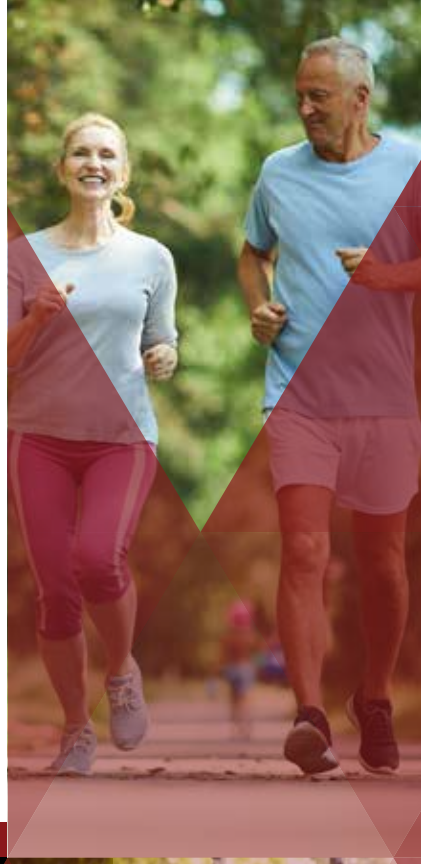
PEZOLD FAMILY
McDONALD'S

VALLEY HOSPITALITY

Benefits Enrollment Guide

BRONZE PLAN: GROUP MEDICAL • GROUP DENTAL

2021 PLAN YEAR



LOOK INSIDE FOR INFORMATION ABOUT:

Dear Team Member:

This document is to provide you with a summary of currently provided benefits as additional compensation. You and your dependent eligibility and benefits are established by the insuring arrangements of the insured.

Eligible Team Members are those who have satisfied the waiting period and attained the required age for participation.

Some benefit plans require the designation of a beneficiary. When there is a change in family status, or to verify current designated beneficiaries, Team Members should contact the Human Resources Department.

The benefit plans reflected in this brochure are for the plan year **January 1, 2021 – December 31, 2021**.

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Medicare Part D Notices – Pages 13-14

About Your Deductions

Your premiums for medical and dental coverage will be deducted on a pre-tax basis because they are covered under your Cafeteria Plan under Section 125 of the Internal Revenue Service code. Once you elect to enroll in this plan, you will not be allowed to drop or change your election until the Company's next Annual Enrollment unless you have a Qualifying Event.

If You're a New Team Member

If you aren't currently enrolled, you and your eligible family members can participate in the benefit package on the 1st day of the month following 60 days of full-time employment. Keep in mind that if you are a new Team Member who is disabled and away from work on the date that your coverage would become effective, you'll have to wait until you return to work before your coverage goes into effect.

Changing Coverage During the Year

You can change your coverage during the year only when you experience a qualified change in status, such as:

- Marriage, divorce, or legal separation
- Birth, adoption, or a child placed with you for adoption
- Start or stop of adoption proceedings
- Change in your child's dependent status
- Death of your spouse or child
- Change in your spouse's benefit or employment status

When a qualifying change occurs, you must notify your Human Resource Department and provide supporting documentation within 30 days of the event (in most circumstances), and your benefit changes must be consistent with the event. If you do not do so within 30 days, you must wait until the next open enrollment to make benefit plan changes.

Please note that this guide is a general summary of your benefits. For specific details, you may refer to each carrier's summary plan description. Every effort has been made to ensure that this booklet accurately represents the benefits. However, if there are any discrepancies between the terms in this booklet and the terms in the plan document, the plan document will prevail.

Carrier Contact Information

Medical and Dental

EBMS
Customer Service: 1-866-326-7475
Website: www.ebms.com

Human Resources

Pezold Management Associates
Name: Betty Johnson
Phone: 706-576-6400
Email: bjohnson@pemanco.com

VALLEY Hospitality
Name: David Hay
Phone: 706-324-1800
Email: dhay@valleyhospitality.com

Member Claims Advocate

Katelin Masterson: 706-576-3555
Shar Barnes: 706-576-3519
mmajslbenefitclaims@marshmma.com

Who is an Eligible Dependent?

- Your spouse: Spouse means the individual to whom a participant is legally married under applicable state law, provided that such marriage is recognized as a legal marriage by the state in which the participant's employer has its principal place of business.
- Your child (married or unmarried), up to age 26 who is:
  - Your biological child;
  - Your stepchild by marriage;
  - Adopted by you (or placed for adoption with you); or
  - A child for whom you have legal guardianship.
- Your child who is recognized under a Qualified Medical Child Support Order (QMCSO) as having a right to enrollment under your group health plan may be covered under the Plan if the child is otherwise eligible; and
- Your incapacitated adult child (see Incapacitated Adult Child Requirements).

Note: Coverage will end, at 11:59 p.m., on the last day of the month in which your dependent child attains age 26.

2021 Enrollment Process

How to Enroll Online

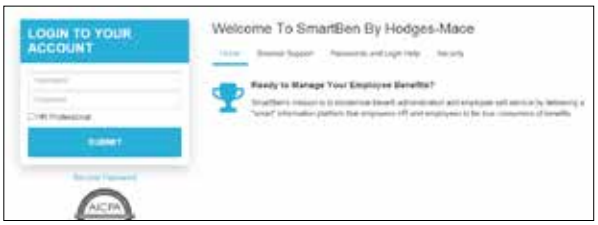
You can access your online enrollment tool via the Internet at pezold.smartben.net. It can be accessed 24 hours a day, seven days a week. The following tips will guide you through the online enrollment process.

Before You Enroll

Take time to review the information in SmartBen under the Plans section to better understand your benefit choices. Click on the Plans icon at the top of the home page, then select the plans you wish to review. You will need to provide the Social Security number and date of birth for any spouse or dependent you enroll.

Step 1: Log on to pezold.smartben.net and enter your username: ENROLL + Last 6 digits SSN and password: MMDDYYY (Date of Birth).

Example: Username ENROLL456789 and Password 01231955



Step 2: You must review the Disclaimer Agreement and accept it in order to move on to the next screen.

Step 3: On the home page you will see a Benefits Enrollment Box. This box shows the date Open Enrollment ends. Underneath the date, there is an *Enroll Now* button. Click the button to begin enrollment.

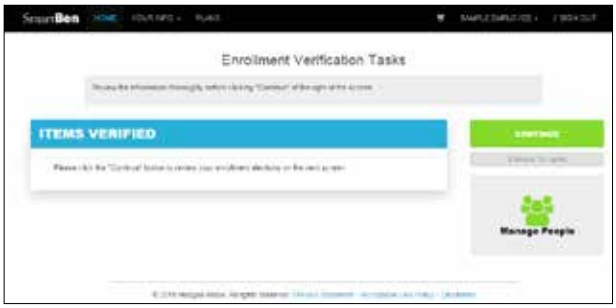
Step 4: The next page shows you what enrollments are available. Click the button for *Annual Enrollment* (or New Hire, if applicable) to begin your enrollment session.

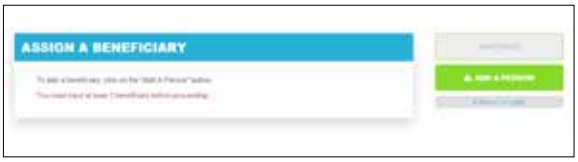
2021 Enrollment Process

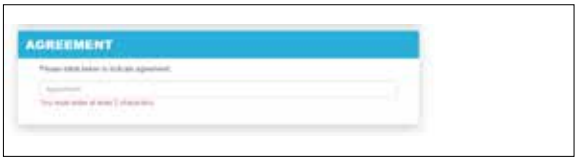
Step 5: Review and Elect Benefits: To enroll or make changes to a benefit, click on a benefit name. When all of your elections are complete, each benefit will have a green light. To proceed to the next step, click the green button labeled *Elect & Continue*.

Note: Adding people into the *People Manager* section DOES NOT assign them to coverage. You must assign your spouse/dependent/ beneficiaries in the enrollment process.

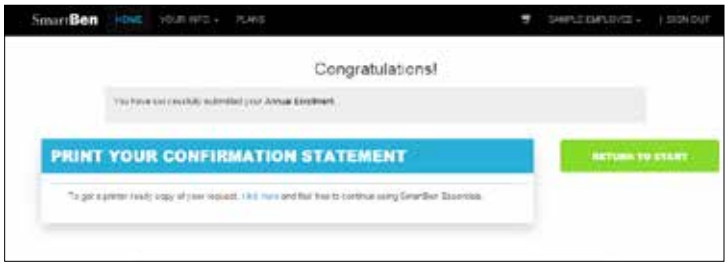
Step 6: Verify Required Data: If you have not entered all required information, the system will not process your enrollment. Click on each item in the *Enrollment Verification Task* List to go to the required page for corrections. Make your corrections, click *Submit*, *Enroll*, or *Save*, whichever is applicable. Please review your elections thoroughly. To confirm your elections, enter your initials at the bottom of the *Confirmation* page under *Agreement* and click *Continue*.







Step 7: *Congratulations!* You have successfully completed the enrollment process. If you would like a copy of your confirmation statement, select the *Click Here* link.



Step 8: **If you have submitted your enrollment and need to edit your elections, please call JOINPlus at 1-866-688-9727.**

The miBenefits Portal through ebms

EBMS is a Third-Party Administrator (TPA) of self-funded benefit plans. That's quite a mouthful, isn't it? Let's put it another way. Your employer has chosen EBMS to administer a benefit plan that fits your needs.

Look, healthcare is complex. We know it. You know it.

You're likely to have a different relationship with EBMS than you've had with other insurance companies. They are committed to making it easy for you to understand and take advantage of all your benefit plan has to offer. In fact, they like to say they are in the business of improving lives.

Customer Service Representatives

EBMS hopes you'll never have to pick up the phone because you're having a problem, but if you do, they have you covered! Their customer service representatives are empowered to resolve most issues in just one call – that's all! They will never leave you to struggle through a problem alone.

You can reach Member Services at 866-326-7475.

Accomplish nearly everything you need to do with just three clicks!

The miBenefits portal provides a simple way to refill a prescription, find a physician, make an appointment, appeal a claim, look up coverage information, and more.

We know you're busy, so we've made navigation a snap. Use the menu on the far left to perform common tasks with just one click. It's as easy as that!

How To Get Started: Setting up access to the miBenefits portal is fast and easy! Grab your ID card and head over to miBenefits.ebms.com and click "register now" to set up your account! Or download the app.

Download on the App Store | GET IT ON Google Play

The miBenefits Portal

The miBenefits portal is one of the best tools you can imagine. The most important step you can take right away is to create your account at miBenefits.ebms.com.

One login gives you access to all your benefits.

Like a digital helping hand, this dynamic portal makes your life easier. All the details you need are easy to find and explained in clear language.

Enjoy easy, at-a-glance views of your healthcare activity!

1. **Track Deductibles:** It's simpler than ever to track where you are in terms of meeting your deductible or reaching an out-of-pocket maximum – because this information is presented visually as well as numerically.
2. **Check claims status (in real-time):** Wondering about the status of a claim? Your three most recent claims appear right here on the home page, and their status is updated in real time. Just click through for more details or to see your full claim history.
3. **Monitor each family member:** If you're on a family plan, you'll appreciate the ability to view each person's individual status – simply click between tabs.

Medical Summary of Benefits

Bronze Plan Summary of Benefits	
In-Network	
Deductible *(Employee / Family)*	$3,000 / $6,000
Out-of-Pocket *(Employee / Family)*	$7,500 / $15,000
Coinsurance	60%
Office Visit Copay Primary Care *(office or telehealth)*	$5 copay per Wellness Clinic visit or subject to deductible & coinsurance
Office Visit Copay Specialist Care *(office or telehealth)*	40% after deductible
Wellness Visit	Covered at 100%
Urgent Care Visit	$50 copay
Emergency Room Copay	$1,000 copay
Inpatient Hospital	$500 copay then 40% after deductible
Outpatient Surgery	$250 copay then 40% after deductible
Speech, Physical and Occupational Therapy *(combined 15 visits limit)*	40% after deductible
Diagnostic Services *(MRI, CT, Ultra Sound, X-Ray, Non-Routine Mammography)*	$150 copay at Columbus Diagnostic Center and Bridgeway Diagnostics; All other apply to deductible and then 40%
Pharmacy	
Rx Deductible	$500 per person
Tier 1	$5 copay at clinic (no retail coverage)
Tier 2	$100 copay after deductible
Tier 3	Not Covered
Tier 4	Not Covered

High cost prescriptions are required to use Concierge Service to waive copay. Failure to use the service will result in plan copay forfeiture.

Bi-Weekly Payroll Deductions	Healthy Lifestyle Plans		Bronze Plan	
	4 of 4 Biometrics	2 of 4 Biometrics	Standard Plan	Tobacco Rates
Employee	$47.00	$52.00	$57.00	$95.00
Employee + Child(ren)	$125.00	$162.00	$180.00	$225.00

Tier 1 smoking cessation medications will be available at the Employee Wellness Clinic. Non-tobacco user premium available anytime during the year upon clinic administration of nicotine test. Employee must pay for the test and is responsible for turning in test results to appropriate human resources manager.

Dental

Dental benefits are available to you and your eligible family members to cover routine care such as exams, x-rays and cleanings, as well as fillings, dentures, bridgework and periodontal care. The Pezold dental plan benefits have been designed to allow Team Members and their dependents to use the dental provider of their choice, regardless of their network status. If you choose to see an out-of-network provider your out-of-pocket costs may be higher. You can access a provider directory online at www.cigna.com or for help locating a network provider, call 866-326-7475.

Dental Summary of Benefits		
	Standard	**Enhanced**
Annual Deductible	$50 Individual / $150 Family	$0 Individual / $0 Family
Calendar Year Maximum	$1,000	$4,000
Preventive Services	100%	100%
Emergency Treatment	80%	90%
Basic Services	80%	90%
Sealants	80%	90%
Fillings	80%	90%
Oral Surgery	80%	90%
Major Services	50%	90%
Periodontics	50%	90%
Orthodontia	50%	80%
Orthodontia Lifetime Maximum	$1,500	$4,000
Out-of-Network Basis	90th Percentile	90th Percentile

Bi-Weekly Payroll Deductions	Standard	Enhanced
Employee	$10.75	$20.00
Employee + Family	$20.00	$23.00

Employee Wellness Clinic

The Clinic is a primary care facility with trained professionals who provide services for the following:

- Primary, Preventative and Urgent Care *(Age 2+ years)*
- Colds and Flu
- Sore throats, including Strep
- Ear ache and Headache
- Sinus infections
- In-stock Generic Medications ($5 Copay)
- Urinary Tract Infections
- Acute Injuries
- Strains and Sprains
- Minor Lacerations
- Lab Work
- Flu Shots
- Medication Management
- Wart, Mole and Skin Tag Removal
- Pap and Breast Exams
- Allergy Shots
- Weight Management

Employee Wellness Clinic is open:

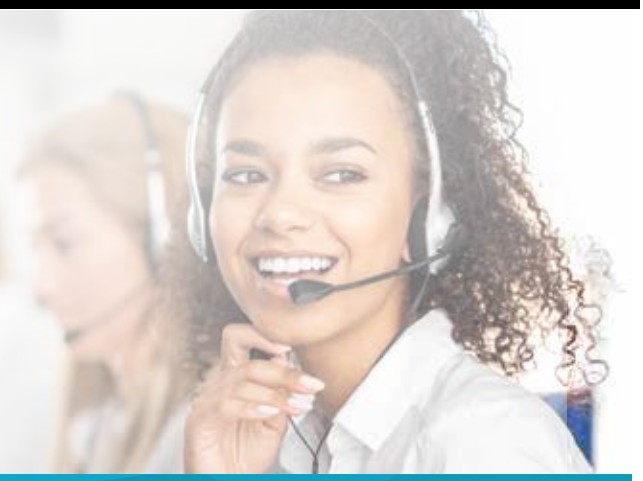
Monday, Tuesday, Thursday, Friday from 8-5
(closed on Wednesday)

The Employee Wellness Clinic is located at:

350 Manchester Expressway
Columbus, Georgia 31904
706-243-0250

MARSH & McLENNAN AGENCY

LOCALLY KNOWN AS J. SMITH LANIER & CO.



Employee Benefit Assistants You Can Count On

Member Claims Advocate

Marsh & McLennan Agency, locally known as J. Smith Lanier & Co., provides you and your family members a complimentary member claims service to help with claims, billing, missing ID cards and more!

Give Member Claims Advocate a call if:

- You received a provider bill or EOB but do not feel the claim was processed correctly.
- You are at the doctor or pharmacy and having trouble with your coverage.
- You need to confirm if a provider is In-Network.
- You are missing your ID card.

It's our business to be there for you in the MOMENTS THAT MATTER.

You can reach the Member Claims Advocate team by phone or email.

Monday through Friday, 8:15 AM EST – 5:15 PM EST

Email: mmajslbenefitclaims@MarshMMA.com

Katelin Masterson: (706) 576-3555
Shar Barnes: (706) 576-3519
Toll Free: (800) 226-4518

Important Legal Notices

Newborns' and Mothers' Health Protection Act

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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

Under the Women's Health and Cancer Rights Act of 1998, a plan participant or beneficiary who elects breast reconstruction in connection with a covered mastectomy is also entitled to the following benefits: all states of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications of the mastectomy, including lymphedemas. Health plans must provide coverage of mastectomy-related benefits in a manner determined in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services are subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

Summary Plan Descriptions (SPD)

As required under the Employee Retirement Income Security Act (ERISA), all employees and their covered dependents must be given access to a copy of the Summary Plan Description (SPD) for the employee welfare benefit plans. The SPD outlines the eligibility, schedule of benefits and covered/excluded items of the benefit plans.

1. Medical and Dental SPD's are known as Certificate Booklets. A copy of the medical or dental SPD/Certificate Booklet can be requested by contacting EBMS.
2. You may also request a paper copy of a SPD from the Human Resources Department.

Privacy Rights under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandates that your private health information is protected and confidential. This Plan, the Plan Administrator and the Plan Sponsor will not disclose information that is protected by HIPAA, as required by law. To obtain a copy of your HIPAA Privacy Rights, contact your Human Resources Department.

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

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

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

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

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

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

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: 1-800-541-5555

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child- health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: https://medicaid.georgia.gov/health-insurance- premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: http://www.indianamedicaid.com
Phone: 1-800-403-0864

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/default.htm
Phone: 1-800-792-4884

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public- assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and- families/health-care/health-care-programs/programs-and- services/medical-assistance.jsp
[Under ELIGIBILITY tab, see "what if I have other health insurance?"]
Phone: 1-800-657-3739

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

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/hipp/
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://wyequalitycare.acs-inc.com/
Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 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
1-866-444-EBSA (3272)

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

Medicare Part D Notice: Prescription Drug Coverage and Medicare

Bronze Plan

If you are or will soon be eligible for Medicare please read this notice carefully before making your medical plan selection. Enrollment in the HSAOAP8 5K/20 plan could result in higher Medicare Part D premiums in the future.

This notice has information about your current prescription drug coverage with Pezold Management and 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.

Please note: If you are not Medicare eligible, and none of your covered family members are Medicare eligible, no action is required on your part.

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

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- Pezold Management has determined that the prescription drug coverage offered by the Bronze plan is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Pezold Management Plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.
- You can keep your current coverage from Pezold Management. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully – it explains your options.

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 through December 7th. This may mean that you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later. You may pay that higher premium (penalty) as long as you have Medicare prescription drug coverage. However, if you decide to drop your current coverage with Pezold Management, since it is employer sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under Pezold Management.

Medicare Part D Notice: Prescription Drug Coverage and Medicare

Bronze Plan

If you are or will soon be eligible for Medicare please read this notice carefully before making your medical plan selection. Enrollment in the HSAOAP8 5K/20 plan could result in higher Medicare Part D premiums in the future.

When will you pay a higher premium (penalty) to join a Medicare Drug Plan?
Since the HDHP plan coverage under Pezold Management is not creditable, depending on how long you go without creditable prescription drug coverage, you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, 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 Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

What happens to your current coverage if you decide to join a Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current coverage will not be affected. See pages 7-9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D. If you do decide to join a Medicare drug plan and drop your current Pezold Management coverage, be aware that you and your dependents will be able to get this coverage back.

For more information about this notice or your current Prescription Drug Coverage:
You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Pezold Management changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare Prescription Drug Coverage: More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

General Notice of COBRA Continuation Coverage Rights

Introduction

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

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

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

What is COBRA Continuation Coverage?

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

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

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

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

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

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

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

When is COBRA Coverage Available?

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

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

General Notice of COBRA Continuation Coverage Rights

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), you must notify the Pezold Benefits Center within 30 days after the qualifying event date.

How is COBRA Coverage Provided?

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

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

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

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the COBRA Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. To notify the COBRA Administrator regarding a disability extension, call 1-866-800-2272.

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

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

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

Keep Your Plan Informed of Address Changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

EBMS
1-866-326-7475

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Betty Johnson; bjohnson@pemanco.com.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Pezold Management		4. Employer Identification Number (EIN) 58-1179998
5. Employer address 600 Brookstone Centre Pkwy		6. Employer phone number (706) 324-1650
7. City Columbus	8. State GA	9. ZIP code 31904
10. Who can we contact about employee health coverage at this job? Betty Johnson		
11. Phone number (if different from above) (706) 576-6400	12. Email address bjohnson@pemanco.com	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☒ Some employees. Eligible employees are:

    Active full-time employees working a minimum of 30 hours per week.

- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:

    Your eligible spouse, children under age 26, and children beyond age 26 if incapable of self-support due to mental or physical handicap.

  - ☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid–year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Valley Hospitality		4. Employer Identification Number (EIN) 58-2368658
5. Employer address 600 Brookstone Centre Pkwy		6. Employer phone number (706) 324-1650
7. City Columbus	8. State GA	9. ZIP code 31904
10. Who can we contact about employee health coverage at this job? David Hay		
11. Phone number (if different from above) (706) 324-1800	12. Email address dhay@valleyhospitality.com	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☒ Some employees. Eligible employees are:

    Active full-time employees working a minimum of 30 hours per week.

- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:

    Your eligible spouse, children under age 26, and children beyond age 26 if incapable of self-support due to mental or physical handicap.

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Notes

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Please note that this guide is a general summary of your benefits. For specific details, you may refer to each carrier's summary plan description. Every effort has been made to ensure that this booklet accurately represents the benefits. However, if there are any discrepancies between the terms in this booklet and the terms in the plan document, the plan document will prevail.