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See page 28 for important information concerning Medicare Part D coverage.

In this guide we use the term “Company” to refer to ClubCorp. This guide is intended to describe the eligibility requirements, enrollment procedures, and coverage effective dates for the health and welfare benefits program offered by the Company. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. This guide is not intended to answer all of your questions, but to provide you with a tool to answer most of your questions. Full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.
Welcome

We are pleased to offer you this comprehensive benefit package for calendar year 2015. This guide is designed to assist both you and your family in making the choices that best meet your needs for the upcoming plan year.

Please read this guide in its entirety as there are some very important changes this year for you to consider.

Enrollment

Eligibility
As a regular, full-time employee partner, you are required to work thirty (30) hours or more per week on a continuous basis to be eligible to participate in the Medical, Dental, Vision, Life and Disability Plans, as well as the Dependent Care Flexible Spending Account and Health Savings Account. The Plan Administrator reserves the right to review the eligibility status of all participants on a periodic basis, including, but not limited to, verification of dependents' status.

Your Eligible Dependents
Please note that verification of eligibility will be required for medical coverage once dependents are enrolled. Proof of dependent status must be received within 31 days after the effective date of coverage.

Dependents eligible for coverage in the ClubCorp benefit Plans include:

- **Medical Plan Only** – Your dependent children up to age 26 (including stepchildren, legally adopted children or children placed with you for adoption, foster children, and any child that you claim as a legal tax dependent) who are United States citizens or legal residents.
- **For Non-Medical Plans** – Your unmarried dependent children up to age 25 who are United States citizens or legal residents and primarily dependent on you for financial support.
- **Your dependent child, regardless of age**, provided that he or she is incapable of self-support due to a mental or physical disability, is fully dependent on you for support as indicated on your federal tax return, and is approved by the Medical Plan to continue coverage past age 26.
- **Your legal spouse who is recognized for United States Federal Tax purposes and who is a United States citizen or legal resident.** This applies to all plans, unless otherwise indicated in the group policy for dental, vision and supplemental life.
When You Can Enroll and When Coverage Becomes Effective

• As a new hire you must enroll prior to your 90-day anniversary. Coverage is then effective on your 90-day anniversary.

• Open Enrollment is your time to make changes to your benefit elections without a qualifying life event. Coverage is effective on January 1 of the following year.

• For medical, dental and vision coverage, you have 31 days from the qualifying life event to enroll or change your coverage election and the effective date is the day of the qualifying life event.

• For Group Life and Accidental Death & Dismemberment, Supplemental Life, Long Term Disability and Short Term Disability coverage, you have 31 days from the qualifying life event to enroll or change your coverage election, and the effective date is the day you enroll.

Qualifying Life Events Include:

• Change in your legal marital status (marriage, divorce, or legal separation)

• Change in the number of your dependents (for example, through birth or adoption, or if a child is no longer an eligible dependent)

• Change in your spouse's employment status (resulting in a loss or gain of coverage)

• Change in your employment status from full time to part time, or part time to full time, resulting in a loss or gain of coverage

• Entitlement to Medicare or Medicaid

• Change in your address or location that affects the plans for which you are enrolled

Any change to your benefits must be consistent with the qualifying life event. For example: If a child is born, you may add the newborn but you may not decrease other dependent coverage.
Preparing to Enroll

ClubCorp pays a portion of the cost of your benefits, and the remaining amount you pay will depend on the plan choices that you make. Payroll contributions for your Medical, Dental, Vision, Basic Life, Dependent Care Flexible Spending Account and Health Savings Account benefits are deducted on a pre-tax basis, which means your taxes are based on the reduced salary resulting in a lessened tax liability.

Please note that employee partner contributions for medical, dental and vision coverage vary depending on the plan you select. In general, the greater level of coverage the plan provides to you, the higher your employee partner contribution will be.

Keep in mind that you may select any combination of Medical, Dental, and/or Vision Plans and any combination of coverage categories. For example, you could select medical coverage for you and your entire family, but select dental and vision coverage only for yourself. The only requirement is that you, as an employee partner, must elect coverage for yourself in order to elect any dependent coverage.

Be sure to have the Social Security numbers and birth dates for any eligible dependent(s) that you plan to enroll. You cannot enroll your dependent(s) without this information.

Important Information About Medical Plan Coverage for Dependents — Proof Required

If you enroll your dependent(s) for Medical Plan coverage, proof of dependent status is required for dependent Medical Plan coverage and must be received no later than 31 days after the effective date of coverage in order for Medical Plan coverage to become effective for your dependent(s). Proof of dependent status is also required for dependent Medical Plan coverage within 31 days of adding a dependent due to a qualifying life event.

Proof of Dependent Status documents may include:

- Spouse: State issued marriage certificate, joint banking account, mortgage/leasing agreements or tax returns.

- Dependent Child(ren): State issued birth certificate, QMSCO, adoption/legal ward papers, school enrollment records, medical and disability documentation.
How and When to Enroll

1. Understand your choices!

Read this Benefits Guide carefully to get answers to your questions. This guide helps you prepare for enrollment and contains very useful reference material. Keep the guide handy so you can refer to it throughout the year.

2. Review your options with your family.

Make sure you include any other individuals who will be affected by your elections in the decision-making process.

3. Enroll!

- **ENROLL BY PHONE at 1-800-800-4615** for Medical, Dental, Vision, Group Life, Supplemental Life insurance and the Long Term Disability Plan during Open Enrollment or prior to your 90-day anniversary if you are a new hire.

- **ENROLL BY FORM** if you want to enroll in the Dependent Care Flexible Spending Account, Supplemental Life*, Short Term Disability or make a Health Savings Account election. You must re-elect the Dependent Care Flexible Spending Account Plan and Health Savings Account elections each year. Forms can be found at www.clubcorp.com/benefits. You can enroll each year during Open Enrollment or prior to your 90-day anniversary if you are a new hire.

- **ENROLL BY FORM WITHIN 31 DAYS OF A QUALIFYING LIFE EVENT** by completing the Health Benefits Change Form found at www.clubcorp.com/benefits.

*You may enroll in the Supplemental Life Plan as a new hire or during annual Open Enrollment. If you enroll during these two periods, you will not be subject to evidence of insurability (when requested benefit amounts are not higher than defined maximums or limits). You may enroll in higher benefit amounts but will be subject to evidence of insurability requirements.

Note: An Employee Partner may also enroll for Supplemental Life at any time during the calendar year. If you are enrolling during this time period, an evidence of insurability form will need to be completed and returned to Lincoln.
Medical Plan

Medical coverage is one of the most important benefits that ClubCorp can provide. Medical benefits provide significant support for and protection against potentially large medical expenses as well as covering preventive care. ClubCorp offers three medical plan options: Plan A (HDHP 1350), Plan B (HDHP 2000), and Plan C (HDHP 5000). All three plans are qualified High Deductible Health Plans and allow you to contribute money to a tax-free Health Savings Account.

It is up to you to choose the plan that best matches your preferences. Please keep in mind that the option you choose will be in place for the entire year, unless you have a qualifying life event. All pharmacy benefits are administered by Prime Therapeutics and coordinated through Blue Cross and Blue Shield of Texas—that means you will have one ID card for both medical and pharmacy.

How To Find a Provider

To see the most current list of Blue Choice BCBSTX Network providers online, go to www.bcbstx.com. If you do not have internet access, please call BCBSTX Customer Service at 1-800-521-2227 for assistance. If you live in Florida, please select your state and the Network Blue network. If you live in Georgia, select your state and the Blue Open Access POS Network. If you live in California, select your state and the Select PPO Network.

Blue Distinction Centers for Specialty Care

Blue Distinction Centers for delivering specialty care are available through BCBSTX and provide access to medical facilities that have demonstrated expertise in the delivery of quality health care at a better value. These centers are limited to specialty care for cardiac care services, transplants, bariatric surgery, and complex and rare cancers. For more information go to the Blue Distinction Center Finder at www.bcbs.com/clubcorp or call BCBSTX at 1-800-521-2227.

Blue Value Advisor - Your BCBS Health Care Advisor

If you are enrolled in one of the Medical Plans, you have access to enhanced customer service through Blue Value Advisor. This is a service available to covered participants and is designed to simplify the complexity of your health care needs. They will help you:

- Plan for your health care by giving you a cost estimate for health care services or procedures
- Select in-network providers
- Schedule a doctor or procedure appointment if you like
- Better understand your benefits
- To become familiar with online educational tools

For more information, please contact Blue Value Advisor at 1-800-521-2227.
### Medical Plan Summary

The chart below gives a summary of the ClubCorp medical options. All covered services are subject to medical necessity as determined by the plan. **Out-of-network services are NOT covered.**

#### EMPLOYEE PARTNER BIWEEKLY COST

<table>
<thead>
<tr>
<th>COVERAGE LEVEL</th>
<th>MEDICAL PLAN A (HDHP 1350)</th>
<th>MEDICAL PLAN B (HDHP 2000)</th>
<th>MEDICAL PLAN C (HDHP 5000)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Non-Tobacco User¹</td>
<td>Tobacco User¹</td>
<td>Non-Tobacco User¹</td>
</tr>
<tr>
<td>Employee Partner Only</td>
<td>$104.57</td>
<td>$67.68</td>
<td>$135.98</td>
</tr>
<tr>
<td>Employee Partner + Spouse</td>
<td>$283.30</td>
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</tr>
<tr>
<td>Employee Partner + 2 Children (or Less)</td>
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<tr>
<td>Employee Partner + 3 or More Children</td>
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<td>$152.03</td>
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<td>Employee Partner + Spouse + 2 Children (or Less)</td>
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<td>$380.04</td>
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<tr>
<td>Employee Partner + Spouse + 3 or More Children</td>
<td>$370.35</td>
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</tbody>
</table>

¹ Please refer to “Medical Plan Contribution Discounts for Non-Tobacco Users and the Tobacco Cessation Program” on page 8.

#### MEDICAL PLAN A (HDHP 1350) | MEDICAL PLAN B (HDHP 2000) | MEDICAL PLAN C (HDHP 5000)

<table>
<thead>
<tr>
<th>DEDUCTIBLE PER CALENDAR YEAR</th>
<th>Non-Tobacco User¹</th>
<th>Tobacco User¹</th>
<th>Non-Tobacco User¹</th>
<th>Tobacco User¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Partner Only</td>
<td>$1,350</td>
<td>$2,000</td>
<td>$5,000</td>
<td></td>
</tr>
<tr>
<td>Employee Partner + Dependents¹</td>
<td>$4,000</td>
<td>$6,000</td>
<td>$10,000</td>
<td></td>
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</tbody>
</table>

² All Prescription costs will apply to the out-of-pocket maximum.

#### OUT-OF-POCKET MAXIMUM² (after out-of-pocket is met, eligible charges are covered at 100%)

<table>
<thead>
<tr>
<th>DEDUCTIBLE PER CALENDAR YEAR</th>
<th>Non-Tobacco User¹</th>
<th>Tobacco User¹</th>
<th>Non-Tobacco User¹</th>
<th>Tobacco User¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Partner Only</td>
<td>$6,000</td>
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<td>$6,450</td>
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<tr>
<td>Employee Partner + Dependents¹</td>
<td>$12,500</td>
<td>$12,500</td>
<td>$12,900</td>
<td></td>
</tr>
</tbody>
</table>

3 When a generic is available, you pay the applicable coinsurance plus the cost difference between the generic and brand-name drug.
Medical Plan Contribution Discounts for Non-Tobacco Users and Tobacco Cessation Program

In an effort to encourage overall good health for covered employee partners and their covered dependents, employee partners and dependents covered under the ClubCorp Medical Plan who are non-smoker/non-tobacco users can receive discounted medical contributions on their Medical Plan coverage.

You will need to telephonically certify the tobacco user status for you and any newly added dependents when you call to enroll. Your eligibility for the non-tobacco user discount is subject to change based on, and after, receipt of the tobacco test results.

ClubCorp is offering an opportunity to receive a free tobacco test for employee partners and spouses who are enrolling for the first time in the Medical Plan and who wish to receive contribution rate discounts for the Medical Plan in 2015. **Testing is done at no cost to you at an approved location and must be completed within 31 days from the effective date of coverage in order to qualify you to receive the discounts.** These test results will be shared with ClubCorp Medical Plan in order to determine your eligibility for the non-tobacco user discounts in 2015.

Please review the tobacco instructions in your enrollment packet for more information.

For covered employee partners and dependents 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 dependents 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 contributions.

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 contributions – 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.

Proof of successful completion of the Medical Plan smoking/tobacco cessation program is a certificate/diploma issued to the participant by the American Institute for Preventive Medicine after a participant has completed the program requirements and final exam (with a passing score).

**To enroll in the Medical Plan smoking/tobacco cessation program, please call the American Institute for Preventive Medicine at 1-800-345-2476 x1. You or your covered dependents can enroll any time once your Medical Plan coverage becomes effective.**
One is considered a **non-smoker/non-tobacco user** if you (and your covered dependents):

- Have not used tobacco products (cigarettes, cigars, chewing tobacco, etc.), for at least 6 months (from the date you certify your tobacco user status), and pass the tobacco test; or

- Enroll in the ClubCorp Medical Plan smoking/tobacco cessation program offered in partnership with the American Institute of Preventive Medicine and provide proof of successful completion. Upon receipt of the proof of successful completion from you, ClubCorp Benefits will apply the discounted Medical Plan contributions.

One is considered a **smoker/tobacco user** if:

- You (or your covered dependents) are currently using any form of tobacco (cigarettes, cigars, chewing tobacco, etc.) in any amount (including occasional social use), fail the tobacco test; or

- You (or your covered dependents) have used tobacco based products (cigarettes, cigars, chewing tobacco, etc.) within the last 6 months (from the date you certify your tobacco user status).

Any of the above applies if you (or your covered dependents) do not enroll in and successfully complete the ClubCorp Medical Plan smoking/tobacco cessation program.

**Definition of smoker:** An employee partner (or your covered dependents) who smokes cigarettes, cigars or chews tobacco, etc. Casual or social smoking constitutes smoking by the ClubCorp Medical Plan definition.

**Right to request documentation:** ClubCorp People Strategy Benefits has the right to request documentation at any time from an employee partner or covered dependent who declares him/herself a smoker enrolled in the approved smoking/tobacco cessation program or from the vendor providing the smoking/tobacco cessation program to the employee partner or covered dependent for the sole purpose of verifying enrollment and participation.

**Recourse for making a false statement:** An employee partner who intentionally falsifies his/her or covered dependent's non-smoking status will be subject to immediate revocation of the non-smoker contribution discount and could face a loss of coverage for intentional falsification of enrollment.
Prescription Drug Coverage for Medical Plans

Your prescription drug program is administered by Prime Therapeutics and coordinated through BCBSTX. All prescription drug products on the Generics Plus drug list are assigned as Generic, Preferred Brand and Non-Preferred Brand. You may find individualized information on your benefit coverage, search for network pharmacies and view the Generics Plus list by logging on to www.bcbstx.com/clubcorp or calling BCBSTX at 1-800-521-2227.

### GENERIC DRUGS

One way to get more value from your health care plan is to use generic drugs when they are available, which will allow you to pay less for your personal health needs. A generic drug is chemically identical to the corresponding brand-name version. The additional costs of marketing brand-name drugs are essentially the only difference between brand-name drugs and the generic options. **Same benefit. Lower price.**

A generic is not always prescribed and is not always available, but that shouldn't stop you from asking for the generic every time.

### PREFERRED BRAND-NAME DRUGS

A preferred brand-name drug is a brand-name drug that is on your provider’s list of approved drugs. You can check online to see a complete list of preferred drugs.

### NON-PREFERRED DRUGS

Non-preferred drugs have higher copayments and are typically newer drugs on the market. Like generic equivalents, you can request a preferred drug equivalent. You can be a better consumer by doing your research, asking the right questions and buying at the lowest price.

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### PRESCRIPTION DRUG COVERAGE

<table>
<thead>
<tr>
<th>Network Retail Pharmacy / 30-day supply</th>
<th>YOUR COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Drug*</td>
<td>$20 Copay (copay applies after the HDHP deductible is satisfied)</td>
</tr>
<tr>
<td>Preferred Brand-Name Drug*</td>
<td>30% after deductible</td>
</tr>
<tr>
<td>Non-Preferred Brand Drug*</td>
<td>50% after deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Network Mail Order Pharmacy / up to 90-day supply (mandatory for maintenance medications)</th>
<th>YOUR COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Drug*</td>
<td>$40 Copay (copay applies after the HDHP deductible is satisfied)</td>
</tr>
<tr>
<td>Preferred Brand-Name Drug*</td>
<td>30% after deductible</td>
</tr>
<tr>
<td>Non-Preferred Brand Drug*</td>
<td>50% after deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Network Specialty Drugs</th>
<th>YOUR COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Drug*</td>
<td>$20 Copay (copay applies after the HDHP deductible is satisfied)</td>
</tr>
<tr>
<td>Preferred Brand-Name Drug*</td>
<td>30% after deductible</td>
</tr>
<tr>
<td>Non-Preferred Brand Drug*</td>
<td>50% after deductible</td>
</tr>
</tbody>
</table>

*When a generic is available, you pay the coinsurance plus the cost difference between generic and brand-name drugs.
Mail Order Prescription Benefits

Mandatory Mail Order for Maintenance Medications
To receive prescription benefits, you must order maintenance medications through the mail service. Maintenance medications are drugs taken regularly to treat conditions such as high cholesterol, high blood pressure, acid reflux or depression. Through Prime Therapeutics, you can have up to a 90-day supply of covered medications delivered directly to the address of your choice and save money. For a list of mandatory mail order medications, please visit www.clubcorp.com/benefits and click on BCBSTX under Quick Links or call 1-800-521-2227.

For other medications not included on the mandatory mail order list, do your research and check to see if mail ordering your prescriptions can work for you and save you money.

The copayment amounts are indicated on your schedule of coverage. When you mail your prescription orders to the address provided on the Mail Service Prescription Drug Program Claim Form, you must send in your payment.

Specialty Drugs (including high cost injectables)
Enhanced medical management applies to more specialty drugs. Specialty medications are generally prescribed to treat chronic, complex medical conditions, such as multiple sclerosis, hepatitis C and rheumatoid arthritis. These medications are typically received by injection or infusion, but may be topical or taken by mouth. Specialty drugs often require careful adherence to a treatment plan and have special handling or storage requirements and may not be stocked by retail pharmacies.

Some specialty medications must be given by a health care professional, while others are self-administered. Medications that require professional services for administration are usually covered under your medical benefit. Your doctor will order these medications.

Specialty medications are covered according to the prescription drug benefit when you or your provider uses the Prime Specialty Pharmacy through BCBSTX. Through this program, providers can submit prescriptions by fax or phone. Please contact BCBSTX at 1-800-521-2227 for more information. If you choose to use a different pharmacy for specialty medications, they will not be covered by the Medical Plan.
Step Therapy:
The step therapy program encourages safe and cost-effective medication use. Under this program, a “step” approach is required to receive coverage for certain high-cost medications. This means that to receive coverage, you may need to first try a proven, cost-effective medication before using a more costly treatment, if needed. Remember, treatment decisions are always between you and your doctor.

The step therapy program requires that you have a prescription history for a “first-line” medication before your benefit plan will cover a “second-line” drug.

- A first-line drug is recognized as safe and effective in treating a specific medical condition, as well as being cost-effective.
- A second-line drug is a less-preferred or sometimes more costly treatment option.

Step 1
When possible, your doctor should prescribe a first-line medication appropriate for your condition.

Step 2
If your doctor determines that a first-line drug is not appropriate for you or is not effective for you, your prescription drug benefit will cover a second-line drug when certain conditions are met.

Prior Authorization
The prior authorization program encourages safe and cost-effective medication use. The program applies to certain high-cost drugs that have the potential for misuse. Before medications included in the prior authorization program can be covered under your benefit plan, your doctor will need to get approval through Blue Cross and Blue Shield of Texas.

If you are already taking or are prescribed a drug that is part of the prior authorization program, your doctor can submit a prior authorization request form so your prescription can be considered for coverage. Your doctor can find prior authorization forms on the provider website at www.bcbstx.com. Your doctor may also call 800-289-1525 with questions or to get a form.

If the prior authorization request is approved: You will pay the appropriate amount based on your prescription drug benefit when you fill your prescription.

If the prior authorization request is not approved: The medication will not be covered under your prescription drug benefit. You can still purchase the medication, but you will be responsible for the full cost. You can talk to your doctor to find out if another drug might be right for you. Remember, treatment decisions are always between you and your doctor. As always, the appeal rights provided by your benefit plan are available to you.
Wellness Incentives and Health Care Accounts

The following wellness incentives are offered:

• $50 to each of the first 400 covered employee partners who complete a Health Risk Assessment (HRA).

• $50 for the first covered employee partner or covered dependent who qualifies, enrolls and participates in a recommended Condition Management program (See page 25 for more information). The second covered person receives $25. The annual maximum incentive per covered family is $75.

• $50 for a covered employee partner or spouse who enrolls during the first 12 weeks of pregnancy and participates in the Special Beginnings prenatal management program.

Wellness incentives are deposited into a Limited Purpose Health Care Account (HCA) to pay for eligible expenses such as dental or vision expenses for you or your covered dependents. If you participate in the HDHP, HCA funds can be used for vision and dental expenses not paid for under another health plan or HSA. HCA funds are available for each plan year and do not carry-over.

Call BCBSTX at 1-800-521-2227 for more information.
Health Savings Accounts (HSAs)

Health Savings Accounts (HSAs) will be available for employee partners enrolled in a HDHP. A HSA is a personal health care bank account that you can use to pay out-of-pocket medical expenses with pre-tax dollars. You will own and administer your account, and there are no “use it or lose it” restrictions like with Flexible Spending Accounts (FSAs). HSAs allow you to save and “roll over” money if you do not spend it in the calendar year. These are individual accounts. If you change health plans or jobs, the money in the account is yours to keep. There are no vesting requirements or forfeiture provisions.

HSA Contributions

You can make a contribution to your HSA each year that you are eligible. You, or anyone you elect to contribute on your behalf, can contribute no more than:

- $3,350 for employee partner only coverage
- $6,650 for family coverage

Who Can Have an HSA?

Any adult can contribute to an HSA if they:

- Have coverage under a HSA-qualified “High Deductible Health Plan” (HDHP).
- Are NOT covered under another Medical Plan that is not a HDHP.
- Are NOT covered under any Health Care Flexible Spending Account that reimburses medical expenses (even a spouse’s FSA plan), unless the FSA is used for qualified Limited Purpose expenses.
- You are not enrolled in Medicare or TRICARE for Life.
- Cannot be claimed as a dependent on someone else’s tax return.
- Have a zero dollar balance in the FSA.

If you make a contribution outside of your pre-tax payroll contributions, you can deduct the contributions (even if you do not itemize deductions) when completing your federal income tax return. Contributions to the account must stop once you are enrolled in Medicare. However, you can keep the money in your account and use it to pay for medical expenses tax free.

Opening Your Health Savings Account

When you enroll in the HDHP, you will receive information from Benefit Wallet about two weeks after your enrollment date. It is up to you to open an account. Contributions cannot be posted until you complete the Bank of NY - Mellon signature process.
Dental Plans

Proper dental care plays an important role in your overall good health. ClubCorp offers two Dental Plans designed to encourage preventive treatment, allowing employee partners to achieve oral health while striving to minimize dental costs. Full-time employee partners may participate in the Dental Provider Organization (DPO) or Dental Health Maintenance Organization (DHMO), which are offered by Delta Dental.

1. DPO Network Dentists
   You can see any provider to receive care; however, when using a network dentist, your out-of-pocket costs are lower. This is because the network dentists have agreed to charge lower fees, and your Plan’s in-network services cover a larger share of the charges. If you choose to use a dentist who doesn’t participate in the network, while the Plan of benefits is the same, your out-of-pocket costs will be higher, and you are subject to charges beyond reasonable & customary.

   To find a network dentist, contact:
   Delta Dental at www.deltadentalins.com (Delta Dental DPO option) or call 1-800-521-2651.

2. DeltaCare USA (DHMO) Plan
   You will need to select a contracted DeltaCare USA dentist for both yourself and your eligible dependents at the time of enrollment. You must receive treatment from your selected DeltaCare USA contract dentist in order for your dental services or treatment to be covered.

   To find a contract DeltaCare USA dentist, contact:
   Delta Dental at www.deltadentalins.com (DeltaCare USA option) or call 1-800-422-4234.

Dental Employee Premiums
Premium contributions for dental will be deducted from your pay check on a before-tax basis. Your tier of coverage will determine your biweekly rates.

<table>
<thead>
<tr>
<th>DPO Biweekly Rates</th>
<th></th>
<th>DHMO Biweekly Rates</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Partner</td>
<td>$15.28</td>
<td>Employee Partner + Spouse</td>
<td>$31.74</td>
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<tr>
<td>Employee Partner + Child(ren)</td>
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<td>Employee Partner + Family</td>
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<tr>
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<td>Employee Partner + Family</td>
<td>$13.66</td>
<td>Employee Partner + Family</td>
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</table>
## Dental Plan Summary

<table>
<thead>
<tr>
<th>DELTA DENTAL</th>
<th>DPO</th>
<th>DHMO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Your Cost/Covered At</strong></td>
<td><strong>Your Cost</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Annual Deductible</strong></td>
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<tr>
<td>Individual</td>
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<td>None</td>
</tr>
<tr>
<td>Family</td>
<td>$150</td>
<td>None</td>
</tr>
<tr>
<td><strong>Calendar Year Maximum (for covered services)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Partner and each covered family member</td>
<td>$1,500 per person</td>
<td>None</td>
</tr>
<tr>
<td><strong>Class I: Preventive and Diagnostic Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visits</td>
<td>100% no deductible</td>
<td>None</td>
</tr>
<tr>
<td>Cleanings</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>X-rays</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td><strong>Class II: Basic Restorative Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Filings</td>
<td>20%/80%*</td>
<td>$0 - $75</td>
</tr>
<tr>
<td>Simple Extraction</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Root Canal</td>
<td></td>
<td>$95-$335</td>
</tr>
<tr>
<td><strong>Class III: Major Restorative Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crown</td>
<td>50%*</td>
<td>$355</td>
</tr>
<tr>
<td><strong>Class IV: Orthodontia</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult</td>
<td>Not Covered</td>
<td>$2,100</td>
</tr>
<tr>
<td>Child</td>
<td></td>
<td>$1,900</td>
</tr>
<tr>
<td><strong>States where plan is offered</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All States (offered as Delta Dental PPO in states outside of Texas)</td>
<td>Alabama, Arkansas, Arizona, California, Colorado, District of Columbia, Florida, Georgia, Kansas, Kentucky, Louisiana**, Maryland, Michigan, Mississippi**, Nevada, New York, Ohio, Pennsylvania, South Carolina (small number of providers in this state), Tennessee, Texas, Washington, Wisconsin, West Virginia. You must select and use a DeltaCare USA contracted dentist in order for dental services to be covered.</td>
<td></td>
</tr>
</tbody>
</table>

*After plan deductible

**In Louisiana and Mississippi, the DeltaCare program is delivered through the Delta Dental PPO network. For purposes of this program, dentists in the Louisiana and Mississippi PPO network are referred to as DeltaCare USA dentists. While enrollees do not need to select a DeltaCare USA contracted dentist, they are required to use Delta Dental PPO dentists in order to receive the DeltaCare USA benefits.
Vision Plan

Eye health is an indicator of overall health. Regular eye exams can detect diseases like glaucoma, diabetes, and blindness. Vision benefits provide access to quality vision care. So that you and your family will get the care you need, ClubCorp offers full-time employee partners a comprehensive vision benefit provided by Vision Service Plan (VSP).

You can elect vision coverage for you and your dependents.

VSP network professionals provide vision services at discounted rates. When you want vision care, you may choose to see a:

- VSP provider, who contacts VSP for authorization. There are no claims to file. You pay the copayment for the exam and materials, and the plan pays the rest. Discounts for laser vision correction surgery (LASIK or PRK), special lenses, cosmetic extras, prescription glasses and sunglasses and contacts are available from certain VSP providers.

- Non-VSP provider. You pay all charges at the time of your appointment. You can then file an itemized receipt with VSP.

To find a network provider, contact:

Vision Service Plan: www.vsp.com or call 1-800-877-7195
Vision Plan Summary

### VSP

<table>
<thead>
<tr>
<th>Copay</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination</td>
<td>$15</td>
<td>Up to $50 allowance</td>
</tr>
<tr>
<td>Materials (Lenses and Frames)</td>
<td>$15</td>
<td>See Covered Services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefit Frequencies</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination</td>
<td>12 months</td>
<td>12 months (Calendar Year)</td>
</tr>
<tr>
<td>Lenses</td>
<td>12 months</td>
<td>12 months (Calendar Year)</td>
</tr>
<tr>
<td>Frames</td>
<td>24 months</td>
<td>24 months (Calendar Year)</td>
</tr>
<tr>
<td>Contacts (in lieu of Lenses &amp; Frames)</td>
<td>12 months</td>
<td>12 months (Calendar Year)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Covered Materials</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Lenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Single Vision Lenses</td>
<td>100% after copay</td>
<td>Up to $50 allowance</td>
</tr>
<tr>
<td>• Bifocal Lenses</td>
<td>100% after copay</td>
<td>Up to $75 allowance</td>
</tr>
<tr>
<td>• Trifocal Lenses</td>
<td>100% after copay</td>
<td>Up to $100 allowance</td>
</tr>
<tr>
<td>Frames</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Retail Frame Equivalent</td>
<td>100% up to $120 allowance after $15 copay</td>
<td>Up to $70 allowance</td>
</tr>
<tr>
<td>Contact Lenses*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Medically Necessary</td>
<td>100%</td>
<td>Up to $210 allowance</td>
</tr>
<tr>
<td>• Elective</td>
<td>100% up to $120 allowance</td>
<td>Up to $105 allowance</td>
</tr>
</tbody>
</table>

*In lieu of lenses/frames

### Vision Biweekly Rates

<table>
<thead>
<tr>
<th></th>
<th>$3.66</th>
<th>$5.45</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Partner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Partner + Child(ren)</td>
<td>$5.83</td>
<td></td>
</tr>
<tr>
<td>Employee Partner + Spouse</td>
<td></td>
<td>$9.31</td>
</tr>
<tr>
<td>Employee Partner + Family</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Flexible Spending Account (FSA)

Dependent Care Reimbursement Account
Reimbursement for dependent care claims is limited to the total amount that is deposited in your account at that time.

- Allows you to set aside up to $5,000 to pay for child or elder care expenses on a pre-tax basis.
- Eligible dependents include children under age the age of 13 and dependents of any age that are incapable of caring for themselves.
- Dependent care expenses are reimbursable as long as the provider is not anyone considered your dependent for income tax purposes.
- In order to be reimbursed, you must provide the tax identification number or Social Security number of the party providing care.

Eligible Dependent Care Reimbursement Account Expenses
This account covers dependent day care expenses that are necessary for you and your spouse to work, or attend school full time. The dependent must be a child under age 13 and claimed as a dependent on your federal income tax return, or a disabled dependent that spends at least eight (8) hours a day in your home. Examples of eligible dependent care expenses include:

- In-home baby-sitting services (not by an individual you claim as a dependent)
- Care of a preschool child by a licensed nursery or day care provider
- Before- and after-school care
- Day camp
- In-house dependent care provider
General FSA Rules and Restrictions
In exchange for the tax advantages FSAs offer, the IRS has imposed the following rules and restrictions for Dependent Care FSAs:

- For Dependent Care FSAs, your expenses must be incurred during the plan year. The filing deadline is the last day in April following plan year end or 30 days after termination.
- You cannot participate in Dependent Care FSA and claim a tax deduction at the same time.
- You must “use it or lose it”— any unused funds will be forfeited.
- You cannot change FSA election in the middle of the plan year unless you have a qualified life status change such as a marriage, divorce or birth of a child.

Important Rules Regarding Health Savings Accounts (HSAs) and Health Care Flexible Spending Accounts
If you participated in a regular Health Care FSA in 2014 that had a balance at the end of the year and are participating in the HSA in 2015, IRS rules prohibit you from contributing to your HSA until April 1, 2015 (if your regular Health Care FSA balance was $0 at the end of 2014, you can contribute to the HSA beginning January 1, 2015).
Survivor Benefits

Basic Life and Accidental Death and Dismemberment (AD&D) Insurance

Basic Life and Accidental Death and Dismemberment (AD&D) are a part of ClubCorp's benefits Plan and are essential to your future financial security. It is important to understand how your Plan works and what benefits you will receive. Just as you would keep track of money that you put into a bank or other financial institution, it is in your best interest to keep track of your survivor benefits.

Life insurance offers financial protection in the event of your death. AD&D insurance provides financial protection if you have specific injuries or die as a result of an accident. This coverage is for employee partners only. You and the Company share in the cost of this coverage. Your coverage amount is 1½ times your salary, up to a maximum benefit of $50,000.

How to Calculate the Cost for Basic Life and AD&D

• Take your annual earnings x 1.5 (not to exceed $50,000) = Your coverage amount
• Take your coverage amount divided by 1,000 x $0.12 = Total monthly cost
• Take the total monthly cost x 50% = Your monthly cost
• Multiply your monthly cost x 12 then divide by 26 = Your biweekly cost
Voluntary Supplemental Life & Voluntary Supplemental Dependent Life

Full-time employee partners may purchase Voluntary Supplemental Life insurance for themselves and their family. Premiums are paid through post-tax payroll deductions. You must purchase Voluntary Supplemental Life insurance for yourself to purchase Voluntary Supplemental Life insurance for your spouse and child(ren).

<table>
<thead>
<tr>
<th>COVERAGE AMOUNT</th>
<th>BASIC LIFE</th>
<th>VOLUNTARY SUPPLEMENTAL LIFE</th>
<th>DEPENDENT VOLUNTARY SUPPLEMENTAL LIFE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.5X annual salary (maximum $50,000)</td>
<td>Increments of $10,000 up to 3X annual salary (maximum $380,000)</td>
<td>Spouse — Increments of $10,000 up to 50% of your coverage amount (maximum $100,000) Children — Increments of $5,000 (maximum $25,000)</td>
</tr>
<tr>
<td>WHO PAYS</td>
<td>You pay 50% ClubCorp 50%</td>
<td>You pay full cost</td>
<td>You pay full cost</td>
</tr>
<tr>
<td>WHEN BENEFITS ARE PAYABLE</td>
<td>If you die while covered under the Plan</td>
<td>If you die while covered under the Plan. This benefit is in addition to your Basic Life benefit.</td>
<td>If your dependent dies while covered under the Plan.</td>
</tr>
<tr>
<td>MAXIMUM BENEFIT</td>
<td>$50,000</td>
<td>Not to exceed 7X annual salary or $500,000</td>
<td>$100,000 for a spouse $25,000 for children</td>
</tr>
<tr>
<td>WHEN EVIDENCE OF INSURABILITY IS REQUIRED</td>
<td>Not applicable</td>
<td>For any election over 3X your annual salary or $380,000 or if you choose to increase your election or enroll after your original enrollment period.</td>
<td>For a spouse, any election exceeding $30,000 and any election after original enrollment period.</td>
</tr>
</tbody>
</table>

To calculate how much your Voluntary Supplemental Life coverage will cost:

\[
\text{Benefit Elected} \div 1,000 = \text{Weekly Premium} \times \text{Age Based Rate} = \text{Weekly Premium}
\]

### EMPLOYEE PARTNER AND SPOUSE VOLUNTARY SUPPLEMENTAL LIFE INSURANCE

<table>
<thead>
<tr>
<th>Age (as of January 1)</th>
<th>Rate / $1,000 (weekly)</th>
<th>Age (as of January 1)</th>
<th>Rate / $1,000 (weekly)</th>
<th>Age (as of January 1)</th>
<th>Rate / $1,000 (weekly)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 30</td>
<td>$0.080</td>
<td>45–49</td>
<td>$0.430</td>
<td>65–69</td>
<td>$2.880</td>
</tr>
<tr>
<td>30–34</td>
<td>$0.110</td>
<td>50–54</td>
<td>$0.710</td>
<td>70–74</td>
<td>$4.400</td>
</tr>
<tr>
<td>35–39</td>
<td>$0.135</td>
<td>55–59</td>
<td>$1.220</td>
<td>75+</td>
<td>$6.660</td>
</tr>
<tr>
<td>40–44</td>
<td>$0.225</td>
<td>60–64</td>
<td>$1.890</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### DEPENDENT VOLUNTARY SUPPLEMENTAL LIFE INSURANCE

Child(ren) — $0.20 / $1,000
Income Protection

Disability Benefits
Disability coverage helps protect part of your income if you get hurt or sick and cannot work. Disability benefits are reduced by any benefits you receive from Social Security or other disability income benefits. ClubCorp offers two disability plans:

Long Term Disability (LTD) — 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, Food & Beverage Directors, Golf Course Superintendent, Head Golf Professional, Head Tennis Professional, Membership Directors, Member Relations Director, Operations Manager, Private Event Director or Service Director.

Short Term Disability (STD) — Full-time employee partners not eligible for the LTD Plan may participate in the STD Plan (except for employee partners working in clubs located in California, New Jersey or New York due to state-mandated disability plans already made available to you).

Short Term Disability (STD) Plan — not available in CA, NJ and NY
(For full-time employee partners not eligible for Long Term Disability — see above)

You pay 100% of the cost of this benefit on a post-tax basis. The cost of this benefit will depend upon your age and the benefit amount you elect. After a 14-day waiting period, the STD Plan will provide a weekly benefit for up to 13 weeks if you are disabled due to an accident or illness.

Pre-existing conditions apply to this benefit. For this Plan, a pre-existing condition is a disability by injury or illness for which medical advice, diagnosis, care or treatment was recommended or received during the 6 months prior to becoming eligible for this Plan. You must have 12 months of coverage from the date you become covered under this Plan to receive benefits on a pre-existing condition.

You will choose one of the following weekly benefit amounts that is not greater than 60% of your average weekly salary — $100, $200, $300, $400 or $500 (your average weekly salary includes pay such as regular salary, commission, lessons and service charge distributions, but does not include extra pay such as overtime, bonus, etc).

For Example…

... if you are 27 years old and your average weekly salary is $400, here is how you would determine how much coverage you may elect:

$400 (Your average weekly salary) x 60% = $240

In this example, you may elect a weekly benefit amount of $100 or $200. If you chose the $100 weekly benefit, you would pay $81.64 per year to receive up to 13 weeks for a maximum benefit of $1,300 if you became disabled and could not work. The personalized enrollment form included with your enrollment materials will show the coverage amounts that you may elect.
Long Term Disability (LTD) Plan
(For regular full-time eligible positions only — see page 23)

You can elect LTD coverage for you only and you pay 50% of the cost on a pre-tax basis. After completing a 90-day waiting period, the LTD plan replaces 60% of your weekly pay as long as you are disabled or until you reach age 65. To cover your loss of income during the 90-day waiting period, you will receive salary continuation benefits.

Pre-existing conditions apply to this benefit. For this Plan, a pre-existing condition is a disability by injury or illness for which medical advice, diagnosis, care or treatment was recommended or received during the following time periods if you enroll for the first time:

- As a newly eligible employee partner — Within 3 months immediately before the date you become covered, you may not receive benefits for 12 months after coverage begins.
- During Open Enrollment — Within 12 months immediately before the date you become covered, you may not receive benefits for 24 months after coverage begins.
- You are required to use any earned but unused sick time followed by vacation 1) during any waiting periods prior to receiving benefits through a State- or Company-sponsored wage supplement benefit program such as salary continuation, and 2) during any time period that you do not receive any form of State- or Company-sponsored wage supplement benefit program. Please see Employee Partner handbook for further details.

IF YOU ARE DISABLED, THE LTD PLAN PAYS...

<table>
<thead>
<tr>
<th>Salary Contribution</th>
<th>LTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days 15 – 90</td>
<td></td>
</tr>
<tr>
<td>0%</td>
<td>60%</td>
</tr>
<tr>
<td>2 or more years of service</td>
<td>66.67% (or 2/3)</td>
</tr>
<tr>
<td>Weekly Benefit Maximum</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

How to Calculate Your LTD Cost

- Take your monthly salary divided by $100 = The basis amount
- Take the basis number x $0.38 = The total monthly cost
- Take the total monthly cost x 50% = Your monthly cost
- Take your monthly cost x 12 then divide by 26 = Your biweekly cost
Additional Benefits

Medical Plan

Nurseline 24/7
Good health starts by asking the right questions at the right time. And we all know that sometimes those questions come up unexpectedly, like when the doctor’s office is closed. Whatever the time, you can get the answers to your health care questions with the 24/7 Nurseline from BCBSTX. Call 1-800-462-3275.

Special Beginnings®
The Special Beginnings program provides prenatal risk assessment and education, and coordinates with the patient’s physician to provide case management services to help reduce the chance of low birth-weight infants and/or premature delivery. Call BCBSTX at 1-800-462-3275 for more information or to enroll.

Condition Management
If you’re living with a chronic health condition, you may face daily challenges in managing your condition. You want to have the best knowledge and tools available to help you stay as healthy as possible.

This voluntary program helps support those who have:

- Asthma
- Diabetes
- Congestive Heart Failure
- Chronic Obstructive Pulmonary Disease
- Lower Back Pain
- Metabolic Syndrome (high blood pressure, high cholesterol)
- Coronary Artery Disease

Disease/Condition Management programs work together with your health plan, doctor and you to help identify the best way to manage your condition more effectively.

Enroll and take control with Disease/Condition Management programs and online resources that help educate you, teach you self-management strategies and, most importantly, put the quality back in your life.

Call 1-800-462-3275 to enroll or find out more.
Additional Benefits Through the Life Insurance Plans

If you are enrolled in either the Group Life or Supplemental Life Plans

TravelConnect
As part of your employee partner benefits package, your Lincoln Financial Group® life insurance coverage includes our TravelConnect program, which focuses on travel, medical and safety-related services you may need while traveling. The TravelConnect benefit is provided at no additional cost to you and includes a wealth of services when traveling just 100 miles or more from home. Services are provided for both business and leisure travel. Whether you want the weather forecast for your destination or need emergency medical help halfway around the world, FrontierMEDEX has the staff and resources to provide support 24 hours a day, seven days a week.

LifeKeys
LifeKeys services help you meet life’s challenges. When you choose life insurance, you’re planning for your family’s future—assuring their comfort and securing their plans. With Lincoln Term Life Insurance, you can also access services that make a real difference now as well as in the future. LifeKeys services, included at no additional cost and includes EstateGuidance® will preparation, GuidanceResources® Online is the place to go for articles, tutorials, streaming videos and “Ask the Expert” personal responses on topics such as law and regulations, money and investments and health and wellness, and Identify Theft resources.
Additional Benefits Through the Long Term Disability Plan

If you are enrolled in the Long Term Disability Plan

EmployeeConnect
No matter what the issue, we can help you 24/7 with confidential support, guidance and resources.

• Assistance for you or an immediate household family member who is age 16 or older
• In-person help with short-term issues
• Toll-free phone and Web access 24/7
• Phone access to legal counsel and a 25% discount on follow-up services
• Work/life services for assistance with:
  » Childcare, eldercare and adoption
  » Relationships
  » Financial issues

To learn more about the Lincoln Financial EmployeeConnect program, visit www.eapadvantage.com (password = connect) or talk with a specialist at 877 757-7587.
Required Notices

Important Notice from ClubCorp USA, Inc. About Your Prescription Drug Coverage and Medicare under the BCBS of Texas plans HDHP 1350 and HDHP 2000

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with ClubCorp USA, Inc. and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

2. ClubCorp USA, Inc. has determined that the prescription drug coverage offered by the BCBS of Texas plans HDHP 1350 and HDHP 2000 is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. You may also enroll each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current ClubCorp USA, Inc. coverage will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan’s summary plan description or contact Medicare at the telephone number or web address listed herein.

If you do decide to join a Medicare drug plan and drop your current ClubCorp USA, Inc. coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with ClubCorp USA, Inc. and don’t join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

Important Notice from ClubCorp USA, Inc. About Your Prescription Drug Coverage and Medicare under the BCBS of Texas Plan HDHP 5000

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with ClubCorp USA, Inc. and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

2. ClubCorp USA, Inc. has determined that the prescription drug coverage offered by the BCBS of Texas plan HDHP 5000 is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the ClubCorp USA, Inc. plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

3. You can keep your current coverage from ClubCorp USA, Inc. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.
When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. You may also enroll each year from October 15th through December 7th.

However, if you decide to drop your current coverage with ClubCorp USA, Inc., since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under the ClubCorp USA, Inc. plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current ClubCorp USA, Inc. coverage will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan’s summary plan description or contact Medicare at the telephone number or web address listed herein.

If you do decide to join a Medicare drug plan and drop your current ClubCorp USA, Inc. coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
Since the coverage under ClubCorp USA, Inc. is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn’t join, if you go 63 continuous days or longer without prescription drug coverage that’s creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage…
Contact the person listed at the end of these notices for further information.
NOTE: You’ll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through ClubCorp USA, Inc. changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
» Visit www.medicare.gov
» Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
» Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

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

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

Date: January 1, 2015
Name of Entity/Sender: ClubCorp USA, Inc.
Contact—Position/Office: People Strategy
Address: 3030 LBJ Freeway, Suite #600
Dallas, TX 75234
Phone Number: 800-800-4615

Women’s Health and Cancer Rights Act
The Women’s Health and Cancer Rights Act of 1998 was signed into law on October 21, 1998. The Act requires that all group health plans providing medical and surgical benefits with respect to a mastectomy must provide coverage for all of the following:
» Reconstruction of the breast on which a mastectomy has been performed
» Surgery and reconstruction of the other breast to produce a symmetrical appearance
» Prostheses
» Treatment of physical complications of all stages of mastectomy, including lymphedema

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions which apply for the mastectomy. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description or contact People Strategy Benefits at 800-800-4615.
HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for health care benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. The Notice of Privacy Practices has been recently updated. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact People Strategy Benefits at 800-800-4615.

HIPAA Special Enrollment Rights

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

Loss of eligibility includes but is not limited to:

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

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 31 days after your or your dependent(s)’ other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact People Strategy Benefits at 800-800-4615.
Important Contacts

ClubCorp — People Strategy Benefits
• General Plan and Enrollment Information
• Life and LTD Claims
  1-800-800-4615 (8:00 am – 5:00 pm, CST)
  www.clubcorp.com/benefits

BCBSTX Medical and Prescription Drug Coverage
  1-800-521-2227
  www.bcbstx.com/clubcorp

Blue Value Advisor (Medical Plan Concierge Services) provided by BCBSTX
  1-800-521-2227
  www.bcbstx.com/clubcorp

Blue Distinction Centers of Excellence Information (Delivery of Speciality Care)
  1-800-521-2227
  www.bcbstx.com/clubcorp

Nurseline — 24/7 Nurses to answer your questions
  1-800-462-3275

Delta Dental — Dental Coverage
  1-800-521-2651 DPO
  1-800-422-4234 DHMO
  www.deltadentalins.com

VSP — Vision Coverage
  1-800-877-7195
  www.vsp.com

PayFlex — Dependent Care Flexible Spending Account
  1-800-284-4885
  www.mypayflex.com or www.healthhub.com

Benefit Wallet™ - Health Savings Account (HSA) administrator
  1-877-472-4200
  www.mybenefitwallet.com

Lincoln Financial - STD Claims
  1-800-423-2765