FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

2022
Plan Year

TODAY, TOMORROW, TOGETHER

Benefits for Full-Time Employees
YMCA OF GREATER FORT WAYNE

Important Contacts

BENEFIT CONSULTANT

HYLANT

Be prepared: When contacting any of the companies below, it is important to have the insurance card or ID card number(s) of the subscriber for the coverage you are calling about as well as any appropriate paperwork, such as an explanation of benefits, a denial letter, receipts, etc.

Questions About	Contact	Phone	Website
Medical	Physicians Health Plan	260-432-6690	www.phpni.com
Prescription Drug	Physicians Health Plan	260-432-6690	www.phpni.com
Mail Order Prescription Drug	Medco	800-473-3455	
Employee Assistance Programs	Optum	800-980-6921	www.liveandworkwell.com Access Code: 9622
Health Savings Account	The HSA Authority	888-472-8697, Option 1	www.thehsaauthority.com
Dental	Principal Financial Group	800-247-6495	www.principal.com
Life / AD&D	Principal Financial Group	800-245-1522	www.principal.com
Voluntary Life / AD&D	Principal Financial Group	800-245-1522	www.principal.com
Disability	Principal Financial Group	800-245-1522	www.principal.com
Retirement	YMCA of Greater Fort Wayne Retirement Fund	800-738-9622	www.yretirement.org
General Information & Life Change of Status	YMCA of Greater Fort Wayne - Human Resources Department	260-422-6488	human_resources@fwymca.org
Hylant	Mary Sullivan - Client Service Consultant	260.969.3936	mary.sullivan@hylant.com
Hylant	Melanie Minobe - Claims Advocate	260.969.3941	melanie.minobe@hylant.com
YMCA Human Resources		260-422-6488	human_resources@fwymca.org

The benefits in this document are effective: January 1, 2021 – December 31, 2021

COVID-19 Related Relief

Please note that, due to the COVID-19 pandemic, agency-issued guidance impacting Plan participants is constantly evolving. If you have concerns under the Plan with respect to your coverage or meeting an applicable deadline due to the national emergency concerning the COVID-19 outbreak, please contact Human Resources to determine if relief may be available to you.

Table of Contents

If you (and/or) your dependents have Medicare or will become eligible for Medicare in the next 12 months, a Federal law give you more choices about your prescription Drug coverage. Please see page 25 for more details.

ELIGIBILITY

As a benefits-eligible employee, YMCA of Greater Fort Wayne offers a health and welfare program that offers you and your family coverage that helps reduce your medical expense, improve your health and well-being, and protect you while you are an active employee. Benefits are available to all full-time employees who work a minimum of 40 hours per week.

DEPENDENT ELIGIBILITY

Your dependents may also be covered under the benefit plans described below.

Benefit	Legal Spouse	Dependent Child(ren)
Medical	√	Up to age 26
Dental	√	Up to age 26
Voluntary Life and AD&D	√	Up to age 24

DEPENDENT VERIFICATION

You may be asked to provide Human Resources proof of dependent eligibility, which may include one or more of the following:

- Marriage Certificate
- Birth Certificate
- Affidavit of Qualifying Adult
- Adoption Certificate
- Placement Certificate
- Document of Guardianship
- Other as necessary

SPOUSAL COVERAGE

If your spouse is employed and eligible for medical benefits through his/her employer, he/she is eligible for the YMCA of Greater Fort Wayne health insurance plan. If your spouse is employed and eligible for medical benefits through his/her current or former employer, you will incur a monthly spousal surcharge in addition to your medical coverage contributions/premiums if you elect to enroll your spouse in the YMCA of Greater Fort Wayne health insurance plan.

NEW HIRE COVERAGE

As a new employee you have 31 days from date of hire to make your benefit elections. It is important you review the benefit information and enroll in benefits during your initial new hire eligibility period. If you do not enroll by that deadline, you will not be eligible for coverage until the following annual open enrollment period or if you experience a qualifying event. Following enrollment, your coverage is effective the first of the month following the date of full-time, active employment.

TERMINATION OF COVERAGE

If employment is terminated, all coverage will end at the end of the month following termination.

COBRA CONTINUATION OF COVERAGE

When you or any of your dependents no longer meet the eligibility requirements under this plan, you may be eligible for continued coverage as required by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985.

WELCOME BABY! Don't forget to notify Human Resources within 30 days of birth of a newborn to add dependent(s) to the plan.

MAKING CHANGES DURING THE YEAR

Unless you experience a life-changing qualifying event, you cannot make changes to your benefits until the next open enrollment period. You must notify Human Resource of such change(s) within the noted days from the event as shown in the below table. Failure to notify Human Resources within the timeframe noted (and provide any necessary dependent documentation) will require you to wait until the next open enrollment period to make your change. Qualifying events may require documentation of the event such as marriage certificate, birth certificate, divorce decree, etc. to finalize the event change. For questions, please see your Human Resource representative.

Qualifying Event	Timeframe to Notify Human Resources*
Marriage, divorce or legal separation	30 days
Birth, adoption or placement for adoption	30 days
Death of a dependent	30 days
Change in your Spouse's employment status	30 days
Change in coverage status under your spouse's plan	30 days
A loss of eligibility for other health coverage	30 days
Change in dependent child's status, either newly satisfying the requirements for dependent child status or ceasing to satisfy them	30 days
Judgment, decree or court order allowing you to add or drop coverage for a dependent child	30 days
Change in eligibility for Medicare or Medicaid	60 days
Termination of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP)	60 days
Becoming eligible for a premium assistance subsidy under Medicaid or a state CHIP	60 days

** days from the qualifying event*

TURNING AGE 65 AND BECOMING MEDICARE ELIGIBLE

If you are an active employee and have reached the age of 65, you may be wondering about Medicare. If you are already receiving Social Security benefits, you should receive an advisory notice from Medicare about three (3) months before your 65th birthday for your initial enrollment period. Otherwise, you must actively enroll in Medicare yourself by contacting your local Social Security office as you will not receive a mailed notice of eligibility.

If you are turning age 65 during the plan year but will continue working in a benefits-eligible position, you have the option of enrolling in Medicare Part A (hospital) coverage, which is typically premium-free. You may also enroll in Part B (medical) coverage at your cost. If you do so, your Group Health medical plan remains your primary and Part B (Medical Insurance), which does have a fee involved, would coordinate as secondary coverage to your Group Health medical plan.

Medicare will allow you to delay your enrollment in Medicare Part B until you officially retire, without a late enrollment penalty (enrollment in Medicare Part A is optional). Employees more typically enroll in Part A and defer Part B until retirement. For additional information on Medicare eligibility and enrollment periods, please visit www.Medicare.gov.

BENEFICIARY DESIGNATION

In addition to electing or making benefit changes during open enrollment, it is important to designate a beneficiary for your life insurance and Health Savings Account (HSA). Your beneficiary is the person(s) who will receive your life insurance benefits and any remaining HSA balance when you die. If you have a beneficiary in place, or if your family situation has changed, now is the time to ensure all information on record is correct.

If you do not name a beneficiary, your benefits will be distributed in accordance with the provisions stated in the Certificate of Coverage. For additional information contact Human Resources.

COST OF COVERAGE SUMMARY

2022 PAYROLL DEDUCTIONS (24 PAYS)

	Employee	Employee/ Child	Employee/ Spouse 1	Employee/ Spouse 2	Family 1	Family 2
MEDICAL						
Legacy 5000 HSA H1	$40.47	$76.90	$85.00	$263.09	$123.04	$307.60
Legacy 3000 HSA H5	$55.77	$105.96	$117.11	$295.20	$169.53	$354.09

	Employee	Employee/ Child	Employee/ Spouse	Family
DENTAL				
Dental PPO	$3.31	$8.67	$6.65	$12.55

UNDERSTANDING YOUR PRE-TAX BENEFIT PAYROLL DEDUCTIONS

The Section 125 Cafeteria Plan allows you to pay for many of the benefits we offer with “before-tax” dollars (e.g., medical, dental and vision coverage). By paying premiums with “before-tax” dollars, you may reduce the amount of income and Social Security taxes that you otherwise would be required to pay. The elections made during the Cafeteria Plan enrollment period are effective for the entire 12-month plan year. Unless you experience a life-changing qualifying event, you cannot make changes to your benefits until the next open enrollment period. Refer to the preceding page of this guide for information on what constitutes a qualifying event, and the associated timeframe you have to notify Human Resources if you intend to make a change.

COST OF COVERAGE SUMMARY (Continued)

VOLUNTARY LIFE

Below is the cost for the Voluntary Life Insurance coverage. The rates/premium are age banded based on the **employee's age** as of the first day of the plan year for both the employee and spouse.

EMPLOYEE MONTHLY PAYROLL DEDUCTIONS										
Coverage Amounts	< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
$10,000	$0.83	$1.03	$1.50	$2.18	$3.47	$5.62	$9.44	$14.67	$27.18	$54.40
$20,000	$1.66	$2.06	$3.00	$4.36	$6.94	$11.24	$18.88	$29.34	$54.36	$108.80
$30,000	$2.49	$3.09	$4.50	$6.54	$10.41	$16.86	$28.32	$44.01	$81.54	$163.20
$40,000	$3.32	$4.12	$6.00	$8.72	$13.88	$22.48	$37.76	$58.68	$108.72	$217.60
$50,000	$4.15	$5.15	$7.50	$10.90	$17.35	$28.10	$47.20	$73.35	$135.90	$272.00
$60,000	$4.98	$6.18	$9.00	$13.08	$20.82	$33.72	$56.64	$88.02	$163.08	$326.40
$70,000	$5.81	$7.21	$10.50	$15.26	$24.29	$39.34	$66.08	$102.69	$190.26	$380.80
$80,000	$6.64	$8.24	$12.00	$17.44	$27.76	$44.96	$75.52	$117.36	$217.44	$435.20
$90,000	$7.47	$9.27	$13.50	$19.62	$31.23	$50.58	$84.96	$132.03	$244.62	$489.60
$100,000	$8.30	$10.30	$15.00	$21.80	$34.70	$56.20	$94.40	$146.70	$271.80	$544.00
AD&D (Per $1,000	$0.025									

SPOUSE MONTHLY PAYROLL DEDUCTIONS										
Coverage Amounts	< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
$5,000	$0.42	$0.52	$0.75	$1.09	$1.74	$2.81	$4.72	$7.34	$13.59	$27.20
$10,000	$0.83	$1.03	$1.50	$2.18	$3.47	$5.62	$9.44	$14.67	$27.18	$54.40
$15,000	$1.25	$1.55	$2.25	$3.27	$5.21	$8.43	$14.16	$22.01	$40.77	$81.60
$20,000	$1.66	$2.06	$3.00	$4.36	$6.94	$11.24	$18.88	$29.34	$54.36	$108.80

CHILD(REN) MONTHLY PAYROLL DEDUCTIONS	
$5,000	$1.00
$10,000	$2.00

HEALTH & WELL-BEING COVERAGE

MEDICAL

The following is a summary of your medical benefits. For a more detailed explanation of benefits, please refer to your Summary of Benefits and Coverage. You may access a list of participating providers through the carrier's website.

www.phpni.com 260-432-6690

BENEFITS AT-A-GLANCE

	Legacy 5000 HSA H1 Prime (Plan Option 1)	Legacy 3000 HSA H5 Prime (Plan Option 2)
	In-Network	**In-Network**
DEDUCTIBLES	Calendar Year	Calendar Year
Individual	$5,000	$3,000
Family	$10,000	$6,000
COINSURANCE		
Plan Pays	100%	80%
You Pay	0%	20%
Annual Maximum (single/family)	N/A	N/A
OUT-OF-POCKET MAXIMUM (Includes Deductibles, Coinsurance and Copays)		
Individual	$5,000	$5,000
Family	$10,000	$10,000
COMMONLY USED SERVICES		
Primary Physician Visit	100% after deductible	80% after deductible
Specialist Visit	100% after deductible	80% after deductible
Preventive Care Services	100% coverage	100% coverage
Urgent Care Visit	100% after deductible	80% after deductible
Emergency Room	100% after deductible	80% after deductible
Diagnostic Labs & X-Rays	100% after deductible	80% after deductible
Hospitalization	100% after deductible	80% after deductible
Mental Health*	100% after deductible	80% after deductible
Substance Abuse*	100% after deductible	80% after deductible
PRESCRIPTION DRUGS		
Tier 1 (Retail & Mail Order)	100% after deductible	80% after deductible
Tier 2 (Retail & Mail Order)	100% after deductible	80% after deductible
Tier 3 (Retail & Mail Order)	100% after deductible	80% after deductible
Tier 4 (Retail & Mail Order)	100% after deductible	80% after deductible
Tier 5 (Retail)	100% after deductible	80% after deductible

**See Summary Plan Description for additional details. You may also contact the plan administrator regarding benefits.*

WELLNESS

TAKE CHARGE OF YOUR HEALTH & WELL-BEING

The Y exists to strengthen communities through youth development, healthy living and social responsibility. As a member of our Y family, we value your health and well-being. Our employee wellness program provides resources for you to support your well-being journey. The program offers resources through Activities, Physical Activity, Y Programs and Wellness Screening both inside and outside of the YMCA OF GREATER FORT WAYNE for full-time and part-time employees. We encourage you to participate!

brian_west@fwymca.org 260-432-8953

EARN POINTS FOR INCENTIVES

Employees can earn prizes and additional HSA contributions by participating in the Employee Wellness Program. The program is reviewed and distributed annually in November, and employees must register in Daxko to participate. Points are earned throughout the year by completing monthly Physical Activity Logs (5-7 points based on minutes of activity), Health Screenings (1-3 points), Programs/Events (1-3 Points), and Special Challenges (5 Points Each), then submitting completed logs forms to Brian West.

See the Employee Wellness Program Document, your ADP Self-Service Portal, or contact Brian West brian_west@fwymca.org for more information.

PHYSICAL ACTIVITY

Document your physical activity each month with a physical activity log and turn in to Brian West at the Skyline Branch by the 10th of each month for point accumulation towards prize incentives.

- Full-time employees participating in health coverage through the YMCA of Greater Fort Wayne are eligible for additional contributions into their HSA.
    - Log at Least 300-599 min. per month and receive a $10/mo. HSA Contribution
    - Log at Least 600 min. per month and receive a $25/mo. HSA Contribution

Y FACILITY USE AND PROGRAMS *(See Employee Handbook for details)*

As an employee, your Y membership has value. The value for full-time and part-time employees ranges from $906.00 to $588.00 per year depending on full-time or part-time status. We encourage you to make use of this benefit in support of your well-being journey. Some of the values available to you in our facilities are programs are:

- Unlimited access to 8 branches
- Free child care in our Child Watch while you work out
- Unlimited participation in free group exercise classes like CycleFit, Zumba® and AquaFit every week for every fitness level!
- Free health and wellness consultations and the use of Mobile Fit (available at the Jorgensen and Parkview Branches), access to Fitness Coaches and Wellness for Life Orientation.
- Professionally trained staff to support you in your Y experience
- Free Blood Pressure Screening at any Branch Wellness Center
- Up to 50% discount off regular member rates for programs and individualized services such as: Personal Training, Swim Lessons, Early Learning Center fees, Before/After School Age Child Care, and Summer/Holiday Day Camps (if participation is in personalized service like personal training, swim lessons or a program that is being ran by Independent Contractor, then the employee would pay cost incurred by YMCA).
    - Resident Summer Camps are available at a 40% discount.

FULL-TIME EMPLOYEES

- Full-time employees are eligible for a family membership.
- Unless otherwise mentioned, fee-based programs are free for full-time employees and their dependent family members (except for independent contractor ran programs or individualized services such as personal training, private swim lessons, early learning child care, and resident camp, then see discounts as stated above).
- Use of the Central Branch health center is available at no cost. Register by contacting the Central branch.

HEALTH SAVINGS AND SPENDING ACCOUNTS

HEALTH SAVINGS ACCOUNT

WHAT IS A HEALTH SAVINGS ACCOUNT?

A Health Savings Account, commonly known as an "HSA," is an individual account you can open, add money to, and spend on eligible healthcare expenses. If you elected the high deductible health plan, you are eligible for an HSA.

SETTING UP YOUR HSA

Once you are covered by a qualified health plan you may set up your HSA through Old National Bank. **If you are electing a YMCA of Greater Fort Wayne medical plan for the first time, you will need to open an HSA. Follow the instructions on The HSA Authority/Old National Bank document in your packet.** You will need to identify yourself as an employee of the YMCA of Greater Fort Wayne by entering the following Employer Code when prompted: 102012

Once you set up your HSA, any payroll deductions you have elected may begin. It is important to get your HSA set up as quickly as possible because you cannot turn in expenses incurred before the account was set up.

ADDING MONEY

The government sets the annual dollar maximum that can be contributed to an HSA depending on the level of coverage you have under your health insurance. Coverage of two or more people is considered family coverage. People who are age 55 or older can make additional catch-up contributions.

USING HSA MONEY

You decide when to spend money from your HSA. If you pay out of pocket for an eligible medical expense, you can choose to not reimburse yourself and let the money in your HSA build up or you can reimburse yourself for the expense from your HSA.

HSA Maximum 2022 Contribution Limits	
Employee Only	**$3,650**
Employee + Dependent(s)	**$7,300**

If you use your HSA money for expenses that are not eligible, you will pay a 20% penalty plus income tax on the amount. Once you turn age 65, you may use your HSA money for any expense, medical or not, but you will pay income taxes on those non-medical expenses. To view the full list of eligible expenses, visit **www.irs.gov/publications** and refer to Publication 969.

Note: It is your responsibility to familiarize yourself with IRS regulations on HSAS and maintain records of all transactions pertaining to your HSA for audit purposes.

ELIGIBLE EXPENSES

The money in your HSA must be used for eligible medical, dental, vision, and prescription drug expenses. In general, eligible expenses are those that qualify toward the deductibles, copays, and coinsurance with your health plan. If you use money for a dental, vision or medical expense that is not covered by the medical plan, it is important you understand your medical plan deductible still needs to be met if an expense is incurred.

PORTABILITY	FLEXIBILITY	TAX SAVINGS	PREMIUM SAVINGS
• You own 100% of the deposited funds, meaning if you change employers or retire, you do not lose the money in the accounts regardless of whether you contributed the money or if it was an employer contribution	• You can choose whether to spend the money on current medical expenses or you can save your money for future use • Any unused funds will automatically roll over to the following year as there is no "use it or lose it" provision	• Contributions are tax free (pre-tax through payroll deductions or tax deductible) • Earnings are tax free • Funds withdrawn for eligible medical expenses are tax free	• By choosing the HDHP available, your payroll premium cost is lower than the traditional PPO plan.

HEALTH SAVINGS ACCOUNT (Continued)

HEALTH SAVINGS ACCOUNT COMPANY CONTRIBUTIONS

	Company Contribution Legacy 5000 HSA H1	Company Contribution Legacy 3000 HSA H3	IRS Contribution 2021 Limit
Employee only	$100.00	$100.00	$3,600
Employee + Spouse	$200.00	$200.00	$7,200
Employee + Dependent(s)	$200.00	$200.00	$7,200

YOU CHOOSE HOW TO USE YOUR HSA DOLLARS

Spend Your Funds Today

Use your pre-tax HSA dollars to pay for eligible healthcare expenses such as your annual deductible, physician visits and prescription drugs.

Save for Tomorrow

Accumulate contributions and save them for future use. Any remaining funds at the end of each year roll over to the next. The money in your HSA is yours, even if you leave your employer.

Age 65 and HSAs:

Enrolling in Medicare ends your HSA eligibility in one of two ways:

- If Medicare is your only health insurance, you are no longer eligible to contribute to an HSA because Medicare is not a HDHP.
- If you have Medicare as secondary coverage in addition to an employer-sponsored HDHP, you will also lose HSA eligibility because you have "other coverage."

DENTAL COVERAGE

The following is a summary of your dental benefits. For a more detailed explanation of benefits, please refer to your benefit summary.

www.principal.com 800-247-6495

BENEFITS AT-A-GLANCE

	Dental PPO	
	In-Network	**Out-of-Network**
Type I—Preventive Services: Oral Exams, Bitewing X-Rays, Full Mouth X-Ray Prophylaxis Treatments, Fluoride Treatments, Space Maintainers, Sealants	100% coverage	95% coverage
Type II—Basic Services: Oral Surgery, Restorative, Endodontic Treatment, Periodontics Treatment, Re-linings and Re-basing of Existing Removable Dentures Repair or Re-cementing of Crowns, Inlays, Onlays, Dentures or Bridgework	80% after deductible	80% after deductible
Type III—Major Services: Crowns, Bridges, Dentures, Implants, TMJ Prosthodontics Benefits	50% after deductible	50% after deductible
Type IV—Orthodontics Up to age 19	50% coverage	50% coverage

DEDUCTIBLE *Waived for Preventive Services*	Calendar Year Deductible	
Individual	$50	$50
Family	$150	$150

MAXIMUM BENEFIT LIMITS		
Annual Limit: Basic and Major Services	$1,000	$1,000
Lifetime Limit: Orthodontics	$1,500	$1,500

THINKING IT THROUGH…

- Do you visit a dentist for regular cleanings and maintenance?
- What kind of dental expenses will you have next year?
- Do you expect to have certain dental procedures performed?
- Do you have dependents who will require orthodontia services?
- Does your dentist participate in the network?

INCOME PROTECTION BENEFITS

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Life insurance provides a monetary benefit to your beneficiary in the event of your death while you are employed at the company. Accidental Death and Dismemberment (AD&D) insurance is equal to your life insurance benefit amount and is payable to your beneficiary in the event of your death as a result of an accident and may also pay benefits in certain injury instances. Basic Group Term Life & AD&D Insurance is provided by the YMCA for employees and their dependents.

800-245-1522

BENEFITS AT-A-GLANCE

	LIFE AND AD&D COVERAGE
Life Insurance	**Employee**: $10,000 **Spouse**: $5,000 **Child**: 0 days, but less than 6 months: $1,000 6 months and older: $2,000
Accidental Death and Dismemberment	Employee: $10,000
Benefit Reduction Schedule	65% at age 65; 50% at age 70

VOLUNTARY LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Employees have the opportunity to elect to purchase Voluntary Life Insurance that provides an additional life insurance benefit for you, your spouse and/or your dependent child(ren). If you waive voluntary life coverage when you are initially eligible you will be required to provide ***Evidence of Insurability (EOI)*** *when enrolling at a later date. EOI is the documentation of good health in order to be approved for coverage. The carrier will review and determine approval based on EOI documentation*. Benefits may be limited and/or denied based on EOI results. Claims incurred prior to the approval of your coverage will not be covered. Voluntary Life & AD&D is voluntary and paid for by the employee.

800-245-1522

BENEFITS AT-A-GLANCE

	VOLUNTARY LIFE AND AD&D COVERAGE		
	EMPLOYEE	**SPOUSE**	**DEPENDENT CHILD(REN)**
Increments	Increments of $10,000	Increments of $5,000	$5,000 / $10,000
Guarantee Issue Amounts*	$100,000	$25,000	$10,000
Maximum	$300,000	$100,000	$10,000

** EOI not required*

LONG TERM DISABILITY

Long Term Disability Insurance provides income protection in the event you become disabled and are unable to work for an extended period of time. Long Term Disability Insurance is provided by the YMCA for employees.

800-245-1522

BENEFITS AT-A-GLANCE

Benefit Amount	60% of monthly earnings
Benefit Maximum	$6,000
Benefits Begin After	90 days
Maximum Benefit Period	Social Security Normal Retirement Age
Pre-Existing Waiting Period	Pre-existing condition limitations may apply for new hires or employees with less than 12 months of service.

This benefit is available after 1 month of employment.

YMCA of Greater Fort Wayne Employee Wellness Program

The Y exists to strengthen communities through youth development, healthy living and social responsibility. As a member of our Y family, we value your health and well-being. Our employee wellness program provides resources for you to support your well-being journey. The program offers resources through Activities, Physical Activity, Y Programs and Wellness Screening both inside and outside of the YMCA of Greater Fort Wayne for full-time and part-time employees. We encourage you to participate! Register in Daxko to get started.

Earns Points for Incentives

Employees can earn prizes and additional HSA contributions by participating in the Employee Wellness Program. The program is distributed annually in November, and employees must register in Daxko to participate. Points are earned throughout the year by completing monthly Physical Activity Logs (5-7 points based on minutes of activity), Health Screenings (1-3 points), Programs/Events (1-3 Points), and Special Challenges (5 Points Each), then submitting completed logs forms to Brian West.

See the Employee Wellness Program Document, your ADP Self-Service Portal, or contact Brian West brian_west@fwymca.org for more information.

Physical Activity

Document your physical activity each month with a physical activity log and turn in to Brian West at the Skyline Branch by the 10th of each month for point accumulation towards prize incentives.

- Full-time employees participating in health coverage through the YMCA of Greater Fort Wayne are eligible for additional contributions into their HSA.
  - Log at Least 300-599 min. per month and receive a $10/mo. HSA Contribution
  - Log at Least 600 min. per month and receive a $25/mo. HSA Contribution

Y Facility Use and Programs

As an employee, your Y membership has value. The value for full-time and part-time employees ranges from $906.00 to $588.00 per year depending on full-time or part-time status. We encourage you to make use of this benefit in support of your well-being journey. Some of the values available to you in our facilities are programs are (See Employee Handbook for details):

- Unlimited access to 8 branches
- Free child care in our Child Watch while you work out
- Unlimited participation in free group exercise classes like CycleFit, Zumba® and AquaFit every week for every fitness level!
- Free health and wellness consultations and the use of Mobile Fit (available at the Jorgensen and Parkview Branches), access to Fitness Coaches and Wellness for Life Orientation.
- Professionally trained staff to support you in your Y experience
- Free Blood Pressure Screening at any Branch Wellness Center
- Up to 50% discount off regular member rates for programs and individualized services such as: Personal Training, Swim Lessons, Early Learning Center fees, Before/After School Age Child Care, and Summer/Holiday Day Camps (if participation is in personalized service like personal training, swim lessons or a program that is being ran by Independent Contractor, then the employee would pay cost incurred by YMCA).
- Resident Summer Camps are available at a 40% discount.

Full-Time Employees

- Full-time employees are eligible for a family membership.
- Unless otherwise mentioned, fee-based programs are free for full-time employees and their dependent family members (except for independent contractor ran programs or individualized services such as personal training, private swim lessons, early learning child care, and resident camp, then see discounts as stated above).
- Use of the Central Branch health center is available at no cost. Register by contacting the Central branch.

Career Development & Training

All employees are encouraged to seek training opportunities to grow as an individual and provide our members and participants with the best service and experience while in our facilities and programs. Reimbursement is made for reasonable expenses for attendance at work-related conferences, seminars, conventions, and membership dues including travel expenses, lodging, and registration fees with the pre-approval of the immediate supervisor or Executive Director.

Cell Phone Reimbursement

Cell phone is necessary for some employees to carry out their day-to-day duties and to provide timely access. Cell phone usage will be reimbursed to certain employees based on the approval of the CEO. Levels of reimbursement are based on job position. Contact your Supervisor or Executive Director for more information.

Staff Recognition

The YMCA of Greater Fort Wayne encourages the recognition of individual and team accomplishments. The YMCA of Greater Fort Wayne specifically recognizes an employee's tenure milestones with the YMCA of Greater Fort Wayne of Greater Fort Wayne. Employees are recognized for every 5-year period of service.

Retirement

The Retirement Plan

The Retirement Plan is a 401(a) defined contribution, money purchase, church pension plan under which contributions plus Interest Credits are accumulated in individual accounts to provide benefits to eligible employees after they retire. Each employee of a YMCA of Greater Fort Wayne is eligible to participate in the Retirement Plan after he or she satisfies the Retirement Plan's service and age eligibility requirements. Upon satisfying the service and age eligibility requirements, the YMCA of Greater Fort Wayne will enroll you in the Retirement Plan. The YMCA of Greater Fort Wayne participates at a contribution rate of 12%.

An employee becomes eligible and is automatically enrolled in the Retirement Plan following age 21 and 1,000 hours in each of two years beginning on their date of hire or anniversary date. Once enrolled, you are immediately vested.

For complete details, see the Summary Plan Description for the YMCA of Greater Fort Wayne Retirement Fund Retirement Plan on the YMCA of Greater Fort Wayne Retirement Fund's website at www.yretirement.org. The YMCA of Greater Fort Wayne reserves the right to amend its participation in Plan at any time within the terms and conditions set by the YMCA of Greater Fort Wayne and the YMCA of Greater Fort Wayne Retirement Fund.

The Savings Plan

The Savings Plan is a 403(b) plan, which offers you a way to save additional money for your future, from your first day of employment at a YMCA of Greater Fort Wayne. The account is tax-deferred, so income taxes on contributions and earnings are postponed until you take a withdrawal or start your annuity. You can start, stop, or change the amount you want to save at any time.

As soon as you start working for a YMCA of Greater Fort Wayne, you can begin to save with a 403(b) Smart Account. You can also roll over money from eligible employer pension plans or certain IRAs to a Rollover Account. Contact Human Resources to enroll.

Holidays

All full-time employees receive paid holiday pay for holidays observed by the YMCA of Greater Fort Wayne. A schedule of holidays observed by the YMCA of Greater Fort Wayne will be issued annually by the CEO or designate. If a full-time, non-exempt employee is required to work on a holiday, time-off within that same work-week or pay will be arranged through a mutual agreement with the employee and the YMCA of Greater Fort Wayne.

The following holidays are observed by the YMCA of Greater Fort Wayne: New Year's Day, Martin Luther King Jr., Good Friday, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, Day after Thanksgiving, Christmas Eve, Christmas Day and New Year's Eve. If a full day holiday falls on a Saturday or Sunday or works on an observed holiday, the employee must schedule their holiday within the week the holiday falls or within the week immediately following. The day scheduled must be approved by the employee's supervisor.

Funeral Leave

Time off with pay will be granted to full-time employees to attend the funeral of an immediate family member (mother, father, sister, brother, child, grandchild grandparent, in-laws, husband/wife). Maximum time granted will be 5 days for each occurrence.

Vacation

The YMCA of Greater Fort Wayne believes that it is beneficial to both the full-time employee and the YMCA of Greater Fort Wayne that paid vacation is taken annually. Vacation is to be scheduled in advance and approved by your immediate supervisor. The vacation year runs from Jan. 1 through Dec. 31st; there will be no cash payment for unused vacation except during the year of termination or retirement (unless the employee does not complete one year of service). Unused earned vacation cannot be carried over into another calendar year.

The first year of vacation for full-time employees is pro-rated and is allocated based on the month of hire. Based on hire date, the first-year employee will receive the following vacation days their first year:

Hire Month	Vacation Days Received
January	10
February	10
March	9
April	8
May	7
June	6
July	5
August	4
September-October	3
November	2
December	1

Based on the employee's full-time service as of Dec. 31st, employees shall receive vacation in January based on the following schedule:

1-4 years of service = 10 days	5-9 years of service = 15 days
10-14 years of service = 20 days	15+ years of service = 25 days

Personal Time

Following three months of employment, full-time employees receive four (4) days of paid personal time each calendar year. Personal time is to be scheduled in advance and approved by your immediate supervisor. Personal time does not roll-over to a subsequent calendar year and is not paid upon termination.

Sick Time

Full-time employees who are absent due to personal illness or accident, or the illness of a spouse, parent, dependent child will receive compensation, based on accumulated sick leave at the time the incapacity begins. One sick day is accrued at time granted at full time hire, then time is accrued at the rate of one day for each completed month worked up to a maximum of 60 days. Sick leave is not paid upon termination.

HEALTH SAVINGS TIPS

STRETCHING YOUR HEALTHCARE DOLLAR

As healthcare costs continue to rise, it is increasingly important that you take an active role in decisions about your health, the care you receive and your benefits. Here are some tips to help get you the most for your money.

CHOOSE A PRIMARY CARE PHYSICIAN

Selecting a primary care physician is one of the best things you can do for your health. This person knows your health history and schedules routine screening tests that frequently help prevent and detect diseases, such as heart disease, cancer, and diabetes. Your PCP can provide necessary medical advice and identify health concerns before they become a major issue.

STAY IN-NETWORK

In-network providers have a contract with the health insurance company to provide services at reduced rates. In most cases, if you visit a physician or other provider within the network, the amount you will be responsible for paying will be less than if you go to an out-of-network provider.

DON'T SKIP PREVENTIVE CARE

Be sure your child gets routine checkups and vaccines as needed, both of which can prevent medical problems (and bills) down the road. Also, adults should get the preventive screenings recommended for their age in order to detect health conditions early.

PRICE COMPARE PRESCRIPTIONS

Ask your provider for the generic version of a prescription. If you order your maintenance medications in bulk (90-day supply) through mail order, search for the least expensive pharmacy option near you, or check to ensure prescribed medications are on the plan's formulary list.

LIVE A HEALTHY LIFESTYLE

Focus on eating nutritiously, cutting down on fast food and getting more physical exercise. Take advantage of tobacco cessation programs. Take a walk at lunch to manage stress. Striving toward a healthier lifestyle and maintaining a healthy weight can drastically reduce future medical conditions and diseases.

USE THE PLAN'S TOOLS & RESOURCES

Many health plans provide access to free disease management programs for chronic conditions like asthma, diabetes and heart disease. These programs can help you stay healthy and manage your condition and can possibly save you money in the long run. Look for other available resources or programs that are designed to prevent illness and lower health costs over the long run.

PRESCRIPTION OPIOID AWARENESS

BE INFORMED

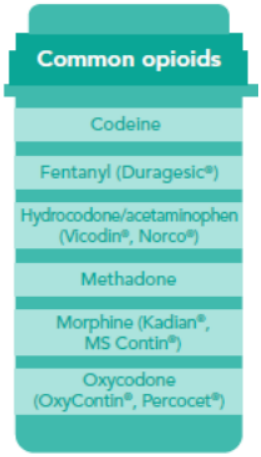
You've no doubt heard that there's a national opioid epidemic, affecting people of all ages and income levels. Someone you know – a friend, a family member or even a coworker – might be misusing, abusing or addicted to prescription painkillers.

WHAT'S AN OPIOID

Prescription opioids can be used to help relieve moderate-to-severe pain and are often prescribed following a surgery or injury, or for certain health conditions. These medications can be an important part of treatment but also come with serious risks. It is important to work with your healthcare provider to make sure you are getting the safest, most effective care.

KNOW YOUR OPTIONS

Before accepting a prescription, talk to your doctor:



· Make the most informed decision.
· Work with your doctor to create a plan on how to manage your pain.
· Know your options and consider ways to manage your pain that do not include opioids.
· Talk to your doctor about any and all side effects and concerns.
· Follow up regularly with your doctor.

IF YOU ARE PRESCRIBED OPIOIDS

Make sure you know the name of your medication, how much and how often to take it, and its potential risks & side effects.

Never take opioids in greater amounts or more often than prescribed.

Avoid taking opioids with alcohol and other substances or medications you have not discussed with your doctor.

Store prescription opioids in a secure place and out of reach of others (this may include visitors, children, friends, and family).

Safely dispose of unused prescription opioids.

SIDE EFFECTS

Prescription opioids carry serious risks of addiction and overdose, especially with prolonged use. An opioid overdose, often marked by slowed breathing, can cause sudden death. The use of prescription opioids can have a number of side effects as well, even when taken as directed:

Tolerance	Sleepiness/dizziness
Physical dependence	Confusion
Increased sensitivity to pain	Depression
Constipation	Itching and sweating
Low levels of testosterone	
Nausea, vomiting and dry mouth	

ALTERNATIVES FOR PAIN MANAGEMENT

Talk with your doctor about the benefits of using one of the below methods if you suffer from chronic pain. Some of the options may even work more effectively than opioids, depending on the type of pain. Here are some of the alternative solutions proposed by the CDC:

- Acetaminophen (Tylenol) or ibuprofen (Advil)
- Cognitive behavioral therapy—a psychological, goal-directed approach in which patients learn how to modify physical, behavioral, and emotional triggers of pain and stress
- Exercise therapy, including physical therapy
- Medications for depression or for seizures
- Interventional therapies (injections)
- Exercise and weight loss
- Other therapies such as acupuncture and massage

HOW TO GET HELP

If you believe you or a loved one may be struggling with addiction, tell your health care provider and ask for guidance or call the Substance Abuse and Mental Health Services Administration (SAMHSA) National Helpline at 1-800-662-HELP (4357). Be Informed!

IMPORTANT TERMS

Balance Billing When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. An in-network provider typically may not balance bill you for covered services.

Brand A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine. You generally pay a higher copay for brand name drugs and your employer pays a higher amount when the claim is paid as well.

Coinsurance After you meet the deductible amount, you and the plan share the cost of covered expenses. Coinsurance is always a percentage totaling 100%. For example, if your plan pays 70% coinsurance, you pay the remaining coinsurance share, 30% of the cost.

Copayment or Copay A form of medical cost-sharing whereby a member pays at time of service (or purchase for prescription drugs) a fixed dollar amount, regardless of whether you have met your deductible for the year.

Deductible The fixed amount of cost-sharing you are responsible for during the benefit period before the plan will pay. The deductible typically does not apply to preventive care and certain other services. Plans may have both per individual and family deductibles. Deductibles may differ if services are received in-network versus out-of-network.

Evidence of Insurability (EOI) A medical questionnaire used to determine whether an applicant will be approved or declined for coverage. This may be required for certain types of insurance coverage.

Explanation of Benefits (EOB) The statement made available to a member by their carrier after services have been received and the claim has been processed, which lists the services received, amount paid by the plan, and the amount to be paid by the member.

Flexible Spending Accounts Health or Dependent Care (HCFSA or DCFSA): An account you put money into that you use to pay for certain out-of-pocket health or childcare costs with pre-tax dollars. This means you'll save an amount equal to the taxes you would have paid on the money you set aside. Funds deposited into a health FSA will be forfeited if you do not use them by the IRS deadline.

Formulary A list of prescription drugs covered by the plan that will be used to determine the coverage for the drug based on the tier the drug is listed.

Generic Medications that have the same active ingredients, dosage, and strength as their brand-name counterparts. Generic drugs generally have the same efficacy as their brand name counterparts at a much lower cost for you and your employer.

Guaranteed Issue When an insurance policy is offered to any eligible applicant without regard to the health status of the individual that applies. Typically, no health questionnaires (EOI) or exams are required.

Health Savings Account (HSA) A tax-free, individually-owned savings account used to pay for you and your eligible dependents' insurance deductibles and qualified out-of-pocket medical, dental and vision expenses. Account owners must be enrolled in a high deductible health plan and have no access to first dollar coverage such as Medicare or Direct Primary Care. Money deposited in an HSA stays with you, regardless of employer or plan, and unused balances roll over year to year. The employer and the employee can contribute to the HSA up to the annual limit for an individual or a family as stated by IRS guidelines.

High Deductible Health Plan (HDHP) Also called a "Consumer Driven Health Plan" (CDHP), has lower premiums and higher deductibles than a traditional health plan. With the exception of preventive care, employees must meet the annual deductible before the plan pays benefits even for office visits and prescriptions.

In-network Doctors, clinics, hospitals and other providers with whom the plan has an agreement to care for its members. Plans cover a greater share of the cost for in-network providers than for providers who are out-of-network and the member pays a lower amount for those services.

Mandatory Generic When you request a brand name drug when there is a generic equivalent, you pay the generic copay plus the cost difference between the brand and generic drug. Dispense as written (DAW) may be allowed. With DAW you will not be charged a cost difference if DAW is written indicated by the prescribing physician.

Non-Preferred Brands These medications generally have generic alternative and/or one or more preferred brand options within the same drug class which causes these drugs to cost more. You and your employers usually pay more for non-preferred brand medications. Also known as non-formulary brands.

Out-of-Network A physician, healthcare professional, facility or pharmacy that doesn't participate in the plan's network and doesn't provide services at a discounted rate. Using an out-of-network healthcare professional or facility will cost you more.

Out-of-Pocket Maximum The maximum dollar amount a member is required to pay out of pocket for allowable covered expenses under a plan during a benefit period before the plan will pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or services your plan doesn't cover. Some plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.

Preferred Drug A list of prescription medicines that are preferred based on an evaluation of effectiveness and cost. Another name for this list is a "formulary" or "formulary brand." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs not on the preferred drug list may not be covered.

Payroll Deduction The amount you pay out of your paycheck in order to be enrolled in the medical, dental and/or vision insurance plans and possible other offered benefits.

Prior Authorization/Pre-Service Notification The decision by the plan that a service, treatment plan, prescription drug, medical equipment, or other services defined in the certificate of coverage and/or Summary Plan Description (SPD), is medically necessary. The plan may require preauthorization for certain services before receiving them, in order for the service to be covered.

Provider A physician (medical, dental or vision), healthcare professional or health care facility licensed, certified or accredited as required by state law recognized for payment by the plan.

Qualifying Event An occurrence defined by IRS Section 125 such as marriage/divorce, death, termination of employment, child birth/adoption, involuntary loss of coverage, etc. which triggers an employee's ability to make changes to their benefit elections at the time the qualifying event occurs outside of open enrollment.

Usual, Customary and Reasonable (UCR) The determined going rate for a service in a geographic area based on what providers in the area usually charge for the same or similar service. The UCR amount is sometimes used to determine the allowed amount and is used typically when services are provided by an out-of-network provider.

Note to All Employees

Certain Federal Regulations require employers to provide disclosures of these regulations to all employees. The remainder of this document provides you with the required disclosures related to our employee benefits plan. If you have any questions or need further assistance, please contact your Plan Administrator as follows:

January 1, 2021

YMCA of Greater Fort Wayne
Human Resources
347 West Berry Street
Fort Wayne, Indiana 46802
260-918-2152

Notice Regarding Special Enrollment Rights

If you do not timely or properly complete the enrollment process, you and your Eligible Dependents generally will not be covered under the applicable Plan for the remainder of the Plan Year, except as described below. Also, if you fail to specifically enroll your Eligible Dependents on the enrollment form, your Eligible Dependents will not be covered under the applicable Plan for the remainder of the Plan Year, except as otherwise provided below.

(a.) If you decline enrollment for yourself or your dependents because you or your dependent had other health insurance or group health plan coverage, either through COBRA or otherwise, you may enroll yourself and Eligible Dependents in the Health Program within **30 days** of the loss of that coverage. For this purpose, "loss of coverage" will occur if the other group health plan coverage terminates as a result of: (i) termination of employer contributions for the other coverage; (ii) exhaustion of the maximum COBRA period; (iii) legal separation or divorce; (iv) death; (v) termination of employment; (vi) reduction in hours of employment; or (vii) failure to elect COBRA coverage.

However, a loss of coverage will not be deemed to occur if the other coverage terminates due to a failure to pay premiums or termination for cause. At the time you enroll in the Employer's Plan, you must provide a written statement from the administrator of the other health plan that you no longer have that coverage.

(b.) You are eligible to enroll yourself and your Eligible Dependent in the Health Program within **30 days** of the date you acquire a new Eligible Dependent through marriage, birth, adoption or placement for adoption. Your enrollment will become effective on the date of marriage, birth, adoption or placement for adoption.

(c.) You are eligible to enroll yourself and your Eligible Dependent in the Plan within **60 days** after either:

(1.) You or your Eligible Dependent's Medicaid coverage under title XIX of the Social Security Act or CHIP coverage through a State child health plan under title XXI of the Social Security Act is terminated as a result of loss of eligibility for such coverage; or

(2.) You or your Eligible Dependent is determined to be eligible for employment assistance under Medicaid or CHIP to help pay for coverage under the Plan.

Notice Regarding Women's Health and Cancer Rights Act (Janet's Law)

On October 21, 1998, Congress passed a Federal Law known as the Women's Health and Cancer Rights Act. The law includes important new protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and patient, for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas

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

If you would like more information on WHCRA benefits, please call your plan administrator.

Notice Regarding Michelle's Law

On Thursday, October 9, 2008, President Bush signed into law H.R. 2851, known as Michelle's Law. This law requires employer health plans to continue coverage for employees' dependent children who are college students and need a medically necessary leave of absence. This law applies to both fully insured and self-insured medical plans.

The dependent child's change in college enrollment must meet the following requirements:

The dependent is suffering from a serious illness or injury.

The leave is medically necessary.

The dependent loses student status for purposes of coverage under the terms of the plan or coverage.

Coverage for the dependent child must remain in force until the earlier of:

- One year after the medically necessary leave of absence began.
- The date the coverage would otherwise terminate under the terms of the plan.

A written certification by the treating physician is required. The certification must state that the dependent child is suffering from a serious illness or injury and that the leave is medically necessary. Provisions under this law became effective for plan years beginning on or after October 9, 2009.

HIPAA Privacy

The Plan complies with the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These requirements are described in a Notice of Privacy Practices that was previously given to you. A copy of this notice is available upon request.

Health Insurance Marketplace Coverage Options and Your Health Coverage

There is an additional way to buy health insurance: The **Health Insurance Marketplace**. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

Each year, the open enrollment period for health insurance coverage through the Marketplace runs from Nov. 1 through Dec. 15 of the previous year. After Dec. 15, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

Can I Save Money on my Health Insurance Premiums in the Marketplace?

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

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.83 percent of your household income for 2021 (9.78 percent for 2020), or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **www.HealthCare.gov** for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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	**FLORIDA – Medicaid**
Website: **http://myalhipp.com/** Phone: 1-855-692-5447	Website: **http://flmedicaidtplrecovery.com/hipp/** Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – 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://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp** Phone: 678-564-1162 ext 2131
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: **http://myarhipp.com/** Phone: 1-855-MyARHIPP (855-692-7447)	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: **http://www.indianamedicaid.com** Phone 1-800-457-4854
CALIFORNIA – Medicaid	**IOWA – Medicaid**
Website: **https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx** Phone: 916-440-5676	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
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**KANSAS – Medicaid**
Health First Colorado: **https://www.healthfirstcolorado.com/** Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: **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	Website: **http://www.kdheks.gov/hcf/default.htm** Phone: 1-800-792-4884

KENTUCKY – Medicaid	NEW HAMPSHIRE – 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: h**ttps://kidshealth.ky.gov/Pages/index.aspx** Phone: 1-877-524-4718 Kentucky Medicaid Website: **https://chfs.ky.gov**	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
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: **www.medicaid.la.gov** or **www.ldh.la.gov/lahipp** Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	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
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: **http://www.maine.gov/dhhs/ofi/public-assistance/index.html** Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: **https://www.maine.gov/dhhs/ofi/applications-forms** Phone: 1-800-977-6740 TTY: Maine relay 711	Website: **https://www.health.ny.gov/health_care/medicaid/** Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA - Medicaid**
Website: **http://www.mass.gov/eohhs/gov/departments/masshealth/** Phone: 1-800-862-4840	Website: **https://medicaid.ncdhhs.gov/** Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA - 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: **http://www.nd.gov/dhs/services/medicalserv/medicaid/** Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: **http://www.dss.mo.gov/mhd/participants/pages/hipp.htm** Phone: 573-751-2005	Website: **http://www.insureoklahoma.org** Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: **http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP** Phone: 1-800-694-3084	Website: **http://healthcare.oregon.gov/Pages/index.aspx** **http://www.oregonhealthcare.gov/index-es.html** Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: **http://www.ACCESSNebraska.ne.gov** Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: **https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx** Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Medicaid Website: **http://dhcfp.nv.gov** Medicaid Phone: 1-800-992-0900	Website: **http://www.eohhs.ri.gov/** Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: **https://www.scdhhs.gov** Phone: 1-888-549-0820	Website: **https://www.coverva.org/hipp/** Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON - Medicaid**
Website: **http://dss.sd.gov** Phone: 1-888-828-0059	Website: **http://www.hca.wa.gov/** Phone: 1-800-562-3022
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: **http://gethipptexas.com/** Phone: 1-800-440-0493	Website: **http://mywvhipp.com/** Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: **https://medicaid.utah.gov/** CHIP Website: **http://health.utah.gov/chip** Phone: 1-877-543-7669	Website: **https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf** Phone: 1-800-362-3002
VERMONT - Medicaid	**WYOMING – Medicaid**
Website: **http://www.greenmountaincare.org/** Phone: 1-800-250-8427	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)

Medicare Notice

You must notify YMCA of Greater Fort Wayne when you or your dependents become Medicare eligible. YMCA of Greater Fort Wayne is required to contact the insurer to inform them of your Medicare status. Federal law determines whether Medicare or the group health plan is the primary payer. You must also notify Medicare directly that you have group health insurance coverage. Privacy laws prohibit Medicare from discussing coverage with anyone other than the Medicare beneficiary or their legal guardian. The toll-free number to Medicare Coordination of Benefits is 1-855-797-2627.

If you have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices in your prescription drug plan. Please see the complete Medicare Part D Coverage Notice that follow.

MEDICARE-CREDITABLE NOTICE BEGINS

Medicare Part D Coverage Notice – Important Information About Your Prescription Drug Coverage and Medicare

Please note that the following notice only applies to individuals who are or will become eligible for Medicare in the next 12 months.

Medicare eligible individuals may include employees, spouses or dependent children who are Medicare eligible for one of the following reasons.

- Due to the attainment of age 65
- Due to certain disabilities as determined by the Social Security Administration
- Due to end-stage renal disease (ESRD)

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

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

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

When Can You Join a Medicare Drug Plan?

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

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

If you decide to join a Medicare drug plan, your current coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. The prescription drug coverage is part of the Group Health Plan and cannot be separated from the medical coverage. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. You have the option to waive the coverage provided under the Group Health Plan due to your eligibility for Medicare. If you decide to waive coverage under the Group Health Plan due to your Medicare eligibility, you will be entitled to re-enroll in the plan during the next open enrollment period.

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 and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join

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

For More Information About This Notice or Your Current Prescription Drug Coverage

Contact your HR Representative. You will receive this notice each year and again, if this coverage through your company 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, visit U.S. Social Security Administration's at **www.socialsecurity.gov** or call 1-800-772-1213 (TTY 1-800-325-0778).

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

Wellness Program Privacy Notice

The YMCA of Greater Fort Wayne offers a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you may be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for cholesterol, glucose, and other standard blood chemistry measures. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will be eligible for a grand prize drawing reward at the end of the year for earning at least 66 points (see page 10 for details). You are not required to complete the HRA or participate in the biometric screening. Only employees who earn 66 points will be eligible for the reward.

Additional incentives and rewards may be available for employees who participate in certain health-related activities. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the Wellness Program Administrator.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks and may also be used to offer you services through the wellness program, such as health coaching or lifestyle improvement opportunities. You also are encouraged to share your results or concerns with your own doctor.

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and the YMCA of Greater Fort Wayne may use aggregate information it

collects to design a program based on identified health risks in the workplace, the wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are the health screening provider in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the wellness program administrator, refer to your wellness program document, or log into the self-service portal.

COBRA NOTICE

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. If you're an associate, 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 associate, 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-associate dies;
The parent-associate's hours of employment are reduced;
The parent-associates employment ends for any reason other than his or her gross misconduct;
The parent-associate 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 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 associate;
Commencement of a proceeding in bankruptcy with respect to the employer; or
The associate's becoming entitled to Medicare benefits (under Part A, Part B, or both).

You Must Give Notice of Some Qualifying Events

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

Notification should be in writing and include official documentation of qualifying event

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered associates 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 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. Please provide Social Security disability determination confirmation to Infinisource.

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 associate or former associate 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.

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.

Notice of Rescission of Coverage

Under Health Care Reform, your coverage may be rescinded (i.e., retroactively revoked) due to fraud or intentional misrepresentation regarding health benefits or due to failure to pay premiums. A 30-day advance notice will be provided before coverage can be rescinded.

Summary of Benefits & Coverage (SBC)

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

The Summary of Benefits & Coverage (SBC) is a document intended to help people understand their health coverage and compare health plans when shopping for coverage. The federal government requires all healthcare insurers and group healthcare sponsors to provide this document to plan participants. SBCs will be created for each medical plan offered. Group health plan sponsors must provide a copy of the SBC to each employee eligible for coverage under the plan. The SBC includes:

- A summary of the services covered by the plan
- A summary of the services not covered by the plan
- A glossary of terms commonly used in health insurance
- The copays and/or deductibles required by the plan, but not the premium
- Information about members' rights to continue coverage
- Information about members' appeal rights
- Examples of how the plan will pay for certain services