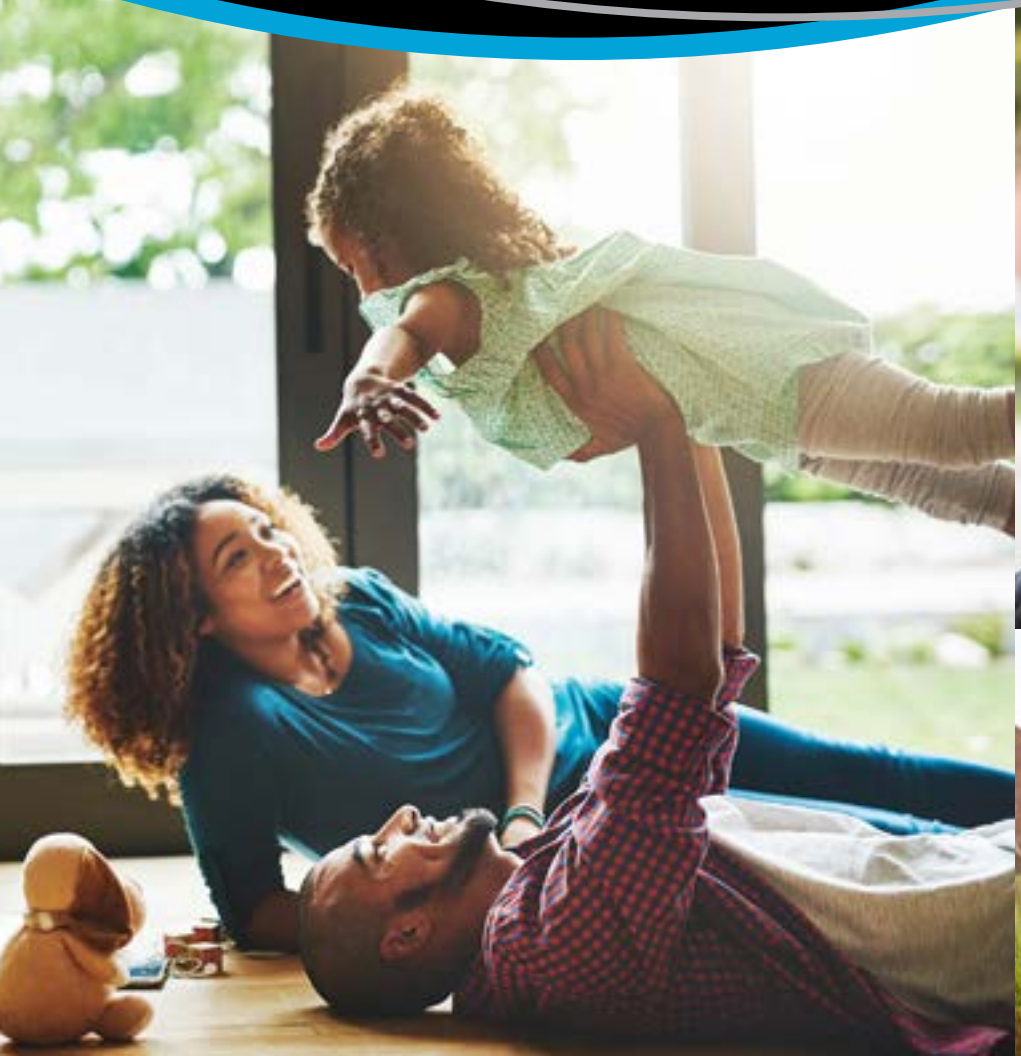
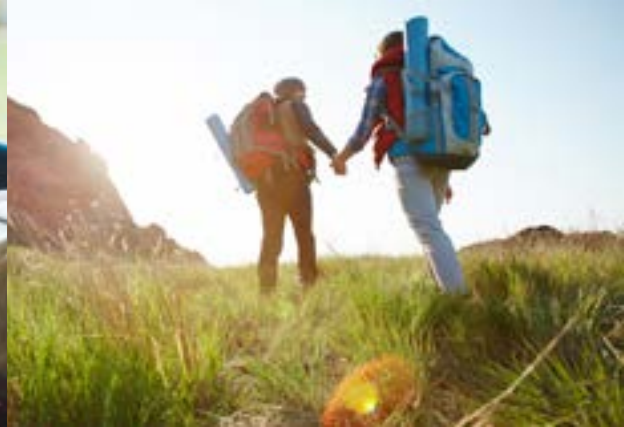
GAME ONE

BENEFITS GUIDE 2026





WHAT'S INSIDE

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see pages 29-30 for more details.

This guide provides a summary of plan highlights. This is not a binding contract. In the event of any difference between the information contained herein and the plan documents, the plan documents will supersede and control over this guide. Please consult the Summary Plan Description for information on covered charges, limitations, and exclusions.

IMPORTANT CONTACTS

Be prepared: When contacting any of the companies below, it is important to have the insurance card or ID card number(s) of the subscriber for the coverage you are calling about, as well as any appropriate paperwork, such as an explanation of benefits, a denial letter, receipts, etc.

QUESTIONS ABOUT	CONTACT	PHONE	WEBSITE
Medical	United Healthcare	PPO: (866)-633-2446 HDHP: (866)-314-0335	www.myuhc.com
Prescription Drugs	RxBenefits/OptumRx	(800) 334-8134	www.member.RxBenefits.com Email: CustomerCare@RxBenefits.com
Telemedicine	United Healthcare	(855) 615-8335	www.myuhc.com/virtualvisits
Employee Assistance Program	United Healthcare	(888) 887-4114	www.myuhc.com
Health Savings Account	Optum	(866) 234-8913	www.optumbank.com
Dental	MetLife	(800) GET-MET8	www.metlife.com/mybenefits
Vision	United Healthcare	(800) 638-3120	www.myuhcvision.com
Life / AD&D	United Healthcare	(888) 299-2070	www.myuhcfp.com
Disability	United Healthcare	(888) 299-2070	www.myuhcfp.com
Flexible Spending Accounts	WEX	(866) 451-3399	www.wexinc.com
Accident, Critical Illness & Hospital Indemnity	AFLAC	(800) 433-3036	www.aflacgroupinsurance.com

WELCOME

We are pleased to provide you with a wide range of competitive benefits that are a vital part of your total compensation. You have the flexibility to select from a full range of benefits to keep you and your family healthy, provide financial protection in the event of an unforeseen event, and help you build long-term security for retirement. This brochure was designed to answer some of the basic question you may have about your benefits. Please take the time to review this brochure to make sure you understand the benefits that are available to you and your family — then be sure to take action.

ELIGIBILITY

If you work at least 30 hours per week, you are eligible for benefits. Most of your benefits are effective on the first day of the month following your date of hire for Exempt Employees, or on the first day of the month following 30 days of hire for Non-Exempt Employees. You may also enroll your eligible dependents for coverage. This includes the following:

- Your legal spouse or qualified domestic partner
- Children under the age of 26, regardless of student, dependency, or marital status
- Children who are past the age of 26 and are fully dependent on you for support due to a mental or physical disability, and who are indicated as such on your federal tax return

QUALIFYING LIFE EVENTS

Generally, you may only change your benefit elections during the Open Enrollment period. However, since life happens, you also may change your benefit elections during the year if you experience a Qualified Life Event. Also, if your spouse is eligible for medical and prescription drug coverage through their employer at $200 or less per month, they must elect that insurance as primary. Failure to do so may result in the termination of their coverage through Game One.

CHANGING BENEFITS AFTER ENROLLMENT

During the year, you cannot make changes to your Medical, Dental, Vision, Accident, Hospital Indemnity, Health Care, or Dependent Care Flexible Spending Accounts unless you have a Qualified Life Event. If you do not contact Human Resources within 30 days of the Qualified Life Event, you will have to wait until the next annual Open Enrollment period to make changes (unless you experience another Qualified Life Event).

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

BODY AND MIND

BENEFITS COSTS

Game One pays the full cost of many of your benefits; however, for others, you share the cost, or you pay the full cost. Pretax means the cost comes out of your pay before taxes are deducted. After-tax means the cost comes out of your pay after taxes are deducted.

BENEFIT	WHO PAYS	TAX TREATMENT
Medical, Prescription Drugs	You share the cost	Pretax
Dental	You share the cost	Pretax
Vision	You pay 100%	Pretax
Basic Life and Accidental Death & Dismemberment (AD&D) Insurance	No cost to you	N/A
Voluntary Life and Accidental Death & Dismemberment (AD&D) Insurance	You pay 100%	After-tax
Short-Term Disability - Core	No cost to you	N/A
Short-Term Disability - Buy-up	You pay 100%	After-tax
Voluntary Long-Term Disability	You pay 100%	After-tax
Flexible Spending Accounts	You pay 100%	Pretax
401(k) Retirement Savings Plan	You share the cost	Pretax or After-tax
Employee Assistance Program	No cost to you	N/A
Critical Illness	You pay 100%	After-tax
Accident + Hospital Indemnity	You pay 100%	Pretax

MEDICAL

United Healthcare

RxBenefits Optum Rx

HOW A HEALTH PLAN WORKS

Preventive care—like physical exams, flu shots, and screenings—is always covered 100% when you use in-network providers. The key difference between the plans is the amount of money you'll pay each pay period and when you need care. The plans have different:

- **Annual deductible amounts** – the amount you pay each year for eligible in-network and out-of-network charges before the plan begins to pay.
- **Out-of-pocket maximums** – the most you will pay each year for eligible network services including prescriptions. After you reach your out-of-pocket maximum, the plan picks up the full cost of covered medical care for the remainder of the year.
- **Copay** – A copay is a fixed amount you pay for a health care service. Copays do not count toward your deductible but do count toward your annual out-of-pocket maximum.
- **Coinsurance** – Once you've met your deductible, you and the plan share the cost of care, called coinsurance. For example, you pay 20% for services and the plan will pay 80% of the cost until you have reached your out-of-pocket maximum.

Medical insurance is essential to your well-being and our medical coverage provides you and your family the protection you need for everyday health issues or when the unexpected happens. To find an in-network medical provider or facility, visit www.myuhc.com. To look up a medication, visit member.RxBenefits.com.

You can also download the OptumRx mobile application from the Apple App Store or Google Play, where you can:

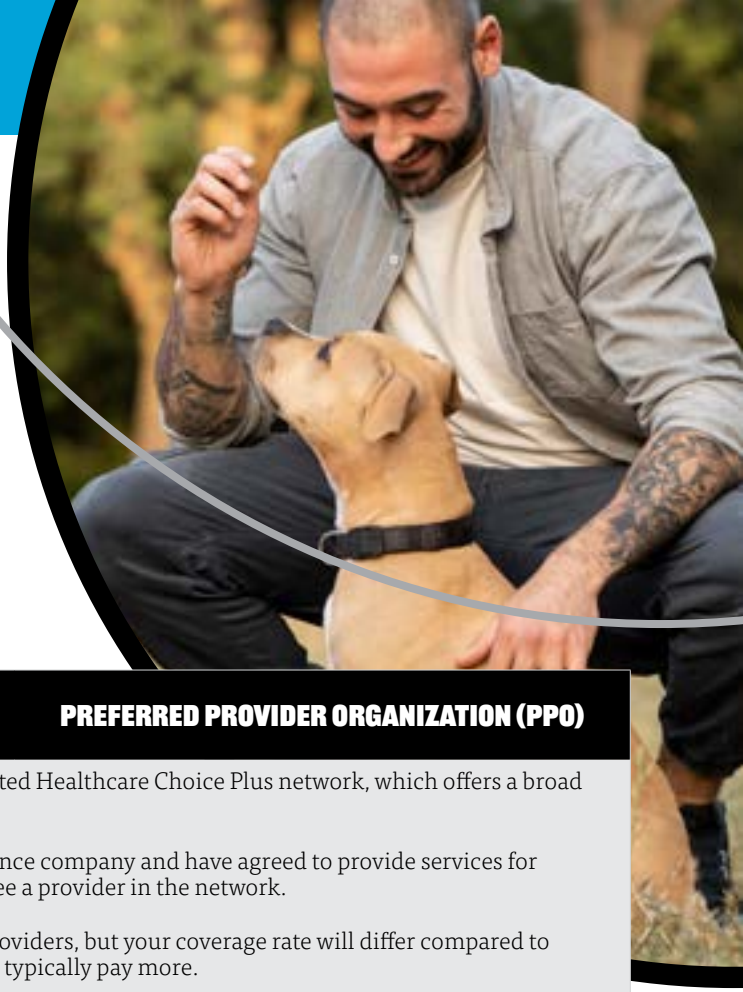
- Locate a pharmacy
- Access your ID card
- Find drug prices and lower cost options
- Set up reminders
- View your prescription claim history or order status
- Transfer a retail prescription to home delivery
- Refill or renew a home delivery prescription

MEDICAL PLAN COMPARISON	PPO		HDHP	
	IN-NETWORK (CHOICE PLUS)	OUT-OF-NETWORK	IN-NETWORK (CHOICE PLUS)	OUT-OF-NETWORK
CALENDAR YEAR DEDUCTIBLE				
Individual	$2,000	$10,000	$3,400	$7,000
Family	$4,000	$20,000	$6,800	$14,000
COINSURANCE				
Coinsurance	10%	50%	0%	30%
BENEFIT HIGHLIGHTS				
Preventive Care	$0	50%*	$0	30%*
Primary Care Physician	$15 copay	50%*	0%*	30%*
Specialist	Designated Network: $50 copay In-Network: $100 copay	50%*	0%*	30%*
Urgent Care	$25 copay	50%*	0%*	0%*
Emergency Room	$300 copay	$300 copay	0%*	30%*
Inpatient/Outpatient Services	10%*	50%*	0%*	30%*
Virtual Visit	Designated Virtual Network Provider: $0	Not covered	Designated Virtual Network Provider: $0	Not covered
Mental Health/Substance Abuse	Inpatient: 10%* $15 copay	50%*	0%*	30%*
CALENDAR YEAR OUT-OF-POCKET MAXIMUM				
Individual	$4,150	$20,000	$3,400	$19,000
Family	$8,300	$40,000	$6,800	$38,000

**After deductible*

PRESCRIPTION DRUGS RXBENEFITS-OPTUMRX	PPO		HDHP	
	30-DAY SUPPLY	90-DAY SUPPLY	30-DAY SUPPLY	90-DAY SUPPLY
Tier 1	$10 copay	$25	0%*	0%*
Tier 2	$35 copay	$87.50	0%*	0%*
Tier 2	$70 copay	$175	0%*	0%*

**See Summary Plan Description for additional details. You may also contact the plan administrator regarding benefits.*



HDHP VS PPO

When it comes to choosing the right medical insurance plan, there are many factors to consider based on your personal health, the health of your covered family members, and your financial situation.

- **High-Deductible Health Plan (HDHP):** Designed to provide more flexibility when it comes to health care spending and savings.
- **Preferred Provider Organization (PPO):** A traditional type of managed health care plan that allows a degree of service flexibility.

	HIGH-DEDUCTIBLE HEALTH PLAN (HDHP)	PREFERRED PROVIDER ORGANIZATION (PPO)
Plan Network	Both the HDHP plan and the PPO plan utilize the United Healthcare Choice Plus network, which offers a broad choice of in-network providers. In-network providers have a contract with the insurance company and have agreed to provide services for members at a specified rate. You will pay less if you see a provider in the network. You may obtain medical care from out-of-network providers, but your coverage rate will differ compared to getting those same services in-network. You will also typically pay more. Referrals from Primary Care Physicians are not required under either plan.	
Cost	Higher deductibles than most traditional health care plans, often meaning much lower premiums. Many enrolled in HDHPs can use Health Savings Accounts to help cover out-of-pocket expenses.	Higher premiums but choice of lower deductibles designed to fit different budgets.
Copays	No copay on Game One plan.	Copay amount differs based on type of service.
Preventive Care	Because preventive care services are covered before you meet your deductible, the costs of these services don't count toward your deductible.	Preventive care services covered at 100% when obtained through in-network providers.

*Cost is always lower when using in-network providers.

IMPORTANCE OF A PRIMARY CARE PHYSICIAN (PCP)

A primary care physician (PCP) is your essential partner in health, providing long-term medical care and helping you stay healthy through preventive services. They coordinate your overall health care, addressing non-emergency issues, and guiding you to specialists when necessary.

PCPs conduct regular check-ups, screenings, and immunizations, offering patient education and advice on disease prevention. This relationship fosters better care and satisfaction, as patients who trust their PCPs tend to have improved health outcomes. Sharing your health history and any relevant symptoms with your doctor is vital for effective care. Quality health care is a collaborative effort, so don't hesitate to ask questions. By prioritizing this partnership, you can focus on your health and well-being with confidence.

TELEHEALTH

United Healthcare

SEE A DOCTOR WHENEVER, WHEREVER.

When you need care — anytime, day or night — or when your primary care provider is not available, telemedicine can be a convenient option. With ***telemedicine***, you don't have to drive to the doctor's office or sit in a waiting room when you're sick — you can see your doctor from the comfort of your own bed or sofa.

USING TELEMEDICINE IS EASY

- Avoid germs in the ER, urgent care clinic, or doctor's office.
- See a board-certified, licensed, telehealth-trained doctor on your schedule with on-demand virtual visits 24/7, including nights, weekends, and holidays.
- Get treated for more than 80 common conditions including colds, flu, allergies, and more
- Get a prescription or short-term refill of any existing prescription sent to a pharmacy nearby, in less time than your usual doctor visit.

Avoid costly copays and deductibles of the ER and urgent care clinic.

VIRTUAL VISITS

Get access to care 24/7 with virtual visits. A virtual visit lets you see a doctor from your mobile device or computer without an appointment.

Choose from a designated virtual network provider and pay $54 or less for the visit.

To learn more and start a visit, go to **myuhc.com/virtualvisits** or the United Healthcare app.

Virtual Visits are covered under your health plan benefits with either plan you decide to enroll in.

TIPS FOR REGISTERING:

1. Locate your member ID number on your health plan ID card.

2. Have your credit card ready to cover any costs not covered by your health plan.

3. Choose a pharmacy that's open in case you're given a prescription.

CHOOSING THE RIGHT HEALTH CARE SETTING

When you need medical attention, you should go to your primary care doctor whenever you can. Your doctor knows you best and has quick access to your medical records. However, there are times when you might need to go to a facility other than your doctor's office. The cost of medical care can widely vary. Your cost depends on where and how you receive care. Knowing the facts can help you manage your health and your health care dollars.

CONVENIENCE CARE CLINICS are often located in malls or retail stores offering fast walk-in services for minor health conditions such as:

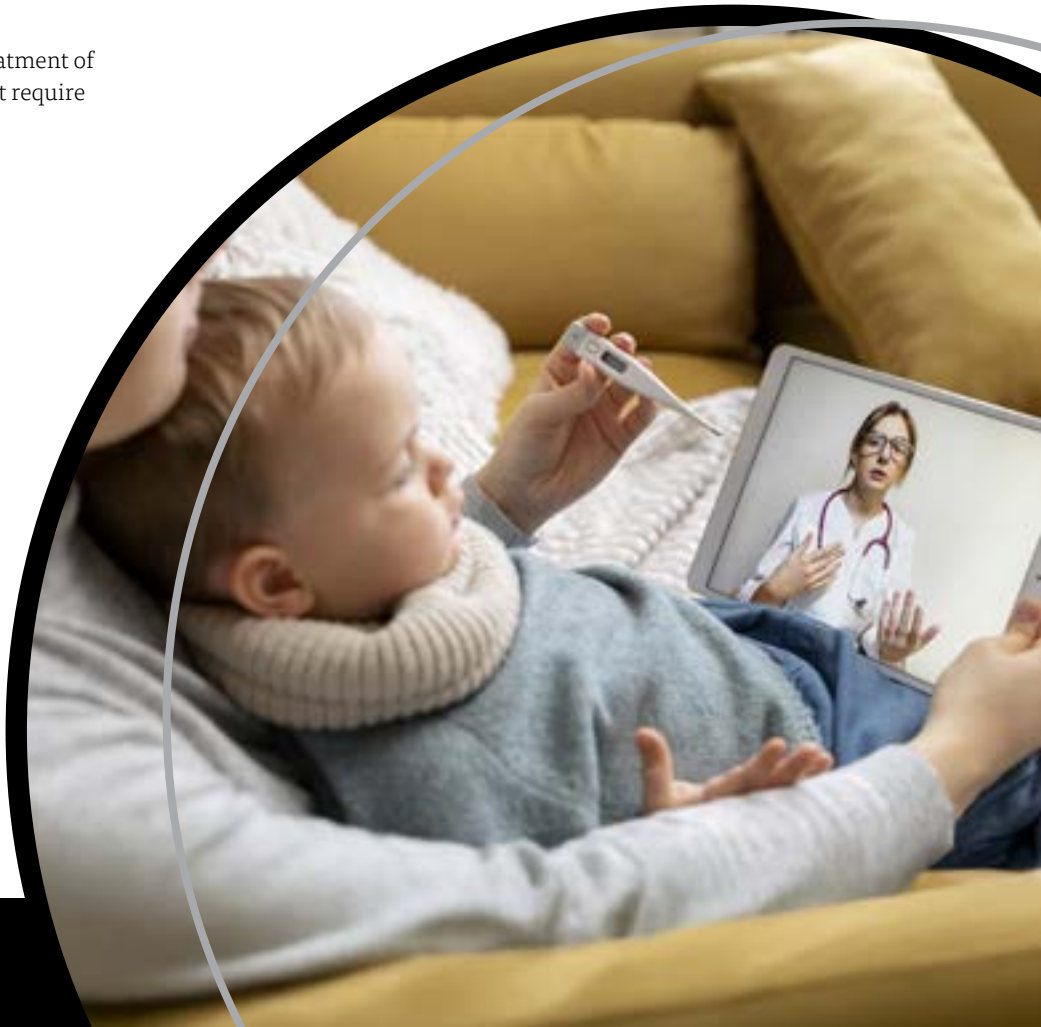
- Common infections (e.g. strep throat)
- Minor skin conditions (e.g. poison ivy)
- Vaccinations – Tetanus shots, flu shots
- Minor Injuries – cuts, burns, bruises
- Earaches

URGENT CARE CENTERS offer treatment for urgent but not life-threatening injuries or illnesses. Patients are accepted on a walk-in basis for treatment of such conditions as:

- Sprains and strains
- Minor broken bones (e.g. finger)
- Minor infections
- Small cuts that may need a few stitches
- Minor burns

THE EMERGENCY ROOM is for the treatment of life-threatening or very serious conditions that require immediate medical attention such as:

- Heavy bleeding
- Large open wounds
- Sudden change in vision
- Chest pain
- Sudden weakness or trouble talking
- Major burns
- Spinal injuries
- Severe head injury
- Difficulty breathing
- Major broken bones



HOW A HEALTH SAVINGS ACCOUNT WORKS

A Health Savings Account (HSA) is a personal savings account you can use to pay for qualified out-of-pocket medical expenses with pretax dollars — now or in the future. Once you're enrolled in the HSA, you'll receive a debit card to help manage your HSA reimbursements. Your HSA can also be used for your expenses and those of your spouse and dependents, even if they are not covered by the HDHP medical plan.

ELIGIBILITY

You must be enrolled in the High Deductible Health Plan. You are **ineligible** for an HSA if you meet any of the following:

- If you're covered by any other medical plan that is not a qualified HDHP. This includes a spouse's medical coverage unless it's also a qualified HDHP .
- If you're enrolled in a traditional Health Care FSA in the same calendar year .
- If you're enrolled in Medicare, including Parts A or B, Medicaid or Tricare .
- If you're claimed as a dependent on another person's tax return .
- If you're a veteran who has received treatment, other than preventive care, through the Department of Veterans Affairs within the past three months.

CONTRIBUTIONS

You contribute on a pretax basis and can change how much you contribute from each paycheck up to the IRS maximum of $4,400 if you enroll only yourself or $8,750 if you enroll in family coverage. You can make an additional catch-up contribution of up to $1,000 if you are age 55 or older.

HSAS AND YOUR TAXES

All withdrawals from your HSA are tax-free, as long as you use the money to pay for eligible health care expenses. In addition, all the money in the account is yours and will never be forfeited. It rolls over from year to year, and you can take it with you if you leave the company or retire. After age 65, you can withdraw funds for any reason without a tax penalty — you pay ordinary income tax only if the withdrawal isn't for eligible health care expenses.

Note: You won't pay federal taxes on HSA contributions. However, you may pay state taxes depending on your residence. Consult your tax advisor to learn more.

ELIGIBLE EXPENSES

You may use your HSA funds to cover medical, dental, vision, and prescription drug expenses incurred by you and your eligible family members. To view eligible HSA expenses, see IRS Publication 502, available at **www.irs.gov**.

USING YOUR ACCOUNT

Use the debit card linked to your HSA to cover eligible expenses or pay for expenses out of your own pocket and save your HSA money for future health care expenses.

YOUR HSA IS ALWAYS YOURS — NO MATTER WHAT

One of the best features of an HSA is that any money left in your HSA account at the end of the year rolls over so you can use it next year or sometime in the future. And if you leave the Company or retire, your HSA goes with you so you can continue to pay for or save for future eligible health care expenses.

HEALTH SAVINGS ACCOUNTS

Optum

Just as it sounds, Supplemental Medical plans can help you pay for costs you may incur after an accidental injury, illness, or hospitalization. These plans are 100% voluntary.

ACCIDENT INSURANCE

Accident insurance pays out a lump sum directly to you if you become injured from an accident. Qualifying injuries include a broken limb, loss of a limb, burns, lacerations, paralysis, and much more. You may use the funds any way you choose—such as out-of-pocket medical expenses, transportation, and lodging. Coverage is available for you, your spouse, and eligible dependent children, and you do not need to answer medical questions to receive coverage.

CRITICAL ILLNESS

If you suffer from a serious illness, such as cancer, stroke, or a heart attack, medical insurance may not provide all the coverage you need. Critical Illness insurance can ease the financial strain and help you focus on your recovery. Upon diagnosis of a covered illness, you'll receive a lump-sum benefit to cover your deductible, coinsurance, living expenses, mortgage or rent, or other expenses you may have.

HOSPITAL INDEMNITY

Hospital expenses can add up quickly, even with medical coverage. With Hospital Indemnity insurance, you will receive a cash benefit if you or a covered family member has a hospital stay. You may use the money to pay for out-of-pocket medical expense**s.**

HEALTH SCREENING/WELLNESS BENEFIT

The Accident, Critical Illness, and Hospital Indemnity plans all include a $50 health screening benefit, payable once per calendar year, for wellness or health screening tests performed as a part of preventive care.

SUPPLEMENTAL MEDICAL

Aflac.

DENTAL

MetLife

With a focus on prevention, early diagnosis, and treatment, Dental insurance can greatly reduce your costs when it comes to restorative and emergency procedures. Once you're enrolled, you may take advantage of online self-service capabilities with MyBenefits, such as checking the status of your claims, locating a participating dentist, accessing MetLife's Oral Health Library, and electing to view your Explanation of Benefits online. To register, go to **www.metlife.com/mybenefits.** MetLife's mobile app allows you to quickly access and manage your information - anytime, anywhere. Search "MetLife" in the App Store or Google Play to download the MetLife US Mobile App.

DENTAL COVERAGE		
	IN-NETWORK (PDP PLUS)	OUT-OF-NETWORK*
CALENDAR YEAR PLAN MAXIMUM		
Per Individual	$2,000 per individual	
	YOU PAY	
CALENDAR YEAR DEDUCTIBLE		
Individual	$25	$25
Family	$75	$75
PREVENTIVE CARE		
Exams, Cleanings, X-rays, Sealants, Space Maintainers, Fluoride Treatment	$0	$0
BASIC SERVICES		
Fillings, Simple Extractions, Emergency Exams	20% after deductible	20% after deductible
MAJOR PROCEDURES		
Surgical Extractions, Crowns, Inlays/Onlays, Dentures, and Bridgework, Repairs	50% after deductible	50% after deductible
ORTHODONTIA		
Children (up to 19th birthday)	50%, up to a lifetime maximum benefit of $1,000 per individual (deductible waived)	

* Out-of-network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary Charge is based on the lesser of: the dentist's actual charge (the 'Actual Charge'), or the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the "Customary Charge'). For your plan, the Customary Charge is based on the 99th percentile.

VISION

United Healthcare

Healthy eyes and clear vision are an important part of your overall health and quality of life. You may enroll yourself and your eligible dependents, or you may waive vision coverage.

The table below summarizes the key features of the vision plan. Please refer to the official plan documents for additional information on coverage and exclusions. To find an in-network vision provider, visit **www.myuhc.com**.

VISION PLAN		
	IN-NETWORK	OUT-OF-NETWORK
	YOU PAY	REIMBURSEMENT
Exam	$10 copay	Up to $40 reimbursement
Lenses	$10 copay	Single Vision Lenses: Up to $40 Lined Bifocal Lenses: Up to $60 Lined Trifocal Lenses: Up to $80 Lenticular Lenses: Up to $80
Frames	$120 retail allowance; 30% discount off balance at participating providers	Up to $45 reimbursement
Contacts (Medically Necessary)	$10 copay	Up to $210 reimbursement
Contacts in lieu of Frames/Lenses	Formulary: up to 6 boxes of disposable contacts Nonforumulary: $150 allowance	Up to $150 reimbursement
BENEFIT FREQUENCY		
Exam	Once every 12 Months	
Lenses	Once every 12 Months	
Frames	Once every 24 Months	
Contacts	Once every 12 Months	

* Contact lens exams are separate from standard eye exams.

FSAs

wex

HEALTH CARE FSA

Contribute up to $3,400 per year, pretax, to pay for deductibles, copays, coinsurance, prescription expenses, lab exams and tests, dental expenses, contact lenses, eyeglasses, and more.

DEPENDENT CARE FSA

Contribute up to $7,500 per year ($3,750 if married and filing separate tax returns), pretax, to pay for day care expenses associated with caring for elder or child dependents that are necessary for you or your spouse to work or attend school full-time. You cannot use your Health Care FSA to pay for Dependent Care expenses.

USE IT OR LOSE IT

Be conservative when estimating your annual election amount. The IRS has a strict "use it or lose it" rule. If there is a balance in your account after the $500 rollover, you will forfeit any funds left.

$500 ROLLOVER

At the end of the year you have the option to Use-it or Roll-it-Over. This means instead of losing all remaining funds in your FSA, you can roll over up to $500 to use in the upcoming plan year.

RUN OUT PERIOD

The FSA plan has a 90 day run-out period after the end of the plan year, until March 31, in which you may still file claims for reimbursement. The eligible expense, however, must have been incurred during the plan year of January 1 – December 31.

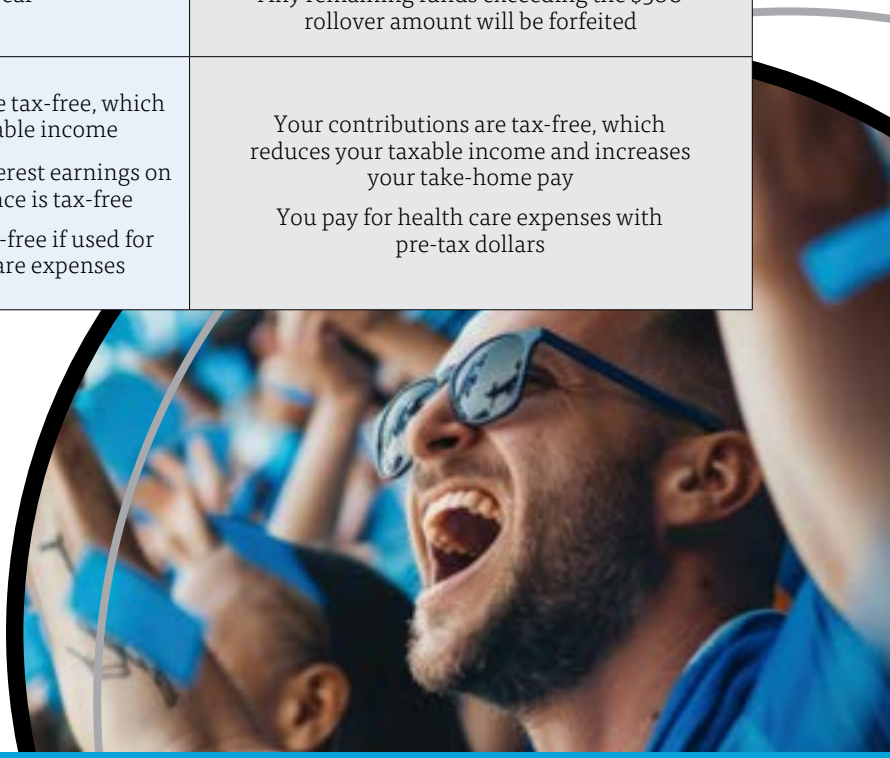
To view eligible FSA expenses, see IRS Publication 502 available at www.irs.gov.

HSA & FSA COMPARISON

This chart compares the features of the Health Care FSA and the Health Savings Account (HSA).

	HSA	HEALTH CARE FSA*
Available if you select these plans	High-Deductible Health Plan	Traditional PPO
How much you may contribute	$4,400 (EE only) $8,750 (all other coverage levels) Catch-up contributions of up to $1,000 for 2026 year for age 55+	Up to $3,400 for plan year
	Out-of-pocket:	Out-of-pocket expenses incurred during the current calendar year
	Medical Prescription Drugs Dental Vision	Medical Prescription Drugs Dental Vision
Account balance available to reimburse expenses	Current account balance	Entire contribution amount elected for the plan year
Time limits for using your account balance	No limit	Must use 2026 account balance for expenses incurred through 12/31/2026 Claims must be filed by 3/31/2027
If you don't use all your account balance each year	Any account balance carries over from year-to-year	You must submit claims by 3/31/2027 for all expenses incurred through 12/31/2026 Any remaining funds exceeding the $500 rollover amount will be forfeited
How it saves you money	Your contributions are tax-free, which reduces your taxable income Any investment or interest earnings on your account balance is tax-free Distributions are tax-free if used for qualified health care expenses	Your contributions are tax-free, which reduces your taxable income and increases your take-home pay You pay for health care expenses with pre-tax dollars

* You don't have to participate in a company medical plan to enroll in a Health Care FSA.



LIFE INSURANCE

United Healthcare

Life insurance pays a lump-sum benefit to your beneficiary(ies) to help meet expenses in the event of your death. Accidental Death & Dismemberment (AD&D) insurance pays a benefit if you die or suffer certain serious injuries as the result of a covered accident. In the case of a covered accidental injury (e.g., loss of sight, loss of a limb), the benefit you receive is a percentage of your total AD&D coverage based on the severity of the accidental injury. The Life and AD&D insurance is paid by Game One and there is no cost to employees.

LIFE INSURANCE		
Coverage Level	**Coverage Amount**	**Benefit Reduction Schedule**
Life Insurance	Minimum of $30,000, varies by position	To 65% at age 65; to 40% at age 70; to 25%

VOLUNTARY LIFE AND AD&D

You may purchase additional life insurance at group rates on a voluntary basis. You pay the full cost of this coverage through payroll deductions. Voluntary Life and AD&D insurance for you and your dependents can help protect your family during difficult times.

VOLUNTARY LIFE AND AD&D INSURANCE		
Coverage Level	**Coverage Amount**	**Guaranteed Issue Amounts***
Employee	Increments of $10,000 not to exceed 5 times your salary or $500,000.	$150,000
Spouse	Increments of $5,000 up to $250,000 – not to exceed 50% of employee coverage.	$20,000
Child(ren) age 14 days – 26 years	Increments of $2,000 up to $10,000 – not to exceed 50% of employee coverage.	$10,000

BENEFIT REDUCTION SCHEDULE	
Coverage Level	**Benefit Reduction Schedule**
Employee, Spouse, Child(ren)	To 65% at age 65; to 40% at age 70; to 25% at age 75.

*GUARANTEED ISSUE AND EVIDENCE OF INSURABILITY

Employees and spouses who elect Voluntary Life and AD&D coverage when they are first eligible can elect up to the Guaranteed Issue (GI) amount without Evidence of Insurability (EOI). If the amount requested is more than GI, or if you choose to enroll at a later date, you will need to provide EOI before the amount over GI becomes effective.

Please note: upon loss of eligibility or termination of employment, you and/or your dependents may elect to continue your employer-sponsored Basic or Voluntary Term Life insurance coverage by either porting or converting it.

If you are eligible to continue your life insurance policy, you can port it, which means continuing the same type of policy, or you can convert it, which means changing it to a new type of individual policy. No matter which option you choose, you become responsible for the premium payments.

DISABILITY

United Healthcare

Disability insurance can keep you financially stable should you experience a qualifying disability and become unable to work.

It can help provide a sense of security, knowing that if the unexpected should happen, you'll still receive a monthly income. A qualifying disability is a sickness or injury that causes you to be unable to perform any other work for which you are or could be qualified by education, training, or experience.

SHORT-TERM DISABILITY - CORE (EMPLOYER-PAID)	
Coverage	60% of your weekly earnings to a $500 maximum for 12 weeks
When Benefits Begin	Benefit begins after 7 days for accident or 7 days for illness
Election Required	Full-time employees working 36+ hours per week are automatically enrolled

VOLUNTARY SHORT-TERM DISABILITY - BUY-UP (EMPLOYEE-PAID)	
Coverage	66.67% of your weekly earnings to a $1,500 maximum for 12 weeks ($500 Core benefit + $1,000 additional benefit)
When Benefits Begin	Benefit begins after 7 days for accident or 7 days for illness
Pre-Existing Condition Limitation	A 3/12 pre-existing condition limitation applies to enrollees
Election Required	Full-time employees working 36+ hours per week are eligible to enroll

VOLUNTARY LONG-TERM DISABILITY (EMPLOYEE-PAID)	
Coverage	60% of your monthly earnings up to a maximum benefit of $5,000 per month for 5 years or until you recover, whichever is sooner
When Benefits Begin	Benefit begins after 90 days of disability
Pre-Existing Condition Limitation	A 12/12 pre-existing condition limitation applies to enrollees
Election Required	Full-time employees working 36+ hours per week are eligible to enroll

EMPLOYEE ASSISTANCE

Game One members enrolled in the UHC medical plan automatically have access to the Employee Assistance Program (EAP). This program provides professional, confidential, telephonic or face-to-face counseling services to you and your household members at no cost. The EAP can help you resolve personal issues and problems before they affect your health, relationships, and work performance.

- Three (3) counseling sessions per incident per year are available.

This program is available 24 hours a day, 365 days a year for confidential counseling, referral, and follow-up services for issues such as:

- Stress
- Marital or family problems
- Anxiety and depression
- Substance abuse (alcohol and/or drugs)
- Child care issues – including identifying schools, day care, tutors, and more
- Financial issues
- Aging parents
- Pet care
- Maintenance and repair providers
- Community volunteer opportunities

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

One call puts you in touch with a clinician, counselor, mediator, lawyer, or financial adviser who could help change your life for the better.

Contact EAP directly 24/7 at 1-888-887-4114.

401(K) PLAN

ELIGIBILITY

Invest in yourself and take advantage of your retirement savings plan benefit.

- You must have completed 1 month of service by the next plan entry date.
- You must have attained 21 years of age on the next plan entry date.
- You will be automatically enrolled into the Plan. A voluntary elective contribution of 2% will be deducted from your pay before-taxes and deposited in your retirement account in the Plan's default fund. For more information, including important dates, please refer to your Welcome Letter.
- If you decide now is not the right time to start saving, you can decline enrollment through My.ADP.com, Voice-Response System or ADP Mobile Solutions App. You can always change your mind and enroll later.

CONTRIBUTIONS

You can take an active part in your financial wellness by contributing as much as you can to your retirement account. Your contribution option(s) are listed below

- **Before-tax:** 1% to 90%
- **Roth:** 1% to 90%
- The total maximum amount you may contribute to the Plan is 90%.
- You have the option of electing a flat dollar amount to contribute each pay period.
- If you are considered a Highly Compensated Employee, the total maximum amount you may contribute to the Plan may be limited.
- The total dollar amount you may contribute to the Plan is $24,500.
- **Catch-up Contributions:** If you're 50 years of age or older, you may also make a catchup contribution in excess of Internal Revenue Code or Plan Limits. This year, you can save an additional $8,000. (Ages 60-63 can contribute up to an additional $10,000.)

CONSOLIDATE RETIREMENT ACCOUNTS WITH A ROLLOVER

Savings from your previous qualified retirement plan(s) or a Rollover Individual Retirement Account (IRA) are accepted into the Plan, even if you have not yet met the Plan's age and service requirements. Consolidating retirement accounts can be beneficial to your long-term retirement planning. Access to your savings in one place can save time and make it easier to track your progress. If you ever have a financial need, you will have access to these assets as part of your overall account balance.

To get started, click on the **Consolidate Accounts** tile, once you have logged into your account or in your ADP Mobile Solutions App.You will be guided through each step of the process.

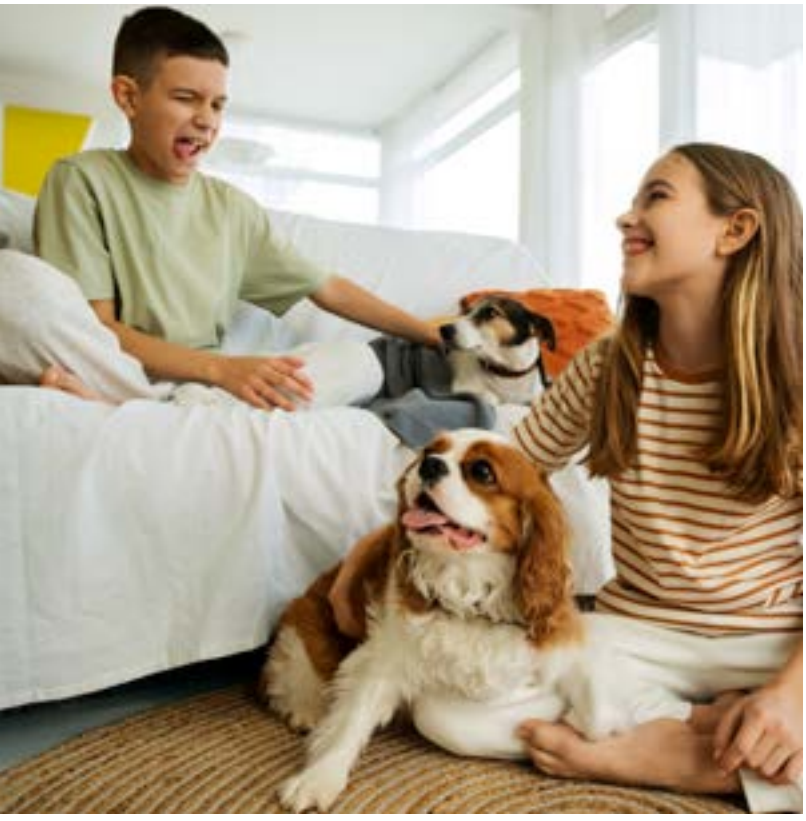
For additional information, please visit our **Rollover Resource Page** at http://bit.ly/RolloverResourcePage.

EMPLOYER CONTRIBUTIONS

- Your company may make a matching contribution and/or profit-sharing contribution to your account. These contributions are discretionary and may change from year to year.
- The current match is $.50 for each $1.00 contributed, up to 4% of pay.

VESTING

- Your contribution and any amounts you rolled into the Plan, adjusted gains and losses, are always 100% yours.
- The company match is 100% vested after one year of employment.



DISTRIBUTION OPTIONS

Planning for your retirement is a long-term commitment and the money you have saved should be considered "untouchable" and used only as income in retirement. In the event of a financial need, you have the following distribution options available to you:

LOANS

- Number of outstanding loans allowed at any one time: 1. Minimum loan amount: $1000.00
- Maximum repayment period: Generally, 5 years, unless for the purchase of a primary residence
- Loan interest rate information can be obtained by logging into your account > Loans & Withdrawals > View or Request a Loan
- A fee may apply if you take a loan from your retirement plan account. Fee information can be obtained by logging into your account > Plan Information > Participant Fee Disclosure > Individual Expenses

WITHDRAWALS WHILE EMPLOYED

- Rollover
- Age 59½
- Hardship

WITHDRAWALS AFTER EMPLOYMENT

You may receive a distribution of the vested portion of some or all of you retirement account balances in the Plan for the following reasons:

- Termination of employment
- Normal retirement
- Disability
- Death

Special rules exist for each type of withdrawal. You may be subject to a 10% penalty in addition to federal and state taxes if you withdraw money before age 59½. For more information, review the Special Tax Notice located in the retirement plan website.

ACCOUNT RESOURCES

You can access your retirement savings account anytime, make changes, and perform transactions through:

- ADP Mobile Solutions App
- **my.ADP.com**
- 1-866-695-7526

QUESTIONS?

Representatives are available Monday through Friday, 8am – 9pm, Eastern Time.

- Check account balances
- Enroll and make account changes
- Research plan investments and request investment changes
- Access retirement planning tools and calculators
- Get prospectuses

QUARTERLY ACCOUNT STATEMENTS

Stay informed about your progress. Your statement has details about your account, investment performance, and account activity for the period and is located in the My Account section once you have logged into your account.

BENEFICIARY DESIGNATIONS

Naming a beneficiary for your retirement account is important. In the event of your death, your account will be passed to the person(s) you name.

If you are single or married and want to name your spouse as your sole primary beneficiary, you can designate your beneficiary online.

If you are married and want to designate someone other than your spouse or significant other, you must print the form available online and follow the instructions to complete it.

You will need the names and birth dates of your beneficiary(ies) and each Social Security Number. If you do not have all of this information, you can always log into your account and add it later.

Congratulations on taking the first step to invest in yourself and your retirement. Once enrolled in the plan, be sure to take advantage of several features, such as:

SAVE SMART®

This is a plan feature that allows you to automatically increase your retirement plan contribution percentage. You can elect a 1%, 2%, or 3% increase to your before-tax contribution. The increase will go into effect each year, on the date you choose.

You should evaluate your ability to continue saving in the event of a prolonged market decline, unexpected expenses, or an unforeseeable emergency.

AUTOMATIC ACCOUNT REBALANCING

This is an account tool that allows you to keep your current investment mix (balance by investment fund) consistent with your current investment strategy for new contributions. Once you have made an investment allocation election for new contributions, Automatic Account Rebalancing will rebalance your account based on your preference: quarterly, semi-annually, or annually.

Keep in mind that rebalancing your funds and switching out of an investment when the market is doing poorly means locking in the loss.

PARTICIPANT ADVISORY SERVICES FROM EDELMAN FINANCIAL ENGINES®

This is an advisory service made available by your employer. Through this service, you can access and use certain investment advisory components provided by Edelman Financial Engines® without incurring any fees. If you elect to enroll in the Edelman Financial Engines® Professional Management program, you will pay an annual fee based on your account balance. For more information or to enroll in the service, visit **my.ADP.com** or call (844) 861-0028.

You can also access this service through the ADP Mobile Solutions App.

CONTRIBUTIONS

All contributions shown are per pay period (24 pay periods per year).

MEDICAL - PPO	
Employee Only	$103.95
Employee + Spouse*	$269.33
Employee + Child(ren)	$250.43
Employee + Family*	$392.70

MEDICAL - HDHP	
Employee Only	$57.75
Employee + Spouse*	$196.35
Employee + Child(ren)	$180.08
Employee + Family*	$286.65

*Spousal Affidavit Required

DENTAL	
Employee Only	$10.53
Employee + Spouse	$17.30
Employee + Child(ren)	$20.90
Employee + Family	$27.50

VISION	
Employee Only	$3.59
Employee + Spouse	$6.80
Employee + Child(ren)	$7.15
Employee + Family	$10.50

VOLUNTARY LIFE AND AD&D			
AGE	**RATE PER $1,000**	**AGE**	**RATE PER $1,000**
Under 25	$0.058	**55-59**	$0.329
25–29	$0.065	**60-64**	$0.493
30–34	$0.079	**65-69**	$0.928
35-39	$0.086	**70+**	$1.492
40-44	$0.094	**Child Rate**	$0.057
45-49	$0.129		
50-54	$0.186		

CONTRIBUTIONS

All contributions shown are per pay period (24 pay periods per year).

ACCIDENT		CRITICAL ILLNESS		HOSPITAL INDEMNITY	
Employee Only	$4.04	**Employee Only**	Rate varies based on age and coverage level	**Employee Only**	$5.27
Employee + Spouse	$7.01	**Employee +**		**Employee +**	$10.59
Employee +	$9.31	**Employee +**		**Employee +**	$8.51
Employee + Family	$12.27	**Employee +**		**Employee +**	$13.83

VOLUNTARY SHORT-TERM DISABILITY BUY-UP			
AGE	**RATE PER $10 OF WEEKLY BENEFIT**	**AGE**	**RATE PER $10 OF WEEKLY BENEFIT**
Under 25	$0.190	**55-59**	$0.275
25-29	$0.200	**60-64**	$0.325
30-34	$0.195	**65+**	$0.360
35-39	$0.175		
40-44	$0.200		
45-49	$0.185		
50-54	$0.220		

VOLUNTARY LONG-TERM DISABILITY			
AGE	**RATE PER $100 OF COVERED PAYROLL**	**AGE**	**RATE PER $100 OF COVERED PAYROLL**
Under 25	$0.080	**55-59**	$0.610
25-29	$0.100	**60-64**	$0.735
30-34	$0.120	**65+**	$0.735
35-39	$0.165		
40-44	$0.230		
45-49	$0.340		
50-54	$0.455		

BENEFIT TERMS

Beneficiary: A person designated by a participant, or by the terms of an employee benefit plan, which is or may become entitled to a benefit under the plan.

Claim: A request for payment that you or your health care provider submits to your health insurer after receiving a service or item.

Coinsurance: Coinsurance is your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. Your coinsurance will begin after you have met your deductible. For example, if the health plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health plan pays the rest of the allowed amount.

Copay: A copay is a fixed dollar amount you pay for a health care service. The amount can vary by the type of service. Your copays will not count toward your deductible but will count toward your out-of-pocket maximum.

Deductible: The deductible is the amount you owe for covered health care services before your plan begins to pay benefits. For example, if your deductible is $2,800, your plan won't pay anything until you've met your $2,800 deductible for covered health care services subject to the deductible. Preventive care is not subject to the deductible as it is covered 100% by any medical plan option.

Evidence of Insurability (EOI): Application process in which you provide required documentation on the condition of your or your dependents' health to get or increase the amount of certain types of insurance coverage.

Explanation of Benefits (EOB): An EOB is a statement from the insurance company showing how claims were processed. The EOB tells you what portion of the claim was paid to the health care provider and what portion of the payment, if any, you are responsible for.

Formulary: A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a drug list.

In-Network vs. Out-of-Network: A network is composed of all contracted providers. Networks request providers to participate in their network, and in return, in-network providers agree to offer discounted services to their patients. If you pick an out-of-network provider, your claims will be higher because you will not receive the discounts the in-network providers offer.

Out-of-Pocket Maximum: The out-of-pocket maximum is designed to protect you in the event of a catastrophic illness or injury. Your out-of-pocket maximum includes your deductible, coinsurance, and copays that come out of your pocket. After you have paid the specified out-of- pocket amount during a policy year, the plan pays the remaining covered services at 100%.

Pre-Existing Condition: A health problem you had before the date that new health coverage starts.

Preauthorization: A decision by your health insurer or plan that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval, or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Premium: The amount you pay for your health insurance every month. In addition to your premium, you usually have to pay other costs for your health care, including a deductible, copayments, and coinsurance.

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

Reasonable and Customary: The amount of money a health plan determines is the normal or acceptable range of charges for a specific health-related service or medical procedure. If your health care provider submits higher charges than what the health plan considers normal or acceptable, you may have to pay the difference.

Specialist: A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

REQUIRED NOTICES

PLAN NOTICES, DISCLOSURES & LEGAL DOCUMENTS

Note to All Employees

Certain Federal Regulations require employers to provide disclosures of these regulations to all employees. The remainder of this document provides you with the required disclosures related to our employee benefits plan. If you have any questions or need further assistance, please contact your Plan Administrator as follows:

ASB Sports Acquisition Inc
11500 Tailwinds Drive
Swanton, OH 43558
(567) 703-0732
peg.sanders@game-one.com

For General Inquiries, please contact the Benefits Department at **Payroll@Game-One.com**

NOTICE REGARDING SPECIAL ENROLLMENT RIGHTS

This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

If you are declining 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).

If you have a new dependent as a result of a 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, or placement for adoption. (Note pre-tax payments may not be made for retroactive coverage due to marriage.)

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

To request special enrollment or obtain more information, please contact your Plan Administrator (identified at the beginning of this section).

NOTICE REGARDING WOMEN'S HEALTH AND CANCER RIGHTS ACT (JANET'S LAW)

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Refer to your benefit materials for specific deductibles and coinsurance that apply.

If you would like more information on WHCRA benefits, please call your Plan Administrator (identified at the beginning of this section).

NEWBORN & MOTHERS HEALTH PROTECTION NOTICE

For maternity hospital stays, in accordance with federal law, the Plan does not 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 delivery.

However, federal law generally does not prevent the mother's or newborn's attending care provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). The plan cannot require a provider to prescribe a length of stay any shorter than 48 hours (or 96 hours following a Cesarean delivery).

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% (indexed) of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution - as well as your employee contribution to employer-offered coverage - is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact your Plan Administrator (identified at the beginning of this section). The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost.

Please visit www.**HealthCare.gov** for more information, including online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

MEDICARE NOTICE

You must notify ASB Sports Acquisition when you or your dependents become Medicare eligible. ASB Sports Acquisition is required to contact the insurer to inform them of your Medicare status. Federal law determines whether Medicare or the group health plan is the primary payer. You must also notify Medicare directly that you have group health insurance coverage. Privacy laws prohibit Medicare from discussing coverage with anyone other than the Medicare beneficiary or their legal guardian. The toll-free number to Medicare Coordination of Benefits is **1-855-797-2627**.

If you have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices in your prescription drug plan. Please see the complete Medicare Part D Coverage Notice(s) that follow(s).

Medicare Part D Coverage Notice – Important Information About Your Prescription Drug Coverage and Medicare

Please note that the following notice only applies to individuals who are or will become eligible for Medicare in the next 12 months.

Medicare eligible individuals may include employees, spouses or dependent children who are Medicare eligible for one of the following reasons:

- Due to the attainment of age 65
- Due to certain disabilities as determined by the Social Security Administration
- Due to end-stage renal disease (ESRD)

You are responsible for providing this notice to your spouse, your domestic partner or any dependent who is or will become Medicare eligible in the next 12 months. If your spouse, your domestic partner or any dependent resides at a different address then you, please contact us to provide that individual's address as soon as possible.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with ASB Sports Acquisition 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:

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.

The prescription drug coverage offered by the Group Health Plan 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 15 through December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. The prescription drug coverage is part of the Group Health Plan and cannot be separated from the medical coverage. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. You have the option to waive the coverage provided under the Group Health Plan due to your eligibility for Medicare. If you decide to waive coverage under the Group Health Plan due to your Medicare eligibility, you will be entitled to re-enroll in the plan during the next open enrollment period.

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 through the Group Health Plan 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 19 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 your Plan Administrator (identified at the beginning of this section). You will receive this notice each year and again if this coverage through your company 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 U.S. Social Security on the web at **www.socialsecurity.gov** or call **1-800-772-1213 (TTY 1-800-325-0778)**.

SUMMARY OF BENEFITS & COVERAGE (SBC)

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

The Summary of Benefits & Coverage (SBC) is a document intended to help people understand their health coverage and compare health plans when shopping for coverage. The federal government requires all healthcare insurers and group healthcare sponsors to provide this document to plan participants. SBCs will be created for each medical plan offered.

Group health plan sponsors must provide a copy of the SBC to each employee eligible for coverage under the plan. The SBC includes:

- A summary of the services covered by the plan
- A summary of the services not covered by the plan
- A glossary of terms commonly used in health insurance
- The copays and/or deductibles required by the plan, but not the premium
- Information about members' rights to continue coverage
- Information about members' appeal rights
- Examples of how the plan will pay for certain services

The SBCs are available electronically on ADP. A paper copy is also available, free of charge, by calling your benefits administrator at 567-703-0732 or submitting your request by email to **Payroll@game-one.com**.

CHIP NOTICE

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 Game One, 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 on the following page, 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, dial **1-877-KIDS NOW**, or visit **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility.

To see if any other states have added a premium assistance program since July 31, 2025 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

STATE	WEBSITE/EMAIL	PHONE
Alabama (Medicaid)	http://www.myalhipp.com/	1-855-692-5447
Alaska (Medicaid)	Premium Payment Program: http://myakhipp.com/ Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx E-mail: CustomerService@MyAKHIPP.com	1-866-251-4861
Arkansas (Medicaid)	http://myarhipp.com/	1-855-692-7447
California (Medicaid)	http://dhcs.ca.gov/hipp hipp@dhcs.ca.gov	916-445-8322 916-440-5676(fax)
Colorado (Medicaid and CHIP)	Medicaid: https://www.healthfirstcolorado.com/ CHIP: https://hcpf.colorado.gov/child-health-plan-plus HIBI: https://www.mycohibi.com/	1-800-221-3943 1-800-359-1991 1-855-692-6442 State relay 711
Florida (Medicaid)	https://www.flmedicaidtplrecovery.com/ flmedicaidtplrecovery.com/hipp/index.html	1-877-357-3268 34

STATE	WEBSITE/EMAIL	PHONE
New York (Medicaid)	https://www.health.ny.gov/health_care/medicaid/	1-800-541-2831
North Carolina (Medicaid)	https://medicaid.ncdhhs.gov/	919-855-4100
North Dakota (Medicaid)	https://www.hhs.nd.gov/healthcare	1-844-854-4825
Oklahoma (Medicaid and CHIP)	http://www.insureoklahoma.org	1-888-365-3742
Oregon (Medicaid)	http://healthcare.oregon.gov/Pages/index.aspx	1-800-699-9075
Pennsylvania (Medicaid and CHIP)	Medicaid: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx CHIP: https://www.dhs.pa.gov/chip/pages/chip.aspx	Medicaid: 1-800-692-7462 CHIP: 1-800-986-KIDS(5437)
Rhode Island (Medicaid and CHIP)	http://www.eohhs.ri.gov/	1-855-697-4347 or 401-462-0311 (Direct RIte)
South Carolina (Medicaid)	https://www.scdhhs.gov	1-888-549-0820
South Dakota (Medicaid)	http://dss.sd.gov	1-888-828-0059
Texas (Medicaid)	https://www.hhs.texas.gov/services/financial/ health-insurance-premium-payment-hipp-program	1-800-440-0493
Utah (Medicaid and CHIP)	Medicaid: https://medicaid.utah.gov/ CHIP: http://health.utah.gov/chip	1-877-543-7669
Vermont (Medicaid)	https://dvha.vermont.gov/members/medicaid/hipp-program	1-800-250-8427
Virginia (Medicaid and CHIP)	https://coverva.dmas.virginia.gov/learn/premiumassistance/ famis-select https://coverva.dmas.virginia.gov/learn/premiumassistance/ health-insurance-premium-payment-hipp-programs	1-800-432-5924
Washington (Medicaid)	https://www.hca.wa.gov/	1-800-562-3022
West Virginia (Medicaid)	https://dhhr.wv.gov/bms/http://mywvhipp.com/	Medicaid: 304-558-1700 CHIP: 1-855-699-8447
Wisconsin (Medicaid and CHIP)	https://www.dhs.wisconsin.gov/badgercareplus/p-10095. htm	1-800-362-3002
Wyoming (Medicaid)	https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/	1-800-251-1269

This brochure highlights the main features of the Game One Employee Benefits Program. It does not include all plan rules, details, limitations, and exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be an inconsistency between this brochure and the legal plan documents, the plan documents are the final authority. Game One reserves the right to change or discontinue its employee benefits plans at any time.