ClubCorp USA, Inc. dba Invited Employee Benefit Plan

SUMMARY PLAN DESCRIPTION

This is merely a summary of the main features of the Plan and not a detailed description of all of its provisions. If, in the future, the provisions described herein should change for any reason, you will be provided with a summary of the changes.

IF, FOR ANY REASON, THERE IS AN OMISSION OR MISSTATEMENT IN THIS SUMMARY, OR ANY DIFFERENCE BETWEEN THIS SUMMARY AND THE LEGAL DOCUMENTS, THE LEGAL DOCUMENTS WILL IN ALL RESPECTS CONTROL AND GOVERN.

Dear Employee:

We are pleased to provide you with a health and welfare benefit plan which offers valuable financial security for you and your eligible dependents. The following summarizes the benefits provided by your employer for all eligible employees and their eligible dependents.

It is important for you to carefully study and understand your benefits so you can make the best decision regarding their use. You are encouraged to ask questions and obtain clarification on any matters about which you are uncertain.

Your benefit program has been carefully designed to provide protection against the sudden and unexpected cost of illness or injury. The program also helps you prepare for secure retirement years, and it helps take care of your family in the event of your death. These are matters of concern to all of us.

The following does not include every detail and administrative procedure of the Plan. You are encouraged to discuss issues which may not be clearly or completely explained with your benefits representative before taking any action which could result in an unreimbursed expense. In all situations involving the interpretation or clarification of a policy, procedure or application, the decision of the Plan Administrator will be final and binding. Notwithstanding the foregoing, a claim for benefits that has been denied is subject to review pursuant to the Claims Procedure Section specified in this Summary.

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1 - GENERAL PLAN INFORMATION

Plan Name:	ClubCorp USA, Inc. dba Invited Employee Benefit Plan
Type of Plan:	Welfare Benefit Plan
Plan Year:	Twelve (12) month period beginning on January 1, 2025, and ending on December 31, 2025.
Plan Sponsor:	ClubCorp USA, Inc. dba Invited
Participating Related Employers:	See listing in the Attachment C Section of this Summary.
Plan Administrator:	The Company
Claims Administrator:	Medical Benefits – Self-Insured

Medical Benefits – Self-Insured
United Healthcare
Group Policy #925871
High Deductible Health plan
Choice Plus PPO Plan
Group Policy #7800-000101
Healthy Start MEC Plan
Plan Details Attached

The above benefits are administered by the Claims Administrator, United Healthcare

Medical Benefits – Self-Insured
SimplePay
Group Policy #20422
Aetna Simple Pay Health Plan
Plan Details Attached

The above benefits are administered by the Claims Administrator, SimplePay

Pharmacy Benefits – Self-Insured
OptumRX
Group Policy #INVITED
Rx BIN: 610011
Rx PCN: IRX
CVS Caremark
Group Policy #RX274B
Rx BIN: 004336
Rx PCN: ADV
Plan Details Attached

The above benefits are administered by the Claims Administrator, OptumRX and CVS Caremark

Dental Benefits – Fully Insured
Delta Dental
Group Policy #05813
DHMO
DPPO
Plan Details Attached

The above benefits are administered by the Claims Administrator, Delta Dental

Vision Benefits – Fully Insured
Superior Vision by MetLife
Group Policy #34013
Plan Details Attached

The above benefits are administered by the Claims Administrator, Superior Vision by MetLife

Short-Term Disability Benefits – Fully Insured
MetLife
Group Policy #119217
Plan Details Attached

The above benefits are administered by the Claims Administrator, MetLife

Long-Term Disability Benefits – Fully Insured
MetLife
Group Policy #119217
Plan Details Attached

The above benefits are administered by the Claims Administrator, MetLife

Group Term Life and AD&D Benefits – Fully Insured
MetLife
Group Policy #119217
Plan Details Attached

The above benefits are administered by the Claims Administrator, MetLife

Voluntary Life and AD&D Benefits – Fully Insured
MetLife
Group Policy #119217
Plan Details Attached

The above benefits are administered by the Claims Administrator, MetLife

Health Flexible Spending Account – Self-Insured
Tax Savers
Plan #501
Plan Details Attached

The above benefits are administered by the Claims Administrator, Tax Savers

Dependent Care Flexible Spending Account – Self-Insured
Tax Savers
Plan #501
Plan Details Attached

The above benefits are administered by the Claims Administrator, Tax Savers

Health Savings Account - Self-Insured
Tax Savers
Plan #501
Plan Details Attached

The above benefits are administered by the Claims Administrator, Tax Savers

Business Address for Plan Sponsor:	5221 N. O'Connor Blvd Suite #300 Irving, TX 75039
Business Telephone #:	945-301-0030
Employer ID # for Plan Sponsor:	75-2114856
Plan Number:	501
Legal Agent:	Emily Decker General Counsel 5221 N. O'Connor Blvd Suite 300 Irving, TX 75039 945-301-0030

Service of legal process may be made to the Plan Administrator or the legal agents at the business address listed above.

Effective Date of the Plan:	January 1, 2022
Effective Date of the Amended and Restated Plan:	January 1, 2025
Date of the Summary Plan Description:	January 1, 2025

2 - IMPORTANT DEFINITIONS

As you read about your benefits, you may find terms which have specific meaning. This section lists important terms and their meanings under the Plan. Any term not included in this section, but used in this Summary shall have the same meaning as specified in the Plan.

AD&D means accidental death and dismemberment insurance.

Cafeteria Plan means a cafeteria plan under Code Section 125 established by the Company under a separate document.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985.

Company means the Plan Sponsor indicated in Article 1 above.

Component Benefit Program means those benefits programs specified in Section 3 of the Plan.

Dependent means an Employee's Spouse or other dependents that satisfies the dependent eligibility requirements specified in the Adoption Agreement.

Employee means any common-law employee of the Employer who is (select all that who satisfies the eligibility provisions of Section 4 and who is not excluded from participation by the terms of benefits under the Component Benefit Program.

Employer means the Company and any related employers who are participating under this Plan.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

Health Flexible Spending Account means the portion of the Cafeteria Plan that reimburses unreimbursed medical expenses under Code Section 213(d)

Health Reimbursement Arrangement means a health reimbursement arrangement sponsored by the Company.

HIPAA means the federal Health Insurance Portability and Accountability Act of 1996, which is far-reaching legislation designed to improve the portability of health coverage and to make other changes to the health care delivery system.

HITECH means the Health Information Technology for Economic and Clinical Health Act.

Insurer means any insurance company with whom the Company has contracted to provide one or more of the benefits under the Component Benefit Program to you and

your eligible Dependents in exchange for a premium paid. It is the Insurers' duty to pay claims covered under the benefit provided under the Component Benefit Program in which you and your Dependents are enrolled.

Named Fiduciary means the individual(s) entity or entities specified in the Adoption Agreement.

Plan means this Employee Benefit Plan.

Plan Administrator means the individual or entity specified in Section 1 of this Summary.

Protected Health Information ("PHI") means individually identifiable health information that is maintained or transmitted by a covered entity, subject to specified exclusions as provided in federal regulations.

PPACA means the Patient Protection and Affordable Care Act.

Spouse means an individual who is legally married to a Participant and specified in each of the benefits though the Component Benefits Program.

USERRA means the Uniformed Services Employment and Reemployment Act of 1994.

3 - COMPONENT BENEFIT PROGRAM INFORMATION

What benefits are offered under the Plan?

The Company maintains the Plan for the exclusive benefit of its eligible Employees and their Spouses and other Dependents to provide certain health and welfare benefits. The Plan provides these benefits through the Component Benefit Program. They include:

- Medical Benefits
- Pharmacy Benefits
- Dental Benefits
- Vision Benefits
- Short-Term Disability Benefits
- Long-Term Disability Benefits
- Group Term Life and AD&D Benefits
- Voluntary Life and AD&D Benefits
- Health Flexible Spending Account
- Dependent Care Flexible Spending Account
- Health Savings Account

Some benefits under the Component Benefit Program require you to make an annual election to enroll for coverage. The details of such annual elections are described in the Cafeteria Plan.

Where can you find information regarding the benefits?

Each of these benefits under the Component Benefit Program is summarized in a certificate of insurance issued by an Insurer, a summary plan description or another governing document prepared by the Company. A copy of each booklet, summary or other governing document is provided in the Attachment B Section to this Summary.

This document and its Attachments constitute the summary plan description for each of the Component Benefit Programs as required by ERISA Section 102.

Are the Medical Benefits provided under the Component Benefit Program Grandfathered?

No.

What are the important limitations?

Benefits hereunder are provided pursuant to an insurance contract or governing written plan document adopted by the Company. If the terms of this document conflict with the terms of such insurance contract or governing plan document, then the terms of the insurance contract or governing plan document will control, rather than this document, unless otherwise required by law.

4 - ELIGIBILITY AND PARTICIPATION REQUIREMENTS

When are you or your Dependents eligible to participate under the Plan?

If you are an eligible Employee, you, your eligible Spouse and/or other Dependents may be eligible for coverage under one or more of the benefits under the Component Benefit Program. To determine whether you, your Spouse or your other Dependents are eligible to participate in one or more of the benefits under the Component Benefit Program, please read the eligibility information contained within Attachment A.

To enroll in coverage for which you, your Spouse and/or your other Dependents are eligible, you must submit a completed enrollment which reflects who will participate in the Plan. This completed enrollment must be submitted to the Plan Administrator before any participation or coverage under the Plan can occur. Enrollment instructions may be obtained by contacting your Human Resources representative.

How do you enroll your Dependents?

To enroll your eligible Dependents, or if you later gain Dependents, you must complete and return a new enrollment form to the Plan Administrator. They become eligible for coverage on the date they first qualify as a Dependent and if you have enrolled them to participate.

If you incur a change in family status during the Plan Year, as defined under HIPAA, you can change your tier of coverage election under:

- Medical, Dental, Vision, Health and Dependent Care FSAs.

Generally, changes in family status include, but are not limited to marriage, divorce, birth or adoption of a child, or death of a Dependent.

Newborn or newly adopted children are covered under the group health plans as soon as they meet the definition of a Dependent, provided you enroll the child in the Plan within 30 days from the child's birth or placement for adoption. Coverage for a new Spouse is effective no later than the first day of the month following the date the plan receives the completed request for enrollment. *If you do not enroll a newborn child, a newly adopted child, or a new Spouse within the specified 30-day period, coverage starts when you complete the appropriate enrollment paperwork.* Contact your designated benefits representative to enroll newly acquired Dependents. You may need to show proof of the status change before you can elect new benefits.

Under what circumstances may you enroll yourself, your Spouse, and your other Dependents in the Plan during the Plan Year when you, your Spouse and/or your other Dependents lose other coverage?

If you, your Spouse and/or your eligible other Dependents choose not to enroll in the any of the benefits specified above in the previous question at the time that you initially become eligible because you maintain coverage under another group health coverage, you may be provided with an opportunity to elect coverage in the event your previously held coverage ends. To be eligible to elect coverage under this special enrollment opportunity, you must have lost coverage under one of the following circumstances:

- You and/or your Dependents lost coverage under your prior plan because you and/or your eligible Dependents became ineligible under that plan or because the Company's contribution made to coverage under the plan had ended; or

- You and/or your Dependents were enrolled in coverage under COBRA and the COBRA coverage period expired.

In either case, no special enrollment period will be provided to you and/or your Dependents where your previous coverage maintained (either COBRA or non-COBRA)

ended because you and/or your Dependents failed to pay the required premiums for the coverage in a timely manner.

Are there any other situations where you can enroll yourself, your Spouse, and your other Dependents in the Plan during the Plan Year?

Yes. If you, your Spouse and/or your eligible other Dependents are eligible but did not enroll in the benefits under the Component Benefit Program, you and/or your eligible Dependents may enroll in these benefits under two additional circumstances, which are becoming eligible for a premium assistance subsidy in the Medical Benefit, under Medicaid or a State Child Health Insurance Plan.

You must request coverage under the Plan within 60 days of termination or the date it is determined that you or your child are eligible for assistance to be entitled to these special enrollment rights.

When does your participation in the Plan end?

If you terminate employment (including retirement), or you or your covered Dependents otherwise become ineligible for benefits (i.e., because of age restrictions or divorce), coverage will cease under the terms of the benefits under the Component Benefit Program. If the Company decides to terminate the Plan, coverage will end on the termination date.

Under these circumstances (unless coverage ends because your employment is terminated due to gross misconduct), you and your covered Dependents may be eligible to continue benefits under the Component Benefit Program under COBRA as provided in Section 8 of this Summary.

Note: During the 31-day period following termination of your coverage, you may be able to convert some of your benefits under the Component Benefit Program to individual policies without providing evidence of insurability. You should consult the certificate of insurance booklets, summary plan descriptions and other governing documents for the Component Benefit Programs for additional information.

If you terminate your employment for any reason, including (but not limited to) disability, retirement, reduction in force, layoff, or voluntary resignation, and then are rehired, you will be:

- If an employee is rehired, he or she will be reinstated with the same benefit options in 30 days.

If you (whether or not a Participant) terminate employment and are not rehired within the time specified above or cease to be an eligible employee or any other reason, including (but not limited to) a reduction in hours, and then become eligible again, you must complete the waiting period described in the benefits under the Component

Benefit Program before again becoming eligible to participate in the Plan, unless your collectively bargaining agreement provides otherwise.

5 - SUMMARY OF PLAN BENEFITS

Who pays for the benefits under the Plan?

The cost of benefits provided through the Component Benefit Program will be funded wholly or in part by employer contributions, or wholly in part by employee contributions. These employee contributions can be either pre-tax or post-tax depending on the terms of the Cafeteria Plan, if applicable. The Company will determine and periodically communicate your share of the cost of the benefits provided through the Component Benefit Program, and it may change that determination at any time.

The Company will make its contributions in an amount that (in the Company's sole discretion) is at least sufficient to fund the benefit or a portion of the benefits that are not otherwise funded by your contributions. The Company will pay its contribution and your contributions to the Insurer, or with respect to benefits that are self-funded, will use contributions to pay benefits directly to or on behalf of your or your eligible Dependents from the Company's general assets. Your contributions toward the cost of a particular benefit will be used in their entirety prior to using Employer contributions to pay the cost of such benefit.

How are the Medical Benefits coordinated with Medicare?

For active employees (or Spouses of active employees) age 65 and over, any group health coverage is primary, and Medicare is secondary if the Company has twenty (20) or more employees. You or your Spouse may elect Medicare as primary coverage, but if you do, the Employer can't offer you group medical coverage, even on a secondary basis.

For active Employees (or Spouses and other Dependents of active Employees) who are disabled, the Medical Benefits are primary, and Medicare is secondary if the Company has one hundred (100) or more employees.

In each of these situations, your Spouse has the same choices for benefit coverage as indicated above or the employee aged 65 and over.

Regardless of the choice made by you or your Spouse, each one of you should apply for Medicare Part A coverage about three months prior to becoming age 65. If you elect to be covered under the program, you may wait to enroll for coverage under Medicare Part B. You will be able to enroll for Medicare Part B later during special enrollment periods without penalty.

What is a Qualified Medical Child Support Order?

Some benefits under the Component Benefit Program must be provided as required by any Qualified Medical Child Support Order (QMCSO). A QMCSO is an order issued by a court or by an administrative agency pursuant to state law directing an individual to provide certain Benefits for an otherwise eligible dependent child, even if the individual is the non-custodial parent.

The Plan has detailed procedures for determining whether an order qualifies as a QMCSO, and such determinations will be made by the Plan Administrator within a reasonable period. For an order to be qualified, it must generally include all of the following:

- The child's name and last known mailing address for which the coverage must be furnished;

- Your name and last known mailing address;

- A reasonable description of the type of health coverage to be provided for each child included in the order; and

- The period or length of time for which coverage must be furnished.

As a part of this process, the Plan Administrator may provide Plan and benefit information necessary for the preparation of a QMCSO to the custodial parents of a child and/or any state child support enforcement agencies acting on the child's behalf. Upon receipt of an order, the Plan Administrator will notify you and your child or child's custodial parent or guardian and will provide copies of the Plan's procedures for determining whether the order is qualified. You and your beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

After making its determination, you, your child or child's custodial parent or guardian, and any applicable state agencies will be notified by the Plan Administrator of its determination as to whether the order is qualified. The Plan Administrator has no obligation to determine whether the court or administrative agency issuing the order has correctly applied State law. Furthermore, the Plan has no responsibility for ensuring that the individual identified in an order as an alternate recipient is in fact your child, or that service was properly made on the parties. Finally, the child who the order requires to be covered by you must meet the eligibility requirements for a Dependent under the Plan to be enrolled into coverage.

Where a medical child support order is qualified, the eligible child must be enrolled into coverage under the applicable benefit under the Component Benefit Program as soon as possible following such a determination. If you are not enrolled or participating in the applicable benefit at the time an order is determined to be qualified, then the Plan Administrator will enroll you in coverage as the same date as the child. If there is a

waiting period following enrollment for coverage to begin, coverage will begin on the first possible date following the waiting period. Once the waiting period has expired, you and/or your child shall be eligible for coverage under the Plan. The Company has the discretion to add an alternate recipient to the corresponding Employee's coverage so long as the alternate recipient meets the Plan's dependent eligibility requirements.

Your child and/or child's custodial parent or guardian will be provided with a copy of all Plan related notices and communications that you would normally receive. If you are aware of a QMCSO, you may contact the Plan Administrator.

What are your rights under the Newborns' and Mothers' Health Protection Act of 1996?

Medical plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally doesn't prohibit the mother's or newborn's attending medical care provider from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable) after consulting with the mother. In any case, federal law prohibits the Plan from requiring that a medical care provider obtain authorization for a length of stay that's less than or equal to 48 (or 96) hours.

What happens to your coverage if you suffer from end stage renal disease?

You are eligible for Medicare if you require regular dialysis or kidney transplant services. Medicare coverage becomes primary, and this medical coverage becomes secondary after a 30-month coordination of benefits period (This 30-month period applies if you are already enrolled in Medicare because of age or disability.)

What is the coverage for Mastectomy?

Federal law requires a medical plan to provide coverage for the following services to an individual receiving Plan benefits in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications at all stages of mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

Coverage for breast reconstruction and related services will be subject to deductibles and co-insurance amounts that are consistent with those that apply to other benefits under the Plan.

What is required under Michelle's Law?

Michelle's Law provides continued healthcare reimbursement coverage under the Plan for dependent children who are covered under the Plan as a student but lose their student status because they take a medically necessary leave of absence from school.

As a result, if your child is no longer a student, as defined in the Plan, because he or she is on a medically necessary leave of absence, your child may continue to be covered under the Plan for up to one year from the beginning of the leave of absence. This continued coverage applies if, immediately before the first day of the leave of absence, your child was (1) covered under the plan and (2) enrolled as a student at a post-secondary educational institution (includes colleges and universities).

For purposes of this continued coverage, a "medically necessary leave of absence" means a leave of absence from a post-secondary educational institution, or any change in enrollment of the child at the institution, that:

- begins while the child is suffering from a serious illness or injury,
- is medically necessary, and
- causes the child to lose student status for purposes of coverage under the plan.

The coverage provided to dependent children during any period of continued coverage:

- is available for up to one year after the first day of the medically necessary leave of absence, but ends earlier if coverage under the plan would otherwise terminate, and
- stays the same as if your child had continued to be a covered student and had not taken a medically necessary leave of absence.

If the coverage provided by the Plan is changed during this one-year period, the Plan must provide the changed coverage for the dependent child for the remainder of the medically necessary leave of absence unless, because of the change, the Plan no longer provides coverage for dependent children.

If you believe your child is eligible for this continued coverage, the child's treating physician must provide a written certification to the plan stating that your child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

Coordination with COBRA Coverage

If your child is eligible for Michelle's Law's continued coverage and loses coverage under the plan at the end of the continued coverage period, continuation coverage under COBRA will be available at the end of Michelle's Law's coverage period and a COBRA notice will be provided at that time.

How do leaves of absence (such as under FMLA) affect my benefits?

FMLA Leaves of Absence. If you go on a qualifying leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by FMLA, your Company will continue to maintain FMLA applies and all benefits under the Component Benefit Program continue. on the same terms and conditions as if you were still active (that is, the Company will continue to pay its share of the premium to the extent that you opt to continue coverage). If employee contributions are required for benefit premiums, the employee makes contributions after the leave is completed and returns.

If your benefits coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be entitled to re-enter such benefits, as applicable, upon return from such leave on the same basis as you were participating in the Plan before the leave, or otherwise required by FMLA.

You are entitled to have coverage for such benefits automatically reinstated so long as coverage for Employees on non-FMLA leave is automatically reinstated upon return from leave. But despite the preceding sentence, with regard to benefits under the Cafeteria Plan, if your coverage ceased, you will be entitled to elect whether to be reinstated in your benefits under the Cafeteria Plan at the same coverage level as in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro-rata for the period of FMLA leave during which you did not pay premiums. If you elect the pro-rata coverage, the amount withheld from your compensation on a payroll-by-payroll basis for the purpose of paying for reinstated benefits under the Cafeteria Plan will equal the amount withheld before FMLA leave.

If you are commencing or returning from FMLA leave, your election for non-health benefits will be treated in the same way as under the Company's policy for providing such benefits for participants on a non-FMLA leave. If that policy permits participants to discontinue contributions while on leave, Participants will upon returning from leave be required to repay the premiums not paid by the Participant during leave. Payment will be withheld from your compensation either on a pre-tax or after-tax basis, as may be agreed upon by the Plan Administrator and the Participant or as the Plan Administrator otherwise deems appropriate.

How do leaves of absence (under applicable state leave laws and rules) affect my benefits?

Your benefits coverage will continue to be provided during leave as required by state leave laws and rules.

Are there any special coverage requirements if you go on military leave under USERRA?

If you are in the military and you are called up for service, you will be eligible for a leave of absence receiving protection under USERRA. Under USERRA, you may elect to continue benefits under the Component Benefit Program selected by the Company, for up to 24 months after the leave of absence begins, or the period of absence, whichever is shorter. During your leave, you will not be required to pay more than 102% of the full premium for the coverage. If the leave due to uniformed service is extended for 30 days or less, you will not be required to pay more than the normal employee share of any premium.

On your return from service and leave, benefits under the Component Benefit Program will be reinstated without any waiting period or exclusions for preexisting conditions, other than waiting periods or exclusions that would have applied even if there had been no absence for uniformed service.

To elect coverage under USERRA, please follow the same procedures for electing coverage under COBRA, explained in Section 8 below in this Summary.

What are the requirements under the Genetic Information Nondiscrimination Act of 2008 ("GINA")?

The Genetic Information Nondiscrimination Act of 2008 ("GINA") prohibits the Plan from discriminating against individuals based on genetic information in providing any the benefits under the Component Benefit Program.

GINA generally:

- prohibits the Plan from adjusting premium or contribution amounts for a group on the basis of genetic information;
- prohibits the Plan from requesting or mandating that an individual or family member of an individual undergo a genetic test, provided that such prohibition does not limit the authority of a health care professional to request an individual to undergo a genetic test, or preclude a group health plan from obtaining or using the results of a genetic test in making a determination regarding payment;
- allows the Plan to request, but not mandate, that a participant or beneficiary undergo a genetic test for research purposes if the Plan does not use the information for underwriting purposes and meets certain disclosure requirements; and
- prohibits the Plan from requesting, requiring, or purchasing genetic information for underwriting purposes, or with respect to any individual in advance of or in connection with such individual's enrollment.

What rules apply to Mental Health and Substance Abuse Benefits?

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") imposes significant new requirements on the Plan that offer mental health and substance abuse benefits. Current law prohibits health plans from imposing lower annual and lifetime limits on mental health coverage than on other types of medical coverage. The MHPAEA further limits other types of financial and non-financial limitations that plans may impose on mental health coverage and substance abuse benefits. Some of the MHPAEA's key provisions are as follows:

- financial limitations—including limitations on deductibles, copayments, coinsurance, and out-of-pocket expenses—imposed on mental health and substance abuse benefits may not be higher than those imposed on other types of medical coverage;
- the Plan may not place limits on the scope or duration of treatment for mental health or substance abuse that are more restrictive than for other types of medical treatment;
- the Plan must provide, upon request, information to plan participants and providers regarding the criteria for determining whether mental health or substance abuse treatment is medically necessary, and the reasons for denial of coverage; and
- coverage of mental health and substance abuse benefits by out-of-network providers must be on par with out-of-network coverage for medical treatment.

6 - PLAN ADMINISTRATION

Who administers the Plan?

The administration of the plan is under the supervision of the Plan Administrator. The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of people entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of the benefits, and authorizing benefit payments and gathering information necessary for administering the Plan. The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility.

The Plan Administrator has the discretionary authority to interpret the Plan to make eligibility and benefit determinations as it may determine in its sole discretion.

The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan.

The Company will bear the incidental costs of administrating the Plan. The Company may shift from time-to-time certain administration costs to Participants. The Company will communicate to the Participants the details of any cost shifting arrangements.

If any benefits provided under the Component Benefit Program are insured, who provides them?

Certain benefits provided under the Component Benefit Program are fully insured. Those Insurers providing benefits and the terms of benefits provided are summarized in the copy of each booklet, summary or other governing document attached, as noted above in the Attachment B section of this Summary.

Under those benefits provided by the Insurers, the Insurers are responsible for (1) determining eligibility for any benefits payable; and (2) prescribing claims procedures to be followed and claim forms to be used by Employees pursuant to their respective benefit plans.

If you have questions regarding your eligibility for or the amount of, any benefit payable under the fully-insured Component Benefit Programs, please contact the Insurer.

If any benefits provided under the Component Benefit Program are self-funded, who provides them?

The Company provides certain benefits under the Component Benefit Programs that are self-funded. The benefits that are self-funded are indicated in the Attachment B Section of this Summary. They are funded by the general assets of the Company. If you have any general questions regarding the Plan or regarding your eligibility for or the amount of any benefit payable under the Component Benefit Program, please contact your benefits representative, who acts on behalf of the Plan Administrator.

7 - COORDINATION OF BENEFITS

You or your Dependents may be covered by other employer sponsored health and welfare plans. If so, benefits from that plan and Benefits under the Component Benefit Program are coordinated so both plans don't pay for the same expenses.

If both you and your Spouse work at the Employer, you cannot claim each other as dependents and submit claims for benefits twice. Only one of you can claim your children as Dependents.

How does coordination of benefits work?

If you are covered by two or more plans, one plan is "primary" and the others are “secondary." The primary plan pays benefits first without regard to any other plans. The secondary plans adjust their benefits so that total benefits available will not exceed allowable expenses. If the Plan is not primary, you will receive the difference between what the primary plan paid and the total amount of eligible covered expenses. However, neither plan would pay more than it would without the coordination provision.

Coordination of benefits ensures that benefits do not exceed 100% of the Reasonable and Customary charges for covered expenses. "Covered expenses" are any Reasonable and Customary charges for health care services for a non-occupational sickness or injury, at least partially covered by at least one of the plans under which you have coverage. If the plan provides services rather than cash benefits, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.

Which Plan is determined to be primary?

In general, the Plan covering the patient as an employee will be the primary plan, the plan that pays benefits first.

When the patient is an employee in more than one plan, the plan covering the individual for the longer period shall be the primary payor.

When the patient is an active employee of one plan and a retiree of another, the plan covering the patient as an active employee shall be primary payor. The plan covering the patient as a retiree shall be the secondary payor.

If your Dependent child is covered under both your and your Spouse's plan, the plan of the parent whose birthday (month and day only) is earlier in the year will be primary. If you and your Spouse have the same birthday, the plan that has covered the parent for the longest time will be primary. If your Spouse's plan does not have this birth date provision, his or her plan will determine the order of payment for Dependents.

If you are legally separated or divorced, the order of payment for Dependents is:

- The plan of the parent with custody of the child.
- The plan of the Spouse of the parent with custody of the child.
- The plan of the parent without custody of the child.

However, if a court decree has given one parent financial responsibility for the child's health care expenses, that plan is primary.

If another plan does not have a Coordination provision, it will be the primary plan.

An Example:

Suppose the primary plan covers 80% for a certain expense and this Plan covers the same expense at 70%. You would receive 80% from your primary plan and 20% from this Plan. Together, 100% of covered expenses would be paid.

What information must be provided about your other coverage?

If you or your Dependents are covered under another plan, you must supply information about that plan to the Plan Administrator to receive benefits under this Plan. The Plan Administrator, on behalf of the Employer, has the right to release or obtain any information regarding coverage, expenses, and benefits under any other plan without your consent.

If the benefits you receive from more than one Plan exceed your total covered charges, you have been overpaid.

If an overpayment is made under this Plan because of failure to report other coverage or otherwise, the Plan Administrator on behalf of the Employer, will have the right to recover such overpayment. If payments which should have been made under this Plan have been made under other plans, the claims administrator on behalf of the Employer, will have the right to reimburse any organizations making such other payments any amounts it considers proper according to the intent of these provisions, and those amounts will be counted for all purposes as benefits paid under this Plan.

8 - COBRA COVERAGE

What is COBRA coverage?

Under COBRA, the Company is required to provide you and your Qualified Beneficiaries with the opportunity to continue coverage under the following benefits in the Component Benefit Program:

- Medical, Dental, Vision and Health Flexible Spending Account.

(Such coverage will be referred to as "COBRA Coverage"). COBRA Coverage is offered for a limited period unless your employment is terminated due to gross misconduct. This coverage is paid by you or your Qualified Beneficiaries when certain defined events occur that otherwise would cause you and/or your Qualified Beneficiaries to lose coverage.

Please note that COBRA coverage for any of the above benefits will not be offered if you or your Qualified Beneficiaries were not covered for these benefits prior to your qualifying event.

What other options may be available to you when you lose medical coverage under the Plan?

You may be eligible to buy individual medical insurance coverage through the Health Insurance Marketplace. By enrolling in medical insurance coverage through the Health Insurance Marketplace, you may qualify for lower cost on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another employer group medical plan for which you are eligible (such your spouse's plan), even if that plan generally doesn't accept late enrollees.

What benefits are available through COBRA coverage?

Following a qualifying event (described below), the Company must offer you and your Qualified Beneficiaries the opportunity to continue those benefits under the Component Benefit Program, listed above, you had on the day before your qualifying event. You will be responsible for the full cost of such insurance premiums for COBRA Coverage. Your participation in the Health Flexible Spending Account can also continue an after-tax basis through the remainder of the Plan Year in which you qualify for COBRA (as explained below) The opportunity to elect the same coverage that you had at the time the qualifying event occurred extends to all Qualified Beneficiaries.

The COBRA coverage that the Company offers is not fixed. If the Company changes the terms of its benefits under the Component Benefit Program for regular employees, Spouses and Dependents, these changes also apply to you and your Qualified Beneficiaries under COBRA. Also, Qualified Beneficiaries will have the same opportunity as active employees to change benefit elections during annual enrollment or special enrollment periods for benefit options previously elected.

If you make contributions to the Health Flexible Spending Account for the year in which your qualifying event occurs, you may continue to make these contributions on an after-tax basis. This way, you can be reimbursed for certain medical expenses you incur after your qualifying event, but before the end of the Plan Year.

You may be offered to continue your coverage under the Health Flexible Spending Account if you have not overspent your account. The determination of whether your account for a plan year is overspent or underspent as of the date of the qualifying event depends on three variables: (1) the elected annual limit for the Qualified Beneficiary for the Plan Year (e.g., $2,650 of coverage); (2) the total reimbursable claims submitted to the Cafeteria Plan for that plan year before the date of the qualifying event; and (3) the maximum amount that the Cafeteria Plan is permitted to require to be paid for COBRA coverage for the remainder of the plan year. The elected annual limit less the claims submitted is referred to as the "remaining annual limit." If the remaining annual limit is less than the maximum COBRA premium that can be charged for the rest of the year, then the account is overspent.

You may not re-enroll in the Health Flexible Spending Account during any annual enrollment for any Plan Year that follows your qualifying event.

Who is a Qualified Beneficiary?

This term refers to you and your Spouse and/or dependent child(ren) who are or were covered under one of the benefit options listed above on the day before the qualifying event, and who have experienced a qualifying event that leads to a loss of coverage. This also includes a child who is born or placed for adoption with you during the period of COBRA coverage. Whether an individual is a Qualified Beneficiary is important because each Qualified Beneficiary has a separate right to elect COBRA coverage. COBRA documents may use the term "Qualified Beneficiary" which refers to you and your qualified beneficiaries.

Please remember that if you did not enroll any of your Dependents in any of the Company's benefit options under the Component Benefit Program (for whatever reason) prior to a qualifying event, even though they were otherwise eligible, they will not be considered Qualified Beneficiaries for COBRA coverage.

What events trigger COBRA coverage?

COBRA coverage is offered to you and/or any Qualified Beneficiary when a qualifying event occurs. A qualifying event is defined as a loss of Benefit coverages due to one of the following reasons:

- Your death;
- A change in your employment status—such as your termination of employment from the Company or reduction in working hours;
- Your divorce or legal separation;
- The bankruptcy of the Company;
- You or any of your qualified beneficiaries are on military leave;
- You elect Medicare as primary coverage; or
- Your dependent child loses eligibility for coverage.

What is the maximum length of COBRA coverage?

The general rule is that following your COBRA enrollment, COBRA coverage extends for 18 months from the date of the qualifying event if the event is your termination of employment or reduction in hours**.** However, a special 11-month extension (for a total COBRA period of 29 months) is available to Qualified Beneficiaries who are disabled (according to Title II or XVI of the Social Security Administration Act) at the time of a qualifying event or are disabled within the first 60 days of COBRA coverage. In addition, the 29-month coverage period also applies to your non-disabled qualified beneficiaries

even if they are not disabled. For all other qualifying events, COBRA coverage will be offered for 36 months.

Special "multiple qualifying event" rules allow Qualified Beneficiaries who receive COBRA coverage upon your termination of employment or reduction in hours to extend the length of their coverage if a second qualifying event—such as your divorce or death—occurs during the initial 18-month period. In no event will COBRA coverage continue for more than 36 months.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you do not enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you do not enroll in Medicare and elect COBRA coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA coverage and later enroll in Medicare Part A or B before the COBRA coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA coverage and Medicare, Medicare will generally pay first (primary payer), and COBRA coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

When can COBRA coverage be terminated early?

COBRA coverage may be terminated before the end of the applicable coverage period (18, 29 or 36 months) under any of the following circumstances:

- You or any Qualified Beneficiary fails to make a timely COBRA premium payment. An initial premium payment following the election of COBRA coverage is considered timely if received within 45 days of such election. Any subsequent premium is considered timely if it is paid within 30 days from the due date.

- You or any Qualified Beneficiary receives coverage under another group plan after the date of election. COBRA coverage will be terminated if a Qualified Beneficiary becomes covered under any other group health plan that contains no restrictions or limitations on coverage of "pre-existing conditions" after the date of his or her COBRA election.
- The Company terminates all medical, dental, vision and prescription drug plans.
- You or any Qualified Beneficiary becomes, after the date of election, entitled to Medicare.
- Determination is made that you or any Qualified Beneficiary are no longer disabled, but only after the initial 18-month COBRA coverage period has ended. This is applicable to disabled qualified beneficiaries that were granted 11 months of COBRA coverage in addition to the basic 18-month coverage period. COBRA coverage will terminate at the beginning of the next month after there has been a determination by the Social Security Administration that the individual is no longer disabled. You or your qualified beneficiaries are required to notify the Plan Administrator within 30 days of such determination.
- You notify the Plan Administrator that you wish to cancel your coverage.
- For cause, on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA participants.

What are your or any Qualified Beneficiary notification requirements?

You or your Qualified Beneficiaries must notify the Plan Administrator if your Spouse either divorces or legally separates from you or your Dependent(s) loses his or her "eligibility status" under the plan. You are required to notify the Company of family status changes within 60 days of the event date. Your enrollment change will trigger a COBRA packet, which will be mailed to you.

If you do not make enrollment changes within 60 days or if your Qualified Beneficiaries wish to notify the Company of the qualifying event, then you, your Spouse, or your other Dependents must notify the Plan Administrator. Loss of coverage occurs on the last day worked.

Remember that the Company will not offer any Qualified Beneficiaries the opportunity to elect COBRA coverage if you or your Qualified Beneficiaries fail to provide the required written notice of a qualifying event.

To qualify for the 11-month extension of COBRA coverage, disabled Qualified Beneficiaries must notify the Plan Administrator of their disability status within 60 days of their disability determination by the Social Security Administration. Such notice must be given no later than the end of the regular 18-month COBRA coverage period that applies whenever there is a change in employment status.

When will you or any Qualified Beneficiary be given notice of your COBRA rights?

When the Plan Administrator receives notice of a qualifying event, it is required to notify you and any Qualified Beneficiary in writing of your COBRA rights. If you, your Spouse and Dependent child(ren) live together at the same address, the Plan Administrator satisfies this requirement by mailing one notice to you. The notice will be mailed to your current address on file. It is important to keep your address information current on file with the Plan Administrator. Following the Plan Administrator's receipt of notice of the qualifying event, it has forty-four (44) days from the date of receiving notice of any qualifying event to mail the notification.

When must you or any Qualified Beneficiary elect COBRA coverage?

Once you and any Qualified Beneficiary receive notice of your COBRA rights from the Plan Administrator, you have 60 days from the date of the notification, or the date your coverage terminates (whichever is later), to elect COBRA coverage. You or any Qualified Beneficiary elect COBRA coverage by completing and returning the election form sent with the notice, to the Plan Administrator at the address listed on the form by the deadline specified.

When you or your Qualified Beneficiary elect COBRA coverage, you or each of your Qualified Beneficiaries will have a separate election for each benefit or one election for all benefits:

- There is separate election for each benefit.

Qualified Beneficiaries may waive their rights to COBRA coverage rather than make a COBRA election. However, Qualified Beneficiaries are permitted to revoke such waiver at any time during the 60-day election period if they change their minds and decide to elect COBRA coverage. If Qualified Beneficiaries revoke a waiver, coverage doesn't have to be provided for any period before the revocation. Once the 60-day election period ends, the waiver cannot be revoked.

Are there any delays in the notice and payment requirements because of the Coronavirus pandemic?

There are temporary suspensions of COBRA election, payment, and notice deadlines during the Outbreak Period (defined below) related to the COVID-19 pandemic. During this period, otherwise applicable deadlines for electing COBRA coverage, making certain COBRA payments, or providing certain COBRA notices may be temporarily extended.

Outbreak Period

The “Outbreak Period” begins on March 1, 2020, and ends 60 days after the earlier of:

The date the national emergency declared by the President ends; or
The date the COVID-19 outbreak for the applicable part of the United States ends.

The Outbreak Period has not ended because the government has not announced the end of the national emergency, or the end of the COVID-19 outbreak.

If you or your dependents are considering electing COBRA coverage, please confirm with the Employer whether the Outbreak Period has ended.

Suspended Election Deadline

Your election deadline (the day by which you must submit your completed election form to the Employer). As stated in your Election Notice, your election deadline is 60 days after the later of (1) the date of the election notice or (2) your last day of plan coverage. If the election deadline is on or after March 1, 2020, the portion of the 60-day period which occurs on or after March 1 is suspended (does not run) for the duration of the Outbreak Period.

Suspended 45-Day Period for First Premium Payment

You are allowed to delay the first premium payment for COBRA coverage for up to 45 days after the date you mail or hand-deliver your completed election form. If any portion of the 45-day period occurs on or after March 1, 2020, it is suspended (does not run) for the duration of the Outbreak Period.

Extended 30-Day Grace Period for Paying Monthly COBRA Premiums

After you have made your first COBRA premium payment, future COBRA premiums are due for each month on the first day of that month. As described in your Election Notice, these monthly payments are subject to a 30-day grace period after the first day of the month. If any portion of a 30-day grace period occurs on or after March 1, 2020, it is suspended (does not run) for the duration of the Outbreak Period. COBRA premium payments apply to the earliest month for which a payment is owed.
Extended Deadlines for Notice of Disability Determination

COBRA coverage can be extended for up to 11 additional months when any Qualified Beneficiary is disabled. For this extension to apply, you must provide notice of the disability determination to the Employer (1) before a 60-day deadline expires and (2) before a separate 18-month deadline expires. If any portion of the 60-day period or 18-month period occurs on or after March 1, 2020, it is suspended (does not run) for the duration of the Outbreak Period. If suspended, the last day of the 60-day period and/or the last day of the 18-month period is extended after the Outbreak Period by the length

of the suspension. Caution: If either of these deadlines expired before March 1, 2020, the notice period is not extended.

Extended Deadlines for Notice of Disability Determination

COBRA coverage can be extended for up to 11 additional months when any Qualified Beneficiary is disabled. For this extension to apply, you must provide notice of the disability determination to the Employer (1) before a 60-day deadline expires and (2) before a separate 18-month deadline expires. If any portion of the 60-day period or 18-month period occurs on or after March 1, 2020, it is suspended (does not run) for the duration of the Outbreak Period. If suspended, the last day of the 60-day period and/or the last day of the 18-month period is extended after the Outbreak Period by the length of the suspension. Caution: If either of these deadlines expired before March 1, 2020, the notice period is not extended.

Extended Deadline for Notice of Second Qualifying Event

Under certain circumstances, the COBRA coverage of a spouse or dependent child can be extended up to 18 months due to a second qualifying event (see your Election Notice for more information). Notice of the second qualifying event must be provided within 60 days after the second qualifying event occurs. If any portion of the 60-day period occurs on or after March 1, 2020, that portion is suspended (does not run) for the Outbreak Period. The suspended portion of the 60-day period begins to run again on the first day after the Outbreak Period and runs for the length of the suspension.

Are there other coverage options besides COBRA Coverage?

Yes. Instead of enrolling in COBRA coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other employer group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA coverage. You can learn more about many of these options at www.Medical.gov.

If you have questions:

Questions concerning your Plan, or your COBRA continuation coverage rights should be addressed to the contact or contacts identified in this Summary. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.Medical.gov.

Do Qualified Beneficiaries have independent election rights under COBRA?

Yes. Each Qualified Beneficiary may independently elect or waive COBRA coverage.

For example, although you may not elect COBRA coverage on your own behalf, any Qualified Beneficiary may elect COBRA coverage independently of you. And, if there's a choice among types of coverage, each Qualified Beneficiary is entitled to make a separate election from among the different types of coverage offered under the various plan options. So, even if you elect certain coverages, your Spouse or other Dependent(s) may elect different coverages.

You or your Spouse (except in the case of your death or divorce or legal separation), are permitted to make the election on behalf of other Qualified Beneficiaries affected by the qualifying event. In such cases, you or your Spouse's decision is binding on the other qualified beneficiaries in the family and the other family members lose their right to make an independent election.

Must you keep the Plan informed of any address changes?

To protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

What amount do you and any Qualified Beneficiary pay for COBRA coverage?

The premium you and any Qualified Beneficiary are charged for COBRA coverage is based on the applicable total (the Company and employee) premium cost under the Benefit options for "similarly situated" employees. The Company charges the covered employee and any Qualified Beneficiary no more than 102% of the applicable plan option premium cost. The additional 2% above the premium cost covers the Company's cost of administering COBRA.

Disabled Qualified Beneficiaries that are granted the special 11-month extension are charged up to 150% (rather than 102%) of the applicable plan premium during the 11-month period of extended coverage.

9 - CIRCUMSTANCES THAT MAY AFFECT BENEFITS

When may you be denied or lose your benefits?

Your benefits (and the benefits of your Dependents) under the Component Benefit Program will cease when your participation in the Plan terminates, as indicated above in Section 4.

Your benefits will also cease upon the termination of the Plan.

Other circumstances can result in the termination of coverage, and they include:

- Termination of employment
- Reduction of hours
- Transfer to a noneligible employee group
- The loss or eligibility in one or all the benefits under the Component Benefit Program

You should consult the certificate of insurance booklets, summary plan descriptions and other governing documents for the benefits under the Component Benefit Program attached to this Summary for additional information.

When will the Plan ask you to repay benefits paid to you?

The purpose of the Plan is to provide you and your Dependents with coverage for benefits under the Component Benefit Program that are not the responsibility of any third party. If you and/or your covered Dependents incur a claim for medical, dental and/or vision expenses because of injuries caused by someone else's negligence, wrongful act or omission, the Plan is not responsible to pay these expenses. If this happens, the Plan Administrator or the Insurer will contact you and ask you to sign a subrogation agreement. This means that the Company or the Insurer can take steps to recover what it paid to cover medical expenses from the third party that caused injury or illness. If you do not sign a subrogation agreement, your claims for medical expenses related to the injury or illness may be denied.

What rights does the Plan have to recover expenses it paid to you?

If the Plan pays your and/or your covered Dependent's claim(s) for medical, dental and/or vision expenses, and if a third party or entity should pay the claim, you, as the Participant, agree to the following conditions:

- The Plan shall be subrogated to all of you and/or your Dependent's rights of recovery arising out of any claim or cause of action which may result or be attributable to a third party's negligent or wrongful acts or omission to the extent of amounts paid.

- You also agree to reimburse the Plan for any benefits under the Component Benefit Program paid to you if you recover any amounts from a third party for the injury or illness.

- The Plan's subrogation and reimbursement rights shall apply to any recoveries by you, your covered Dependents, or your estate because you (or your covered Dependents), suffered an injury or illness that could be attributed to a third party's negligence, wrongful act or omission. The Plan shall have first priority rights and such rights shall extend to, but not be limited to, the following recoveries by you:

- Any payment made by or on behalf of a third-party benefits, by your insurance company, such as a settlement, judgment, or arbitration award, or otherwise.
- Any payment because of a settlement, judgment, arbitration award or otherwise made by an insurance company for uninsured or underinsured motorist coverage (It doesn't matter whose insurance coverage it is – yours or the other person's).
- Any payment from any source that is intended to compensate you or your covered Dependents for the injury resulting from the negligence or alleged negligence of a third party.
- Any payment under Workers' Compensation.
- Any payment under no-fault or other state required motor vehicle insurance.
- Any payment made through your automobile, school, or homeowner's insurance policy to cover you for the injury.

- You will fully cooperate and do your part to ensure the Plan's right of recovery and subrogation are secured. If necessary, you will grant a lien on any money that you may receive, equal to the value of any amounts paid by the Plan. You will not take any action or be a party to an agreement that does not recognize the rights of the Plan to recover expenses. You shall grant a lien on any amounts recovered from a third party and assign it to the Plan for any expenses paid. Similarly, you may not assign rights to any third party to recover money, including your minor children, without the written consent of the Plan Administrator.
- The Plan has a prior lien against all amounts that you may recover, even those amounts designated exclusively for non-benefit expense damages. You or your Dependents shall not defeat or reduce the Plan's recovery rights by using the "Made-Whole Doctrine", "Rimes Doctrine" or any doctrine that is intended to take away the Plan's rights to recover its expenses.
- You may not incur any expenses on behalf of the Plan to pursue a payment. You may not deduct court costs or attorney's fees from any amount reimbursed to the Plan, without written consent from the Plan Administrator. You or your Dependents cannot use the "Fund Doctrine", "Common Fund Doctrine" or "Attorney's Fund Doctrine" to use the Plan's funds for these purposes. The benefits under the Plan are secondary to any coverage under no-fault or similar insurance.
- If you and/or your covered Dependents fail or refuse to honor the Plan's recovery and subrogation rights, the Plan may recover any costs to enforce its rights. This includes, but is not limited to attorney's fees, litigation, court costs and other expenses.

10 - PRIVACY RIGHTS

What disclosures of enrollment/disenrollment information are permitted?

The Plan may disclose to your Employer information on whether you are participating in any benefits under the Component Benefit Program or are enrolled in or have disenrolled in such benefits.

For purposes of this section, "Protected Health Information" ("PHI") means individually identifiable health information that is maintained or transmitted by the Plan for medical benefits under the Component Benefit Program, subject to specified exclusions as provided in federal regulations. For purposes of this section, Electronic Protected Health Information or Electronic PHI means PHI that is transmitted by or maintained in electronic media, as provided under HIPAA and HITECH.

What uses and disclosures of summary health information are permitted?

The Plan may disclose Summary Health Information to your Employer, provided your Employer requests the Summary Health Information for the purpose of (a) obtaining premium bids from plans for providing coverage for the above benefits under the Component Benefit Program or (b) modifying, amending, or terminating the Plan for such benefits.

"Summary Health Information" means information that (a) summarizes the claims history, claims, expenses, or type of claims experienced by individuals for whom your Employer had provided group health benefits under the Component Benefit Program; and (b) from which the information has been deleted, except that the geographic information need only be aggregated to the level of a five-digit zip code.

What required uses and disclosures of PHI are permitted for plan administrative purposes?

Unless otherwise permitted by law, and subject to the conditions of disclosure and obtaining written certification, the Plan (or an insurance company on behalf of the Plan) may disclose PHI and Electronic PHI to your Employer, provided your Employer uses or discloses such PHI and Electronic PHI only for Plan administration purposes. "Plan administration purposes" means administration functions performed by your Employer on behalf of the Plan, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by your Employer in connection with any other benefit or benefit plan of your Employer, and they do not include any employment-related functions.

Enrollment and disenrollment functions performed by your Employer are performed on behalf of you and your dependents and are not Plan administration functions. Enrollment and disenrollment information held by the Employer is held in its capacity as the plan sponsor and is not PHI.

Notwithstanding the provisions of this Plan to the contrary, in no event shall your Employer be permitted to use or disclose PHI in a manner that is inconsistent with federal regulations.

Under what conditions can PHI be disclosed for plan administration purposes?

Your Employer agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Plan (or an Insurer on behalf of the Plan), your Employer shall:

- Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;
- Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan, agrees to the same restrictions and conditions that apply to your Employer with respect to PHI;
- Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of your Employer;
- Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for and to notify each individual whose PHI in its possession that has been, or is reasonably believed to have been accessed, acquired, or disclosed in an unauthorized manner that compromises the privacy of such information as and when required under the federal law as recently amended by the American Recovery and Reinvestment Act of 2009;
- Make available PHI to comply with HIPAA's right to access in accordance with federal regulations;
- Make available PHI for amendment and incorporate any amendments to PHI in accordance with federal regulations;
- Make available the information required to provide an accounting of disclosures in accordance with federal regulations;
- Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements;
- If feasible, return or destroy all PHI received from the Plan that your Employer still maintains, in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

- Ensure that the adequate separation between the Plan and your Employer (i.e., the "firewall"), required in federal regulations, is established.

Your Employer further agrees that if it creates, receives, maintains, or transmits any Electronic PHI (other than enrollment/disenrollment information and Summary health Information and information disclosed pursuant to a signed authorization that complies with the federal requirements which are not subject to these restrictions) on behalf of the Plan, it will:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives maintains or transmits on behalf of the Plan;
- Ensure that the adequate separation between the Plan and your Employer (i.e., the firewall), is supported by reasonable and appropriate security measures;
- Ensure that any agent, including a subcontractor, to whom it provides Electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and
- Report to the Plan Administrator any security incident of which it becomes aware, as follows: your Employer will report to the Plan, with such frequency and at such times as agreed, the aggregate number of unsuccessful, unauthorized attempts to access, use, disclose, modify, or destroy Electronic PHI or to interfere with systems operations in an information system containing Electronic PHI; in addition the Employer will report to the Plan as soon as feasible any successful unauthorized access, use disclosure, modification or destruction of Electronic PHI or interference with systems operations in an information system containing Electronic PHI.

Who is permitted to disclose information?

Your Employer shall allow those classes of employees or other persons in your Employer's control designated by your Employer to be given access to PHI. No other person shall have access to PHI. These specified employees (or classes of employees) shall only have access to and use PHI to the extent necessary to perform the plan administration functions that your Employer performs for the Plan. In the event any of these specified employees do not comply with the provisions of this Section, that employee shall be subject to disciplinary action by your Company for non-compliance pursuant to your Employer's employee discipline and termination procedures.

Your Employer shall ensure that the provisions of this section are supported by reasonable and appropriate security measures to the extent that the persons designated above create, receive, maintain, or transmit Electronic PHI on behalf of the Plan.

When can PHI be disclosed to your Employer?

The Plan shall disclose PHI to your Employer only upon the receipt of a certification by your Employer that the Plan has been amended to incorporate the provisions of federal regulations, and that your Employer agrees to the conditions of disclosure set forth in this summary.

11 - CLAIMS PROCEDURES

What are the claims procedures for insured benefits?

For purposes of the determination of the amount of, and entitlement to, benefits under the Component Benefit Program provided under insurance contracts, the Insurer is the Named Fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance contract.

To obtain benefits from the Insurer under the Component Benefit Program, you must follow the claims procedures under the applicable insurance contract, which may require you to complete, sign and submit a written claim on the Insurer's form. In that case, the form is available from the Plan Administrator.

The Insurer will decide your claim in accordance with its reasonable claim procedures, as required by ERISA. The Insurer has the right to secure independent medical advice and to require such other evidence as it deems necessary to decide your claim. If the Insurer denies your claim, in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the Insurer for a review of the denied claim. The Insurer will decide your appeal in accordance with its reasonable claim procedures, as required by federal law. If you don't appeal on time, you will lose your right to file a suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which is generally a prerequisite to bringing a suit in state or federal court).

After your appeal(s) has been denied by the Insurer, you shall be eligible to file a request for review under the external review procedure. Please contact the Plan Administrator for further details.

The Certificate of Insurance booklet contains more information regarding how to file a claim and details regarding the Insurer's claims procedures.

For more details regarding how to file a claim and the procedures applicable to your claim, please consult the Certificate of Insurance, which is included in the Attachment section of the Summary Plan Description.

What are claims procedures for self-funded benefits?

For purposes of determining the amount of, and entitlement to benefits under the Component Benefit Program provided through the Employer's general assets, the Plan Administrator, with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided through a self-funded arrangement.

To obtain benefits from a self-funded arrangement, you must complete, execute, and submit to the Plan Administrator a written claim.

The Plan Administrator has the right to secure independent medical advice and to request such other evidence as it deems necessary to decide your claim.

The Plan Administrator will decide your claim in accordance with reasonable claims procedures, as required by ERISA.

The Plan Administrator has the right to secure independent medical advice and to request any other evidence as it deems necessary to decide your claim. If the Plan Administrator denies your claim, in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the Named Fiduciary for a review of the denied claim. The Named Fiduciary will decide your appeal in accordance with reasonable claims procedures, as required by ERISA. If you don't appeal on time, you will lose your right to file a suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which is generally a prerequisite to bringing a suit in state or federal court).

After your appeal(s) has been denied by Named Fiduciary, you shall be eligible to file a request for review under the external review procedure. Please contact the Plan Administrator for further details.

For determining the appeal, the Company shall be designated as the Named Fiduciary.

For more details regarding how to file a claim and the procedures applicable to your claim, please consult the Summary Plan Description for the Benefits under the Component Benefit Program contained in the Attachments Section of this Summary.

12 - ERISA RIGHTS

You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

What information must you receive about the Plan and benefits?

ERISA provides that all Plan participants shall be entitled to:

- Examine without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.

How must Plan fiduciaries act?

In addition to creating rights for you, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries.

No one, including your Employer, union, or any other person, may fire you or otherwise discriminate against you in any way to prevent a Participant from obtaining a benefit or exercising your rights under ERISA.

How do you enforce your rights?

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file a suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file a suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning a benefit claim, you may file a suit in federal court. If it should happen Plan

fiduciaries misused the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds the claim is frivolous.

How do you receive assistance with your questions?

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

13 - MISCELLANEOUS PROVISIONS

What rights does the Company have under the Plan?

The Company reserves the right to terminate, modify, amend, or change any or all benefit plans at any time and for any reason without the prior consent or agreement of you or your Dependents. Your participation in the Plan doesn’t guarantee the availability of benefits in the future.

Participants will be notified of any changes through the Company’s employee publications, including enrollment materials and updates to this and other relevant summaries.

The Company, the Insurer Claims Administrator and the Plan Administrator have the right to check stated facts, eligibility, and benefit amounts. They can adjust benefits and/or make retroactive payroll adjustments if any relevant facts have been misstated.

The Company and each of the Employers recognize the value of providing benefits for you and the value of the benefits described in this document. However, the benefits described here are not conditions of employment. The language used in this document isn’t intended to create, nor is it to be construed to constitute, a contract between Employer and any of its employees for either employment or the provision of any benefit. Employment for employees for the Employer remains at-will.

What requirements does the Plan have to comply with under State and Federal laws?

With respect to benefits under the Component Benefit Program, the Plan will comply, to the extent applicable, with the requirements of all applicable state and federal laws.

This Plan is governed by federal laws in existence at the time that this Summary Plan Description was amended and restated (or as they may be amended from time to time). In no event shall the Company guarantee any favorable tax treatment sought by this Plan. To the extent not preempted by Federal law, the provisions of this Plan shall be construed, enforced and administered according to the laws of the State of Texas.

What if the information in this Summary Plan Description differs from another existing Plan documentation?

If the terms of this Summary Plan Description conflict with the terms of the contract with any Insurer or governing Plan document, then the terms of the contract with the Insurer or governing Plan document will control, rather than this document, unless otherwise required by law.

Can you sell or convey your benefits under the Plan to anyone else?

No. Benefits payable at any time under this Plan shall not be subject in any manner to alienation, sale, transfer, assignment, pledge, attachment, or encumbrance of any kind.

What if a provision in this Summary Plan Description is invalid or unenforceable under the law?

If any of the terms, conditions or provisions of this Plan are found to be invalid or unenforceable, such invalidity or unenforceability shall not affect any other provisions within the Summary Plan Description, and this Plan shall be construed and enforced as if such provisions had not been included.

What happens if you become physically or mentally incapacitated while covered under the Plan?

In the event it is demonstrated to the satisfaction of the Plan Administrator that you, your Spouse and/or your other Dependents is unable to care for his or her affairs because of mental or physical incapacity, any payment due may be applied, in the discretion of the Plan Administrator, to the payment of any benefits under the Component Benefit Program for you or your Dependents or withheld until appointment of a legally-appointed guardian or representative. Payment may be made in this manner or withheld unless prior to payment a claim will have been made for payment of any benefits under the Component Benefit Program by your or your Dependent's' legally appointed guardian, committee, or other legal representative. Any payment under this

section will, to the extent of payment, completely discharge the Company's or Insurer's liability with respect to your or your Dependents' interest.

What other communications is the Company required to provide to you and your Dependents?

The Company agrees to provide additional documentation to you and your Dependents in compliance with applicable Federal and State laws and as designated within the Summary Plan Description.

Does your participation in the Plan vest you with any ownership of the rights and benefits provided under the Plan?

Nothing in this Summary Plan Description shall be construed to create any vested rights in any Employee, Spouse or other Dependent enrolled under the Plan and the Company reserves the right to terminate benefits at any time without any requirement for providing additional coverage, subject to COBRA and other applicable laws noted within the Plan document.

Can I bring a lawsuit against other Employees within the Company for errors in the Plan's administration?

The Company shall indemnify all officers and Employees of the Employer assigned fiduciary responsibility under federal law to the extent that such officers or participants incur loss or damage which may result from such officers' or participants' duties, exercise of discretion under the Plan, or any other act or omission hereunder.

Who is responsible for and has authority regarding the distribution, or other use, of dividends, demutualization and/or the Medical Loss Ratio rebates, if any, from group health insurers?

Under ERISA, the Plan Administrator of the group health plan may have fiduciary responsibilities regarding distribution of dividends, demutualization, and use of the Medical Loss Ratio rebates from group health insurers. Some or all rebates may be an asset of the plan, which must be used for the benefit of the participants covered by the policy. Participants should contact the Plan Administrator directly for information on how the rebate will be used.

IN WITNESS HEREOF, the Company has caused this Summary Plan Description to be executed on January 1, 2024, to be amended and restated effective as of the date set forth in the Introduction by its duly authorized Officer on the date indicated below:

ClubCorp USA, Inc. dba Invited

By:

__________ ____________________________________

(Date) (Signature & Title of Officer)

ATTACHMENTS

A

Benefit Eligibility under the Component Benefit Program

Available as of January 1, 2025

All Full-time Employees scheduled to work at least 30 hours per week can participate.

Employees are eligible on the 1st of the month following date of hire.

Part-Time, Seasonal, Contract, Non-Resident Aliens, Employees under the age of 18, and Union Employees (unless bargaining agreement provides coverage) are excluded from participation.

The Company determines full-time status using the Look-Back Measurement Method:

OFFER OF MINIMUM ESSENTIAL COVERAGE POLICY
SECTION I

For the purposes of providing medical coverage under Plan, the Company intends for the eligibility rules of the medical Benefits under the Plan to be administered in such a way as to avoid the imposition of penalties under federal law with respect to each Employee who participates in this coverage. This Policy applies to Standard Stability Periods under the medical coverage beginning on or after the start of the ClubCorp USA, Inc. dba Invited Employee Benefit Plan Year.

SECTION II

Definitions. For purposes of this Policy, the following terms are defined as follows:

(n) “Affordable” means as defined under the Treasury Regulations.

(o) “Employee means an individual employed by the Company.

(p) “Full-Time Employee” means a common law employee of the Company who works an average of 30 hours or more per week, determined as described in this Policy in a manner consistent with Treasury Regulations.

(q) “Hours of Service” means as defined under the Treasury Regulations

(r) "Initial Administrative Period" means a 1-month period commencing after the end of the Initial Measurement Period.

(s) “Initial Measurement Period” means the 12-month period commencing with first day of the first calendar month following the Employee’s date of hire, as described in Treasury Regulations.

(t) “Initial Stability Period” means the 12-month period commencing after the end of the Initial Administrative Period.

(u) “Minimum Essential Coverage” means the medical coverage options offered through the Plan.

(v) “Minimum Value” means as defined in the Treasury Regulations

(w) “Standard Administrative Period” means a period of up to 3-month period following the end of the Standard Measurement Period, as described in the Treasury Regulations.

(x) “Standard Measurement Period” means the 12-month period measured from October 1.

(y) “Standard Stability Period” means the 12-month period measured from January 1.

(z) “Variable Hour Employee” means an individual who meets the definition set forth in the Treasury Regulations.

SECTION III

Determination of Full-Time Employee. If you are determined to be a Full-Time Employee, you will be considered an “Eligible Employee” for purposes of the medical coverage only under the Plan (unless you would otherwise be considered to an Eligible Employee notwithstanding this Policy, in which case you shall be considered an "Eligible Employee" for all other Benefits under the Plan). You will be determined to be a Full-Time Employee for a Standard Stability Period as follows:

(e) Ongoing Employees. This subsection applies to if you were hired prior to the first day of the Standard Measurement Period that immediately precedes the subject Standard Stability Period. The Company shall determine whether you are a Full-Time Employee for the subject Standard Stability Period by calculating the average Hours of Service worked during the applicable Standard Measurement Period that relates to the subject Standard Stability Period. Such a determination shall be effective for the Standard Stability Period (i.e., Standard Stability Period) immediately following the Standard Administrative Period that relates to such Standard Measurement Period.

(f) New Hires. If, at the time of your hiring, the Company determines that you are a Variable Hour Employee, the Company shall determine whether you are a Full-Time Employee by calculating the Hours of Service you worked during the Initial Measurement Period. If you on average, 30 or more Hours of Service per week during such Initial Measurement Period, you will be considered a Full-Time Employee for a period of 12-month periods that commences on the first day of the month following 1-month period after your hire date.

(g) Determination by IRS. This subsection applies If you are not offered Minimum Essential Coverage within the time prescribed in this Section III below. If, after the beginning of a Standard Stability Period, the Internal Revenue Service assesses a penalty under federal law against the Company, the Company shall

have the discretion to reclassify any individuals as Full-Time Employee prospectively as of the date of the IRS' penalty assessment. Additionally, the Plan shall have discretion to retroactively enroll you for coverage as a Full-Time Employee, consistent with any applicable federal laws.

(h) Rehires or Recommencement of Employment After an Absence. The "Full-Time Employee" determination for individuals who are rehired or who resume employment after a period of absence without pay shall be administered in accordance with the Treasury Regulations.

SECTION IV

Offer of Coverage. The Company shall offer Affordable, Minimum Value Minimum Essential Coverage to each Full-Time Employee. Except as otherwise described in Section III(b) above, such offer of coverage shall be made upon the date of hire or, if applicable, within the time prescribed in the Treasury Regulations.

Notwithstanding the foregoing, the Company shall have the discretion to exclude certain Full-Time Employees from coverage under the Plan, but only if such exclusion does not cause the Company to be subject to a tax penalty under federal law.

SECTION V

Affordability. If the Company is charged with a penalty under federal law because the Minimum Essential Coverage offered to a Full-Time Employee is not Affordable Coverage or of Minimum Value, the Plan shall have the discretion to reduce the cost of coverage for such individual.

B
Benefits under the Component Benefit Program

Available as of January 1, 2025

(Employee contributions are re-determined each year – Please reference Human Resources for current contribution levels).

Benefit	How provided?
Medical Benefits	Self-Insured
United Healthcare	
Group Policy #925871	
High Deductible Health plan	
Choice Plus PPO Plan	
Group Policy #7800-000101	
Healthy Start MEC Plan	
SimplePay	Self-Insured
Group Policy #20422	
Aetna Simple Pay Health Plan	
Pharmacy Benefits	Self-Insured
OptumRX	
Group Policy #INVITED	
Rx BIN: 610011	
Rx PCN: IRX	
CVS Caremark	
Group Policy #RX274B	
Rx BIN: 004336	
Rx PCN: ADV	
Dental Benefits	Fully Insured
Delta Dental	
Group Policy #05813	
DHMO	
DPPO	
Vision Benefits	Fully Insured
Superior Vision by MetLife	
Group Policy #34013	

B

Benefits under the Component Benefit Program (Continued)

Available as of January 1, 2025

(Employee contributions are re-determined each year – Please reference Human Resources for current contribution levels).

Benefit	How provided?
Short-Term Disability Benefits MetLife Group Policy #119217	Fully Insured
Long-Term Disability Benefits MetLife Group Policy #119217	Fully Insured
Group Term Life and AD&D Benefits MetLife Group Policy #119217	Fully Insured
Voluntary Life and AD&D Benefits MetLife Group Policy #119217	Fully Insured
Health Flexible Spending Account Tax Savers Plan #501	Self-Insured
Dependent Care Flexible Spending Account Tax Savers Plan #501	Self-Insured
Legal Benefits MetLife Group Policy #119217	Fully Insured

C
Participating Related Employers

As of January 1, 2025

Name of Employer	Employer Identification Number
ClubCorp USA, Inc. dba Invited	75-2114856