2024-2025

George G. Glenner Alzheimer's Family Centers, Inc.®

Employee Benefit Guide

December 1, 2024 - November 30,2025

GEORGE G. GLENNER ALZHEIMER'S FAMILY CENTERS, INC.®

2024-2025 Benefits Overview

Welcome to your

2024-2025 BENEFITS

We know that benefits are an integral part of the overall compensation package provided to all of our eligible employees, which is why we take great care to review all available benefits options on an annual basis. During this year's review, we focused not only on providing quality medical plans but also on controlling the cost and financial risk for our employees. We offer multiple options to meet the individual needs of our employees and their dependents.

NOT SURE HOW TO GET STARTED?

DON'T WORRY!

Prior to open enrollment, you will receive step-by-step enrollment instructions by email from our HR team.

Until then, now is the perfect time to prepare by doing the following:

- Review the benefits in which you are currently enrolled,
- Take a look at the changes for 2024-2025, *and*
- Get a sneak peek at the plans being offered for the coming year.

Consider this booklet your enrollment survival guide. Inside, you'll find everything you need to make informed benefits decisions, including in-depth information regarding your plan options, our policies and more.

As always, we value you as a member of the George G. Glenner Alzheimer's Family Centers, Inc.® family and look forward to a healthy and safe year.

IMPORTANT DATES

Plan year runs
December 1, 2024 -
November 30, 2025

REMEMBER! Open enrollment is the one time of year you can make any adjustments you'd like for the upcoming plan year.

Table of Contents

CONTACT INFORMATION

If you have any questions regarding your benefits, please contact Sharp, Humana, Colonial Life, your Glenner Human Resources Representative, or our CBIZ representative listed here.

Want to learn more?

Throughout this guide, you'll find clickable video and link icons that will take you to resources that provide additional info on your available benefits.

MEDICAL INSURANCE
Sharp Health Plan
www.sharphealthplan.com
800-359-2002

DENTAL INSURANCE
Humana
www.humana.com
800-233-4013

VOLUNTARY PRODUCTS
Colonial Life
Peter Crosby,
peter.crosby@coloniallifesales.com
858-673-6995

YOUR BENEFITS TEAM
Fernando Moscoso
accounting@glenner.org
619-543-4700 x402

CBIZ REPRESENTATIVE
Noelia Henning, Account Executive
nhenning@cbiz.com
858-795-7453

MEDIEXCEL
www.mediexcel.com
855-633-4392

Eligibility and Plan Options

ELIGIBILITY

Employee

All Full-Time Employees working 30 or more hours per week shall be eligible for group benefits effective on the 91st day from your date of hire (or full-time date).

Dependents

In addition to enrolling yourself, you may also enroll any eligible dependents in the medical plan. Eligible dependents include:

Spouse/Domestic Partner: Spouse is defined as a person to whom you are legally married. Such a person remains a spouse until a decree of divorce is issued. Domestic Partner is defined as same sex or opposite sex couples, or if one or both partners are age 62 or over, whose relationship constitutes the same obligations, support and responsibilities typically attributed to marriage.

Child: A legal dependent child under the age of 26. Coverage will cease at the end of the month in which the dependent reaches age 26.

Life Changes

Benefit elections remain in place for the entire benefit plan year. Changes can only be made during the initial enrollment period and annual open-enrollment. The exception to this rule would be if there was a qualifying change in family status as defined by the IRS: Examples, include, but are not limited to, the following:

- Marriage, divorce, legal separation, or annulment
- Birth or adoption of a child
- Change in your residence or workplace (if your benefit options change)
- Loss of other health coverage
- Change in your dependent's eligibility

SELECT YOUR MEDICAL CARRIER

Sharp Health Plan:

- Two medical plan options: Platinum HMO & Gold HMO Options
- Higher premium contributions, but providers located in United States
- No deductible
- Routine preventive exams are covered at 100%

MediExcel:

- Platinum Plan Option
- Lower premium contributions, but providers located in Mexico.
- No deductible
- Routine preventive exams are covered at 100%

Care Options & When to Use Them

YOUR CARE OPTIONS

While we recommend that you seek routine medical care from your primary care physician whenever possible, there are alternatives available to you. Services may vary, so it's a good idea to visit the care provider's website. Be sure to check that the facility is in-network by calling the toll-free number on the back of your medical ID card, or by visiting www.sharphealthplan.com.

Primary Care vs. Urgent Care vs. ER

PRIMARY CARE

- Routine, primary/preventive care
- Non-urgent treatment
- Chronic disease management

For routine, primary/ preventive care or non-urgent treatment, we recommend going to your doctor's office.

Your doctor knows you and your health history best — and already has access to your medical records. You'll also likely pay the least amount out-of-pocket.

TELEHEALTH

- Cold/flu
- Diarrhea
- Fever
- Rash
- Sinus problems

A "virtual visit," lets you talk to a doctor anytime, anywhere from your mobile device or computer — no appointment necessary.

CONVENIENCE CARE

- Common infections (ear infections, pink eye, strep throat & bronchitis)
- Flu shots & Vaccines
- Pregnancy tests
- Rashes
- Screenings

If you're unable to get to your doctor's office and your condition is not urgent/an emergency, these providers serve as a good alternative.

They are often located in malls or retail stores (such as CVS, Walgreens, Wal-Mart and Target), and generally serve patients 18 months of age or older without an appointment. Services may be provided at a lower out-of-pocket cost than an urgent care center.

URGENT CARE

- Sprains & Strains
- Small cuts
- Minor infections
- Sore throats
- Mild asthma attacks
- Back pain or strains

Sometimes you need medical care fast, but a trip to the emergency room may not be necessary. During office hours, you may be able to go to your doctor's office.

Outside regular office hours — or if you can't be seen by your doctor immediately — you may consider going to an Urgent Care Center where you can generally be treated for many minor medical problems faster than at an emergency room.

EMERGENCY ROOM

- Heavy bleeding
- Large open wounds
- Chest pain
- Spinal injuries
- Difficulty breathing
- Major burns
- Severe head injuries

An emergency medical condition is any condition (including severe pain) that you believe may result in serious injury or death without immediate medical care.

Emergency services are always considered in-network. If you receive treatment for an emergency in a non-network facility, you may be transferred to an in-network facility once your condition has been stabilized.

If you believe you are experiencing a medical emergency, go to the nearest emergency room or call 9-1-1, even if your symptoms are not described here.

Medical Insurance - Sharp

Sharp Health Plan Options	Premier Gold NG 2	Premier Platinum NG 2
	IN-NETWORK	IN-NETWORK
DEDUCTIBLE **Individual / Family**	$0 / $0	$0 / $0
COINSURANCE (Member Pays)	45%	0%
OUT-OF-POCKET MAXIMUM Individual / Family	$9,450 / $18,900	$2,900 / $5,800
OFFICE VISITS Preventative Care Primary Care Physician / Specialist Diagnostic Lab / X-Ray Urgent Care	Covered at 100% $45 / $50 copay $15 / $50 copay $50 copay	Covered at 100% $15 / $15 copay $10 / $10 copay $15 copay
MENTAL HEALTH CARE Inpatient Outpatient	45% coinsurance $45 copay	$250/day ($750 max copay) $15 copay
HOSPITAL VISITS Inpatient Care (Facility / Physician) Outpatient Surgery Major Diagnostics & Imaging Emergency Room	45% coinsurance 45% coinsurance $150 copay $100 copay (waived if admitted)	$250/day ($750 max copay) $250 copay $100 copay $100 copay (waived if admitted)
PRESCRIPTION DRUG Deductible Retail (Generic/Brand/Non-Form)	None $16 / $35 / $70	None $15 / $35 / $50

Premiums can be withheld from your paycheck on a pre-tax basis for Medical and Dental insurance. Based upon your individual tax bracket, this could save you a considerable amount of money.

Your election can only be changed during the plan year if you experience a qualifying life status change. You must notify Human Resources within 30 days of the event.

Both plans are detailed in Sharp's 2024 Certificate of Coverage (COC). This is a brief summary only. For exact terms and conditions, please refer to your certificate.

Medical Insurance Rates - Sharp

	EMPLOYEE ONLY MONTHLY RATES WITH EMPLOYER CONTRIBUTION		DEPENDENT MONTHLY RATES CONTRIBUTIONS DOES NOT APPLY	
Age Band	SHARP PREMIER Platinum HMO NG 2 (0/15/250) Platinum / HMO 12/1/2024	SHARP PREMIER Gold HMO NG 4 (0/40/40%) Gold / HMO 12/1/2024	SHARP PREMIER Platinum HMO NG 2 (0/15/250) Platinum / HMO 12/1/2024	SHARP PREMIER Gold HMO NG 4 (0/40/40%) Gold / HMO 12/1/2024
0-14	$122.03	$50.02	$322.03	$250.02
15	$150.66	$72.24	$350.66	$272.24
16	$161.60	$80.74	$361.60	$280.74
17	$172.55	$89.23	$372.55	$289.23
18	$184.34	$98.39	$384.34	$298.39
19	$196.12	$107.54	$396.12	$307.54
20	$208.33	$117.01	$408.33	$317.01
21	$220.96	$126.82	$420.96	$326.82
22	$220.96	$126.82	$420.96	$326.82
23	$220.96	$126.82	$420.96	$326.82
24	$220.96	$126.82	$420.96	$326.82
25	$222.64	$128.13	$422.64	$328.13
26	$231.06	$134.66	$431.06	$334.66
27	$241.17	$142.51	$441.17	$342.51
28	$257.58	$155.25	$457.58	$355.25
29	$271.05	$165.71	$471.05	$365.71
30	$277.79	$170.94	$477.79	$370.94
31	$287.89	$178.78	$487.89	$378.78
32	$298.00	$186.63	$498.00	$386.63
33	$304.31	$191.53	$504.31	$391.53
34	$311.05	$196.76	$511.05	$396.76
35	$314.41	$199.37	$514.41	$399.37
36	$317.78	$201.99	$517.78	$401.99
37	$321.15	$204.60	$521.15	$404.60
38	$324.52	$207.22	$524.52	$407.22
39	$331.25	$212.45	$531.25	$412.45
40	$337.99	$217.67	$537.99	$417.67
41	$348.09	$225.52	$548.09	$425.52
42	$357.77	$233.04	$557.77	$433.04
43	$371.24	$243.49	$571.24	$443.49
44	$388.08	$256.57	$588.08	$456.57
45	$407.87	$271.93	$607.87	$471.93
46	$431.44	$290.23	$631.44	$490.23
47	$457.96	$310.82	$657.96	$510.82
48	$488.27	$334.35	$688.27	$534.35
49	$518.16	$357.55	$718.16	$557.55
50	$551.83	$383.70	$751.83	$583.70
51	$585.09	$409.52	$785.09	$609.52
52	$621.71	$437.95	$821.71	$637.95
53	$658.76	$466.71	$858.76	$666.71
54	$698.75	$497.76	$898.75	$697.76
55	$738.74	$528.81	$938.74	$728.81
56	$782.10	$562.47	$982.10	$762.47
57	$825.88	$596.46	$1,025.88	$796.46
58	$872.61	$632.73	$1,072.61	$832.73
59	$895.76	$650.71	$1,095.76	$850.71
60	$942.49	$686.99	$1,142.49	$886.99
61	$982.90	$718.36	$1,182.90	$918.36
62	$1,009.42	$738.95	$1,209.42	$938.95
63	$1,042.67	$764.77	$1,242.67	$964.77
64+	$1,062.88	$780.46	$1,262.88	$980.46

MediExcel HEALTH PLAN

2024 P5 Platinum HMO Plan
Summary of Benefits & Coverage

Individual/Family Overall Annual Deductible	**$0**
Individual/Family Annual Out–of–Pocket Maximum	$4,500/$9,000

Medical Event	Service Type	Copay
Health Care Provider's Office or Clinic Visit	Office Visits – Primary Care (including mental health)	$5 copay per visit
	Office Visits – Specialist	$10 copay per visit
	Office Visits - Other Healthcare Practitioners	$5 copay per visit
	Preventive Care/Screening/Immunization	No Copay
	Primary Care Telemedicine Consultation	No Copay
	Dental Prophylaxis Cleaning	No Copay
Tests	Laboratory Tests	$5 copay per visit
	X-rays & Diagnostic Imaging	$5 copay per visit
	Imaging – (CT/Pet Scans, MRIs)	$100 copay per visit
Outpatient Prescription Drug Coverage to Treat Illness or Condition	Tier 1	$10 copay per drug
	Tier 2	$15 copay per drug
	Tier 3	$20 copay per drug
	Tier 4	40%, up to $250 per script
Outpatient Services	Surgery Facility Fee	$78 copay per visit
	Physician/Surgeon Fee	No Copay
	Outpatient Visit	10%
Emergency & Urgent Care (Need Immediate Attention)	Emergency Room Facility Fee	25%, up to $250
	Emergency Medical Transportation	15% coinsurance
	Urgent Care in Mexico	$15 copay per visit
	Urgent Care in the US/Outside of Mexico	$35 copay per visit
Hospital Stays	Inpatient Hospital Facility Fees (including labor/delivery, mental/behavioral health, and substance use disorder)	$50 copay/day, up to 5 days
	Inpatient Physician/Surgeon Fees	No Copay
Mental Health, Behavioral Health, or Substance Abuse Needs	Mental/Behavioral Health and Substance Use Disorder Outpatient Office Visits	$5 copay per visit
	Mental/Behavioral Health and Substance Use Disorder Other Outpatient Items & Services	No Copay
Pregnancy	Prenatal Care & Preconception Visits	No Copay
Help Recovering or Other Special Health Needs	Home Health Care	No Copay
	Outpatient Rehabilitation/Habilitation Therapy Services	$10 copay per visit
	Skilled Nursing Care	$25 copay/day, up to 5 days
	Durable Medical Equipment (including diabetic equipment)	20% coinsurance
	Prosthetics/Orthotics	20% coinsurance
	Hospice Services	$50 copay per day
Child Eye Care	Eye Exam	No Copay
	1 Pair of Glasses/Year (or contact lenses in lieu of glasses)	No Copay
Child Dental Diagnostic & Preventive Services	Oral Exam	No Copay
	Preventive – Cleaning & X-ray	No Copay
	Sealants per Tooth	No Copay
	Topical Fluoride Application	No Copay
	Space Maintainers – Fixed	No Copay
Child Dental Basic Services	Amalgam Fill - 1 Surface	$25
Child Dental Major Services	Root Canal - Molar	$300
	Gingivectomy per Quad	$150
	Extraction - Single Tooth Exposed Root or Erupted	$65
	Extraction - Complete Bony	$160
	Porcelain with Metal Crown	$300
Child Orthodontics	Medically Necessary Orthodontics	$1,000

End Notes:

1) Family out-of-pocket maximums are equal to 2 times the individual values. Cost-sharing payments (copayments and coinsurance, but not yet premiums) made by each individual in a family contribute to the family's out-of-pocket maximums. Once the family out-of-pocket maximum is reached, the Plan pays all costs for covered services for all family members. In a family plan, an individual's out-of-pocket contribution is limited to the individual's annual out-of-pocket maximum.

Form B421 (072023 NRM) Effective 01/01/2024

U.S. Urgent Care

MediExcel Health Plan has the largest U.S. urgent care provider network in San Diego and Imperial County. MediExcel members have access to numerous local clinics as well as the 77 MinuteClinic© locations throughout California, inside select CVS/Pharmacies©.

minute clinic™

77 locations in select CVS/Pharmacies© in California. Visit **cvs.com/minuteclinic** for store locator.

Concentra®

13 locations in SD County. Visit **https://bit.ly/3wYTiiS** for clinic locator.

american family care URGENT CARE

6 locations in SD County. Visit **afcurgentcareclairemont.com/locations** for clinic locator.

SOUTH BAY URGENT CARE

1628 Palm Avenue
San Diego, CA 92154
Mon-Fri: 9 AM - 8 PM
Sat-Sun: 10 AM - 6 PM
(619) 591-9999

SAN YSIDRO HEALTH

678 Third Ave.,
Chula Vista, CA 91910
Mon-Fri: 8 AM - 8 PM
Sat: 8 AM - 4 PM
(619) 662-4100

SAN YSIDRO HEALTH

333 H Street, Ste. 2080,
Chula Vista, CA 91910
Mon-Sun: 8 AM - 8 PM
(619) 662-4100

LA MAESTRA COMMUNITY HEALTH CENTERS
City Heights · El Cajon · National City · Lemon Grove

4060 Fairmount Ave.,
San Diego, CA 92105
Mon-Fri: 8:30 AM - 6 PM
Sat: 9 AM - 2 PM
(619) 255-9155

VCC Vista Community Clinic

1000 Vale Terrace Drive,
Vista, CA 92084
Mon-Thu: 8 AM - 8 PM
Fri: 8 AM - 5 PM
Sat: 9 AM - 4 PM
(844) 308-5003

VO MEDICAL CENTER

EasyAccess Urgent Care
222 E. Cole Blvd.,
Calexico, CA 92231
Mon-Fri: 8 AM - 5 PM
Sat: 10 AM - 12 PM
(760) 352-2551

ALL VALLEY URGENT CARE

2026 N. Imperial Ave.,
El Centro, CA 92243
Mon-Fri: 10 AM - 9 PM
Sat-Sun: 10 AM - 6 PM
(760) 592-4351

innercare
Making life healthy from the inside out

900 Main St.,
Brawley, CA 92227
Mon-Fri: 7 AM - 8:30 PM
Sat: 7 AM - 4 PM
(760) 344-6471

Medical Insurance Rates - MediExcel

	EMPLOYEE ONLY MONTHLY RATES WITH EMPLOYER CONTRIBUTION	DEPENDENT MONTHLY RATES CONTRIBUTIONS DOES NOT APPLY
Age Band	**MediExcel Ultra Platinum Plan P5 12/1/2024**	**MediExcel Ultra Platinum Plan P5 12/1/2024**
0-14	$0.00	$99.56
15	$0.00	$108.41
16	$0.00	$111.80
17	$0.00	$115.18
18	$0.00	$118.83
19	$0.00	$122.47
20	$0.00	$126.25
21	$0.00	$130.15
22	$0.00	$130.15
23	$0.00	$130.15
24	$0.00	$130.15
25	$0.00	$130.67
26	$0.00	$133.27
27	$0.00	$136.40
28	$0.00	$141.47
29	$0.00	$145.64
30	$0.00	$147.72
31	$0.00	$150.84
32	$0.00	$153.97
33	$0.00	$155.92
34	$0.00	$158.00
35	$0.00	$159.04
36	$0.00	$160.08
37	$0.00	$161.13
38	$0.00	$162.17
39	$0.00	$164.25
40	$0.00	$166.33
41	$0.00	$169.46
42	$0.00	$172.45
43	$0.00	$176.61
44	$0.00	$181.82
45	$0.00	$187.94
46	$0.00	$195.23
47	$3.42	$203.42
48	$12.80	$212.80
49	$22.04	$222.04
50	$32.45	$232.45
51	$42.73	$242.73
52	$54.05	$254.05
53	$65.51	$265.51
54	$77.87	$277.87
55	$90.23	$290.23
56	$103.64	$303.64
57	$117.18	$317.18
58	$131.62	$331.62
59	$138.78	$338.78
60	$153.23	$353.23
61	$165.72	$365.72
62	$173.92	$373.92
63	$184.20	$384.20
64+	$190.45	$390.45

Flexible Spending Accounts (FSA)

SELECT YOUR FSA ACCOUNTS

- *Health Care Flexible Spending Account*
- *Dependent Care Expense Account*

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

This account enables you to pay medical, dental, vision, and prescription drug expenses that may or may not be covered under your insurance program (or your spouse's) with pre-tax dollars. You can also pay for dependent health care, even if you choose single (vs. family) coverage. The total amount of your annual election is available to you up front, reducing your chance of incurring a large out-of-pocket expense early in the plan year. Be aware — any unused portion of the account at the end of the plan year is forfeited.

ELIGIBLE EXPENSES EXAMPLES

- Coinsurance & copayments
- Contraceptives
- Crutches
- Dental expenses
- Dentures
- Diagnostic expenses
- Eyeglasses, including exam fee
- Feminine hygiene products
- Nutrition counseling
- Hearing devices & batteries
- Hospital bills
- Deductible amounts
- Laboratory fees
- Licensed practical nurses
- Orthodontia
- Orthopedic shoes
- Over-the-counter medication
- Prescription drugs
- Psychiatric care
- Psychologist expenses
- Routine physical
- Seeing-eye dog expenses
- Prescribed vitamin supplements (medically necessary)

HOW THE HEALTH CARE FLEXIBLE SPENDING ACCOUNT WORKS

When you have out-of-pocket expenses (such as copayments and deductibles), you can either use your FSA debit card to pay for these expenses at qualified providers or submit an FSA claim form with your receipt to CBIZ Flex.

Reimbursement is issued to you through direct deposit into your bank account, or by check.

ANNUAL LIMITS

Health Care Flexible Spending account	$3,200 max
Dependent Care Expense account	$5,000 max
Health Care FSA Rollover limit	$640

Full list of Health Care FSA Eligible Expenses

What is a Dependent Care FSA?

DEPENDENT CARE EXPENSE ACCOUNT

This account gives you the opportunity to redirect a portion of your annual pay on a pre-tax basis to pay for dependent care expenses. An eligible dependent is any member of your household for whom you can claim expenses on your Federal Income Tax Form 2441, "Credit for Child and Dependent Care Expenses." Children must be under age 13. Qualified care centers include dependent care centers, preschool educational institutions, and qualified individuals (as long as the caregiver is not a family member and reports income for tax purposes). Before deciding to use the Dependent Care Expense Account, it would be wise to compare its tax benefit to that of claiming a child care tax credit when filing your tax return. You may want to check with your tax advisor to determine which method is best for you and your family. Any unused portion of your account balance at the end of the plan year is forfeited.

CONTACT INFORMATION

Request a full statement of your accounts at any time by calling 855-410-2249 or log on to https://myplans.cbiz.com to review your FSA balance. **At http://myplans.cbiz.com, you can:**

- View account information and activity
- File claims
- Manage your profile
- View notifications
- Access forms

What Is a Flexible Spending Account?

Voluntary Dental Insurance - Humana

REVIEW YOUR DENTAL PLAN

HUMANA IS THE DENTAL CARRIER FOR 2024-2025

The dental plan is an HMO that offers coverage in-network only. There is no annual maximum or deductible.

Dependent children are eligible until the end of the month in which they turn age 26.

What is Dental Insurance?

Humana Liberty DHMO LS 100	Employee Cost Per Month	
Employee Only	$24.88	
Employee + Spouse	$56.72	
Employee + Child(ren)	$47.77	
Employee + Family	$80.60	
Services	**ADA Code**	**Copay**
Dental Annual Maximum		Unlimited
Annual Deductible		None
Diagnostic & Preventive		
- Exam / Diagnosis / Cleaning	150	No Charge
- Full Mouth X-Rays	210	No Charge
- Sealant (per tooth)	1351	$5 Copay
Restorative Treatment		
- Amalgam (per surface)	2140	No Charge
- Resin	2330	No Charge
Endodontics		
- Pulp Cap	3110	No Charge
- Root Canal (molar)	3330	$100 Copay
Periodontics (per quadrant)		
- Scaling and Root Planing	4341	$20 Copay
- Osseous Surgery	4260	$200 Copay
Oral Surgery		
- Simple Extraction	7111	No Charge
- Tissue Impaction	7220	$45 Copay
- Partial Bony Impaction	7230	$55 Copay
Crowns		
- Porcelain Crown	6751	$70 Copay
Prosthetics		
- Complete Upper or lower Denture	5110	$120 Copay
Orthodontics		
- Child	8070	$1,550
- Adult	8090	$1,695

MediExcel Health Plan
Dental HMO Plan

Dental Plan 200

Benefit Summary

THIS MATRIX IS ONLY A SUMMARY AND IS INTENDED TO HELP YOU COMPARE COVERAGE BENEFITS. FOR A DETAILED DESCRIPTION OF BENEFITS AND LIMITATIONS, PLEASE CONSULT YOUR *EVIDENCE OF COVERAGE* AND PLAN CONTRACT.

Using Your Dental Plan

Your Plan grants you access to a network of dental providers without deductibles or filing claim forms. To schedule an appointment, including referrals for consultation and emergency services, contact MediExcel's Member Line at (619) 365-4346.

PLAN FEATURES	IN-NETWORK PROVIDERS
Calendar Year Deductible	$0
Annual Benefit Maximum	None

ADA CODE	COVERED SERVICES	COPAY
	DIAGNOSTIC SERVICES	
D0120	Oral Evaluations	$0
D0210	Full Mouth Series X-rays	$0
D0220	Periapical X-ray Film	$0
D0230	Each Additional Film	$0
D0460	Pulp Vitality Test	$0
D1130	Emergency Oral Examinations	$0
	PREVENTIVE SERVICES	
D1110	Cleaning (Prophylaxis) – Adult	$0
D1120	Cleaning (Prophylaxis) – Child	$0
D1203	Fluoride - Child	$0
D1204	Fluoride - Adult	$0
- Diagnostic and Preventive services may be subject to age and frequency limitations. See your Evidence of Coverage for details.		
	SPACE MAINTAINERS	
D1510	Space Maintainer – Fixed Unilateral	$20
D1520	Space Maintainer – Removable Unilateral	$25
	RESTORATIVE SERVICES	
	PRIMARY OR PERMANENT TEETH	
D2140	Amalgam (Cavity) – 1 Surf Primary of Permanent	$5
D2150	Amalgam (Cavity) – 2 Surf Primary of Permanent	$8
D2160	Amalgam (Cavity) – 3 Surf Primary of Permanent	$10
D2161	Amalgam (Cavity) – 4+ Surf Primary of Permanent	$10
D2210	Silicate Cement – Per Restoration	$15
D2310	Acrylic or Plastic Restoration, Anterior	$15
D2330	Resin-Based Composite 1 Surf, Anterior	$20
D2331	Resin-Based Composite 2 Surf, Anterior	$20
D2332	Resin-Based Composite 3 Surf, Anterior	$25
D2335	Resin-Based Composite 4+ Surf, Anterior	$25

	CROWNS/BRIDGES	
D2740	Crown – Porcelain/Ceramic Substrate	$50
D2751	Crown – Porcelain Fused to Predominantly Base Metal	$50
D2753	Crown – Acrylic	$45
D2754	Crown – Acrylic with Metal	$45
D2791	Crown – Full Cast Predominantly Base Metal	$15
D2810	Crown – 3/4	$50
D2910	Recement Inlay, Onlay or Partial Coverage Restoration	$5
D2920	Recement Crown	$5
D2930	Prefabricated, Stainless-Steel Crown – Primary Tooth	$15
D2931	Prefabricated, Stainless-Steel Crown – Permanent Tooth	$15
D2950	Core Buildup, Including Any Pins	$35
D2952	Post & Core in Addition to Crown	$40
D6211	Pontic – Cast Predominantly Base Metal	$60
D6241	Pontic – Porcelain Fused to Predominantly Base Metal	$70
D6251	Pontic – Resin with Predominantly Base Metal	$60
- Full mouth rehabilitation is defined as 6 or more units of covered crowns and/or pontic under one treatment plan. - Charges for crowns and bridgework are per unit. There will be additional charges for the actual cost of the gold/high noble metal.		
	ENDODONTIC SERVICES	
D3110	Pulp Cap – Direct (excluding final restoration)	$5
D3120	Pulp Cap – Indirect (excluding final restoration)	$10
D3220	Therapeutic Pulpotomy (excluding final restoration)	$10
D3310	Root Canal Therapy – Anterior (excluding final restoration)	$30
D3320	Root Canal Therapy – Bicuspid (excluding final restoration)	$40
D3330	Root Canal Therapy – Molar (excluding final restoration)	$50
D3346	Retreatment of Previous Root Canal Therapy – Anterior	$50
D3410	Apicoectomy/Periradicular Surgery – Anterior	$50
D3411	Apicoectomy/per tooth, each additional root	$50
D3430	Retrograde Filling – Per Root	$60
D3940	Recalcification	$5
D3999	Culturing Canal	$5
	PERIODONTICS SERVICES	
D4210	Gingivectomy or Gingivoplasty – 4 or More Teeth – Per Quadrant	$25
D4211	Gingivectomy or Gingivoplasty – 1-3 Teeth – Per Tooth	$8
D4220	Gingival Curettage – Per Quadrant	$18
D4250	Mucogingival Surgery – Per Quadrant	$36
D4260	Osseous Surgery – 4 or More Teeth – Per Quadrant	$36
D4341	Periodontal Scaling and Root Planing – 4 or More Teeth – Per Quadrant	$30
D9110	Palliative (Emergency) Treatment	$5
	PROSTHODONTICS - REMOVABLE	
D5110	Complete Denture – Maxillary	$63
D5120	Complete Denture – Mandibular	$63
D5130	Immediate Denture – Maxillary	$63
D5140	Immediate Denture – Mandibular	$63
D5211	Maxillary Partial Denture – Resin Base (including retentive/clasping materials, rests, and teeth)	$63
D5212	Mandibular Partial Denture – Resin Base (including retentive/clasping materials, rests, and teeth)	$63
D5213	Maxillary Partial Denture – Cast Metal Framework with Resin Denture Bases (including any conventional clasps, rests, and teeth)	$63
D5214	Mandibular Partial Denture – Cast Metal Framework with Resin Denture Bases (including any conventional clasps, rests, and teeth)	$63
D5410	Adjust Complete Denture – Maxillary	$10
D5411	Adjust Complete Denture – Mandibular	$10

D5421	Adjust Partial Denture – Maxillary	$10
D5422	Adjust Partial Denture - Mandibular	$10
	REPAIRS TO PROSTHETICS	
D5510	Repair Broken Complete Denture Base	$15
D5520	Replace Missing or Broken Teeth – Complete Denture (each tooth)	$10
D5610	Repair Resin Denture Base	$20
D5630	Repair or Replace Broken Retentive/Clasping Materials – per tooth	$20
D5640	Replace Broken Teeth – Per Tooth	$10
D5650	Add Tooth or Existing Partial Denture ($5 each additional tooth)	$15
D5660	Add Clasp to Existing Partial Denture	$5
D5730	Reline Complete Maxillary Denture (Chairside)	$15
D5731	Reline Complete Mandibular Denture (Chairside)	$15
D5740	Reline Maxillary Partial Denture (Chairside)	$15
D5741	Reline Mandibular Partial Denture (Chairside)	$15
D5750	Reline Complete Maxillary Denture (Lab)	$18
D5751	Reline Complete Mandibular Denture (Lab)	$18
D5760	Reline Maxillary Partial Denture (Lab)	$18
D5761	Reline Mandibular Partial Denture (Lab)	$18
D5820	Interim Partial Denture (Maxillary)	$10
D6930	Recement Bridge	$10
	ORAL SURGERY SERVICES	
D7110	Single Tooth	$8
D7120	Each Additional Tooth	$8
D7210	Surgical Removal of Erupted Tooth	$15
D7220	Removal of Impacted Tooth – Soft Tissue	$30
D7230	Removal of Impacted Tooth – Partially Bony	$35
D7240	Removal of Impacted Tooth – Completely Bony	$50
D7285	Biopsy of Oral Tissue – Hard	$0
D7286	Biopsy of Oral Tissue – Soft	$0
D7310	Alveoloplasty in Conjunction with Extractions – 4 or More Teeth or Tooth Spaces – Per Quadrant	$15
D7510	Incision and Drainage of Abscess – Intraoral Soft Tissue	$0
D7960	Frenulectomy (Frenectomy, Frenotomy) Separate Procedure	$25
	MISCELLANEOUS	
D9110	Palliative (Emergency) Treatment of Dental Pain – Minor Procedure	$5
D9215	Local Anesthesia	$0
D9310	Consultation (Diagnostic Service by Additional Dentist)	$0
D9430	Post-Operative Visit	$0
D9440	Office Visit – After Hours	$10
D9999	Broken Appointment (less than 24 hours)	$10
	ORTHODONTICS	
D8080	Comprehensive Orthodontic Treatment - Adolescent	$1,200
D8090	Comprehensive Orthodontic Treatment - Adult	$1,400
	PLAN EXCLUSIONS AND LIMITATIONS*	

***Services that May Not Be Covered Under the Plan:**

1. Services or supplies that are covered in whole or in part:
   (a) under any other part of this Dental Plan; or
   (b) under any other plan of group benefits provided by or through your employer.

2. Services and supplies to diagnose or treat a disease or injury that is not:
   (a) a non-occupational disease; or
   (b) a non-occupational injury
3. Services not listed in the Dental Care Benefit Summary that applies, unless otherwise specified in the Evidence of Coverage.

4. Those for replacement of a lost, missing, or stolen appliance, and those for replacement of appliances

MediExcel Health Plan
Vision Plan

Vision Plan 100

Benefit Summary

THIS MATRIX IS ONLY A SUMMARY AND IS INTENDED TO HELP YOU COMPARE COVERAGE BENEFITS. FOR A DETAILED DESCRIPTION OF BENEFITS AND LIMITATIONS, PLEASE CONSULT YOUR *EVIDENCE OF COVERAGE* AND PLAN CONTRACT.

Using Your Vision Plan

Your Plan grants you access to a network of vision providers without deductibles or filing claim forms. To schedule an appointment, contact MediExcel's Member Line at (619) 365-4346.

IN-NETWORK PROVIDER

Service	Copay	Frequency
Eye Exam	$0 copay	every 12 months
Frame Allowance	$100 retail frame allowance *Member pays any amount over allowance.*	every 24 months
Standard Lenses (*up to 61mm*)	$0 copay for: • Single Vision • Bifocal	every 12 months
Lens Coatings	No copay for Pink or Rose Tints #1 or #2 *Upgrades for lens treatments such as UV coating, standard polycarbonate, standard transitions, standard progressive lenses are at an agreed discounted rate with the selected provider.*	
Elective/Convenience Contact Lenses*	$100 retail contact lens allowance. **In lieu of frame and lenses. Members pay any amount over allowance. Fit and Follow-Up additional cost.*	every 12 months
LASIK**	$900 per eye ***In lieu of frame allowance/standard lens and contact lens benefit* *Qualifications:* *• 6 month no refraction change* *• Age 20-50* *• Moderate Nearsightedness (-2.25/-5.00 refraction)*	

OUT-OF-NETWORK PROVIDER

Service	Copay	Frequency
Not covered.		

LIMITATIONS:
- Repeat, follow-up procedures, or refinements are not covered.
- Contact lenses and contact lens fitting, except as specifically provided. In lieu of frames and lenses.
- Eyewear when there is no prescription change, except when benefits are otherwise available.
- Lenses or frames which are lost, stolen, or broken will not be replaced, except when benefits are available.
- Custom lenses (*non-standard*) such as no-line, (*blended type*) progressive, polycarbonate, beveled, faceted, coated or oversize exceeding the Schedule of Allowances.
- Tints, other than pink or rose #1 or #2 except as specifically provided.
- LASIK procedure is only covered at IDOC inside Excel Hospital in Tijuana.

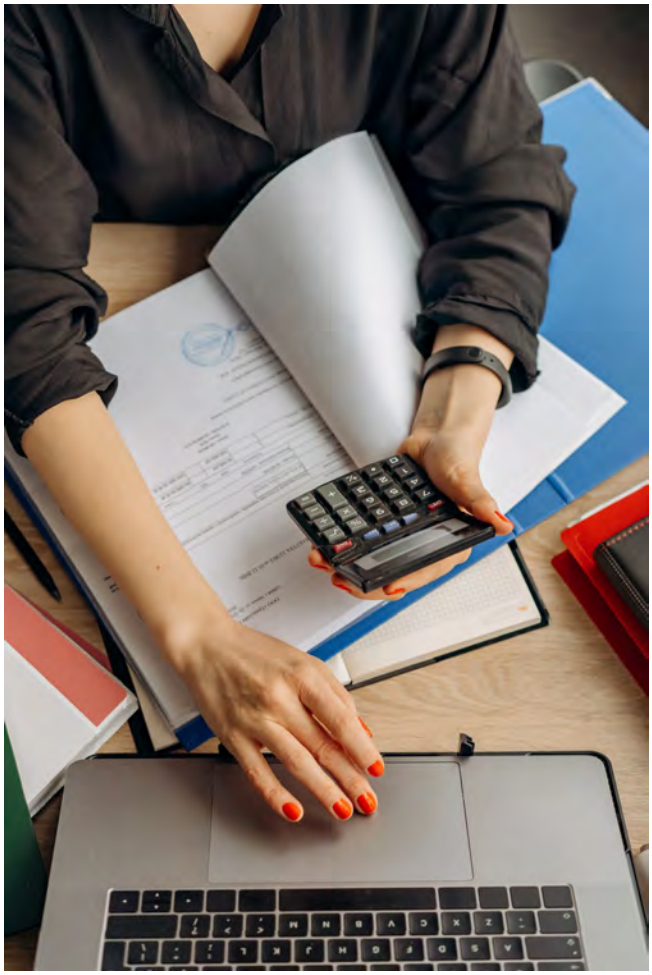
EXCLUSIONS:
- Medical or Surgical treatment of the eyes.
- Non-Prescription (*plano*) eyewear.
- Orthoptics, Vision Training, Subnormal or Low Vision Aides.
- Services that are experimental or investigational in nature.

This is a partial list of exclusions and limitations others may apply. Please check your Evidence of Coverage for details. Contact MediExcel's Member Line at (855) 633-4392 for additional questions.

Colonial Life

COLONIAL LIFE VOLUNTARY PRODUCTS

Colonial Life voluntary products provide peace of mind and protect your lifestyle when life throws unexpected challenges your way. Offered through your employer, our voluntary benefits help protect your income and provide financial security for you and your family.



VOLUNTARY PRODUCTS AVAILABLE

- CALIFORNIA CARE
- ACCIDENT 1.0
- SHORT-TERM DISABILITY
- CANCER 100
- UNIVERSAL LIFE

Video Library

MEDICAL PLANS

- Medical Plans Explained
- Primary Care vs. Urgent Care vs. ER
- HMO Overview

INSURANCE 101

- Benefits Key Terms Explained
- How to Read an EOB
- What is a Qualifying Event?

ANCILLARY BENEFITS

- What is Dental Insurance?
- What are voluntary benefits?

Glossary of Medical Terms

INSURANCE TERMS

Coinsurance—The plan's share of the cost of covered services which is calculated as a percentage of the allowed amount. This percentage is applied after the deductible has been met. You pay any remaining percentage of the cost until the out-of-pocket maximum is met. Coinsurance percentages will be different between in-network and out-of-network services.

Copays—A fixed amount you pay for a covered health care service. Copays can apply to doctor's office visits, as well as urgent care and emergency room services. Copays will not satisfy any part of the deductible. Copays should not apply to any preventive services.

Deductible—The amount of money you pay before services are covered. Services subject to the deductible will not be covered until it has been fully met. It does not apply to any preventive services, as required under the Affordable Care Act.

> ***Embedded Deductible–** The single team member deductible is *embedded* into the family deductible, meaning no one person covered under the plan can contribute more than the single amount toward the family deductible.

Lifetime Benefit Maximum—All plans are required to have an unlimited lifetime maximum.

Network Provider—A provider who has a contract with your health insurer or plan to provide services at set fees. These contracted fees are usually lower than the provider's normal fees for services.

Out-of-Pocket Maximum—The most you will pay during a set period of time before your health insurance begins to pay 100% of the allowed amount. The deductible, coinsurance and copays are included in the out-of-pocket maximum.

Preauthorization (also known as Prior Authorization (PA))—A process conducted by your health insurer or plan to determine if any service, treatment plan, prescription drug or durable medical equipment is medically necessary. This is sometimes called prior authorization, prior approval or precertification.

UCR (Usual, Customary and Reasonable)—The amount paid for medical services in a geographic area based on what providers in the area usually charge for the same or similar service.

MEDICAL TERMS

Prescription Drugs—Each plan offers its own unique prescription drug program. Specific copays apply to each tier and a medical plan can have one to five separate tiers. The retail pharmacy benefit offers a 30-day supply. Mail order prescriptions provide up to a 90-day supply. Sometimes the deductible must be satisfied before copays are applied.

Urgent Care—Care for an illness, injury or condition serious enough that a reasonable person would seek immediate care, but not so severe to require emergency room care.

Emergency Room—Services you receive from a hospital for any serious condition requiring immediate care.

Preventive Services—All services coded as Preventive must be covered 100% without a deductible, coinsurance or copayments.

Medically Necessary—Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms, which meet accepted standards of medicine.

IMPORTANT NOTICES

MEDICARE PART D CREDITABLE COVERAGE

Important Notice from George G. Glenner Alzheimer's Family Centers, Inc.® 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 George G. Glenner Alzheimer's Family Centers, Inc.® 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. George G. Glenner Alzheimer's Family Centers, Inc.® has determined that the prescription drug coverage offered by the Sharp health plans are, 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 15th to December 7th.

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 George G. Glenner Alzheimer's Family Centers, Inc.® coverage **may** be affected. You can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop the George G. Glenner Alzheimer's Family Centers, Inc.® medical plan, **be aware that you and your dependents may not be able to get this coverage back**.

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 George G. Glenner Alzheimer's Family Centers, Inc.® 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 October 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 George G. Glenner Alzheimer's Family Centers, Inc.® 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:	12/01/2024
Name of Entity/Sender:	George G. Glenner Alzheimer's Family Centers, Inc.®
Contact--Position/Office:	Fernando Moscoso
Address:	2765 Main Street, Suite A, Chula Vista, CA 91911
Phone Number:	619-543-4700 x 402

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 July 31, 2024. Contact your State for more information on eligibility –

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

To see if any other states have added a premium assistance program since July 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 Control Number 1210-0137 (expires 1/31/2026)

INITIAL COBRA NOTICE *[FOR NEW HIRES OR NEW BENEFITS ELIGIBLE ONLY]*

INTRODUCTION

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

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

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

WHAT IS COBRA CONTINUATION COVERAGE?

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

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

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

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

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

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

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

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 30 days after the qualifying event occurs. You must provide this notice to: *Fernando Moscoso*

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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

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

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

DISABILITY EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

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

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

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

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

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

CAN I ENROLL IN MEDICARE INSTEAD OF COBRA CONTINUATION COVERAGE AFTER MY GROUP HEALTH PLAN COVERAGE ENDS?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

IF YOU HAVE QUESTIONS

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

PLAN CONTACT INFORMATION

Fernando Moscoso, 619-543-4700 x 402

MARKETPLACE COVERAGE OPTIONS *[FOR NEW HIRES ONLY]*

PART A: GENERAL INFORMATION

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

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

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

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

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

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

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

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution, as well as your employee contribution to employer-offered coverage is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.[1]

HOW CAN I GET MORE INFORMATION?

For more information about your coverage offered by your employer, please check your summary plan description or contact George G. Glenner Alzheimer's Family Centers, Inc.® HR department.

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

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

MARKETPLACE COVERAGE OPTIONS CONTINUED *[FOR NEW HIRES ONLY]*

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

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

Employer Name: George G. Glenner Alzheimer's Family Centers, Inc.®	**Employer Identification Number (EIN):** 95-3794678
Employer Address: 2765 Main Street, Suite A, Chula Vista, CA 91911	**Employer Phone Number:** 619-543-4700
Who can we contact about employee health coverage at this job? Fernando Moscoso	**Phone Number:** 619-543-4700 x 402 **Email Address:** accounting@glenner.org

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

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☑ Full time employees, working a minimum 30 hours per week on a regular basis. Employees will be effective the 91st day following their date of hire (or full-time date).
  - ☐ Some employees. Eligible employees are:
- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are: Spouses, Domestic Partners, and Children
  - ☐ We do not offer coverage.

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

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

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

WOMEN'S HEALTH AND CANCER RIGHTS 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 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.
- Treatment of physical complications at all stages of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your Plan Administrator at 619-543-4700 x 402.

IMPORTANT INFORMATION REGARDING 1095 FORMS

As an employer with 50 or more full-time employees, we are required to provide 1095-C forms to each employee who was employed as a full-time employee for at least one month during the calendar year, without regard to whether they were covered by our group health plan. These employees should expect to receive their Form 1095-C in early March 2025. We are also required to send a copy of your 1095-C form to the IRS.

The information reported on Form 1095-C is used in determining whether an employer owes a payment under the employer shared responsibility provisions under section 4980H. Form 1095-C is also used by you and the IRS to determine eligibility for the premium tax credit.

SPECIAL ENROLLMENT NOTICE

During the open enrollment period, eligible employees are given the opportunity to enroll themselves and dependents into our group health plans.

If you elect to decline coverage because you are covered under an individual health plan or a group health plan through your parent's or spouse's employer, you may be able to enroll yourself and your dependents in this plan if you and/or your dependents lose eligibility for that other coverage. You must request enrollment within 30 days after the other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll any new dependent within 30 days of the event.

If you or your dependents become ineligible for Medicaid or CHIP, you may be able to enroll yourself and your dependents in the plan. You must request enrollment within 60 days.

If you or your dependents become eligible for premium assistance from Medicaid or CHIP, you may be able to enroll yourself and your dependents in the plan. You must request enrollment within 60 days.

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

NEWBORNS' AND MOTHER'S HEALTH PROTECTION ACT

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g. your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). For plan participants residing in California, the following maternity minimum stay provisions also apply: If the hospital stay is less than 48 hours after a normal vaginal delivery or less than 96 hours after a cesarean delivery, this plan will cover a follow-up visit for the mother and newborn within 48 hours of discharge, when prescribed by the treating physician. This visit shall be provided by a licensed health care provider whose scope of practice includes postpartum and newborn care. The treating physician, in consultation with the mother, shall determine whether this visit shall occur at home, in a medical facility, or at the physician's office.

MANDATORY INSURER REPORTING LAW

Employees are required to provide Social Security numbers for all dependents enrolled in the medical plan. You will be asked to enter Social Security numbers for all dependents you enroll on your medical plan. The reason for this requirement is the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMESA). This law requires that providers of group health plans must report certain information (Social Security numbers of plan participants) to the Secretary of Health and Human Services (HHS) to determine Medicare entitlement. The reporting party will be the insurer or third-party administrator, or plan administrator or fiduciary if the plan is self-insured and self-administered. The law also provides penalties for noncompliance. This law became effective on January 1, 2009.

GENETIC INFORMATION NON-DISCRIMINATION ACT (GINA)

In accordance with GINA, this Plan does not deny coverage or benefits, or charge a higher rate or premium, to an otherwise healthy individual found to have a potential genetic condition or genetic predisposition towards a disease or disorder. If PHI is used or disclosed for underwriting purposes, the Plan is prohibited from using or disclosing any of your PHI that is genetic information for such purposes. GINA defines genetic information as that obtained from an individual's genetic test results, as well as genetic test results of family members and the occurrence of a disease or disorder in family members.

MENTAL HEALTH PARITY & ADDICTION EQUITY ACT (MHPAEA) NOTICE

The MHPAEA imposes the following requirements on plans that provide both medical and surgical benefits as well as mental health or substance use disorder benefits:

- The financial requirements that apply to mental health or substance use disorder benefits cannot be more restrictive than the predominant financial requirements that apply to substantially all medical and surgical benefits under the Plan, and no separate cost-sharing requirements can be applied only to mental health or substance use disorder benefits.

- The treatment limitations that apply to mental health or substance use disorder benefits cannot be more restrictive than the predominant treatment limitations that apply to substantially all medical and surgical benefits under the Plan, and no separate treatment limitations can be applied only to mental health or substance use disorder benefits.

Large plans and self-insured plans are not required to provide coverage for mental health conditions or substance use disorders, but if they do they must comply with the MHPAEA. Small insured plans are required under the Affordable Care Act to provide coverage for mental health conditions and substance use disorders, beginning with the 2014 plan year.

GEORGE G. GLENNER
ALZHEIMER'S FAMILY CENTERS, INC.®

© Copyright 2024. CBIZ, Inc. NYSE Listed: CBZ. All rights reserved.

The purpose of this booklet is to describe the highlights of your benefit program. Your specific rights to benefits under the Plans are governed solely, and in every respect, by the official plan documents and insurance contracts, and not by this booklet. If there is any discrepancy between the description of the plans as described in this material and official plan documents, the language of the documents shall govern.