NOVEMBER 2023

23 RESTAURANT SERVICES

BENEFITS GUIDE

FOR HOURLY EMPLOYEES

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[23RS 1-4-7]

23 RESTAURANT SERVICES AND 1-4-7

As the trusted hospitality champion for iconic brands, 23 Restaurant Services prides ourselves on 1-4-7: one mission and vision, four commitments and seven principles.

MISSION:

As devoted partners and brand stewards, our mission is to create connections for iconic brands. Our delicious, immersive, and innovative experiences entertain and leave people craving more.

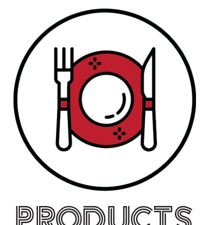
VISION:

Our vision is to be the trusted hospitality champion for iconic brands.

COMMITMENTS:

OUR PEOPLE ARE THE SOURCE OF OUR STRENGTH.

WE ARE BRAND AMBASSADORS AND PASSIONATELY REPRESENT.



WE CREATE "VIBE" WITH DELICIOUS AND IMMERSIVE EXPERIENCES.

OUR SALES AND PROFITS DRIVE FUTURE GROWTH AND OPPORTUNITY.

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PRINCIPLES:

DARE TO BE COURAGEOUS AND EMBRACE WHAT'S NEXT.

GREAT IS NOT GOOD ENOUGH. BE A BADASS!

SELFLESS CONVICTION TO MAKE THE RIGHT CHOICE.

TRUST EACH OTHER. EARN IT. GIVE IT.

STRONGER TOGETHER. WE ARE ONE TEAM.

WORK WITH PURPOSE. YOU'RE NOT BREAKING ROCKS; YOU'RE BUILDING A CATHEDRAL.

BRING THE ENERGY. LOVE WHAT YOU DO.

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[FOURTH EMPLOYEE PORTAL]

Fourth Employee Portal

What is Fourth?

Fourth is your one-stop-shop for things like pay stubs, benefits / open enrollment, PTO, tax document info, team member discounts, and more!

Accessing the Portal

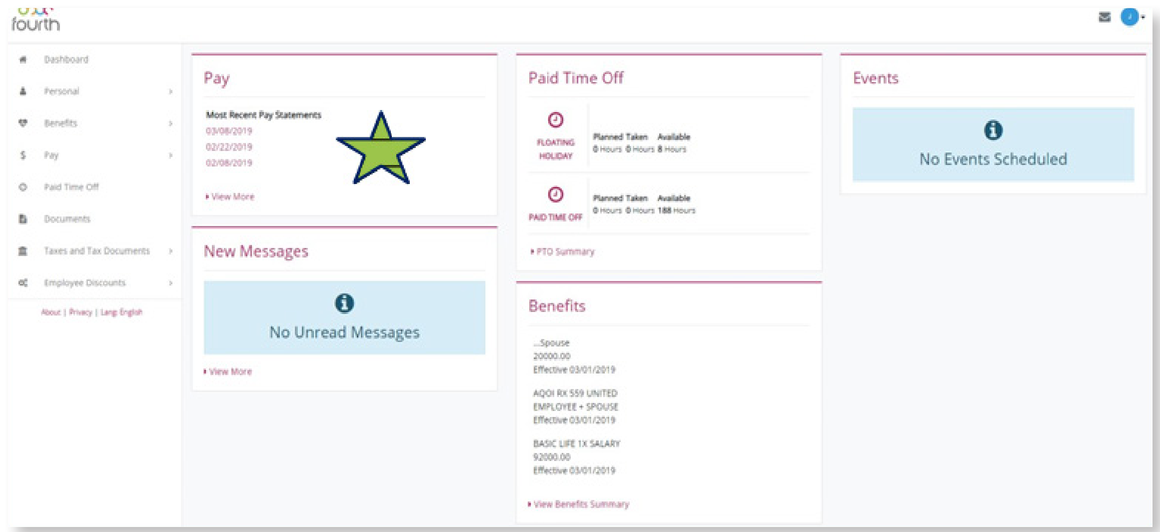
1. Navigate to www.fourth.com, click on **Login**, and then select **Fourth Payroll (Employee)**.

2. If you haven't already created a username, click on **Register** to create a new one.

   Please note:

   - Registration information must match exactly to hiring information for the system recognize the account.
   - If you previously registered, enter in the same username and password you have always used. You do not need to register again, even if you worked for another employer.

3. Once registered and logged in, you will be directed to your personal dashboard which displays a quick view of some of your most important employment information.



Don't forget to take advantage of our Fourth provided Employee Discount programs. Click on the Employee Discounts tab to begin. The code to join Tickets at Work is FOURTH.

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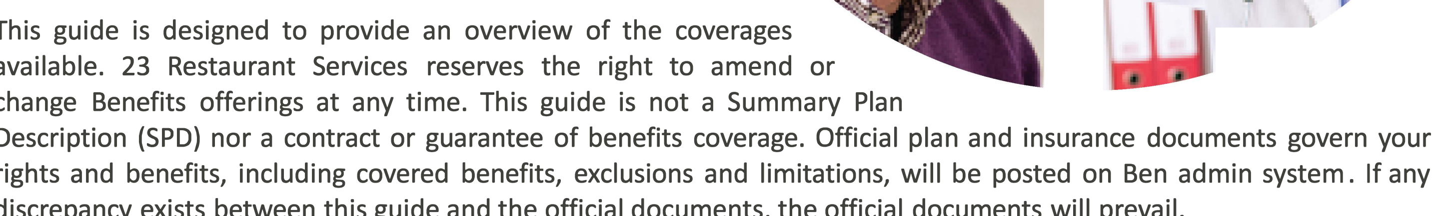
[BENEFITS OVERVIEW]

OUR COMMITMENT



23 Restaurant Services understands the importance of offering valuable benefits to our employees. Since the company's inception, we have endeavored to provide plan and coverage options to employees and their families, understanding the needs of each family are different.

This guide is designed to provide an overview of the coverages available. 23 Restaurant Services reserves the right to amend or change Benefits offerings at any time. This guide is not a Summary Plan Description (SPD) nor a contract or guarantee of benefits coverage. Official plan and insurance documents govern your rights and benefits, including covered benefits, exclusions and limitations, will be posted on Ben admin system. If any discrepancy exists between this guide and the official documents, the official documents will prevail.

WHO TO CONTACT

Coverage / Provider	Contact For?	Phone Number	Website / Email
Fourth Benefits	General Benefits Questions	877-315-0004 ext. 3	www.fourth.com
BKS Partners (Medical Insurance Only)	Employee Care Center	866-784-2242	mybenefits@bks-partners.com
United Healthcare	Medical	866-414-1959	www.myuhc.com
TASC	FSA / HSA	800-422-4661	www.tasconline.com
MetLife	Dental / Vision	800-638-5433	www.metlife.com/mybenefits
MetLife	Life and AD&D	800-638-5433	www.metlife.com/mybenefits
Lincoln	Disability: Lincoln	800-423-2765	www.lincoln4benefits.com
Principal	Disability: Principal	800-843-1371	www.principal.com

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[BENEFIT ENROLLMENT INSTRUCTIONS]

How To Enroll

1. Visit https://ces-ep.prismhr.com

2. Review the benefits available to you.

3. Choose the plans that best meet your needs and fit your budget.

Take advantage of all the helpful information and resources available on the enrollment site.

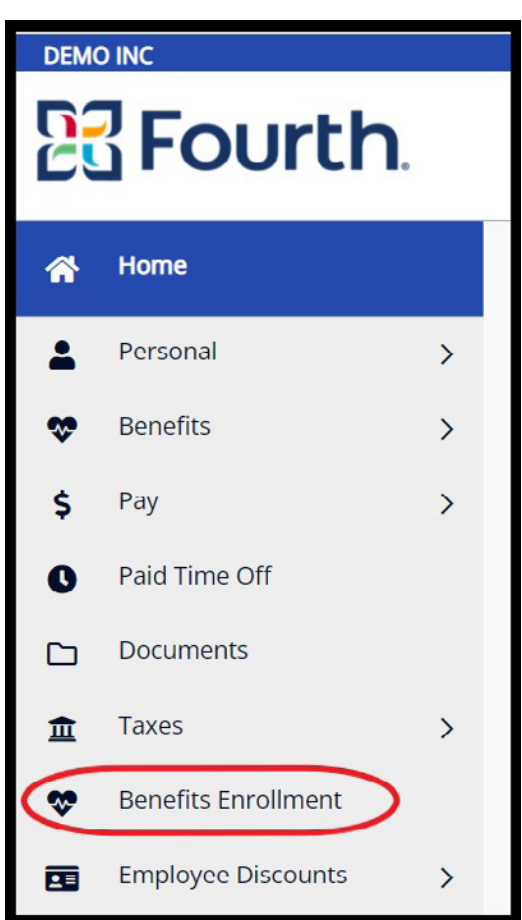
As you enroll, you'll find key information displayed for each plan, including coverage details and cost. You'll also find a variety of tools, educational videos, and reference documents to help you better understand your benefits.

What you need to get started

– Your Social Security Number
– Dependent's SSN & Dates of Birth

You will receive an **email notification** with a link to start your enrollment, but you can also start your enrollment by logging into:

1. www.fourth.com
2. Select Fourth Payroll Employee Login
3. Select **Benefits Enrollment** which will take you to the Welcome to the Benefit Enrollment Platform



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Entering Dependent Profiles

The system will now take you to the Dependent Information section: To enter a dependent, click the icon to add dependent, select the relationship of the dependent, for example Wife, Husband, Son, Daughter or Domestic Partner.

Then, enter First name, Middle Initial, and Last Name of your dependent.

Next, select Gender (Male or Female). Last, key in Social Security Number and click save.

Note: *You only need to add dependents that you would like to enroll for coverage. You will choose which dependents to enroll for each plan when you reach the election screen.*

Making Benefit Plan Elections

Click the "Next" button at the bottom of the screen. The system will take you to a Benefit Plan on the Benefit Enrollment Platform. Each benefit plan and your options will be displayed one by one.

To enroll in a plan, click on the plan you desire, and it will turn green.

Completing Your Enrollment

Once you have completed your enrollment for every plan, the system will take you to the Benefit Summary page.

This screen shows you a summary of the benefit elections you made and your premium amounts in total. If you need to logoff before completing enrollment, any data you entered will be saved. The next time you log on, you will be taken directly to the last saved screen.

To complete the enrollment process:
Please Click "Submit."

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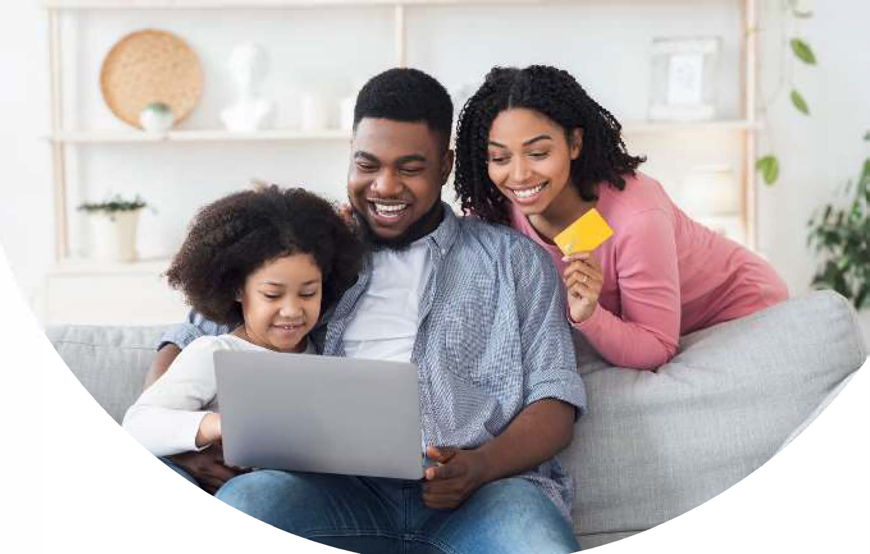
[ELIGIBILITY FOR FULL-TIME TEAM MEMBERS]

WHO IS ELIGIBLE



TEAM MEMBERS

Team members with full-time status, who work at least 30 hours a week, are eligible for insurance benefits effective on the first of the month following the date of hire.

DEPENDENTS

You may also elect coverage for your dependents in some circumstances. Eligible dependents may include your spouse, domestic partner, and dependent children. The term children includes:

- A natural or legally adopted child.
- A foster child, if placed in your home with state statutes prior to their 18th birthday.
- A spouse's child(ren) residing with you and dependent upon for your support; or a child whom you or your spouse have a legal obligation to support, even though not living with you.

COVERAGE	MAX AGE	END DATE	COVERAGE EXCEPTIONS*
Medical	Up to age 26; 30 FL Statute	End of the calendar year in which the child reaches the maximum age	Coverage from age 26 - 30 if they: 1. Are unmarried 2. Have no dependents of their own 3. Live in the same state as employee or are a full-time, out-of-state student 4. Don't have coverage as a named subscriber/covered person under any group health insurance plan including group, blanket or franchise health policy. 5. Do not have individual health insurance or entitle benefits under Medicare

**It is your responsibility to notify HR of a dependent's change in eligibility status. See HR for any extension requests.*

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Changing Your Benefits
Section 125 & Pre-Tax Benefits

Some of the benefits offered by Fourth are covered under the IRS Section 125 Plan. This plan allows your premium contributions to be taken out of your paycheck before taxes are applied. This results in a greater take-home pay for you. Because your premiums are taken from your paycheck on a pre-tax basis, the IRS requires that you only make the changes to your elections during open enrollment or when you experience a qualifying life event.

Examples of Qualifying Life Events Include

Marriage, Divorce, Legal Separation or Annulment

Birth, Adoption, Death of a Child or Spouse

Qualified Medical Child Support Order (QMCSO)

Change in your Dependent(s) Eligibility Status

Loss of Coverage from Another Plan

Change in your Residence or Workplace (if your Benefit Options Change)

Loss of Coverage through Medicaid or Children's Health Insurance Program (CHIP)

Eligibility for a state's Employer Plan Premium Assistance Program

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[MEDICAL INSURANCE]

Summary Plan
Description & Benefit Coverage

Summary Plan Description

Please note this guide is designed to provide an overview of the coverages available. Your employer reserves the right to amend or change benefit offerings at any time.
This guide is not a Summary Plan Description (SPD) nor a contract or guarantee of benefits coverage.
Official plan and insurance documents govern your rights and benefits, including covered benefits, exclusions, and limitations. *If any discrepancy exists between this guide and the official documents, the official documents will prevail.* If you would like a printed copy of the materials, please contact Fourth and one will be provided for you.

Summary of Benefit Coverage

The Patient Protection and Affordable Care Act (Affordable Care Act or ACA) requires health plans and health insurance issuers to provide a Summary of Benefits and Coverage (SBC) to applicants and enrollees. **The SBC is provided by your Medical carrier.** Its purpose is to help health plan consumers better understand the coverage they have and to help them make easy comparisons of different options when shopping for new coverage. This information is available when you apply for coverage, by the first day of coverage (if there are any changes), when your dependents are enrolled off your annual open enrollment period, upon plan renewal and upon request at no charge to you.

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MEDICAL INSURANCE

Provider Network: NHP / INS Choice Plus

PLAN BASICS	FL NHP HMO DBZ8 HSA RX NH21-HSA	FL INS Choice Plus PPO DB66-M HSA RX 570 - HSA	FL NHP HMO OA Plan DBPU RX NH11	FL INS Choice Plus Plan CRXC RX
Calendar Year Deductible				
Individual	$5,000	$5,000	$3,000	$3,000
Family (Individual/Family Max)	$5,000 / $10,000	$5,000 / $10,000	$3,000 / $6,000	$3,000 / $6,000
Out-of-Pocket Maximum	All Covered Expenses		Includes Deductible, Per Admission Deductible, Copays & Rx	
Individual	$6,500	$8,050	$8,500	$7,500
Family (Individual/Family Max)	$6,500 / $13,000	$8,050 / $16,100	$8,500 / $17,000	$7,500 / $15,000
Coinsurance (Amount Member Pays)	20%	20%	20%	20%

HEALTH BENEFITS	FL NHP HMO DBZ8 HSA RX NH21-HSA	FL INS Choice Plus PPO DB66-M HSA RX 570 - HSA	FL NHP HMO OA Plan DBPU RX NH11	FL INS Choice Plus Plan CRXC RX
Office Visit Copay				
Preventive	$0	$0	$0	$0
Primary Care Physician	20% after deductible	20% after deductible	$10	$0
Specialist	20% after deductible	20% after deductible	Designated: $40 Network: $80	$100
In-Patient Hospital Visit	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Outpatient Surgery—Hospital	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Outpatient Surgery—Ambulatory	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Emergency Room Visit	20% after deductible	20% after deductible	20% after $300 POD and deductible	20% after $250 POD and deductible
Urgent Care Visit	20% after deductible	20% after deductible	$40	$75

INDEPENDENT LAB AND DIAGNOSTIC TESTING	FL NHP HMO DBZ8 HSA RX NH21-HSA	FL INS Choice Plus PPO DB66-M HSA RX 570 - HSA	FL NHP HMO OA Plan DBPU RX NH11	FL INS Choice Plus Plan CRXC RX
Lab	20% after deductible	20% after deductible	$40	20% after deductible
X-Ray	20% after deductible	20% after deductible	$40	20% after deductible
Advanced Imaging (MRI, PET, CT Scans)	Designated: 20% after deductible	Designated: 20% after deductible	Designated: $500	20% after deductible

OUT-OF-NETWORK BENEFITS	FL NHP HMO DBZ8 HSA RX NH21-HSA	FL INS Choice Plus PPO DB66-M HSA RX 570 - HSA	FL NHP HMO OA Plan DBPU RX NH11	FL INS Choice Plus Plan CRXC RX
Deductible (Individual / Family)	Not Covered	$10,000 / $20,000	Not Covered	$10,000 / $20,000
Coinsurance (Amount Member Pays)		50%		50%
Out-of-Pocket Max (Individual / Family)		$20,000 / $40,000		$20,000 / $40,000

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PRESCRIPTION BENEFITS

PRESCRIPTION BENEFITS	FL NHP HMO DBZ8 HSA RX NH21-HSA	FL INS Choice Plus PPO DB66-M HSA RX 570 - HSA	FL NHP HMO OA Plan DBPU RX NH11	FL INS Choice Plus Plan CRXC RX
Tier 1	$10 after Ded.	$10 after Ded.	$10	$10
Tier 2	$35 after Ded.	$35 after Ded.	$60	$50
Tier 3	$70 after Ded.	$70 after Ded.	$100	$85
Specialty	See PDL	See PDL	See PDL	See PDL
Mail Order Rx (90-day supply)	2.5 x Tier Copay	2.5 x Tier Copay	2.5 x Tier Copay	2.5 x Tier Copay

$

Tier 1

Typically generics. Lowest-cost medications that have the same strength and active ingredients as the brand name, but often cost much less – in some cases, up to 85% less.

$$

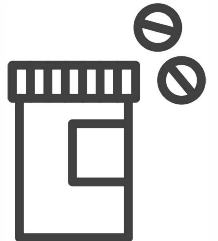
Tier 2

Typically preferred brand medications. Medium-cost medications. These medications usually cost more than generics, but may cost less than non-preferred brands.

$$$

Tier 3

Higher-cost medications. These medications usually have generic and/or preferred brand alternatives that are used to treat the same condition.



MAIL ORDER RX

With United Healthcare mail services, you can get your medicines sent right where you want them. Skip driving to the pharmacy and don't wait in line for your prescriptions to be filled. Plain, unmarked packaging protects your privacy. You can receive up to a 90-day supply of long-term medicine at a time. Call 866-414-1959 or visit www.myuhc.com.

DID YOU KNOW?

Some retailers, pharmacies, and drug manufacturers have discount programs or coupons that may help you save money. Talk to your pharmacy or provider for more information, or you can use websites like GoodRx.com to check your prescribed medications for options like this.

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MEDICAL RATES

WEEKLY (52) DEDUCTIONS *Hourly Team Members*	FL NHP HMO DBZ8 HSA RX NH21-HSA	FL INS Choice Plus PPO DB66-M HSA RX 570 - HSA	FL NHP HMO OA Plan DBPU RX NH11	FL INS Choice Plus Plan CRXC RX
Team member Only	$37.40	$91.31	$108.24	$130.45
Team member + Spouse	$216.39	$296.93	$321.31	$374.16
Team member + Child(ren)	$146.34	$216.46	$237.93	$278.79
Team member + Family	$312.37	$407.19	$435.57	$504.84

KEY TERMS TO KNOW

Copay

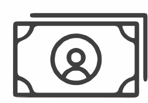
A fixed dollar amount that you pay for certain covered services. Typically, your copay is due up front at the time of service.

Deductible

The amount that you must pay each year for certain covered health services before the insurance plan will begin to pay.

Coinsurance

After you meet your deductible, you may pay a coinsurance, which is your share of the costs of a covered service.



Out-of-Pocket Maximum

Includes copays, deductibles, and coinsurance. Once you meet this amount, the plan will pay 100% of covered services the rest of the year.

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[HEALTH SAVINGS ACCOUNT]

HEALTH SAVINGS ACCOUNT

A health savings account (HSA) is a benefit that allows you to choose how much of your paycheck you'd like to set aside, before taxes are taken out, for healthcare expenses or use as a retirement savings tool.

If you enroll in a high deductible health plan (HDHP), you are eligible to enroll in the HSA offered by 23 Restaurant Services , bank information and options will be found in Fourth.

See the chart below for the IRS-mandated annual HSA contribution maximums.

HSA CONTRIBUTION MAXIMUM (Employee Funds)	
Individual	$4,150
Individual + 1 or more	$8,300
Catch up contribution (over age 55)	$1,000

USING YOUR FUNDS

Upon your enrollment, you will receive a debit card, which can be used at the time of purchase of HSA-eligible items.

The account acts like a regular checking account with a debit card that accrues interest. All money in the account is owned by you and is fully vested as soon as it is deposited. Funds can accumulate over time and the account is portable. Any unused monies left in your HSA at the end of the calendar year will roll over to the next year for you to use.

When you use the funds for qualified health expenses, you will not pay taxes. If you use the money for other expenses, you'll pay a tax and a penalty fee.

WHAT DOES IT COVER?

There are thousands of HSA-eligible items. The list includes, but is not limited to:

- Copays, coinsurance
- Doctor visits and surgeries
- Over-the-counter medications
- Dental and orthodontia
- Vision expenses, such as frames, contacts, prescription sunglasses, etc.

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Save money on healthcare expenses for today *and* tomorrow.

A Health Savings Account (HSA) works with your High Deductible Health Plan (HDHP) and lets you set aside a portion of your paycheck—before taxes—into an account.

Use your HSA funds to help pay for medical expenses that aren't covered by your HDHP. Any leftover funds can be transfered into the HSA Investment Account year after year for future growth!

HEALTHCARE EXPENSES

- Deductibles, copays, coinsurance
- Medical care, prescriptions, vaccinations
- Dental/orthodontic care services
- Eye exams; prescription eye wear

It's simple. It's smart. It'll save you money and help you plan for future medical expenses.

- Each $1 you contribute to your HSA reduces your taxable income by $1.
- Your employer may offer other types of Benefit Accounts too; ask for details
- For a complete list of eligible expenses, see IRS Publications 502 & 969 at **irs.gov**

A triple tax advantage.

The HSA is a tax-advantaged investment vehicle that offers three separate tax benefits:

1. Contributions into an HSA are pretax.
2. Earned interest on investment funds is tax-free.
3. Withdrawals for qualified medical expenses are tax-free.

Pay for current healthcare expenses with tax-free monies and save tax-free for future healthcare costs.

Similar to a Roth IRA, earned interest grows tax-free but you also get the benefit of a current pretax deduction.

You own the HSA.

You are the account-owner of an HSA, not your employer. The account and its funds stay with you, even if you change jobs. The account also stays active if you're no longer covered by an HDHP.

In addition, your HSA funds never expire and may be used for expenses incurred any year beyond enrollment into the TASC HSA plan.

With an HSA, you have more control, ownership, and stability when it comes to your healthcare.

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How to participate.

It's easy to start saving with a TASC HSA. Just follow 3 simple steps:

1. DECIDE how much you want contribute for the upcoming plan year

The more you contribute, the lower your taxable income will be. And with no risk of forfeiture, you can contribute the annual maximum every year. Leftover funds will rollover or may be transferred to the investment account (funds in excess of $2000). Also consider:

- The money you contribute to the TASC HSA can only be used for qualified healthcare expenses *(until age 65)*.
- You can make contributions anytime during the Plan Year, up to the annual maximum, and withdraw funds anytime, tax-free.
- You can use the HSA to save for medical expenses in retirement, when healthcare expenses generally rise.

PLANNING TIPS

You and your employer can contribute money into your TASC HSA, up to an annual per person or family limit set by the IRS.

View current IRS limits at: **www.tasconline.com/benefits-limits.**
If your estimated expenses are higher than the annual contribution limits, consider making the maximum contribution allowed.

2. ENROLL by completing the online enrollment process each year

Your contribution will be deducted in equal amounts from each paycheck, pretax, throughout the plan year. HSA funds are only available as money is contributed *(money in, money out)*.

When you enroll online and set up your TASC HSA investment accounts, you'll be given access to a secure, easy-to-use web portal where you can access and manage your account.

SPECIAL FEATURES

Individual Giving Account: Every participant receives a complimentary TASC giving account.

Identify Theft Protection: All active participants receive TASC Identity Theft Protection.

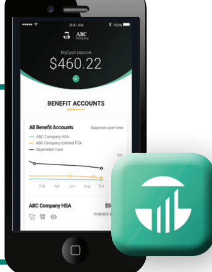
3. ACCESS your funds easily using the TASC Card

This convenient card automatically approves and deducts most eligible purchases from your benefit account with no paperwork required. Plus, for purchases made without the card, you can request reimbursement online, by mobile app, or using a paper form.

Reimbursements happen fast — within 12 hours — when you request to have them added to the MyCash balance on your TASC Card. You can use the MyCash balance on your card to get cash at ATMs or to buy anything you want anywhere Mastercard is accepted!

Track and manage all TASC benefits and access numerous helpful tools, anywhere and anytime—with just one app!

Search for "TASC" (green icon)



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[FLEXIBLE SPENDING ACCOUNT]

Financial Protection
Flexible Spending Accounts (FSAs)

FSAs are **"use-it-or-lose-it"** accounts. You will forfeit any amount remaining in the account at the end of the plan year.*

Tax-advantaged Flexible Spending Accounts or FSAs are a great way to save money. The money you contribute to these accounts comes out of your paycheck without being taxed, and you withdraw it tax-free when you pay for eligible health care and dependent care expenses.

Fourth Offers You The Following FSAs

Health Care FSA

Pay for eligible health care expenses, such as plan deductibles, copays, other health care, dental, vision, prescription and Over-The-Counter (OTC) medications/ supplies expenses, and coinsurance for you and your dependents.**

Contribute up to **$3,200**

Dependent Care FSA

Pay for eligible dependent care expenses, such as day care for a child, babysitters, summer non-overnight day camps, and home care for dependent elders, and related expenses so you and/or your spouse can work, look for work, or attend school full time.**

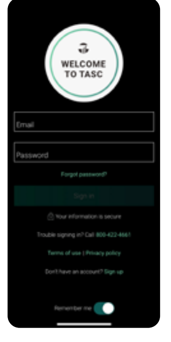
Contribute up to **$5,000 or $2,500** if you are married and file separate tax returns.

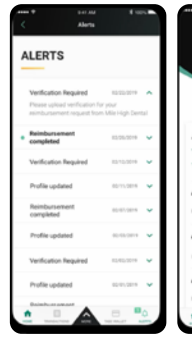
** No unused funds will rollover from 2024 to 2025 so you must use all funds prior to 1/1/2025.*
*** To learn more, see IRS Publication 502 at www.irs.gov.*
Enrollment for HSAs/FSAs will occur separately during December

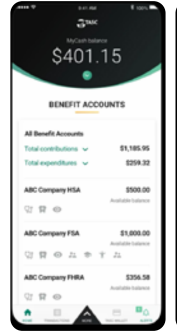
TASC Account Management Tools

When you enroll in a Health Care FSA, you will receive a debit card, which you can use to pay for eligible expenses. Depending on the transaction, you may need to submit receipts or other documentation to your FSA administrator.

Debit Card for Healthcare FSA







Smart Phone App for iPhones and Androids

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Save up to 30% on eligible expenses

Enroll in a TASC Flexible Spending Account (FSA) so you can use pretax dollars to pay for common, everyday expenses and reduce your taxable income.

Below is a partial list of reimbursable expenses that may be incurred by you, your spouse, or qualified dependents.
NOTE: If you (or your spouse) enroll in an HSA Plan, you may only enroll in a Limited-Purpose Healthcare FSA (LPFSA). The eligible expenses under an LPFSA are limited to Dental and Vision expenses only.

Eligible Medical Expenses

- Acupuncture
- Artificial limbs
- Bandages
- Birth control, contraceptive devices
- Birthing classes/Lamaze – only the mother's portion (not the coach/spouse) and the class must be only for birthing instruction, not child rearing
- Blood pressure monitor
- Chiropractic therapy/exams/adjustments
- Contact lens and contact lens solutions
- Co-payments
- Crutches (purchased or rented)
- Deductibles and co-insurance
- Diabetic supplies
- Eye exams
- Eyeglasses, contacts, or safety glasses (prescription)
- Flu shots
- Hearing aids and hearing aid batteries
- Heating pad
- Incontinence supplies
- Infertility treatments
- Insulin
- Lactation expenses (breast pumps, etc.)
- Laser eye surgery; LASIK
- Legal sterilization
- Medical supplies to treat an injury or illness
- Mileage to and from doctor appointments
- Nasal strips
- Optometrist's or ophthalmologist's fees
- Orthopedic inserts
- Physical exams
- Physical therapy (as medical treatment)
- Physician's fee and hospital services
- Pregnancy test
- Prescription drugs and medications
- Psychotherapy, psychiatric and psychological service
- Sales tax on eligible expenses
- Sleep apnea services/products (as prescribed)
- Smoking cessation programs
- Treatment for alcoholism or drug dependency
- Vaccinations
- Wrist supports, elastic wraps
- X-ray fees

Eligible OTC Medicines and Drugs

As of January 1, 2020, over-the-counter (OTC) medicines and drugs are reimbursable via FSA, HRA, and HSA.

- Bengay, Flexall, pain relieving creams or gels
- Calamine lotion
- Canker/cold sore relievers
- Cold medicines
- Corn removal
- Diaper rash ointment
- GasX, baby gas drops
- Hemorrhoid creams and treatments
- Hydrogen peroxide or rubbing alcohol
- Indigestion or anti-acid relievers
- Laxatives
- **NEW: Menstrual care products**
- Nicotine patch
- Pain relievers (Tylenol, Advil, Aspirin, etc.)
- Sinus medicines
- Suppositories
- Teething gel
- Wart removal medication

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Use your TASC Card to pay for eligible expenses at the point of purchase instead of paying out-of-pocket and requesting a reimbursement.

Eligible Dental Expenses

- Braces and orthodontic services
- Cleanings
- Crowns
- Deductibles, co-insurance
- Dental implants
- Dentures, adhesives
- Fillings

Eligible Dependent Care Expenses

- Fees for licensed day care or adult care facilities
- Before and after school care programs for dependents under age 13
- Amounts paid for services (including babysitters or nursery school) provided in or outside of your home
- Nanny expenses attributed to dependent care
- Nursery school (preschool) fees
- Summer Day Camp – primary purpose must be custodial care and not educational in nature
- Late pick-up fees
- Does not cover medical costs; use Healthcare FSA for medical expenses incurred by you or your dependents

For more information regarding eligible expenses, please review IRS Publication 502/503 at **irs.gov** or ask your employer for a copy of your Summary Plan Description (SPD).

Eligible Disability Expenses

- Automobile equipment and installation costs for a disabled person in excess of the cost of an ordinary automobile; device for lifting a mobility impaired person into an automobile
- Braille books/magazines in excess of cost of regular editions
- Note-taker for a hearing impaired child in school
- Seeing eye dog (buying, training, and maintaining)
- Special devices, such as a tape recorder or typewriter for a visually impaired person
- Visual alert system in the home or other items such as a special phone required for a hearing impaired person
- Wheelchair or autoette (cost of operating/ maintaining)

Requiring Additional Documentation

The following expenses are eligible only when incurred to treat a diagnosed medical condition. Such expenses require a ***Letter of Medical Necessity*** from your physician, containing the medical necessity of the expense, diagnosed condition, onset of condition, and physician's signature.

- Ear plugs
- Massage treatments
- Nursing services for care of a special medical ailment
- Orthopedic shoes (excess cost of ordinary shoes)
- Oxygen equipment and oxygen
- Support hose
- Varicose vein treatment
- Veneers
- Vitamins and supplements
- Wigs (for mental health condition of individual who loses hair because of a disease)

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Do your dependent care expenses qualify for reimbursement?

The TASC Dependent Care FSA allows you to use pretax dollars to pay for eligible expenses related to care for your child, disabled spouse, elderly parent, or other dependent who is physically or mentally incapable of self-care, so you (or your spouse) can work, look for work, or attend school full-time. **Medical expenses for your dependent are not eligible for reimbursement under the TASC Dependent Care FSA.**

Eligibility for the dependent care benefit requires that certain criteria be met, which are outlined in this document.

A) **The dependent care expenses must be work-related.** The care must be necessary for the employee and/or the employee's spouse to work, to look for work, or to attend school full-time, or if they are physically unable to care for their children.

B) **The dependent care expenses provided during a calendar year cannot exceed $5,000.** In the case of a separate return by a married individual, the limit is $2,500. This amount may be less if the employee's earned income or spouse's earned income is less than $5,000.

Dependent care expenses must be for the care of one or more qualifying persons.

A "Qualifying Person" is defined as one of the following:

- A dependent child who was under age 13 when care was provided and for whom a tax exemption can be claimed.
- A spouse who was physically or mentally unable to care for themselves and lived with you for more than half the year.
- A dependent who was physically or mentally unable to care for themselves and for whom an exemption can be claimed, and lived with you for more than half the year.

Eligible and Ineligible Expenses for Dependent Care FSA Reimbursement (partial list)

Allowed for Reimbursement:

- ☑ Fees for licensed day care or adult care facilities
- ☑ Before and after school care programs for dependents under age 13
- ☑ Amounts paid for services (including babysitters or nursery school) provided in or outside of your home
- ☑ Nanny expenses attributed to dependent care
- ☑ Nursery school (preschool) fees
- ☑ Summer Day Camp – primary purpose must be custodial care and not educational in nature
- ☑ Late pick-up fees

NOT Allowed for Reimbursement:

- ⃠ Medical expenses
- ⃠ Baby-sitter in or out of your home for reasons other than to enable you to work
- ⃠ Activity fees/educational supplies
- ⃠ Food, clothing, and entertainment
- ⃠ Transportation expenses
- ⃠ Child support payments
- ⃠ Kindergarten fees
- ⃠ Overnight camp
- ⃠ Late payment charges

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For more information regarding eligible Dependent Care expenses, please review IRS Publication 503 or ask your employer for a copy of your Summary Plan Description (SPD).

You can also find current contribution limits on our resource page at:

www.tasconline.com/benefits-limits

To receive the dependent care benefit, one must follow these procedures:

A) All persons and organizations that provide dependent care for a qualified person must be identified. This information is requested on IRS Form 2441. The name, address, and Taxpayer Identification Number (TIN) of the provider must be included. Under certain circumstances, the TIN will be a Social Security number (SSN).

B) If the care is being provided by a center that cares for more than six (6) persons, the center must comply with all state and local regulations.

C) Payments made to relatives who are not dependents can be included; however, do not include amounts paid to a dependent for whom you can claim an exemption or for your child who is under age 19 at the end of the year, regardless of whether they are your dependent.

D) Use IRS Form W-10 to request the required information from the care provider.

Special rules apply to children of divorced or separated parents:

Even if you cannot claim your child as a dependent, they are treated as your qualifying person if all of the following are true:

- The child was under age 13 or was not physically or mentally able to care for themselves.
- One or both parents provided more than half of the child's support for the year and are divorced, legally separated, or lived apart at all times during the last six (6) months of the calendar year.
- One or both parents had custody of the child for more than half of the year.
- You were the child's custodial parent. The custodial parent is the parent having custody for the greater portion of the calendar year. If the child was with both parents for an equal number of nights the parent with the higher adjusted gross income is the custodial parent.

A non-custodial parent that is entitled to claim the child as a dependent on their tax return may not treat the child as a qualifying individual for the dependent care benefit even when that parent is financially responsible for providing the care. Only one parent (the custodial parent) may qualify for the dependent care benefit for a taxable year. The regulations do not provide any relief for a non-custodial parent that incurs dependent care expenses for the portion of the year in which they have custody of the child to enable the non-custodial parent to work.

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[UHC REWARDS]

UHC Rewards

Good news — your health plan comes with a way to earn up to $1,000. UnitedHealthcare Rewards is included in your health plan at no additional cost.

There's so much good to get

With UHC Rewards, a variety of actions—including things you may already be doing, like tracking your steps or sleep—lead to rewards. The activities you go for are up to you, and the same goes for ways to spend your earnings.

Here are just a few of the ways you can earn:

Activity	Reward
Connect a tracker	$65
Take a health survey	$25
Get an annual checkup	$50
Get a biometric screening	$75

Visit UHC Rewards for the full list of rewardable activities that are available to you—and look for new ways of earning rewards to be added throughout the year.

Earn up to

$1,000

There are 2 ways to get started

On the UnitedHealthcare® app

- Scan this code to download the app
- Sign in or register
- Select **UHC Rewards**
- Activate UHC Rewards and start earning
- Though not required, connect a tracker and get access to even more reward activities

On myuhc.com®

- Sign in or register
- Select **UHC Rewards**
- Activate UHC Rewards
- Choose reward activities that inspire you—and start earning

Your health

Get in on an experience that's designed to help inspire healthier habits

Your goals

Personalize how you earn by choosing the activities that are right for you

Your rewards

Earn up to $1,000 for completing rewardable activities

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[ONE PASS SELECT]

One Pass Select

One Pass Select helps you reach your fitness goals, while finding new passions along the way. Choose a membership tier that fits your lifestyle and provides everything you need for whole body health in one easy, affordable plan. You and your eligible family members (18+) can get started with One Pass Select on January 01, 2024.

Find your fit with One Pass Select

At the gym

Choose from our large nationwide network of gym brands and local fitness studios. Use any gym in the network and create a routine just for you.

$29/Mo **Classic** 11,000+ gym locations	**$64/Mo** **Standard** 12,000+ gym and premium locations
$99/Mo **Premium** 14,000+ gym and premium locations	**$144/Mo** **Elite** 16,000+ gym and premium locations

An enrollment fee may apply.
Or get started with a digital-only plan for $10/Mo.

Enroll in One Pass Select starting on January 1, 2024*

*Eligible One Pass Select members will not be able to enroll in One Pass Select until January 01, 2024. More Information on the enrollment process will be provided at a later date.

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[DENTAL BENEFITS]

DENTAL BENEFITS

	MetLife		
	DHMO: Dental HMO/Managed Care	Low PPO: PDP Plus	High PPO: PDP Plus
DEDUCTIBLE			
Individual / Family	See Fee Schedule	$50 / $150	$50 / $150
Calendar Year Maximum	See Fee Schedule	$1,000	$1,500
PREVENTIVE CARE			
Benefit Percentage	See Fee Schedule	0%	0%
OTHER SERVICES			
Basic Services	See Fee Schedule	20%	10%
Major Services	See Fee Schedule	50%	40%
ORTHODONTIA			
Benefit Percentage	See Fee Schedule	Not Covered	50%
Child Only or Child + Adult	See Fee Schedule	Not Covered	Child(ren) to age 19
Lifetime Maximum	See Fee Schedule	Not Covered	$1,000
OUT-OF-NETWORK			
Individual / Family Deductible	Not covered	$100 / $300	$50 / $150
Preventive Services	Not covered	20%	0%
Basic Services	Not covered	30%	20%
Major Services	Not covered	60%	50%
Orthodontia	Not covered	Not covered	50%
Calendar Year Maximum (Preventive, Basic & Major)	Not covered	$1,000	$1,500
Lifetime Maximum (Orthodontia)	Not covered	Not covered	$1,000

WEEKLY (52) DEDUCTIONS	DHMO	Low PPO	High PPO
Employee Only	$2.93	$6.22	$8.34
Employee + Spouse	$5.13	$12.71	$17.04
Employee + Child(ren)	$6.15	$13.61	$19.12
Employee + Family	$8.65	$21.46	$29.82

DID YOU KNOW?

A printed ID card is not needed to receive benefits from dental and vision providers. All members can give their provider their name, carrier and group policy number to verify coverage. Should you need an ID card, you can access it online.

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[VISION BENEFITS]

VISION BENEFITS

	MetLife: VSP	
EYE EXAM	**In-Network**	**Out-of-Network**
Exam Copay	$10	$45 allowance
Frequency	Once every 12 months	
LENSES		
Single Vision	$25	$30 allowance
Bi-focal	$25	$50 allowance
Tri-Focal	$25	$65 allowance
Frequency	Once every 12 months	
FRAMES		
Frame Benefit / Allowance	$130 allowance with 20% discount off balance over the $130 frame allowance. ($70 allowance at Costco, Walmart and Sam's)	$70 allowance
Frequency	Once every 24 months	
CONTACT LENSES		
Elective	Fitting and Evaluation: covered in full with a maximum copay od $60 Contacts: $130 Allowance	$105 allowance
Medically Necessary	$25 copay	$210 allowance
LASER VISION CORRECTION		
Benefit / Discount	Discount Pricing	N/A

WEEKLY (52) DEDUCTIONS

Employee Only	$1.49
Employee + Spouse	$2.99
Employee + Child(ren)	$2.53
Employee + Family	$4.17

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[BENEFITS PROVIDER LOOKUP INSTRUCTIONS]

Benefits Provider
Lookup Instructions

Locating a Medical Provider (United Healthcare)

1. Visit www.uhc.com and select **Find a Provider**. *(Note: Some users may see **Find a Doctor**. If so, select that and then choose **Search as Guest** on the next screen.)*
2. On the next screen, select **Medical Directory**, then click on **Employer and Individual Plans**.
3. Select the appropriate plan:
   - FL NHP (DBZ8 & DBPU): **NHP HMO/POS**
   - INS Choice Plus (DB66-M & CRXC): **Choice Plus**

Locating a Dental Provider (MetLife)

1. Visit www.metlife.com and scroll down to **Find a Dentist**.
2. For PPO select **PDP Plus Network**.
3. For DMHO select **Dental HMO**, DMHO **Type SGX290**.

Locating a Vision Provider (MetLife)

1. Visit www.metlife.com and scroll down to **Find a Vision Provider**.
2. For PPO select **MetLife Vision PPO**.

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[LIFE + AD&D INSURANCE]

LIFE AND AD&D INSURANCE

VOLUNTARY LIFE AND AD&D

Voluntary Life insurance gives you the opportunity to purchase additional life insurance for you and your family. Your cost per pay period is determined by your election. To determine your cost per pay period please log in to Ben admin system.

EMPLOYEE

Increments	$10,000
Maximum	the lesser of $500,000 or 5 x annual earnings.
Guarantee Issue	$150,000

SPOUSE

Increments	$5,000
Maximum	$100,000, not to exceed 50% of the employees elected amount
Guarantee Issue	$50,000

DEPENDENT CHILD(REN)

Increments	$1,000, $2,000, $4,000, $5,000 or $10,000
Maximum	$10,000
Guarantee Issue	$1,000, $2,000, $4,000, $5,000 or $10,000

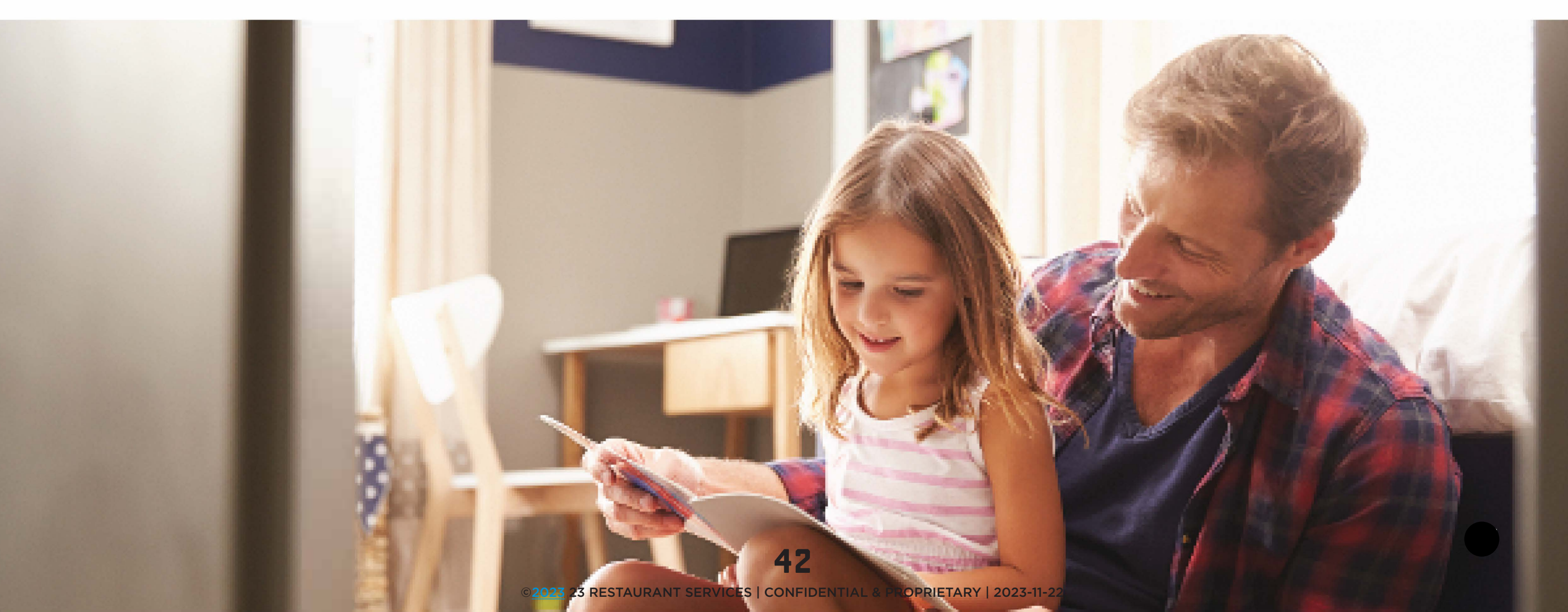
Note: You may be able to port/convert the above policies to individual policies, within 31 days of your employment termination with 23 Restaurant Services . Please contact HR for details.

IMPORTANT INFORMATION

The Guarantee Issue amount means that if you apply for insurance during your initial eligibility period, you're not required to answer health questions to qualify for coverage up to a certain amount.

You and your covered dependents are responsible for completing an Evidence of Insurability (EOI) form if:

- You are electing an amount of coverage greater than the GI amount.
- You waived coverage in the past and now are electing the benefit.
- You are increasing your current election amount.



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[DISABILITY INSURANCE: LTD + STD]

DISABILITY INSURANCE

SHORT-TERM DISABILITY

Short-Term Disability (STD) is insurance for your paycheck. This benefit is setup to help provide you with lost income in the event you become injured or ill for a period of time. STD is voluntary and 100% paid for by the employee. Please log in to Ben admin system for customized rates.

SHORT-TERM DISABILITY BENEFITS: LINCOLN

Benefit Percentage	60%
Maximum Weekly Benefit	$1,000
Elimination Period	Accident: 14 days Illness: 14 days
Benefit Duration	13 weeks
*Pre-Existing Limitation	3 / 6

**Pre-Existing Condition: if you are treated for a condition 3 months prior to the effective date that results in a disability in first 6 months of coverage, you will not receive benefits. Once you have been covered for 6 months the pre-existing clause no longer applies.*

For short-term disability coverage, you are responsible for completing an Evidence of Insurability (EOI) form if you waived coverage in the past and are now electing the benefit. It is your responsibility to complete and submit the EOI form to Lincoln, and it is recommended you keep a copy for your records.

LONG-TERM DISABILITY

Long-Term Disability (LTD) is another benefit available to provide income protection. It provides for long term income continuation if you become disabled from a qualified accidental bodily injury or illness. LTD is voluntary and 100% paid for by the employee.

LONG-TERM DISABILITY BENEFITS: LINCOLN

Benefit Percentage	60%
Maximum Monthly Benefit	$5,000
Elimination Period	90 days
Own Occupation Period	24 Months
Benefit Duration	Later of Age 65 or Normal Social Security Retirement Age
*Pre-Existing Limitation	3 / 12

**Pre-Existing Condition: if you are treated for a condition 3 months prior to the effective date that results in a disability in first 12 months of coverage, you will not receive benefits. Once you have been covered for 12 months the pre-existing clause no longer applies.*

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[LEGAL PROTECTIONS]

Legal Protections

Legal Shield & ID Shield

A network of dedicated law firms across the U.S. and Canada made up of seasoned lawyers with an average of 22 years of experience who provide legal protection to millions of members any time they need it, even in covered emergency situations, 24/7, 365 days a year.

Advice, Consultation & Representation. Letters & Phone Calls on Your Behalf, Contract and Document Review, and Representation.

24/7 Legal Emergency Assistance. Arrested or detained, Seriously injured in an auto accident, Served with a criminal warrant, State attempts to take your child(ren) Family Matters. Uncontested Name Change Assistance, Uncontested Adoption Representation, and Uncontested Separation/Divorce Representation.

Document Preparation. Standard Will Preparation/ annual reviews and updates, Living Will, Health Care Power of Attorney, Durable Power of Attorney, and Residential Loan (Mortgage) Document Assistance.

Traffic. Non-criminal moving traffic violation assistance, Motor vehicle related criminal charge assistance, Driver's license reinstatement, and property damage collection assistance. (Available for members with a valid driver's license and driving a non-commercial motor vehicle.)

IRS. Audit Assistance: advice, consultation and assistance when notified of an audit, additional assistance if no settlement in the first thirty days, assistance if your case goes to court. (Coverage for this service begins with the tax return due April 15th of the year you enroll.)

Business services plans are also available.

Monthly Legal Shield Rates	
Employee (EE)	$15.95
EE + Family	$15.95

Members have unlimited access to identity consultation services provided by our Licensed Private Investigators. They will advise you on best practices for identity management tailored to your specific situation.

Consultative service. Privacy and Security Best Practice, and Event-Driven Consultation Support.

Security Monitoring. Username/Password (Credentials Monitoring, Court Records Monitoring, High Risk Credit Account Monitoring, Instant Hard Credit Inquiry Alerts, Credit Score Tracker, Payday Loan Monitoring, Dark Web Surveillance (Internet Monitoring), Address Change Verification, and Social Media Monitoring.

Identity Restoration. $1 Million Protection Policy with an Unlimited Service Guarantee that we will do whatever it takes for as long as it takes to restore your identity to its pre-theft status.

Our Licensed Private Investigators perform the bulk of the restoration work required to restore a member's identity to pre-theft status.

Monthly ID Shield Rates	
Employee (EE)	$8.45
EE + Family	$15.95

Monthly Combined Shield Rates	
Employee (EE)	$24.50
EE + Family	$28.90

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[ADDITIONAL TEAM MEMBER SAVINGS]

FULL-TIME STATUS NOT REQUIRED

[LIFEMART + TICKETS AT WORK]

Financial Protection
Discount Programs

TicketsatWork® is the leading Corporate Entertainment Benefits provider, offering exclusive discounts, with special offers from and access to preferred seating and tickets to top brands and attractions, theme parks, shows, sporting events, movie tickets, hotels, home essentials, electronics, streaming services, apparel, food delivery, educational programs, automotive, health and wellness, and more.

TicketsatWork® is a unique benefit offered exclusively to companies like yours and their employees.

Company Sign-Up Code: FOURTH

Employee Discount Program

LifeMart® is one of your employer's way of saying thanks for your hard work and helping you keep more of your paycheck. Access LifeMart anywhere, anytime, on any device. It's the fast and easy, especially with the LifeMart® mobile app.

1. Login to your employee account at www.fourth.com/peo and register
2. Download the LifeMart® mobile app through the Google Play or the iPhone App Store

SAVE
With discounts of up to **40%** or more

on more than five million products and services including:

- Computers and Electronics
- Theme Parks
- Vacation Packages, Car Rentals and Hotels
- Gifts and Retail Shopping
- Concert, Sporting Events and Theater Tickets

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[PET INSURANCE]

FOURTH
is offering Wishbone Pet Insurance to employees.

Nobody wants to imagine their pet getting sick or injured - but when it comes to your pet's health, it's best to expect the unexpected.

Enroll in pet health insurance from Wishbone and receive 90% reimbursement on your pet's veterinary care. With a low deductible of $250, protecting your pet's health and your finances has never been easier!

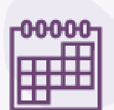
Wishbone Pet Insurance is accepted at any vet in the U.S., including emergency hospitals. Once you file a claim, expect to be reimbursed via mailed check in 5 business days or less. It's that easy!

POLICYHOLDERS ENJOY:

Optional Routine Care Plans

Fast Claims Processing

Easy-to-Use Member Account



Short Waiting Periods

Lost Pet Recovery Service from **ThePetTag**

24/7 Pet Telehealth from **AskVet**

Get a quote & enroll at www.wishboneinsurance.com/fourth

Wishbone Pet Insurance is program managed by Odie Pet Insurance Marketing, Inc. and is underwritten by Clear Blue Insurance Group. Please visit www.getodie.com for more information.

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FOURTH
is offering Total Pet Plan
to employees.

Your pets are part of your family, and you'll do anything to keep them happy and healthy. But with the cost of pet care on the rise, it isn't always easy.

That's why we're offering **Total Pet Plan**, which makes pet care more affordable. Enroll in Total Pet and get the same high-quality products and services your pets are used to, just at a lower price!

$11.75/month for one pet or
$18.50/month for a family plan

For more details and how to enroll, visit petbenefits.com/land/fourth .

TOTAL PET PLAN INCLUDES:

PETplus

DISCOUNTS ON PRODUCTS & RX

- Up to 40% off on products like prescriptions, preventatives, food, toys and more
- Shipping is always free and same-day pickup is available for most human-grade prescriptions

View available products and pricing at petplusbenefit.com.

DISCOUNTS ON VETERINARY CARE

- Instant 25% savings on all of your pet's in-house medical services at participating vets
- No exclusions due to age, health, pre-existing conditions or type of pet

Visit petbenefits.com/search to locate a participating vet.

24/7 PET TELEHEALTH

- Access real-time vet support, even when your vet's office is closed
- Unlimited support on your pet's health, wellness, behavior and more

PetTag

LOST PET RECOVERY SERVICE

- Durable tag can be scanned from any smart phone to access your contact information, helping lost pets return home quicker than a microchip
- Easily update your information online with no need to request a new tag

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[FORD + LINCOLN DISCOUNTS]

THE PRIVILEGE OF PARTNERSHIP
EXCLUSIVE PRICING. EXCEPTIONALLY SIMPLE.

X-PLAN PRICING + CUSTOMER INCENTIVES = GREAT SAVINGS

Take advantage of the impressive savings offered exclusively to Ford Partner organizations like ours. You'll enjoy X-Plan pricing unavailable to the general public, in addition to most other publicly offered programs available at your local Ford dealer![1]

Benefits of X-Plan Partner Recognition:

- Exclusive pricing and special offers
- Exciting product selection — choose from a variety of eligible Ford vehicles
- Employees, retirees and household members are eligible for these terrific offers![2]

To learn more, visit **www.fordpartner.com** and enter our **X-Plan Partner Code**:

1 See selling dealer for details.
2 Driver's licenses are required for proof of residency.

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BOZARD

We'll deliver your new vehicle to your door at X-Plan Pricing!

Ford's Garage employees and their household family members* are invited to take advantage of the impressive savings offered exclusively to Ford Partner Organizations. You'll enjoy X-Plan Pricing not available to the general public in addition to most other public incentives available at Bozard Ford Lincoln.

Call 904-932-1529 for your exclusive offer!

X-PLAN PRICING

X-PLAN PRICING + CUSTOMER INCENTIVES =

THE PRIVILEGE OF PARTNERSHIP

EXCLUSIVE PRICING. EXCEPTIONALLY SIMPLE.

* See dealer for details. Available to employees and their spouse, parent, grandparent, children, sibling residing at same address. Proof of residency required.

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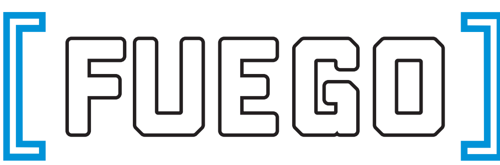
[FUEGO]

23
RESTAURANT SERVICES

Welcome to Fuego™

When you clock out, you can cash out.

Need access to wages today? No problem. It's easy to get your pay when you need it -

- **Step 1**: Download the Fuego app
- **Step 2**: Register under **23 Restaurant Services** so you can access your earned pay
- **Step 3**: Set up direct deposit to the Fuego Visa® Card for wage draws at no cost, or link to an existing debit card or bank account (fees apply)

Employer Name: 23 Restaurant Services

Download Fuego today![1]

For Fuego Customer Service, call us at 1-877-539-5156, or visit www.getfuego.com/help

1. Standard text and data messaging rates may apply.

The Fuego Visa® card is issued by Central Bank of Kansas City, Member FDIC, pursuant to a license from Visa U.S.A., Inc. Certain fees, terms, and conditions are associated with the approval, maintenance, and use of the Card. You should consult your Cardholder Agreement and the Fee Schedule at www.getfuego.com/legal.

If you have any questions regarding the Fuego card or such fees, terms, and conditions, you can contact us toll-free 24/7 at 1-877-539-5156.

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What is Fuego?

- Fuego On-Demand Pay is a downloadable app that offers both Earned Wage Access (EWA) and the Fuego Visa® Card. On-Demand Pay allows employees to draw down up to 50% of their earned wages ahead of payday
- The offer is generated based on the hours worked within the current pay period
- The Fuego Visa Card allows employees to have access to a prepaid card and the setup comes at no cost to you. There may be nominal costs associated with a wage draw depending on the type of transaction

How do I get access?

- Fuego is available as a downloadable app only. Employees can download the app free of charge from either the Google Play Store or Apple App Store, it's not available on a tablet or any other electronic device[1]
- Employees can also log into HotSchedules and a Fuego offer banner will be presented at the top of their schedule prompting employees to download the Fuego app
- The Fuego app can be used both in English and Spanish

How does drawing wages early impact pay?

- The pay will be calculated as normal; the only difference is that there will be a deduction reflected in the payslip, based on the value of any draws and associated fees made during that payroll period

How much does Fuego cost?

- The Fuego app is free to download[1]
- On-Demand draws are free of charge if employee applies for a Fuego Visa Card account and sets up pay to go to that account
- On-Demand draws to other bank accounts or debit cards come with a nominal cost to cover processing any fees

If I leave the company, will this impact my Fuego Visa Card account?

- Not at all, the Fuego Card account is separate to the employer for on-demand pay draws

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How do I set up direct deposit to my Fuego Card?

- Your payroll administrator or HR team will be able to tell you what's needed to set this up

Can I use Fuego to draw wages early?

- Right now using Fuego to draw wages early is only available for hourly employees. Team Fuego is working on a solution for salaried team members to also benefit. In the meantime, you can always download the Fuego app and apply for a Fuego Visa Card Account

I have an issue with the Fuego app, who can I reach out to?

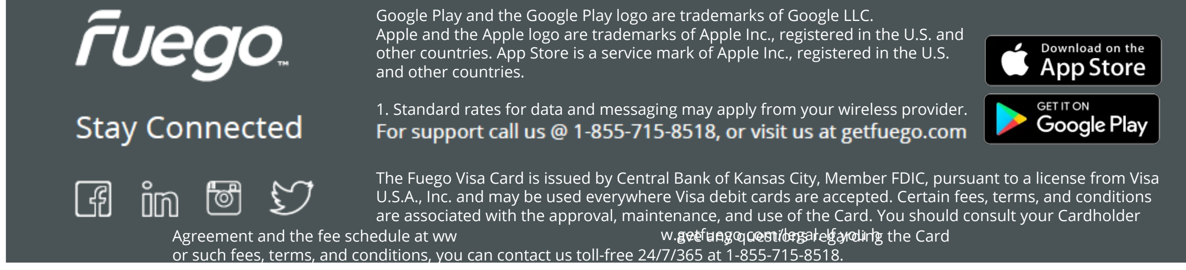
- The best way to get any individual queries resolved is to contact Fuego support by either using the Help & Customer Service section in the Fuego app or by calling 1-855-715-8518

How do I find out more about Fuego?

- You can find more information about Fuego at www.getfuego.com. Additionally, support articles are available on the Customer Success Portal which is where you can also sign up to follow Release Notes about Fuego. Or for live support, you can always call 1-855-715-8518 for support

For general questions,
please visit
www.getfuego.com/help

fuego Introducing Fuego, On-Demand Pay | **GetFuego.com**



[DMHO SUMMARY OF BENEFITS]

Dental

MetLife

Plan Design for: Fords Garage
Original Plan Effective Date: November 1, 2018

Summary of Benefits
Dental Coverage - RQ-revision

Managed Dental Plan		
MET290 - Florida		
Code	**Description**	**Co-Payment**
Diagnostic Treatment		
D0120	Periodic Oral Evaluation – established patient	$0
D0150	Comprehensive Oral Evaluation – New or Established Patient	$0
D0210	Intraoral – Complete Series of Radiographic Images	$0
D0274	Bitewings – Four Radiographic Images	$0
D0330	Panoramic Radiographic Image	$0
Preventive Services		
D1110	Prophylaxis – Adult	$5
D1120	Prophylaxis – Child	$5
D1351	Sealant – per tooth	$0
Restorative Services		
D2140	Amalgam – One Surface, Primary or Permanent	$12
D2330	Resin-Based Composite – One Surface, Anterior	$12
D2391	Resin-Based Composite – One Surface Posterior	$30
Crowns		
D2750	Crown-Porcelain Fused to High Noble Metal	$290
D2751	Crown-Porcelain Fused to Predominantly Base Metal	$290
Endodontics		
D3220	Therapeutic Pulpotomy (excluding final restoration)-removal of pulp coronal to the dentinocemental junction and application of medicament	$40
D3330	Endodontic therapy, Molar (excluding final restoration)	$265
Periodontics		
D4260	Osseous Surgery (Including Flap Entry and closure) – Four or more contiguous teeth or tooth bounded spaces per quadrant	$330
D4341	Periodontal scaling and root planing – Four or more teeth per quadrant	$50
D4381	Localized delivery of antimicrobial agents via controlled release vehicle into diseased crevicular tissue, per tooth	$65
D4910	Periodontal Maintenance	$40
Prosthodontics		
D5110	Complete Denture - Maxillary	$440
D5120	Complete Denture - Mandibular	$440

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D5211	Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	$405
D5212	Mandibular partial denture – resin based (including any conventional clasps, rests and teeth)	$405
Implants		
D6010	Surgical placement of implant body: endosteal implant	$1,005
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$660
Crowns / Fixed Bridges		
D6241	Pontic – Porcelain fused to predominantly base metal	$290
D6750	Retainer Crown - Porcelain fused to high noble metal	$290
Oral Surgery		
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$5
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$50
D7220	Removal of impacted tooth – soft tissue	$50
D7240	Removal of impacted tooth – completely bony	$135
Orthodontics		
D8020	Limited orthodontic treatment of the transitional dentition	$1,095
D8030	Limited orthodontic treatment of the adolescent dentition	$1,095
D8040	Limited orthodontic treatment of the adult dentition	$1,095
D8070	Comprehensive orthodontic treatment of the transitional dentition	$2,095
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$2,095
D8090	Comprehensive orthodontic treatment of the adult dentition	$2,095
Adjunctive General Services		
D9110	Palliative (emergency) treatment of dental pain – minor procedure	$10
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	$0

The above description is only a summary of the Managed Dental Plan being offered. A complete copy of all the terms and conditions of the Managed Dental Plan being offered is set forth in the Managed Dental Plan Schedule of Benefits provided herewith.

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[FEDERAL GUIDELINES]

FEDERAL GUIDELINES

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

AFFORDABLE CARE ACT (ACA) HEALTHCARE REFORM EXCHANGE NOTICE Under ACA, large employers are responsible to provide eligible team member s with coverage that meets the affordability and actuarial value rules set by our government. The plans offered by your employer meet these standards.You will receive a separate notice with specific information.As a result, you and/or your dependents may not be eligible for a federal or state subsidy when applying for coverage in the Healthcare Marketplace.

HIPAA– PRIVACY ACTLEGISLATION The Health Plan and your health care carrier(s) are obligated to protect confidential health information that identifies you or could be used to identify you as it relates to a physical or mental health condition or payment of your health care expenses. If you elect new coverage, you and your beneficiaries will be notified of the policies and practices to protect the confidentiality of your health information.

WOMEN'S HEALTH AND CANCER RIGHTS ACT The Women's Health and Cancer Rights Act (WHCRA) includes protections for individuals who elect breast reconstruction in connection with a mastectomy. WHCRA provides that group health plans provide coverage for medical and surgical benefits with respect to mastectomies. It must also cover certain post-mastectomy benefits, including reconstructive surgery and the treatment of complications (such as lymphedema).Coverage for mastectomy-related services or benefits required under the WHCRA are subject to the same deductible and coinsurance or copayment provisions that apply to other medical or surgical benefits your group contract providers.

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA) OF 2008 Title II of the Genetic Information Nondiscrimination Act of 2008 protects applicants and team member s from discrimination based on genetic information in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment. GINA also restricts employers' acquisition of genetic information and strictly limits disclosure of genetic information. Genetic information includes information about genetic tests of applicants, team member s, or their family members; the manifestation of diseases or disorders in family members (family medical history); and requests for or receipt of genetic services by applicants, team members, or their family members.

SECTION 111 OF JANUARY 1, 2009 Group Health Plans (GHP) are required to comply with the Federal Medicare Secondary Payer Mandatory Reporting provisions in Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007. It requires employers to report specified information regarding their GHP coverage (including social security numbers) in order for CMS to determine primary versus secondary payment responsibility. In essence, it helps determine which plan pays first-Employer plan or Medicare/Medicaid/SCHIP for those team member s covered under a government plan and an employer sponsored plan.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 The Newborns' and Mothers' Health Protection Act of 1996 provides that group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with child birth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally 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). An attending provider is defined as an individual who is licensed under applicable state law to provide maternal or pediatric care and who is directly responsible for providing such care to a mother or newborn child. The definition of attending provider does not include a plan, hospital, managed care organization or other issuer. In any case, plans may not,under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Please contact us if you would like any additional information on The Newborns' and Mothers' Health Protection Act or WHCRA.

MICHELLE'S LAW An amendment to the Employee Retirement Income Security Act (ERISA), the Public Health Service Act (PHSA), and the Internal Revenue Code (IRC). This law ensures that dependent students who take a medically necessary leave of absence do not lose health insurance coverage. Michelle's Law allows seriously ill college students, who are covered dependents under health plans, to continue coverage for up to one year while on medically necessary leaves of absence. The leave must be medically necessary as certified by a physician, and the change in enrollment must commence while the dependent is suffering from a serious illness or injury and must cause the dependent to lose student status. Under the law, a dependent child is entitled to the same level of benefits during a medically necessary leave of absence as the child had before taking the leave. If any changes are made to the health plan during the leave, the child remains eligible for the changed coverage in the same manner as would have applied if the changed coverage had been the previous coverage, so long as the changed coverage remains available to other dependent children under the plan.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA) The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) was signed into law on October 13, 1994. USERRA clarifies and strengthens the Veterans' Reemployment Rights (VRR) Statute. The Act itself can be found in the United States Code at Chapter 43, Part III, Title 38.The Department of Labor has issued regulations that clarify its position on the rights of returning service members to family and medical leave under the Uniformed Services Employment and Reemployment Rights Act (USERRA). See 20 CFR Part 1002.210. USERRA is intended to minimize the disadvantages to an individual that occur when that person needs to be absent from his or her civilian employment to serve in this country's uniformed services. USERRA makes major improvements in protecting service member rights and benefits by clarifying the law and improving enforcement mechanisms. It also provides team members with Department of Labor assistance in processing claims. USERRA covers virtually every individual in the country who serves in or has served in the uniformed services and applies to all employers in the public and private sectors, including Federal employers. The law seeks to ensure that those who serve their country can retain their civilian employment and benefits, and can seek employment free from discrimination because of their service. USERRA provides protection for disabled veterans, requiring employers to make reasonable efforts to accommodate the disability. USERRA is administered by the United States Department of Labor, through the Veterans' Employment and Training Service (VETS). VETS provides assistance to those persons experiencing service connected problems with their civilian employment and provides information about the Act to employers. VETS also assists veterans who have questions regarding Veterans' Preference.

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FEDERAL GUIDELINES

HIPAA SPECIAL ENROLLMENT

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

Loss of Other Coverage 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).

Example: You waived coverage under this plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this health plan.

Marriage, Birth, or Adoption 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.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan.However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP If you or your dependents lose eligibility for coverage under Medicaid or theChildren'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.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage. For More Information or Assistance To request special enrollment or obtain more information, please contact:

Jeff Gabriel

505 E Jackson Street, Suite 302

Tampa, FL 33602

813-390-4167

Note: If you or your dependents enroll during a special enrollment period, as described above, you will not be considered a late enrollee. Therefore, your group health plan may not impose a preexisting condition exclusion period of more than 12 months. Any preexisting condition exclusion period will be reduced by the amount of your prior creditable health coverage.Effective for plan years beginning on or after Jan. 1, 2014, health plans may not impose pre-existing condition exclusions on any enrollees.

HITECH (FROM WWW.CDC.GOV) The American Reinvestment & Recovery Act (ARRA) was enacted on February 17, 2009. ARRA includes many measures to modernize our nation's infrastructure, one of which is the"Health Information Technology for Economic and Clinical Health (HITECH) Act". The HITECH Act supports the concept of electronic health records - meaningful use [EHR-MU], an effort led by Centers for Medicare & Medicaid Services(CMS)and the Office of the National Coordinator for Health IT (ONC). HITECH proposes the meaningful use of interoperable electronic health records throughout the United States health care delivery system as a critical national goal. Meaningful Use is defined by the use of certified EHR technology in a meaningful manner (for example electronic prescribing); ensuring that the certified EHR technology is connected in a manner that provides for the electronic exchange of health information to improve the quality of care; and that in using certified EHR technology the provider must submit to the Secretary of Health & Human Services (HHS) information on quality of care and other measures.

RESCISSIONS The Affordable Care Act prohibits the rescission of health plan coverage except for fraud or intentional misrepresentation of a material fact. A rescission of a person's health plan coverage means that we would treat that person as never having had the coverage. The prohibition on rescissions applies to group health plans, including grandfathered plans, effective for plan years beginning on or after September 23, 2010.

Regulations provide that a rescission includes any retroactive terminations or retroactive cancellations of coverage except to the extent that the termination or cancellation is due to the failure to timely pay premiums. Rescissions are prohibited except in the case of fraud or intentional misrepresentation of a material fact. For example, if an team member is enrolled in the plan and makes the required contributions, then the team member's coverage may not be rescinded if it is later discovered that the team member was mistakenly enrolled and was not eligible to participate. If a mistake was made, and there was no fraud or intentional misrepresentation of a material fact, then the team member's coverage may be cancelled prospectively but not retroactively.

Should a member's coverage be rescinded, then the member must be provided 30 days advance written notice of the rescission. The notice must also include the member's appeal rights as required by law and as provided in the member's plan benefit documents. Please be aware that if you rescind a member's coverage, you must provide the proper notice to the member.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA) MHPAEA generally applies to group health plans and health insurance issuers that provide coverage for both mental health or substance use disorder benefits and medical/surgical benefits. MHPAEA provides with respect to parity in coverage of mental health and substance use disorder benefits and medical/surgical benefits provided by employment-based group health plans. MHPA '96 required parity with respect to aggregate lifetime and annual dollar limits for mental health benefits. MHPAEA expands those provisions to include substance use disorder benefits. Thus, under MHPAEA group health plans and issuers may notimpose a lifetime or annual dollar limit on mental health or substance use disorder benefits that is lower than the lifetime or annual dollar limit imposed on medical/surgical benefits. MHPAEA also requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles), and quantitative treatment limitations (such as visit limits), applicable to mental health or substance use disorder benefits are generally no more restrictive than the requirements or limitations applied to medical/surgical benefits. The MHPAEAregulations also require plans and issuers to ensure parity with respect to no quantitative treatment limitations (such as medical management standards).

PREVENTIVECARE Health plans will provide in-network, first-dollar coverage, without cost-sharing, for preventative services and immunizations as determined under health care reform regulations. These include, but are not limited to, cancer screenings, well-baby visits and influenza vaccines. For a complete list of covered services, please visit: www.healthcare.gov/coverage/preventive-care-benefits/

WELLNESS PROGRAM If applicable – Our company's Wellness Program is a voluntary wellness program available to all team members. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve team member health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

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FEDERAL GUIDELINES

HIPAA PRIVACY NOTICE The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect.

You may request a copy of the current Privacy Practices from the Plan Administrator explaining how medical information about you may be used and disclosed, and how you can get access to this information.As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

You have the right to inspect and copy, the right to an electronic copy of electronic medical records, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice and the right to file a complaint if you believe your privacy rights have been violated.

Individual Rights You may obtain a copy of your health claims records and other health information from us typically within a 30 day period from your request. We may charge a reasonable, cost-based fee. You may ask us to correct your health/claims records if you think they are incorrect. We reserve the right to say "no" to your request, but will give you an explanation in writing within a 60 day period. Requesting a specific way to contact you for confidential reasons is permitted (home or office phone for example), specifically if you would be in danger from a certain form of communication.

If you would like us not to use or share certain health information for treatment, payment or our operations, you are permitted to do so. However, we are not required to agree to your request if it would affect your care. At your request, we will provide you with a list of the times we have shared your health information up to six years prior to your request date, who we shared it with, and why. This list will include all disclosures excluding treatment, payment, and health care operations, as well as other certain disclosures (such as any you ask us to make). We provide one list a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

You can ask for a paper copy of this notice at any time, which we will promptly provide, even if you have agreed to receive the notice electronically. If you have given someone medical power of attorney or if you have a legal guardian, that person can exercise your rights and make choices about your health information. We will make sure they have this authority and can act in your interests before we take any action.

If you feel that we have violated your rights, you may contact us using the information on the back page, or 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/. We can assure no retaliation from us against you for filing a complaint.

For certain health information, you can tell us your choices about what we share. You have the right and choice to tell us to share information with your family, close friends, or others involved in payment for your care, and in a disaster relief situation. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest and when needed to lessen a serious and imminent threat to health or safety. We never share your information for marketing purposes of sale of your information without your expressed written consent.

Our Uses and Disclosures We typically use or share your information in several different ways. We help manage the healthcare treatment you receive by sharing information with professionals who are treating you. We can use and disclose your information to run our organization and contact you when necessary. We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage (this does not apply to long term care plans). Our organization can use and disclose your health information as we pay for your health services, as well as disclose your health information to your health plan sponsor for plan administration.

Other Uses and Disclosures Typically in the matter of public health and safety issues, we can use and share your information. For instance, preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect or domestic violence, as well as preventing or reducing a serious threat to anyone's health or safety, and health research.

We may need to share your information if state or federal law requires it, including the Department of Health and Human Services if it wishes to see that we're complying with federal privacy law. Other organizations and professionals we may share your information with are organ procurement organizations, coroners, medical examiners, and funeral directors. We can share your information in special instances such as for worker's compensation claims, law enforcement purposes, health oversight agencies for activities authorized by law, and for special government functions such as military, national security, and presidential protective services. We can share information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities We are required by law to maintain the privacy and security of your protected health information.We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

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MEDICARE PART D: CREDITABLE COVERAGE

Important Notice from 23 Restaurants 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 23 Restaurants 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. 23 Restaurants has determined that the prescription drug coverage offered by the United Healthcare are, 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, your current 23 Restaurants , coverage will not be affected. You can keep this coverage if you elect part D and United Healthcare will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current 23 Restaurants provided 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 23 Restaurants 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.

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).

Date:	1/1/2024
Name of Entity:	23 Restaurants
Contact:	Jeff Gabriel
Address:	505 E Jackson Street, Suite 302 Tampa, FL 33602
Phone:	813-390-4167

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23
RESTAURANT SERVICES

Ford's
GARAGE
PRIME BURGERS | CRAFT BEER

YEOMAN'S
TOPGOLF
SWING SUITE

DON THE
BEACHCOMBER

Tiki
DOCKS