2019-2020

Glencoe Management, Inc.

Arizona
Employee Benefits Enrollment Guide

Plan Year: August 1, 2019 – July 31, 2020

Shift Manager
Variable Hour Employee (VHE)

Introduction

Glencoe Management, Inc. offers you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

As an employee and participant in our employee benefit programs, you and your beneficiaries may have various rights and privileges related to these programs. Laws governing health care require us to provide you with these notifications. Contained within this guide are important notices to retain for your records.

Elections you make during open enrollment will become effective August 1, 2019.

Important note: The purpose of this guide is to summarize our benefit programs and provide required notifications. Your specific rights to benefits under the Plans are governed solely, and in every aspect by the official Plan Documents and insurance contracts and not by this guide. If there is any discrepancy between the description in this guide and the official Plan Documents, the language of the official Plan Documents will govern. Glencoe Management, Inc. reserves the right to modify, amend or cancel any benefits plan or program at any time, with notice, at the sole discretion of the Glencoe Management, Inc. Management team. This guide is not a contract for purposes of employment or payment of benefits. Except to the extent required by law or as specified in the applicable benefit plan, employees classified as temporary or part-time may not be eligible to participate in Glencoe Management, Inc.'s benefit plans or programs. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this guide, contact Human Resources.

When to Enroll and Make Changes?

You can enroll in benefits during your Initial Eligibility Period or during the Annual Open Enrollment Period.

Initial Enrollment:

- Full-Time Employees are eligible first of the month following 60 days of employment after date of hire.
- Variable Hour Employees (VHE) who maintain an average of 130 hours per month for the 12-month measurement period. Please note there is a (1) month administrative period following the measurement period for VHE Employees.

Please contact Human Resources for additional information @ 702-254-7400.

Who is Eligible?

Any employee who meets eligibility as outlined above. You may cover your dependents on the medical benefit program. Your dependents include:

- Legal Spouse
- Domestic Partners (both same and opposite gender)
- Dependent children under the age of 26, including domestic partner's child(ren), stepchildren, legally adopted children and children for whom you have legal guardianship (provided that the children reside with you).

What if you are Declining Coverage?

You are still required to fill out the application/declination form and provide to Human Resources.

What if you have No Changes to your Current Elections?

You will need to fill out section "A. Employee Information" of the application form and checkmark the box saying you want to keep your current benefits with no changes**.**

Mid-Year Changes:

Please choose your benefits carefully. According to IRS Section 125 regulations, pre-tax benefit elections are irrevocable within the plan year unless you experience a Mid-Year Qualifying Event. You must request those changes within 30 days of the status change. Qualifying Events include (for example):

- Marriage, Domestic Partnership, Legal Separation, Divorce, Death
- Birth or adoption of a child
- Change in employment status of your spouse/ domestic partner
- Qualification for Medicare
- Loss of other coverage for either yourself or a dependent

When Coverage Ends

For most benefits, coverage will end on the last day of the month in which your regular work schedule is reduced to fewer than 30 hours per week, your employment ends, or you stop paying your share of the coverage. Your dependent(s) coverage ends when your coverage ends, or the last day of the month in which the dependent is no longer eligible. Certain benefits may terminate on the date of event.

Contributions

Your contributions for medical benefits, if elected, are deducted from your gross pay before Medicare and Federal taxes are calculated thus reducing your tax liability. Again, if you would like deductions for medical premiums on a post-tax basis, please contact Human Resources.

Anthem Plan Options

The following chart is a brief summary of the 2019-2020 Anthem medical benefits.

Plan Name	**HSA Plan 24E 5000/100%**	**PPO Blue Secure Plan BS11**
MEDICAL BENEFITS	IN NETWORK : OUT NETWORK	IN NETWORK: OUT NETWORK
DEDUCTIBLE - EMPLOYEE	$5,000 : $5,000	$5,500 : $11,000
DEDUCTIBLE - FAMILY	$10,000 : $10,000	$11,000 : $22,000
INPAT HOSP COINS	0%* : 30%*	30%* : 50%*
ER CO-PAY	0%* after deductible	$300 + 30%* : Covered as In-Network
URGENT CARE CO-PAY	0%* after deductible : 30%*	$60 : 50%*
X-RAY, LAB, DIAGNOSTIC	0%* after deductible : 30%*	$0 for lab, $30 x-ray, 30%* out-pt hsp : 50%* Coinsurance
PRE/POST-NATAL CARE	0%* : 30%*	$200 : 50%*
PHYSICIANS CO-PAY	N/A	$30 : 50%*
PHYSICIANS COINSURANCE	0%* : 30%*	N/A
SPECIALIST CO-PAY	N/A	$60 : 50%*
SPECIALIST COINSURANCE	0%* : 30%*	N/A
OUT OF POCKET MAX - SINGLE	$5,000 : $10,000	$6,600 : $13,200
OUT OF POCKET MAX- FAMILY	$10,000 : $20,000	$13,200 : $26,400
PRESCRIPTIONS:	Combined with Medical Deductible 0% Coinsurance* : 30% Coinsurance (includes retail and home delivery)	$15/$45/$75/30% to $500
PREVENTITIVE CARE	100 % Covered : 30%*	No Charge : 50%* Coinsurance

* After calendar year deductible is satisfied.

Please note with HSA Plans (High Deductible Health Plans), employees pay a discounted rate when services are rendered. Employees enrolled in a qualified HSA plan may also contribute to a Health Savings/Bank Account on a pre-tax basis to help them pay for qualified medical expenses.

This summary is for illustration purposes only. Please refer to the Summary of Benefits and Coverage (SBC's) for detailed information concerning what the Anthem plan(s) cover and what you pay for covered services.

The plan(s) indicated above provide the minimum essential coverage as required by law. Furthermore, the plan(s) meets the minimum value standard as described in the Affordable Care Act.

Summary of Benefit Costs

Medical Plans:

HSA Plan 24E 5000/100%	Employee Cost Per Pay Period*
Employee Only	$ 55.00
Employee + Spouse	$ 148.00
Employee + Child(ren)	$ 140.00
Employee + Family	$ 220.00

PPO Blue Secure Plan BS11	Employee Cost Per Pay Period*
Employee Only	$ 105.00
Employee + Spouse	$ 198.50
Employee + Child(ren)	$ 187.50
Employee + Family	$ 317.00

Voluntary Benefits

Health Savings Account (HSA)

HSA's paired with a High Deductible (HSA-qualified) health plan allows employees to make pre-tax payroll deductions to a savings account with Health Equity that can be used to pay for qualified medical expenses.

- The maximum contribution per year are as follows:
  - 2019 calendar year for Individual is $3,500, Family $7,000
  - 2020 calendar year for Individual is $3,550, Family $7,100

With an HSA, you can:

- Pay no taxes on contributions made to your account
- Use that money to pay for qualified health care expenses
- Reduce your federal taxes
- Earn tax-free interest on money in the account
- All money in the account rolls over year to year
- The money is yours, so the account stays with you even if you leave your employer
- Use the HSA debit card to pay health expenses online, or at time of services

How does an HSA bank account work?

- When visiting a hospital or doctor, use your debit card to pay for co-pays and co-insurances
- If you are picking up prescriptions from your pharmacy, pay using your debit card.

Qualified medical expenses include:

- Routine health care such as doctor visits, x-rays, lab work, and prescriptions
- Hospital expenses or surgery coinsurance costs
- Dental Care including cleanings, fillings, and crowns
- Vision care including eye exams, eyeglasses and contacts

Understanding Your Health Care Plan Options

Insurance Plans

HSA Plans (High Deductible Health Plans)
High Deductible Health Plans (HDHP) provide employees with flexible plan options that include both in-network and out-of-network access. HSA plans require a more active approach to health care, as employees must meet their deductible before the coinsurance goes into effect. Typically, employees will pay a discounted rate when services are provided. The rate is negotiated between Anthem and each medical provider, and as such, your cost can vary depending on the doctor(s) you see.
Employees who choose this health care option are eligible for a Health Savings Account (HSA), allowing you to save money through payroll deductions on a pre-tax basis to help you pay for qualified medical expenses. You may also be eligible for a Limited Flexible Spending Account (FSA) on a pre-tax basis to cover costs for dental and vision care.

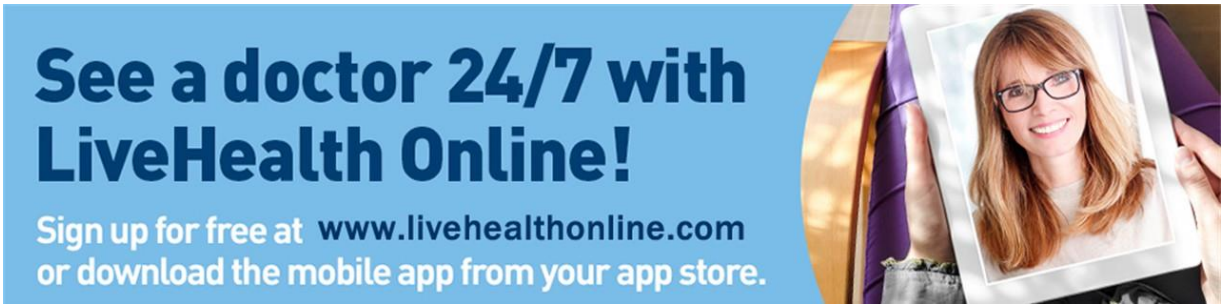
PPO Plans
Preferred Provider Organization (PPO) Plans gives employees more control over their choices of doctors and specialists. Employees can visit any in-network physician, or healthcare provider without requiring a referral from a primary care physician. PPO's offer a co-pay option for office and specialist visits, with a lower deductible than HSA Plan options. Depending on the doctors you chose, you can control your out of pocket costs by using an Anthem Preferred Provider under the Pathways Network (Tier 1), and in some cases paying a lower co-pay.
Employees who enroll in a PPO plan are not eligible for a Health Savings Account; however, they can sign up for a Flexible Spending Account to set aside funds through payroll deductions on a pre-tax basis to pay for specific expenses.

See Voluntary Benefits for more information on Health Savings Accounts (HSA), and Flexible Spending Account (FSA).

Medical Insurance Plans have two levels of benefits:

In-Network Benefits
When you utilize the Anthem network providers, you will receive the highest level of benefits (in-network benefits), and your out-of-pocket medical costs will be lower. In-network benefits have a lower deductible and lower coinsurance (compared to out-of network benefits) for medical services such as hospitalization, diagnostic testing and durable medical equipment. Coinsurance is your share of the cost of services and is based on a percentage of the total cost. For other types of medical services, such as primary care and specialist office visits, you may pay a fixed payment called a copay; or depending on the plan you chose, may pay a discounted rate that has been negotiated between the insurance carrier and the provider. There is an annual out-of-pocket maximum that includes covered medical and prescription out-of-pocket costs. After you meet your annual out of-pocket maximum, the plan will pay 100 percent of covered services for the remainder of the calendar year.

Out-of-Network Benefits
The plans offered by Anthem and outlined within this guide offer out-of-network coverage. An out-of-network provider means they are not contracted with your insurance carrier. If you chose to visit a doctor or service provider that it out-of-network, your out of pocket costs will usually be higher. Many plans have a separate out-of-network deductible, and you must meet the separate deductible before your plan pays any out-of-network benefits. Unless the situation in which you were seeking treatment is deemed as a life-threatening emergency, it's best to use an in-network provider. If you are treated for an emergency at an out-of-network provider, you may be required to pay the entire cost of the service at the time of services, then file a claim for reimbursement. For more information concerning out of network benefits or other questions about your coverage, please contact Anthem at 1-877-811-3106, or online at anthem.com.



LiveHealth Online

Have a health question? Under the weather? With LiveHealth Online, you don't have to schedule an appointment, drive to the doctor's office, and then wait for your appointment. In fact, you don't even have to leave your home or office. Doctors can answer questions, make a diagnosis, and even prescribe basic medications when needed.*

With LiveHealth Online:

- Available 24 hours a day, 7 days a week, 365 days a year.
- Immediate doctor visits through live video.
- Available anywhere you have a computer/mobile device with Internet access.
- Your choice of in-network, board-certified doctors.
- Help at the same or lower cost than your regular doctor visits.
- Allows doctors to e-prescribe medications utilizing local pharmacies.*
- Private, secure and convenient online visits.

$10 Co-pay with the PPO Medical Plan

When can you use LiveHealth Online?

As always, you should call 911 with any emergency. Otherwise, you can use LiveHealth Online whenever you have a health concern and don't want to wait, some of the most common uses include:

- Cold and Flu symptoms, such as cough, fever and headaches
- Allergies, or Sinus Infections
- Family Health Questions

Start a conversation now! Just enroll for free at livehealthonline.com or on the app, and you are ready to see a doctor.

*As legally permitted in certain states

Urgent Care vs. Emergency Room

It's important to know where to go when you're dealing with an illness or injury. If you need immediate medical attention, your first thought may be to go to the emergency room (ER). But if your condition isn't serious or life-threatening, you may have a less expensive choice. An urgent care center provides quality care like an ER, but can save you hundreds of dollars.

If you have a life-threatening situation, go to your nearest emergency room or call 911.

Urgent care centers

Urgent care centers handle non-life-threatening situations, and many are staffed with doctors and nurses who have access to x-rays and labs onsite, and can even handle situations like a broken bone, ear infection, or minor cuts, sprains or burns. Most urgent care centers are open late and on weekends and holidays.

Choosing an in-network urgent care center over the emergency room (ER) can save you time and money. To find the nearest Urgent Care, download the Anthem app, go online at anthem.com or call the member services phone number on the back of your ID card.

LEGAL INFORMATION REGARDING YOUR PLANS ACA:

Please see the accompanying files which include the medical plan SBCs.

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, 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)**.

Important Notice about Your Prescription Drug Coverage and Medicare: Creditable Coverage

If you (and/or your dependents) have Medicare, or will become eligible for Medicare within the next 12 months, federal law gives you more choices about your prescription drug coverage.

Please read this notice carefully. It has information about your prescription drug coverage under the Glencoe Management, Inc. health plan and the coverage options available to Medicare Part-D eligible individuals. This Notice also provides information on resources that may help you decide which prescription drug coverage to choose.
You should keep this notice with your important records. If you or your family members aren't currently covered by Medicare and won't become covered in the next 12 months, this notice doesn't apply to you.

Notice of Creditable Coverage

The purpose of this notice is to advise you that the Employer Plan prescription drug coverage listed below is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay. This is known as "creditable coverage."

- Anthem- HSA Plan 24E 5000/100%
- Anthem- PPO Blue Secure Plan BS11

Why this is important: Coverage under one of these plans may help you avoid a Medicare Part D late enrollment penalty. If you or your covered dependent(s) are enrolled in the Employer Plan and are currently or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty—as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment.

Late Enrollment Penalty (Higher Premium Charge)

You should know that if you waive or drop coverage under the Employer Plan and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Medicare Part D premium may go up by at least 1% per month for every month that you do not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium may consistently be at least 19% higher than what most other people pay. You may have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Medicare Part D.

Medicare Prescription Drug Coverage

You may have heard about Medicare's prescription drug coverage (called Medicare Part D), and wondered how it would affect you. Medicare offers prescription drug coverage to everyone with Medicare. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium. Individuals can enroll in a Medicare prescription drug plan when they first become Part D eligible, and each year thereafter during Medicare open enrollment (October 15 through December 7). Individuals who decide to drop their creditable employer/union coverage may be eligible for a two month Medicare Special Enrollment Period.

Interaction between Coverages

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or a family member of an active employee, your current Employer Plan coverage will be affected. In addition, if you waive or drop your current Employer Plan coverage to enroll in a Medicare Part D plan, you and your dependents will be able to re-enroll in the Employer Plan coverage at open enrollment or when you have a special enrollment event.

Additional Information

Contact the person listed at the end of this Notice for further information about your current prescription drug coverage. **NOTE:** You may receive this notice at other times in the future—such as before the next period you can enroll in Medicare prescription drug coverage, if the Employer Plan coverage changes, or upon your request.
More detailed information about Medicare plans that offer prescription drug coverage is in the *Medicare & You* handbook. Medicare participants will receive a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans: Visit www.medicare.gov.

- Call your State Health Insurance Assistance Program (see a copy of the *Medicare & You* handbook for the telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. For information about this extra help, contact the Social Security Administration (SSA) online at www.socialsecurity.gov or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan, you may be required to provide a copy of this notice when you join a Part D plan to show that you have maintained creditable coverage and, therefore, may not be required to pay a higher Part D premium.

HIPAA Notice of Availability of Notice of Privacy Practices

This Plan is required by law to provide notice of the Plan's duties and privacy practices with respect to covered individuals' protected health information by providing a Notice of Privacy Practices (NOPP) to participants. The Plan's NOPP is available upon request. To obtain a copy of the NOPP, or for more information regarding the Plan's privacy policies or your rights under HIPAA, contact Glencoe Management, Inc.

HIPAA Special Enrollment Rules

HIPAA requires we notify you about your right to later enroll yourself and eligible dependents for coverage in the Glencoe Management, Inc. health plan under "special enrollment provisions" briefly described below.

- **Loss of Other Coverage.** If you decline enrollment for yourself or for an eligible dependent because you have other group health plan coverage or other health insurance, you may be able to enroll yourself and your dependents under Glencoe Management, Inc.' health plan if you or your dependents lose eligibility for that other coverage, or if the other employer stops contributing toward your or your dependents' other coverage. You must request enrollment within 30 days after you or your dependents' other coverage ends, or after the other employer stops contributing toward the other coverage.
- **New Dependent by Marriage, Birth, Adoption, or Placement for Adoption.** If you gain a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents under the Glencoe Management, Inc. health plan. You must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. In the event you acquire a new dependent by birth, adoption, or placement for adoption, you may also be able to enroll your spouse, if your spouse was not previously covered.
- **Enrollment Due to Medicaid/CHIP Events.** If you or your eligible dependents are not already enrolled in the Glencoe Management, Inc. health plan, you may be able to enroll yourself and your eligible dependents if: (i) you or your dependents lose coverage under a state Medicaid or children's health insurance program (CHIP), or (ii) you or your dependents become eligible for premium assistance under state Medicaid or CHIP. You must request enrollment within 60 days from the date of the Medicaid/CHIP event. The CHIP Model Notice containing additional information about this right as well as contact information for state assistance is included below. You may also request a copy from the Plan Administrator.

Please contact the Plan Administrator for details, including the effective dates of coverage applicable to each of these special enrollment provisions. Additional information regarding your rights to enroll in group health coverage is found in the applicable group health plan summary plan description(s) or insurance contract(s).

Continuation of Coverage Rights under COBRA

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it**.

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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact Glencoe Management, Inc.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as 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 are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- 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 any of the following qualifying events happen:

- 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
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is 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), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Your notice must provide the type of qualifying event, the date of the qualifying event, and the name and address of the employee, spouse or dependent who underwent the qualifying event. You must provide this notice to the Human Resources Department of Glencoe Management, Inc.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

- ***Disability extension of 18-month period of continuation coverage:*** If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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 continuation coverage.
- ***Second qualifying event extension of 18-month period of continuation coverage:*** If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family may extend their COBRA continuation coverage, for a maximum of 36 months (as measured from the first qualifying event), if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

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

If You Have Questions

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

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of 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

Glencoe Management, Inc. Human Resources

Women's Health and Cancer Rights Act of 1998

In the case of an employee or dependent who receives benefits under the plan in connection with a mastectomy and who elects breast reconstruction (in a manner determined in consultation with the attending physician and the patient), coverage will be provided for:

- Reconstruction of the breast on which mastectomy has been performed, including nipple and areola reconstruction and regimentation to restore the physical appearance of the breast;
- Surgery and reconstruction on the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment for physical complications of all stages of mastectomy, including lymphedemas.

Coverage for reconstructive breast surgery may not be denied or reduced on the grounds that it is cosmetic in nature or that it otherwise does not meet the coverage definition of "medically necessary". Benefits will be provided on the same basis as for any other illness or injury under the Plan.
If you would like more information on WHCRA benefits, call your Plan Administrator.

Newborns' and Mothers' Health Protection Act 1996

Under federal law (Newborns' Act), 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 child birth 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 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). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification.
A number of states adopted requirements for benefits covering maternity stays prior to the enactment of the Newborns' Act. The federal law does not preempt state law if the state law meets certain criteria. For information on pre-certification, contact your Plan Administrator.

California Maternity Coverage

Group health plans and health insurance issuers with policies or contracts issued in the State of California generally may not, under California law, restrict benefits for inpatient hospital care to a time period less than 48 hours following a normal vaginal delivery and less than 96 hours following a delivery by caesarean section. However, coverage for inpatient hospital care may be for a time period less than 48 or 96 hours if both of the following conditions are met: (a) the decision to discharge the mother and newborn before the 48- or 96-hour time period is made by the treating physicians in consultation with the mother; (b) the contract or policy covers a post discharge follow-up visit for the mother and newborn within 48 hours of discharge, when prescribed by the treating physician. Furthermore, the Plan may not:

- Reduce or limit the reimbursement of the attending provider for providing care to an individual enrollee/insured in accordance with the coverage requirements.
- Provide monetary or other incentives to an attending provider to induce the provider to provide care to an individual enrollee/insured in a manner inconsistent with the coverage requirements.
- Deny a mother or her newborn eligibility, or continued eligibility, to enroll or to renew coverage solely to avoid the coverage requirements.
- Provide monetary payments or rebates to a mother to encourage her to accept less than the minimum coverage requirements.
- Restrict inpatient benefits for the second day of hospital care in a manner that is less than favorable to the mother or her newborn than those provided during the preceding portion of the hospital stay.
- Require the treating physician to obtain authorization from the health care service plan or insurer prior to prescribing any services.

Health Care Reform

Patient Protection Disclosure – Non-Grandfathered Plans
Anthem plans allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you and/or your family members until you make this designation, Anthem designates one for you. For information on how to select a primary care provider, and for a list of participating primary care providers, call Anthem or visit their website.

For children, you may designate a pediatrician as the primary care provider.
You do not need prior authorization (including from a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network or specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact call Anthem.

USERRA

The Uniformed Services Employment and Reemployment Rights Act (USERRA), protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

Right To Be Free From Discrimination and Retaliation

If you are a past or present member of the uniformed service; have applied for membership in the uniformed service; or are obligated to serve in the uniformed service; then an employer may not deny you: initial employment; reemployment; retention in employment; promotion; or any benefit of employment because of this status. In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

Health Insurance Protection

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

Enforcement

The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations. For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website at http://www.dol.gov/vets. An interactive online USERRA Advisor can be viewed at http://www.dol.gov/elaws/userra.htm. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

GINA

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to any requests for medical information, if applicable. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

PATIENT PROTECTION

Your carrier generally requires or allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you designate a primary care provider, your carrier may designate one for you. For children, you may have the ability to designate a pediatrician as the primary care provider as defined in component plan documents.
You may not need prior authorization from your carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating primary care provider, obstetrics or gynecology, contact your Plan Administrator. Your carrier generally requires or allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may have the ability to designate a pediatrician as the primary care provider as defined in component plan documents.
You may not need prior authorization from your carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating primary care provider, obstetrics or gynecology, contact your Plan Administrator.

For additional information or questions please contact:

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