2021 Benefit Summary

Helping you make informed choices
about your employee benefits.

Cafe Rio
MEXICAN GRILL®

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IMPORTANT:

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, federal law gives you more choices about your prescription drug coverage. Please see page 28 for more details.

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

This guide provides you with a basic summary of the benefits available to you for the 2021 calendar year. You are responsible for understanding these benefits and making enrollment decisions that best suit your personal and family health needs. If there are any conflicts between information provided in this guide and the official carrier plan documents, the carrier plan document is the final authority.

Benefits Overview

Welcome to the Cafe Rio 2021 Benefits Guide. This guide is designed to highlight your benefit options so that you can make the best possible decision for you and your family. We hope that this guide will be a resource to use throughout the year for services and benefits provided and offered to you as a valued Cafe Rio employee.

Know Your Benefits

Making wise decisions about your benefits requires planning. By selecting benefits that provide the best care and coverage, you can optimize their value and minimize the impact to your budget. The best thing you can do is "shop" for benefits carefully, using the same type of decision-making process you use for other major purchases.

1. **Take advantage of the tools available to you.** That includes this guide, access to plan information, provider directories, and enrollment materials.
2. **Be a smart shopper.** If you were buying a car or purchasing a home, you would do a lot of research beforehand. You should do the same for benefits because the wrong decision could be costly.
3. **Don't miss the deadline and keep record of your enrollment!** Pay attention to the enrollment deadline and be sure make your online elections in a timely manner. It is important to review your paycheck to ensure the accuracy of payroll deductions. Notify HR immediately if there are any discrepancies.

Who Is Eligible?

For most benefits, if you are hired into a full-time position coverage will begin on the first day of the month following date of hire. You can also enroll your eligible dependents in the same plans you choose for yourself. Eligible dependents include your legal spouse , your domestic partner, and/or your natural, adopted or step-child(ren) to age 26.

How We Define Medical Benefits Eligibility

We are a large employer according to the Employer Shared Responsibility provisions of the ACA. The enrollment guidelines listed in this guide may vary if you are hired to work less than 30 hours per week (130 hours per month) or your hours worked drop below the threshold. Please contact us for our complete policy on Measurement Methods to determine full-time benefits eligibility status under the Employer Shared Responsibility.

When to Enroll

You can enroll in coverage within 30 days of your date of hire, or during the annual open enrollment period. Outside of your open enrollment period, the only time you can change your coverage is within 30 days after you experience a qualifying life event.

When Coverage Ends

For most benefits, coverage will end on the last day of the month in which:

- Your regular work schedule is reduced to fewer than 30 hours per week
- Your employment with Cafe Rio ends

Your dependent(s) coverage ends:

- When your coverage ends, or
- The last day of the month in which the dependent is no longer eligible

Making Changes During the Year

The IRS provides strict regulations about the changes to pre-tax elections during the plan year. Once you enroll in benefits, you will not be able to make any changes to your elections until the next annual open enrollment period, unless you experience a qualified life event.

Qualified life events include, but are not limited to:

- Change in your legal marital status
- Change in number of dependents
- A dependent no longer meets the eligibility requirements
- You and/or your dependent becomes eligible or loses eligibility for Medicare, Medicaid or the Children's Health Insurance Program (CHIP)
- Employee or dependents change in employment status resulting in loss or gain of eligibility for employer sponsored benefits
- A court or administrative order

It is your responsibility to make changes online at **www.mycaferio.com** within 30 days after a qualified life event. Any benefit changes must be directly related to the qualified life event.

What's New In 2021?

It's important to review your options and learn what has changed or what is new. Be sure to take the time to review your current benefit options before deciding whether or not to make changes to your coverage during open enrollment.

Online Enrollment

This year is an active enrollment meaning you need to review your benefits and make active elections for all benefits, even if they are not changing. If you would like to enroll, decline or make changes to your 2021 benefits, you will need to do this during open enrollment scheduled for **November 16 to November 30th**. All elections and changes can be made by speaking with a dedicated enrollment counselor over the phone, **888.598.2040 (English) 877.256.4248 (Spanish)** or going to **www.mycaferio.com**. Your current retirement plan elections including 401(k) and Roth will carryover to the new plan year. There are enrollment instructions contained within this guide to assist you with this process.

Health Savings Account (HSA) – Increase in Contribution Limits for 2021

The annual HSA contribution limit will increase for individual coverage to $3,600 and $7,200 for family coverage.

The Coronavirus Aid, Relief and Economic Security Act (CARES Act) enacted these changes listed below.

During the National Public Health Emergency starting **January 31, 2020** FDA approved COVID Testing covered at no cost share:

- Regardless of the plan you are enrolled in COVID testing and test related visits are covered at 100%, but only when ordered by a physician or health care professional for purposes of diagnosis or treatment of a member. Normal coinsurance and copayments will apply for treatment.
- Once released the vaccine will be covered at 100%

Retroactive to January 1, 2020 the IRS Qualified Medical Expenses list was expanded to include:

- Over the Counter Medications – Prescriptions are no longer required in order to use your Health Savings Account / HSA to purchase over-the-counter (OTC) drugs, including items like pain relievers, cough medicine and more.
- Menstrual care products – these items have been added to the list of qualifying expenses under an HAS

Outbreak period starting March 1, 2020 has extended HIPAA Special Enrollment Rights

Due to COVID-19 you might be entitled to an extended time-line for certain life events changes.

Please contact HR for any additional questions.

Critical Illness

An Infectious Disease Benefit as been added for individuals enrolled in Critical Illness insurance. Our standard plan design now pays a 25% benefit for: Diagnosis of a severe infectious disease by a Doctor, including COVID-19, when a diagnosis occurs on or after coverage effective date; and Confinement to a Hospital for five (5) or more consecutive days, or in a transitional facility for fourteen (14) or more consecutive days.

How to Enroll in Benefits

» This year is a an active open enrollment which means you must actively re-elect your benefits even if you are not making changes.

» You may enroll in your Cafe Rio benefit options within 30 days from your hire date or effective date into a qualified position and annually during open enrollment.

» Open Enrollment for the 2021 plan year will be conducted November 16th to November 30th.

» You may also enroll within 30 days of qualified life events.

How to Enroll Over the Phone

Enrolling is easy.

» Go to **www.caferiobenefits.com** to review the benefit material.

» When ready, phone the Benefits Call Center to enroll.

» If possible, be in front of a computer when calling.

» Our representative will then enroll you over the phone.

Please Note: when you call in, make sure you have your dependents birth dates and social security numbers. This information is required to enroll your dependents in eligible benefits and to complete your beneficiary designations.

888.598.2040 (English Speaking)
877.256.4248 (Spanish Speaking)
Monday-Friday 7:00am-4:00pm CST

How to Enroll Online:

STEP 1: Log In

» To get started go to **www.mycaferio.com**.

» Enter your User Name and Password, then click Log In.

» **User Name:** First initial of first name, full last name + @xrxhf

» **Password:** Will be reset on ADP site

» If this is your first time logging in you will be prompted to change your password and set up some security questions.

STEP 2: Edit Your Beneficiary and Dependent Information

» Once you are logged in, on your homepage click on the 2021 Open Enrollment link

» View and update your beneficiary and dependent information, then click **next**.

- To update an existing beneficiary, dependent, or emergency contact click on his/her name, then click **edit**.
- To add a new beneficiary, dependent, or emergency contact, click **add**.
- Be prepared to enter the full name, social security number, date of birth, gender, and relationship.
- Be sure to click to select the Dependent and/or Beneficiary check box(es), then click **Save**.

STEP 3: Select Your Benefits

» Enroll or Decline the benefits on each page.

» After making the election on each page, select the **next** arrow to advance through each open enrollment benefit.

STEP 4: Confirm Your Changes

» Once you make your elections, you will be able to view a summary of your new benefit elections.

» To make changes to any of your new elections click on the plan name link.

» You can print the page for your records.

STEP 5: Submit Your Elections

» Once you confirm your elections, click **submit**. Congratulations, you have completed your enrollment!

NOTE: If you do not click the **submit** button, your elections will not be processed.

Medical Benefits

Administered by UMR

Our UMR high deductible health plan (HDHP) options put you in control of your healthcare giving you the flexibility to decide how you spend your healthcare dollars. You can find participating providers by calling UMR directly at **800.826.9781** or by accessing **www.member.umr.com** and clicking **Find a Provider** in the bottom left corner. Select under "U" the United Healthcare Choice Plus Network (English) or (Spanish) or type United Healthcare Choice Plus in the search bar at the top. Click the "View Providers" button in the bottom left and you will be linked to United Healthcare's website where you can search by doctor, facility, or specialty based off of your zip code.

	High Deductible Health Plan Option 1	
	In-Network	Out-of-Network
Deductible Calendar Year (non-embedded)	$1,750 / employee only $3,500 / other coverage levels	$3,500 / employee only $7,000 / other coverage levels
Out-of-Pocket Maximum (non-embedded)	$4,000 / employee only $8,000 / other coverage levels	$10,000 / employee only $20,000 / other coverage levels
Lifetime Maximum	Unlimited	
Preventive Care	Plan pays 100%	You pay 40% AD
Office Visits	You pay 20% AD	You pay 40% AD
Urgent Care	You pay 20% AD	You pay 40% AD
Laboratory and Radiology	You pay 20% AD	You pay 40% AD
Inpatient Hospital Services	You pay 20% AD	You pay 40% AD
Outpatient Hospital Services	You pay 20% AD	You pay 40% AD
Emergency Room	You pay 20% AD	
Pharmacy	Once the medical deductible is met, the member is responsible for the copay TIER 1: $15 TIER 2: $40 TIER 3: $70	Not covered

AD = after deductible

Employee Cost	
Status	Employee Premium Per Pay Period
Employee Only	$55.97
Employee + Spouse	$132.30
Employee + Child(ren)	$100.59
Family	$195.83

	High Deductible Health Plan Option 2	
	In-Network	Out-of-Network
Deductible Calendar Year (non-embedded)	$2,500 / employee only $5,000 / other coverage levels	$5,000 / employee only $10,000 / other coverage levels
Out-of-Pocket Maximum (embedded)	$5,000 / employee only $10,000 / other coverage levels	$10,000 / employee only $20,000 / other coverage levels
Lifetime Maximum	Unlimited	
Preventive Care	Plan pays 100%	You pay 50% AD
Office Visits	You pay 20% AD	You pay 50% AD
Urgent Care	You pay 20% AD	You pay 50% AD
Laboratory and Radiology	You pay 20% AD	You pay 50% AD
Inpatient Hospital Services	You pay 20% AD	You pay 50% AD
Outpatient Hospital Services	You pay 20% AD	You pay 50% AD
Emergency Room	You pay 20% AD	
Pharmacy	Once the medical deductible is met, the member is responsible for the copay TIER 1: $15 TIER 2: $40 TIER 3: $70	Not covered

AD = after deductible

Employee Cost	
Status	Employee Premium Per Pay Period
Employee Only	$37.37
Employee + Spouse	$95.13
Employee + Child(ren)	$72.56
Family	$140.12

Preventive Care and Virtual Visits

Preventing disease and detecting health issues at an early stage is essential to living a healthy life. Following these preventive care guidelines – and your physician's advice – will help you stay healthy. Be sure to discuss specific health questions and concerns with your doctor. These preventive services are covered at 100% and costs you nothing as a plan participant. This is just a list of the most common tests – the full list is available on **www.healthcare.gov/coverage/preventive-care-benefits/**.

Health screenings, counseling and services for:

» Alcohol Misuse
» Anemia
» Annual Physical Exams
» Bacteriuria
» Blood Pressure
» Breast Cancer
» Breast Cancer Chemo Prevention
» Breastfeeding Equipment
» Breastfeeding – lactation support and counseling
» Breastfeeding Supplies
» Cervical Cancer
» Chlamydia Infection
» Cholesterol
» Colorectal Cancer
» Congenital Hypothyroidism
» Contraceptive Devices
» Depression Screening
» Diabetes (Type 2)
» Diabetes (Gestational)
» Hepatitis B for Pregnant Women
» Hepatitis C
» HIV Screening
» Interpersonal and Domestic Violence
» Metabolic Screening
» Obesity
• Osteoporosis
• Phenylketonuria (PKU)
• Skin Cancer
• Sterilization
• Tobacco Use
• Well-Child Exams

Immunizations

Please consult with your physician for frequency

» Diphtheria, Pertussis, Tetanus (DPT)
» Haemophilus Influenzae Type B (Hib)
» Hepatitis A
» Hepatitis B
» Herpes Zoster (shingles)
» Human Papillomavirus (HPV)
» Inactivated Poliovirus
» Influenza
» Measles, Mumps, Rubella (MMR)
» Meningococcal
» Pneumococcal
» Rotavirus
» Varicella

Prescription Medications

Medications require a prescription

» Aspirin for the prevention of cardiovascular disease
» Contraceptive Injectables
» Contraceptive Pills
» Contraceptive Products – Topical
» Emergency Contraceptive Products
» Fluoride Supplements
» Folic Acid Supplements
» Iron Supplements
» Tobacco Use
» Vitamin D Supplement

Teladoc - Access to care at any time, anywhere on your phone or computer

A Teladoc virtual visit lets you see and talk to a doctor from your phone or computer without an appointment. Most visits take about 10-15 minutes and doctors can write a prescription, if needed, that you can pick up at your local pharmacy. This is available if you are enrolled in the UMR Medical plan and will cost you no more than $50 per visit before you have met your deductible and a 20% coinsurance after you have met your deductible.

Conditions commonly treated through a virtual visit: bladder infection/UTI, bronchitis, cold/flu, diarrhea, fever, migraine/headaches, pink eye, rash, sinus problems, sore throat & stomach ache.

You can access Teladoc by calling **1.800.TELADOC** or at **www.teladoc.com**. Have you UMR member ID information on hand so that your Teladoc visit can be linked to your UMR health plan through Cafe Rio.

Teladoc®

24/7 doctor visits via phone or mobile app

Teladoc gives you access 24 hours, 7 days a week to a U.S. board-certified doctor through the convenience of phone, video or mobile app visits. It's an affordable option for quality medical care.

Talk to a doctor anytime, anywhere you happen to be

Receive quality care via phone, video or mobile app

Prompt treatment, median call back, in 10 minutes

A network of doctors that can treat every member of the family

Prescriptions sent to pharmacy of choice if medically necessary

Teladoc is less expensive than the ER or urgent care

Talk to a doctor anytime!

Teladoc.com 1-800-Teladoc

Get the care you need

Teladoc doctors can treat many medical conditions, including:

- *Cold & flu symptoms*
- *Allergies*
- *Pink eye*
- *Respiratory infection*
- *Sinus problems*
- *Skin problems*
- *And more*

With your consent, Teladoc is happy to provide information about your Teladoc visit to your primary care physician.

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Health Savings Account

Administered by HealthEquity

Cafe Rio's medical options are both High Deductible Health Plans (HDHPs). An HDHP is a health insurance plan that is eligible for a Health Savings Account (HSA). Cafe Rio contributes funds into your Health Savings Account at and encourages you to also contribute funds pre-tax out of your paycheck. If you are joining either medical plan for the first time with Cafe Rio, the company will contribute $750 if you are enrolled in Employee Only coverage or $1,500 if you are enrolled with at least one other dependent on your effective date of coverage. These amounts will be pro-rated throughout the year if you join the plan mid-year.

If you have been on the plan and are continuing coverage, Cafe Rio will annually contribute $750 for Employee Only coverage and $1,500 if you are enrolled with at least one other dependent. Cafe Rio contributions will be made on a per pay period basis throughout the year.

What is a Health Savings Account

An HSA is like a personal bank account that you own. You may use the money in your HSA to pay for any qualified health care expenses for you, your spouse and your tax dependents, even if they are not covered on your plan.

Examples of qualified health care expenses include:

» Your insurance plan deductibles, copayments and coinsurance
» Doctor's office visits
» Prescriptions
» Dental treatments and x-rays
» Eyeglasses and vision exams

To view and entire list of qualified expenses visit **www.irs.gov/pub/irs-pdf/p502.pdf**.

Who Is Eligible?

In order to open an HSA, you must meet the following requirements:

- Be enrolled in one of Cafe Rio's Medical Plans
- Be at least 18 years old
- Not claimed as a dependent on someone else's tax return
- Not enrolled in Medicare
- Not covered by dual medical plans unless enrolled in another HDHP plan

Getting Started

An HSA through HealthEquity will be opened for you when you enroll in one of Cafe Rio's medical plans. Your account will be funded with both Cafe Rio's contributions and your own contributions if you've elected to contribute to your account. Contributions you make are funded over the year and can be changed at any time. See the table below for the Cafe Rio contribution schedule. Contributions you make to your HSA and receive from Cafe Rio should not exceed the IRS contribution limits for the calendar year. The limits include both the employer and employee contributions.

2021 Cafe Rio Contribution		
Enrollment	Employees newly enrolled as of January 1, 2021*	Existing enrolled employees as of January 1, 2021*
Employee Only	$750 funded in full on January 1, 2021	$750 annually; $28.85 per pay period funding
Family	$1,500 funded in full on January 1, 2021	$1,500 annually; $57.69 per pay period funding

*These amounts will be prorated if coverage begins mid-year.

IRS HSA Contribution Limits	
Status	**2021**
Employee Only	$3,600
Family	$7,200

If you are age 55 or older, you may contribute an additional $1,000 to your HSA.

Why HSA?

One of the main reasons to contribute to an HSA is for the tax benefits. As an HSA user, you save in several ways:

» Reduce federal income taxes – your payroll deductions reduce federal taxes, because it reduces your taxable earnings by the amount you deposit into your HSA.

» Tax-free interest – money in your HSA earns interest while it's in the account and earnings grow tax free.

» Tax-free withdrawals – withdrawals remain tax free as long as the money is used to pay for qualified health expenses.

With an HSA, you own the account and all contributions. Your entire HSA balance rolls over from year to year and remains available for qualified expenses even if you change health plans, retire, or leave the company. Once you reach a determined account balance, you can invest your HSA funds for increased earning potential.

Learn More

» **www.healthequity.com/hsalearn**

» **866.346.5800**

* HSAs are never taxed at a federal income level when used appropriately for qualified medical expenses. Also, most states recognize HSA funds are tax-free with very few exceptions. Please consult a tax advisor regarding your state's specific rules.

Dental Benefits

Administered by UMR

Good health includes healthy teeth and gums. Our dental plans are designed to help you maintain a healthy smile through regular preventive dental care, and to fix any problems as soon as they occur. Because preventive care is so important, both plans cover these services in full with no deductible or copay when you visit participating UMR in-network plan providers. To find a participating provider, call UMR at **800.826.9781** or go online at **www.member.umr.com**.

Network: PPO 30

	Dental PPO $2,000 Plan		Dental PPO $1,000 Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible (waived for Preventive Services and Orthodontics)	$50 per person		$50 per person	
Calendar Year Out-of-Pocket Maximum	$2,000 per person (excludes orthodontics)		$1,000 per person	
Preventive Services (e.g. x-rays, cleanings, exams)	100%	100%	100%	100%
Basic Services (e.g. fillings, extractions, root canals)	90%	90%	80%	80%
Major Services (e.g. dentures, crowns, bridges)	60%	60%	50%	50%
Orthodontics (children up to age 19)	50%	50%	Not covered	Not covered
Orthodontic Lifetime Maximum	$1,500 per person		No coverage	

AD = after deductible

Employee Cost Per Pay Period		
Status	PPO $2,000	PPO $1,000
Employee Only	$5.50	$4.00
Employee + Spouse	$10.00	$7.50
Employee + Child(ren)	$11.00	$9.00
Family	$17.00	$13.00

Vision Benefits

Administered by UMR

The vision plan includes benefits for eye exams, eye glasses, and contact lenses through UMR. You may visit a doctor within the UMR network and take advantage of higher benefits coverage, or visit an out-of-network provider of your choice for a reduced benefit. To find a participating provider contact UMR at **800.638.3120** or go online to **www.member.umr.com**.

	Vision Plan	
	In-Network	Out-of-Network
Exam (once every 12 months)	$10	Up to $45
Frames (once every 24 months)	Up to $130	Up to $45
Materials Copay	$25	N/A
Lenses (Once every 12 months)		
Single Vision	Covered 100% after Materials copay	Up to $40
Bifocal		Up to $60
Trifocal		Up to $80
Lenticular		Up to $80
Contact Lenses (Once every 12 months)		
Elective	Up to $125	Up to $125
Therapeutic	Covered 100%	Up to $210

Employee Cost	
Status	Employee Cost Per Pay Period
Employee Only	$1.75
Employee + Spouse	$3.50
Employee + Child(ren)	$4.50
Family	$5.50

Life and AD&D

Administered by Lincoln Financial

Life Insurance and Accidental Death & Dismemberment (AD&D) benefits provide you and your loved ones financial protection in the event of an illness, accident, or death. To learn more, contact Lincoln Financial at **800.423.2765** or go online at **www.lfg.com**.

Employer Paid Basic Life and Accidental Death and Dismemberment (AD&D)

Cafe Rio provides you with a base level of life insurance and accidental death & dismemberment insurance for you, your spouse and children at no cost to you provided you are a restaurant manager or non-restaurant employee. The covered amount is one times your annual salary up to a maximum of $175,000. Spouse and Child life insurance is also paid for in the amount of $5,000.

Employee Paid Supplemental Life Insurance and AD&D

To supplement the coverage provided by Cafe Rio, you can purchase additional life insurance and AD&D coverage for yourself in increments of $10,000 up to a maximum of $500,000 (not to exceed 5x salary). The guaranteed issue amount is $200,000 for new hires only. This means that you will not be required to answer any health questions for any application for $200,000 or less.

If you elected additional coverage for yourself, you may also purchase term life insurance and AD&D for your spouse in increments of $10,000 up to $250,000. The guaranteed issue amount is $30,000 for new hires only.

You may purchase additional term life insurance for your child(ren) in the amounts of $10,000 or $20,000, if you elected additional coverage for yourself.

Evidence of Insurability

During open enrollment or your new hire eligibility period, you are not required to complete Evidence of Insurability (EOI) unless you are applying for coverage amounts that exceed the guarantee issue. You will be guaranteed the amount up to the GI, but any additional amounts would be subject to medical underwriting.

Beneficiary Designation

We recommend you designate a beneficiary for your life insurance policy(ies). A beneficiary is the person (or people, estate, trust, etc.) to whom, benefits will be paid to in the event of your death. You may change your beneficiary at any time during the plan year.

Monthly Optional Life and AD&D Rates Per $1,000 of Benefit		
Age	Employee	Spouse
Under 20	$0.057	$0.057
20 – 24	$0.090	$0.090
25 – 29	$0.090	$0.090
30 – 34	$0.090	$0.090
35 – 39	$0.110	$0.110
40 – 44	$0.159	$0.159
45 – 49	$0.239	$0.239
50 – 54	$0.379	$0.379
55 – 59	$0.610	$0.610
60 – 64	$0.935	$0.935
65 – 69	$1.714	$1.714
70 – 74	$3.494	$3.494
75 – 79	$7.058	$7.058
80 – 99	$14.022	$14.022

Dependent Child Optional Life (no AD&D) *Premiums are per family, not per child*	
Term Life Coverage	Monthly Premium
$10,000	$2.97
$20,000	$3.35

Calculating Your Monthly Premiums			
Term Life Coverage	Increment	Rate	Monthly Cost
Employee $______	/ $10,000 x	$______=	$______
Spouse $______	/ $10,000 x	$______=	$______
TOTAL MONTHLY COST =		$____________	

Short- and Long-Term Disability

Administered by Lincoln Financial

Disability insurance benefits replace a portion of your income if you are unable to work for a period of time due to a qualified off-the-job injury or illness. To learn more, contact Lincoln Financial at **800.423.2765** or go online at **www.lfg.com**.

Employer Paid Short-Term Disability

Short-term disability provides a source of income should your qualified disability keep you from working for more than a week.

Employer Paid Long-Term Disability

Long-term disability provides an ongoing source of income if your disability is prolonged.

Definition of Disability

The definition of disability is used to determine an employee's eligibility for benefits. An individual's physical or mental inability to perform the major duties of his or her occupation because of illness or injury.

Eligibility

If you are a restaurant manager or non-restaurant employee, you are eligible for the employer-paid Short-Term and Long-Term Disability benefits at no cost to you.

Disability Benefits		
	Short-Term Disability	Long-Term Disability
Benefit Amount	60% of weekly earnings	60% of monthly salary
Maximum Benefit	$1,385 weekly	$6,000 monthly
Benefit Waiting Period	14 days	180 days
Maximum Benefit Duration	24 weeks	Social Security Normal Retirement Age
Definition of Earnings	Employee's annual wage or salary. It does not include overtime, bonuses, commissions or other extra compensation.	

Voluntary Supplemental Benefits

Administered by Voya

Voluntary benefits can help safeguard your personal finances. They are designed to supplement medical plans by providing financial protection in the event of a serious health problem or accident. These plans are not intended to replace true medical coverage. This is a brief summary of each plan offered; for more details see the brochures available on your enrollment portal.

Eligibility & Enrollment

» Benefit-eligible employees working

» Spouses can be enrolled if under age 70 and children may be enrolled up to age 26 (you must elect coverage yourself).

» Enroll online. Health questions will not be asked; you are guaranteed coverage.

» Plans are effective January 1, 2021. These plans are compatible with Health Savings Accounts.

Voya Group Hospital Indemnity Insurance

An overnight stay in the hospital is expensive, and there may be additional costs unrelated to your stay such as having a baby or missing work. Hospital Confinement coverage pays a cash benefit when you are admitted for an overnight stay. The plan also pays a daily benefit each day for up to 30 days per confinement. When confined in the ICU, the daily benefit pays double. You can use the monies to pay for medical bills not covered by insurance, or in any way you see fit.

Benefits from a Hospital Indemnity plan can be used to assist you in paying deductibles, coinsurance, out-of-network costs, daily living expenses, etc. Benefits are paid regardless of other coverage and this plan is compatible with Health Savings Accounts. Benefits include:

» Daily Benefits pay per confinement; the admission benefit is paid once in the calendar year.

» Rehabilitation Unit – payable for up to 30 days

» Wellness Benefit of $50 per employee/spouse and up to four $25 wellness benefits for children payable per calendar year

Hospital Benefits			
First Day Hospital Confinement	Daily Hospital Benefit *Up to 30 days*	Intensive Care Benefit *Up to 15 days*	Rehabilitation Unit *Up to 30 days*
$1,600	$200	$400	$100

Hospital Plan Bi-Weekly Premiums			
Employee Only	Employee & Spouse	Employee & Child(ren)	Family
$12.32	$27.10	$21.21	$35.99

Voya Group Accident Insurance (off-the-job)

Accident insurance can help provide you with a cushion to help cover expenses and living costs if you are hurt unexpectedly off-the-job. While you can count on health insurance to cover medical expenses, it doesn't usually cover indirect costs that can arise with a serious, or even not-so-serious injury. You may end up paying out of your own pocket for things like transportation, over-the-counter medicine, day care and extra help around the house. With accident insurance, the benefits you receive can help take care of these extra expenses and anything else that comes up.

With Voya Group Off-the-Job Accident Insurance you can have peace of mind knowing:

» Coverage is guaranteed issue – no evidence of insurability required at initial enrollment

» Benefits are paid directly to you unless assigned to someone else

» Benefits are paid in addition to any other coverage

» Coverage is portable and may be continued if the employee leaves the group

Plan Highlights include:

» Urgent care/emergency room benefits, fractures, dislocations, stitches, ambulance, hospitalization and more (see plan documents) . It also includes an annual wellness benefit that can help offset the premium cost.

Accident Insurance	
Benefit Schedule	Employee Cost Per Pay Period
Dislocations and Fractures	Up to $6,400
Ambulance	$300 Regular / $1,250 Air
Urgent Care Services	$200
Emergency Room Services	$200
Hospital Confinement	$1,125 ($350/day)
Wellness Benefit	$50 per employee/spouse $25 for up to 4 children

Accident Plan Bi-Weekly Premiums			
Employee Only	Employee & Spouse	Employee & Child(ren)	Family
$5.43	$9.08	$11.45	$14.22

Voya Group Critical Illness Insurance

Critical Illness insurance provides a lump sum benefit to help you cover the out-of-pocket expenses associated with a critical illness diagnosis. Voya will pay out the amount you elect up to two times for each illness (except Cancer) as long as a 6 month period goes by in between a diagnosis.

With Voya Group Critical Illness Insurance you can have peace of mind knowing:

» Coverage is guaranteed issue – no evidence of insurability required

» Employee can elect from $10,000 or $20,000

» Employee's spouse can elect from $5,000 or $10,000

» Coverage reduces by 50% at age 70 but premiums do not reduce

» Dependent children under the age 26 are covered at no additional cost under the employees coverage. The child's Critical Illness benefit amount is 50% of your benefit amount.

» Coverage is portable and may be continued if employee leaves the group

Plan Highlights Include:

Heart Attack	Coronary Artery Bypass (25%)	Amyotrophic Lateral Sclerosis
Stroke	Coma	Parkinson's Disease
Major Organ Failure	Benign Brain Tumor	Alzheimer's Disease
Cancer and Skin Cancer (10%)	Deafness	Infectious Disease
Permanent Paralysis	Occupational HIV	End Stage Renal (Kidney) Failure
Carcinoma in Situ (25%)	Blindness	Multiple Sclerosis
Infectious Disease (25%)	Hepatitis B or C	Pacemaker Placement (10%)

Wellness Benefit

Pays $50 for employee and Spouse payable per calendar year

Critical Illness Rates (attained age)

Non-Tobacco Bi-Weekly Rates Employee and Child Coverage		
Age	$10,000	$20,000
<30	$2.77	$4.94
30-39	$3.32	$6.07
40-49	$6.32	$12.05
50-59	$12.60	$24.60
60-64	$20.35	$40.11
65-69	$26.08	$51.55
70+	$30.74	$60.88

Bi-Weekly Tobacco Rates Employee and Child Coverage		
Age	$10,000	$20,000
<30	$3.74	$6.88
30-39	$4.94	$9.28
40-49	$9.78	$18.97
50-59	$20.40	$40.20
60-64	$34.29	$67.98
65-69	$40.11	$79.62
70+	$46.11	$91.62

Non-Tobacco Bi-Weekly Rates Spouse Coverage		
Age	$5,000	$10,000
<30	$1.80	$3.00
30-39	$2.08	$3.55
40-49	$3.62	$6.65
50-59	$7.22	$13.85
60-64	$11.45	$22.29
65-69	$14.33	$28.06
70+	$23.79	$46.98

Bi-Weekly Rates Spouse Coverage		
Age	$5,000	$10,000
<30	$2.33	$4.06
30-39	$2.93	$5.26
40-49	$5.45	$10.29
50-59	$11.49	$22.38
60-64	$19.11	$37.62
65-69	$21.97	$43.34
70+	$36.42	$72.23

Claims Information

To obtain claim forms, contact phone numbers and mailing Information, or to submit your claims to Voya electronically, visit the Voya Claims Center at: **www.voya.com**.
You can file your wellness benefit telephonically (no claim form or proof of exam required) by calling: **877.236.7564**.

Legal Services

Administered by Nationwide

LegalGUARD is an insurance plan that provides support and protection from unexpected personal legal issues and provides coverage for you, your spouse, your dependent children and your parents for $16.03 per month. With LegalGUARD you will get:

» An attorney with expertise specific to your personal legal matter

» Access to a national network of attorneys/option to use "out of network benefits

» Help navigating common individual or family legal issues

Being a member saves legal fees and provides paid in full coverage for:

HOME & RESIDENTIAL	**AUTO & TRAFFIC**
FINANCIAL & CONSUMER	**FAMILY**
ESTATE PLANNING & WILL	**GENERAL**

Additional Plan Highlights:

Immigration Assistance: Unlimited Advice and consultation, preparation of affidavits & power of attorney, assistance with court preparation ***Plan covers all covered and non – covered family members up to 15 hours per year per person	**5 Hours of Miscellaneous**: Nationwide has offered Café Rio employees 5 additional hours that can be used on top of any covered or non-covered services including but not limited to representation in court for immigration matters.

Additional Benefits included at no cost up to 10 hours per member per year:

» Debt

» Budgeting

» Elder Law and Financial

» Identity Theft Prevention and Restoration

» Credit

» Financial Planning

» Immigration Assistance (15 hours per year)

401(k) and Roth Retirement Benefits

Administered by John Hancock

Cafe Rio offers you a valuable benefit to help you save for the future. Saving now can help you have the income you will need at retirement, so get started today and take the first step toward a brighter financial future!

Why Retirement Plans?

There are significant tax advantages to contributing to a 401(k). For example, your qualifying contributions and all earnings on your account are not subject to current federal income tax (or, where applicable, state or local taxes) until you take them out of the Plan. This tax deferral gives your retirement savings the ability to grow under the most favorable terms possible.

Roth contributions will be included as taxable income. Earnings on Roth contributions will accumulate tax free, and retirement withdrawals may be exempt from federal income tax.

When and Who Can Participate?

Participation is open to employees who have attained age 21. Eligible employees may join the Plan on the January 1 or July 1 following the date the eligibility requirement is met.

How Do I Get Started?

» Go to **www.mycaferio.com** during your enrollment time period and elect a percentage to be withheld from your paychecks either pre-tax 401(k) or after-tax Roth.

» You may elect to contribute as much as $19,500, in total, to all accounts with an additional $6,500 if over the age of 50

» You will then need to go to **www.johnhancock.com** to select the investment options where your contributions will be allocated. You will need Cafe Rio's contract # 104198 to login. If selections are not made, your contributions will go to the default investment option.

Can I Stop or Change My Contributions

You may stop your contributions at the end of each quarter if desired. Once you discontinue contributions, you may start again as of the end of each subsequent quarter. You may increase or decrease the amount of your contributions quarterly.

Company Contributions

You will receive a dollar for dollar employer match on the first 4% you contribute to your 401(K) account. All funds are also 100% vested from day one.

Additional Benefits

Other important benefits, tools, and resources available to you through Cafe Rio.

Employee Assistance Program (Provided by ComPsych)

Because unresolved personal issues can affect every aspect of one's life, Cafe Rio automatically provides you and your family with an Employee Assistance Program (EAP) through Lincoln Financial. Our EAP is available to you at no cost and can be accessed 24 hours a day, 7 days a week. Our EAP provides unlimited telephonic confidential assistance with nearly any personal matter you may be experiencing. You are also eligible for in-person consultations with short-term issues; up to four sessions per person, per issue, per year. Licensed counselors can assist you with financial problems, domestic violence, managing stress, gambling and substance abuse, anxiety, depression and more. Please contact Lincoln Financial Employee Connect at **888.628.4824** or visit **GuidanceResources.com (username: LFGSupport | password: LFGSupport1)**.

Summary of Benefits and Coverage (SBC) and Uniform Glossary

In addition to the plan information in this Benefits Guide, you can also review a Summary of Benefits and Coverage for each medical plan. This requirement of the ACA standardizes health plan information so that you can better understand and compare plan features. We will automatically provide you a copy of the SBC and Uniform Glossary annually during open enrollment. Please contact HR should you need an additional copy.

Dependent Care FSA

Administered by APA Benefits

A dependent care FSA allows you to put aside money on a pre-tax basis to use for qualified dependent care expenses. This includes childcare for children under 13, eldercare expenses, or care for a disabled dependent who is your tax dependent of any age.

You may elect up to $5,000 (or $2,500 if married filing separately) to put aside each year to use for dependent care expenses while you (and your spouse, if married) are working or in school.

Your election amount will be taken out of your paycheck in equal installments over the year until the yearly maximum you've specified is reached.

To use this account, you will receive a debit card loaded with your election amount. You can use the card to pay for eligible dependent care expenses as they occur. You can also use another payment form and submit for reimbursement from your Dependent Care FSA.

You may be asked to provide substantiation for your expenses so always retain your receipts or invoices for your dependent care expenses.

Contact Information

Need Help?			
If you have questions regarding…	**Contact**	**Call**	**Click**
Enrollment Questions	Benefits Call Center	888.598.2040 (English Speaking) 877.256.4248 (Spanish Speaking)	benefits@caferio.com
General Benefits Questions, Replacement Cards etc.	Benefits Team	801.441.5000 (option 4, then option 2)	benefits@caferio.com
Medical	UMR	800.826.9781	www.member.umr.com
Pharmacy	UMR	800.826.9781	www.member.umr.com
Dental/Vision	UMR	800.826.9781	www.member.umr.com
Life And Ad&D/Disability	Lincoln Financial	800.423.2765	www.lfg.com
Health Savings Account	HealthEquity	866.346.5800	www.healthequity.com
Hospital Indemnity	Voya	877.236.7564	www.voya.com
Accident			
Critical Illness			
Legal Plan	Nationwide	800.248.9000	www.legaleaseplan.com/caferio
Employee Assistance Program	Lincoln Financial Employee Connect	888.628.4824	GuidanceResources.com username: LFGSupport password: LFGSupport1
Dependent Care Fsa	APA Benefits	801.561.4980	info@apabenefits.com or www.apabenefits.com

Important Notices and Disclosures

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan.

If you would like more information on WHCRA benefits, please contact Human Resources.

HIPAA Special Enrollment Rights

If you are declining enrollment 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 you or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

To request special enrollment or obtain more information, contact Human Resources.

Qualified Medical Child Support Orders

Coverage will be provided to any of your dependent child(ren) if a Qualified Medical Child Support Order (QMCSO) is issued, regardless of whether the child(ren) currently reside with you. A QMCSO may be issued by a court of law or issued by a state agency as a National Medical Support Notice (NMSN), which is treated as a QMCSO. If a QMCSO is issued, the child or children shall become an alternate recipient treated as covered under the Plan and are subject to the limitations, restrictions, provisions, and procedures as all other plan participants.

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

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

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **866.444.EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your state for more information on eligibility.

ALABAMA – Medicaid
http://myalhipp.com 855.692.5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program http://myakhipp.com/ | 866.251.4861 CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
http://myarhipp.com 855.MyARHIPP (855.692.7447)
CALIFORNIA – Medicaid
https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx 916.440.5676

COLORADO – Medicaid and CHIP
Health First Colorado (Colorado's Medicaid Program)
https://www.healthfirstcolorado.com
Member Contact Center: 800.221.3943 | State Relay 711
Child Health Plan Plus (CHP+)
https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
Customer Service: 800.359.1991 | State Relay 711
Health Insurance Buy-In Program (HIBI)
https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 855.692.6442

FLORIDA – Medicaid
www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
877.357.3268

GEORGIA – Medicaid
https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
678.564.1162, ext. 2131

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
http://www.in.gov/fssa/hip/ | 877.438.4479
All other Medicaid
http://www.indianamedicaid.com | 800.403.0864

IOWA – Medicaid and CHIP (Hawki)
Medicaid: https://dhs.iowa.gov/ime/members | 800.338.8366
Hawki: http://dhs.iowa.gov/Hawki | 800.257.8563

KANSAS – Medicaid
http://www.kdheks.gov/hcf/default.htm
800.792.4884

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
855.459.6328 | KIHIPP.PROGRAM@ky.gov
KCHIP: https://kidshealth.ky.gov/Pages/index.aspx | 877.524.4718
Medicaid: https://chfs.ky.gov

LOUISIANA – Medicaid
www.medicaid.la.gov or www.ldh.la.gov/lahipp
888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)

MAINE – Medicaid
Enrollment: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
800.442.6003 | TTY: Maine relay 711
Private Health Insurance Premium: https://www.maine.gov/dhhs/ofi/applications-forms
800.977.6740 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
http://www.mass.gov/eohhs/gov/departments/masshealth
800.862.4840

MINNESOTA – Medicaid
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
800.657.3739

MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
573.751.2005

MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
800.694.3084

NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov
Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178

NEVADA – Medicaid
http://dhcfp.nv.gov
800.992.0900

NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/oii/hipp.htm
603.271.5218 | Toll-Free:800.852.3345, ext. 5218

NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid
609.631.2392
CHIP: http://www.njfamilycare.org/index.html
800.701.0710

NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/
800.541.2831

NORTH CAROLINA – Medicaid
https://medicaid.ncdhhs.gov/
919.855.4100

NORTH DAKOTA – Medicaid
http://www.nd.gov/dhs/services/medicalserv/medicaid
844.854.4825

OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org
888.365.3742

OREGON – Medicaid
http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
800.699.9075

PENNSYLVANIA – Medicaid
https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
800.692.7462

RHODE ISLAND – Medicaid and CHIP
http://www.eohhs.ri.gov
855.697.4347 or 401.462.0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov
888.549.0820

SOUTH DAKOTA – Medicaid
http://dss.sd.gov
888.828.0059

TEXAS – Medicaid
http://gethipptexas.com
800.440.0493

UTAH – Medicaid and CHIP
Medicaid: https://medicaid.utah.gov
CHIP: http://health.utah.gov/chip
877.543.7669

VERMONT – Medicaid
http://www.greenmountaincare.org
800.250.8427

VIRGINIA – Medicaid and CHIP
https://www.coverva.org/hipp/
Medicaid: 800.432.5924
CHIP: 855.242.8282

WASHINGTON – Medicaid
https://www.hca.wa.gov/ 800.562.3022
WEST VIRGINIA – Medicaid
http://mywvhipp.com/ 855.MyWVHIPP (855.699.8447)
WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm 800.362.3002
WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ 800.251.1269

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

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

Employee Retirement Income Security Act of 1974 (ERISA)

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

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

Continue Group Health Plan Coverage
Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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

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

Enforce Your Rights
If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these cost and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HIPAA Privacy Notice

This notice describes how medical information about you may be used and disclosed by the employer and its affiliates, if any, and how you can get access to this information as mandated for health plans that are subject to HIPAA. Please review it carefully.

The Health Insurance and Portability and Accountability Act of 1996 (HIPAA) requires certain health plans to notify plan participants and beneficiaries about its policies and practices to protect the confidentiality of their health information (45 Code of Federal Regulations parts 160 and 164). Where HIPAA applies to a health plan sponsored by the Employer, this document is intended to satisfy HIPAA's notice requirement for all health information created, received, or maintained by the Employer-sponsored health plans (the plans). The regulations will supersede any discrepancy between the information in this notice and the regulations.

The plans need to create, receive, and maintain records that contain health information about you to administer the plans and provide you with health care benefits. This notice describes the plans' health information privacy policy for your health care, dental, personal spending account and flexible reimbursement account benefits. The notice tells you the ways the plans may use and disclose health information about you, describes your rights, and the obligations the plans have regarding the use and disclosure of your health information. It does not address the health information policies or practices of your health care providers.

Our Commitment Regarding Health Information Privacy

The privacy policy and practices of the plans protect confidential health information that identifies you or could be used to identify you and relates to a physical or mental health condition or the payment of your health care expenses. This individually identifiable health information is known as "protected health information' (PHI). Your PHI will not be used or disclosed without a written authorization from you, except as described in this notice or as otherwise permitted by Federal and State health information privacy laws.

Privacy Obligations of the Plans

The plans are required by law to: (a) make sure that health information that identifies you is kept private; (b) give you this notice of the plans' legal duties and privacy practices for health information about you; and (c) follow the terms of the notice that is currently in effect.

How the Plans May Use and Disclose Health Information about You

The following are the different ways the plans may use and disclose your PHI without your written authorization:

For Treatment. The plans may disclose your PHI to a health care provider who renders treatment on your behalf. For example, if you are unable to provide your medical history as the result of an accident, the plans may advise an emergency room physician about the types of prescription drugs you currently take.

For Payment. The plans may use and disclose your PHI so claims for health care treatment, services, and supplies you receive from health care providers may be paid according to the terms of the plans. For example, the plans may receive and maintain information about surgery you received to enable the plans to process a hospital's claim for reimbursement of surgical expenses incurred on your behalf.

For Health Care Operations. The plans may use and disclose your PHI to enable it to operate or operate more efficiently or make certain all of the plans' participants receive their health benefits. For example, the plans may use your PHI for case management or to perform population-based studies designed to reduce health care costs. In addition, the plans may use or disclose your PHI to conduct compliance reviews, audits, actuarial studies, and/or for fraud and abuse detection. The plans may also combine health information about many plan participants and disclose it to the Employer and its affiliates, if any, in summary fashion so it can decide what coverages the plans should provide. The plans may remove information that identifies you from health information disclosed so it may be used without the Employer's learning who the specific participants are.

To the Employer. The plans may disclose your PHI to designated Employer personnel so they can carry out their plan-related administrative functions, including the uses and disclosures descried in this notice. Such disclosures will be made only to the Employer's Privacy Officer and personnel under the Privacy Officer's supervision. These individuals will protect the privacy of your health information and ensure it is used only as described in this notice or as permitted by law. Unless authorized by you in writing, your health information: 1) may not be disclosed by the plans to any other employee and 2) will not be used by the Employer for any employment-related actions and decisions or in connection with any other employee benefit plan sponsored by the Employer.

To a Business Associate. Certain services are provided to the

plans by third-party administrators known as "business associates." For example, the plans may input information about your health care treatment into an electronic claim processing system maintained by the business associate so your claim may be paid. In so doing, the plans will disclose your PHI to its business associate so it can perform its claims payment function. However, the plans will require its business associates, through contract, to appropriately safeguard your health information.

Treatment Alternatives. The plans may use and disclose your PHI to tell you about possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. The plans may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

Individual Involved in Your Care or Payment of Your Care. The plans may disclose PHI to a close friend or family member involved in or who helps pay for your health care. The plans may also advise a family member or close friend about your condition, your location (for example, that you are in the hospital), or death.

As Required by Law. The plans will disclose your PHI when required to do so by Federal, State, or local law, including those that require the reporting of certain types of wounds or physical injuries.

To the Secretary of the Department of Health and Human Services (HHS). The plans may disclose your PHI to HHS for the investigation or determination of compliance with privacy regulations.

Special Use and Disclosure Situations

The plans may also use or disclose your PHI under the following circumstances:

Lawsuits and Disputes. If you become involved in a lawsuit or other legal action, the plans may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other lawful due process.

Law Enforcement. The plans may release your PHI if asked to do so by a law enforcement official, for example, to identify or locate a suspect, material witness, or missing person or to report a crime, the crime's location or victims, or the identity, description, or location of the person who committed the crime.

Worker's Compensation. The plans may disclose your PHI to the extent authorized by and to the extent necessary to comply with worker's compensation laws and other similar programs.

Military and Veterans. If you are or become a member of the U.S. armed forces, the plans may release medical information about you as deemed necessary by military command authorities.

To Avert Serious Threat to Health or Safety. The plans may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.

Public Health Risks. The plans may disclose health information about you for public health activities. These activities include preventing or controlling disease, injury or disability; reporting births and deaths; reporting child abuse or neglect; or reporting reactions to medication or problems with medical products or to notify people of recalls of products they have been using.

Health Oversight Activities. The plans may disclose your PHI to a health oversight agency for audits, investigations, inspections, and licensure necessary for the government to monitor the health care system and government programs.

Research. Under certain circumstances, the plans may use and disclose your PHI for medical research purposes.

National Security, Intelligence Activities, and Protective Services. The plans may release your PHI to authorized Federal officials: 1) for intelligence, counterintelligence, and other national security activities authorized by law and 2) to enable them to provide protection to the members of the U.S. government or foreign heads of state, or to conduct special investigations.

Organ and Tissue Donation. If you are an organ donor, the plans may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation and transplantation.

Coroners, Medical Examiners, and Funeral Directors. The plans may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. The plans may also release your PHI to a funeral director, as necessary, to carry out his or her duty.

Your Rights Regarding Health Information About You

Your rights regarding the health information the plans maintain about are as follows:

Right to Inspect and Copy. You have the right to inspect and copy your PHI. This includes information about your plan eligibility, claim and appeal records, and billing records, but does not include psychotherapy notes. To inspect and copy health information maintained by the plans, submit your request in writing to the Privacy Officer. The plans may charge a fee for the cost of copying and/or mailing your request. In limited circumstances, the plans may deny your request to inspect and coy your PHI. Generally, if you are denied access to health information, you may request a review of the denial.

Right to Amend. If you feel that health information the plans have

about you is incorrect or incomplete, you may ask to amend it. You have the right to request an amendment for as long as the information is kept by or for the plans. To request an amendment, send a detailed request in writing to the Privacy Officer. You must provide the reason(s) to support your request. The plans may deny your request if you ask to amend health information that was: accurate and complete, not created by the plans; not part of the health information kept by or for the plans; or not information that you would be permitted to inspect or copy.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures". This is a list of disclosures of your PHI that the plans have made to others, except for those necessary to carry out health care treatment, payment, or operations; disclosures made to you; disclosures made prior to this effective date at the end of this notice; or in certain other situations. To request an accounting of disclosures, submit your request in writing to the Privacy Officer. Your request must state a time period, which may not be longer than six years prior to the date the account was requested.

Right to Request Restrictions. You have the right to request a restriction on the health information the plans use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information the plans disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend. For example, you could ask that the plans not use or disclose information about a surgery you had. To request restrictions, make your request in writing to the Privacy Officer. You must advise us: 1) what information you want to limit; 2) whether you want to limit the plans' use, disclosure, or both; and 3) to whom you want the limit(s) to apply. Note: The plans are not required to agree to your request.

Right to Request Confidential Communications. You have the right to request that the plans communicate with you about health matters in a certain way or at a certain location. For example, you can ask hat the plans send you explanation of benefits (EOB) forms about your benefit claims to a specified address. To request confidential communications, make your request in writing to the Privacy Officer. The plans will make every attempt to accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

A Note About Personal Representatives

You may exercise your rights through a personal authorized representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual; or
- An individual who is the parent of a minor child.

The plans retain discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Change to this Notice

The plans reserve the right to change this notice at any time and to make the revised or changed notice effective for health information the plans already have about you, as well as any information the plans receive in the future. The plans will post a copy of the current notice in the Employer's office. All individuals covered under the Plan will receive a revised notice within 60 days of a material revision to the notice.

Notice of Breach of PHI

You have a right to receive a notice when there is a breach of your unsecured PHI.

Complaints

If you believe your privacy rights under this policy have been violated, you may file a written complaint with the Privacy Officer at the address listed below. Alternatively, you may file a complaint with the Secretary of the U. S. Department of Health and Human Services (Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington D.C. 20211), generally within 180 days of when the act or omission complained of occurred. Note: The plans, the Employer, and nay of its affiliates will not retaliate against you for filing a complaint.

Other Uses and Disclosures of Health Information

A plan must obtain your written authorization to use or disclose psychotherapy notes, to use PHI for marketing purposes, or to sell PHI. An authorization for a use or disclosure of psychotherapy notes may only be combined with another authorization for a use and disclosure of psychotherapy notes.

Plans (excluding long-term care plans) are prohibited from using or disclosing PHI that is genetic information for underwriting purposes.

Other uses and disclosures of health information not covered by this notice or by the laws that apply to the plans will be made only with your written authorization. If you authorize the plans to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you authorize the plans to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the plans will no longer use or disclose your PHI for the reasons covered by your written authorization; however, the plans will not reverse any uses or disclosures already made.

Contact Information: If you have any questions about this notice, please contact the Privacy Officer at the Employer, Attention: Privacy Officer.

Updated and effective March 26, 2018

Prescription Drug Coverage and Medicare

Date of this Notice: October 2020

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Cafe Rio has determined that the prescription drug coverage offered by Cafe Rio is, on average, for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (penalty) if you later decide to join a Medicare drug plan.

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

What Happens To Your Current Coverage If You Decide to Join a Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current coverage will be affected. If you do decide to enroll in a Medicare prescription drug plan and drop your prescription drug coverage, be aware that you may not be able to get this coverage back.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. In addition, your current coverage pays other health expenses in addition to prescription drugs, and you will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

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 and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About Your Options Under Medicare Prescription Drug Coverage
More detailed information about Medicare plans that offer prescription drug coverage is in the Medicare and You handbook. You will receive 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 inside back cover of your copy of the Medicare and 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.**

Remember to 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).

Newborn's Act Disclosure

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following 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). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Patient Protection Disclosure Notice

The Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the medical carrier listed under "Contacts" in Guide.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the medical carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in our network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating healthcare professionals who specialize in obstetrics or gynecology, contact the medical carrier listed under "Contacts" in this Guide.

Preventive Care

Certain preventive care services must be provided by non-grandfathered group health plans without member cost-sharing (such as deductibles or copays) when these services are provided by a network provider. Please refer to your insurance company for more information. Contact information is listed under "Contacts" in this Guide.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email **ebsa.opr@dol.gov** and reference the OMB Control Number 1210-0137.

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

COBRA & Cal-COBRA

Federal COBRA is a U.S. law that applies to employers who employ 20 or more individuals and sponsor a group health plan. Under Federal COBRA you may be eligible to continue your same group health insurance for up to 18 months if your job ends or your hours are reduced. You are responsible for COBRA premium payments.

Cal-COBRA is a California law that is similar to Federal COBRA. Under Cal-COBRA you may be eligible to continue your group health insurance coverage for up to a total of 36 months. Cal-COBRA applies to the UMR group insurance plans.

Family Medical Leave Act

Family & Medical Leave Act (FMLA)

FMLA is designed to help employees balance their work and family responsibilities by allowing them to take reasonable unpaid leave for certain family and medical reasons. It also seeks to accommodate the legitimate interests of employers and promote equal employment opportunity for men and women. FMLA applies to all public agencies, all public and private elementary and secondary schools, and companies with 50 or more employees. There may be times when you need an extended leave of absence. The company has a Family and Medical Leave Policy that is in compliance with The Family and Medical Leave Act of 1993 (FMLA), as amended. FMLA provides an entitlement of up to 12 weeks, which protects employees' jobs and benefits in the event of a medical or family circumstance, which requires the employee to take time off from work without pay. In general, the employee must have worked for at least 12 months and at least, 1,250 hours within the last 12 months immediately prior to the first day of leave.

Circumstances Permitting Family and Medical Leave

- Birth of an employee's child (within 12 months after birth)
- Adoption of a child by an employee (within 12 months after
- placement)
- Placement of a child with the employee for foster care (within
- 12 months after placement)
- Care of a child, spouse or parent having a serious health
- condition
- Incapacity of the employee due to a serious health condition
- Military Leave

Additional leave laws may apply to you depending upon your specific state and if you or a dependent or a military member. Whenever possible leave must be requested in advance. If you have questions about FMLA or any leave requests, please contact Human Resources.

Notes

This benefit summary prepared by

Gallagher

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