ClubLife

2022 BENEFITS GUIDE

Your Health & Wellness

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WELCOME TO YOUR 2022 BENEFITS!

ClubLife is pleased to provide you and your family with a wide range of competitive benefits. Your benefits are an important part of your total compensation. You have the flexibility to choose the benefits that are right for you and your family — to keep you physically and financially healthy now and in the future.

This benefits guide provides important information about your benefits and how to use them to your best advantage. Please review this information carefully, ask questions if needed, and make sure to enroll by the deadline.

ELIGIBILITY

If you are regularly scheduled to work at least 30 hours per week, you are eligible for the ClubLife benefits program. For newly hired individuals, most of your benefits are effective the first day of the month following 30 days of full-time employment. You may also enroll your eligible dependents for coverage. Eligible dependents include:

- Your legal spouse who is recognized for United States Federal Tax purposes and who is a United States citizen or legal resident;
- Children under the age of 26, regardless of student, dependency or marital status;
- Children past the age of 26 who are fully dependent on you for support due to a mental or physical disability (and are indicated as such on your federal tax return).

For details on eligibility and when your benefits begin and end, refer to your summary plan documents.

Benefits End

Your medical, dental, and vision benefits end on the last day of the month in which your employment ends. Your life and disability benefits end on your date of termination.

Changing Benefits After Enrollment

During the year, you cannot make changes to your medical, dental, vision or Health Care or Dependent Care Flexible Spending Accounts unless you experience a Qualified Life Event, such as marriage or the birth of a child. If you experience a Qualified Life Event (examples below), you should contact People Operations at 800-800-4615 within 31 days of the event, or you will have to wait until the next annual open enrollment period to make changes (unless you experience another Qualified Life Event).

ELIGIBILITY

Qualified Life Event	Possible Documentation Needed
Change in marital status	
Marriage	Copy of marriage certificate
Divorce/Legal Separation	Copy of divorce decree
Death	Copy of death certificate
Change in number of dependents	
Birth or adoption	Copy of birth certificate or copy of legal adoption papers
Stepchild	Copy of birth certificate plus a copy of the marriage certificate between employee and spouse
Death	Copy of death certificate
Change in employment	
Change in your eligibility status (i.e., full-time to part-time)	Notification of increase or reduction of hours that changes coverage status
Change in spouse's benefits or employment status	Notification of spouse's employment status that results in a loss or gain of coverage

ELIGIBILITY

Dependent Verification

Important Information About Medical Plan Coverage for Dependents — Proof Required

If you enroll your dependent(s) in Medical Plan coverage, proof of dependent status is required. Dependent Verification documents must be received no later 31 days after your benefit effective date. Please go to www.clubcorp.com/benefits and click on Eligibility (Employee & Dependents). For the 2022 Open Enrollment, you must provide verification documents on or before December 17, 2021.

Proof of Dependent Status Documents Submission

Verification documents can be

- Emailed to psbenefits@clubcorp.com or
- Faxed to 972-888-7558 or
- Uploaded to www.myclublifeonline.com.

  To load the documents to www.myclublifeonline.com, select the Benefits icon. In the Benefits screen, select the Dependent Verification Documents box and select the Add button in the right corner of the Document Records page.

Disabled Dependent Verification

For disabled dependents age 26 and older, an additional verification document is required. Go to www.clubcorp.com/benefits and click on the ClubCorp Declaration of Adult Dependency form.

Unacceptable Verification Documents

- Utility Bill
- Doctor Bill
- Auto Insurance
- Home-Owners Insurance
- Cable Bill
- Driver's License

Unverified Dependent(s)

If the valid dependent verification documentation is not received by the deadline, the dependent(s) coverage in the ClubCorp Medial plan will not be active. Only your coverage and the coverage of verified dependent(s) will take active in the ClubCorp Medical plan.

HOW TO ENROLL

If you are a new hire, you have 90 days to enroll from your date of hire. You must complete your enrollment to receive benefit coverage for the plan year.

Before You Enroll

- Carefully review the benefits listed in this guide and determine the medical, dental, vision and other coverage that's best for you and your family.
- Ensure family members meet the eligibility requirements.
- Understand the cost of the plans you selected.
- Log in (if you have an account) or Register (new users) at www.myclublifeonline.com.
- Select, review and submit your desired coverage.
- Be sure to complete beneficiary information for Life and AD&D benefits.

Check with People Operations at 800-800-4615 if you have questions.

Oracle Enrollment Instructions

To enroll, simply follow these steps:

If you have a ClubCorp or OurClub email address

- Navigate to www.clubcorp.com/hr
- HCM login instructions on the left hand side
- Use the SSO login option

If you DO NOT have a ClubCorp or OurClub email address

- Please call the ClubCorp Help Desk at 972-888-7777 to have them give you your Oracle HCM username and reset your Oracle HCM password.
- Once you have your new Oracle HCM password, navigate to www.myclublifeonline.com
- Enter your User ID as given.
- Enter your password as given. You will be prompted to change your password.
- If you were unable to successfully log in, please follow up with the ClubCorp Help Desk.

You must elect/confirm your COVID Vaccination and Tobacco User status, even if you are not enrolling in a ClubLife medical plan.

STAYING CONNECTED YEAR-ROUND

Patient Advocacy – The Health Wallet

Patient advocacy, through Health Wallet, can help you:

- Coordinate care and services
- Identify and access providers and facilities
- Facilitate communications with your health care providers
- Help you schedule and understand tests, medical treatments and medications prescribed
- Locating and arranging special need services

To get started, download "The Health Wallet" app from the Apple Store or Google Play. Use your Social Security Number (SSN) or Member ID and your birthday to login.

Once logged in, click on My Plan Info to access your ID cards and benefit coverage information.

Telemedicine – Virtual Visits

Under the weather and need a doctor visit fast? Telemedicine gives you 24/7 access to U.S. board-certified doctors through the convenience of your phone. You and a practitioner can speak or video chat to answer questions, make a diagnosis and even prescribe some medications. This convenient and affordable option provides you on-demand access to treat many medical conditions. As always, call 911 for any emergency.

Telemedicine is provided through UnitedHealthcare at no cost as long as you are enrolled in one of the ClubLife medical plans. Telemedicine can be accessed by contacting the Dedicated A4Me Customer Service Number that will be on your ID card.

STAYING CONNECTED YEAR-ROUND

UnitedHealthcare Mobile App

Managing health care on the go just got easier with the UnitedHealthcare app! Designed to help you save time by providing easy access to your information, you can:

- Find and manage providers
- Manage claims
- View and share your ID card
- View cost estimates
- Review your benefits
- View personalized recommendations for preventative care

Search for the UnitedHealthcare mobile app in the App Store or Google Play to get started!

MEDICAL

ClubLife's medical coverage, through UnitedHealthcare, provides you and your family the protection you need for everyday health issues or unexpected medical expenses.

How Medical Coverage Works

When you enroll in medical coverage, you pay a portion of your health care costs when you receive care and the plan pays a portion, as detailed below. Note that preventive care — like physical exams, flu shots and screenings — is always covered 100% when you use in-network providers. The key difference between the plans is the amount of money you'll pay each pay period and when you need care. The plans have different:

- **Deductibles** – the amount you pay each year for eligible in-network and out-of-network charges before the plan begins to pay a portion of the costs.
- **Copays** – a fixed amount you pay for a health care service. Copays do not count toward your annual deductible but do count toward your annual out-of-pocket maximum.
- **Coinsurances** – Once you've met your deductible, you and the plan share the cost of care, which is called coinsurance. For example, you pay 20% for services and the plan pays 80% of the cost until you reach your annual out-of-pocket maximum.
- **Out-of-pocket maximums** – the most you will pay each year for eligible in- or out-of-network services, including prescriptions. After you reach your out-of-pocket maximum, the plan pays the full cost of eligible health care services for the rest of the year.
- **Prescriptions** – You are responsible for the applicable copays until the out-of-pocket maximum has been met.

Before You Enroll

Consider this:

1. Think about the per-pay-period cost and out-of-pocket expenses you will incur and your possible future medical expenses. The option that has the highest per-pay-period cost typically pays more, which results in lower deductibles, coinsurance, and/or copays when you need care.
2. Want to stay with your doctor? Ensure they are in the plan's network by visiting www.uhc.com/find-a-doctor and selecting the Choice Plus network. If they're out of network, services may not be covered or may be more expensive.
3. Consider the cost of services and prescription drugs you expect to receive during the year.

MEDICAL

The table below summarizes the key features of the medical coverage. Please refer to the official plan documents for additional information on coverage and exclusions. Using a Tier 1 provider for certain services will save you money.

	Complete Plan	Balanced Plan	Healthy Start MEC Plan
	Choice Plus Network In-Network	Choice Plus Network In-Network	Choice Network In-Network
Calendar Year Deductible			
Individual | Family	$3,000 | $8,500	$5,000 | $10,000	None
Calendar Year Out-of-Pocket Maximum (Includes Deductible)			
Individual | Family	$7,900 | $15,800	$8,500 | Unlimited	$9,100 | $18,200
	You pay	You pay	You pay
Coinsurance	Tier 1: 30% / Tier II: 40%	Tier I: 30% / Tier II: 40%	N/A
Preventive Care	$0	$0	$0
Telemedicine	$0	$0	$0
Primary Care Physician	$20 / $40	$30 / $50	$25
Specialist	$50 / $70	$60 / $80	$50
Urgent Care	$75	$100	$150
Emergency Room	Emergency: $500 Non-Emergency: 30%*	Emergency: $500 Non-Emergency: 30%*	Not covered
Minor Lab & X-ray	Covered under office visit	Covered under office visit	Varies by location
Hospitalization	30%*	30%*	Not covered
Diagnostic Imaging (MRI/CT)	Varies by location	Varies by location	Varies by location

*After Deductible

MEDICAL

	Complete Plan				Balanced Plan				Healthy Start Plan			
	Choice Plus Network				Choice Plus Network				Choice Network			
Pharmacy												
Rx Deductible	None				None				None			
Rx Out-of-Pocket Max	Included in medical				Included in medical				None			
Retail Rx (up to 30-day supply)												
Tier 1 – Preferred Generic	$0				$0				Discount card			
Tier 2 – Non-Preferred Generic	$25				$30				Discount card			
Tier 3 – Preferred Brand	$50				$60				Discount card			
Tier 4 – Non-Preferred Brand	30%*				30%*				Discount card			
Specialty	50%*				50%*				N/A			
Mail Order Rx (90-day supply)	2x copay				2x copay				N/A			
Medical Bi-Weekly Payroll Deductions	Bi-Weekly	COVID 19 Surcharge	Smoking Surcharge	COVID + Smoking Surcharge	Bi-Weekly	COVID 19 Surcharge	Smoking Surcharge	COVID + Smoking Surcharge	Bi-Weekly	COVID 19 Surcharge	Smoking Surcharge	COVID + Smoking Surcharge
Employee Only	$104.37	$127.45	$179.37	$202.45	$36.92	$60.00	$111.92	$135.00	$29.00	$52.08	N/A	N/A
Employee + Spouse	$313.11	$336.19	$388.11	$411.19	$221.52	$244.60	$296.52	$319.60	$52.08	$75.16	N/A	N/A
Employee + Child(ren)	$257.73	$280.81	$332.73	$355.81	$174.66	$197.74	$249.66	$272.74	$52.08	$75.16	N/A	N/A
Employee + Family	$394.05	$417.13	$469.05	$492.13	$298.20	$321.28	$373.20	$396.28	$52.08	$75.16	N/A	N/A

*After Deductible

MEDICAL

COVID Vaccination Incentive

Maintaining a healthy workforce is critical to ClubCorp's continued success. We want to keep doors open and people working in a safe environment. We are highly recommending all employees and their dependents to get the COVID-19 vaccination.

- Employees and their dependents who receive the vaccination and are enrolled a ClubCorp medical plan will pay a lower medical plan premium in 2022.
- Getting vaccinated reduces the probability of severely sick and possible death from COVID by five times.
- Getting vaccinated reduces the severity of the illness and transmission.
- Getting vaccinated mitigates the severity of the impact of your co-workers having to work double time due to unvaccinated people.

With proof of COVID vaccination for you and your spouse provide proof of COVID vaccination, you are eligible for reduced medical premiums. You will designate you and your spouse's COVID vaccination status during the 2022 Open Enrollment process on www.myclublifeonline.com.

If you do not actively identify you and your spouse's (if applicable) COVID vaccination status, ClubCorp will automatically default you to NON-VACCINATED until you otherwise indicate.

Tobacco Cessation Program

In an effort to encourage overall good health for covered Employees and their covered dependents, Employees and spouses covered under the ClubCorp Medical Plan who are non-smoker/non-tobacco users can receive discounted medical bi-weekly rates on their Medical Plan coverage. You will need to certify your tobacco user status for you and any newly added spouses when you enroll.

For covered Employees and spouses who are smokers/tobacco users, ClubCorp offers assistance with the company-sponsored smoking/ tobacco cessation program through the American Institute for Preventive Medicine. You and/or your covered spouse can participate in the Medical Plan smoking/tobacco cessation program (at no cost to you) beginning on your coverage effective date. Upon receipt of proof of successful completion of the smoking/tobacco cessation program, you will receive the discounted Medical Plan bi-weekly rates. If it is unreasonably difficult due to a health factor for you to meet the requirement or if it is medically inadvisable for you to attempt to meet the requirements of this program, we are making available a reasonable alternative standard for you to obtain the discounted Medical Plan Bi-Weekly Rate – the Medical Plan smoking/tobacco cessation program. If satisfying this reasonable alternative outlined above is medically inadvisable and you can provide a physician's statement indicating so, then please contact the ClubCorp People Strategy Benefits Department, who will work with you to develop an additional reasonable alternative.

To enroll in the Medical Plan smoking/tobacco cessation program, please call the American Institute for Preventive Medicine at 800-345-2476, extension 1.

The deadlines for you or your covered spouse to complete a "Smokeless" program and submit the diploma to the Benefits department are as follows:

- Open Enrollment: No later than January 31, 2022.
- New Hires: No later than 90 days from the effective date of your medical coverage.

DENTAL

You may enroll yourself and your eligible dependents — or you may waive dental coverage. You do not have to be enrolled in medical coverage to elect a dental plan.

Taking care of your oral health is not a luxury; it is necessary for optimal long-term health. With a focus on prevention, early diagnosis and treatment, dental coverage can greatly reduce the cost of restorative and emergency procedures.

ClubLife offers dental coverage through Delta Dental. For information on finding a dental provider using the Delta Dental PPO network, visit www.deltadental.com and click on Find a dentist.

Before You Enroll

Consider this:

1. Most in-network preventive cleanings and exams are covered at 100%.
2. You may receive dental care in- or out-of-network. However, when you go out of network, the provider can charge more and the plan will only reimburse up to the reasonable and customary rates.

DPO Option

Preventive services at in-network providers are generally covered at no cost to you and include routine exams and cleanings. You pay a small deductible and coinsurance for basic and major services.

DHMO Option

If you decide to enroll in the DHMO Option for the first time or add new dependents under this option, you need to select a primary care dentist. You can only change your dentist once per year and you can choose a different DHMO dentist for yourself and each covered dependent.

You should consult the participating provider directory prior to enrolling. The directory lists the dentists who are members of the network. You can view an online provider directory by visiting www.deltadental.com.

The DHMO plan is offered in AL, AR, AZ, CA, CO, DC, FL, GA, KS, KY, LA, MD, MI, MS, NV, NY, OH, PA, SC (small number of providers), TN, TX, WA, WI, and WV.

DENTAL

This table summarizes the key features of the dental plan. Please refer to the official plan documents for additional information on coverage and exclusions.

	DPPO Plan		DHMO Plan**	
	Delta Dental PPO Network		Delta Dental PPO Network	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible				
Individual | Family	$50 | $150		None | None	
Calendar Year Benefit Maximum				
Per Individual	$1,500		None	
	You pay		You pay	
Services				
Office Visit	None		$20	
Preventive Care				
Exams, Cleanings, X-rays, Fluoride Treatments	0%		See schedule	
Basic Services				
Fillings, Space Maintainers, Extractions, Oral Surgery, Endodontics, Periodontics	20%*		See schedule	
Major Services				
Crowns, Inlays/Onlays, Dentures and Bridgework, Repairs	50%*		See schedule	
Orthodontia				
Adults	Not covered		$2,100	
Children (up to 19th birthday)			$1,150	
Dental Bi-Weekly Payroll Deductions				
Employee Only	$15.74		$7.23	
Employee + Spouse	$33.34		$12.42	
Employee + Child(ren)	$32.70		$12.50	
Employee + Family	$53.01		$18.01	

**After deductible*

**Please refer to the summary plan description for a full list of the assigned copays. Any in-network claims are reimbursed at contracted rates.

VISION

Healthy eyes and clear vision are an important part of your overall health and quality of life. You may enroll yourself and your eligible dependents — or you may waive vision coverage. You do not have to be enrolled in medical coverage to elect a vision plan.

This table summarizes the key features of the vision plan. Please refer to the official plan documents for additional information on coverage and exclusions.

ClubLife offers vision coverage through Superior Vision using the Superior Vision network. For information on finding a vision provider, visit www.superiorvision.com.

	Vision Plan	
	In-Network	Out-of-Network
	You pay	Reimbursement
Cost		
Exam	$15	Opthamologist: Up to $42 Optometrist: Up to $37
Materials	$15	See Below
Covered Services – Lenses		
Single Lenses	$15	Up to $26
Bifocals	$15	Up to $34
Trifocals	$15	Up to $50
Frames	$15 copay, $125 allowance	Up to $50
Covered Services – Contacts in lieu of Frames/Lenses		
Contacts – Medically Necessary	$0	Up to $210
Contacts – Elective	$120 allowance	Up to $100
Benefit Frequency		
Exams	Once every 12 Months	
Lenses	Once every 12 Months	
Frames	Once every 24 Months	
Contacts (in lieu of lenses)	Once every 12 Months	
Vision Bi-Weekly Payroll Deductions		
Employee Only	$2.93	
Employee + Spouse	$4.36	
Employee + Child(ren)	$4.66	
Employee + Family	$7.45	

FLEXIBLE SPENDING ACCOUNTS (FSAs)

Flexible Spending Accounts (FSAs) allow you to pay for eligible health care and dependent care expenses using tax-free dollars. There are two types of FSAs — the Health Care FSA and the Dependent Care FSA:

- **Health Care FSA** – Used to pay for out-of-pocket expenses associated with your medical, dental or vision plan such as copayments, coinsurance deductibles, prescription expenses, lab exams and tests, contact lenses and eyeglasses.
- **Dependent Care FSA** – Used to pay for day care expenses associated with caring for elder or child dependents that are necessary for you or your spouse to work or attend school full-time.

You cannot use your Health Care FSA to pay for dependent care expenses, and you cannot use your dependent care FSA to pay for health care expenses.

Important: The IRS has a "use it or lose it" rule. If you do not spend all of the money in your FSA by the annual deadline, any unused dollars in your account(s) will be forfeited.

How the Health Care FSA Works
You may contribute up to $2,750 per year, pretax
You receive a debit card to pay for eligible medical expenses (funds must be available in your account)
Eligible expenses include medical copays, coinsurance, deductibles, eyeglasses and over-the-counter medications prescribed by your doctor
Submit claims up to March 31 of the following year for expenses from January 1 to December 31
At the end of the calendar year, participants can roll over their unused health care funds.

How the Dependent Care FSA Works
You may contribute up to $5,000 per year, pretax, or $2,500 if married and filing separate tax returns
You submit claims for reimbursement; no debit cards are provided
Can be used to pay for eligible dependent care expenses including day care, after-school programs and elder care programs
Submit claims up to March 31 of the following year for expenses from January 1 to December 31
If you do not spend all the money in this FSA by March 31, unused dollars will be forfeited per IRS regulations

FLEXIBLE SPENDING ACCOUNTS (FSAs)

How You Can Save on Taxes with FSAs

Here's an example of how much you can save when you use the FSAs, through TaxSaver Plan, to pay for your predictable health care and dependent care expenses.

	Health Care FSA		Dependent Care FSA	
	Without FSA	With FSA	Without FSA	With FSA
Your taxable annual income	$50,000	$50,000	$50,000	$50,000
Account deposit (before taxes)	N/A	$2,750	N/A	$5,000
Taxable wages	$50,000	$47,250	$50,000	$45,000
Federal and Social Security taxes	$14,325	$13,609	$14,325	$12,894
Expense (after taxes)	$2,750	N/A	$5,000	N/A
Take home (net)	$32,925	$33,641	$30,675	$32,106
Annual tax savings with the FSAs	$0	$716	$0	$1,431

BASIC LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

Life insurance, provided by MetLife, pays a lump-sum benefit to your beneficiaries to help meet expenses in the event you pass away. Accidental death and dismemberment (AD&D) insurance pays a benefit if you die or suffer certain serious injuries as the result of a covered accident. In the case of a covered accidental injury (such as loss of sight or the loss of a limb), the benefit you receive is a percentage of the total AD&D coverage you elected based on the severity of the accidental injury.

Beneficiary Information

Situations often change, resulting in the need to update beneficiary information. You should review and update this information every year, or prior to retirement. Check with People Operations at 800-800-4615 for more information.

Guaranteed Issue (GI) and Evidence of Insurability (EOI)

Employees and spouses who elect coverage when they are first eligible can elect up to the Guaranteed Issue (GI) amount without Evidence of Insurability (EOI). Any coverage over the GI amount requires an EOI form for medical underwriting approval.

Basic Life / AD&D Insurance - For You	
	Basic Life and AD&D
Coverage Amount	Hourly employees: $10,000 Salaried employees: $25,000
Evidence of Insurability (EOI) / Proof of Good Health	Not required
Age Reduction Schedule	Benefits reduce by 35% at age 65 and 55% at age 70.

SUPPLEMENTAL LIFE

Supplemental life insurance allow you to tailor coverage for your individual needs and provide financial protection for your beneficiaries in the event of your death. Supplemental life insurance for you and your dependents, also provided by MetLife, can help protect your family during difficult times.

Before You Enroll

Consider this:

1. Typically, the right amount of coverage will depend on your age, your family situation, and any personal savings you may have.
2. It's important to understand any EOI rules that apply. If you enroll when you first become eligible, Supplemental Term Life Insurance for you and your spouse is guaranteed up to the amounts shown in the table. If you initially waive this coverage but want to enroll at a later date, you may need to provide satisfactory EOI before any coverage can take effect.
3. Think about who you want to designate as beneficiaries and make sure to name them as beneficiaries on your policy.

Supplemental Life Insurance – For You and Your Dependents

	Employee	Spouse	Child(ren) up to age 26
Coverage Amount	Increments of $10,000 up to $500,000 - not to exceed 7 times your salary	Increments of $10,000 up to $100,000 – not to exceed 50% of Employee coverage	Increments of $5,000 to a maximum of $25,000; $1,000 for children under 6 months
Guaranteed Issue	$380,000	$30,000	$25,000
Evidence of Insurability (EOI) / Proof of Good Health	Required if electing coverage over the Guaranteed Issue amount	Required if electing coverage over the Guaranteed Issue amount	Not required

Supplemental Life Rate per $1,000 by Age

<25	$0.072	50-54	$0.640
25-29	$0.072	55-59	$1.100
30-34	$0.099	60-64	$1.700
35-39	$0.122	65-69	$2.590
40-44	$0.203	70-74	$3.960
45-49	$0.387	75+	$5.940
Child Life rate per $1,000		$0.200	

SHORT-TERM DISABILITY

Disability insurance replaces a portion of your income when you are unable to work due to a qualified illness or non-work-related injury. ClubLife provides you with the opportunity to elect Short-Term Disability (STD) coverage through MetLife.

Disability Eligibility

Eligible Employees not eligible for the LTD plan may participate in the STD Plan (except for Employees working in clubs located in CA, NJ or NY due to state-mandated disability plans already available to you).

Short-Term Disability Benefits at a Glance	
Weekly Benefit	$100, $200, $300, $400 or $500, not greater than 60% of your average weekly salary
Weekly Maximum	$500 per week
Benefit Duration	13 weeks
Elimination Period	14 days
Pre-Existing Limitation	6/12*

**Benefits may not be paid for any condition treated within 6 months prior to your effective date until you have been covered under this plan for 12 months.*

Voluntary STD Rate per $100	
Any age	$0.413

Pre-Existing Conditions

A pre-existing condition is an injury or illness for which you have received advice or treatment from a doctor within 6 months prior to the effective date of your insurance plan.

Evidence of Insurability

If you decline coverage when first eligible or if you elect coverage and wish to increase your benefit amount at a later date, Evidence of Insurability (EOI) — proof of good health — may be required before coverage is approved.

A qualifying disability is a non-work related sickness or injury that causes you to be unable to perform any other work for which you are or could be qualified by education, training or experience.

LONG-TERM DISABILITY

Disability insurance replaces a portion of your income when you are unable to work due to a qualified illness or non-work-related injury. ClubLife provides you with the opportunity to elect Long-Term Disability (LTD) coverage through MetLife.

Disability Eligibility

You must be in one of the following positions to be eligible to participate in the LTD Plan:

- Home Office and Regional Staff,
- General Managers, or
- Salaried Department Heads who are primarily responsible for managing a department, such as (but not limited to): Athletic Director, Executive Chef, F&B Director, Golf Course Superintendent, Head Golf and Tennis Pro, Membership Director, Private Events Director or Service Director.

Long-Term Disability Benefits at a Glance	
Monthly Benefit	60% of monthly earnings
Monthly Maximum	$2,308 per month
Benefit Duration	To age 65
Elimination Period	90 days
Pre-Existing Limitation	6/12*

**Benefits may not be paid for any condition treated within 6 months prior to your effective date until you have been covered under this plan for 12 months.*

Voluntary LTD Rate per $1,000 by Age			
<25	$0.75	45-49	$0.77
25-29	$0.68	50-54	$0.95
30-34	$0.70	55-59	$1.11
35-39	$0.62	60-64	$1.29
40-44	$0.68	65+	$1.42

Salary Continuation Provision		
	Salary Continuation Days 15-90	LTD
< 2 years of service	0%	60%
2+ years of service	66.67% (or 2/3)	60%
Weekly Benefit Maximum	$2,000	$2,308

Pre-Existing Conditions

A pre-existing condition is an injury or illness for which you have received advice or treatment from a doctor within 6 months prior to the effective date of your insurance plan.

Evidence of Insurability

If you decline coverage when first eligible or if you elect coverage and wish to increase your benefit amount at a later date, Evidence of Insurability (EOI) — proof of good health — may be required before coverage is approved.

A qualifying disability is a non-work related sickness or injury that causes you to be unable to perform any other work for which you are or could be qualified by education, training or experience.

ADDITIONAL BENEFITS

Employee Assistance Program

ClubLife also provides you access to the Employee Assistance Program (EAP) at no cost. This program, available through LifeWorks, provides professional, confidential telephonic or face-to-face counseling services to you and your loved ones. You and your eligible household members are eligible to receive five phone or video sessions per issue, per calendar year. The EAP can help you resolve personal issues and problems before they affect your health, relationships and work performance.

This program is available 24 hours a day, 365 days a year for confidential assistance and referral services with items such as:

- Managing stress
- Marital or family problems
- Anxiety and depression
- Substance abuse (alcohol and/or drugs)
- Financial issues
- Childcare issues including identifying schools, daycare, tutors, and more
- Aging parents

It's important to note that all EAP conversations are voluntary and strictly confidential. If you and your counselor determine that additional assistance is needed, you'll be referred to the most appropriate and affordable resource available. Although you're responsible for the cost of referrals, these costs are often covered under your medical plan.

ADDITIONAL BENEFITS

Beneficiary Support Services

Beneficiary support services, provided by Massachusetts Mutual Life Insurance Company (MassMutual) through a partnership with MetLife, is provided to you through your life and AD&D policy.

Through this benefit, financial professionals can help you plan, reduce stress, and navigate life's twists and turns. Your eligible beneficiaries receive dedicated support and guidance from financial professionals upon request of a beneficiary or family member. The specialists work with your beneficiaries and your family to file paperwork, annuity claims, and government benefits. Specialists also provide information about local resources, government programs and financial planning.

For more information, contact MetLife at 866-492-6983.

IMPORTANT CONTACTS




Coverage	Administrator	Phone	Email / Website
ClubCorp Benefits	ClubLife	800-800-4615	www.clubcorp.com/benefits benefits@clubcorp.com
Dependent Verification	ClubLife	800-800-4615 Fax: 972-888-7558	psbenefits@clubcorp.com www.myclublifeonline.com
Patient Advocacy – The Health Wallet	Health Wallet		
Telemedicine – Virtual Visits	UnitedHealthcare	800-865-9386	www.myuhc.com
Medical	UnitedHealthcare	800-865-9386	www.myuhc.com
Tobacco Cessation Program	American Institute for Preventive Medicine	800-345-2476	www.healthylife.com
Dental	Delta Dental	PPO: 800-521-2651 DHMO: 800-422-4234	www.deltadental.com
Vision	Superior Vision	800-507-3800	www.superiorvision.com
Flexible Spending Accounts (FSAs)	TaxSaver Plan	800-328-4337	www.taxsaverplan.com
Life and AD&D	MetLife	866-492-6983	www.metlife.com
Disability	MetLife	800-438-6388	www.metlife.com
Employee Assistance Program (EAP)	LifeWorks	888-319-7819	www.metlifeeap.lifeworks.com Username: metlifeeap Password: EAP
Beneficiary Support Services	MetLife	866-492-6983	www.metlife.com

GLOSSARY

Allowed Amount: Maximum amount on which payment is based for covered health care services. This may be called “eligible expense,” “payment allowance” or “negotiated rate.” If your provider charges more than the allowed amount, you may have to pay the difference (see Balance Billing).

Annual Maximum Benefit: A cap on the benefits your insurance company will pay in a year while you’re enrolled in a particular benefit plan. After an annual limit is reached, you must pay all associated health care costs for the rest of the year.

Balance Billing: When a provider bills you for the difference between the provider’s charge and the allowed amount. For example, if the provider’s charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A provider who balance bills is typically known as an out-of-network provider. An in-network provider cannot balance bill you for covered services.

Coinsurance: The percentage of costs of a covered health care service you pay (20%, for example) after you’ve paid your deductible.

Copayment (copay): A fixed amount ($20, for example) you pay for a covered health care service after you’ve paid your deductible. Copays can vary for different services within the same plan, like drugs, lab tests, and visits to specialists.

Deductible: The amount you pay for covered health care services before your insurance plan starts to pay. With a $2,000 deductible, for example, you pay the first $2,000 of covered services yourself. After you pay your deductible, you usually pay only a copayment or coinsurance for covered services. Your insurance company pays the rest.

Guarantee Issue Amount: The amount of coverage you can be automatically approved for. If you apply for more coverage than the guarantee issue amount you will have to complete an Evidence of Insurability form, and be approved for your coverage amount. Usually only available at your first enrollment opportunity.

In-Network: Providers who contract with your insurance carrier. In-network coinsurance and copayments usually cost you less than out-of-network providers.

Out-of-Network: Providers who don’t contract with your insurance carrier. Out-of-network coinsurance and copayments usually costs you more than in-network coinsurance. In addition, you may be responsible for anything above the allowed amount (see Balance Billing).

Out-of-Pocket Maximum: The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your plan pays 100% of the costs of covered benefits. The out-of-pocket limit doesn’t include your monthly premiums. It also doesn’t include anything you may spend for services your plan doesn’t cover.

Prescription Drug Formulary: A list of prescription drugs covered by a prescription drug plan. Also called a drug list.

Prior Authorization: Approval from a health plan that may be required before you get a service or fill a prescription in order for the service or prescription to be covered by your plan.

Preventive Care: Routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.

MARSH & McLENNAN AGENCY