA eligibility

To establish and contribute to an HSA, you:

- Must be enrolled in Aristocrat's Aetna HDHP plan.
- Cannot be covered by any other medical plan that is not a qualified high deductible plan. This includes a spouse's medical coverage unless it's an HSA-qualified plan.
- Cannot be enrolled in any reimbursement plan that pays for medical expenses before meeting the Aetna HDHP deductible
- Cannot be enrolled in a traditional Health Care FSA in 2026.
- Cannot be enrolled in Medicare, including Parts A or B, Medicaid, or TRICARE.
- Cannot be claimed as a dependent on another person's tax return.
- Have not received any Veteran's Administration health benefits for a non-service connected disability in the last three months.
- Have not used Indian Health Services coverage in the last three months.

USING **YOUR HSA**

1 START IT

When you enroll in the HDHP medical plan, you will be eligible for the HSA account. Elect how much you want to contribute up to the IRS limit.

2 BUILD IT

Aristocrat will deposit an **employer contribution** into your account each pay period. You can change how much you contribute throughout the year if it doesn't exceed the IRS limit.

3 USE IT

Use your HSA balance to pay for eligible expenses, tax-free, including your deductible, coinsurance, prescriptions, and more.

4 GROW IT

Unused money in your HSA automatically rolls over from year to year. **You never lose funds in your HSA.**

** All tax references are for federal income taxes. State and other taxes vary, depending on your residency. Check with your tax advisor for more details.*

Flexible Spending Accounts (FSAs)

Now let's take a quick look at the other type of account you may be able to select — a spending account.

Aristocrat offers three types of flexible spending accounts (FSAs) to help you save on medical, dental, vision, and many daycare expenses: Health Care FSA, Limited-Purpose FSA, and Dependent Care FSA

Remember, you can't have a full-service Health Care FSA and an HSA at the same time. You can, however, choose an HSA along with a Limited-Purpose FSA to use for dental and vision expenses only.

FSA *Fast Facts*

Contribution limits. Set aside up to $3,400 for eligible health care expenses and $3,750 or $7,500 for dependent care expenses. Unused funds, except what can be rolled over, are forfeited at year's end.

Lower your taxable income. Money you set aside is pretax dollars, so you pay taxes on a smaller amount.

Take advantage of payroll deduction. Contribute equal amounts each pay period.

Changes not allowed. Unless you experience a qualifying life event, you cannot change your annual contribution amount.

Separate accounts. You cannot use Health Care FSA funds to pay dependent care expenses, or vice versa.

Use-It-Or-Lose-It Rule

Plan your health care FSA contribution amount carefully. Any unused funds greater than any allowed rollover amount are forfeited. Visit www.hsabank.com for help estimating expenses. Be sure to keep all expense receipts for your tax records because you may need to provide proof of eligible expenses and how the funds were used.

Quick Look: YOUR FSA OPTIONS

	HEALTH CARE FSA	LIMITED-PURPOSE FSA	DEPENDENT CARE FSA
Who may enroll?	Non-HDHP plan participants	HDHP plan participants	All employees
What types of expenses are reimbursable?[1]	Eligible medical, dental, vision, and prescription drug expenses (includes deductibles, copays, and coinsurance)	Eligible dental and vision expenses only (includes deductibles, copays, and coinsurance)	Eligible dependent care expenses (includes childcare, day camps, after school care, and adult daycare)
What is the maximum annual contribution?	$3,400	$3,400	$3,750 or $7,500[2]
Does the Company contribute?	No	No	No
Do leftover funds roll over each year?	Yes, up to $680 can be rolled over from your 2026 FSA account		No, you must ***use it or lose it*** – funds remaining at the end of the plan year are forfeited

[1] *For a list of eligible expenses, visit* www.irs.gov/pub/irs-pdf/p503.pdf..

[2] *The dependent care FSA contribution limit is $3,750 for single filers and couples filing jointly and $7,500 for married couples filing separately.*

Flexible Spending Accounts (FSAs) continued

Tax-advantaged FSAs are a great way to save money. The money you contribute to these accounts comes out of your paycheck without being taxed, and you withdraw it tax-free when you pay for eligible health care and dependent care expenses.

HSA vs. Health Care FSA: What's the difference?

	HSA	Health Care FSA
Available if you enroll in a …	**HDHP Plan**	Non-HDHP plan
Eligible for Company contributions	Yes	No
Change your contribution amount any time	Yes	No
Access your entire annual contribution amount from the beginning of the plan year	No	Yes
Access only funds that have been deposited	Yes	No
"Use-it-or-lose-it" at year-end	No	Yes*
Money is always yours to keep	Yes	No

** Except for allowed rollover amount.*

Managing your FSA(s)

When you enroll in a Health Care FSA, you will receive a debit card, which you can use to pay for eligible expenses. Depending on the transaction, you may need to submit receipts or other documentation to your FSA administrator.

What's an eligible expense?

Health Care FSA – Plan deductibles, copays, coinsurance, and other health care expenses. To learn more, see IRS Publication 502 at **www.irs.gov**.

Dependent Care FSA – Child day care, babysitters, home care for dependent elders, and related expenses. To learn more, see IRS Publication 503 at **www.irs.gov**.

Commuter Benefits

Another way to save money through tax-free spending is with Aristocrat's commuter benefits program. You can use before-tax dollars to pay for monthly parking or transit costs related to your work commute. It's easy and flexible. Before-tax deductions are allowed up to the IRS limit of $340 per month for parking or transit.

For more information, call Aristocrat Commuter Benefits at 800-357-6246 or visit **www.hsabank.com**



Dental

Healthy teeth and gums are important to your overall wellness. That's why it's important to have regular dental checkups and maintain good oral hygiene. Learn about the dental plans available to help you maintain your oral health.

Delta Dental DHMO

With this plan, you choose a primary dental provider to manage your care and it is in-network benefit coverage only. There are no charges for most preventive services, no claim forms and no deductibles. Reduced, pre-set charges apply to other services.

Delta Dental DPPO

These plans offer you the freedom and flexibility to use the dentist of your choice. However, you will maximize your benefits and lower your out-of-pocket costs if you choose a dentist who participates in the Delta Dental network.

Key Dental Benefits	DHMO	DPPO 1000 (Base)		DPPO 2000 (Buy-Up)	
	In-Network Only	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible (per calendar year)					
Individual / Family	None / None	$50 / $150		$50 / $150	
Benefit Maximum (per calendar year; preventive, basic and major services combined)					
Per Individual	None	$1,000		$2,000	
Covered Services					
Preventive Services	No charge	No charge		No charge	
Basic Services	See Schedule	20%*		10%*	
Major Services	See Schedule	50%*		40%*	
Orthodontia (Child & Adult)	$1,900 Max. Adult, $1,700 Children; see schedule for details	Not covered		50%*, $2,000 Lifetime Maximum	

**Benefits with an asterisk (*) require the deductible be met before the Plan beings to pay.*

Dental 2026 per-paycheck deductions (before tax)

Plan	Employee Only	Employee + Spouse/DP	Employee + Child(ren)	Employee + Family
DHMO Plan	$0.00	$0.00	$0.00	$0.00
PPO Plan 1000	$5.13	$10.94	$17.68	$26.20
PPO Plan 2000	$13.74	$24.72	$29.39	$44.12



Vision

Having vision coverage allows you to save money on eligible eye care expenses, such as periodic eye exams, eyeglasses, contact lenses, and more for you and your covered dependents.

VSP 130 Plan

This plan, with premiums 100% covered by Aristocrat for all tier levels, includes comprehensive coverage with an annual eye exam and pays up to $130 towards contacts every year or glasses every 2 years.

VSP 150 Plan

This plan provides more comprehensive coverage, which includes an annual eye exam and pays up to $150 towards contacts every year or glasses every year. This plan also offers LightCare, $150 allowance for ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses, instead of a prescription glasses or contacts.

VSP Easy Choice Plan

This plan has the most comprehensive coverage with an annual eye exam. This plan allows employees 1 upgrade option per year which allows for one of the following additional benefits.

$250 Frame Allowance, Anti-Reflective Lenses, Progressive Lenses, Photochromatic Lenses, Contacts (in lieu of glasses), $200 General Allowance

Key Vision Benefits	VSP 130 (Base)		VSP 150 (Buy-Up) & VSP Easy Choice	
	In-Network	Out-of-Network Reimbursement	In-Network	Out-of-Network Reimbursement
Exam	$25	Up to $45	$10	Up to $45
Materials Copay	$25	N/A	$10	N/A
Lenses Single Vision Bifocal Trifocal	Covered after Materials copay	Up to $30 Up to $50 Up to $65	Covered after Materials copay	Up to $30 Up to $50 Up to $65
Frame	$130	Up to $70	$150	Up to $70
Contact Lenses (in lieu of glasses)	$130	Up to $105	$150	Up to $105
Frequency (Exam, Lenses, Frames)	12 / 12 / 24 months		12 / 12 / 12 months	

Vision 2026 per-paycheck deductions (before tax)

Plan	Employee Only	Employee + Spouse/DP	Employee + Child(ren)	Employee + Family
VSP 130 Plan	$0.00	$0.00	$0.00	$0.00
VSP 150 Plan	$1.86	$3.76	$4.03	$6.48
VSP Easy Choice	$3.05	$6.20	$6.64	$10.65

Money-Saving Tip

Remember, you may be able to use your health savings or spending account for qualified out-of-pocket dental and vision expenses

Focus on Wellness

The wellness programs and services below are available to either all employees, or to medical plan members based upon your specific plan choice. Use these resources to help you and your family live a healthier lifestyle, remain active and enjoy the best life possible.

Wellness Programs

Employee Assistance Program

Life is full of challenges, and sometimes balancing them all can be difficult. We are proud to provide a confidential program dedicated to supporting the emotional health and well-being of our employees and their families. The EAP is provided at NO COST to you through Lyra.

The EAP can help with the following issues:

- Mental health
- Relationships or marital conflicts
- Child and eldercare
- Substance abuse
- Grief and loss
- Legal or financial issues

EAP benefits:

- Up to 12 in-person coaching or counseling sessions per issue, per year, per individual (through Health Plan Integration, members can continue past 12 sessions in-network)
- Medication management through Health Plan Integration
- Unlimited toll-free phone access and online resources

Contact the EAP anytime, day or night, by calling (877) 248-1047 or by visiting www.aristrocrat.lyrahealth.com.

Virtual Care

Gone are the days when you must be stuck in traffic or even leave your home to visit the doctor for non-life-threatening issues. Telemedicine services provide a convenient, low-cost, and time-saving alternative for health care via computer, tablet, or smartphone.

Teladoc (through Aetna Medical)

Aetna Virtual Primary Care™ powered by Teladoc Health® (AVPC) is a nationwide virtual primary care solution that connects members to care when and where they need it, conveniently and affordably. This product offers a virtual provider, supported by a robust care team, to coordinate care across the entire health care journey. Members can message their provider and care team at any time and be connected with in-person care at MinuteClinic and CVS HealthHUB locations, or in-network providers, when needed.

Virtual Dentistry (through Delta Dental)

Virtual dentistry offers members convenient access to a Delta Dental dentist for answers to questions, quick checkups, second opinions or other oral health needs in between visits to the dentist's office. Virtual assessments don't count towards exam frequency limitations and are a covered benefit for Delta Dental PPO™ and Delta Dental Premier® members.

Teladoc: www.Teladoc.com/Aetna

Virtual Dentistry: www.deltadentalins.com

Caregiving Support

Wellthy is for anyone who finds themselves managing care for a loved one, or themselves (in any capacity, big or small). For families with childcare or complex, chronic, and ongoing care needs (i.e. parent with dementia, spouse with cancer, child whose daycare is closed, sibling with a mental health condition), you can save time, money, and stress with Wellthy.

What Wellthy's support covers:

- Parenting Support
- Teen Support
- Pet Care Support
- Care Planning
- Natural Disaster Care and Support
- End of Life and Loss Support

Learn more at www.wellthy.com/member/aristocrat (Company Code: aristocrat23) or by calling 877-588-3917

Take advantage of preventive care benefits

Good preventive care can help you stay healthy and detect any "silent" problems early, when they're most likely to be treatable. Most in-network preventive services are covered in full, so there's no excuse to skip it.

- **Have a routine physical exam each year.** You'll build a relationship with your doctor and can reduce your risk for many serious conditions.
- **Get regular dental cleanings.** Numerous studies show a link between regular dental cleanings and disease prevention — including lower risks of heart disease, diabetes, and stroke.
- **See your eye doctor at least once every two years**. If you have certain health risks, such as diabetes or high blood pressure, your doctor may recommend more frequent eye exams.

Don't have a personal doctor? You should. Here's why.

- **Better health.** Getting the right health screenings each year can reduce your risk for many serious conditions. And remember, preventive care doesn't cost you anything.
- **A healthier wallet.** A PCP can help you avoid costly trips to the emergency room. Your doctor will also help coordinate specialist care, if needed.
- **Peace of mind.** Advice from someone you trust means a lot when you're healthy, but it's even more important when you're sick.

TOUCHCARE

Your personal healthcare assistant to offer free and confidential assistance

As an employee who receives benefits through your school or company, you have access to TouchCare's services. TouchCare is here to help answer any and all of your health care and benefit questions at no cost to you!

Download the TouchCare app on your smartphone's app store or visit www.touchcare.com to get started

How To Begin?

To Open a case, members simply need to register via TouchCare online portal at www.touchcare.com or through the iOS / Android app

Click "new member" on the sign-up page

Verify your email

Complete your registration by filling out the intake form and creating a username and password

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As a TouchCare member, you have a personal Health Assistant in your pocket. TouchCare is here to help answer any and all of your health care and benefit questions (at no cost to you)

- Benefit Navigation
- Bill Negotiation
- Cost Comparison
- Provider Search
- Prescription Assistance
- And more!

SCAN ME

Scan the QR code to sign up and get started!

Get in Touch

Call TouchCare between 8am – 9pm (ET) Monday through Friday at **866-486-8242** or email assist@touchcare.com.

TouchCare is your Number One point of contact for any and all healthcare related questions!

WEALTH *benefits*

Aristocrat's life and disability insurance programs are designed to help secure your income and provide your family with peace of mind knowing their financial needs will be looked after if something happens to you.

Life and AD&D Insurance

Employee basic life and AD&D insurance

You automatically receive basic life and accidental death and dismemberment (AD&D) insurance so that you can protect those you love from the unexpected. There is no cost to you for this coverage. Your benefit amount will be one times your base salary up to $500,000.

Benefit Amount (Company-Paid)	
Employee	1x Annual Salary up to $500,000

Employee supplemental life and AD&D insurance

If you want added protection, you can purchase supplemental life and AD&D insurance for yourself. You may elect coverage up to 5 times your base annual salary, in $10,000 increments up to $1,000,000

Spouse/domestic partner voluntary life and AD&D insurance

You may also purchase life and AD&D insurance for your spouse/domestic partner up to $250,000 (not to exceed your coverage).

Child voluntary life and AD&D insurance

You have the option of purchasing child life and AD&D insurance at $5,000 or $10,000 benefit amounts.

Benefit Amount by Coverage Tier (Supplemental)		Guaranteed Issue[1]
Employee	$10,000, up to 5x annual salary up to $1,000,000	$500,000
Spouse/DP	100% of employee amount up to $250,000	$50,000
Child(ren)	$5,000 or $10,000	$10,000

1. During your initial eligibility period only, you can receive coverage up to the Guaranteed Issue amounts without having to provide Evidence of Insurability (EOI, or information about your health). Coverage amounts that require EOI will not be effective unless approved by the insurance carrier.
2. If you are currently enrolled in supplement life, you can increase your coverage by $10,000 during open enrollment without needing an EOI.

What is AD&D insurance?

Should you lose your life, sight, hearing, speech or use of your limb(s) in an accident, AD&D provides additional benefits to help keep your family financially secure. AD&D benefits are paid as a percentage of your coverage amount — from 50% to 100% — depending on the type of loss.

Have you named a beneficiary?

Be sure you've selected a beneficiary for all your life and accident insurance policies. The beneficiary will receive the benefit paid by a policy in the event of the policyholder's death. It's important to designate a beneficiary and keep that information up-to-date. Beneficiary information must be listed in Workday.

Disability insurance

The loss of income due to illness or disability can cause serious financial hardship for your family. Our disability insurance programs work together to replace a portion of your income when you're unable to work. The disability benefits you receive allow you to continue paying your bills and meeting your financial obligations during this difficult time.

Quick Look:
DISABILITY INSURANCE

	Short-Term Disability	Basic Long-Term Disability
Who pays	Employer	Employer
Benefit provided	Up to 66.67% of before-tax weekly earnings	Up to 60% of before-tax monthly earnings
Maximum benefit payable	$2,500 per week	$10,000 per month
Maximum benefit duration	26 weeks	Until you're no longer considered disabled or you reach normal retirement age, whichever comes first
When benefits begin (Elimination Period)	Immediately or the day you become disabled (due to injury), immediately (due to pregnancy), or on the 8th day (due to sickness)	180 days

1. **Short-Term Disability (STD):** You are automatically enrolled in the STD benefit but will still need to submit a claim to receive benefits.

2. **Long-Term Disability (LTD):** You are automatically enrolled in the LTD benefit but will still need to submit a claim to receive benefits. which begins after 180 days of disability.



What the STD and LTD Plans Do Not Cover

The STD and LTD plans don't cover disabilities caused by:

- An accident that occurs on the job
- Self-inflicted injury, whether you are sane or insane
- War, whether declared or not, or international armed conflict
- Active participation in a riot
- Disabilities during employment with another employer
- Disability incurred while participating in an illegal act

Retirement savings plan

401(k) savings plan

Your Company 401(k) Savings Plan, administered by Charles Schwab, provides advantages you may not get with other types of savings plans and helps you meet one of life's important goals — saving for a financially secure retirement.

Eligibility

You are automatically eligible for the Aristocrat 401(k) plan on your date of hire, but your deferral can take up to at least 30 days to be taken from your check.

Your contributions

You can contribute to your 401(k) with before-tax money, Roth after-tax money, or both. The type of contributions you make will depend on your financial goals and circumstances. Both before-tax and Roth after-tax contributions count toward the IRS maximum of $24,500 for 2026. You can contribute 1% – 100% of your eligible earnings up to IRS limits and If you are age 50 or older, you may make additional catch-up contributions — up to $32,500 for 2026

Beginning in 2025, anyone age 60-63 may make a special annual catch-up contribution up to the greater of $10,000 or 150% of the "standard" catch-up contribution amount in effect for the taxable year (indexed for inflation annually).

Company matching contributions

Once eligible and enrolled, Aristocrat matches 100% up to the first 4% of your contributions to support your retirement saving efforts.

Traditional vs. Roth 401(k) plan

There are two main types of 401(k) retirement savings plans: traditional and Roth. The difference really comes down to a single word: **TAXES**.

TRADITIONAL 401(k) - This one's for anyone who wants to put off paying taxes. Any money you save or invest isn't taxed until you withdraw it in retirement. Withdrawals are considered income and will be taxed at your current (retirement) federal and state tax rates. A traditional 401(k) also reduces your overall annual income, so you'll pay lower taxes while working.

Example: *If your annual salary is $35,000 and you contribute $5,000 to a traditional 401(k), you'll only pay taxes on $30,000 for that year.*

ROTH 401(k)* - A Roth 401(k) functions similarly to a traditional 401(k) plan, with one big difference — you make contributions to a Roth 401(k) with after-tax dollars. This type of plan is for anyone who wants to pay taxes now. Then, when you pull money out of the plan during retirement, you won't pay any taxes on the withdrawal.

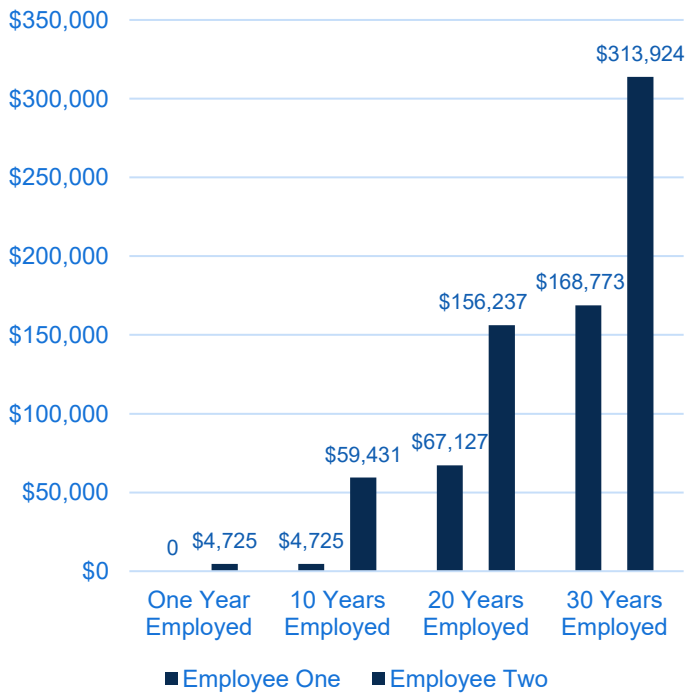
** There are no taxes on a withdrawal/distribution from ROTH 401(k) if it is a qualified distribution:*

1. *At least 5 years must have passed from the first day of the calendar year in which you made your first Roth 401(k) contribution.*
2. *Triggering event – the withdrawal is after you've turned age 59 ½*
3. *You've become disabled*
4. *Your death*

Starting early pays off!

Compounding interest example

Starting your retirement savings journey early can pay off. As your account balance grows, you earn a larger amount due to compounding interest. Take for example two employees. Employee One begins contributing his first year of employment, while Employee Two waits until his 10th year of employment. Both employees contribute 5% to their 401(k) and receive a 4% match from Aristocrat.** When both employees are ready to retire at age 67, Employee One who signed up for the 401(k) plan the first year has nearly double the amount of Employee Two who waited several years to join the plan. Employee One's money was invested longer and was able to take advantage of compounding interest for more years.



*** Based on both employees receiving the same average rate of return.*

Traditional 401(k) Highlights

Pros:

Employee-managed – Easy way to save using payroll deductions. Choose from several investment funds.

Contribute more each year – Higher contribution limit and catch-up feature for anyone 50 or older. 2026 Limit: $24,500 ($32,500 after the age of 50). **Note:** Limits are for traditional and Roth 401(k) contributions combined.

Increased savings potential – Contributions aren't taxed when deducted from your paycheck, so you save more each pay period. This means more interest earned, and more money in the long run.

Cons:

Taxes at withdrawal – When you take money out at retirement, you'll pay taxes at the current federal and state rates, which could be higher if rates rise each year.

Roth 401(k) Highlights

Pros:

Employee-managed – Easy way to save using payroll deductions. Choose from several investment funds.

Similar contributions – A Roth 401(k) has the same annual contribution limits as a traditional 401(k). **Note:** Limits are for traditional and Roth 401(k) contributions combined.

Secure – Again, this type of 401(k) is transferable if you leave the Company.

No taxes upon withdrawal – When you retire, the money you see in your Roth 401(k) is what you get — no tax deductions occur.

Cons:

Contributions are not tax deductible – Roth contributions do not allow you to lower your taxable income at the time contributions are withheld from your paycheck.

Investment elections

The plan offers you a variety of investment options to choose from. It's important to carefully consider your investment goals, retirement timeframe, and risk tolerance when deciding how to invest your plan contributions. Visit www.workplace.schwab.com. to learn more about your investment options.

Vesting

Vesting refers to your ownership of the money in your account. You are always 100% vested in your own contributions. You become fully vested in any Company contributions after 2 years of employment.

Enrolling in the plan

Charles Schwab will receive your demographic data after you receive your first paycheck. They will then create an account for you and auto-enroll you for a 4% deferral the first of the month after 30 days. If you would like to opt out of the plan or defer a different percentage, you will need to contact Charles Schwab at (800) 724-7526 or online at www.workplace.schwab.com.

Please note that you will not be able to make these changes until your account is set up with Charles Schwab and that will not occur until after your first paycheck is received.

After-tax contributions

Made to your Plan account after taxes are deducted from your eligible pay, these contributions allow you to save beyond the IRS limit placed on pre-tax and Roth 401(k) contributions. You may contribute up to 100% of your eligible pay in combined pre-tax, Roth 401(k), and after-tax contributions, not to exceed the annual additions limit. The annual additions limit is the total dollar amount that you and your employer may contribute to your Plan account each year. This limit for 2026 is $72,000, excluding any catch-up contributions. Any earnings on after-tax contributions are taxable upon withdrawal. After- tax contributions are not eligible for the employer match.

SELF *benefits*

Aristocrat's voluntary benefits, such as accident, critical illness, and hospital indemnity insurance, provide an added layer of protection by paying a cash benefit for specifically covered events that you can use for out of pocket expenses that you choose. Accident, Critical Illness and Hospital Indemnity Insurance are limited benefit policies. They are not health insurance and they do not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

Supplemental health insurance

Accident insurance

No matter how good your medical insurance plan is, it won't cover everything if you have a serious accident. This means you'll still have out-of-pocket expenses. If you miss work because of an accident, your living expenses such as food, a mortgage, utilities, etc. won't stop.

Accident insurance pays you benefits for specific injuries and events resulting from a covered accident that occurs outside of work. Covered injuries or events include such things as a broken bone, burn, concussion or ruptured disc.

Meet Mary

A **broken leg** meant Mary had to stay off her feet for a while, with several weeks of physical therapy. While she was recovering, Mary's accident insurance helped her cover her out of pocket expenses.

Mary used part of her accident insurance benefit toward her physical therapy copays. She used the rest toward after school care for her children while she was at physical therapy appointments.

Provided as an example only. Actual results may vary.

Hospital indemnity insurance

A hospital stay, whether unexpected or not, can affect your finances even when you do have medical insurance. But having Hospital Indemnity Insurance coverage in place before a hospitalization can help minimize the financial impact and provide support at a time when it's needed most.

Hospital indemnity insurance pays a cash benefit if you have a covered stay in a hospital. This benefit is paid directly to you and is intended to help you with those out of pocket expenses that range from copays to parking to groceries while you recover. You can use the cash benefits however you wish.

See the product brochure, certificate of coverage and any applicable riders for the definition of covered facilities, along with complete provisions, exclusions and limitations.

Meet Miguel

Miguel was having trouble breathing and had to be hospitalized for several days. He used his hospital indemnity insurance to pay out of pocket that his primary medical plan didn't cover.

Provided as an example only. Actual results may vary.

Critical illness insurance

The treatment to recover from a critical illness is vital, but it can also be expensive. Your medical coverage may only cover some of the costs associated with treatment. You're likely still responsible for deductibles and coinsurance. And if you miss work because of treatments, that only adds to the financial impact.

Critical illness insurance pays a lump-sum benefit if you are diagnosed with a covered disease or condition on or after your effective date. You choose benefits to protect yourself and any eligible family members. Once enrolled, if you are diagnosed with a covered critical illness, you will receive a lump-sum cash benefit. You decide how to use the cash benefits.

See the product brochure, certificate of coverage and any applicable riders for a complete list of covered conditions, along with complete provisions, exclusions and limitations.

Meet Steve

A **heart attack** forced Steve to take an extended leave. While he has medical insurance through Aristocrat, Steve was still responsible for paying out-of-pocket costs that he didn't anticipate. With his critical illness insurance, Steve was able to pay for some of his out of pocket expenses without dipping into his savings.

Steve used part of his critical illness insurance benefit toward his deductible and coinsurance for a surgery and hospital stay. He used the rest toward ongoing costs for outpatient cardiac rehabilitation and prescription medications.

Provided as an example only. Actual results may vary.

Voluntary Benefits

Legal Services

ARAG Legal insurance is a voluntary benefit that provides access to attorneys who can offer help and advice on a variety of legal issues. The plan can cover you and your eligible dependents. The plan gives you access to identity theft services, guardianship services, home buying services, home equity loans, home refinancing services, and more!

Identity theft protection

LifeLock™ with Norton™ Benefit Plans help protect your digital life by combining leading identity theft protection, device security, and more, in an always-connected world. Everyday things like online shopping, banking and even browsing can expose personal information and make you vulnerable to cybercriminals and identity theft. LifeLock helps monitor your personal accounts and sends you alerts* if they detect potential threats to your identity. If you should become a victim of identity theft, they'll work to resolve it. Norton's multi-layered, advanced security helps protect against existing and emerging malware threats to your devices and helps protect your private and financial information when you go online.

Learn more about this benefit offering by reviewing the microsite at www.Norton.com/PremPremierPlus

No one can prevent all identity theft or cybercrime.
** Norton LifeLock does not monitor all transactions at all businesses.*

Pet insurance

Voluntary Pet insurance, through Nationwide helps you save on unexpected veterinary expenses plus optional coverage to help pay for routine veterinary care, such as vaccines, wellness exams, and teeth cleaning. Premiums are paid directly to Nationwide.

Pet Discount and Pharmacy Plan

Pet Benefit Solutions provide voluntary pet discount programs to help you save on your pet care needs. Pet Assure provides discounts on veterinary services like office visits, vaccinations, hospitalizations and more. Pet Assure also includes access to a lost pet recovery service. PetPlus provides discounts on pet products and prescriptions such as medications, vitamins, treats, and more. PetPlus includes access to a 24/7 pet telehealth staffed by licensed vets. Enroll in either the pet discount program, the pharmacy plan, or both at any time throughout the year.

TIP: You won't pay income tax on any voluntary benefits you choose because contributions are deducted on a post-tax basis. This means premiums are paid with after tax dollars, so any reimbursements or payouts you receive from these plans are not taxable income



Contacts

Please contact the appropriate provider listed below to learn more about a specific benefit plan.

Benefit Plan	Provider	Policy #	Phone Number	Website
ATI Benefits	–	–	–	www.atibenefits.com mypc@aristocrat.com
Healthcare Concierge Service	TouchCare	–	866-486-8242	assist@touchcare.com www.touchcare.com/ask
HEALTH *benefits*				
Medical	Aetna	231720	866-831-0016	www.aetna.com
Virtual Visits	Teladoc	Benefit through Aetna	855-Teladoc (835-2362)	www.teladoc.com/Aetna
Online Benefits Counselor	ALEX	–	–	www.start.myalex.com/aristocrat
Prescription Drug Coverage	Express Scripts	-	800-282-2881	www.express-scripts.com
HSA/FSA/Commuter Benefits	HSA Bank	–	800-357-6246	www.hsabank.com
Dental	Delta Dental	DPPO: 18597 DHMO: 79080	PPO: 800-521-2651 HMO: 800-422-4234	www.deltadentalins.com
Vision	VSP	30071075	800-877-7195	www.vsp.com, imember@vsp.com
Employee Assistance Program (EAP)	Lyra	–	877-248-1047	www.aristocrat.lyrahealth.com, care@lyrahealth.com
COBRA	Optum Financial	–	855- 687-2021	www.cobra.optumfinancial.com
WEALTH *benefits*				
Life and AD&D Insurance	Mutual Of Omaha	GLUG-BML6, GVTL-BML6	800-775-8805, (Fax 402-997-1835)	www.mutualofomaha.com, submitgrplife@mutualofomaha.com
Disability Insurance	Mutual Of Omaha	GLTD-BML6, GUSI-BML6	800-877-5176, (Fax 402-997-1865)	www.mutualofomaha.com, newdisabilityclaim@mutualofomaha.com
401(k) Savings Plan	Charles Schwab	–	800-724-7526	www.workplace.schwab.com
SELF *benefits*				
Voluntary Benefits (Accident, Critical Illness, Hospital Indemnity)	Voya	71358-9CAC2, 71358-9CCI2, 71358-9CHI	877-236-7564	www.presents.voya.com/EBRC/aristocrat
Caregiving	Wellthy	–	877-588-3917	www.wellthy.com/member/aristocrat Company Code: aristocrat23
Legal Plan	ARAG	18209	800-247-4184	www.ARAGlegalcenter.com Access Code: 18209ari
Identity Theft Protection	Norton Lifelock Identity Theft Protection	–	800-607-9174	www.norton.com/PremPremierPlus
Pet Insurance	Pet Benefit Solutions	3896	800-891-2565	www.petbenefits.com/land/aristocrattechnologiesinc
	Nationwide	–	877-738-7874	www.petinsurance.com/aristocrat

Important notice to employees from Aristocrat Technologies about creditable prescription drug coverage and Medicare

The purpose of this notice is to advise you that the prescription drug coverage listed below under the Aristocrat Technologies medical plan are expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2026. This is known as “creditable coverage.”

Why this is important. If you or your covered dependent(s) are enrolled in any prescription drug coverage during 2026 listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty – as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

If you or your family members aren’t currently covered by Medicare and won’t become covered by Medicare in the next 12 months, this notice doesn’t apply to you.

Please read the notice below carefully. It has information about prescription drug coverage with Aristocrat Technologies and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

Notice of creditable coverage

You may have heard about Medicare’s prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered by one of the Aristocrat Technologies prescription drug plans, you’ll be interested to know that the prescription drug coverage under the plans is, on average, at least as good as standard Medicare prescription drug coverage for 2025. This is called creditable coverage. Coverage under one of these plans will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage. In this case, the Aristocrat Technologies Group plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop Aristocrat Technologies coverage, Medicare will be your only payer. You can re-enroll in the employer plan at annual enrollment or if you have a special enrollment or other qualifying event, or otherwise become newly eligible to enroll in the Aristocrat Technologies plan mid-year, assuming you remain eligible.

You should know that if you waive or leave coverage with Aristocrat Technologies and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future – such as before the next period you can enroll in Medicare prescription drug coverage, if this Aristocrat Technologies coverage changes, or upon your request.

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. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

- Visit medicare.gov for personalized help.
- Call your State Health Insurance Assistance Program (see a copy of the Medicare & You handbook for the telephone number) or visit the program online at https://www.shiptacenter.org/.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

For more information about this notice or your prescription drug coverage, contact:

Aristocrat Technologies
10220 Aristocrat Way
Las Vegas, NV 89135
(800) 482-3723

mypc@aristocrat.com

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 July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**ALASKA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
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	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – 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	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)	**KANSAS – Medicaid**
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	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – 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	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	**MASSACHUSETTS – Medicaid and CHIP**
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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
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)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825; or 1-866-614-6005
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – 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)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542; Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	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 (regionally-restricted); or 1-855-242-8282
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	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	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, 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

Notice of Special Enrollment Rights for Medical plan coverage

As you know, if you have declined enrollment in Aristocrat Technologies' medical plan for you or your dependents (including your spouse) because of other health insurance coverage, you or your dependents may be able to enroll in some coverages under this plan without waiting for the next open enrollment period, provided that you request enrollment within 30 days after your other coverage ends. 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 eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Aristocrat Technologies will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have *60 days* – instead of 30 – from the date of the Medicaid/CHIP eligibility change to request enrollment in the Aristocrat Technologies group health plan. Note that this new 60-day extension doesn't apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another medical plan

Women's Health and Cancer Rights Act notice

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your medical carrier at the phone number listed on the back of your ID card.

Newborns' and Mothers' Health Protection Act notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your medical carrier at the phone number listed on the back of your ID card.

Aristocrat Technologies HIPAA privacy notice

Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by Aristocrat Technologies health plans. This information, known as protected health information, includes almost all individually identifiable health information held by a plan — whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of these plans: *Medical, Dental, Vision, EAP*. The plans covered by this notice may share health information with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

The Plan's duties with respect to health information about you

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not Aristocrat Technologies as an employer — that's the way the HIPAA rules work. Different policies may apply to other Aristocrat Technologies health programs or to data unrelated to the Plan.

How the Plan may use or disclose your health information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- **Treatment** includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.
- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing "behind the scenes" plan functions, such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.
- **Health care operations** include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include evaluating vendors; engaging in credentialing, training, and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the

HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

How the Plan may share your health information with Aristocrat Technologies

The Plan, or its health insurer, may disclose your health information without your written authorization to Aristocrat Technologies for plan administration purposes. Aristocrat Technologies may need your health information to administer benefits under the Plan. Aristocrat Technologies agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Human Resources employees are the only Aristocrat Technologies employees who will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Plan and Aristocrat Technologies, as allowed under the HIPAA rules:

- The Plan, or its insurer, may disclose "summary health information" to Aristocrat Technologies, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.
- The Plan, or its insurer, may disclose to Aristocrat Technologies information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option offered by the Plan.

In addition, you should know that Aristocrat Technologies cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by Aristocrat Technologies from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs — is *not* protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws

Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protective services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the Plan's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws

Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or programs if the Plan is being paid to make those communications. If we keep psychotherapy notes in our records, we will obtain your authorization in some cases before we release those records. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use, or disclosure of your unsecured health information as required by law.

The Plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

Your individual rights

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service

not be disclosed to the Plan for purposes of payment or health care operations if you have paid out of pocket and in full for the item or service.

Right to receive confidential communications of your health information

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible on site), the Plan will provide you with one of these responses:

- The access or copies you requested
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous, and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan's cost.

Right to amend your health information that is inaccurate or incomplete

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your

request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

- Make the amendment as requested
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- For treatment, payment, or health care operations
- To you about your own health information
- Incidental to other permitted or required disclosures
- Where authorization was provided
- To family members or friends involved in your care (where disclosure is permitted without authorization)
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances
- As part of a "limited data set" (health information that excludes certain identifying information)

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the Plan upon request

You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the information in this notice

The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on January 1, 2026. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice.

Complaints

If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint, contact mypc@aristocrat.com.

Contact

For more information on the Plan's privacy policies or your rights under HIPAA, contact mypc@aristocrat.com.

No Surprises Act notice

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 U.S. Department of Health and Human Services. The federal phone number for information and complaints is: 1-800-985-3059. Visit No Surprises Act | CMS for more information about your rights under federal law.

Visit your carrier's website for more information about your rights under federal law:

Aetna: https://www.aetna.com/individuals-families/member-rights-resources/rights/federal-no-surprises-act.html

Marketplace/Exchange Notice

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than **9.96% for 2026**[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed **9.96% for 2026** [2] of the employee's household income.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-25-25.pdf for the applicable year.
[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Benefits Department at (800) 482-3723.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

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

1. Employer name	**Aristocrat Technologies, Inc.**		2. Employer Identification Number (EIN)		**88-0097390**
3. Employer address	**10220 Aristocrat Way**		4. Employer phone number		**(800) 482-3723**
5. City	**Las Vegas**	6. State	**Nevada**	7. Zip Code	**89135**
8. Who can we contact about employee health coverage at this job?			**Shawn Nelson, Benefits Manager**		
9. Phone number (if different from above):			10. Email address		**Shawn.nelson@aristocrat.com**

Here is some basic information about health coverage offered by this employer:

As your employer, we offer a health plan to:
☐ All employees.
X Some employees. Eligible employees are: Full-time employees working at least 30 hours per week

With respect to dependents:
X We do offer coverage. Eligible dependents are: Spouse (Opposite and Sex), Domestic Partner (Opposite and Same Sex), Child(ren) (including disabled & court ordered dependents), Domestic Partner's Child(ren) (including disabled), Step Child(ren)
☐ We do not offer coverage.

X If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.



This guide is intended to describe the eligibility requirements, enrollment procedures, plan highlights, and coverage effective dates for the benefits offered by Aristocrat. It is not a legal plan document and does not imply a guarantee of employment or continuation of benefits. While this guide is a tool to answer many of your benefit questions, full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plan's operation. The noted plan changes in this guide may serve as a Summary of Material Modifications (SMM) to the SPD. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will prevail.

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