EMPLOYEE BENEFITS GUIDE

April 1, 2021 - March 31, 2022

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CREATED BY:
AssuredPartners MCM

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WHAT'S INSIDE?

This guide is designed to help you understand your benefits program so that you can make informed decisions about your health care. It provides an overview of the benefits in which you are eligible to participate. Please review this information carefully.

IMPORTANT NOTICE

For complete details including plan terms, exclusions, and limitations, please refer to your carrier booklets. In the event of ambiguity or inconsistency between this guide and the carrier booklet, the provisions of the insurance documents shall supersede the information listed in the guide.

WHAT IS THE COST?

Listed below is the monthly cost to enroll in our benefit plans. These rates are valid from April 1, 2021 through March 31, 2022.

Medical	Virtual Plus Plan	Access PPO Plan
Employee	$181.93	$240.04
Employee + Spouse/DP*	$767.70	$919.40
Employee + Child(ren)	$509.40	$619.81
Employee + Family	$1,095.17	$1,299.13

Voluntary Dental

Employee	$29.61
Employee + Spouse/DP*	$57.87
Employee + Child(ren)	$76.47
Employee + Family	$110.35

Voluntary Vision

Employee	$5.31
Employee + Spouse/DP*	$11.19
Employee + Child(ren)	$11.96
Employee + Family	$19.16

Life AD&D

Eligible Participant	$1.12

*DP = Domestic Partner

Premiums are automatically deducted pre-tax unless you instruct HR otherwise. You may not make changes to your elections mid-year when premiums are deducted pre-tax, unless you experience a permitted election change event. In that case, generally you have 30 days from the time of the event to make a change.

If you cover a domestic partner (or domestic partner's dependents) deductions will be taken on a post-tax basis unless your domestic partner qualifies as a dependent under Internal Revenue Code Section 152. In addition, unless your domestic partner qualifies under IRC section 152, our contribution to your domestic partner's premium will be included in your taxable income.

INSURANCE ASSISTANCE

The APMCM Employee Service Center

EMPLOYEE SERVICE CENTER

A Free & Confidential Service

Benefit advocates are specially trained individuals who can assist with benefit questions and claim issues for you and your covered family members.

EXAMPLES OF BENEFIT QUESTIONS

- What are my benefits?
- How will a specific service be covered?
- Does this service require prior authorization?
- How do I find an in-network provider?

EXAMPLES OF CLAIM QUESTIONS

- Why did my insurance pay nothing?
- Why did my insurance pay only part of the bill?
- How do I submit a claim?
- How do I file an appeal for a denied service?

(206) 343-4175 OR (888) 343-3330
TTY/TDD: (206) 748-9578 OR (855) 877-4726
Email: mcm.esc@assuredpartners.com

Monday-Friday
7:30 AM to 5:00 PM PST
Language Interpretation Services Available

Carrier Contacts

Kaiser Permanente	Medical/RX Virtual Plus Group #: 2198100 Access PPO Group #: 8519300	888.901.4636 Nurseline: 800.297.6877	Network: Access PPO Network: Virtual Plus - Connect www.kp.org/wa
Principal	Voluntary Dental/Voluntary Vision/ Life/AD&D Group #: 1108713	800.986.3343	Network: Dental PPO www.principal.com
Principal via VSP	Vision	800.877.7195	Network: VSP Choice www.vsp.com
Benefit Website	Benefit Information	Username: tuttabella Password: benefits	http://tuttabella.apmcmportal.com

Visit the websites above for more information about carrier resources. Most carriers have mobile apps, provider network search capabilities, cost provider estimator tools, and much more.

Medical and Prescription Drug Benefits

Plan Features **Kaiser Permanente**

	In-Network Virtual Plus Plan** Virtual Plus Connect	In-Network Access PPO Plan Kaiser Permanente, First Choice, First Health (outside of service area)
Calendar Year Deductible	$1,000 Individual $2,000 Family	$1,500 Individual $3,000 Family
Calendar Year Out-of-Pocket Maximum	$3,000 Individual $6,000 Family	$6,000 Individual $12,000 Family
Coinsurance	20%	30%
Preventive Care	Covered in full deductible waived	Covered in full deductible waived
Physician Office Visits (Non-Preventive)	Virtual Visit: Covered in full deductible waived Referred: $20 copay deductible waived Non-Referred: 20% after deductible	$30 copay, deductible waived Kaiser: $20 copay, deductible waived
Specialist Office Visits	Virtual Visit: Covered in full deductible waived Referred: $40 copay deductible waived Non-Referred: 20% after deductible	$60 copay, deductible waived Kaiser: $40 copay, deductible waived
Urgent Care	$20 copay*** deductible waived	$30 copay deductible waived
Spinal Manipulations	$20 copay deductible waived (10 visits per calendar year)	$30 copay deductible waived (20 visits per calendar year)
Acupuncture	$20 copay deductible waived (12 visits per calendar year)	$30 copay deductible waived (12 visits per calendar year)
Lab and Radiology	20% after deductible	30% after deductible
Inpatient Hospital Care	20% after deductible	30% after deductible
Emergency Room	$200 copay 20% after deductible	$50 copay 30% after deductible
Retail Prescription Drugs (30 Day Supply)	$15 / $35 / $150**** (preferred generic / preferred brand / preferred specialty)	$10 / $35 / $70 Kaiser: $10 / $30 / $65 (preferred generic / preferred brand / non-preferred)
Mail Order Prescription Drugs (90 Day Supply)	$5 / $70 / $150	$20 / $60 / $130
	Out-of-Network Non-Contracted*	
Calendar Year Deductible	Not Available	$3,000 Individual $6,000 Family
Calendar Year Out-of-Pocket Maximum	Not Available	$12,000 Individual $24,000 Family
Coinsurance	Not Available	50%

*Out-of-network providers may balance bill you for charges over the non-contracted allowed amount. Balance billed amounts do not accrue toward your out-of-pocket maximum.

**Virtual Plus Plan: All services delivered via telehealth and 1st non-preventative primary care office visit are covered in full. Deductible and coinsurance do not apply to authorized outpatient visits in the clinic but do apply to all non-authorized outpatient services, including all surgical services. All other services covered at applicable cost shares.

***Care at Kaiser Permanente walk-in clinics is not considered urgent care and requires a referral in order to pay a lower out-of-pocket cost.

****Fill the first medication of a new prescription at an in-network pharmacy or through mail order, then get most refills and maintenance medications through mail order.

Your Kaiser Permanente Medical Network Options

Virtual Plus Plan

Your first level of care with the Virtual Plus Plan is **virtual with a Kaiser Permanente doctor or clinician**. Virtual visits are covered in full, deductible waived, and if you are referred to in-person care, your cost will be lower than if you started with in person care on your own.

Kaiser Permanente Network: Kaiser medical offices offer primary care, pharmacy services, X-ray, lab, and several specialty services, all under one roof.

- **Other In-Network Community Providers:** Additionally, Kaiser contracts with a large network of community providers to ensure coverage is meet in locations where they don't have Kaiser medical offices or for services or procedures that aren't offered at Kaiser Permanente facilities.
- **Hospital Care:** Kaiser teams up with community and regional hospitals in locations across the Washington state service area.
- **Emergency Care in a Non-Network Hospital:** If you need emergency care and are admitted to a non-network hospital, you or a family member must notify Kaiser within 48 hours after care begins, or as soon as is reasonably possible. Call the notification line listed on the back of your Kaiser Permanente member ID card to help make sure your claim is accepted. Keep receipts and other paperwork from non-network care. You'll need to submit them with any claims for reimbursement.

The Virtual Plus network includes doctors and hospitals in King, Kitsap, Pierce, Snohomish, Spokane, and Thurston counties. Their medical offices offer primary care, pharmacy services, X-ray, lab, and several specialty services, all under one roof. To find Virtual Plus Connect providers, go to kp.org/wa/provider-directory.

Filling prescriptions with Virtual Plus: You can fill prescriptions at any Virtual Plus Connect network pharmacy, including pharmacies located at Kaiser Permanente medical offices, or through Kaiser's mail-order service. You may fill the first medication of a new prescription at an in-network pharmacy or through mail order, then get most refills and maintenance medications through mail order.

Emergency Care in a Non-Network Hospital: If you need emergency care and are admitted to a non-network hospital, you or a family member must notify Kaiser within 48 hours after care begins, or as soon as is reasonably possible. Call the notification line listed on the back of your Kaiser Permanente member ID card to help make sure your claim is accepted. Keep receipts and other paperwork from non-network care. You'll need to submit them with any claims for reimbursement.

How your Virtual Plus Plan works:

For most care, including care from a specialist, members will start with a virtual visit. A Kaiser Permanente doctor or clinician will give members the care and prescriptions they need or refer them for in-person care through your Connect network.

Members can also be referred for additional in-person care by a provider during an in-person visit.

When you get in-person care through a referral, your cost will be lower than if you started in-person care on your own.

Highlights:

- No charge or referral needed for virtual care, first in-person primary care visit and all preventive care
- Get virtual care through 24/7 Care Chat online messaging or nurse phone line, scheduled video visits and phone appointments, e-visits or email for non-urgent questions
- Virtual visits are with Kaiser Permanente doctors and clinicians - the same ones you'd find in our medical facilities
- Fill the prescription for a new medication at an in-network pharmacy or mail order. Delivery is free and usually takes 1 to 2 days.
- Includes worldwide in-person emergency and urgent care coverage.
- Care at Kaiser Permanente walk-in clinics is not considered urgent care and requires a referral in order to pay a lower out-of-pocket cost.

Your Kaiser Permanente Medical Network Options

Access PPO Plan

In-Network Provider Access for the Access PPO Plan: Each of the networks listed below are considered "In-Network" benefit coverage:

- **Kaiser Permanente Network:** Throughout Washington State, you have access to more than 26,000 providers. Beyond care found in Kaiser Permanente facilities, you have access to providers at UW Medicine, Swedish Physicians, CHI Franciscan Health, and many more.
- **First Choice Health:** if you live or travel in the northwest, you can seek care through First Choice Health network of providers in Oregon, Alaska, Montana, Idaho, and Washington. Beyond the Kaiser PPO network, you can access in-network care from an additional 50,000 doctors in the region. Look up providers near you by visiting: www.fchn.com.
- **First Health Network:** For areas beyond, care can be found through the First Health Network. You can access in-network care from more than 590,000 providers in all states nationwide (except for Washington, Oregon, Idaho, Alaska, and Montana) from this national network. Find providers by visiting: www.myfirsthealth.com.

Washington Coverage

- **Kaiser Providers and Facilities:** A select group of providers, including physicians and pharmacies at Kaiser Permanente Washington, offer an enhanced benefit — lower copays or cost shares for office visits and some drugs. To find these providers, go to kp.org/wa/provider-directory.
- **WA Expanded Coverage - First Choice Network**: In addition to Kaiser's Core network, you have access to in-network coverage through First Choice. To find First Choice providers, go to www.fchn.com.

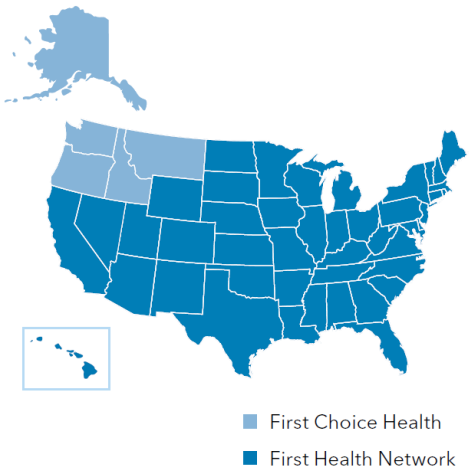
National Coverage

When located or traveling outside of WA you have access to a national network of providers through the First Choice and First Health networks.

- **First Choice Network:** Oregon, Alaska, Montana, Idaho, and Washington, go to www.fchn.com
- **First Health Network**: All other states, go to www.firsthealth.com

Filling a Prescription with Access PPO:

- In addition to Kaiser pharmacies, you have access to the OptumRx nationwide network of pharmacies, which includes many well-known pharmacy chains



Source: Kaiser Permanente Washington Core HMO and Access PPO Member Guides.

Voluntary Dental Benefits

Plan Features **Principal**

	Dental PPO	Nonparticipating*
Calendar Year Deductible	$0	$25 Individual $75 Family
Calendar Year Benefit Maximum	$1,000 per individual	
Class I: Preventive & Diagnostic Services	Covered in full	20% deductible waived
Class II: Basic & Restorative Services	20%	30% after deductible
Class III: Major Services	50%	60% after deductible

*Nonparticipating dentists may bill you the difference between their billed charges and their contracted amount.

Voluntary Vision Benefits

Plan Features **Principal via VSP**

	VSP Choice
Copays	$10 Exam copay Up to $60 Contact lens exam copay $25 Glasses copay
Exam	Once every 12 months
Lenses	Once every 12 months Single vision, lined biofocal, and lined trifocal lenses covered in full. Lens enhancements available with an average savings of 20-25%.
Frames	Once every 24 months $130 allowance, with 20% savings on the amount over your allowance.
Contact Lenses	$130 allowance in lieu of hardware Once every 12 months

*For out-of-network benefits, please contact member services.

Life/AD&D Insurance

You have the option to purchase life and AD&D insurance through Principal.

Benefit Amount	$15,000
Benefit Reductions due to age	Begin at age 65

INSURANCE ELIGIBILITY REQUIREMENTS

Variable Hour Employees:

- An employee is a variable hour employee if, based on the facts and circumstances at the date the employee begins providing services to the employer (the start date), it cannot be determined that the employee is reasonably expected to work on average at least 30 hours per week. As a restaurant with varying shift lengths, business cycles, flexible scheduling, and hours being allocated in part based on performance, it is difficult to have this expectation at the time of hire for many restaurant positions.
- Variable hour employees are eligible for insurance benefits if they average at least 30 hours per week over a measurement period. There are two types of measurement period; "Initial" and "Ongoing.

New Hire 6 Month "Initial" Measurement Period:

New hires are measured 6 months from their hire date. At the same time, they are transiting onto the "Ongoing" measurement period outlined below.

Example: Employee's Hire Date is Nov 1, 2021
Measurement Period: Nov 1, 2021 to April 30, 2022
Admin Period: May 1, 2021 – May 31, 2021
Stability Period: June 1, 2021 – Nov 30, 2021

6 Month "Ongoing" Measurement Period:

1st Measurement Period: Aug 1st to Jan 31st
1st Admin Period: Feb 1st to March 31st
1st Stability Period: April 1st to Sept 30th

2nd Measurement Period: Feb 1st to July 31st
2nd Admin Period: Aug 1st to Sept 30th
2nd Stability Period: Oct 1st to March 31st

- In addition to measurement periods, you see the "Admin" period which is used to determine eligibility, administer the coverage information and carrier enrollment. If an employee is measured for 6 months and averages 30 or more hours per week, then they will become eligible for insurance coverage to be effective the first of the month after the end of the admin period. In the example above the insurance benefits, if elected, would be effective on June 1. Note that the admin periods are 30 days for new-hires and 60 days for ongoing.
- The "stability" period is how long an employee will remain eligible for insurance benefits before being measured again to determine if they remain eligible in an ongoing basis.

Full-Time Hourly Employees (Hired for a Full-Time position):

- A full-time employee is an employee who is hired for a position with the firm expectation that at least 30 hours per week will be worked. As a restaurant with varying shift lengths, business cycles, flexible scheduling, and hours being allocated in part based on performance, it is difficult to have this expectation at the time of hire for many restaurant positions.
- If the employee hired as full-time does work 30 or more hours per week and is expected to continue to do so, then the employee will be eligible for insurance benefits beginning the 1st of the month following 60 days.
- If 30 or more hours per week has not been met or is not expected to continue, the employee will follow the eligibility requirements of Variable Hour Employees.

INSURANCE ELIGIBILITY REQUIREMENTS

Salaried Employees & Managers

- Eligible for insurance enrollment upon date of hire or promotion.
- Enrollment is effective on the 1st of the month following date of hire or promotion.

Enrollment Process for all Eligible Employees

- Restaurants are notified each month of any employees who based on meeting the eligibility requirements are newly eligible for insurance enrollment effective the 1st of the following month. The restaurant will provide the newly eligible employee with a description of benefits packet, enrollment form and waiver of coverage forms.
- Enrollment is effective on the 1st of the month following the admin period if the employee elects coverage by completing and turning in the Insurance Enrollment Form within the specified time.
- All newly eligible employees must either enroll or sign a waiver of coverage.
- Any eligible employee who waives coverage will not be eligible again until open enrollment the following March, for coverage effective April 1st, unless he/she experiences a qualifying event (i.e. loss of other coverage through no fault of his/her own, marriage, birth or adoption of a child).

Contribution Toward Insurance Premiums

- Each employee enrolled in coverage will pay 50% of the monthly premium for the Tutta Bella Virtual Plus medical insurance coverage. If electing the Access PPO medical coverage the employee will pay the difference in premium between the two plans in addition to the 50%. Dental and Vision coverage is 100% employee paid. Spouse and dependent coverage are paid 100% by the employee after the deduction of the employee only portion. The employee's portion of the monthly premium is automatically deducted pre-tax from their paycheck over the first two pay periods of each month.

Upon Separation From Employment

- All insurance benefits terminate at the end of the month that the employee separates from employment, or the last day of the month for which premiums have been paid.

ADDITIONAL RESOURCES

Kaiser Permanente Member Resources

www.kp.org/wa: Access your personal and plan information at any time. You can view your benefits, print temporary ID cards, find doctors in your area, sign up for paperless Explanation of Benefits, and learn about other features offered with your Kaiser Permanente plan.

Kaiser Permanente Washington: Staying on top of your health care benefits is easier than ever with the Kaiser Permanente Washington app. From finding a doctor and comparing costs, to paying claims, and viewing your ID card, this smartphone or tablet app is all you need to manage all of your benefits.

Consulting Nurse Service: Connect with a 24/7 nurse line that provides immediate support for everyday health issues and questions. This service is offered in addition to your medical plan to help you get information and support when you need it. Call **(800) 297-6877** to speak with a nurse and get help to avoid any unnecessary doctor or emergency room visits.

Virtual Visits: Schedule phone, video and e-visits through Kaiser Permanente's online services. With these convenient options, Kaiser Permanente offers urgent, primary, pediatric, and specialty care services, all of which are available at no additional costs.

Cost Estimation Tools: You can get an estimate for how much a treatment, procedure, test, or other medical service will cost. Estimates are based on the average cost of a service in your area, the benefits in your coverage plan, and your progress in meeting your annual deductibles and out-of-pocket maximum.

Tools and Resources for Good Health: Kaiser Permanente believes good health goes beyond the doctor's office. See below for some examples of ways you can save:

- Wellness coaching over the phone - helping you reach your health goals with one-on-one support
- Healthy lifestyle programs - find discounts on fitness facilities, exercise videos, and workout equipment
- Help to quit smoking
- 20% discount on acupuncture, naturopathy, chiropractic care, yoga, Pilates and more
- Classes and support groups

Principal Member Resources

Employee Assistance Program (EAP): The EAP, provided by Magellan Healthcare is available for you and your immediate family. You have 24/7 access to counselors trained to guide you through a variety of life's everyday - and not so everyday - challenges.
Call: **(800) 450-1327**
Visit: **MagellanHealth.com/member**

Travel Assistance: With AXA travel assistance, you have access to help with lost or stolen items or medical assistance while you are traveling. To learn more, visit **principal.com/travelassistance**
To receive assistance while traveling:
Call within the US: **(888) 647-2611**
Call collect outside the US: **(630) 766-7696**

Will & Legal Document Center: With this Center you have access to help with any of the following:

Generating and updating your will
Granting someone your healthcare power of attorney
Generating and updating your living will
Granting consent for medical personnel to treat your dependents if you are away

This service also gives you access to Identity Theft prevention and assistance should you be a victim of identity theft. Call **(866) 539-1728** for any questions or to receive services.

Discounts and Services: Principal offers discounts to help improve your life - financially, mentally, and physically. Below are some examples of ways you can save. Visit **principal.com** for more information:

- Laser vision correction
- Hearing exams and equipment
- Dental consultations

GLOSSARY OF MEDICAL TERMS

ALLOWED AMOUNT
Maximum amount on which payment is based for covered health care services. This may be called “eligible allowance” or “negotiated rate.” If your out-of-network provider charges more than the allowed amount, you may have to pay the difference.

IN-NETWORK
The facilities, providers, and suppliers that your health insurer or plan has contracted with to provide health care services.

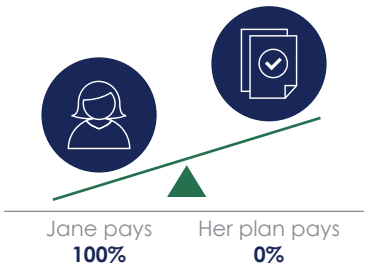
BALANCE BILLING
When an out-of-network provider bills you for the difference between the provider’s charge and the allowed amount. For example, if the provider’s charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. An in-network provider may not balance bill you for covered services.

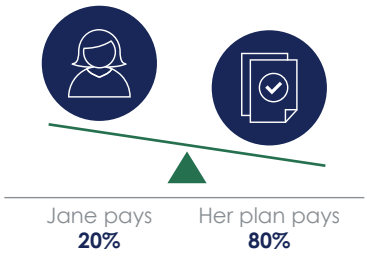
COPAYMENT
A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

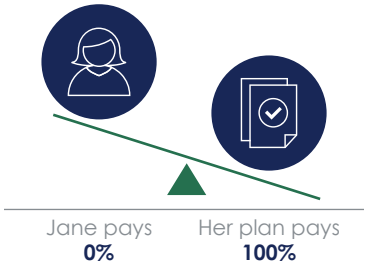
DEDUCTIBLE
The amount you owe for health care services, before insurance begins to pay. For example, if your deductible is $500, your plan won’t pay anything until you’ve met your $500 deductible for covered services subject to the deductible. The deductible does not apply to all services.

COINSURANCE
Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if the health insurance or plan’s allowed amount for an office visit is $100 and you’ve met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

OUT-OF-POCKET MAXIMUM
The most you pay during a calendar year before your health insurance or plan begins to pay 100% of allowed amount for in-network covered services. The limit includes office visit copay, prescription drug copays, deductibles and coinsurance.







IMPORTANT INFORMATION AND ANNUAL REQUIRED NOTICES

Conversion Rights

You may have the option to keep your life/AD&D coverage through either the conversion provisions of the contract. You must apply within 31 days from the date of termination. For information about these options please contact Human Resources.

Permitted Mid-Year Election Change Events

In most cases, once you have made your benefit elections for the plan year, you cannot change them until the next annual open enrollment period, unless you experience a permitted election change event. These include:

- Change in legal marital status (marriage, divorce, legal separation)
- Gain or loss of eligibility by one of your dependents
- Birth, adoption, or placement for adoption
- Loss of other health coverage by employee, spouse, or dependent(s)
- Gain or loss of eligibility for Medicare or Children's Health Insurance Program (CHIP)
- Change in coverage under another employer health plan

If you experience an event that allows you to make changes to your benefit elections, notify Human Resources within 30 days of the event (60 days in the case of birth or adoption). You may need to provide proof of the change, such as a marriage or birth certificate. For more information regarding permitted mid-year election changes, please contact Human Resources.

Notice of Special Enrollment Rights

You may be eligible to participate in Tutta Bella's Group Health Plan. A federal law called HIPAA requires that we notify eligible participants about the right to enroll in the plan under its "special enrollment provision."

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. 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 new dependents. However, you must request enrollment within 30 days after the marriage or within 60 days after birth, adoption, or placement for adoption.

Eligibility for Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

All questions about the plan's special enrollment provision should be directed to Brian Flickinger/Human Resources .

Notice of the Women's Health and Cancer Rights Act

This notice is being sent to you as required by the Women's Health and Cancer Rights Act of 1998, which states you must be advised annually of the presence of benefits for mastectomy-related services, including reconstruction and surgery to achieve symmetry of the breasts, prostheses and complications resulting from a mastectomy. Please refer to your medical benefit booklet for additional information. Benefits

for these services may be subject to annual deductibles and coinsurance consistent with those established for other benefits.

Notice of Creditable Prescription Drug Coverage Medicare Part D – Prescription Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Tutta Bella 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. Tutta Bella has determined that the prescription drug coverage offered by Tutta Bella health and welfare plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Tutta Bella coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current Tutta Bella coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact the Human Resources Department or your Benefit Advocate for more information about what happens to your coverage if you 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 Tutta Bella and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…Contact the person listed below for further information. NOTE: 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 Tutta Bella 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).

REMEMBER: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: April 1, 2021
Name of Entity/Sender: Tutta Bella
Contact--Position/Office: Brian Flickinger/Human Resources
Address: 4914 Ranier Ave South, Suite B Seattle, WA 98118

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, 2021. Contact your State for more information on eligibility.

To see if any other states have added a premium assistance program since January 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

U.S. Department of Health and Human Services Employee Benefits Security Administration Centers for Medicare & Medicaid Services

www.dol.gov/agencies/ebsa www.cms.hhs.gov

1-866-444-EBSA (3272) 1-877-267-2323, Menu Option 4, Ext. 61565

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)

IMPORTANT INFORMATION AND ANNUAL REQUIRED NOTICES

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: Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Email: hipp@dhcs.ca.gov

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
Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
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/
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: https://www.in.gov/medicaid/
Phone 1-800-457-4584

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
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/
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

Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: -800-977-6740.
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa
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/other-insurance.jsp
Phone: 1-800-657-3739

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

IMPORTANT INFORMATION AND ANNUAL REQUIRED NOTICES

NEW HAMPSHIRE – Medicaid and CHIP

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/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

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