YMCA EMPLOYEE BENEFITS
A nonprofit benefit Plan exclusively serving YMCAs since 1970.

HEALTH & WELFARE PLAN ANNUAL NOTICES

As required by law, please distribute this collection of legal notices to all eligible employees as part of your YMCA's enrollment materials.

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information.

Privacy & Confidentiality Statement: WellnessWorks Program

This notice provides answers to common questions regarding plan members' privacy while taking part in the Rally Health survey and other activities as part of YMCA Employee Benefits' WellnessWorks Program.

Suprise Medical Billing Disclosure

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected by federal law from surprise billing or balance billing.

Patient Protection and Affordable Care Act (PPACA)

This notice outlines your rights to designate a Primary Care Provicer and access obstetrical and gynecological care without prior authorization.

Women's Health & Cancer Rights Act of 1998 (WHCRA)

The Women's Health & Cancer Rights Act of 1998 (WHCRA) is a federal law that provides protections to patients who choose to have breat reconstruction in connection with a mastectomy.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act (the Newborns Act) provides protections for mothers and their newborn children relating to the length of their hospital stays following childbirth.

Special Rights Under MHPA and MHPAEA

The Mental Health Parity Act (MHPA) and Paul Wellstone and Pete Deomenic Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

Premium Assistance Under Medicaid and 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.

General Notice of COBRA Continuation Coverage Rights

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

NOTICE OF PRIVACY PRACTICES

General Information About This Notice

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The National Council of the YMCA of the USA (the "Plan Sponsor") continues its commitment to maintaining the confidentiality of your private medical information. This Notice describes our efforts to safeguard your health information from improper or unnecessary use or disclosure. A federal law known as the "HIPAA privacy rules" requires the YMCA Employee Benefits (the "Plan") to provide you with this summary of the Plan's privacy practices and related legal duties and your rights in connection with the use and disclosure of your Plan information.

I. The Group Health Plan

This Notice describes the privacy practices of the Plan. The Plan provides health benefits to the eligible employees of the Plan Sponsor, eligible employees of adopting local YMCAs, and their eligible dependents.

II. The Plan's Privacy Obligations

The Plan is required by federal and applicable state law to protect the privacy of individually identifiable health information about you that it creates or receives ("Your Protected Health Information") and to provide you with this Notice of its legal duties and privacy practices. When the Plan uses or discloses Your Protected Health Information, it is required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure).

The HIPAA privacy rules require the Plan to establish policies and procedures for safeguarding a category of medical information called "protected health information," or "PHI," received or created in the course of administering the Plan. PHI is health information that can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or payment for your health care. A claim form for medical or dental benefits and the explanation of benefits statements (EOBs) sent in connection with payment of your claims are examples of documents containing PHI.

This Notice only applies to health-related information received by or on behalf of the Plan. If the Plan Sponsor obtains your health information in another way – for example, if you are hurt in a work accident or if you provide medical records with your request for leave under the Family and Medical Leave Act – then this Notice does not apply, but the Plan Sponsor will safeguard that information in accordance with other applicable laws and policies. Similarly, health information obtained in connection with a non-Plan benefit, such as long-term disability or life insurance, is not protected under this Notice. This Notice also does not apply to information that does not identify you and with respect to which there is no reasonable basis to believe that the information can be used to identify you.

III. Uses and Disclosures With Your Written Authorization

The Plan may use or disclose to others Your Protected Health Information for any purpose other than the purposes described in Section IV below, only when you give the Plan your authorization on its authorization form. You may revoke your authorization, except to the extent the Plan has taken action in reliance on it, by delivering a written revocation statement to the Plan's Privacy Officer identified below.

A. Substance Use Treatment Information. The Plan may use or disclose any information it receives or maintains about you from a substance use disorder treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program") for treatment, payment and health care operations purposes as described in this Notice, only if the Plan received or maintained your Part 2 Program record through a general consent you provide to the Part 2 Program to use and disclose your Part 2 Program record for purposes of treatment, payment or health care operations. If the Plan receives or maintains your Part 2 Program record through specific consent you provide to the Plan or another third party, the Plan will use and disclose your Part 2 Program record only as expressly permitted by you in your consent as provided to the Plan. In no event will the Plan use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, **unless authorized by your consent or the order of a court after it provides you notice of the court order.**

IV. Uses and Disclosures Without Your Written Authorization

The Plan may use and disclose to others Your Protected Health Information without your written authorization for the following purposes. To the extent required under the HIPAA privacy rules, the PHI used and disclosed by the Plan will be limited to the minimum amount of PHI necessary for these purposes.

A. Treatment. The Plan may disclose Your Protected Health Information to your health care provider for its provision, coordination, or management of your health care and related services — for example, for managing your health care with the Plan or for referring you to another provider for care.

B. Payment. The Plan may use and disclose Your Protected Health Information to obtain payment for your coverage and to determine and fulfill the Plan's responsibility to provide health benefits—for example, to make coverage determinations, administer claims and coordinate benefits with other coverage you may have. The Plan also may disclose your Protected Health Information to another Plan or a health care provider for its payment activities—for example, for the other Plan to determine your eligibility or coverage, or for the health care provider to obtain payment for health care services provided to you.

C. Health Care Operations. The Plan may use and disclose Your Protected Health Information for its health care operations — for example, for disease management, arrange for medical review and conduct quality assessment and improvement activities. The Plan also may disclose Your Protected Health Information to another Plan or a health care provider that has or had a relationship with you for it to conduct quality assessment and improvement

activities; accreditation, certification, licensing, or credentialing activities; or for the purpose of health care fraud and abuse detection or compliance — for example, for the other Plan to perform case management or evaluate health care provider performance, or for the health care provider to evaluate the outcomes of treatments or conduct training programs to improve health care skills.

D. To Comply with the Law. The Plan may use and disclose your Protected Health Information to the extent required to comply with applicable law.

E. Disclosures to Your Employer Sponsoring Your Plan. The Plan may disclose Your Protected Health Information to certain employees or other individuals under the control of the Plan Sponsor as necessary for them to carry out the Plan Sponsor's responsibilities to administer Plan, as described in this Notice. The Plan Sponsor cannot use your PHI obtained from the Plan for any employment-related actions without your written authorization.

In addition, the Plan Sponsor may use or disclose "summary health information" for purposes of obtaining premium bids or modifying, amending, or terminating the Plan. Summary health information is information that summarizes claims history, claims expenses, or types of claims experienced by individuals for whom the Plan Sponsor provides benefits under the Plan and from which the individual identifying information, except for five-digit zip codes, has been deleted. The Plan Sponsor also may use or disclose Plan eligibility and enrollment information – for example, for payroll processing.

F. Marketing Communications. The Plan may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be useful to you. The Plan may use and disclose Your Protected Health Information to communicate face-to-face with you to encourage you to purchase or use a product or service that is not part of the health benefits provided by the Plan, or to provide a promotional gift of nominal value to you.

G. Public Health Activities. The Plan may disclose Your Protected Health Information for the following public health activities and purposes: (1) to report health information to public health authorities that are authorized by law to receive such information for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse or neglect to a government authority that is authorized by law to receive such reports; (3) to report information about a product or activity under the jurisdiction of the U.S. Food and Drug Administration to a person who has responsibility for activities related to the quality, safety or effectiveness of such FDA-regulated product or activity; and (4) to alert a person who may have been exposed to a communicable disease if the Plan is authorized by law to give such notice.

H. Health Oversight Activities. The Plan may disclose Your Protected Health Information to a government agency that is legally responsible for oversight of the health care system or for ensuring compliance with the rules of government benefit programs such as Medicare or Medicaid, or other regulatory programs for which health information is necessary for determining compliance.

I. Judicial and Administrative Proceedings. The Plan may disclose Your Protected Health Information in the course of a judicial or administrative proceeding in response to a legal order or other lawful process. However, in no event will the Plan use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

J. Law Enforcement Officials. The Plan may disclose Your Protected Health Information to the police or other law enforcement officials as required by law or in compliance with a court order or other process authorized by law, or if you are deceased, to allow a coroner or medical examiner to identify you or determine your cause of death, or to allow a funeral director to carry out his or her duties.

K. Health or Safety. The Plan may disclose Your Protected Health Information to prevent or lessen a serious and imminent threat to the health or safety of an individual or the public.

L. Specialized Government Functions. The Plan may disclose Your Protected Health Information to units of the government with special functions, such as the U.S. military or the U.S. Department of State. The Plan may disclose your PHI to the U.S. Department of Health and Human Services in connection with a review or inquiry of the Plan's compliance with the HIPAA privacy rules or to an appropriate government authority to report suspected instances of abuse, neglect, or domestic violence or for purposes of public safety or national security.

M. Workers' Compensation. The Plan may disclose Your Protected Health Information as necessary to comply with workers' compensation laws.

N. Third Party Providers (Business Associates). The Plan contract with third party administrators and various service providers, called business associates, to perform certain plan administration functions. The Plan' business associates will receive, create, use, and disclose your PHI, but only after the business associates have agreed in writing to appropriately safeguard and keep confidential your PHI. Third party administrators and pharmacy benefit managers are examples of Plan business associates. Business associates are also legally obligated to enter into agreements with their subcontractors to protect the confidentiality of your health information.

O. Disclosures to Family Members and Friends. The Plan may disclose your PHI to your family members, close friends, or other persons involved in your health care if you are present and you do not object to the disclosure (or if it can be inferred that you do not object), or, if you are not present or are unable to object due to incapacity or emergency, the disclosure is in your best interest. Disclosure will be limited to your PHI that is directly relevant to the person's involvement in your health care.

P. Research. The Plan (or a business associate) may use or disclose your PHI for research purposes, as long as certain privacy-related standards are satisfied.

Q. Public Health. The Plan may use or disclose your PHI for certain public health activities, including to a public health authority for the prevention or control of disease, injury, or disability; to a proper government or health authority to report child abuse or neglect; to report reactions to medications or problems with products regulated by the Food and Drug Administration; to notify individuals of recalls of medication or products they may be using; or to notify a person who may have been exposed to a communicable disease or who may be at risk for contracting or spreading a disease or condition.

State law may further limit the permissible was the Plan uses or discloses your PHI. If an applicable state law imposes stricter restrictions, the Plan will comply with that state law.

V. Your Individual Rights

A. Right to Request Additional Restrictions. You may request restrictions on a Plan's use and disclosure of your PHI. While the Plan will consider all requests for additional restrictions carefully, the Plan generally are not required to agree to a requested restriction. However, if you request a restriction on the disclosure of your PHI to another Plan, the Plan are required to approve your request if (i) the disclosure is being made for payment or health care operations reasons, and (ii) the restricted PHI pertains solely to a health care item or service provided by a health care provider who has been paid out-of-pocket in full (in other words, the Plan have not paid for any part of the item or service).

If you wish to request restrictions on a Plan's use and disclosure of your PHI, you may obtain a request form from the Privacy Officer. Most PHI relating to your health benefits is used or disclosed by third party vendors that administer the Plan (for example, most dental PHI is maintained by the dental claims administrator). To request restriction on the use or disclosure of your PHI by these vendors, you may wish to contact the vendors directly. For more information on your right to request restrictions, or for contact information for the Plan vendors, call or write to the Privacy Officer at the address below.

B. Right to Receive Confidential Communications. You may request to receive your PHI by alternative means of communication or at alternative locations. Your request must specify how or where you wish to be contacted. The Plan will try accommodate any reasonable request for confidential communication. Please note that in certain situations, such as with respect to eligibility and enrollment information, the Plan are obliged to communicate directly with the employee/retiree rather than a dependent unless your request clearly states that disclosure of that information through the normal methods could endanger you. If you wish to request confidential communication of your PHI, you may obtain a request form from the Privacy Officer. Most communications of PHI relating to your health benefits are made by third party vendors that administer the Plan. To request confidential communication of your PHI by these vendors, you may wish to contact the vendors directly. For more information on your right to request confidential communication of your PHI, or for contact information for the Plan vendors, call or write to the Privacy Officer at the address below.

C. Right to Inspect and Copy Your Protected Health Information. You may request access to the Plan's records that contain Your Protected Health Information in order to inspect and request copies of the records. If you request copies, the Plan may charge you copying, mailing, and labor costs. Effective as of February 17, 2010, to the extent that your PHI is maintained in an electronic health record, you may request that the Plan provide a copy to you or to a person or entity designated by you in an electronic format. Under limited circumstances, the Plan may deny you access to a portion of your records. If you desire access to your records, you may obtain a request form from the Privacy Officer. Most PHI relating to your health benefits is created or maintained by third party vendors that administer the Plan. For access to that information, you may wish to contact the vendors directly. For more information on your right to inspect and request copies of your PHI, or for contact information for the Plan vendors, call or write to the Privacy Officer at the address below.

D. Right to Amend Your Records. You have the right to request that the Plan amend Your Protected Health Information maintained in the enrollment, payment, claims adjudication and case or medical management record systems maintained by or for the Plan and any other records used by or for the Plan to make decisions about your benefits. The Plan will comply with your request for amendment unless special circumstances apply. A Plan may deny your request for amendment if you do not provide a reason to support your request or if the Plan believes that the information is accurate. In addition, a Plan may deny your request if you ask it to amend information that was created by another Plan or health care provider (but the Plan will inform you of the source of the information, if known). If your physician or other health care provider created the information that you desire to amend, you should contact the health care provider to amend the information. To make a request for amendment, you may obtain a request form from the Privacy Officer. Most PHI relating to your health benefits is created or maintained by third party vendors that administer the Plan. To request amendment of that information, you may wish to contact the vendors directly. For more information on your right to request amendment of your PHI, or for contact information for the Plan service vendors, call or write to the Privacy Officer at the address below.

E. Right to Receive an Accounting of Disclosures. Upon request, you may obtain an accounting of certain disclosures of your PHI made by the Plan made within six years of the date of your request. The accounting will generally be provided free of charge, but if you request an accounting more than once during a twelve (12) month period, the Plan may charge you a reasonable fee for any subsequent accounting statements. You will be notified of the costs involved, and you may choose to withdraw or modify your request before you incur any expenses. The accounting will not include all disclosures of your PHI. For example, the accounting will not include disclosures (i) to carry out treatment, payment or health care operations activities; (ii) made to you; (iii) made to friends or family members in your presence or because of an emergency; (iv) made pursuant to your written authorization; (v) for national security or intelligence purposes; or (vi) to correctional institutions or law enforcement officials. If you wish to request an accounting, you may obtain a request form from the Privacy Officer. Most PHI relating to your health benefits is used or disclosed by third party vendors that administer the Plan. For an accounting of disclosures by a Plan vendor, you may wish to contact the vendor directly. For more information on your right to request an accounting, or for contact information for the Plan vendors, call or write to the Privacy Officer at the address below. You will be notified if there is any use or disclosure of your PHI which is not otherwise required by law or permitted under the terms of HIPAA and this notice.

F. Right to Receive Paper Copy of this Notice. Upon request, you may obtain a paper copy of this Notice.

G. Personal Representatives. You may exercise your rights through a personal representative who will be required by the Plan to produce evidence of his or her authority, under applicable state law, to act on your behalf. Proof of authority may be made by a notarized power of attorney, a court order of appointment of the person as your legal guardian or conservator, or if you are the parent of a minor child. The Plan reserves the right to deny access to your personal representative.

H. For Further Information/Complaints. If you desire further information about your privacy rights, are concerned that the Plan has violated your privacy rights, or disagree with a decision that the Plan made about access to Your Protected Health Information, you may contact the Plan's Privacy Officer. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services. Upon request, the Privacy Officer will provide you with the correct address for the Secretary. Neither the Plan Sponsor nor the Plan will not retaliate against you if you file a complaint with it or the Secretary.

VI. Effective Date and Duration of This Notice

A. Effective Date: This Notice is effective as of February 16, 2026.

B. Right to Change Terms of this Notice. The Plan may change the terms of this Notice at any time. If the Plan changes this Notice, it may make the new notice terms effective for all of Your Protected Health Information that it maintains, including any information created or received prior to issuing the new notice. If the Plan changes this Notice, it will send the new notice to you if you are then covered by the Plan. You also may obtain any new notice by contacting the Privacy Officer.

VII. Privacy Officer

You may contact the Privacy Officer at:

Allison Scheer

YMCA Employee Benefits

101 N Wacker Drive

Chicago, IL 60606

Telephone: (312) 419-8786

E-mail: allison.scheer@ymca.net

VIII. Keep Your Plan Informed of Address Changes

In order to protect your and your family's Plan privacy rights, you should keep the Human Resources Department informed of any changes in your address and the addresses of your covered family members. In the event that your PHI has been breached, the Plan will notify you at your address on record.

INSTRUCTIONS REGARDING AUTHORIZATION

A signed Authorization gives the Plan permission to use and disclose an Individual's protected health information ("Protected Health Information") for reasons other than treatment, payment, or health care operations.

You generally do not need to obtain an Authorization if disclosure is for any of the following reasons:

- required by law;
- for public health activities or purposes;
- regarding child abuse, neglect, or domestic violence;
- to a health oversight agency for activities authorized by law;
- for a judicial or administrative proceeding;
- for law enforcement purposes;
- for identification purposes regarding a deceased person;
- for organ, cadaveric, eye, or tissue donations;
- for certain approved research purposes;
- to avert a serious threat to health or safety;
- for specialized government functions; or
- for workers' compensation purposes, if the disclosure is required by law.

You may require an Individual to sign an Authorization as a condition of their enrollment in the Plan or their eligibility for Plan benefits. Please note that even if the Individual signs the Authorization form, the Plan is not permitted to use or disclose an Individual's psychotherapy notes, except as required by or consistent with applicable law.

An Individual must be permitted to revoke his or her Authorization by completing the Authorization Revocation form. Since certain Plan decisions regarding enrollment and eligibility for benefits are conditioned on Individual Authorization, revocation of an Authorization could negatively impact an Individual's rights and benefits under the Plan.

Once you are aware that an Individual has revoked his or her Authorization, or once an Individual's Authorization has expired, you must discontinue using the Individual's Protected Health Information. However, you are not required to retrieve Protected Health Information already used or disclosed based on the prior Authorization.

An Individual may designate a personal representative to sign an Authorization or an Authorization Revocation. If this is the case, a Personal Representative Form must be attached to the Authorization or Authorization Revocation Form unless such form is not applicable.

You must provide a copy of the signed Authorization to the Individual (or his or her personal representative).

Please remember that completed Authorization, Authorization Revocation, and Personal Representative Forms must be retained by the Plan for six years (or longer if required under applicable state law) after the effective date of the Individual's Authorization, revocation, or representative designation.

PRIVACY & CONFIDENTIALITY STATEMENT: WELLNESSWORKS PROGRAM

Part of our WellnessWorks Program rewards YMCAs and their covered plan members for taking a Health Survey, and rewards plan members for participating in various programs or activities. The information provided and collected through these activities is protected by the Health Insurance Portability and Accountability Act (HIPAA). See below for common questions regarding the confidentiality of this information.

What happens to my personal information when I complete the Health Survey, or when I submit a biometric screening form or at-home kit?

After you complete the Health Survey, you'll receive instant feedback on the website regarding your health, including content and recommendations intended to help you with your health and wellness goals. Once you submit a biometric screening form or at-home kit, your biometric data will be loaded into your personal health record to access later. The information you provide through these activities may also be used by UnitedHealthcare or Surest to identify any health improvement resources or clinical programs that you may be eligible for. If you do qualify for additional resources, your insurance carrier may reach out to you via phone, email, or mail to tell you about these programs.

Who can see my answers or results?

The information you disclose as a part of any of the WellnessWorks program incented activities or programs is confidential. No one at your YMCA, or at YMCA Employee Benefits, will have access to your private health information or your answers to the Health Survey. YMCA Employee Benefits and your YMCA may receive reporting that shows aggregate data from all plan members combined. If your YMCA offers a separate incentive for its employees to complete the Health Survey, YMCA Employee Benefits will share only the names of those who take the survey in order to administer the incentive.

Can the information I provide affect my eligibility or how much I have to pay for health insurance?

No, the information you provide will not be seen by the people who determine rates or eligibility for coverage. Neither your YMCA, nor YMCA Employee Benefits, will have access to your individual results. All programs/activities in our WellnessWorks Program are voluntary. However, YMCA Employee Benefits and your YMCA may choose to offer financial incentives to encourage participation. This can include gift cards, cash bonuses, insurance premium adjustments, health savings account deposits, etc.

YOUR RIGHTS & PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected by federal law from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as deductibles, copayments, and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Air Ambulance Services
If you have an emergency medical condition and get emergency transport through an out-of-network air ambulance service, the most the provider may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency air ambulance services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing.

You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

Your health plan generally must:

- Cover emergency services without requiring you to get approval for services in advance (prior authorization).
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact UnitedHealthcare at 877-BEN-YMCA or you may contact the Department of Health and Human Services (HHS). Visit: https://www.cms.gov/nosurprises/consumers or call 1-800-985-3059 for more information about your rights under federal law.

PATIENT PROTECTION & AFFORDABLE CARE ACT (PPACA)

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator 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 the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on your ID card.

WOMEN'S HEALTH & CANCER RIGHTS ACT of 1998 (WHCRA)

As required by the Women's Health and Cancer Rights Act of 1998, the Plan provides Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- 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 and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service.

Limitations on Benefits are the same as for any other Covered Health Service.

NEWBORNS' AND MOTHERS' 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). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization or notify the Claims Administrator. For information on notification or prior authorization, contact your issuer.

SPECIAL RIGHTS UNDER MHPA AND MHPAEA

The Mental Health Parity Act ("MHPA") and Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") contain certain requirements for group health plans and health insurance issuers concerning certain mental health and substance use disorder benefits. Any benefit plan that is subject to these requirements will provide for applicable parity of any aggregate lifetime dollar limits and annual dollar limits with respect to any mental health and substance use disorder benefits that may be provided. In addition, each such benefit plan will provide for applicable parity between any medical and surgical benefits offered by the benefit plan, on the one hand, and any mental health and substance use disorder benefits, on the other, as to any financial requirements (such as deductibles, copayments, co-insurance and out-of-pocket maximums) and quantitative treatment limitations (such as the number of treatments, visits or days of coverage). Such benefit plan also will comply with other applicable parity-related requirements for any non-quantitative treatment limitations (such as medical management standards). However, this should not be construed to require the Employer to provide any coverage for any mental health or substance use disorder benefits under any benefit plan, except as required by applicable law. Please refer to the applicable benefit plan materials or designated SPD materials, if any, for additional information.

PREMIUM ASSISTANCE UNDER MEDICAID & 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 –

Alabama – Medicaid

Website:
http://myalhipp.com/

Phone:
1-855-692-5447

Alaska – Medicaid

The AK Health Insurance Premium Payment Program Website:
http://myakhipp.com/ | Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com

Medicaid Eligibility:
https://health.alaska.gov/dpa/Pages/default.aspx

Arkansas – Medicaid

Website:
http://myarhipp.com/

Phone:
1-855-MyARHIPP (855-692-7447)

California – Medicaid

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

Colorado – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website:
https://www.healthfirstcolorado.com/

Health First Colorado Member Contact Center:
1-800-221-3943 / State Relay 711

CHP+:
https://hcpf.colorado.gov/child-health-plan-plus

CHP+ Customer Service:
1-800-359-1991 / State Relay 711

Health Insurance Buy-In Program (HIBI):
https://www.mycohibi.com/

HIBI Customer Service: 1-855-692-6442

Florida – Medicaid

Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html

Phone:
1-877-357-3268

Georgia – Medicaid

GA HIPP Website:
https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp

Phone: 678-564-1162, Press 1

GA CHIPRA Website:
https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra

Phone: (678) 564-1162, Press 2

Indiana – Medicaid

Health Insurance Premium Payment Program
All other Medicaid

Website:
https://www.in.gov/medicaid/
http://www.in.gov/fssa/dfr/

Family and Social Services Administration
Phone: 1-800-403-0864

Member Services Phone: 1-800-457-4584

Iowa – Medicaid

Medicaid Website:
https://dhs.iowa.gov/ime/members

Medicaid Phone: 1-800-338-8366

Hawki Website:
http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563

HIPP Website:
https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp

HIPP Phone: 1-888-346-9562

Kansas – Medicaid

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

Phone:
1-800-792-4884

HIPP Phone:
1-800-967-4660

Kentucky – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx

Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov

KCHIP Website:
https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718

Kentucky Medicaid Website:
https://chfs.ky.gov/agencies/dms

Louisiana – Medicaid

Website:
www.medicaid.la.gov or www.ldh.la.gov/lahipp

Phone:
1-888-342-6207 (Medicaid hotline)
or 1-855-618-5488 (LaHIPP)

Maine – Medicaid

Enrollment Website:
https://www.mymaineconnection.gov/benefits/s/?language=en_US

Phone: 1-800-442-6003
TTY: Maine relay 711

Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms

Phone: -800-977-6740.
TTY: Maine relay 711

Massachusetts – Medicaid & CHIP

Website:
https://www.mass.gov/masshealth/pa

Phone:
1-800-862-4840
TTY: 711

Email:
masspremassistance@accenture.com

Minnesota – Medicaid

Website:
https://mn.gov/dhs/health-care-coverage/

Phone: 1-800-657-3672

Missouri – Medicaid

Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm

Phone: 573-751-2005

Montana – Medicaid

Website:
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP

Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

Nebraska – Medicaid

Website:
http://www.ACCESSNebraska.ne.gov

Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

Nevada – Medicaid

Medicaid Website:
http://dhcfp.nv.gov

Medicaid Phone:
1-800-992-0900

New Hampshire – Medicaid

Website:
https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program

Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

New Jersey – Medicaid

Medicaid Website:
http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/

Medicaid Phone:
1-800-356-1561

CHIP Premium Assistance Phone:
609-631-2392

CHIP Website:
http://www.njfamilycare.org/index.html

CHIP Phone:
1-800-701-0710 (TTY: 711)

New York – Medicaid & CHIP

Website:
https://www.health.ny.gov/health_care/medicaid/

Phone:
1-800-541-2831

North Carolina – Medicaid

Website:
https://medicaid.ncdhhs.gov/

Phone: 919-855-4100

North Dakota – Medicaid

Website:
https://www.hhs.nd.gov/healthcare

Phone: 1-844-854-4825

Oklahoma – Medicaid & CHIP

Website:
http://www.insureoklahoma.org

Phone:
1-888-365-3742

Oregon – Medicaid

Website:
http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html

Phone:
1-800-699-9075

Pennsylvania – Medicaid

Website:
https:://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html

Phone:
1-800-692-7462

CHIP Website:
https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx

CHIP Phone: 1-800-986-KIDS (5437)

Rhode Island – Medicaid & CHIP

Website:
http://www.eohhs.ri.gov/

Phone:
1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

South Carolina – Medicaid

Website:
https://www.scdhhs.gov

Phone:
1-888-549-0820

South Dakota– Medicaid

Website:
http://dss.sd.gov

Phone:
1-888-828-0059

Texas – Medicaid

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

Phone:
1-800-440-0493

Utah – Medicaid & CHIP

Utah's Premium Partnership for Health Insurance (UPP) Website:
https://medicaid.utah.gov/upp/

Email: upp@utah.gov

Phone: 1-888-222-2542

Adult Expansion Website: https://medicaid.utah.gov/expansion/

Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/

CHIP Website: https://chip.utah.gov/

Vermont – Medicaid

Website:
https://dvha.vermont.gov/members/medicaid/hipp-program

Phone:
1-800-250-8427

Virginia – Medicaid & CHIP

Website:
https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select

https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs

Medicaid/CHIP Phone: 1-800-432-5924

Washington – Medicaid

Website:
https://www.hca.wa.gov/

Phone:
1-800-562-3022

West Virginia – Medicaid & CHIP

Website:
https://dhhr.wv.gov/bms/
http://mywvhipp.com/

Medicaid Phone:
304-558-1700

CHIP Toll-free phone:
1-855-MyWVHIPP (1-855-699-8447)

Wisconsin – Medicaid & CHIP

Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm

Phone:
1-800-362-3002

Wyoming – Medicaid

Website:
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/

Phone:
1-800-251-1269

To see if any other states have added a premium assistance program since 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

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

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."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the YMCA through which you have retiree health coverage, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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;
- Commencement of a proceeding in bankruptcy with respect to the employer;]; 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 60 days after the qualifying event occurs. You must provide this notice to your Plan Administrator/Human Resources department at your YMCA. If you do not know who to contact, check your YMCAs YBenefits.org page.

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[1] 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.

[1] https://www.medicare.gov/sign-up-change-plans

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

Please contact the Human Resources department at your YMCA. If you do not know who to contact, check your YMCA's www.YBenefits.org website for contact information.