DECEMBER
2024

RESTAURANT SERVICES

BENEFITS GUIDE
FOR HOURLY TEAM MEMBERS

Ford's GARAGE PRIME BURGERS | CRAFT BEER
YEOMAN'S TOPGOLF SWING SUITE
DON THE BEACHCOMBER
THE GANTT RESERVE COLLECTION
Arnold Palmer's CENTERCUP
Tiki DOCKS

Table of Contents

[23RS 1-4-7]

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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.

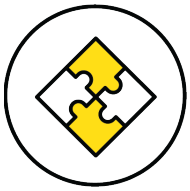
VISION:

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

COMMITMENTS:

PEOPLE

OUR PEOPLE ARE THE SOURCE OF OUR STRENGTH.

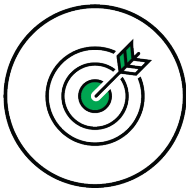


PARTNERSHIPS

WE ARE BRAND AMBASSADORS AND PASSIONATELY REPRESENT.

PRODUCTS

WE CREATE “VIBE” WITH DELICIOUS AND IMMERSIVE EXPERIENCES.



PERFORMANCE

OUR SALES AND PROFITS DRIVE FUTURE GROWTH AND OPPORTUNITY.

PRINCIPLES:

1
INNOVATION

DARE TO BE COURAGEOUS AND EMBRACE WHAT'S NEXT.

2
EXCELLENCE

GREAT IS NOT GOOD ENOUGH. BE A BADASS!

3
INTEGRITY

SELFLESS CONVICTION TO MAKE THE RIGHT CHOICE.

4
TRUST

TRUST EACH OTHER. EARN IT. GIVE IT.

5
TEAMWORK

STRONGER TOGETHER. WE ARE ONE TEAM.

6
IMPACT

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

7
ENERGY

BRING THE ENERGY. LOVE WHAT YOU DO.

[FOURTH EMPLOYEE PORTAL]

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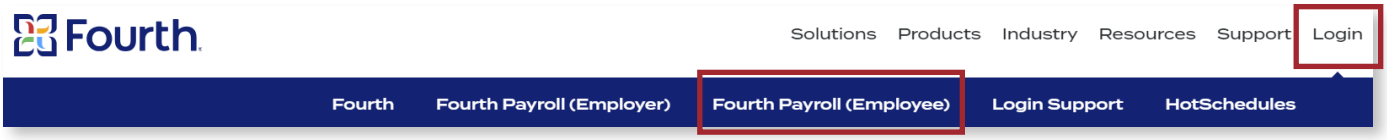
Fourth Employee Portal

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)**.

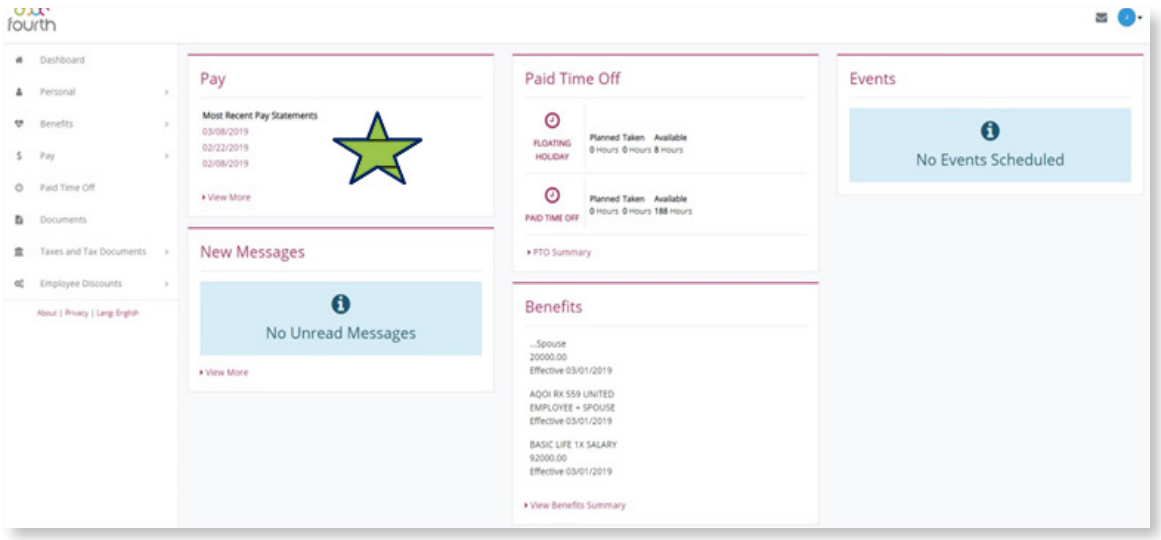


2. If you haven't already created a username, click on **Register** to create a new one.

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.

[BENEFITS OVERVIEW]

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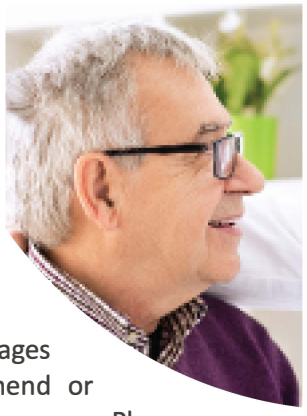
OUR COMMITMENT



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 Fourth. 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
Baldwin Group (Medical Insurance Only)	Employee Care Center	866-784-2242	mybenefits@baldwin.com
Florida Blue	Medical	800-352-2583	www.floridablue.com
American Benefit Administrators (ABA)	FSA / HSA	866-742-4900	support@ americanbenefitadministrators.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

BENEFIT ENROLLMENT INSTRUCTIONS

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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.

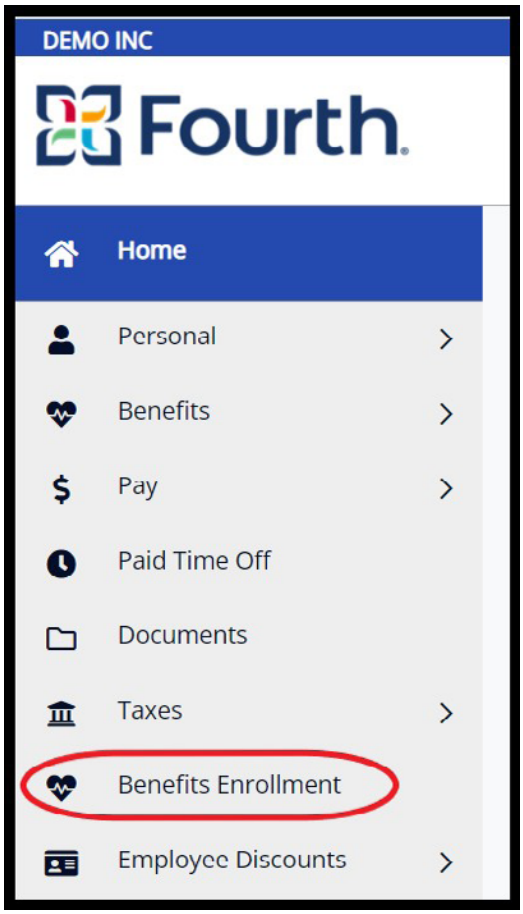
As you enroll, you'll find key information displayed for each plan, including coverage details and cost. You'll also find a variety of tools, educational videos, and reference documents to help you better understand your benefits.

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



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."**

ELIGIBILITY

FOR FULL-TIME TEAM MEMBERS

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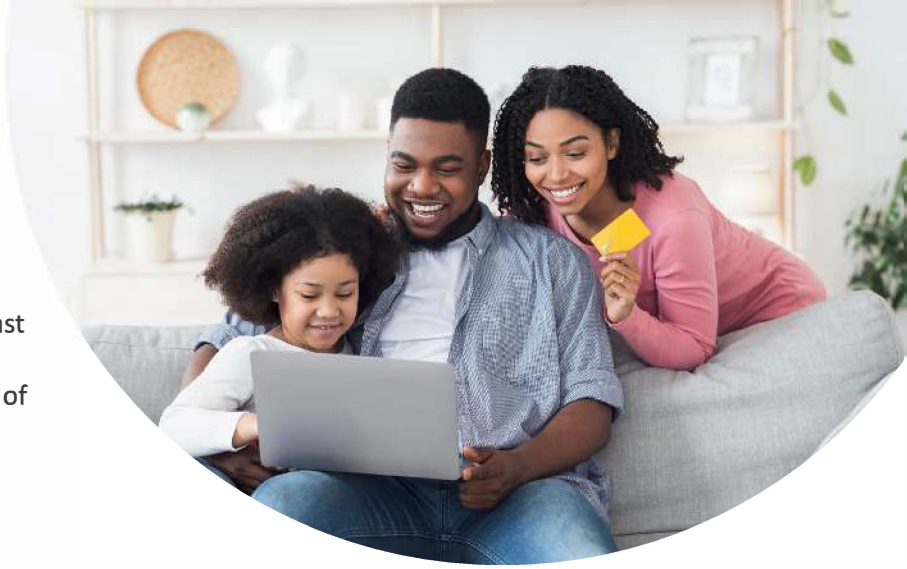
WHO IS ELIGIBLE



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.*

Changing Your Benefits
Section 125 & Pre-Tax Benefits

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

[MEDICAL INSURANCE]

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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.

MEDICAL INSURANCE

Florida Blue

	BlueCare HSA Plan 122/123 (FL Only)	BlueOptions HSA Plan 05172/05173	BlueCare Plan 49 (FL Only)	BlueOptions Plan 05774
Provider Network	BlueCare	BlueOptions	BlueCare	BlueOptions
Calendar Year Deductible				
Individual	$5,000	$5,000	$3,000	$3,000
Family	$10,000	$10,000	$9,000	$9,000
Coinsurance	10%	10%	20%	20%
Out-of-Pocket Maximum				
Individual	$6,850	$6,850	$6,350	$6,350
Family	$13,100	$13,100	$12,700	$12,700
COMMON SERVICES				
Inpatient Facility	10% after Deductible	10% after Deductible	$500 PAD + 20% after Deductible	$500 PAD + 20% after Deductible
Outpatient Facility	10% after Deductible	10% after Deductible	Ambulatory: $350 / Hospital: 20% after Deductible	Ambulatory: $350 / Hospital: 20% after Deductible
Preventive Care	$0	$0	$0	$0
Primary Care Physician	10% after Deductible	10% after Deductible	$40	$40
Specialist	10% after Deductible	10% after Deductible	$100	$100
Urgent Care	10% after Deductible	10% after Deductible	$100	$100
Emergency Room	10% after Deductible	10% after Deductible	$400	$400
LAB AND DIAGNOSTIC TESTING				
Lab / X-Ray	10% after Deductible	0% after Deductible / 10% after Deductible	$0 / $50	$0 / $50
Advanced Imaging	10% after Deductible	10% after Deductible	$400	$400
OUT-OF-NETWORK BENEFITS				
Deductible	Not Covered		Not Covered	
Individual		$10,000		$6,000
Family		$20,000		$18,000
Coinsurance		20%		50%
Out-of-Pocket Maximum				
Individual		$10,000		$15,000
Family		$20,000		$30,000

PRESCRIPTION BENEFITS

Florida Blue

	BlueCare HSA Plan 122/123 (FL Only)	BlueOptions HSA Plan 05172/05173	BlueCare Plan 49 (FL Only)	BlueOptions Plan 05774
Tier 1	$10 after deductible	$10 after deductible	$10	$10
Tier 2	$50 after deductible	$50 after deductible	$60	$50
Tier 3	$80 after deductible	$80 after deductible	$100	$80

$

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 Florida Blue 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 800-352-2583 or visit www.floridablue.com.

TIPS TO HELP YOU SAVE ON YOUR PRESCRIPTION COSTS

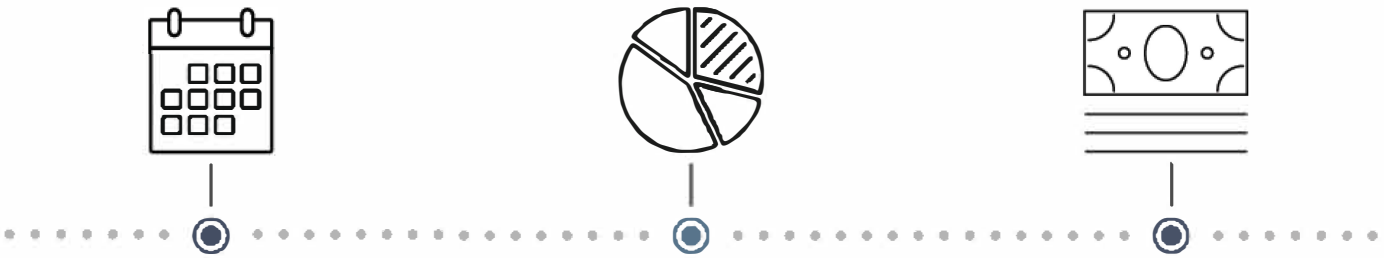
1. **Choose Generic Versions:** Generic medications offer the same effectiveness as brand-name drugs but often come with a significantly lower price tag. You can also utilize price-comparison tools to identify the most cost-effective option for your medications.
2. **Consider Pill Splitting:** Consult with your doctor about the possibility of pill splitting for certain medications. This involves getting a higher-dose prescription and splitting the pills, effectively lowering the cost per dose while maintaining the prescribed dosage.
3. **Stay Informed:** Stay informed about changes in your insurance coverage and prescription drug formularies. Be proactive in discussing alternatives with your healthcare provider if needed.

MEDICAL RATES

WEEKLY DEDUCTIONS

	BlueCare HSA Plan 122/123 (FL Only)	BlueOptions HSA Plan 05172/05173	BlueCare Plan 49 (FL Only)	BlueOptions Plan 05774
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

STEPS TO SELECTING YOUR MEDICAL PLAN



01

Annualize Your Premium

You are responsible for the premium you pay each pay period.

This amount does not change based on your plan utilization.

02

How Do You Use the Plan?

Ask yourself questions such as:

- How often do I go to the doctor?
- Am I anticipating surgery this year?
- What is the most I'm comfortable paying for my healthcare expenses?

03

Estimate Your Expenses

Add your annual premium to your expected medical expenses to estimate your total healthcare costs.

[HEALTH SAVINGS ACCOUNT]

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Getting Started With Your Health Savings Account

Your health savings account (HSA) has a lot of benefits.

You can use it for out-of-pocket medical, dental, and vision expenses, and it can help you achieve your financial goals.

Advantages of your HSA

Triple-tax savings

Employee and employer contributions are tax-free (contribute pre-tax through payroll or deduct at tax time), investments grow tax-free, and you can take out tax-free funds at any time to pay for or reimburse eligible out-of-pocket healthcare expenses.

Build a safety net

HSAs are not "use-it-or-lose-it" accounts. Unlike flexible spending accounts (FSAs), unused HSA dollars roll over every year and continue to grow tax-free.

Your HSA for life

Your HSA belongs to you, including employer contributions, even if you leave your job.

Accessing and using your HSA is easy and convenient

You can log in to your online account or mobile app to:

- Check your balance
- Check if an expense is eligible
- Upload receipts or EOBs for tax purposes
- Enter, view, and pay expenses
- Contribute to your HSA
- View and manage investments
- Contact customer service

It's never too late to achieve financial security, especially since we're living longer lives than ever before. It's important to build your savings while you're still in the workforce. Savings goal calculators and easy-to-use tools can guide your goal-setting and decision-making.

Make your HSA work for you

When you contribute and invest $4,000 a year to your HSA, your account can grow to $90,630 in 15 years and even to $279,000 in 30 years!

**Based on an annual contribution of $4,000, no distributions, and an annual ROI of 5%.*

But wait, there's more!

The more you contribute to your HSA, the more you save on taxes. And, at age 55, you can contribute an additional $1,000 over the IRS annual contribution limit.

[FLEXIBLE SPENDING ACCOUNT]

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Flexible Spending Account

Why should I choose a flexible spending account (FSA)?

A flexible spending account (FSA) lets you save money by setting aside pre-tax dollars to pay for eligible medical, dental, vision and dependent care expenses incurred by you, your spouse or your eligible dependents.

Take home more money
Putting money into an FSA decreases your taxable income, which means you'll take home more money.

Plan better for health expenses
Spend your funds on the eligible health expenses you incur throughout the year. The IRS has a "use it or lose it" rule for FSAs, which means funds must be spent by the end of the plan year unless your employer offers a grace period or carryover.

Flexibility
You can use your funds for eligible expenses occurred by you, your spouse, or your eligible dependents. Thousands of products and services are FSA eligible. (Eligible expenses are determined by the IRS.)

Funds on Day 1
All of your FSA dollars are available on the very first day of the plan year. For example, if you choose to contribute $1,200 to your FSA, your contributions will be deducted evenly across all of your paychecks for the year, but you have access to all $1,200 on Day 1.

Can I enroll?
Yes, as long as you or your spouse aren't actively enrolled and contributing to a Health Savings Account (HSA).

Carryover

A carryover allows you to transfer up to $610 of your remaining balance at the end of the plan year into the following year.

If you end up spending less than you anticipated when you made your elections during open enrollment, you can tap into those funds next year.

- Carryover funds become available to you January 1st.
- You're able to carry over up to $610 while still electing the full maximum annual election in the new plan year.

End of year planning reminder: If you have an expense that was billed after the plan year has ended be sure to NOT use your debit card to pay the bill but submit for manual reimbursement.

Contribution limits + IRS regulations

The IRS sets the maximum dollar amount you can elect to contribute to a medical FSA. The annual contribution limit for 2024 is $3200.

Tip: Review how much you spend on eligible healthcare expenses every year to determine how much to elect.

Changing your election

In order to make changes to your election after open enrollment, you need to experience a qualifying life event. These events include:

- Change in marital status or in the number of dependents
- Increase due to birth, adoption, or marriage
- Decrease due to death, divorce, or loss of eligibility
- Gain or loss of eligibility due to a change in participant, spouse, or dependent employment status

If you experience a qualifying life event, contact your employer to make changes to your election.

ABA AMERICAN BENEFIT ADMINISTRATORS

Dependent Care FSA

Contribution Limits & IRS Regulations

The IRS sets the maximum dollar amount you can elect and contribute to a dependent care eligible spending account (dependent care FSA). The annual contribution limit for is:

- **Per household: $5000.00**
- **Per person (if married and filing separately): $2500.00**

Although most people incur more than the limit per year, we recommend reviewing how much you spend on eligible dependent care expenses every year to determine your election.

Funds available as you contribute

Funds will be available to you as they're deducted from your paycheck and contributed to the plan. This means when payroll is processed and your paycheck is available to you, your dependent care FSA contributions will be applied to your account and available for reimbursement.

Use-or-lose

Don't forget to spend your FSA dollars. If you have not used all of your FSA dollars before the end of the plan year, you will forfeit any money left in your account. (Check with your employer to confirm how many days you have to submit claims for reimbursement after the plan year ends.)

Fast Fact

A great way to set it and forget it is to use our Recurring Dependent Care Form that allows you to submit one claim for the entire year and you will be reimbursed after each payroll.

Changing your dependent care FSA election

In order to make changes to your election after open enrollment, you need to experience a qualifying life event. (If you experience a qualifying life event, contact your employer to make changes to your election.) These events include:

- Change in marital status
- Change in the number of dependents
- Increase due to birth, adoption or marriage
- Decrease due to death, divorce or loss of eligibility
- Gain or loss of eligibility due to a change in participant, spouse or dependent employment status
- Change in daycare providers
- Child turning age 13
- Increase or decrease in the cost of qualifying daycare expenses
- Judgement, decree or order requiring a change in coverage

https://americanbenefitadministrators.com

AMERICAN BENEFIT ADMINISTRATORS

[ABA MOBILE APP]

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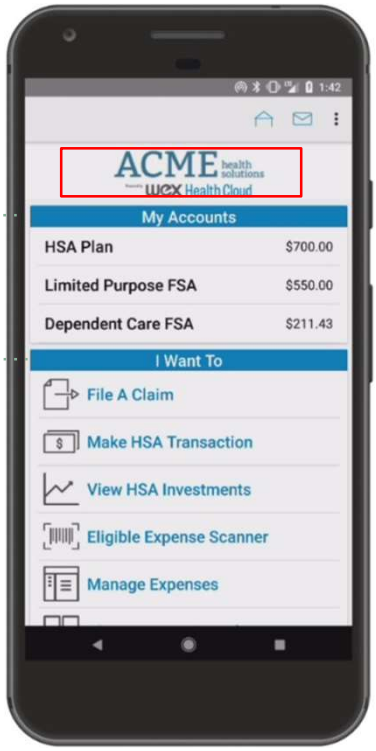
Manage your health benefits on the go

Want a simple, easy way to check your healthcare account balances and submit receipts from anywhere? The ABA Mobile lets you securely access your health benefit accounts with a touch of a finger. Designed so you can quickly find what you need most, our Mobile App provides easy, on-the-go access to all your health accounts.



View balance information for all your account(s) right away.

Use the "I Want To" section to quickly take any number of actions from making payments to viewing HSA investments to scanning items for eligibility and more.

Stay up to speed

With ABA Mobile, you can get to the healthcare account information you need—fast. Wondering whether you have enough money to pay a bill or make a purchase? ABA Mobile puts the answers at your fingertips*:

- Enjoy real-time access including an intuitive app design and navigation
- Log in to your account(s) with ease using your fingerprint
- Quickly check available balances and account details for medical and dependent care FSA, HSA, HRA, and Transportation plans
- View charts summarizing account information
- View in-app messages and text alerts that provide instant notifications about your account(s)
- Link to an external web page to obtain helpful information such as a list of eligible expenses
- Retrieve a lost username or password
- Use your device of choice – including Apple® and Android™-powered smartphones

Tap to take action

Our easy-to-use app helps you quickly find what you need to make a payment, capture a receipt or take any number of actions – whether you're on the couch or waiting in line. With ABA Mobile, you can get it done fast and enjoy the rest of your day*.

- Submit claims for medical and dependent care FSA, HRA, and transportation plans
- Snap a photo of a receipt and submit with a new or existing claim, or store in your camera roll for claim filing
- Make an HSA distribution or contribution and view HSA investment details
- Use the Eligible Expense Scanner to scan items to determine if they're qualified medical expenses before you get to the checkout lane
- Access your account funds to pay yourself or someone else such as doctor
- Add and store information on new payees
- Enter and view expense information and receipts
- Report a debit card as lost or stolen

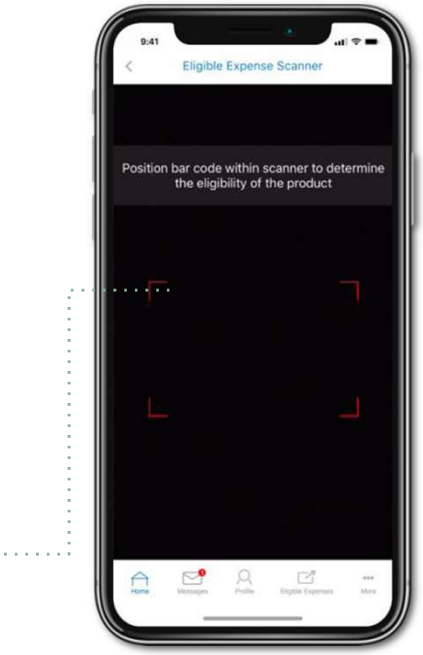
Imagine what you could do with ABA Mobile

Check Balances

Wondering whether you can pay for an elective procedure or a mounting bill? Do a quick account check to see your current balance. No need to wait for an answer – it's right at your fingertips.

Scan Expenses

How can you easily determine which products can be paid for using your account funds? With ABA Mobile, you can simply scan a product bar code to help determine eligibility as a qualified medical expense. That's peace of mind with a touch of a button.



With a quick barcode scan, you'll know in an instant whether an item qualifies as an eligible expense

https://americanbenefitadministrators.com/

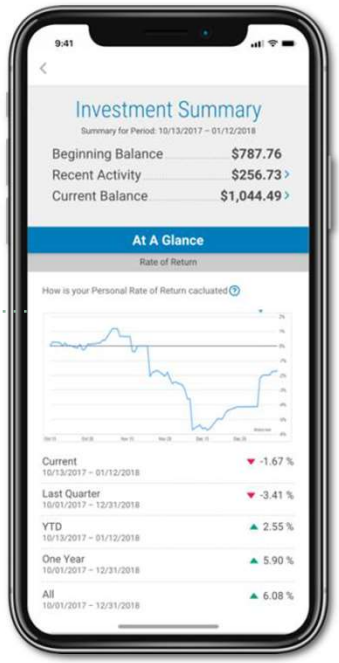
ABA AMERICAN BENEFIT ADMINISTRATORS

Make Payments Quickly

Record a health expense and capture the receipt the moment the transaction happens. Easily add payees and pay bills from any account. And, if you pay out-of-pocket, file a claim with a receipt or request a distribution from your HSA -- right from your phone.

Manage HSA Investments

Keep track of your HSA investment performance wherever you are. In addition to balance and activity details, a graphical snapshot shows the rate of return and performance over time. Analyze your asset mix and allocations with easy- to-read graphs to make informed decisions about your healthcare.



Check the activity of your HSA investments at any time, right from your mobile device.

Get started with ABA Mobile in minutes.

Download on the App Store | ANDROID APP ON Google Play

Download the ABA Mobile app for your chosen device from the Apple App Store or Google Play and log in using the password you use to access the American Benefit Administrators, LLC consumer portal.

* Some functionality listed may require additional products and services

https://americanbenefitadministrators.com/

ABA AMERICAN BENEFIT ADMINISTRATORS

[FSA / HSA ELIGIBLE ITEMS]

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RESTAURANT SERVICES

Know Your Health Care Eligible and Ineligible Expenses

Maximize the Value of Your Reimbursement Account - Your Health Care Flexible Spending Account (FSA) and Health Savings Account (HSA) dollars can be used for a variety of out-of-pocket health care expenses that qualify as federal income tax deductions under Section 213(d) of the Internal Revenue Code ("IRC").

- Health Care FSA and HSA dollars can be used to reimburse you for medical and dental expenses incurred by you, your spouse or eligible dependents (children, siblings, parents and other dependents which are defined in your Plan Documents).

IMPORTANT: The IRS defines which medical expenses are eligible under a tax-deferred account. Not all expenses are eligible under all plans. An employer may limit which expenses are allowable under their Health Care FSA. If you are unsure of what your Health Care FSA dollars may be used for, please contact your Plan Administrator.

Here is a sample list of expenses currently eligible and not eligible by the Internal Revenue Service ("IRS") as deductible medical expenses. This list is not necessarily inclusive or exclusive, and may be subject to change based on regulations, IRS revenue rulings and case law. It is solely based on our current interpretation of IRC Section 213(d) and is not intended to be legal advice.

Sample List of Eligible Expenses

BABY/CHILD TO AGE 13
- Lactation Consultant*
- Lead-Based Paint Removal
- Special Formula*
- Tuition: Special School/Teacher for Disability or Learning Disability*
- Well Baby /Well Child Care

DENTAL
- Dental X-Rays
- Dentures and Bridges
- Exams and Teeth Cleaning
- Extractions and Fillings
- Oral Surgery
- Orthodontia
- Periodontal Services

EYES
- Eye Exams
- Eyeglasses and Contact Lenses
- Laser Eye Surgeries
- Prescription Sunglasses
- Radial Keratotomy

MEDICAL EQUIPMENT/SUPPLIES
- Air Purification Equipment*
- Arches and Orthotic Inserts
- Contraceptive Devices
- Crutches, Walkers, Wheel Chairs
- Exercise Equipment*
- Hospital Beds*
- Mattresses*
- Medic Alert Bracelet or Necklace
- Nebulizers
- Orthopedic Shoes*
- Oxygen*
- Post-Mastectomy Clothing
- Prosthetics
- Syringes
- Wigs*

MEDICATIONS
- Insulin
- Prescription Drugs

OBSTETRICS
- Breast Pumps and Lactation Supplies
- Doulas*
- Lamaze Class
- OB/GYN Exams
- OB/GYN Prepaid Maternity Fees (reimbursable after date of birth)
- Pre- and Postnatal Treatments

PRACTITIONERS
- Allergist
- Chiropractor
- Christian Science Practitioner
- Dermatologist
- Homeopath
- Naturopath*
- Optometrist
- Osteopath
- Physician
- Psychiatrist or Psychologist

246 Inverness Center Parkway, Birmingham, Alabama 35242
Toll Free Customer Care (866) 742-4900 www.americanbenefitadministrators.com

Sample List of Eligible Expenses (Cont.)

HEARING
- Hearing Aids and Batteries
- Hearing Exams

LAB EXAMS/TESTS
- Blood Tests and Metabolism Tests
- Body Scans
- Cardiograms
- Laboratory Fees
- X-Rays

MEDICAL PROCEDURES/SERVICES
- Acupuncture
- Alcohol and Drug/Substance Abuse (inpatient treatment and outpatient care)
- Ambulance
- Fertility Enhancement and Treatment
- Hair Loss Treatment*
- Hospital Services
- Immunization
- In Vitro Fertilization
- Physical Examination (not employment-related)
- Reconstructive Surgery (due to a congenital defect, accident, or medical treatment)
- Service Animals
- Sterilization/Sterilization Reversal
- Transplants (including organ donor)
- Transportation*

THERAPY
- Alcohol and Drug Addiction
- Counseling (not marital or career)
- Exercise Programs*
- Hypnosis
- Massage*
- Occupational
- Physical
- Smoking Cessation Programs*
- Speech
- Weight Loss Programs*

This list is not meant to be all-inclusive, as other expenses not specifically mentioned may also qualify. Also, expenses marked with an asterisk (*) are "potentially eligible expenses" that may require a Note of Medical Necessity from your health care provider to qualify for reimbursement. For additional information, check your Summary Plan Document or contact your Plan Administrator.

Please Note: As of January 1, 2020 eligible over-the-counter (OTC) products that are medicines or drugs (e.g., acne treatments, allergy and cold medicines, antacids, etc.) will be eligible for reimbursement from your Health Care FSA and Health Savings Account.

Sample List of Eligible Over-the-Counter (OTC) Medicines and Drugs

- Acid controllers
- Acne medications
- Allergy & sinus
- Antibiotic products
- Antifungal (Foot)
- Antiphrastic treatments
- Antiseptics & wound cleansers
- Anti-diarrhea's
- Anti-gas
- Anti-itch & insect bite
- Baby rash ointments & creams
- Baby teething pain
- Cold sore remedies
- Contraceptives
- Cough, cold & flu
- Denture pain relief
- Digestive aids
- Ear care
- Eye care
- Feminine antifungal & anti-itch
- Fiber laxatives (bulk forming)
- First aid burn remedies
- Foot care treatment
- Hemorrhoidal preps
- Homeopathic remedies
- Incontinence protection & treatment products
- Laxatives (non-fiber)
- Medicated nasal sprays, drops, & inhalers
- Medicated respiratory treatments & vapor products
- Menstrual care products
- Motion sickness
- Oral remedies or treatments
- Pain relief (includes aspirin)
- Skin treatments
- Sleep aids & sedatives
- Smoking deterrents
- Stomach remedies
- Unmedicated vapor products

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OTC items that are not medicines or drugs remain eligible for purchase with FSAs and HSAs.

Sample List of Eligible Over-the-Counter (OTC) Items (Product categories are listed in bold face; common examples are listed in regular face.)

- **Baby Electrolytes and Dehydration**
  Pedialyte, Enfalyte
- **Contraceptives**
  Unmedicated condoms
- **Denture Adhesives, Repair, and Cleansers**
  PoliGrip, Benzodent, Plate Weld, Efferdent
- **Diabetes Testing and Aids**
  Ascencia, One Touch, Diabetic Tussin, insulin syringes; glucose products
- **Diagnostic Products**
  Thermometers, blood pressure monitors, cholesterol testing
- **Ear Care**
  Unmedicated ear drops, syringes, ear wax removal
- **Elastics/Athletic Treatments**
  ACE, Futuro, elastic bandages, braces, hot/cold therapy, orthopedic supports, rib belts
- **Eye Care**
  Contact lens care
- **Family Planning**
  Pregnancy and ovulation kits
- **First Aid Dressings and Supplies**
  Band Aid, 3M Nexcare, non-sport tapes
- **Foot Care Treatment**
  Unmedicated corn and callus treatments (e.g., callus cushions), devices, therapeutic insoles
- **Glucosamine &/or Chondroitin**
  Osteo-Bi-Flex, Cosamin D, Flex-a-min Nutritional Supplements
- **Hearing Aid/Medical Batteries**
- **Home Health Care (limited segments)**
  Ostomy, walking aids, decubitis/pressure relief, enteral/parenteral feeding supplies, patient lifting aids, orthopedic braces/supports, splints & casts, hydrocollators, nebulizers, electrotherapy products, catheters, unmedicated wound care, wheel chairs
- **Incontinence Products**
  Attends, Depend, GoodNites for juvenile incontinence, Prevail
- **Nasal Care**
  Saline Nasal Spray
- **Prenatal Vitamins**
  Stuart Prenatal, Nature's Bounty Prenatal Vitamins
- **Reading Glasses and Maintenance Accessories**

Please Note: Currently, the IRS does NOT allow the following expenses to be reimbursed under Health Care FSAs or HSAs as they are not prescribed by a physician for a specific ailment.

Sample List of Ineligible Expenses

- Contact Lens or Eyeglass Insurance
- Cosmetic Surgery/Procedures
- Electrolysis
- Marriage or Career Counseling
- Swimming Lessons
- Personal Trainers
- Sunscreen (SPF less than 30)

Note: This list is not meant to be all-inclusive.

For a complete up-to-date list of FSA Eligible Products & Services please reference the FSAStore.com.

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[DENTAL BENEFITS]

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RESTAURANT SERVICES

MetLife

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.

[VISION BENEFITS]

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RESTAURANT SERVICES

MetLife

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

BENEFITS PROVIDER LOOKUP INSTRUCTIONS

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RESTAURANT SERVICES

Benefits Provider
Lookup Instructions

Locating a Medical Provider (Florida Blue)

1. Visit www.floridablue.com and select **Find a Doctor**.
2. Scroll down to **Just browsing? Search Our Provider Networks**. Then, enter your zip code.
3. Under **Select a Plan**, scroll down to **BlueCare** or **BlueOptions**.
4. On the next screen, it will prompt you to either log in or indicate if it is an employer plan. If you have your ID card containing your group number, go ahead and indicate **Yes**. If you do not, indicate **No** so you can browse in-network providers.

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**.

Fourth Florida Blue MetLife

[LIFE + AD&D INSURANCE]

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RESTAURANT SERVICES

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.

DISABILITY INSURANCE: LTD + STD

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RESTAURANT SERVICES

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.*

[LEGAL PROTECTIONS]

23
RESTAURANT SERVICES

Legal Protections
Legal Shield & ID Shield

LegalShield℠

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

IDShield℠

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

LegalShield℠ | IDShield℠

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

ADDITIONAL TEAM MEMBER SAVINGS

FULL-TIME STATUS NOT REQUIRED

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RESTAURANT SERVICES

[LIFEMART + TICKETS AT WORK]

23
RESTAURANT SERVICES

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

LifeMart®
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

[PET INSURANCE]

23
RESTAURANT SERVICES

Fourth®

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.

Fourth®

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!

$2.94/pay period for Single Pet Plan

$4.27/pay period for 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.

Pet Assure

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.

AskVet

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

[FORD + LINCOLN DISCOUNTS]

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RESTAURANT SERVICES

Ford Partner Recognition
X-Plan Vehicle Pricing

THE PRIVILEGE OF PARTNERSHIP
EXCLUSIVE PRICING. EXCEPTIONALLY SIMPLE.

FORD **BRONCO SPORT** FORD **EXPLORER** FORD **F-150**

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:**

M7IOZ

X-PLAN
PRICING
+ CUSTOMER INCENTIVES
= GREAT SAVINGS

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

Ford
Go Further

BOZARD

Ford

LINCOLN

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!

Ford's GARAGE

X-PLAN PRICING

X-PLAN PRICING + CUSTOMER INCENTIVES =

GREAT SAVINGS!

Ford Partner Recognition X-Plan Vehicle Pricing

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.

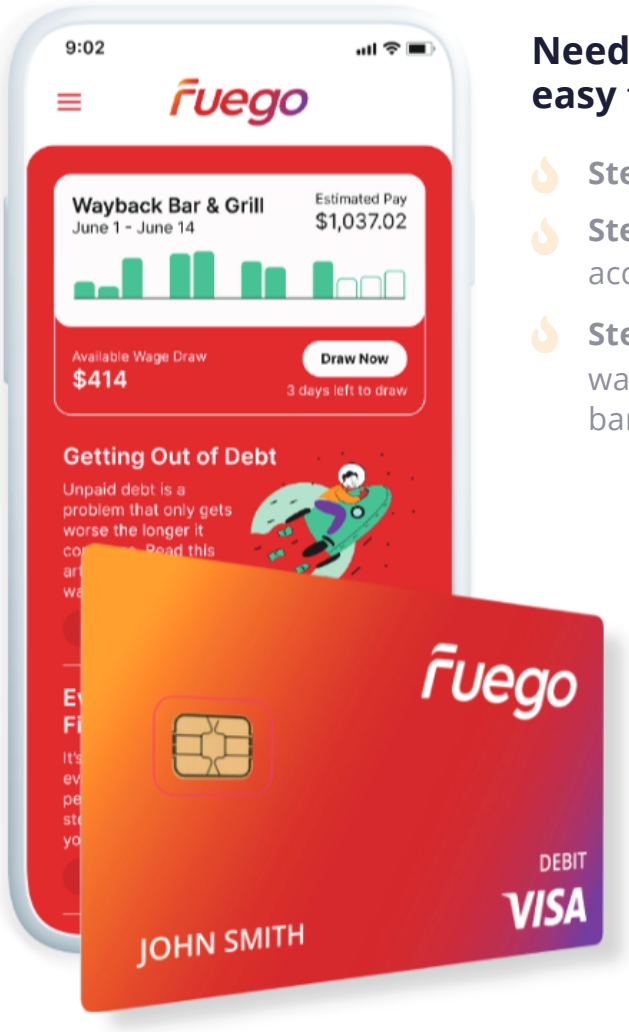
[FUEGO]

23
RESTAURANT SERVICES

Welcome to Fuego™

23 RESTAURANT SERVICES

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

Download on the App Store

GET IT ON Google Play

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.

Fourth.

Fuego FAQs

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

FAQs

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

Introducing Fuego, On-Demand Pay | GetFuego.com

Stay Connected

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Download on the App Store

GET IT ON Google Play

1. Standard rates for data and messaging may apply from your wireless provider.
For support call us @ 1-855-715-8518, or visit us at getfuego.com

The Fuego Visa Card is issued by Central Bank of Kansas City, Member FDIC, pursuant to a license from Visa U.S.A., Inc. and may be used everywhere Visa debit cards are accepted. 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 ww w.getfuego.com/legal (varies) or such fees, terms, and conditions, you can contact us toll-free 24/7/365 at 1-855-715-8518. ...ge questions regarding the Card

DMHO SUMMARY OF BENEFITS

23
RESTAURANT SERVICES

Dental

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

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.

[FEDERAL GUIDELINES]

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RESTAURANT SERVICES

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 members 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 ACT LEGISLATION 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 provides.

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA) OF 2008 Title II of the Genetic Information Nondiscrimination Act of 2008 protects applicants and team members 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 members 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.

FEDERAL GUIDELINES

HIPAA 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 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.

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 East Jackson Street

Tampa, FL 33602

877-315-0004

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 pre-existing condition exclusion period of more than 12 months. Any pre-existing condition exclusion period will be reduced by the amount of your prior creditable health coverage. Effective for plan years beginning on or after January 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 not impose 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 MHPAEA regulations also require plans and issuers to ensure parity with respect to no quantitative treatment limitations (such as medical management standards).

PREVENTIVE CARE: Health plans will provide in-network, first-dollar coverage, without cost-sharing, for preventive 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.

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, 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 your health or safety. We never share your information for marketing purposes or sell 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.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Dear Employee, Spouse and Dependent Children:

We have been retained by your sponsoring employer to provide you with information concerning your rights under COBRA. You are receiving this notice because you have recently become covered or will become covered under your sponsoring employer's group health plan ("the Plan"). **This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. This notice only gives a summary of your continuation coverage rights under the Plan. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator or the COBRA administrator.

What is COBRA Continuation Coverage?

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

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

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

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

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

Qualified beneficiaries also include a child born to or placed for adoption with the covered employee who satisfies the plan eligibility requirements and becomes covered under the Plan during the period of COBRA coverage.

Retirees

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your sponsoring employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the COBRA administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the sponsoring employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the COBRA administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child) causing a loss of coverage, you must notify the COBRA administrator in writing within 60 days after the later of the date the qualifying event occurs or the date that you would lose benefits due to a qualifying event. The employee or family member can provide notice on behalf of themselves as well as other family members affected by the qualifying event. The written notice of the qualifying event should be sent to the COBRA administrator, at the address provided in this notice, and should include all of the following:

- Date (month/day/year)
- Spouse/Dependent's Name
- Social Security Number/ID#
- Spouse/Dependent's Address
- Spouse/Dependent's Telephone #
- Gender
- Date of Birth (month/day/year)
- Relationship to Employee
- Employer's Name
- Employee's Name
- Employee's SSN/ID#
- Reason for Loss of Coverage
- Loss of Coverage (month/day/year)

If you need help acting on behalf of an incompetent beneficiary, please contact the COBRA administrator for assistance.

How is COBRA Coverage Provided?

Once the COBRA administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. You will not have to show that you are insurable to choose continuation coverage. However, you will have to pay the group rate premium for your continuation coverage plus a 2% administration fee, if applicable.

How long does COBRA coverage last?

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. However, if the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for the spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). There are two ways in which an 18-month period of COBRA continuation coverage can be extended:

1) Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the COBRA vendor in writing in a timely fashion, you and your entire family may be entitled to receive an additional 11 months of COBRA continuation coverage for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. The qualified beneficiary must provide the written determination of disability from the Social Security Administration to the COBRA administrator within 60 days of the latest of the date of the disability determination by the Social Security Administration, the date of the qualifying event or the benefit termination date; and prior to the end of the 18-month COBRA continuation period. You will be required to pay up to 150% of the group rate during the 11- month extension.

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

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

If You Have Questions

Questions concerning your Plan should be addressed to the Plan Administrator of the sponsoring employer. Questions concerning your COBRA continuation coverage rights should be addressed to the COBRA administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Please Note

Some states offer financial aid to help certain individuals pay for COBRA coverage. Contact your appropriate state agency regarding availability and eligibility requirements. Additionally, under certain circumstances, COBRA coverage may be paid with pre-tax dollars from a cafeteria plan under Section 125.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator and the COBRA administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to either the Plan Administrator or the COBRA administrator.

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 and 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 Florida Blue 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 Florida Blue 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:	1/1/2025
Name of Entity:	23 Restaurant Services
Contact:	Jeff Gabriel
Address:	505 East Jackson Street Tampa, FL 33602
Phone:	877-315-0004

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 your employer or the Employee Care Center (ECC) and one will be provided to 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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RESTAURANT SERVICES

Ford's GARAGE
PRIME BURGERS | CRAFT BEER

YEOMAN'S
TOPGOLF SWING SUITE

DON THE BEACHCOMBER

THE GANTT RESERVE COLLECTION

Arnold Palmer's CENTERCUP

TIKI DOCKS