Park Avenue Catering

Benefits Guide

BENEFIT PERIOD | December 1, 2021 – November 30, 2022

Medical Insurance

	CaliforniaChoice Your Health. Your Choice.® HMO Cal Choice Kaiser Permanente Full Silver HMO C	CaliforniaChoice Your Health. Your Choice.® HMO Cal Choice Kaiser Permanente Full Bronze HMO C
	In-Network	In-Network
Network	Kaiser California HMO	Kaiser California HMO
Deductible/Out-of-pocket		
Deductible - Individual	$2,250	$7,000
Deductible - Family	$4,500	$14,000
OOPM - Individual	$8,200	$7,000
OOPM - Family	$16,400	$14,000
Benefits		
Co-insurance	30%	0%
PCP	$55	$0 after deductible
Specialist	$90	$0 after deductible
X-Ray	$90	$0 after deductible
Lab	$55	$0 after deductible
Inpatient Hospital	30% after deductible	$0 after deductible
Outpatient Surgery	30% after deductible	$0 after deductible
Emergency Room	30% after deductible	$0 after deductible
Urgent Care	$55	$0 after deductible
RX		
Rx Individual Ded	$300	Included in Medical
Rx Family Deductible	$600	Included in Medical
Member Copay Tier 1	$17 per script	$0 after deductible
Member Copay Tier 2	$80 per script after deductible	$0 after deductible
Member Copay Tier 3	$80 per script after deductible	$0 after deductible
Member Copay Tier 4	30% after deductible, up to $250 per script	$0 after deductible
Mail Order	2x	1x

Medical Insurance

	CaliforniaChoice Your Health. Your Choice.® **HMO** **Cal Choice** Western Health Full Silver HMO B	CaliforniaChoice Your Health. Your Choice.® **HMO** **Cal Choice** Sutter Health Plus Silver HMO B
	In-Network	In-Network
Network	HMO	HMO
Deductible/Out-of-pocket		
Deductible - Individual	$2,250	$2,250
Deductible - Family	$4,500	$4,500
OOPM - Individual	$8,200	$8,200
OOPM - Family	$16,400	$16,400
Benefits		
Co-insurance	30%	30%
PCP	$55	$55
Specialist	$90	$90
X-Ray	$90	$90 per procedure
Lab	$55	$55
Inpatient Hospital	30% after deductible	30% after deductible
Outpatient Surgery	30% after deductible	30% after deductible
Emergency Room	30% after deductible	30% after deductible
Urgent Care	$55	$55
RX		
Rx Individual Ded	$300	$300
Rx Family Deductible	$600	$600
Member Copay Tier 1	$17 per script	$17
Member Copay Tier 2	$80 per script after deductible	$80 after deductible
Member Copay Tier 3	$110 per script after deductible	$110 after deductible
Member Copay Tier 4	30% after deductible, up to $250 per script	30% after deductible, up to $250 per script
Mail Order	2.5x	2x

Medical Insurance

	CaliforniaChoice Your Health. Your Choice. **HMO** **Cal Choice** Anthem Prudent Buyer - Small Group Silver EPO B
	In-Network
Network	Prudent Buyer (Calchoice)
Deductible/Out-of-pocket	
Deductible - Individual	$2,000
Deductible - Family	$4,000
OOPM - Individual	$6,750
OOPM - Family	$13,500
Benefits	
Co-insurance	30%
PCP	30% after deductible
Specialist	30% after deductible
X-Ray	30% after deductible
Lab	30% after deductible
Inpatient Hospital	30% after deductible
Outpatient Surgery	30% after deductible
Emergency Room	30% after deductible
Urgent Care	30% after deductible
RX	
Rx Individual Ded	Included in Medical
Rx Family Deductible	Included in Medical
Member Copay Tier 1	30% after deductible, up to $250 per script/40% after deductible, up to $250 per script
Member Copay Tier 2	30% after deductible, up to $250 per script/40% after deductible, up to $250 per script
Member Copay Tier 3	30% after deductible, up to $250 per script/40% after deductible, up to $250 per script
Member Copay Tier 4	30% after deductible, up to $250 per script/40% after deductible, up to $250 per script
Mail Order	-

Dental Insurance

DPPO
With the Preferred Provider Organization (PPO) dental plan, you may visit a PPO dentist and benefit from the negotiated rate or visit a non-network dentist. When you utilize a PPO dentist, your out-of-pocket expenses will be less. You may also obtain services using a non-network dentist; however, you will be responsible for the difference between the covered amount and the actual charges and you may be responsible for filing claims.

	Cypress Ancillary Benefits Dental PPO 2500	
Network	DPPO Network	
Benefits	In-Network	Out-of-Network
Calendar Year Maximum	$2,500	$2,500
Individual Deductible	$0	$50
Family Deductible	$0	$150
Waived for Preventive	N/A	No
Class I - Preventive	100%	100%
Class II - Basic	90%	80%
Class III - Major	60%	50%
Class IV - Orthodontia	N/A	N/A
Orthodontia Lifetime Max	N/A	N/A
Ortho Eligibility	N/A	N/A
Dental Reimbursement Sch.	-	90th UCR
Implant Coverage	-	-

Vision Insurance

The vision plan provides professional vision care and high quality lenses and frames through a broad network of optical specialists. You will receive richer benefits if you utilize a network provider. If you utilize a non-network provider, you will be responsible to pay all charges at the time of your appointment and will be required to file an itemized claim.

	Cypress Ancillary Benefits MES Vision by Cypress
Network	VPPO Network
Benefits	
Exams Frequency	12 Months
Lenses Frequency	12 Months
Frames Frequency	12 Months
Contacts Frequency	12 Months
Exam Copay	$10
Materials Copay	$0
Contacts Allowance	$125 (in lieu of frame and lenses)
Frame Allowance	$125

Disclaimers

The information contained herein is intended to serve only as a brief outline of the various insurance coverages. To avoid misunderstanding or misinterpretation as to the full scope of protection afforded, reference must be made to the respective policies for complete coverage details.

Important Notices & Disclosures

This information provides an informal explanation of the statutes as mandated by the Federal Government. Please note that this information is presented as general guidance and should not be considered legal advice. If you have questions about these notices, please contact Human Resources or contact the Employee Benefits Security

Administration (EBSA) regional office nearest you. A list of these offices is on the agency's Website at **www.dol.gov/ebsa**.

Women's Cancer Right Act of 1998

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

- All stages of reconstruction of the breast on which the mastectomy has been performed;

- Surgery and reconstruction of the other breast to produce a symmetrical appearance;

- Prostheses; and

- Treatment of physical complications of all ages of mastectomy, including lymph edema. Benefits for the above coverage are payable on the same basis as any other physical condition covered under the plan, including any applicable deductible and/or copays and coinsurance amounts. If you would like more information on WHCRA benefits, please contact Human Resources.

Newborns' Act Disclosure

Under Federal law, group health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Family & Medical Leave Act (FMLA)

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

Circumstances Permitting Family and Medical Leave

- Birth of an employee's child (within 12 months after birth)

- Adoption of a child by an employee (within 12 months after placement)

- Placement of a child with the employee for foster care (within 12 months after placement)

- Care of a child, spouse or parent having a serious health condition

- Incapacity of the employee due to a serious health condition

- Military Leave

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

Continuation of Coverage during an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be determined by your Employer.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward 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).

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

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

Qualified Medical Child Support Orders

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

Michelle's Law Legislation

On October 9, 2008, President Bush signed into federal law a new statute known as "Michelle's Law" (H.R. 2851). The law amends ERISA, the Public Health Service Act, and the Internal Revenue Code. Michelle's law generally requires group health plans, which provide coverage for dependent children who are postsecondary school students, to continue such coverage if the student loses the required student status because he or she must take a leave of absence from studies due to a serious illness or injury. The law applies to fully insured and self-funded group health plans and will be effective for an employer's plan on the first plan year on or after October 9, 2009.

For research purposes limited information may be disclosed as permitted by law:

- To workers' compensation or similar programs for the payment of benefits for work-related injuries

- To coroners, medical examiners and funeral directors to identify a deceased person, determine cause of death, or to carry out duties

- To comply with court orders, judicial proceedings, or other legal processes related to law enforcement, custody of inmates, legal and administrative actions, and criminal activity

- For U.S. military and veteran reporting regarding members and veterans of the armed forces of U.S. or foreign military

- For national security and intelligence activities such as protective services for the President and other authorized persons

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of October 15, 2021. Contact your state for more information on eligibility.

ALABAMA – Medicaid
http://myalhipp.com
855.692.5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
http://myakhipp.com/ | 866.251.4861
CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
http://myarhipp.com
855.MyARHIPP (855.692.7447)

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp
916.445.8322 | Email: hipp@dhcs.ca.gov

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

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

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

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
http://www.in.gov/fssa/hip/ | 877.438.4479
All other Medicaid
https://www.in.gov/medicaid/ | 800.457.4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid: https://dhs.iowa.gov/ime/members | 800.338.8366
Hawki: http://dhs.iowa.gov/Hawki | 800.257.8563
HIPP: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | 888.346.9562

KANSAS – Medicaid
https://www.kancare.ks.gov/800.792.4884

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

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

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

MASSACHUSETTS – Medicaid and CHIP
https://www.mass.gov/info-details/masshealth-premium-assistance-pa
800.862.4840

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

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

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

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

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

NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/oii/hipp.htm
603.271.5218 | Toll free number for the HIPP program: 800.852.3345, ext. 5218

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

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

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

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

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

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

PENNSYLVANIA – Medicaid
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
800.692.7462

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

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

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

TEXAS – Medicaid
http://gethipptexas.com
800.440.0493

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

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

VIRGINIA – Medicaid and CHIP
https://www.coverva.org/en/famis-select
https://www.coverva.org/hipp/
Medicaid and Chip: 800.432.5924

WASHINGTON – Medicaid
https://www.hca.wa.gov/
800.562.3022

WEST VIRGINIA – Medicaid
http://mywvhipp.com/
855.MyWVHIPP (855.699.8447)

WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
800.362.3002

WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
800.251.1269

To see if any other states have added a premium assistance program since October 15, 2021, or for more information on special enrollment rights, contact either:

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

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

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

Employee Retirement Income Security Act of 1974 (ERISA)

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

Receive Information about Your Plan and Benefits

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

Continue Group Health Plan Coverage

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

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Prudent Actions by Plan Fiduciaries

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

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

Enforce Your Rights

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

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

Assistance with Your Questions

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

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

Privacy Notice

This notice describes how medical information about you 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 Human Resources.

Introduction

The Company along with its corporate affiliates and divisions sponsor a variety of health benefit programs. For the purposes of this Notice, we refer to these health benefit programs collectively as the "**Benefit Plan**."

For example, the Benefit Plan includes medical, dental, vision, prescription drug benefits, and flexible spending accounts. In most cases, these programs are administered through arrangements with health insurance companies, HMOs, and third-party administrators. The Benefit Plan does not include worker's compensation, life insurance, disability benefits, medical leaves, pre-employment physicals, or drug testing.

The Benefit Plan is subject to a federal law called the Health Insurance Portability and Accountability Act of 1996, also known as "HIPAA." HIPAA sets standards to protect the privacy of medical information. We are required by HIPAA to:

Make sure that medical information that identifies you is kept private; give you this Notice of our legal duties and privacy practices with respect to medical information about you; and follow the terms of the Notice that are currently in effect.

Our Pledge Regarding Medical Information

The Benefit Plan is committed to protecting medical information about you. This Notice describes the Benefit Plan's privacy practices and that of all its employees and staff. This Notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

In addition to HIPAA, the Benefit Plan uses and discloses medical information in compliance with all other applicable state and federal laws.

How We May Use and Disclose Medical Information about You

The following categories describe different ways that the Benefit Plan uses and discloses medical information.

For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the following categories.

The Benefit Plan has delegated some plan administration activities to its business associates, such as third-party administrators, who also may use and disclose your medical information to perform services and functions on behalf of the Benefit Plan.

For Treatment. The Benefit Plan may use and disclose medical information about you to provide you with medical treatment or services. For example, if your health care needs to be coordinated, we may give information to your primary care physician or specialist.

For Payment. The Benefit Plan may use and disclose medical information about you so that the treatment and services you receive may be billed and payment may be made to the health care providers that provided care to you. For example, we may need to give your medical information to a third-party administrator so that they will pay claims for your care.

For Health Care Operations. The Benefit Plan may use and disclose medical information about you for Benefit Plan operations. These uses and disclosures are necessary to run the Benefit Plan and ensure that our members receive quality services. For example, we may use medical information to review our coverage options and services and to evaluate the performance of our plan.

Treatment Alternatives. The Benefit Plan may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-related Benefits and Services. The Benefit Plan may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. The Benefit Plan may disclose medical information about you to a close personal friend or family member who is involved in your medical care or payment for your care if you have signed an authorization. Please note that our health insurance companies, HMOs, and third-party administrators may impose different protections when disclosing medical information to individuals involved in your care or payment for your care.

For Special Purposes. The Benefit Plan may disclose medical information about you for special purposes as permitted or required by law, including the following:

- To avert a serious threat to your health or safety, the public, or another person

- For public health and administrative oversight activities such as disease control, abuse or neglect reporting, health and vital statistics, audits, investigations, and licensure reviews

- For organ and tissue donation and transplant

Your Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of certain disclosures we made of medical information about you. Your request must state a time period. We may limit the time period to six years and to disclosures made on or after April 14, 2003. The first list you request within a 12-month period is free. For additional lists, we may charge you for the costs of providing the list or lists.

Your Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you. **We are not required by law to agree to your request.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

Your Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will not ask you the reason for your request. We will accommodate all reasonable requests.

Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with the Benefit Plan. You may also file a complaint directly with the Secretary of the Department of Health and Human Services. **You will not be penalized in any way for filing a complaint.**

Your Rights Regarding Medical Information about You. You have many rights with regard to your medical information. If you wish to exercise any of these rights, please submit your request in writing to Park Avenue Catering, HIPAA Privacy Officer.

Your Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may charge a reasonable fee for the costs of copying, mailing or other supplies associated with your request.

Your Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to add a statement. You must provide a reason that supports your request for an amendment.

Other Uses & Disclosures of Your Medical Information

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you provide us an authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by the written authorization.

You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care that we provide to you.

Changes to this Notice

The Benefit Plan reserves the right to change this Notice. The Benefit Plan reserves the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future.

Prescription Drug Coverage and Medicare

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 Park Avenue Catering 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 19 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, please contact human resources.

Note: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, as well as if this coverage through Park Avenue Catering 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.

- For personalized help, 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 **800.MEDICARE (800.633.4227)**. TTY users should call **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 the agency at **800.772.1213** (TTY **800.325.0778**).

Important Notice from Park Avenue Catering about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with **Park Avenue Catering** 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 facts you need to know about your current coverage and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

- **Park Avenue Catering** has determined that the prescription drug coverage offered by the carrier 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-month (2-month) 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 **Park Avenue Catering** coverage will be affected. **If you decide to enroll in a Medicare prescription drug plan and drop your Park Avenue Catering prescription drug coverage, be aware that you may not be able to get this coverage back.**

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