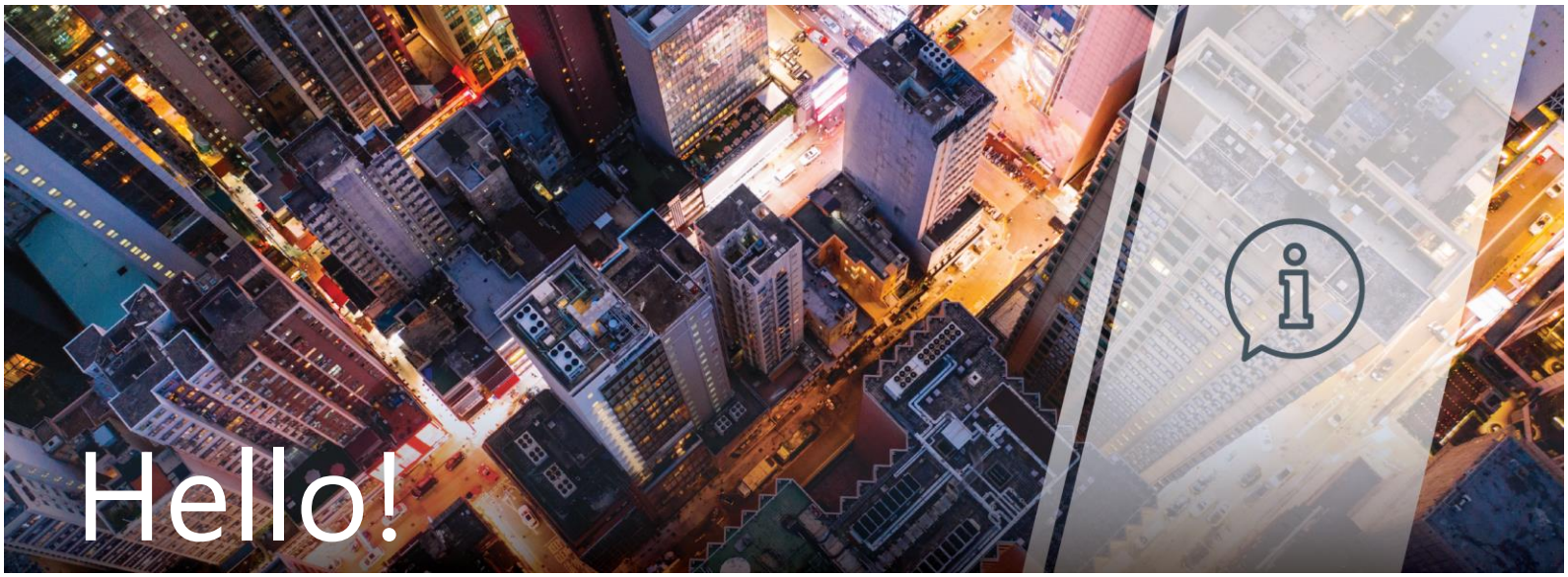
2021

UNDERSTANDING
YOUR OPTIONS

the YMCA

BENEFITS
INFORMATION GUIDE



Hello!

Welcome to your 2021 Benefits Plan Year. YMCA of OC is proud to offer a range of employee benefit plans to help protect you in the case of illness or injury. This Benefits Information Guide is a comprehensive tool designed to familiarize you with the plans and programs you and your family can enroll in for the plan year. If you have any questions regarding your benefits, please contact Human Resources.

Eligibility & Enrollment

Who Can Enroll?

If you are an employee regularly working a minimum of 30 hours per week, you are eligible to participate in the benefits program. Eligible employees may also choose to enroll family members, including a legal spouse/registered domestic partner (as legally defined under state and local law) (hereinafter referred to as "registered domestic partner")/registered domestic partner (as legally defined under state and local law) and unregistered domestic partner (hereinafter referred to as "registered and unregistered domestic partner") and/or eligible children.

An employee may be unable to pay for and/or receive employer contributions on a pre-tax basis for the cost of the benefits of an employee's state registered / unregistered domestic partner that does not meet the definition of the employee's tax dependent under IRC Section 152.

When Does Coverage Begin?

Regular, full-time employees: You are eligible to enroll on your date of hire, but your coverage will not be effective until 30 days from your date of hire OR You are automatically enrolled upon your date of hire and benefits are effective immediately OR Your coverage begins the first of the month following your date of hire

Variable hourly employees: You are eligible to enroll at the end of your Measurement Period (initial or standard), if you successfully average 30 or more hours of service per week during that time period. Your coverage will be effective 30 days following the date you are eligible to enroll in coverage.

Your enrollment choices remain in effect through the end of the benefits plan year, (January 1, 2021 – December 31, 2021).

TIP

If you miss the enrollment deadline, you may not enroll in a benefit plan unless you have a change in status during the plan year. Please review details on IRS qualified change in status events for more information.

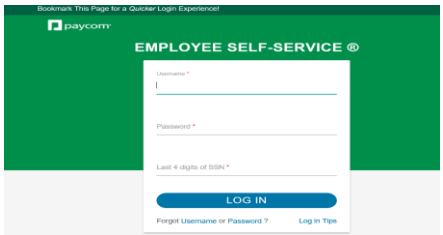
How do I Enroll?

paycom®

Paycom

To enroll, simply follow these steps:

- Log into your Paycom Self Service Portal at www.paycom.com
- Select employee, then enter your username, password, and last 4 digits of your SSN
- Click the" Start Enrollment" button to begin your benefits enrollment



What if My Needs Change During the Year?

You are permitted to make changes to your benefits outside of the open enrollment period if you have a qualified change in status as defined by the IRS. Generally, you may add or remove dependents from your benefits, as well as add, drop, or change coverage if you submit your request for change within 30 days of the qualified event. Change in status examples include:

- Marriage, divorce or legal separation.
- Birth or adoption of a child.
- Death of a dependent.
- You or your spouse's/registered/registered and unregistered domestic partner's loss or gain of coverage through our organization or another employer.
- An employee (1) is expected to average at least 30 hours of service per week, (2) has a change in status where he/she will reasonably be expected to average less than 30 hours of service per week (even if he/she remains eligible to be enrolled in the plan); and (3) intends to enroll in another plan that provides Minimum Essential Coverage (no later than the first day of the second month following the month of revocation of coverage).
- You enroll, or intend to enroll, in a Qualified Health Plan (QHP) through the State Marketplace or Federal Exchange and it is effective no later than the day immediately following the revocation of your employer sponsored coverage.

If your change during the year is a result of the loss of eligibility or enrollment in Medicaid, Medicare or state health insurance programs, you must submit the request for change within 60 days. For a complete explanation of qualified status changes, please refer to the "Legal Information Regarding Your Plans" contents.

Do I Have to Enroll?

Although the federal penalty requiring individuals to maintain health coverage has been reduced to $0, the state of CA has their own state-specific individual mandate.

To avoid paying the penalty in CA , you can obtain health insurance through our benefits program or purchase coverage elsewhere, such as coverage from a State or Federal Health Insurance Exchange.

For information regarding Health Care Reform and the Individual Mandate, please contact Human Resources or visit www.cciio.cms.gov. You can also visit www.coveredca.com to review information specific to the Covered California State Health Insurance Exchange.

You may elect to "waive" medical/dental/and/or vision coverage if you have access to coverage through another plan. To waive coverage, insert requirements of employer. It is important to note that if you waive our medical coverage, you must maintain medical/health coverage through another source. It is also important to note that if coverage is waived, the next opportunity to enroll in our group benefit plans would be on January 1, 2022 or if a qualifying status change occurs.

Cost Breakdown

The rates below are effective January 1, 2021 – December 31, 2021

Coverage Level	Employee Cost Monthly	Employee Payroll Deduction (24)
	Employee Monthly	**Employee Per-Pay Period**
United Healthcare Harmony (Narrow Network)		
Employee Only	$32.94	$16.47
Employee and Spouse	$369.64	$184.82
Employee and Child(ren)	$287.58	$143.79
Employee and Family	$610.14	$305.07
United Healthcare Advantage (Limited Network)		
Employee Only	$148.73	$74.37
Employee and Spouse	$623.21	$311.61
Employee and Child(ren)	$507.58	$253.79
Employee and Family	$962.14	$481.07
United Healthcare Signature Value (Full Network)		
Employee Only	$195.00	$97.50
Employee and Spouse	$724.54	$362.27
Employee and Child(ren)	$595.50	$297.75
Employee and Family	$1,102.79	$551.40
United Healthcare Select Plus PPO		
Employee Only	$521.39	$260.70
Employee and Spouse	$1,439.34	$719.67
Employee and Child(ren)	$1,215.64	$607.82
Employee and Family	$2,095.02	$1,047.51
United Healthcare Dental HMO		
Employee Only	$0.00	$0.00
Employee and Spouse	$12.64	$6.32
Employee and Child(ren)	$12.64	$6.32
Employee and Family	$28.66	$14.33
United Healthcare Dental PPO		
Employee Only	$32.54	$16.27
Employee and Spouse	$68.04	$34.02
Employee and Child(ren)	$81.13	$40.57
Employee and Family	$123.64	$61.82
United Healthcare Vision PPO		
Employee Only	$7.20	$3.60
Employee and Spouse	$12.35	$6.18
Employee and Child(ren)	$12.61	$6.31
Employee and Family	$20.32	$10.16

Benefits Information on the Go

iBenefits

Available for iOS and Android mobile devices, the iBenefits app makes checking your benefits information easier than ever!

With iBenefits, you can:

- View our company's benefit plans, 24/7.
- Access group numbers and review detailed plan information.
- Quickly contact an insurance company.
- Keep up with important benefit plan announcements such as open enrollment dates, deadlines, and more.
- Store images of your ID cards directly in the app.

Download it now from the App Store or Google Play and use our Company Code **YMCA2021** to login to the app.

United Healthcare's Health4Me App!

United Healthcare's Health4Me mobile application will help you manage your health care easier and faster! Use the app to:

- Search for Quick Care, either urgent care or emergency room services
- View and share your member ID card
- Access your account balance and check the status of benefit amounts, such as your deductible and out-of-pocket maximum
- View the latest claims for your plan

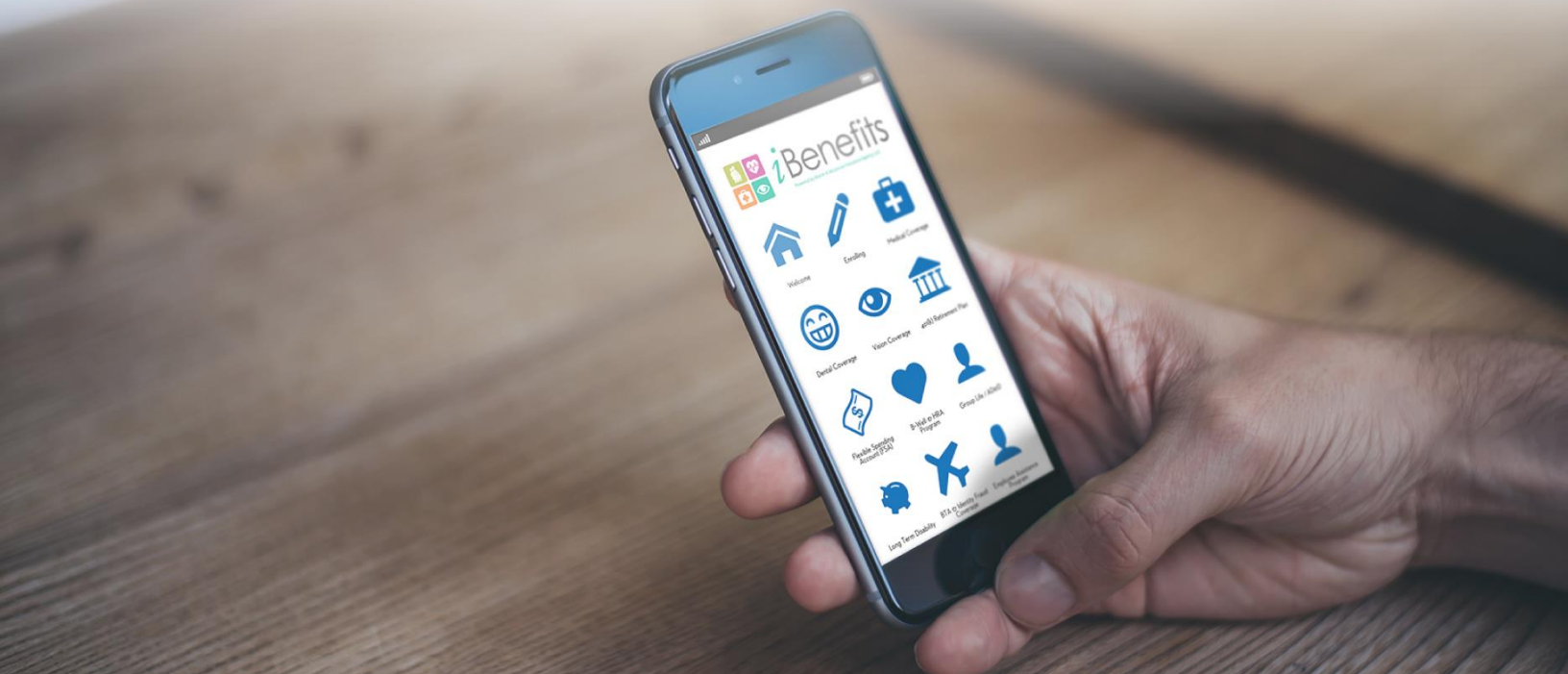
Search for the Health4Me mobile app in the App Store or Google Play to get started!

Difference Card Mobile App!

Difference Card Mobile application will help you manage your health care easier and faster! Use the app to:

- View recent transaction and details
- Contact Administrators from mobile application via email or mobile phone
- Ability to view and submit claims
- Utilize your mobile card

Search for Difference Card Mobile app in the App Store or Google Play to get started!



The Difference Card
Medical Expense Reimbursement

Ready to make your healthcare spend go further?

Working in conjunction with your medical insurance, the Difference Card is a way for you to receive extra funds from your employer to help reduce the out-of-pocket expenses you may incur when enrolled in any of the medical plans. Think of the Difference Card as a debit card you can use to offset eligible copays, or funds available to receive reimbursement for out-of-pocket costs such as office visits, emergency room visits, deductibles and coinsurance expenses. **The best part about the program is there is no additional cost to you!**

How do I access funds?

After you are automatically enrolled in the program, you will access funds through the Difference Card in one of two ways, depending on your healthcare expense:

1. **Through your Difference Card MasterCard**: Your card will be mailed to the address on file and activated immediately upon your first eligible copay charge.
2. **By submitting a Claim Reimbursement Form:** You will need to submit a Reimbursement Form for facility-based services, services that are subject to the deductible and coinsurance, or prescription drugs that are subject to the prescription deductible.

How do I use it?

To get started, refer to the specific summary of benefits that outlines how much the Difference Card will offset from your UHC Medical Plan coverage. For example:

WHEN USING FOR…	THIS IS HOW IT WORKS…
A doctor's visit	1. Your doctor's office will request the full copay amount based on your coverage. 2. Refer to the Difference Card summary of benefits to pay your portion of the copay, listed under the **"You Pay"** column using your personal funds or Flexible Spending Account. 3. Then, use the Difference Card to pay the remaining balance of the copay due. Your Difference Card should be charged as a **CREDIT CARD** when processed.
Facility-based claims such as hospitalization, outpatient surgery, etc.	1. For services that are subject to the deductible, consider alerting your facility in advance of your procedure to request they contact the Difference Card as part of the pre-authorization process and to verify they agree with the payment practice. 2. You will want to request your hospital or medical facility to bill UHC, so that your claim is processed first, before any payment is made. 3. Once your claim is processed, you should obtain an Explanation of Benefits (EOB) from UHC either by mail or by downloading it through UHC's online portal. 4. Then, submit a Reimbursement Form, along with your EOB, to the Difference Card to receive reimbursement. 5. Finally, once you have received the reimbursement funds, you can pay the facility the portion you owe. **Note:** You will NOT use your Difference Card MasterCard for facility-based claims.

How do I file a claim for reimbursement?

When you cannot use your Difference Card MasterCard, you can easily submit a Claim Reimbursement Form using one of the methods below to receive reimbursement. You will submit your Explanation of Benefits (EOB) along with a Difference Card Reimbursement Form. The form can be found in our online enrollment system, Paycom, or online at www.differencecard.com.

1. **Secure Email:** Go to www.differencecard.com and click "Submit Claims." You will need to register for secure email access the first time using this method. Once you have entered the email platform, submit your reimbursement by selecting the "Compose" tab to upload your EOB and Reimbursement Form, then click "Send."
2. **Mail:** Send your Reimbursement Form and EOB to: The Difference Card 245 Main Street, Suite 605 White Plains, NY 10601.
3. **Fax:** Fax your Reimbursement Form and EOB to 914.220.0901.
4. **Mobile App:** Download the "Difference Card Smart Mobile App" app from the App Store or Google Play, take a picture of your EOB, complete the Reimbursement Form and submit.

How do I manage my Difference Card account?

Visit www.differencecard.com to:

- **Set up an online account**
- **Access and submit a Reimbursement Form when necessary**
- **View the status of your claims**

Contact customer service with questions or for assistance at 888.343.2110 or via email at customercare@differencecard.com

Prescription Drug Coverage by United Healthcare

Many FDA-approved prescription medications are covered through the benefits program. Important information regarding your prescription drug coverage is outlined below:

United Healthcare

- Tiered prescription drug plans require varying levels of payment depending on the drug's tier and your copayment or coinsurance will be higher with a higher tier number.
- The United Healthcare Medical plan(s) includes a four-tier prescription benefit plan.
- Tier 1 prescriptions offer the greatest value compared to other drugs that treat the same conditions and are often the lowest cost.
- Tier 2 drugs are generally brand name with a moderate copayment. Some drugs may also be Tier 2 because they are "preferred" among other drugs that treat the same conditions.
- Tier 3 drugs are a higher copayment compared to the lower tiers, as they are higher cost drugs. Some drugs on this list may have a generic counterpart in Tier 1 or Tier 2.
- Many drugs on Tier 4 are "specialty" drugs used to treat complex, chronic conditions, and may require special storage or close monitoring.

For a current version of the prescription drug list(s), go to www.myuhc.com

Why pay more?

There are a few ways you can save money when using the Prescription Drug Plan:

WHY PAY MORE?

There are a few ways you can save money when using the Prescription Drug Plan:

Mail Order

Save time and money by utilizing a mail order service for maintenance medications. A 90-day supply of your medication will be shipped to you, instead of a typical 30-day supply at a walk-in pharmacy.

Shop Around

Some pharmacies, such as those at warehouse clubs or discount stores, may offer less expensive prescriptions than others. By calling ahead, you may determine which pharmacy provides the most competitive price.

Explore Over-the-Counter Options

For common ailments, over-the-counter drugs may provide a less expensive option that serves the same purpose as prescription medications.

What are my Options?

Use the chart below to help compare medical plan options and determine which would be the best for you and your family.

	HMO	PPO
Required to select and use a Primary Care Physician (PCP)	**United Healthcare** Yes	**United Healthcare** No
Seeing a Specialist	PCP referral required	No referral required
Deductible Required	No	Yes
Finding a Provider	• **Go to myuhc.com** • Click **Find a Provider from Find a Doctor** • Click **Medical Directory** • Click **All United Healthcare Plans** • Click **Signature Value Plans** • Click **Medical Directory** • Click **California** • Choose **Signature Value Harmony HMO** or **Signature Value Advantage HMO** or **Signature Value HMO** • Enter **Zip Code,** Select **Provider**	• **Go to myuhc.com** • Click **Find a Provider from Find a Doctor** • Click **Medical Directory** • Click **All United Healthcare Plans** • Click **Select Plus** • Confirm **Zip Code** • Select **Type of Medical Care "Family Doctor"** • Choose **Provider**
Claims Process	• Handled by HMO Medical Group	• In-Network PPO providers will submit claims • For Out-of-Network PPO provider you submit claims
Compatible with your FSA	Yes	Yes
Compatible with your HSA	No	No
Other Important Tips	• This plan requires that you see a doctor in a specific network to receive coverage • Out-of-Network services without proper PCP referral will not be covered • Emergencies covered worldwide	• You may choose in or out of network care, however in network care provides you a higher level of benefit • Out-of-Network PPO Providers may balance bill for any amounts not covered • Emergencies covered worldwide

Please note the above examples are used for general illustrative purposes only. Please consult with your Human Resources Department for more specific information as it relates to your specific plan. For a detailed view of your medical plan summaries, visit www.myuhc.

Plan Highlights	UHC Harmony Advantage Signature Value	Difference Card	You Pay
	In-Network Only	In-Network Only	In-Network Only
Annual Calendar Year Deductible			
Individual	$3,000	$3,000	$0
Family	$6,000	$6,000	$0
Maximum Calendar Year Out-of-pocket (1)			
Individual	$6,000	Shared up to $3,000	$0
Family	$12,000	Shared up to $6,000	$0
Lifetime Maximum			
Individual	Unlimited	Unlimited	Unlimited
Professional Services			
Primary Care Physician (PCP)	$45 Copay	$20(2)	$25 Copay
Specialist	$60 Copay	$20(2)	$40 Copay
Preventive Care Exam	No Charge	Not Funded	No Charge
Well-baby Care	No Charge	Not Funded	No Charge
Diagnostic X-ray and Lab	Lab: $10 Copay X-Ray: No Charge	Lab: $10 Copay X-Ray: No Charge	Lab: $0 Copay X-Ray: No Charge
Complex Diagnostics (MRI / CT Scan)	$150 Copay	$50	$100 Copay
Therapy, including Physical, Occupational and Speech	$45 Copay	$20(2)	$25 Copay
Chiropractic Services (20 visits)	$15 Copay	$0	$15 Copay
Hospital Services			
Inpatient (per admit)	30% (after deductible)	Remaining Deductible	$1,000
Outpatient Surgery (per visit)	30% (after deductible)	Remaining Deductible	$500
Emergency Room	$225 Copay (waived if admitted)	$75 Copay (waived if admitted)	$150 Copay (waived if admitted)
Urgent Care (within service area)	$45 Copay (within service area) / $100 Copay (outside service area)	$20 (2)	$25 Copay (within service area) / $80 Copay (outside service area
Maternity Care			
Physician Visits (prenatal or postnatal)	No Charge	No Charge	No Charge
Hospital Services	30% (after deductible)	Remaining Deductible	$1,000
Mental Health & Substance Abuse			
Inpatient	30% (after deductible)	Remaining Deductible	$1,000
Outpatient	$60 Copay	$20 (2)	$40 Copay
Retail Prescription Drugs (30-day supply)			
Tier 1	$15 Copay	Not Funded	$10 Copay
Tier 2	$30 Copay	Not Funded	$30 Copay
Tier 3	$50 Copay	Not Funded	$50 Copay
Tier 4	30% up to $250 max	Not Funded	30% up to $250 max
Mail Order Prescription Drugs (90-day supply)			
Tier 1	$30 Copay	Not Funded	$30 Copay
Tier 2	$60 Copay	Not Funded	$60 Copay
Tier 3	$100 Copay	Not Funded	$100 Copay
Tier 4	30% up to $250 max	Not Funded	30% up to $250 max

(1) Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider

(2) You may us the Difference Card Mastercard to pay for the partial payment for this service

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Plan Highlights	UHC Select Plus PPO	
	In-Network	**Out-of-Network**
Calendar Year Deductible		
Individual	$1,000	$2,000
Family	$2,000	$4,000
Maximum Calendar Year Out-of-pocket (1)		
Individual	$5,000	$10,000
Family	$10,000	$20,000
Lifetime Maximum		
Individual	Unlimited	Unlimited
Professional Services		
Primary Care Physician (PCP)	$35 Copay	40% (after deductible)
Specialist	$35 Copay	40% (after deductible)
Preventive Care Exam	No Charge	Not Covered
Well-baby Care	No Charge	Not Covered
Diagnostic X-ray and Lab	No Charge	40% X-ray (after deductible) Lab Not Covered
Complex Diagnostics (MRI / CT Scan)	20% (after deductible)	40% (after deductible)
Therapy, including Physical, Occupational and Speech	$35 Copay	Not Covered
Chiropractic / Acupuncture Services (24 visits)	$35 Copay	Not Covered
Hospital Services		
Inpatient	$100 Copay + 20% (after deductible)	$100 Copay + 40% (after deductible)
Outpatient Surgery	20% (after deductible)	40% (after deductible)
Emergency Room	$100 + 20% (after deductible)	$100 + 20% (after deductible)
Urgent Care	$35 Copay	40% (after deductible)
Maternity Care		
Physician Visits (prenatal)	No Charge	40% (after deductible)
Hospital Services	$100 Copay + 20% (after deductible)	$100 Copay + 40% (after deductible)
Mental Health & Substance Abuse		
Inpatient	20% (after deductible)	40% (after deductible)
Outpatient	$35 Copay	40% (after deductible)
Retail Prescription Drugs (31-day supply)		
Tier 1	$10 Copay	$10 Copay
Tier 2	$30 Copay	$30 Copay
Tier 3	$50 Copay	$50 Copay
Mail Order Prescription Drugs (90-day supply)		
Tier 1	$20 Copay	Not Covered
Tier 2	$60 Copay	Not Covered
Tier 3	$100 Copay	Not Covered

(1) Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider

Teladoc

Teladoc provides a national network of U.S. board-certified doctors available 24/7/365 to resolve many of your medical issues. Its quality care when you need it at a price you can afford. Talk to a doctor anytime if you are enrolled in the United Healthcare HMO or PPO plans. This service is offered at no charge to you.

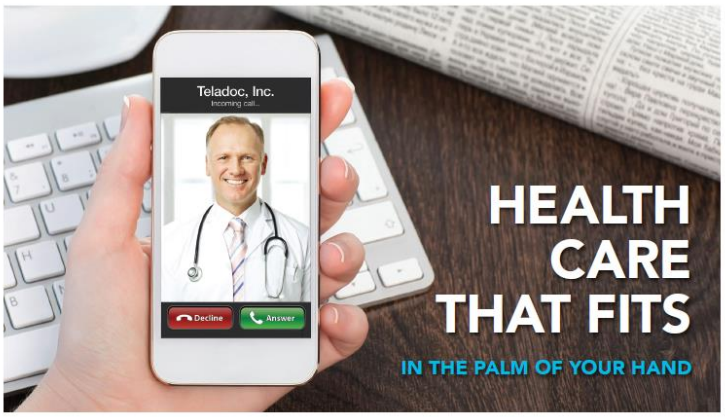
Call 855.835.2362 or go online to www.teladoc.com

Telehealth can be used for:

General Health Issues

Certain Specialty Services

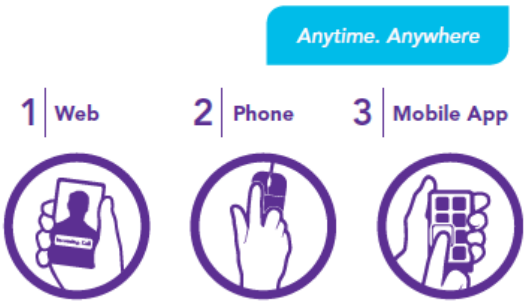
Prescription



Talk to a doctor now via phone, web or mobile app.

Teladoc connects you 24/7/365 to a national network of board-certified doctors who average 15 years experience. Within minutes, a doctor will call you back ready to listen and resolve your issue. **If medically necessary, a prescription will be sent to your pharmacy of choice.** It's health care in the palm of your hand.

Consults are Free



REQUEST A CONSULT 24/7/365

Visit **Teladoc.com** | Call **1-800-Teladoc**
Download the app at **Teladoc.com/mobile** | Join us at **Facebook.com/Teladoc**

Workplace Wellness

Why Wellness?

Healthy, active lifestyles can help reduce the risk of chronic disease and may lower your annual health care costs. We care about your total well-being and encourage all employees to engage in our Wellness Program at no-cost.

Health and Wellness Advantage

The Health and Wellness by UHC called RALLY, is a collection of support and wellness programs that surrounds you with the tools you need to live healthier, feel better and save money.

Personalized information, 24/7 access to a nurse, and trained health management professionals are all available to help you navigate the health care system and use your benefits wisely. Plus, it's part of your plan at no extra cost. Start by taking a Well-Being Assessment at www.myuhc.com, which can analyze the choices you make and the steps you can take such as:

- **Tobacco Cessation:** Educational program and a personalized "quit" plan.
- **Weight Management:** From dietary education to personal coaching, this program coaches members on how to reach and maintain a healthy weight.
- **Stress Management:** Learn how to identify stress triggers and apply proven coping techniques every day.
- **Physical Activity:** Set achievable goals and incentives to keep you motivated, healthier and happier.
- **Diet & Nutrition:** Learn how to make meaningful changes in your diet, even if you do not need to lose weight.

Dental Plan

Your Dental HMO & PPO Plan

This year, you and your eligible dependents will have the opportunity to enroll in a Dental Health Maintenance Organization (DHMO) plan and a Dental Preferred Provider Organization (DPPO) plan offered by United Healthcare. We encourage you to review the coverage details and select the option that best suits your needs.

Using the Plan

If you decide to enroll in the Dental HMO plan, you and your enrolled eligible dependents must first select a primary care dentist who participates in the United Healthcare network. To receive benefits in the Dental HMO plan, your dental care must either be provided by or referred to a specialist by your primary care dentist. If you receive services from a provider from any other dentist, you would be responsible for paying the entire dental bill yourself.

The Dental PPO plan is designed to give you the freedom to receive dental care from any licensed dentist of your choice. Keep in mind, you'll receive the highest level of benefit from the plan if you select an in-network PPO dentist versus an out-of-network dentist who has not agreed to provide services at the negotiated rate. Additionally, no claim forms are required when using in-network PPO dentists.

To view a complete plan summary go to www.myuhc.com.

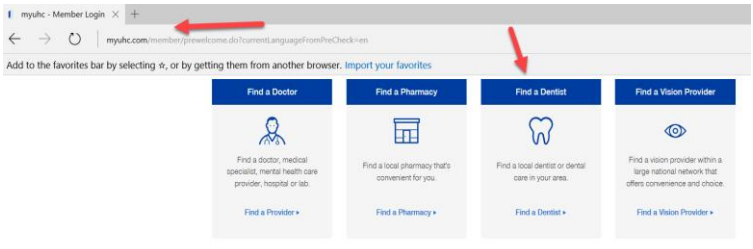
Plan Highlights	UHC Dental HMO	UHC Dental PPO	
	In-Network Only	**In-Network**	**Out-of-Network**
Calendar Year Deductible	$0	$50 Single /$150 Family	$75 Single / $225 Family
Annual Maximum	Does Not Apply	$1,500	$1,500
Preventive	No Charge	No Charge	No Charge
Basic Services	See Fee Schedule	10%	20%
Major Services	See Fee Schedule	40%	50%
Orthodontia Services (Child/Adult)	$1,895	Not covered	Not covered
Cleanings	Once every 6 months	2 times a year	2 times a year

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

TIP

Choose your Primary Care Dentist

It's important to carefully select a dental provider based on the plan you enroll in, the best choice for you may vary. To determine whether your dentist is in your insurance network, go to www.myuhc.com and search the United Healthcare Dental Provider Search (for DHMO) or (for DPPO) networks, or call 800. 800.445.9090



Vision Plan

Your Vision Plan

Vision coverage is offered by United Healthcare as a Preferred Provider Organization (PPO) plan.

Using the Plan

As with a traditional PPO, you may take advantage of the highest level of benefit by receiving services from in-network vision providers and doctors. You would be responsible for a copayment at the time of your service. However, if you receive services from an out-of-network doctor, you pay all expenses at the time of service and submit a claim for reimbursement up to the allowed amount.

To view a complete plan summary, and locate an in-network vision provider, visit www.myuhc.com

Plan Highlights	United Healthcare Vision PPO	
	In-Network	**Out-of-Network**
Exam – Every 12 months	$10	Not Covered
Lenses – Every 12 months		
Single	$25 copay	Reimbursement up to $40
Bifocal	$25 copay	Reimbursement up to $60
Trifocal	$25 copay	Reimbursement up to $80
Frames – Every 24 months	$130 allowance + 30% off balance over $130	Reimbursement up to $45
Contacts – Every 12 months, in lieu of lenses & frames		
Medically Necessary	No charge	Reimbursement up to $210
Covered Formulary Contacts	Up to 4 boxes	Reimbursement up to $130
Non-Formulary	$130 allowance	Reimbursement up to $130
Additional Benefits		
LASIK	15% Discount off standard price or 5% off promotional prices	5% Discount

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions at www.myuhc.com.

TIP

Five Tips for Superior Vision

Do not take your eyes for granted! The following pointers can help you keep your vision strong:

- **Eat lots of leafy greens and dark berries.**
- **Get regular eye exams.**
- **Give your eyes a rest from staring into the computer screen.**
- **Wear sunglasses to protect your eyes from bright light.**
- **Wear safety eyewear whenever necessary.**

Flexible Spending Accounts (FSA)

A flexible spending account through Difference Card, lets you use pre-tax dollars to cover eligible health care, dependent care expenses. There are different types of FSAs that help to reduce your taxable income when paying for eligible expenses for yourself, your spouse, and any eligible dependents, as outlined below:

FSA Type	Detail
Health Care FSA	• Can reimburse for eligible health care expenses not covered by your medical, dental and vision insurance. • Maximum contribution for 2021 is $2,750.
Dependent Care FSA	• Can be used to pay for a child's (up to the age of 13) childcare expenses and/or care for a disabled family member in the household, who is unable to care for themselves. • Maximum contribution for 2021 is $5,000.

What are the benefits?

- Your taxable income is reduced and your spendable income increases
- Save money while keeping you and your family healthy

How do I use it?

To participate in the FSA program, enrollment must be completed each year during the Open Enrollment period for both new and active employees up to the maximum amounts allowed. An annual contribution amount must be determined at the time of enrollment.

Once enrolled, you will have online access to view your FSA balance(s), check on a reimbursement status and more. If you are a first time enrollee, register as a new user. Visit https://www.differencecard.com to access DIFFERENCE CARDS's online portal.

The following sections provide additional information on contributing towards the FSA and using funds, as well as how reimbursements are completed.

A few rules you need to know:

- Although the plan year runs from January 1, 2021 through December 31, 2021, the plan allows an annual run-out period through March 31, 2022, allowing you to seek reimbursement for any expenses incurred during the plan year (from January 1, 2021 to December 31, 2021).
- You will have until March 15, 2022 to use your 2021 FSA Healthcare funds before the 2021 Healthcare FSA funds are forfeited back to the plan.
- Any remaining amounts that are not submitted for expenses incurred between January 1, 2021 through December 31, 2021, by the end of the "run-out period" March 31, 2022, will be forfeited.

For more details about using an FSA, contact Difference Card FSA @ 833.343.2110, Difference Card email: customercare@differencecard.com

Life and Disability

Basic Life and AD&D

Protect your loved ones

In the event of your death, Life Insurance will provide your family members or other beneficiaries with financial protection and security. Additionally, if your death is a result of an accident or if you become dismembered, your Accidental Death & Dismemberment (AD&D) coverage may apply.

Your coverage

Paid for in full by YMCA of Orange County, the benefits outlined below are provided by United Healthcare:

- Basic Life Insurance of 1x annual earnings up to $200,000.
- AD&D of 1x annual earnings up to $200,000.
- Please note, benefits may reduce when you reach age 65.

IRS Regulation: Employees can receive employer paid life insurance up to $50,000 on a tax-free basis and do not have to report the payment as income. However, an amount in excess of $50,000 will trigger taxable income for the “economic value” of the coverage provided to you.

TIP

Required! Are our Beneficiaries up to date?

Beneficiaries are individuals or entities that you select to receive benefits from your policy.

- **You can change your beneficiary designation at any time.**
- **You may designate a sole beneficiary or multiple beneficiaries to receive payment in the percent allocated.**
- **To select or change your beneficiary, log into your benefits by logging into www.paycom.com.**

Voluntary Life and AD&D

If you would like to supplement your employer paid insurance, additional Life and AD&D coverage for you and/or your dependents is available for purchase on a payroll deduction basis through United Healthcare.

- **For employees:** Increments of $10,000 up to a $500,000 maximum with a guarantee issue benefit of $100,000 if you enroll in the plan within 30 days of your initial eligibility.
- **For your spouse:** Increments of $5,000 up to a $250,000 maximum with a guarantee issue benefit of $35,000 if you enroll in the plan within 30 days of your initial eligibility.
- **For your child(ren):** Birth to 6 months old up to $500 coverage limit. Increments of $2,500 for 6 months old up to age 26, $10,000.
- **AD&D:** Combined with Voluntary Life.

Any amounts of insurance over the guarantee issue benefit are subject to review of good health by the insurance company. Insurance amounts subject to review will not be effective until the insurance company approves.

If you do not enroll in the plan within the initial enrollment period, **any** amount of supplemental life insurance will require proof of good health, which is subject to approval by the insurance company before the insurance is effective. For more information regarding this plan, review the plan summary detail.

Please note: Benefits coverage may reduce when you reach age 65. Restrictions may apply if you and/or your dependent(s) are confined in the hospital or terminally ill. Please refer to your Summary Plan Description for exclusions and further detail.

Cost of Employee Voluntary Coverage

Age of Insured	Monthly Rate per $1,000
Less than 25	$0.073
25–29	$0.073
30–34	$0.082
35–39	$0.099
40-44	$0154
45–49	$0.263
50–54	$0.434
55–59	$0.679
60–64	$1.060
65–69	$1.902
70–74	$3.404
AD&D	**$0.025**

Cost of Spousal Voluntary Coverage

Age of Insured	Monthly Rate per $1,000
Less than 25	$0.073
25–29	$0.073
30–34	$0.082
35–39	$0.099
40-44	$0154
45–49	$0.263
50–54	$0.434
55–59	$0.679
60–64	$1.060
65–69	$1.902
70–74	$3.404
AD&D	**$0.025**

Dependent Child Coverage

Benefit Amount	Monthly Premium
$2,500	$0.075
$5,000	$0.125
$7,500	$0.20
$10,000	$0.25
AD&D	**$0.025**

Long Term Disability

Added protection

100% employer paid Long Term Disability provided by YMCA of Orange County. Should you experience a non-work related illness or injury that prevents you from working, disability coverage acts as income replacement to protect important assets and help you continue with some level of earnings. Benefits eligibility may be based on disability for your occupation or any occupation.

Your Plans	Coverage Details
Long Term Disability Coverage (LTD)	• If your disability extends beyond 90 days, the LTD coverage through United Healthcare can replace 60% of your earnings, up to maximum of $6,500 per month. • Your benefits may continue to be paid until you reach social security normal retirement age, as long as you meet the definition of disability.
State Disability Insurance	• The state you reside in may provide a partial wage-replacement disability insurance plan. • For more information regarding statutory disability programs, contact Human Resources.

TIP

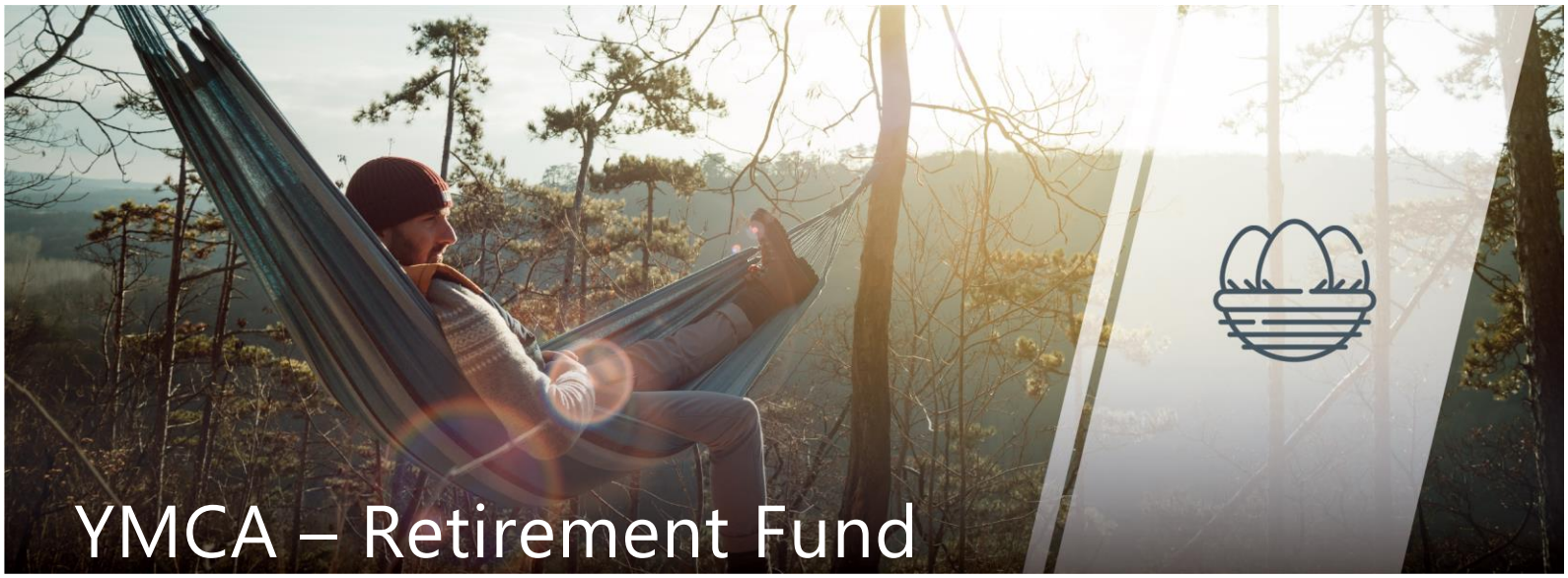
Disability Facts and Figures

- **One in every seven people will become disabled for five years or more in their lifetime.**
- **30% of people use disability coverage.**
- **Nearly half (46%) of all foreclosures are caused by financial hardship due to a disability.**

Source: www.affordableinsuranceprotection.com/disability_facts

Tax considerations

Because disability coverage is an employer-paid benefit and is available for employees at no cost, any disability payments made to you will be taxable.



YMCA – Retirement Fund

403(b): The Funds 403(b) Smart Account is a great place for Y employees to save for retirement through payroll deduction.

- No eligibility requirements to enroll.
- If you are 50 or older, you are eligible to increase your contribution by $6,000 in your 403(b) Smart Account.
- If you have at least 15 years of service at the YMCA, you may eligible to enroll in a catch-up plan to increase your contribution to your 403(b) Smart Account.
- 403(b) Federal contribution limit is $19,500

401(a): The Retirement Plan is a 401(a) defined contribution church pension plan. You must meet the age and service requirement to enroll.

- You must complete 1,000 hours of service during each of any two 12-month periods, beginning with your date of hire or anniversary date. The two 12-month periods do not have to be consecutive.
- Once you have completed the service requirement, you will be enrolled on the first day of the month following your anniversary date, provided you are 21 years of age. If your anniversary falls on the first of the month, you will be enrolled on your anniversary date.
- Contributions to the Retirement Plan are based on your salary. Our Y contributes currently at 11%.

Service Time in Years	Accrual Rate per Month	Accrual Rate per year	Maximum Accrual
1 and 2	8.66	104 hours	200 hours
3, 4, and 5	12.00 hours	144 hours	200 hours
6 and thereafter	15.33 hours	184 hours	240 hours

In addition to the above accrual information, the YMCA of Orange County also provides regular full-time employees with two floating holidays each year.

Once an employee has accumulated the maximum vacation benefit, further vacation accrual will cease. If an employee later uses enough vacation benefits to fall below the maximum, the employee starts to accrue vacation again from the date forward until he or she reaches his or her vacation maximum. Accrued unused vacation is paid on separation of employment.

Vacation Buy-Out: The YMCA of Orange County wants to ensure that employees receive the proper amount of compensation that they rightfully earn each year. The YMCA of Orange County caps vacation accruals based on years of service and encourages employees to use their accrued vacation for rest and relaxation. The YMCA realizes that occasionally an employee may not be able to use sufficient vacation time to stay below the accrual cap. Therefore, the YMCA will allow for vacation buy-out thereby allowing the employee to receive pay instead of time off. See ACCRUED VACATION BUY-OUT POLICY

Sick Pay: All employees who work thirty (30) or more days in California within twelve (12) months of their first day of employment are eligible for paid sick time, whether full-time, part-time, seasonal, substitute, or temporary. Eligible employees begin accruing paid sick leave from their first hour worked in California. Employees can use paid sick leave after ninety (90) days of employment.

Employee Assistance Program (EAP)

YMCA of Orange County understands that you and your family members might experience a variety of personal or work-related challenges. Through United Healthcare's Live and Work Well, you have access to resources, information, and counseling that are fully confidential and no cost to you.

Program Component	Coverage Details
Who Can Utilize	All employees, dependents of employees, and members of your household
Topics May Include	• Childcare • Eldercare • Legal services • Identity theft • Marital, relationship or family problems • Bereavement or grief counseling • Substance abuse and recovery • Financial support • Educational materials • Will Prep • Wealth Management
Number of Sessions	3 face-to-face sessions per year per member per incident

TIP

How to Access:

- **By Phone: 877.660.3806**
- **Online: www.liveandworkwell.com**
- **Create your own user name and password under "Members Login or Register"**
- **You can also access under "Guest Access" and use access code "LTDEAP"**

Summplemental Voluntary Coverage

Supplemental Voluntary Coverage - Cigna

Critical Illness Coverage

Offered by Cigna, critical illness coverage is generally paid in the form of a one-time, lump sum payment, dependent on the illness. This will help reduce expenses associated with life-threatening diseases. Some of the covered medical conditions include:

- Cancer.
- Heart attack.
- Stroke.
- Kidney failure.
- Organ transplant.

Coverage amounts of $5,000, $10,000, and $20,000 for employee. Spouse coverage amounts of $2,500, $5,000, and $10,000. Child coverage amounts of $1,250, $2500, and $5,000. This means you will be permitted to enroll and provided this coverage amount regardless of health status, age, gender or other factors. If you're considering this type of coverage, you must enroll when you first become eligible or during the annual open enrollment period. For more information regarding cost and how to enroll, contact Human Resources.

Hospital Protection

Although medical insurance may pay for a portion of hospital expenses, deductibles, copayments, and out-of-network costs, the expenses can still add up. Having Hospital Protection through Cigna may help by paying cash to you or your family to offset both medical and non-medical bills when you're sick, injured, or on maternity leave. The cash benefits can be used to help pay for services or expenses your other medical plan might not cover, such as:

- Copayments
- Deductibles
- Transportation expenses
- Child care
- Prescriptions
- Lost income.

If you're considering this type of coverage, you must enroll when you first become eligible or during the annual open enrollment period. For more information regarding cost and how to enroll, contact Human Resources.

Accident Plan

Accidents happen when you least expect them and can include motor vehicle accidents, sports injuries, slips, falls or just every day mishaps! Cigna policy may pay cash to help families offset the expenses associated with accidents or injuries. Benefits may be paid for:

- Emergency room and doctor visits
- Follow up and physical therapy visits
- Hospital admission $500 per day
- Hospital confinement, $100 per day
- Intensive Care Unit, $200 per day
- Medical Equipment (crutches, leg braces, etc.).

If you're considering this type of coverage, you must enroll when you first become eligible or during the annual open enrollment period. For more information regarding cost and how to enroll, contact Human Resources.

Global Travel Assistance

If you or your beneficiaries travel 100 miles or more away from home or outside the country, call 1-800-527-0218 to access travel assistance services through United Healthcare 24 hours a day, anywhere in the world. Below are just a few of the services United Healthcare Global Travel provides:

Travel Assistance Services:

- Emergency travel arrangements.
- Assistance in replacing lost or stolen travel documents
- Emergency translation services.

Medical assistance services

- Worldwide medical and dental referrals.
- Relay of insurance and medical information
- Assistance in replacing corrective lenses and medical devices and much more

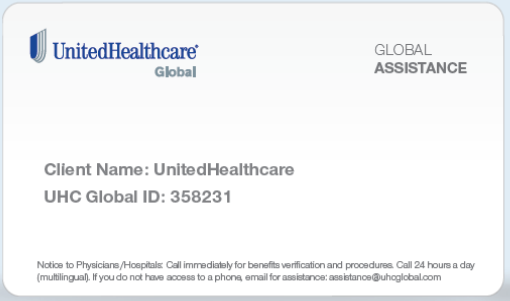
UnitedHealthcare

Get travel help anytime and on the go.

Log in to **UHCGlobal.com** to print your Global Assistance ID card, get up-to-date travel alerts, travel tips and much more.

Create your account:

1. Select **Member Log-in**.
2. Select **Visit Global Intelligence Center**.
3. Select **Create User** and enter the ID number 358231.



YMCA EMPLOYEE PERKS!

Y PERKS

Save on products and brands you use everyday! For use by YMCA employees only.

YMCA OF ORANGE COUNTY • YMCA OF RIVERSIDE COUNTY • YMCA OF EAST SAN GABRIEL VALLEY • YMCA OF POMONA VALLEY

YMCA HEALTH & WELLNESS MEMBERSHIP*

All full-time employees are eligible for a **free family membership** and all part-time employees are eligible for a free adult membership with an opportunity to upgrade to family membership at a lower cost.

*Please see your supervisor for more details.

YMCA PROGRAM DISCOUNTS*

All YMCA employees can recieve a **50% -100%** discount on Child Care and up to **20% discount** on programs. *Please see your supervisor for more details.

Get exclusive discounts, special offers and access to preferred seating and tickets to top attractions, theme parks, shows, sporting events, movie tickets, hotels and much more.
Visit: **www.ticketsatwork.com** and use code **YMCAORANGE17**

Get **10% OFF** pet insurance when you call and say "I am a YMCA of Orange County employee" or visit **HealthyPawsPetInsurance.com/benefits**

With the MORE ZERO program, **file your taxes online for FREE!** Employees also recieve **$25 OFF tax preparation.** For every new client who files in store, H&R Block will donate $20 back to the YMCA. You must present the YMCA Referral flyer and use the Nonprofit Referral ID 40010001097632. Find additional information/resources on yocconnect.org

New customers to Sprint who are Y Employees or Volunteers are eligible for **$5 off line 1** as well as up to **$200 in an instant offer prepaid card.**

Get iPhone Xs for $0/month with eligible trade-in.

Y employees qualify for up to **15% off** their monthly Verizon Wireless service. You must validate your eligibility with current employment information on the Verizon Discount Portal at **verizonwireless.com/discount-program**

Get **30% OFF** all Adidas Swim gear when you use promo code **YMCAOC30** at checkout.
Visit **AdidasSwimming.com**

YMCA EMPLOYEE PERKS!

15% OFF your entire purchase of safeTstep products at Payless.
Use **Discount Code: 251526320** at checkout.

SAVE 30% OFF Skechers. Shop online at skechersdirect.com and use access code: **8PEr2c** at checkout. In a Skechers retail store, give **RETAIL CODE: AL** to the cashier.

15% OFF services and parts. Present code: **NACC** at time of service.

10–40% OFF negotiated items. Visit **staplesadvantage.com/acc** to register your credit card. Then use your card in-store at checkout to get the discounts!

Switch to DirecTV and get a **$100 GIFT CARD!** New customers receive a $100 Gift Card with activation. Call this special phone number: **855-408-4890**

SAVE UP TO 30% on PCs, printers and accessories. Use code: **EP18525**
Shop at www.hpdirect.com/employee/alliancecost or call 866-433-2018.

SAVE UP TO 30% on PCs and select electronics. Shop online at www.dell.com/mpp/AllianceCostContainment, or speak to a sales representative at 1-800-695-8133. Reference Member ID: **GS130092139**

SAVE UP TO 80% on your prescription medications! To print a card that you and your family can start using today, go to humanadiscountrx.com and enter group number: **L13045**.

SPECIAL DISCOUNTS when you use the unique YMCA account number: **XZ58319**. Book at www.nationalcar.com/offer/XZ58319

SAVE UP TO 30%. Go to Avis.com, fill in required information and then click I have a Discount Code. Enter **AWD # Y013705**

SAVE 30% OFF PAINT & 15% OFF SUPPLIES
Use this bar code to receive your discount...

309103280000

Directory, Required Notices, and Costs

Directory & Resources

Below, please find important contact information and resources for YMCA of Orange County.

Information Regarding	Contact Information	
Enrollment & Eligibility		
Human Resources: • YMCA of OC HR Manager: Ashley Smith	714.508.7633 ext.1048	alsmith@ymcaoc.org
Medical Coverage		
United Healthcare • HMO Signature Value • HMO Advantage • HMO Harmony • PPO Select Plus	 800.624.8822 800.624.8822 800.624.8822 866.633.2446	 www.myuhc.com www.myuhc.com www.myuhc.com www.myuhc.com
Teladoc		
Member Service	855.835,2382	www.teledoc.com
Dental Coverage		
United Healthcare • Dental DHMO • Dental DPPO	 800.445.9090 800.445.9090	 www.myuhc.com www.myuhc.com
Vision Coverage		
United Healthcare • Vision PPO	 800.638.3120	 www.myuhcvision.com
Employer Paid Life, AD&D and Disability		
United Healthcare • Basic Life & AD&D United Healthcare • Basic Long Term Disability (LTD)	 888.299.2070 888.299.2070	 www.myuhc.com www.myuhc.com
Voluntary Life and AD&D		
United Healthcare • Voluntary Life and AD&D	 888.299.2070	 www.myuhc.com
Voluntary Work Site Benefits		
Cigna • Accident Plan, Critical Illness, Hospital Indemnity	 800.754.3207	 www.cigna.com
Difference Card		
Member Service	888.343.2110	email: customercare@differencecard.com
Flexible Spending Accounts (FSA)		
FSA Difference Card	888.343.2110	www.differencecard.com
403(b) & 401(a) Retirement Plan Adviser		
YMCA Retirement Fund	800.RET-YMCA (738-9622)	www.YRetirement.org
Employee Assistance Plan		
United Healthcare EAP • Liveandworkwell (guess access code: LTDEAP)	877.660.3806	www.liveandworkwell.com
Travel Assistance		
United Healthcare – UHC Global ID#358231	800.527.0218	Email: assistance@uhcglobal.com
Benefits Broker		
Marsh & McLennan Agency LLC 1 Polaris Way, Suite 300 Aliso Viejo, CA	800.321.4696 949.540.6930 949.544.8478 949.238.0753 949.544.8479	www.MarshMMA.com James.Park@MarshMMA.com Lauren.Romo@MarshMMA.com Tyler.Mahon@MarshMMA.com David.Nava@MarshMMA.com

Guidelines/Evidence of Coverage

The benefit summaries listed on the previous pages are brief summaries only. They do not fully describe the benefits coverage for your health and welfare plans. For details on the benefits coverage, please refer to the plan's Evidence of Coverage. The Evidence of Coverage or Summary Plan Description is the binding document between the elected health plan and the member.

A health plan physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat the members' medical condition. These services and supplies must be provided, prescribed, authorized, or directed by the health plan's network physician unless the member enrolls in the PPO plan where the member can use a non-network physician.

The HMO member must receive the services and supplies at a health plan facility or skilled nursing facility inside the service area except where specifically noted to the contrary in the Evidence of Coverage.

For details on the benefit and claims review and adjudication procedures for each plan, please refer to the plan's Evidence of Coverage. If there are any discrepancies between benefits included in this summary and the Evidence of Coverage or Summary Plan Description, the Evidence of Coverage or Summary Plan Description will prevail.

Medicare Part D notice

Important Notice about Your Prescription Drug Coverage and Medicare

Model Individual CREDITABLE Coverage Disclosure

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare prescription drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Your employer has determined that the prescription drug coverage offered is expected to pay, on average, as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare prescription drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Prescription Drug Plan?

Individuals who are eligible for Medicare should compare their current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in their area.

If you are eligible for Medicare and do decide to enroll in a Medicare prescription drug plan and drop your employer's group health plan prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact Human Resources for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

Your medical benefits brochure contains a description of your current prescription drug benefits.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with your employer and do not join a Medicare prescription drug plan within 63 continuous days after your current coverage ends, you might pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage...

Contact your Human Resources Department for further information NOTE: You will receive this notice annually, before the next period you can join a Medicare prescription drug plan, and if this coverage through your employer changes. You also may request a copy of this notice at any time.

For More Information about Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

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

Remember: **Keep this Creditable Coverage notice. If you decide to join one of the Medicare prescription drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).**

Legal Information Regarding Your Plans

REQUIRED NOTICES

Women's Health & Cancer Rights Act

The Women's Health and Cancer Rights Act (WHCRA) requires group health plans to make certain benefits available to participants who have undergone or who are going to have a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Your plans comply with these requirements.

Health Insurance Portability & Accountability Act Non-discrimination Requirements

Health Insurance Portability & Accountability Act (HIPAA) prohibits group health plans and health insurance issuers from discriminating against individuals in eligibility and continued eligibility for benefits and in individual premium or contribution rates based on health factors.

These health factors include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities), and disability.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, HIPAA Special Enrollment Rights require your plan to allow you and/or your dependents to enroll in your employer's plans (except dental and vision plans elected separately from your medical plans) if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days (60 days if the lost coverage was Medicaid or Healthy Families) after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

Other midyear election changes may be permitted under your plan (refer to "Change in Status" section). To request special enrollment or obtain more information, contact your Human Resources Representative.

"HIPAA Special Enrollment Opportunities" include:

- COBRA (or state continuation coverage) exhaustion
- Loss of other coverage [1]
- Acquisition of a new spouse or dependent through marriage [1], adoption [1], placement for adoption [1] or birth [1]
- Loss of state Children's Health Insurance Program coverage (e.g., Healthy Families) (60-day notice) [1]
- Employee or dependents become eligible for state Premium Assistance Subsidy Program (60-day notice)

"Change in Status" Permitted Midyear Election Changes

- Due to the Internal Revenue Service (IRS) regulations, in order to be eligible to take your premium contribution using pre-tax dollars, your election must be irrevocable for the entire plan year. As a result, your enrollment in the medical, dental, and vision plans or declination of coverage when you are first eligible, will remain in place until the next Open Enrollment period, unless you have an approved "change in status" as defined by the IRS.
- Examples of permitted "change in status" events include:
- Change in legal marital status (e.g., marriage [2], divorce or legal separation)
- Change in number of dependents (e.g., birth [2], adoption [2] or death)
- Change in eligibility of a child
- Change in your / your spouse's / your registered and unregistered domestic partner's employment status (e.g., reduction in hours affecting eligibility or change in employment)
- A substantial change in your / your spouse's / your registered and unregistered domestic partner's benefits coverage
- A relocation that impacts network access
- Enrollment in state-based insurance Exchange
- Medicare Part A or B enrollment
- Qualified Medical Child Support Order or other judicial decree
- A dependent's eligibility ceases resulting in a loss of coverage [3]
- Loss of other coverage [2]
- Change in employment status where you have a reduction in hours to an average below 30 hours of service per week, but continue to be eligible for benefits, and you intend to enroll in another plan that provides Minimum Essential Coverage that is effective no later than the first day of the second month following the date of revocation of your employer sponsored coverage
- You enroll, or intend to enroll, in a Qualified health Plan (QHP) through the State Marketplace (i.e. Exchange) and it is effective no later than the day immediately following the revocation of your employer sponsored coverage.

You must notify Human Resources within 30 days of the above change in status, with the exception of the following which requires notice within 60 days:

- Loss of eligibility or enrollment in Medicaid or state health insurance programs (e.g., Healthy Families)

IMPORTANT INFORMATION ON HOW HEALTH CARE REFORM AFFECTS YOUR PLAN

Primary Care Provider Designations

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries:

- Your HMO generally requires 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 information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Human Resources office

For plans and issuers that require or allow for the designation of a primary care provider for a child:

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

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider:

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

Grandfathered Plans

If your group health plan is grandfathered then the following will apply. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator.

Prohibition on Excess waiting Periods

Group health plans may not apply a waiting period that exceeds 90 days. A waiting period is defined as the period that must pass before coverage for an eligible employee or his or her dependent becomes effective under the Plan. State law may require shorter waiting periods for insured group health plans. California law requires fully-insured plans to comply with the more restrictive waiting period limitation of no more than 60-days.

Preexisting Condition Exclusion

Effective for Plan Years on or after January 1, 2014, Group health plans are prohibited from denying coverage or excluding specific benefits from coverage due to an individual's preexisting condition, regardless of the individual's age. A PCE includes any health condition or illness that is present before the coverage effective date, regardless of whether medical advice or treatment was actually received or recommended

CONTINUATION COVERAGE RIGHTS UNDER COBRA

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.

[1] Indicates that this event is also a qualified "Change in Status"
[2] Indicates that this event is also a HIPAA Special Enrollment Right
[3] Indicates that this event is also a COBRA Qualifying Event

CONTINUATION COVERAGE RIGHTS UNDER COBRA (CONTINUED)

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 for COBRA continuation coverage.

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;

  or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice.

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.

How is COBRA continuation coverage provided? (Continued)

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, 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.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

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

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

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

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

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

If you have questions

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

Keep your Plan informed of address changes

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

EMPLOYEE RIGHTS & RESPONSIBILITIES UNDER THE FAMILY MEDICAL LEAVE ACT

Basic Leave Entitlement

Family Medical Leave Act (FMLA) requires covered employers to provide up to 12 weeks of unpaid, job protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, child or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness [1]; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness. [2]

Benefits & Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months [3], and if at least 50 employees are employed by the employer within 75 miles.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.
[2] The FMLA definitions of "serious injury or illness" for current service members and veterans are distinct from the FMLA definition of "serious health condition"
[3] Special hours of service eligibility requirements apply to airline flight crew employees

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days' notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider; or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information: (866) 4US-WAGE ((866) 487-9243) TYY: (877) 889-5627
www.wagehour.dol.gov

UNIFORMED SERVICES EMPLOYMENT & REEMPLOYMENT RIGHTS ACT NOTICE OF 1994, NOTICE OF RIGHT TO CONTINUED COVERAGE UNDER USERRA

Right to Continue Coverage

Under the Uniformed Services Employment & Reemployment Rights Act of 1994 (USERRA), you (the employee) have the right to continue the coverage that you (and your covered dependents, if any) had under the Company Medical Plan if the following conditions are met:

- You are absent from work due to service in the uniformed services (defined below);
- You were covered under the Plan at the time your absence from work began; and
- You (or an appropriate officer of the uniformed services) provided your employer with advance notice of your absence from work (you are excused from meeting this condition if compliance is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances).

How to Continue Coverage

If the conditions are met, you (or your authorized representative) may elect to continue your coverage (and the coverage of your covered dependents, if any) under the Plan by completing and returning an Election Form 60 days after date that USERRA election notice is mailed, and by paying the applicable premium for your coverage as described below.

What Happens if you do not Elect to Continue Coverage?

If you fail to submit a timely, completed Election Form as instructed or do not make a premium payment within the required time, you will lose your continuation rights under the Plan, unless compliance with these requirements is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

If you do not elect continuation coverage, your coverage (and the coverage of your covered dependents, if any) under the Plan ends effective the end of the month in which you stop working due to your leave for uniformed service.

Premium for Continuing Your Coverage

The premium that you must pay to continue your coverage depends on your period of service in the uniformed services. Contact Human Resources for more details.

Length of Time Coverage Can Be Continued

If elected, continuation coverage can last 24 months from the date on which employee's leave for uniformed service began. However, coverage will automatically terminate earlier if one of the following events takes place:

- A premium is not paid in full within the required time;
- You fail to return to work or apply for reemployment within the time required under USERRA (see below) following the completion of your service in the uniformed services; or
- You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

Reporting to Work / Applying for Reemployment

Your right to continue coverage under USERRA will end if you do not notify Human Resources of your intent to return to work within the timeframe required under USERRA following the completion of your service in the uniformed services by either reporting to work (if your uniformed service was for less than 31 days) or applying for reemployment (if your uniformed service was for more than 30 days). The time for returning to work depends on the period of uniformed service, as follows:

Period of Uniformed Service	Report to Work Requirement
Less than 31 days	The beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, then as soon as is possible
31–180 days	Submit an application for reemployment within 14 days after completion of your service or, if that is unreasonable or impossible through no fault of your own, then as soon as is possible
181 days or more	Submit an application for reemployment within 90 days after completion of your service
Any period if for purposes of an examination for fitness to perform uniformed service	Report by the beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, as soon as is possible
Any period if you were hospitalized for or are convalescing from an injury or illness incurred or aggravated as a result of your service	Report or submit an application for reemployment as above (depending on length of service period) except that time periods begin when you have recovered from your injuries or illness rather than upon completion of your service. Maximum period for recovering is limited to two years from completion of service but may be extended if circumstances beyond your control make it impossible or unreasonable for you to report to work within the above time periods

Definitions

For you to be entitled to continued coverage under USERRA, your absence from work must be due to "service in the uniformed services."

- "Uniformed services" means the Armed Forces, the Army National Guard, and the Air National Guard when an individual is engaged in active duty for training, inactive duty training, or full-time National Guard duty (i.e., pursuant to orders issued under federal law), the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency
- "Service in the uniformed services" or "service" means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active and inactive duty for training, National Guard duty under federal statute, a period for which a person is absent from employment for an examination to determine his or her fitness to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain service by intermittent disaster response appointees of the National Disaster Medical System (NDMS)

HIPAA PRIVACY NOTICE

Notice of Health Information Privacy Practices

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

This notice is EFFECTIVE: 1/1/2021

This notice is required by law under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is intended to provide information about the legal protections that apply to your health information. HIPAA includes numerous provisions that are designed to maintain the privacy and confidentiality of your Protected Health Information (PHI). PHI is health information that contains identifiers (such as your name, address, social security number, or other information that identifies you) and information related to your past, present or future health condition and treatments.

This notice is for participants in the Company Health & Welfare Plan (referred to as the "Plan"), including its component plans.

Required by Law

- The Plan must make sure that health information that identifies you is kept private.
- The Plan must give you this notice of our legal duties and privacy practices with respect to health information about you.
- The Plan must obtain written authorization from you for the use and disclosure of your PHI related to psychotherapy notes; when for purposes of marketing; and/or for disclosures constituting a sale of PHI.
- The Plan must follow the terms of the notice that are currently in effect.

Permitted Plan use of Your Health Information

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, contact the Plan Privacy Officer.

You have both the right and choice to tell us to: share information with your family, close friends, or others involved in payment for your care; share information in a disaster relief situation; and contact you for fundraising efforts.

If you are not able to tell us your preference, for example if you are unconscious, the Plan may go ahead and share your information if it believes it is in your best interest. The Plan may also share your information when needed to lessen a serious and imminent threat to health or safety.

The Plan will never share your information unless you give us written permission for: marketing purposes and the sale of your information.

Treatment: The Plan may use your health information to assist your health care providers (doctors, pharmacies, hospitals and others) to assist in your treatment. For example, the Plan may provide a treating physician with the name of another treating provider to obtain records or information needed for your treatment.

Regular Operations: We may use information in health records to review our claims experience and to make determinations with respect to the benefit options that we offer to employees. We may also use and disclose your information to run our organization and contact you when necessary. If PHI is used or disclosed for underwriting purposes, the Plan is prohibited from using or disclosing any of your PHI that is genetic information for such purposes. The Plan is also not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Payment for Health Services and Administration of the Plan: The Plan can use and disclose your health information when paying for your health services. For example, the Plan may share information about you with your dental plan to coordinate payment for your dental work. The Plan may disclose your health information to your health plan sponsor for plan administration. For example, where your company contracts with an insurer to provide a health plan, and the Plan provides your company with certain statistics to explain the premiums charged.

Business Associates: There are some services provided in our organization through contracts with business associates. Business associates with access to your information must adhere to a contract requiring compliance with HIPAA privacy rules and HIPAA security rules.

As Required by Law: We will disclose health information about you when required to do so by federal, state or local law (this includes the Department of Health and Human Services if it wants to see that the Plan is complying with federal privacy law).

To Respond to Organ and Tissue Donation Requests and Work with a Medical Examiner or Funeral Director: We may share health information about you with organ procurement organizations; and may share health information with a coroner, medical examiner, or funeral director when an individual dies.

Workers' Compensation: We may release health information about you for workers' compensation programs or claims or similar programs. These programs provide benefits for work-related injuries or illness.

Law Enforcement and other Government Requests: We may disclose your health information for law enforcement purposes or with a law enforcement official, in response to a valid subpoena or other judicial or administrative request/order, with health oversight agencies for activities authorized by law, or for special government functions such as military, national security, and presidential protective services.

Public Health and Research: We may also use and disclose your health information to assist with public health activities (for example, reporting to a federal agency) or health oversight activities (for example, in a government investigation). Additionally we may share health information about you when: preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; preventing or reducing a serious threat to anyone's health or safety or for purposes of health research.

Your Rights Regarding Your Health Information

Although your health record is the physical property of the entity that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information where concerning a service already paid for.
- Obtain a paper copy of the notice of health information practices promptly (even if you have agreed to receive the notice electronically) by requesting it from the Plan Privacy Officer.
- Ask to see or get a copy of your health and claims records and other health information we have about you. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Inspect and obtain a copy of your PHI contained in a "designated record set." A designated records set includes medical and billing records; enrollment, payment, billing, claims adjudication and case or medical management record systems; or other information used in whole or in part by or for the covered entity to make decisions about individuals. A written request to access your PHI must be submitted to your company Privacy Officer. Requested information will be provided within 30 days if maintained on site or 60 days if maintained off site.
- Request an amendment/correction to your health information: you can ask us to correct your health and claims records if you think they are incorrect or incomplete. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Ask us to limit what we use or share. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- Obtain an accounting of disclosures of your PHI during the preceding six years, who we shared it with, and why, with the exception of disclosures made for purposes of treatment, payment or health care operations, and certain other disclosures (such as any you asked us to make); made to individuals about their own PHI; or, made through use of an authorization form. A reasonable fee may be charged for more than one request per year.
- Request confidential communications of your health information be sent in a different way (for example, home, office or phone) or to a different place than usual (for example, you could request that the envelope be marked "confidential" or that we send it to your work address rather than your home address). We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
- Revoke in writing your authorization to use or disclose health information except to the extent that action has already been taken, in reliance on that authorization.
- Receive notification within 60 days (5 day for California residents) for any breaches of your unsecured PHI.
- Assign someone as your medical power of attorney or your legal guardian, who can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

Plan Responsibilities

The Plan is required to maintain the privacy of PHI and to comply with the terms of this notice. The Plan reserves the right to change our health privacy practices. Should we change our privacy practices in a material way, we will make a new version of our notice available to you within 60 days of the effective date of any material change to the rights and duties listed in this notice. The Plan is required to:

- Maintain the privacy and security of your health information.
- Make reasonable efforts not to use, share, disclose or request more than the minimum necessary amount of PHI needed to accomplish the intended purpose, unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- Follow the duties and privacy practices described in this notice with respect to information we collect and maintain about you and provide you a copy of the notice.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction, amendment or other request.
- Notify you of any breaches of your protected health information that may have compromised the privacy or security of your information within 60 days (5 days for California residents).
- Accommodate any reasonable request you may have to communicate health information by alternative means or at alternative locations.

The Plan will not use or disclose your health information without your consent or authorization, except as provided by law or described in this notice. The Plan may use or disclose "summary health information" to the plan sponsor for obtaining premium bids or modifying, amending or terminating the Group Health Plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a Group Health Plan; and from which identifying information has been deleted in accordance with HIPAA. The plan is prohibited from using or disclosing PHI that is genetic information of an individual for any purposes, including underwriting.

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

Your Right to File a Complaint

If you believe your privacy rights have been violated, you can file a formal complaint with the Plan Privacy Officer; or with the U.S. Department of Health and Human Services (by mail or email). We will not retaliate against you and you will not be penalized for filing a complaint.

Changes to the Terms of This Notice

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

Contact Person

If you have questions or would like additional information, or if you would like to make a request to inspect, copy, or amend health information, or for an accounting of disclosures, contact the Plan Privacy Officer. All requests must be submitted in writing to the address shown below.

YMCA of Orange County HR
Attention: Director of Human Resources
13821 Newport Ave #200,Tustin, CA 92780

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

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 916-440-5676	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**MONTANA – 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	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – 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	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – 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)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms 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	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	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, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

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

Note Page

Note Page

Note Page

Note Page

The rates quoted for these benefits may be subject to change based on final enrollment and/or final underwriting requirements. This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of the plan or program benefits and does not constitute a contract. Consult your plan documents (Schedule of Benefits, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Booklet, Booklet-certificate, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan. All the terms and conditions of your plan or program are subject to applicable laws, regulations and policies. In case of a conflict between your plan document and this information, the plan documents will always govern.