2023

Benefits Information Guide

OKI Golf

Guidelines/Evidence of Coverage

The benefit summaries listed on the following pages are brief summaries only. They do not fully describe the benefits coverage for your health and welfare plans. For details on the benefits coverage, please refer to the plan's Evidence of Coverage. The Evidence of Coverage or Summary Plan Description is the binding document between the elected health plan and the member.

A health plan physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat the members' medical condition. These services and supplies must be provided, prescribed, authorized, or directed by the health plan's network physician unless the member enrolls in the PPO plan where the member can use a non-network physician.

The HMO member must receive the services and supplies at a health plan facility or skilled nursing facility inside the service area except where specifically noted to the contrary in the Evidence of Coverage.

For details on the benefit and claims review and adjudication procedures for each plan, please refer to the plan's Evidence of Coverage. If there are any discrepancies between benefits included in this summary and the Evidence of Coverage or Summary Plan Description, the Evidence of Coverage or Summary Plan Description will prevail.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, Federal law gives you more choices about your prescription drug coverage. Please see page 33 for more details.

The rates quoted for these benefits may be subject to change based on final enrollment and/or final underwriting requirements. This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of the plan or program benefits and does not constitute a contract. Consult your plan documents (Schedule of Benefits, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Booklet, Booklet-certificate, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan. All the terms and conditions of your plan or program are subject to applicable laws, regulations and policies. In case of a conflict between your plan document and this information, the plan documents will always govern.

Discover Your Benefits

Let's explore your benefit plan options, programs and resources.

Access your benefits from anywhere, anytime!

Eligibility & Enrollment

Eligibility & Enrollment

Time to answer some questions…

Who can enroll?

In accordance with the Affordable Care Act (ACA), if you are a team member regularly working a minimum of 30 hours per week, you are eligible to participate in medical only. Team members working a minimum of 35 hours per week are eligible to participate in the full benefits program. Eligible team members may also choose to enroll family members, including a legal spouse/registered domestic partner (as legally defined under state and local law) and unregistered domestic partner and/or eligible children.

When does coverage begin?

Your enrollment choices remain in effect through the end of the benefits plan year, (October 1, 2023 – September 30, 2024). Benefits for eligible new hires will commence as outlined below:

TIP

If you miss the enrollment deadline, you may not enroll in a benefit plan unless you have a change in status during the plan year. Please review details on IRS qualified change in status events for more information.

How do I get started with my enrollment?

CERIDIAN Dayforce

- After reviewing your options, complete the enrollment process through Ceridian Dayforce.
- If you have questions when completing your enrollment forms, contact Human Resources.

What if my needs change during the year?

You are permitted to make changes to your benefits after the open enrollment period if you have a change in status event as defined by the IRS. Generally, you may add or remove dependents from your benefits, as well as add, drop, or change coverage if you submit your request for change within 30 days of the status change event. Change in status examples include:

- Marriage, divorce or legal separation.
- Birth or adoption of a child.
- Death of a dependent.
- You or your spouse's loss or gain of coverage through our organization or another employer.
- An employee (1) was expected to average at least 30 hours of service per week, (2) has a change in employment status where he/she will reasonably be expected to average less than 30 hours of service per week (even if he/she remains eligible to be enrolled in the plan); and (3) intends to enroll in another plan that provides Minimum Essential Coverage (no later than the first day of the second month following the month of revocation of coverage).
- You enroll, or intend to enroll, in a Qualified Health Plan (QHP) through the State Marketplace or Federal Exchange due to open enrollment or special enrollment period, and coverage is effective no later than the day immediately following the revocation of your employer-sponsored coverage.

If your change during the year is a result of the loss of eligibility or enrollment in Medicaid, Medicare or state health insurance programs, you must submit the request for change within 60 days. For a complete explanation of status change events, please refer to the "Legal Information Regarding Your Plans" contents.

Do I have to enroll?

Although the federal penalty requiring individuals to maintain health coverage has been reduced to $0, some states have their own state-specific individual mandates.

To avoid paying the penalty in some states, you can obtain health insurance through our benefits program or purchase coverage elsewhere, such as from a State or Federal Health Insurance Exchange.

For information regarding Healthcare Reform and the Individual Mandate, please contact Human Resources or visit www.cciio.cms.gov. You can also visit wahealthplanfinder.org to review information specific to the Washington State Health Insurance Exchange.

You may elect to "waive" medical/dental/and/or vision coverage if you have access to coverage through another plan. To waive coverage, you must select to do so in Ceridian Dayforce It is important to note that if you waive our medical coverage, you must maintain medical/health coverage through another source. It is also important to note that if coverage is waived, the next opportunity to enroll in our group benefit plans would be on October 1, 2024, unless a change in status event occurs.

Health Advocate

To assist you and your family in navigating the healthcare system and maximizing your benefits, the services offered by Health Advocate can assist with healthcare issues and treatment decisions, and also help resolve time-consuming claims and other concerns.

Administrative Support

Explain coverage and coordinate benefits.
Research and resolve insurance claims and medical billing issues.
Identify leading in-network doctors using proprietary MEDIS quality care evaluation approach and make appointments.
Facilitate any required pre-authorizations for medical services, Durable Medical Equipment and prescription drugs.
Research ways to reduce prescription drug and other costs.
Facilitate the transfer of medical records between physicians.

Clinical Decision Support

Answer questions about medical diagnoses and review treatment options.
Research and identify the latest, most advanced approaches to care.
Coordinate clinical services related to all aspects of medical care.
Identify top experts and Centers of Excellence across the country for initial consults and second opinions.
·Discuss the cost and quality of medical services to help members make informed decisions.
·Help employees prepare for doctor visits, review results and plan future actions.

TIP

Get in Touch!

Contact your personal Health Advocate Monday through Friday between 5:00 a.m. and 4:00 p.m. Pacific time, toll-free at 866.695.8622

Aetna

With Aetna's mobile app, you can:

Search for a doctor, dentist, hospital, or pharmacy
Use the "Urgent Care Finder" tool to quickly find urgent care centers and walk-in clinics
Register for your secure member site to view claims, coverage details, your ID card and your personal Health record
Contact Aetna by phone or email

Search for Aetna's mobile app in the App Store or Google Play to get started!

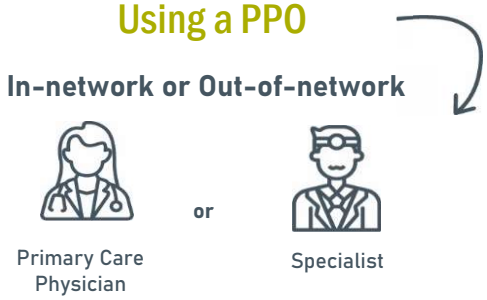
Medical

Medical

Which plan type is right for you?

	PPO
	Aetna
Required to select and use a Primary Care Physician (PCP)	No
Seeing a Specialist	No referral required
Deductible Required	Yes
Finding a Provider	Visit https://www.aetna.com/ Network = “Open Choice PPO” under Aetna Open Access Plans
Claims Process	PPO providers will submit claims You submit claims for non-network providers
Other Important Tips	You may choose in or out of network care, however in-network care provides you a higher level of benefit. Emergencies covered worldwide.

Please note, the above examples are used for general illustrative purposes only. Please consult with your Human Resources department for more specific information as it relates to your specific plan. For a detailed view of your medical plan summaries, visit www.aetna.com.



Prescription Drug (Rx) Benefits

Many FDA-approved prescription medications are covered through the benefits program. Tiered prescription drug plans require varying levels of payment depending on the drug's tier.

Generic formulary (Tier 1): Generic drugs contain the same active ingredients as their brand-name counterparts but are less expensive.

Brand name medications (Tier 2): A brand-name medication can only be produced by one specified manufacturer and is proven to be the most effective in its class.

Non-formulary prescriptions (Tier 3): Although you may be prescribed non-formulary prescriptions, these types of drugs are not on the insurance company's preferred formulary list. This is because there is an alternative proven to be just as effective and safe, but less costly. Ask your doctor or pharmacist for additional information regarding the generic option.

Specialty prescriptions (Tier 4): Specialty medications most often treat chronic or complex conditions and may require special storage or close monitoring.

Why pay more for prescriptions?

Use Mail Order

Save time and money by utilizing a mail order service for maintenance medications. A 90-day supply of your medication will be shipped to you, instead of a typical 30-day supply from a walk-in pharmacy. Go to www.aetna.com to sign-up for mail order delivery service.

Shop Around

Some pharmacies, such as those at warehouse clubs or discount stores, may offer less expensive prescriptions than others. Call ahead to determine which pharmacy provides the most competitive price.

Over-the-Counter Options

For common ailments, over-the-counter drugs may provide a less expensive alternative that serves the same purpose as prescription medications.

"I need specific **medical** care! How much does it cost?"

Plan Highlights — Aetna PPO 1500 (Base) Plan

	In-network	Out-of-network
Annual Calendar Year Deductible		
Individual / Individual of a Family	$1,500	$3,000
Family	$3,000	$6,000
Maximum Calendar Year Out-of-Pocket [1]		
Individual / Individual of a Family	$4,000	$10,000
Family	$8,000	$20,000
Lifetime Maximum		
Individual	Unlimited	Unlimited
Professional Services		
Primary Care Physician (PCP)	$30 Copay	50% after deductible
Specialist	$40 Copay	50% after deductible
Preventive Care Exam	No Charge	50% after deductible
Well-baby Care	No Charge	50% after deductible
Diagnostic X-ray and Lab	20% after deductible	50% after deductible
Complex Diagnostics (MRI/CT Scan)	20% after deductible	50% after deductible
Therapy, including Physical, Occupational and Speech (25 visit limit/year)	$40 Copay	50% after deductible
Chiropractic & Acupuncture (20 visit limit/year)	$40 Copay	50% after deductible
Hospital Services		
Inpatient	20% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible
Emergency Room	$150 Copay + 20% Coinsurance (deductible waived)	
Urgent Care	$50 Copay	50% after deductible
Maternity Care		
Physician Services (prenatal)	No Charge	50% after deductible
Hospital Services	20% after deductible	50% after deductible
Mental Health & Substance Abuse		
Inpatient	20% after deductible	50% after deductible
Outpatient	$30 Copay	50% after deductible
Retail Prescription Drugs (30-day supply)		
Tier 1 – Value Drugs Tier 1A / Generic	$4 Copay / $10 Copay	In-Network Copay + 40% Coinsurance + excess charges
Tier 2 – Preferred Brand	$40 Copay	
Tier 3 – Non-Preferred Generic or Brand	$70 Copay	
Tier 4 – Specialty	30% Coinsurance up to $150/fill	Not Covered
Mail Order Prescription Drugs (90-day supply)		
Tier 1 – Value Drugs Tier 1A / Generic	$8 Copay / $20 Copay	Not Covered
Tier 2 – Preferred Brand	$80 Copay	
Tier 3 – Non-Preferred Generic or Brand	$140 Copay	
Tier 4 – Specialty (30-day supply)	30% Coinsurance up to $150/fill	

[1] Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider.

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

"I need specific **medical** care! How much does it cost?"

Plan Highlights	Aetna PPO 500 (Buy-Up) Plan	
	In-network	Out-of-network
Annual Calendar Year Deductible		
Individual / Individual of a Family	$500	$1,000
Family	$1,000	$2,000
Maximum Calendar Year Out-of-Pocket [1]		
Individual / Individual of a Family	$2,000	$6,000
Family	$4,000	$12,000
Lifetime Maximum		
Individual	Unlimited	Unlimited
Professional Services		
Primary Care Physician (PCP)	$20 Copay	40% after deductible
Specialist	$20 Copay	40% after deductible
Preventive Care Exam	No Charge	40% after deductible
Well-baby Care	No Charge	40% after deductible
Diagnostic X-ray and Lab	20% after deductible	40% after deductible
Complex Diagnostics (MRI/CT Scan)	20% after deductible	40% after deductible
Therapy, including Physical, Occupational and Speech (25 visit limit/year)	$20 Copay	40% after deductible
Chiropractic & Acupuncture (20 visit limit/year)	$20 Copay	40% after deductible
Hospital Services		
Inpatient	20% after deductible	40% after deductible
Outpatient Surgery	20% after deductible	40% after deductible
Emergency Room	$150 Copay + 20% Coinsurance (deductible waived)	
Urgent Care	$40 Copay	40% after deductible
Maternity Care		
Physician Services (prenatal)	No Charge	40% after deductible
Hospital Services	20% after deductible	40% after deductible
Mental Health & Substance Abuse		
Inpatient	20% after deductible	40% after deductible
Outpatient	$20 Copay	40% after deductible
Retail Prescription Drugs (30-day supply)		
Tier 1 – Value Drugs Tier 1A / Generic	$3 Copay / $10 Copay	In-Network Copay + 40% Coinsurance + excess charges
Tier 2 – Preferred Brand	$35 Copay	
Tier 3 – Non-Preferred Generic or Brand	$60 Copay	
Tier 4 – Specialty	30% Coinsurance up to $150/fill	Not Covered
Mail Order Prescription Drugs (90-day supply)		
Tier 1 – Value Drugs Tier 1A / Generic	$6 Copay / $20 Copay	Not Covered
Tier 2 – Preferred Brand	$70 Copay	
Tier 3 – Non-Preferred Generic or Brand	$120 Copay	
Tier 4 – Specialty (30-day supply)	30% Coinsurance up to $150/fill	

[1] Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider.

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Employee Wellness

Employee Wellness

A healthier you starts here – mind and body!

Why Wellness?

Healthy, active lifestyles can help reduce the risk of chronic disease and may lower your annual healthcare costs. We care about your total well-being and encourage all employees to engage in our wellness resources at no-cost.

Altitude Newsletters & Monthly Challenges

Sponsored by MMA, the Altitude Newsletters and Monthly Challenges are intended to raise awareness, provide educational activities, and offer tools and resources you can apply immediately to improve your health and well-being. These resources cover a wide range of topics to help you reach your total health potential.

By voluntarily participating and successfully completing Monthly Challenges, you become eligible to win great prizes sponsored by MMA that total over $1,000 per month in value.


Dental
Plan

Dental Plan

A smile is the nicest thing you can wear.

Using the PPO Plan

The Dental PPO plan is designed to give you the freedom to receive dental care from any licensed dentist of your choice. Keep in mind, you'll receive the highest level of benefit from the plan if you select an in-network PPO dentist versus an out-of-network dentist who has not agreed to provide services at the negotiated rate. Additionally, no claim forms are required when using in-network PPO dentists. To determine whether your dentist is in or out of your insurance network, go to www.aetna.com and search the provider network, or call Aetna.

"I need specific **dental** care! How much does it cost?"

Plan Highlights	Aetna Dental PPO	
	In-Network "Dental PPO/PDN with PPOII"	Out-of-Network
Calendar Year Deductible		
Individual / Family	$50 / $150	
Annual Maximum		
Per Member	$2,000 per person	
Preventive		
Exams, Cleanings, X-Rays	100% (deductible waived)	100% UCR (deductible waived)
Basic Services		
Fillings, Extractions, Periodontics, Endodontics	80%	80% UCR
Major Services		
Crowns, Dentures, Bridges, Implants	50%	50% UCR
Orthodontia Services	Not Covered	

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Vision Plan

Vision Plan

Keep a clear focus on your sight.

Vision coverage is offered by VSP as a Preferred Provider Organization (PPO) plan. As with a traditional PPO, you may take advantage of the highest level of benefit by receiving services from in-network vision providers and doctors. You would be responsible for a copayment at the time of your service. However, if you receive services from an out-of-network doctor, you pay all expenses at the time of service and submit a claim for reimbursement up to the allowed amount. To locate an in-network vision provider, visit www.vsp.com or call 800.877.7195.

"I need specific **vision** care! How much does it cost?"

Plan Highlights	VSP Vision PPO	
	In-Network "VSP Choice"	Out-of-Network
Exam – Every 12 months		
Copay	$10 Copay	Up to $45
Lenses – Every 12 months		
Single	$25 Copay	Up to $30
Bifocal	$25 Copay	Up to $50
Trifocal	$25 Copay	Up to $65
Frames – Every 24 months		
Allowance	$130 allowance + 20% discount on balance	Up to $70
Contacts – Every 12 months, in lieu of lenses & frames		
Medically Necessary	Covered in Full	Up to $210
Cosmetic	$130 allowance	Up to $105

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Spending Accounts

Spending Accounts

Make your money work for you.

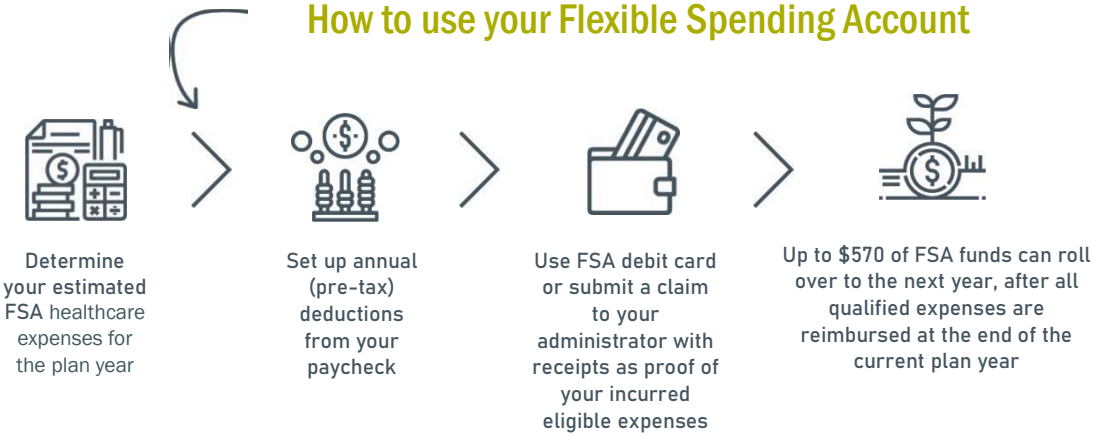
Flexible Spending Accounts (FSA)

A flexible spending account lets you use pre-tax dollars to cover eligible healthcare, and dependent care expenses. There are different types of FSAs that help to reduce your taxable income when paying for eligible expenses for yourself, your spouse, and any eligible dependents, as outlined below:

FSA Type	Detail
Healthcare FSA	• Can reimburse for eligible healthcare expenses not covered by your medical, dental, and vision insurance. • Maximum contribution for 2022-2023 is $2,850.
Dependent Care FSA	• Can be used to pay for a child's (up to the age of 13) childcare expenses and/or care for a disabled family member in the household, who is unable to care for themselves. • Eligibility rules require that if you are married, your spouse needs to be working, looking for work or attending school full-time. • Maximum contribution for 2022-2023 is $5,000.

For more details about using an FSA, contact Human Resources.

How to use your Flexible Spending Account




Life &
Disability

Life & Disability

Protection for your loved ones.

Basic Life and AD&D

In the event of your passing, life insurance will provide your family members or other beneficiaries with financial protection and security. Additionally, if your death is a result of an accident or if you become dismembered, your accidental death & dismemberment (AD&D) coverage may apply.

Paid for in full by Oki Golf, the benefits outlined below are provided by UNUM:

- Basic Life Insurance of 1x annual earnings up to $300,000.
- AD&D of 1x annual earnings up to $300,000.
- Please note, benefits may reduce when you reach age 65.

IRS Regulation: Employees can receive employer paid life insurance up to $50,000 on a tax-free basis and do not have to report the payment as income. However, an amount in excess of $50,000 will trigger taxable income for the “economic value” of the coverage provided to you.

Long Term Disability

Should you experience a non-work related illness or injury that prevents you from working, disability coverage acts as income replacement to protect important assets and help you continue with some level of earnings. Benefits eligibility may be based on disability for your occupation or any occupation.

Your Plans	Coverage Details
Long Term Disability Coverage (LTD)	• If your disability extends beyond 90 days, the LTD coverage through UNUM can replace 60% of your earnings, up to maximum of $6,500 per month. • Your benefits may continue to be paid until you reach social security normal retirement age as long as you meet the definition of disability.

Please note, the state you reside in may provide a partial wage-replacement disability insurance plan.

Retirement

Retirement

Make retirement a reality, not a wish.

Your 401(k) Plan Option

Administered by John Hancock Retirement Plan Services, the 401(k) plan allows you to plan for your future by investing a portion of each paycheck. Once you become eligible, you may elect to have a percentage of your paycheck withheld and invested in your 401(k) account, subject to federal law and plan guidelines. Oki Golf will match a percentage of your contributions each year. The employer matching contribution formula is half of your election up to a 3% election (the maximum company match is 1.5%). The contribution formula is based on your gross compensation for each pay period. You must be with the company for 6 months (the same as the eligibility wait period) before you are eligible for the match contribution.

- Enrollment: Age 18 + 6 months of service with a minimum of 480 hours worked

Enrollment & Account Access

- To enroll in the 401(k) plan, please contact Human Resources. Human Resources will provide the contract number and enrollment codes and then proceed to www.jhancockpensions.com to enroll
- Check your 401(k) account balance, view your contributions, and change your investments and more by visiting www.jhancockpensions.com. For login or password assistance please contact John Hancock Retirement Plan Services at 800.395.1113.

Additional 401(k) Information

Contribution Limits: For 2022, the IRS annual contribution limits are $20,500 for everyone under age 50 or $27,000 for anyone that is age 50 or over prior to December 31, 2022. If you have multiple employers during the year, these limits are combined for all plans that you contribute to during the year. Restrictions may apply to these limits based on plan documents and annual testing requirements.

Contribution Changes: Check with Human Resources for frequency and process for changing your contributions. You may also stop your contribution entirely at any time. Requests to change or stop your contributions must be made through the provider website or in writing to Human Resources.

Employer Contributions: Check with Human Resources for current status of any employer contributions to the plan.

Loans & Hardship Withdrawals: If allowed by the plan document, please see Human Resources for information and requirements for either option.

Rollover Contributions: If you have an outside qualified retirement plan or account such as a 401(k), 403(b), 457(b) or IRA, you may be able to transfer that account into your new plan. Please contact John Hancock Retirement Plan Services or Human Resources for additional information.

Termination of Employment: Upon termination of employment from our organization, regardless of reason, you will be entitled to request a full distribution of your vested account balance. This may be done as a rollover to another plan or IRA. You may also request a lump-sum cash payment to yourself. Please be aware of possible taxes and penalties which may apply to any payment other than a rollover.

Employee Assistance Program (EAP)

Employee Assistance Program (EAP)

Your free and confidential go-to resource.

We can all use an extra helping hand from time to time. Whether you need support with a personal relationship or professional challenge, or you're seeking guidance on a particular subject, the Employee Assistance Program (EAP) provides the tools you need to thrive. Through the EAP, you have access to resources, information, and counseling that are fully confidential and no cost to you.

Program Component	Coverage Details
Number of sessions	3 face-to-face sessions per year per member per incident
How to access	Phone or face-to-face sessions
Topics may include	Mental Health Support: • Marital, relationship or family problems. • Bereavement or grief counseling. • Substance abuse and recovery. Community Support: • Childcare and eldercare. • Legal services and Identity theft. • Financial support. • Educational materials.
Who can utilize	All employees, dependents of employees, and members of your household

Get in touch:

- By phone: 800.854.1446.
- Online: www.unum.com/lifebalance

Perks & More

Perks & More

Let's cover the fun stuff.

To round out your benefits package, we offer these additional perks to support both your personal and professional needs.

Travel Assistance – Assist America

With Assist America, traveling for business or pleasure has never been easier or less stressful! This program helps assist you with any unexpected situation or issues that may arise while traveling. UNUM's Travel Assistance program has multi-lingual, medically certified crisis management professionals that are suited to help you with a medical emergency while traveling. With travel assistance, you have access to:

- Hospital
- Admission assistance
- Emergency medical evaluation
- Prescription replacement assistance
- Transportation for a friend or family member to join a hospitalized patient
- Care and transport of unattended minor children
- Assistance with the return of a vehicle
- Emergency message services
- Critical care monitoring
- Emergency trauma counseling
- Referrals to Western-trained, English-speaking medical providers
- Legal and interpreter referrals
- Passport replacement assistance

If you need travel assistance, UNUM is available to help 24 hours a day, 7 days a week.

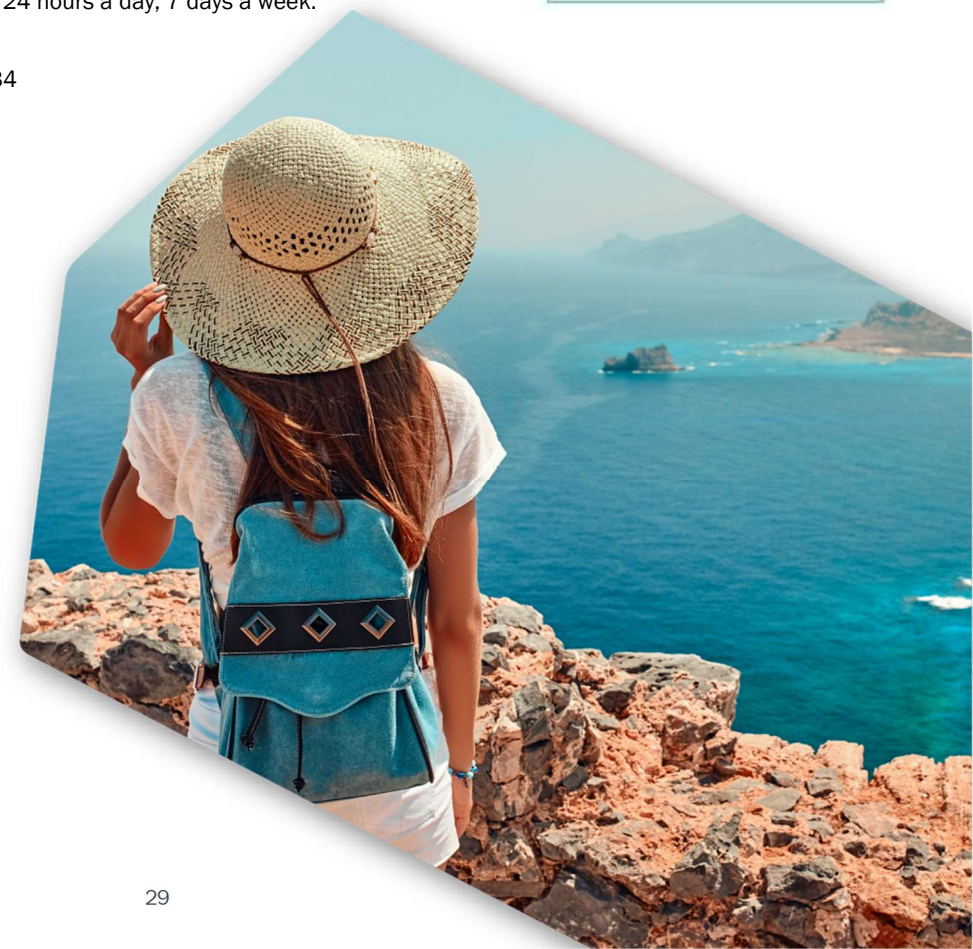
- Within the U.S.: 1.800.872.1414
- Outside the U.S.: (U.S. access code) +609.986.1234
- Email: medservices@assistamerica.com
- Reference number: 01-AA-UN-762490

With the Assist America Mobile App, you can:

- Call Assist America's Operation Center from anywhere in the world with the touch of a button
- Access pre-trip information and country guides
- Search for local pharmacies (U.S. only)
- Download a membership card
- View a list of services
- Search for the nearest U.S. embassy
- Read Assist Alerts

Download and activate the app today from the Apple App Store or Google Play.

Reference Number:
01-AA-UN-762490



Costs, Directory, & Required Notices

Cost Breakdown

All of your rates in one place.

The rates below are effective October 1, 2022 – September 30, 2023.

Coverage Level	Payroll Deduction
If a month has 3 pay periods, deductions will not come out of the third check.	Team Member Cost Per Pay Period
Aetna 1500 PPO Base Plan	
Team Member Only	$60.76
Team Member and Spouse/Registered and Unregistered Domestic Partner	$288.60
Team Member and Child(ren)	$197.47
Team Member and Family	$425.31
Aetna 500 PPO Buy-Up Plan	
Team Member Only	$86.70
Team Member and Spouse/Registered and Unregistered Domestic Partner	$346.81
Team Member and Child(ren)	$242.76
Team Member and Family	$502.86
Aetna Dental PPO	
Team Member Only	$4.82
Team Member and Spouse/Registered and Unregistered Domestic Partner	$21.40
Team Member and Child(ren)	$22.12
Team Member and Family	$38.67
VSP Vision Plan	
Team Member Only	$0.37
Team Member and Spouse/Registered and Unregistered Domestic Partner	$1.04
Team Member and Child(ren)	$1.08
Team Member and Family	$2.20

Directory & Resources

Below, please find important contact information and resources for Oki Golf.

Information Regarding	Group / Policy #	Contact Information	
Enrollment & Eligibility			
Human Resources: • Samuel Dessena		425.646.6976	Samueld@okigolf.com
Medical & Dental Coverage			
Aetna • Medical PPO • Pharmacy • Dental PPO	149959	877.204.9186 800.238.6279 877.238.6200	www.aetna.com
Vision Coverage			
VSP • Vision	30085586	800.877.7195	www.vsp.com
Life, AD&D and Disability			
UNUM • Life/AD&D • LTD	 120286 120286	 800.275.8686 800.275.8686	 www.unum.com www.unum.com
Flexible Spending Accounts			
Navia		800.669.3539	www.naviabenefits.com Company ID: ODI
401(k) Retirement Plan Adviser			
John Hancock Retirement Plan Services		800.395.1113	www.jhancockpensions.com
Health Advocacy			
Health Advocate		866.695.8622	www.healthadvocate.com/members
Employee Assistance Plan			
UNUM		800.854.1446	www.unum.com/lifebalance
Travel Assistance			
Assist America		800.872.1414	www.assistamerica.com Reference #: 01-AA-UN-762490
Benefits Broker			
Marsh & McLennan Insurance Agency LLC 1340 Treat Boulevard, Suite 250 Walnut Creek, CA 94597		925.482.9300	www.MarshMMA.com

Medicare Part D
Creditable Coverage Notice
Important Notice from Oki Golf Management LLC
About Your Prescription Drug Coverage and Medicare

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

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

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

2. **Oki Golf Management LLC has determined that the prescription drug coverage offered by the benefit package is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan while enrolled in Oki Golf Management LLC coverage as an active employee, please note that your Oki Golf Management LLC coverage will be the primary payer

for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits may be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in Oki Golf Management LLC coverage as a former employee.

You may also choose to drop your Oki Golf Management LLC coverage. If you do decide to join a Medicare drug plan and drop your current Oki Golf Management LLC coverage, be aware that you and your dependents may not be able to get this coverage back.

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

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

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Oki Golf Management LLC changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

HIPAA Special Enrollment Rights Notice

If you are declining enrollment in Oki Golf Management LLC group health coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Oki Golf Management LLC sponsors certain group health plan(s) (collectively, the "Plan" or "We") to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the "Notice") describes the legal obligations of Oki Golf Management LLC, the Plan and your legal rights regarding your protected health information held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

1. your past, present or future physical or mental health or condition;
2. the provision of health care to you; or
3. the past, present or future payment for the provision of health care to you.

Note: If you are covered by one or more fully-insured group health plans offered by Oki Golf Management LLC, you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier.

Contact Information

If you have any questions about this Notice or about our privacy practices, please contact the Oki Golf Management LLC benefits department:

Oki Golf Management LLC

Attention: HIPAA Privacy Officer

Maria Vertes

Director of Human Resources

13201 Bel Red Rd
Bellevue, WA 98005

Effective Date

This Notice as revised is effective October 1, 2022.

OUR RESPONSIBILITIES

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories.

For Treatment

We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.

For Payment

We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider.

Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations

We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

To Business Associates

We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

As Required by Law

We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety

We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors

For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

SPECIAL SITUATIONS

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation

If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans

If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation

We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks

We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities

We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement

We may disclose your protected health information if asked to do so by a law enforcement official—

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors

We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities

We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates

If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research

We may disclose your protected health information to researchers when:

1. the individual identifiers have been removed; or
2. when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

REQUIRED DISCLOSURES

The following is a description of disclosures of your protected health information we are required to make.

Government Audits

We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You

When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Notification of a Breach.

We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

OTHER DISCLOSURES

Personal Representatives

We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

1. you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
2. treating such person as your personal representative could endanger you; or
3. in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members

With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations

Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

YOUR RIGHTS

You have the following rights with respect to your protected health information:

Right to Inspect and Copy

You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

Right to Amend

If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures

You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years (three years for electronic health records) or the period ABC Company has been subject to the HIPAA Privacy rules, if shorter.

Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

For more information, please see Your Rights Under HIPAA.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

To file a complaint with the Plan, telephone write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**MAINE – Medicaid**
A HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711
INDIANA – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840

IOWA – Medicaid and CHIP (Hawki)	MINNESOTA – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://mn.gov/dhs/people-we-serve/children-and- families/health-care/health-care-programs/programs-and- services/other-insurance.jsp Phone: 1-800-657-3739
KANSAS – Medicaid	**MISSOURI – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KENTUCKY – Medicaid	**MONTANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
LOUISIANA – Medicaid	**NEBRASKA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: http://www.ACCESSNebraska.ne.govPhone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: http://dhcfp.nv.govMedicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEW HAMPSHIRE – Medicaid	**SOUTH DAKOTA – Medicaid**
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345,ext 5218	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW JERSEY – Medicaid and CHIP	**TEXAS – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.htmlCHIP Phone: 1-800-701-0710	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW YORK – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH CAROLINA – Medicaid	**VERMONT – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH DAKOTA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: https://www.coverva.org/en/famis-selecthttps://www.coverva.org/en/hipp Medicaid Phone:1-800-432-5924 CHIP Phone:1-800-432-5924
OKLAHOMA-Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
OREGON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.htmlPhone: 1-800-699-9075	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
PENNSYLVANIA – Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.dhs.wisconsin.gov/badgercareplus/p- 10095.htm Phone: 1-800-362-3002
RHODE ISLAND – Medicaid and CHIP	**WYOMING – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2022, or for more information on special enrollment rights, contact either:

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

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

OMB Control Number 1210-0137 (expires 1/31/2023)

Women's Health Cancer Rights Act (WHCRA) Notice

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema?

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your plan administrator at (425) 646-6971.

Newborns' And Mothers' Health Protection Act (NMHPA) Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Model General Notice of Cobra Continuation Coverage Rights

** CONTINUATION COVERAGE RIGHTS UNDER COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: anyone listed on the plan.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other 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 continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

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

In general, if you don't 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[1] 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 don't enroll in Medicare and elect COBRA continuation 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 OBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation 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 continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation 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.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. 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/agencies/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.HealthCare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about 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.

Plan contact information

Oki Golf
Attention: Maria Vertes
Director of Human Resources
13201 Bel Red Rd
Bellevue, WA 98005
(425) 646-6971

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

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Prepared by: **Marsh & McLennan Insurance Agency LLC**
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