EMPLOYEE BENEFITS GUIDE

Tutta Bella

April 1, 2024 – March 31, 2025

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CREATED BY AssuredPartners

Welcome

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.

Benefit Overview

Cost Overview

Contact Information

Important Information & Annual Required Notices

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please refer to the Medicare Part D Notice at the back of this Guide for more details.

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 booklets, the provisions of the insurance documents shall supersede the information in this guide.

Health & Wellness

Medical & Prescription Drug Benefits

Kaiser Permanente

Plan Options	Virtual Plus*	Access PPO
Network	**In-Network** **Virtual Plus** **Virtual Connect**	**In-Network** **Access PPO** **Kaiser Permanente** **First Choice Health** (WA, OR, ID, AK, and MT) **First Health** (for All Other States)
Calendar Year Deductible	$1,500 Individual / $3,000 Family	$2,000 Individual / $4,000 Family
Calendar Year Out-of-Pocket Maximum	$5,000 Individual / $10,000 Family	$5,500 Individual / $11,000 Family
Coinsurance	20%	20%
Preventive Care	Covered in full, deductible waived	Covered in full, deductible waived
Physician Office Visit Non-preventive	Virtual Visit: Covered in full, deductible waived Referred: $20 copay, deductible waived Non-Referred: 20% after deductible	$35 copay, deductible waived
Specialist Office Visit	Virtual Visit: Covered in full, deductible waived Referred: $40 copay deductible waived Non-Referred: 20% after deductible	$35 copay, deductible waived
Urgent Care	$20 copay, deductible waived	$35 copay, deductible waived
Lab and Radiology	20% after deductible	20% after deductible
Inpatient Hospital Care	20% after deductible	20% after deductible
Emergency Room	$200 copay, 20% after deductible	$200 copay, 20% after deductible
Retail Prescription Drugs 30-day supply	$15/$35/$150 (preferred generic / preferred brand / preferred specialty)	$20/$40/$60/$150/30%; $10/$20/$30/$150/30% at Kaiser pharmacy (preferred generic / preferred brand / non-preferred / preferred specialty drugs / non-preferred specialty drugs)
Mail Order Prescription Drugs 90-day supply	$5/$70	$20/$40/$60
	Out-of-Network**	**Out-of-Network*****
Calendar Year Deductible	N/A	$4,000 Individual / $8,000 Family
Calendar Year Out-of-Pocket Maximum	N/A	Unlimited
Coinsurance	N/A	50%

*Virtual Plus: Care at Kaiser Permanente walk-in clinics is not considered urgent care and requires a referral to pay the lower out-of-pocket cost. To find in-network urgent care facilities in your area, visit kp.org/wa/find-a-doctor; a referral is not required to receive lower out-of-pocket cost.

**Virtual Plus: Out-of-network benefits and providers are not available with this plan.

***Access PPO: Out-of-network providers generally may balance bill you for charges over the non-contracted allowed amount. Balance billed charges do not accrue toward your deductible or out-of-pocket maximum. The No Surprises Act, however, protects you from balance billing in certain circumstances: emergency care, services performed at in-network facilities by specified out-of-network providers (such as anesthesiologists and radiologists), and air ambulance charges. In these situations, those providers are prohibited from balance billing you for any difference between the plan's payment amount and their billed charges.

Health & Wellness

Medical and Prescription Drug Benefits

	Access PPO	Virtual Plus - Connect Network
How does my plan work?	You can choose from an extensive network of preferred primary and specialty care providers, including Kaiser Permanente medical facilities. You also have the option to get care through regional and national networks.	Virtual Plus gives you convenient ways to start your care virtually with referred in-person care when you need it. Referrals are not required for urgent or emergency care. » $0 charge for virtual care, preventive care, and your first in-person primary care visit. » Lower out-of-pocket cost for in-person care you get through a referral. Higher out-of-pocket cost for most in-person care you get without a referral. » Start with any of these no-charge virtual options: E-visit, 24/7 Care Chat, Phone appointment, Video visit, 24/7 consulting nurse, or Email (for non-urgent questions).
Where do I find in-network coverage?	» Visit kp.org/wa/find-a-doctor for care with Kaiser Permanente clinicians and other network providers through the Access PPO network. » Physicians and pharmacies at Kaiser Permanente Washington offer an enhanced benefit—lower copays or cost shares for office visits and some drugs. » For additional in-network coverage through the First Choice Network, visit fchn.com/ProviderSearch/KFHPWAO (Alaska, Idaho, Montana, Oregon, and Washington). » For additional in-network coverage through the First Health Network, visit myfirsthealth.com (for All Other States).	» Visit kp.org/wa/getcare for virtual care with Kaiser Permanente clinicians. » Visit kp.org/wa/find-a-doctor for in-person care with Kaiser Permanante clinicians and other network providers, through the Virtual Plus- Connect network. » During your virtual care visit, if you are referred for in-person care, your out-of-pocket costs will be lower then if you seek in-person care initially. The Virtual Plus Connect 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.
Do I have out-of-network coverage?	Yes, 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.	No, out-of-network benefits and providers are not available with this plan.
How does emergency care work with my plan?	You're covered for emergency care and medically necessary urgent care anywhere in the world. All Kaiser Permanente medical facilities are included, along with the regional First Choice Health network and national First Health network.	You can get emergency care at any Kaiser Permanente or non-Kaiser Permanente hospital emergency department. You do not need a referral. » 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 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 do I fill a prescription?	You have in-network access to the OptumRx pharmacy network at kp.org/wa/optumrx-wa which includes many well-known pharmacy chains, in addition to pharmacies listed at kp.org/wa/find-a-doctor. For maintenance medications, you may obtain your first fill at any in-network pharmacy or through Kaiser's mail-order pharmacy. Subsequent refills must be filled via mail order.	Fill up to a 30-day supply of your first prescription at a network pharmacy or through mail order, then get most refills through mail order for the lowest cost. Delivery is free and usually arrives in as little as 1-2 days. If your medication can't be mailed, you can get up to a 30-day supply at a network pharmacy.

Health & Wellness

Find the Right Care for You

CLICK

Telehealth

Telehealth allows you to connect with your doctor without needing to go into the doctor's office. You can talk to a doctor live through phone, video chat, or live messaging. Telehealth is designed so that you can receive care when you need it, on your own schedule, right at your fingertips.

CALL

Nurseline

Need immediate support or have a health question? Through the nurseline, you have 24/7 access to certified nurses for any of your questions or concerns. This service can help you avoid unnecessary urgent care or emergency room visits and make the best decision for you and your family, about any medical related issue.

GO

In-Office Visit

Sometimes going into a clinic or doctor's office is the best option for certain medical concerns or questions. By participating in an in-office visit, you receive one-on-one face-to-face care with your doctor. Office visits allow you to get the hands-on care you may need.

Urgent Care

Have a concern that needs to be addressed in-person with a real live doctor but it is after your regular doctor's hours or you can't get an appointment? Urgent care is the best option for when you need to be seen right away for a non-life threatening concern.

For information on how to access these resources, visit the Kaiser Permanente Additional Resources page provided in this benefit guide.

Health & Wellness

Voluntary Dental Benefits

Principal

Plan Features	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 deductible waived	20% after deductible
Class II: Basic & Restorative Services	20% after deductible	30% after deductible
Class III: Major Services	50% after deductible	60% after deductible

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

Voluntary Vision Benefits

Principal via VSP

Plan Features	VSP Choice
Copays	$10 exam copay $25 glasses copay Up to $60 contact lens exam copay
Exam	Once every 12 months
Lenses	Once every 12 months » Single vision, lined bifocal, and lined trifocal lenses covered in full » Lens enhancements available with an average savings of 30%
Frames	$130 allowance, with 20% savings on the amount over your allowance Once every 24 months
Contact Lenses	$130 allowance, in lieu of hardware Once every 12 months

For out-of-network benefits, please contact customer service.

Life and Accidental Death & Dismemberment (AD&D) Insurance

We provide life/AD&D insurance through Principal for eligible employees.

Principal

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

Health & Wellness

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 transitioning into the "Ongoing" measurement period outlined below.

Example 1: Employee's Hire Date is Nov 1, 2023
Measurement Period: Nov 1, 2023 to April 30, 2024
Admin Period: May 1, 2024 - May 31, 2024
Stability Period: June 1, 2024 - Nov 30, 2024

Example 2: Employee's Hire Date is October 15, 2023
Measurement Period: Nov 1, 2023 to April 30, 2024
Admin Period: May 1, 2024 - May 31, 2024
Stability Period: June 1, 2024 - Nov 30, 2024

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.

Health & Wellness

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 45% 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 45%. 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.

Cost Overview

Listed below is the monthly cost to enroll in our benefit plans. These rates are valid from April 1, 2024 through March 31, 2025.

Medical/Rx			
Virtual Plus	**Total Premium**	**Tutta Bella Pays**	**You Pay**
Employee	$439.14	$240.14	$199.00
Employee + Spouse/DP*	$1,146.11	$240.14	$905.97
Employee + Child(ren)	$834.36	$240.14	$594.22
Employee + Family	$1,541.33	$240.14	$1,301.19

Medical/Rx			
Access PPO	**Total Premium**	**Tutta Bella Pays**	**You Pay**
Employee	$552.86	$240.14	$312.72
Employee + Spouse/DP*	$1,442.90	$240.14	$1,202.76
Employee + Child(ren)	$1,050.43	$240.14	$810.29
Employee + Family	$1,940.48	$240.14	$1,700.34

Life			
	Total Premium	**Tutta Bella Pays**	**You Pay**
Employee	$2.97	$1.49	$1.48

Voluntary Dental		
	Total Premium	**You Pay**
Employee	$33.34	$33.34
Employee + Spouse/DP*	$65.15	$65.15
Employee + Child(ren)	$86.10	$86.10
Employee + Family	$124.24	$124.24

Voluntary Vision		
	Total Premium	**You Pay**
Employee	$5.31	$5.31
Employee + Spouse/DP*	$11.19	$11.19
Employee + Child(ren)	$11.96	$11.96
Employee + Family	$19.16	$19.16

*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

Benefit Advocates in the AssuredPartners Employee Service Center can assist with benefit questions and claim issues for you and your covered family members. They are specially trained individuals who can help answer your insurance questions.
This is a service provided at no cost to you. All personal health information is confidential.

EMPLOYEE SERVICE CENTER

mcm.esc@assuredpartners.com

1-888-343-3330 | TTY/TDD: 1-855-877-4726
Monday-Friday, 7:30 am to 5:00 pm PT

Language interpretation services available

Contacts

Benefit	Carrier	Contact	Website
Medical/Rx	**Kaiser Permanente** 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
Voluntary Dental Life and AD&D	**Principal** Group #: 1108713	800.986.3343	Dental Network: PPO www.principal.com
Voluntary Vision	**Principal via VSP**	800.877.7195	Network: VSP Choice www.vsp.com
Benefit Information	**Benefit Website**	Username: tuttabella Password: benefits	https://tuttabellabenefits.com

Additional Resources

Kaiser Permanente Member Resources

Kaiser Permanente App

It's easy to connect to care and get helpful resources right from your phone. Use the Kaiser Permanente app to:

- Refill prescriptions
- Message your care team and access Care Chat
- Use your digital member ID card
- Review after-visit summaries
- View your coverage documents

kp.org/wa

When you set-up an account at **kp.org/wa**, you will be able to find a doctor, check the status of your claims, compare costs, utilize Kaiser wellness resources, refill prescriptions, access virtual care, use health and wellness resources, and much more.

Consulting Nurse Service

Connect with a 24/7 nurse to get 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 **1-800-297-6877** to speak with a nurse and get help to avoid any unnecessary doctor or emergency room visits.

Care Chat & E-Visits

Care Chat is an online messaging feature that lets you get real-time medical care from a Kaiser Permanente care provider. It's available 7 days a week. If your symptoms cannot be diagnosed through Care Chat you have the option to get personalized care via an online e-visit with no appointment needed, connecting you to the appropriate care. You can access these features through the mobile app or by visiting **kp.org/wa/getcare** and signing into your member portal.

Care While Traveling

If you are traveling within another Kaiser Permanente region, outside of the Washington Service area:

- Call member services at **1-888-901-4636** to get a visiting member ID number and have the ability to pay your standard copay and coinsurance.

When traveling in an area without a Kaiser Permanente facility:

- Pay your standard copay and coinsurance by finding the nearest First Choice Health or First Choice Health network provider or visit the closest CVS MinuteClinic or Concentra Urgent Care.

Additional Resources

Principal Member Resources

Discounts & 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
- Emotional health support line
    - Connect with licensed behavioral health clinicians who will provide emotional support and referrals to local resources 24/7. Call **1-800-424-4612**.

Travel Assistance

Whether you're traveling right here in the United States or leaving the country, you can rely on AXA to help your travel experience go off without a hitch. And because you're covered by group term life insurance from Principal, you have access to many travel assistance services for free – no matter if you're traveling for business or pleasure.

Accessing Your Travel Assistance

Call **1-888-647-2611** in the US
Call collect **630-766-7696** outside of the US

Visit **principal.com/travelassistance**

Will Prep

Having the proper documents in place can help ensure you're still in control in case something happens to you. With ARAG's free online resources, you and/or your spouse can create these documents:

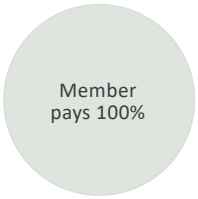
- Generating and updating your will
- Granting someone your healthcare power of attorney
- Generating and updating your living will
- Granting consent for medical personnel to treat your dependents if you are away

Visit **aragwills.com/principal** to get started.

This service also gives you access to Identity Theft prevention and assistance should you be a victim of identity theft. Call **1-800- 642-3788** for any questions or to receive services.

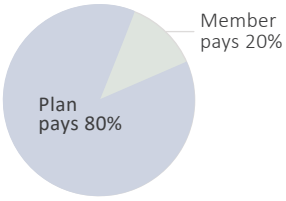
Glossary Of Insurance Terms

The following examples are for illustrative purposes only.



Deductible

The amount you owe for health care services, before insurance begins to pay coinsurance. For example, if your deductible is $1,000, your plan won't pay anything until you've met your $1,000 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 coinsurance plus any deductible you may owe. For example, if the health plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health plan pays the rest of the allowed amount.

Out-of-Pocket Maximum

The most you pay during a calendar year for in-network covered services. Once you've met your calendar year out-of-pocket maximum, your health plan begins to pay 100% of the allowed amount for in-network covered services for the remainder of that calendar year. *Office visit copays, prescription drug copays, deductibles, and coinsurance all accrue towards your out-of-pocket maximum.*

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.

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.

Copay

A fixed amount (for example, $25) you pay for a covered health care service, usually at the time of care. The amount can vary by the type of covered health care service.

In-Network

The facilities, providers, and suppliers with whom your health plan has contracted.

IMPORTANT INFORMATION

CONVERSION AND PORTABILITY RIGHTS

If you are enrolled in the life/AD&D and your employment with Tutta Bella terminates, you may have the option to continue your coverage through either the portability or conversion provisions of the plans. You must apply within 31 days from the date of termination. To determine if either of these options are available to you, consult your certificate(s) of coverage/benefit booklet(s), or contact Human Resources.

PERMITTED MID-YEAR ELECTION CHANGES

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, but are not limited to:

- 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 Medicaid or the 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, you must notify Human Resources within 30 days (60 days for events related to Medicaid or CHIP). 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.

REQUIRED ANNUAL NOTICES

NOTICE OF CREDITABLE PRESCRIPTION DRUG COVERAGE MEDICARE PART D – YOUR 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 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, 2024
Name of Entity/Sender: Tutta Bella
Contact--Position/Office: James To, Director of Human Resources
Address: 660 S Industrial Way, Seattle WA 98108

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 Human Resources.

PPACA NOTICE OF PATIENT PROTECTIONS

Kaiser Permanente generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact James To.

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

NOTICE OF PRIVACY PRACTICES

Effective Date: April 1, 2024

This notice describes how medical information about you under Tutta Bella's self-insured medical, prescription drug, dental, vision, health flexible spending arrangement, health reimbursement arrangement plan(s) may be used and disclosed and how you can get access to this information. **Please review it carefully.**

If you have any questions about this notice, please contact James To at 660 S Industrial Way, Seattle WA 98108

Your Rights
You have the right to:
- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices
You have some choices in the way that we use and share information as we:
- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures
We may use and share your information as we:
- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights
When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records
You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records
You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications
You can ask us to contact you in a specific way (for example, home or office

phone) or to send mail to a different address. We will consider all reasonable requests and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share
You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information
You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
You can complain if you feel we have violated your rights by contacting us using the information on page 1. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Your Choices
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are unable to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we ***never*** share your information unless you give us written permission:
- Marketing purposes
- Sale of your information

Our Uses and Disclosures
How do we typically use or share your health information?
We typically use or share your health information in the following ways.
Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization
We can use and disclose your information to run our organization and contact you when necessary. We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services
We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director
We can share health information about you with organ procurement organizations. We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

Important Information & Required Notices

- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request and we will mail a copy to you.

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.*

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, 2024. 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: https://health.alaska.gov/dpa/Pages/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 Fax: 916-440-5676 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://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ 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
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2
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: 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 / HIPP Phone: 1-800-967-4660

Important Information & Required Notices

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://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

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.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003 / TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740 / TTY: Maine relay 711

MASSACHUSETTS-Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

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
Email: HHSHIPPProgram@mt.gov

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/programs-services/medicaid/health-insurance-premium-program
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: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA-Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON-Medicaid and CHIP

Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA-Medicaid and CHIP

Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

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: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
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

HIPP Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA-Medicaid and CHIP

Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON-Medicaid

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

WEST VIRGINIA-Medicaid and CHIP

Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP 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

To see if any other states have added a premium assistance program since January 31, 2024, 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

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

OMB Control Number 1210-0137 (expires 1/31/2026)

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