



November 8 - November 22, 2022

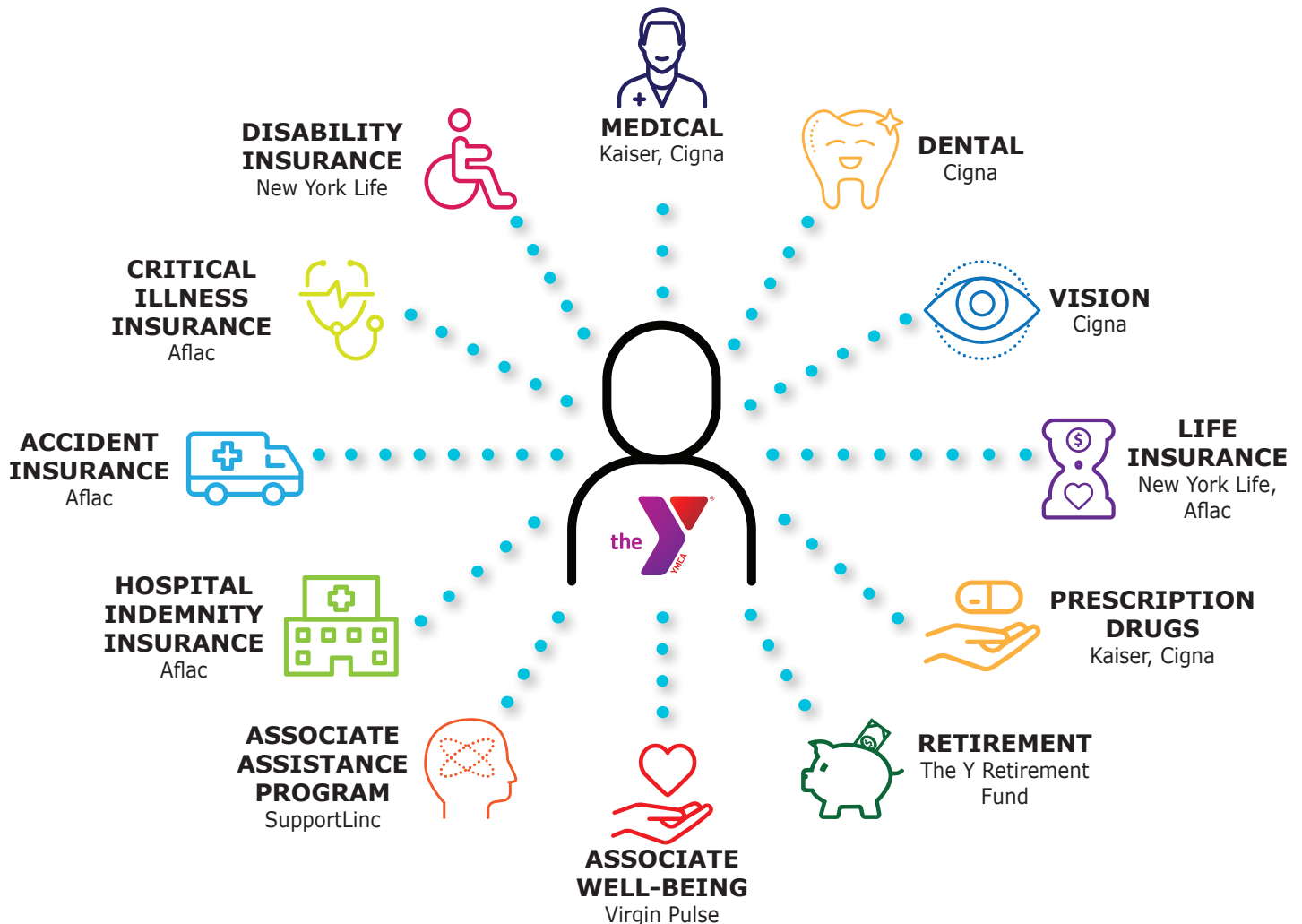
***ALL IN ON LIVING
YOUR BEST LIFE!***

Welcome

The Y in Central Maryland works hard to provide affordable yet comprehensive benefit options for our associates. Not everyone has the same needs when it comes to insurance so we provide a variety of plans to choose from. Your medical costs include not only what comes out of your paycheck each pay period but also your portion of the costs when seeking care.

We encourage you to participate in our Associate Well-being program. In addition to helping support your health and wellness, you can significantly reduce the cost of insurance that comes out of your paycheck just by doing a few simple things.

We hope you take the time to review this guide, discover all the benefit options that are available to you and choose the plan(s) that fit your needs. Our associates are the foundation upon which we serve the community, and as a result, the Y is **"All In On Living Your Best Life!"**



This benefits guide describes the highlights of our benefits in non-technical language. Specific rights to benefits under the plan are governed solely, and in every respect, by the official documents and not the information in this summary. If there is any discrepancy between the descriptions of the programs as contained in this brochure and the official plan documents, the language of the official document shall prevail as accurate. Please refer to the plan-specific documents for detailed plan information. Any plan benefits may be modified in the future to meet Internal Revenue Service rules or otherwise as decided by Y in Central Maryland.

What's Inside & Helpful Apps

What's Inside

Welcome	2
What's Inside and Helpful Apps	3
Where to Go for Help	4
What You Need to Know for 2023	5
Common Benefits Terminology	6
Bonus Benefits	7
Eligibility and Enrollment	8
Eligibility	
Enrollment Instructions	
Qualified Life Status Changes	
Associate Well-Being Experience	9
Associate Assistance Program - NEW!	10
Financial Well-Being & Benefit Hub	11
Voluntary Benefits	12
Accident Insurance	
Critical Illness Insurance	
Hospital Indemnity Insurance	
Whole Life Insurance	

Medical: Cigna - NEW!	14
Medical: Kaiser	16
Virtual Visits	18
Know Your Care Options	18
Payroll Deductions: 12 month	19
Payroll Deductions: 10 month	20
Dental: Cigna	21
Vision: Cigna - NEW!	22
Flexible Spending Accounts	23
Supplemental Life & AD&D	24
Employer Provided Benefits	25
Required Notices	26

Helpful Apps



Kaiser Permanente

Once you have registered on kp.org, you can download the mobile app. You will log in using your kp.org user ID and password. The app provides much of the same functionality as the website but can also let you view and pay bills, check in for appointments and set reminders for prescriptions.



MyCigna (Medical/Dental/Vision)

The myCigna app helps you personalize, organize and access your important plan information on your mobile device. You can: manage and track claims; view, fax or email ID card information; find in-network doctors, and compare cost and quality information; review your coverage; track account balances and deductibles; order your Cigna Home Delivery pharmacy prescriptions online and view order history; and view medication costs based on your plan and look for lower-cost alternatives.



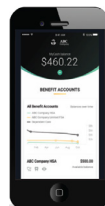
Well-being Program (Virgin Pulse)

Access your well-being program, track your progress, reach your goals and earn those rewards—all from one place!



SupportLine

Get help navigating life challenges with confidential support from licensed counselors, as well as expert content.



TASC

Use the TASC app to access your Flexible Spending account. Use Picture to Pay to request reimbursement, check to see if an expense is eligible for reimbursement or use the TASC Wallet feature to manage all aspects of your account.



GoodRx

- Compare prices at retail pharmacies to find the lowest cost
- Take advantage of discounts on certain prescriptions
- Find information on side effects, dosage and more



BenefitHub

Find deals and discounts on the go.

Where To Go For Help

If you have questions about...	Contact	Phone Number	Website or Email
Medical/Prescription Drug/Vision/Dental			
Kaiser HMO Plan	Kaiser Customer Service	800-777-7902	kp.org
	Medical Advice Line	800-777-7904	
	Away From Home Travel Line	951-268-3900	kp.org/travel
Cigna Medical Plans	Cigna Customer Service 24/7/365	800-CIGNA24 (800-244-6224)	mycigna.com
Cigna Dental			
Cigna Vision		877-478-7557	
If you are not currently a Cigna member, please call 888-806-5042			
Associate Well-Being			
Associate Well-Being Experience	Virgin Pulse/Labcorp Employer Services	855-913-0578	member.virginpulse.com/ yincentralmaryland Support@LEScustomercare.zendesk.com
Assistance and Work/Life Program	SupportLinc (CuraLinc)	888-881-LINC (5462)	supportlinc.com Employer Code: ycmd
Financial Resources			
403(b) Plan	YMCA Retirement Fund (Smart Account)	800-738-9622	yretirement.org
My Secure Advantage (Financial Wellness, Will Prep, ID Theft, Money Coaching)	New York Life	888-724-2262	nylgbs.mysecureadvantage.com
Life, Disability and FMLA Resources			
FMLA/Disability Claims	New York Life	888-842-4462	mynylgbs.com
Life/AD&D Claims	New York Life	800-362-4462	nyl.com/customer-forms
Voluntary Benefits			
Voluntary Benefits (Life with LTC, Accident and Critical Illness)	The Warner Companies	866-870-5093	voluntarybenefits@lwarner.com
Value Added Benefits			
Flexible Spending Accounts (FSA)	TASC	800-422-4661	uba.tasconline.com
Veteran Support Resource	Cigna	855-244-6211	
Travel Assistance	Secure Travel	888-226-4567 group #57	
BenefitHub	Discount portal Voluntary Benefits (Auto, Home, Pet, ID Theft)	866-664-4621	ymaryland.benefithub.com
General Questions	Benefits		benefits@ymaryland.org

What You Need to Know for 2023



Open Enrollment Information

- Open Enrollment begins **Tuesday, November 8** and ends **Tuesday, November 22, 2022**.
- Open Enrollment is **ACTIVE** which means you must log on to Dayforce to **review** or **elect** your benefits. If you do not take any action, you will not have **any** benefits effective January 1, 2023.

Important Benefit Plan Changes

There are a few changes to the benefit offerings this year:

- Associate payroll deductions for all medical plans and the vision plan have been **DECREASED**. Dental payroll deductions will remain the same. See pages 19-20 for more information.
- Cigna will replace United HealthCare as the medical and vision carrier.
- SupportLinc will be offered to **all associates** and will replace the Employee Assistance Program with Cigna.

Speak to a Benefit Counselor

- Benefit Counselors from The Warner Companies will be available to meet with associates to discuss the Voluntary benefit options and answer questions about all benefits offered by the Y.
- You can schedule a virtual or in-person meeting by visiting:
<https://www.eznetscheduler.com/Calendar/ymaryland>
- You can also schedule an appointment by calling 1-866-870-5093.
- All associates who meet or speak with a Benefit Counselor will be entered into a raffle for prizes!

Common Benefits Terminology

Components of Most Health Plans

Copay

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible

The amount you owe for health care services before your healthcare plan begins to pay. For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible. The deductible may not apply to all services. A deductible does not apply for preventive services.

Out of Pocket

The most you pay during the policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Your deductibles and co-insurance payments typically will go towards your out of pocket limit.

Premium

The cost of your insurance.

Co-Insurance

Your share of the costs of a covered health care service, calculated as a percentage of the allowed amount for the service (for example, 20%). You typically pay co-insurance after satisfying any deductibles.

Provider Types

Non-Preferred Provider

A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider or in some plans, visits to non-preferred providers are not covered at all.

Preferred Provider

A provider who has a contract with your health insurer or plan to provide services at an agreed upon rate, typically called the "allowed amount".

Other Insurance Terms

Allowed Amount

The amount agreed upon by the healthcare provider and healthcare plan. It's the amount on which payment is based for covered healthcare services. This may be called "eligible expense," "payment allowance" or "negotiated rate." For example, a provider may charge \$200 for an office visit to those without insurance; but if you are covered by the health plan, the allowed amount is \$100. If your provider charges more than the allowed amount, you may have to pay the difference if you are using an out-of-network provider.

Preventive Care

Care that is covered at 100% with no deductible, coinsurance or copays when provided by an In-Network physician. Preventive care includes periodic well visits, routine immunizations and routine screenings provided to you when you do not have symptoms or have not been diagnosed with a disease. For individuals at increased risk for a particular disease, additional immunizations and screenings may be included.

Bonus Benefits

Many of our benefit offerings include coverage, programs or services that many associates may not be aware of. To ensure you are making the most of your benefit elections, we have highlighted a few of these below. We encourage you to register on the insurance company's website or download their mobile app to ensure you can access these valuable programs.



- **Cigna Lifestyle Management Programs:** These programs are available at **no additional cost to you**. Each program is available when you need it and are available online or via the phone. You will have access to one-on-one wellness coaching, as well as a program workbook and interactive toolkit.
 - **Weight Management:** Reach your goal of maintaining a healthy weight—all without fad diets.
 - **Tobacco Cessation:** Get the help you need to finally quit tobacco.
 - **Stress Management:** Get help lowering your stress levels and raising your happiness levels.
- **Healthy Rewards Discount Program:** Start saving today with Cigna Healthy Rewards. Just use your Cigna ID card when you pay and let the savings begin. Get discounts on health products and programs such as:
 - Nutritional Meal Delivery Service
 - Vision Care, Lasik Surgery,
 - Yoga Products and Virtual Workouts
 - Fitness Memberships and Devices
 - Hearing Aids
 - Alternative Medicine

Visit [myCigna.com](https://mycigna.com) and navigate to "Healthy Rewards Discount Program" or call 800-870-3470.

- **Dental—Oral Health Integration Program:** For members with certain medical conditions, you may be more likely to experience dental problems. This program will provide reimbursement to members for out-of-pocket costs incurred for additional preventive dental treatments. To enroll in the program or see if you qualify, visit mycigna.com, select "Coverage" and "Dental" and complete the online registration form. You can also contact Cigna by calling 800-244-6224.



- **Free Flu Shots:** You can get your flu shot from your Kaiser doctor or at a Kaiser Center. Visit kp.org/flu for all available locations.
- **Self Care Apps:** Members can access three free apps to aid in self-care. *Calm* focuses on meditation, mental resilience, and sleep; *myStrength* helps improve awareness and ways to deal with daily stressors; and, *Ginger* provides 90 days of free coaching for many of life's challenges. More details can be found at kp.org/selfcareapps.
- **Chat with a Nurse:** Members can chat virtually with licensed care providers using kp.org or the mobile app, **all at no cost**. This service offers the same benefits as the 24/7 advice line, including quick advice and referrals. Members can also share pictures through the chat and see their complete chat history.
- **ClassPass:** Kaiser members can access over 4,000 online fitness classes at no cost and get 20% off a monthly package for livestreamed classes. Visit kp.org/exercise for more information.



If you have an Aflac plan, you have access to both of the value added services below:

- **Financial and Legal Fitness:** Phone sessions with licensed, professional counselors who can provide guidance for nearly any financial or legal matter at no cost to you.
- **Medical Bill Saver:** Health Advocate gives you access to skilled negotiators who can help reduce your out-of-pocket costs from bills you incur from out-of-network providers or care not covered by insurance.

Eligibility & Enrollment

Eligibility

Associates working **35 hours or more per week** are eligible for all benefits.

In addition to enrolling yourself, you may also enroll eligible dependents in the Medical, Dental, Vision and Supplemental Life plans.

Eligible dependents include:

- Legal spouse
- Dependent children and step children, including court appointed guardianship, up to the age of 26 regardless of marital status, student status or financial dependency. Coverage ends the last day of the month in which the child turns 26.

Associates working an average of **30-34 hours per week** are eligible for Medical, Dental and Vision benefits.

Associates working an average of **20 hours per week** are eligible for Voluntary benefits.

Enrollment Instructions for Dayforce

To begin your enrollment from the Home Page, click on **Benefits** and then select the Enrollment event assigned to you.

- 1. Associate Information:** Review your personal information for accuracy.
- 2. Dependent/Beneficiary Information:** Add or edit dependent/beneficiary information as necessary.
- 3. Enroll:** The enrollment process will guide you through each benefit you are eligible to elect. The employer-paid plans are automatically elected for you.
- 4. Confirm:** Review your benefit elections for accuracy before clicking on **Submit Enrollment**. Once you have submitted your enrollment please print and keep a copy of your confirmation page.

Qualified Life Status Changes

Benefit elections will stay in place until the next Open Enrollment period unless you have a qualified life status change as defined by the IRS. Examples of qualified life status changes are:

- Marriage, legal separation, or divorce
- Birth or adoption of a child
- Change in eligibility of a child
- Death of a dependent
- Change in you/your spouse's employment status
- Change to your spouse or dependent's employer's plan during an open enrollment period
- When you, your spouse or your dependent becomes entitled to coverage or loss of eligibility for coverage under Medicare or Medicaid

How Do I Request a Life Status Change?

- 1** You must notify the Y's Benefits Specialist within 31 days of the Qualified Life Status Change in order to make benefit elections.
- 2** You must complete a Life Event/Status Change form in Dayforce and submit it along with proper backup documentation.
- 3** Acceptable documentation includes proof of birth from the hospital, adoption papers, divorce decree, proof from spouse's or dependent's employer of gain or loss of group coverage with the effective date, proof of gaining or losing CHIP, Medicaid or Medicare coverage with the effective date.

Associate Well-Being Experience

The Y in Central Maryland is excited to continue our Associate Well-Being Experience. **The experience is voluntary and all full-time benefits-eligible Y associates can participate, whether you are on the Y's Medical benefits or not.**

If you earn 600 points from January 1, 2023 – September 15, 2023, you will pay less for the medical plan in 2024. While future incentives cannot be guaranteed, currently associates receive **up to \$121 per month** for fulfilling the requirements of our well-being experience.

Below are some of the ways you can earn points. The program is reviewed often and additional opportunities may be added during the plan year. Logon to the Well-Being portal for the latest information and a host of wellness resources.

Ways to Earn Points:

Once	Complete A Biometric Screening	100 points
	Complete The Health Check Survey	100 points
	Track Steps At Least Once Per Week For All Weeks Of The Annual Challenge	100 points
	Complete A Preventive Visit*	100 points each
	Complete An Age Appropriate Screening**	25 points each
Monthly	Participate In A Y Wellness Event And/Or Volunteer***	50 points each
	Participate In A Y Wellness Event (Tracked Through Sign In Sheet)	50 points each
	Win Promoted Healthy Habit Challenge	10 points each
	Create A Personal Challenge	10 points each
	Join A Personal Challenge	10 points each
	Track Steps Or Active Minutes 20 Days/Month	20 points each
Quarterly	Complete a Journey	25 points each

*Includes annual physical, vision exam and dental exam

**Includes mammogram, colonoscopy, PSA, PAP and other appropriate screenings

***Includes Turkey Trot, wellness expo, Associate Resource Group participation and volunteer event

If you are new to the Well-Being Experience, visit join.virginpulse.com/yincentralmaryland to get started.

If you already have joined, login to your profile at member.virginpulse.com/yincentralmaryland.

Questions regarding your account can be directed to wcs.support@virginpulse.com or you can call 855-913-0578.



Associate Assistance Program (AAP) - SupportLinc

NEW

At some point in our lives, each of us faces problems or situations that are difficult to resolve. The Y is proud to offer our associates a program to help provide support when you need it. Introducing **SupportLinc**!!

The **SupportLinc** Associate Assistance Program (AAP) is a **confidential** resource that helps you deal with life's challenges and the demands that come with balancing home and work. SupportLinc provides confidential, professional referrals and **up to six (6) sessions of face-to-face or virtual counseling sessions** for a wide variety of concerns, such as:

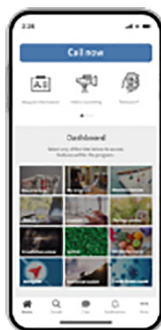
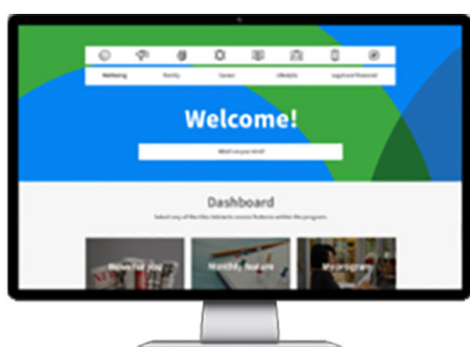
- Anxiety
- Depression
- Marriage and Relationship Problems
- Grief and Loss
- Substance Abuse
- Anger Management
- Stress
- Financial Assistance
- Legal Assistance
- Family Assistance

The SupportLinc program includes the following services/resources:

- In-the-moment support: Reach a licensed clinician by phone 24/7/365 for immediate support.
- Short-term counseling: Access in-person or video counseling sessions to resolve concerns such as stress, anxiety, depression, relationship issues, work-related pressures, or substance abuse.
- Financial expertise: Planning and consultation with a licensed financial counselor.
- Legal consultation: By phone or in-person with a local attorney.
- Convenience resources: Referrals for child and elder care, home repair, housing needs, education, pet care and so much more.
- Virtual Support Connect: Moderated group therapy sessions on an anonymous, chat-based platform.
- Textcoach®: Personalized coaching with a licensed counselor on mobile or desktop.
- Animo: Self-guided and self-paced resources to improve focus, well-being and emotional fitness.

If you aren't sure what type of support may benefit you, access SupportLinc's *Mental Health Navigator* tool. By answering a few questions, you will be provided several options for support.

Support and resources should be accessible in the way that works for you. Therefore, many of the program features can be accessed digitally via the customized web portal or mobile app. However, you can always reach a licensed care navigator 24/7/365 at any time during your care journey by phone at 1-888-881-LINC (5462).



Phone: 1-888-881-LINC (5462)

Web: www.supportlinc.com

Username: ycmd

PLEASE NOTE...

The SupportLinc website will not be available until January 1, 2023.

IMPORTANT NOTE

SupportLinc ensures no one will know you have accessed the program without your written permission except as required by law.

Financial Well-Being

Financial well-being is important and the Y has made a commitment by offering two plans to help you save for the future:

The Y Retirement Fund

The Y Retirement Fund offers a generous employer contribution and rewards the service commitment of our associates. After two years (does not have to be consecutive) and 1,000 hours of service each year, you will automatically be enrolled in the Y Retirement Fund. **The Y will contribute a percentage of your gross earnings** into your retirement account each year. All contributions made by the Y are immediately yours and remain in your account, even when you leave the Y. A welcome kit will be provided to you once you have been enrolled in the plan. NOTE: You must be 21 years of age in order to receive contributions into your account.

403b Retirement Savings Plan

This plan allows you to save for retirement starting on the first day of employment. You determine the amount you wish to contribute per pay into your retirement savings account. Contributions into the account are tax-free until withdrawn at retirement. The account is managed by the Y Retirement Fund and you can learn more about it at www.yretirement.org. To enroll, complete an application and beneficiary form. Please scan and email your forms to HRIS@ymaryland.org.

Summer Savings Program with First Financial (10 month associates)

For associates only working 10 months each year but who would like to receive a paycheck for all 12 months, First Financial Credit Union offers the *Summer Savings Program*. A portion of your Y paycheck will be transferred to a First Financial Savings Account for the 10-month period you are actively working. During the summer, when you are not receiving a paycheck from the Y, First Financial will distribute funds from your savings account to help you with meeting your expenses.

Features:

- No minimum balance
- No monthly fee
- Earns competitive interest
- Contribute through Payroll Deduction during the year
- Withdraw your funds at any time using Online Banking, Phone Banking, or by visiting a branch

If you are interested in this program, please visit www.firstfinancial.org or call 410-321-6060.

BenefitHub

You have access to an online benefit portal called BenefitHub. This portal provides access to:

- Discounts on everyday purchases of goods and services
- Additional benefits such as Pet Insurance and Group Auto/Home Insurance

Discounts and Rewards

BenefitHub provides you access to an online marketplace where you can shop for hundreds of products and services at discounted prices. Examples include tickets to movies, sporting events, theme parks, and concerts, as well as travel deals and discounts for hotels, airfare and car rental. There are also deals on products such as electronics, home appliances and restaurants. The site will allow you to search by zip code to find local deals as well. For many deals, you can earn cash back which can then be used to purchase additional deals.

Additional Benefits

Through BenefitHub, you have access to group rates for several additional benefits. One option is group auto and home insurance where you can obtain quotes from multiple national insurance carriers with no purchase obligation. This can be done online or by calling a customer service representative and takes only a few minutes. You will also have access to Identity Theft insurance and Pet Insurance.

How to Access BenefitHub

You will need to register and create an account. Simply visit www.ymaryland.benefithub.com where you will click on "Activate My Account." You will then enter your Associate ID and your date of birth and click "Continue." Your Associate ID can be found next to your name under your profile in Dayforce. Enter your email address and create a password to finalize your account. You can also download the mobile app to find deals on the go.

Voluntary Benefits - Aflac

The Y offers Aflac voluntary benefit plans to all benefit-eligible associates who work an average of 20 hours or more a week. You can cover yourself, your spouse, and your dependent children. The plans are payroll deducted and portable, so if you leave for any reason, you can take the plan and pay them by direct bill (with certain stipulations).

Group Accident Insurance

Accidents are just that—accidents. You can’t plan for them, but you can protect yourself financially. The Aflac Accident plan pays benefits when you receive treatment for a covered accidental injury, making it a great companion to your major medical plan. You can use the money any way you want, for things like deductibles or copays, mortgage or rent, groceries or utility bills, or anything else you choose. The plan pays for a list of minor to serious injuries like:

- Broken bones
- Fractures or dislocations
- Burns
- Emergency room or urgent care visits
- Hospitalization
- Cuts

Group Critical Illness Insurance

Critical Illness coverage can help keep your focus on your health when it matters most. The Aflac Critical Illness plan pays benefits when a doctor diagnoses you with a covered critical illness, like a heart attack, stroke or cancer.

Examples of covered illnesses include, but are not limited to:

- Heart Attack
- Stroke
- Cancer
- Coma
- Paralysis

Per Pay Contributions	10-month Associates	12-month Associates
Associate	\$7.88	\$6.57
Associate + Spouse	\$13.13	\$10.95
Associate + Child(ren)	\$17.40	\$14.50
Family	\$22.64	\$18.87



Voluntary Benefits - Aflac *continued*

Group Hospital Indemnity Insurance

Maybe you are expecting to have a hospital stay—or maybe not. Either way, you can plan to give yourself an extra financial cushion. The Aflac Hospital Indemnity plan pays benefits when you have a planned, or unplanned hospital stay for a covered illness, injury, surgery or having a baby. Examples of covered benefits for inpatient stays:

- Hospital Stay Admission – \$1,000 per confinement. Once per covered sickness or accident per calendar year for each insured.
- Hospital Stay Daily – \$150.00 per day up to 31 days per covered sickness or covered accident for each insured.
- Hospital Stay Intensive Care Unit – \$150.00 per day up to 10 days per covered sickness or covered accident for each insured.

Per Pay Contributions	10-month Associates	12-month Associates
Associate	\$9.12	\$7.60
Associate + Spouse	\$17.81	\$14.84
Associate + Child(ren)	\$14.28	\$11.90
Family	\$22.97	\$19.14

Group Whole Life Insurance

Aflac Group Whole Life Insurance helps address your loved ones' immediate and future financial needs following your death. Immediate needs can include burial/funeral expenses, uninsured medical costs, and current bills and debts. Future needs could include education plans, ongoing family obligations, emergency funds and retirement expenses. Group Whole Life Insurance from Aflac offers a death benefit, plus a component that may be collected, borrowed, or used to pay the plan's premiums. The plan may remain in force for a lifetime as long as the premiums are paid.

Benefits include:

- Cash value built at a guaranteed rate of return
- Benefits may be paid directly to your named beneficiary
- Eligibility that is easily determined with just a few medical questions
- Premiums will never increase for the benefit amount selected on the original plan

HOW TO ENROLL

Voluntary benefits are only offered annually during the Open Enrollment period. Schedule a virtual meeting with a Benefits Counselor to learn about the plans available. You can make an appointment using the online scheduler at: <https://www.eznetscheduler.com/Calendar/ymaryland> or by calling 1-866-870-5093.

All associates who speak with a Benefit Counselor during Open Enrollment will be entered into a raffle for prizes.

Medical - Cigna

NEW

The Y will offer three medical options with Cigna, each designed to meet the diverse needs of our associates. It's important to look at both the cost per pay of each plan, as well as your expected out of pocket costs when using your medical plan.

The **Open Access Plus HMO** plan provides in network coverage from providers in the national *OAP* network. You DO NOT need to select a primary care physician or obtain referrals to specialists. There is a low deductible that applies to inpatient and outpatient services but many other services are covered in full or subject to just a copay. There is NO prescription deductible and the copay amounts are shown below.

The **Open Access Plus HRA** plan has a higher deductible but provides both in and out-of-network coverage from providers in the national *OAP* network. Most in-network services are covered in full after the deductible is met. This plan includes a Health Reimbursement Arrangement (HRA)—see page 15 for important information. There is NO prescription deductible and the copay amounts are shown below.

The **Local Plus Bronze** plan provides in-network only coverage and has the highest deductible. Services from network providers are covered at 80% after the deductible and prescriptions are subject to the same deductible that applies to medical. This plan uses the *Local Plus* network which is a targeted group of providers that provide quality outcomes at a lower cost. If you use a provider outside the *Local Plus* network, your services will not be covered.

Plan Feature or Covered Service	Open Access+ HMO Plan	Open Access+ HRA Plan		Local+ Bronze Plan
	In-Network	In-Network	Out-of-Network	In-Network
Calendar Year Deductible				
Individual	\$250	\$2,000	\$3,000	\$5,000
Family	\$500	\$4,000	\$6,000	\$10,000
Annual Maximum Out-of-Pocket Cost				
Individual	\$7,350	\$2,000	\$8,000	\$9,100
Family	\$14,700	\$4,000	\$16,000	\$18,200
Note: Copays, deductibles and coinsurance are included in the out-of-pocket maximum for all Plans.				
Preventive Care Services				
Routine adult physical, routine GYN exam, well child care and routine screenings	Covered in full	Covered in full	20% after deductible	Covered in full
Physician's Visits				
Primary care visits	Covered in full	0% after deductible	20% after deductible	20% after deductible
Specialist visits	\$35 copay			
Virtual Visits	\$0/\$35 copay			
Emergency Services				
Emergency room* (waived if admitted)	\$250 copay after deductible then 20%	0% after deductible	0% after in-network deductible	20% after deductible
Urgent care center	\$50 copay		0% after deductible	20% after deductible
Outpatient Hospital (pre-certification applies)	20% after deductible	0% after deductible	20% after deductible	20% after deductible
Inpatient Hospital (pre-certification applies)	20% after deductible	0% after deductible	20% after deductible	20% after deductible
Prescription				
Retail Pharmacy (up to 31 day supply)				(after medical deduct.)
Generic copay	\$5	\$10		\$10
Preferred Brand copay	\$50	\$35		\$30
Non-preferred Brand copay	\$75	\$60		\$50
Specialty copay	\$150	n/a		n/a
Mail Order Pharmacy (up to 90 day supply)	2.5 x Retail Copay			

* Does not include Emergency Room Physician Services. If admitted through a non-network Emergency Room, you must notify the plan within 48 hours.

This summarizes the Plans' main features. A full description of covered services and benefits can be found in the Summary Plan Description.

Medical - Cigna *continued*

How to find a Cigna provider

Go to [Cigna.com](https://www.cigna.com), click on "Find a Doctor" at the top of the screen and select "Employer or School" under "How are you Covered?". Enter the city/state or zip code you want to search, select the search type and enter a name, specialty or other search term. Click on "Continue as Guest" and then choose the *Open Access Plus*, *OA plus*, *Choice Fund OA Plus* network (if you are choosing the Bronze Plan select the *LocalPlus* network). You can then sort, filter and choose additional criteria. After you have enrolled, you will be able to create an account on mycigna.com and the provider network will be customized for your plan and your zip code.

Have questions before you enroll?

If you would like to learn more about the medical options with Cigna before you make an election, you can call 888-806-5042 and speak with a Cigna specialist for:

- Information on specific plans.
- Help finding participating doctors and other health care professionals.
- Comparisons of all Cigna products and resources available to you.

Why should I register on mycigna.com?

After you enroll, you can create an account on [myCigna.com](https://mycigna.com). You can estimate your health care costs, search for providers, manage and track claims, learn how to live a healthier life and more. You can also download the mycigna app. You will need your Cigna ID number or your SSN to register and will need to validate your date of birth and zip code. **Note:** Registration for mycigna.com will not be available until January 1, 2023. If you are already enrolled with Cigna dental and have a mycigna account, your medical coverage will not be visible until January 1, 2023.

Mental Health support your way

Mental Health support should be accessible to everyone and Cigna offers several ways to find the support you need. You can find more information on all of these options at mycigna.com. **All behavioral health services are covered the same no matter the way you access care.**

Traditional face to face using one of Cigna's network providers: Visit mycigna.com to search for a provider that meets your needs and you can then schedule an in-person appointment.

Talkspace: *Talkspace* provides you with digital access to licensed providers where you have the ability to exchange unlimited messages via text, voice, and video.

Virtual counseling with one of Cigna's network providers: Visit mycigna.com and search for "Virtual Counselor" under "Doctor by Type". Call to make an appointment and your provider will advise on how to set up virtual counseling.

Ginger: *Ginger* offers access to digital behavioral health coaching via text-based chats, self-guided learning activities and video-based therapy.

Important Information for those in the HRA plan

If you are enrolled in the HRA plan, the Y will contribute \$250 for associate only coverage and \$500 for dependent coverage into an HRA account. This money is available at the beginning of the plan year and can be used to cover services subject to the medical deductible.

If you are using an in-network provider, advise your provider you have a high deductible plan and request they file the claim directly with Cigna. Cigna will process the claim and determine payment for eligible services, including amounts subject to the deductible.

If there is money available in your HRA, Cigna will pay the doctor from your HRA account, up to the amount available. You will receive an explanation of benefits showing the amount paid from your HRA account, any amount left over and any balance that you may owe. Your doctor should bill you for this amount.

Medical - Kaiser Permanente

Where can I find Kaiser Providers?

This HMO plan offers coverage for health care services provided by Kaiser physicians at Kaiser facilities through their **Signature** network.

Some of the larger Kaiser locations are listed below but a complete list of all locations and physicians can be found at <https://healthy.kaiserpermanente.org/maryland-virginia-washington-dc/doctors-locations#>.

- Abingdon
- Annapolis
- Baltimore Harbor
- Bowie
- Camp Springs
- Columbia Gateway
- Frederick
- Kensington
- Largo
- Lutherville-Timonium
- Marlow Heights
- North Arundel
- Shady Grove
- Silver Spring
- South Baltimore
- West Hyattsville
- White Marsh
- Woodlawn

You will need to choose a primary care physician (PCP) who will coordinate your care and provide referrals to other providers as needed. If you do not choose a PCP during the enrollment process, you will be assigned to a provider at the medical center nearest your home zip code. You can always change your PCP at any time by contacting Kaiser.



Don't Forget...

Preventive care services such as annual physicals and GYN visits, routine screenings and well child visits are covered at 100% with NO out of pocket expense to you AND your Kaiser plan includes coverage for routine eye exams (\$15 copay) and provides discounts on glasses and contact lenses.

What if I need to visit the doctor due to illness or injury?

You will pay a \$15 copay for any visit to a primary care physician or a \$25 copay for a visit with a specialist.

Does this plan have a deductible?

This plan has a \$250 individual deductible and a \$500 family deductible each calendar year. Your deductible must be met before any outpatient, inpatient or major diagnostic services are payable. Once your deductible is met, these services are covered at 90% of the allowed amount.

What is the most I can pay out of pocket for my healthcare expenses?

This plan has a maximum out of pocket amount of \$2,000 for an individual and \$4,000 for a family. Deductibles, copays and coinsurance typically will contribute towards your out-of-pocket amount. Once the out of pocket is reached, services are covered at 100%.

What are my prescription benefits?

When you enroll in the medical plan, you have three options to access prescription drug coverage:

- **Kaiser Medical Center Pharmacy:** If you fill your prescriptions at a Kaiser pharmacy, you will pay the lowest copay for prescriptions; \$10 for generic drugs, \$30 for preferred brand name drugs and \$50 for non-preferred brand name drugs.
- **Participating Retail Pharmacy:** You can get your prescriptions at participating retail pharmacies but will pay a higher copay to do so; \$30 for generic drugs, \$50 for preferred brand name drugs and \$75 for non-preferred brand name drugs.
- **Mail-Order Pharmacy:** Maintenance Drugs or prescriptions that require ongoing, regular use, may be obtained through the mail-order prescription program. You can receive up to a 90-day supply for only two times the Kaiser Pharmacy copay.

Medical - Kaiser Permanente *continued*

What if I have an emergency and I'm traveling outside the MD/VA/DC Kaiser service area?

If you have an emergency where your health is at risk (for example, shortness of breath, chest or other severe pain or loss of consciousness), you should proceed to the nearest emergency room. Regardless of which Emergency Room you go to, you will be covered for emergency services the same as you would in your home service area.

If your condition is not an emergency but requires prompt medical attention (for example, flu symptoms such as sore throat, cough, earaches, minor injuries or minor pain), you can utilize any urgent care center and you will pay the same \$25 copay you would in your home service area.

Note: Depending on where you seek emergency or urgent care, you may be required by the facility to pay upfront. In this case, you would be able to submit a claim to Kaiser who will reimburse you minus your share of the costs. Preventive or routine services are NOT covered outside your local Kaiser service area.

What if I have a dependent that doesn't live with me full-time and I want to cover them?

The Kaiser Signature plan is primarily meant to cover services accessed in the MD/DC/VA region. However, there are circumstances when a dependent may live away from home for a portion of the year. In that case, dependents would have the same access to Emergency or Urgent care as described above. Using kp.org or the Kaiser app, you/your dependent can communicate with your primary physician and/or care team via email at any time.

For dependents living in an area with Kaiser facilities, you can request a 90-day Visiting Member authorization. This would give your dependent temporary access to services using Kaiser facilities near where they live and will provide coverage for more routine and/or non-emergency care.

To provide members with the best experience if you need out of area care, contact the Away From Home Travel Line (951-268-3900) before seeking care. They will be able to locate the nearest facility and in some cases, assist you with making an appointment. You can also visit kp.org/travel for more information.

Why should I register on kp.org?

Registering with Kaiser provides you access to a host of tools and resources you will need to manage your health.

- Search for providers
- Schedule/change appointments
- Communicate with your providers
- View lab/test results and medical records
- Refill or transfer prescriptions
- Print vaccination records
- Access health and wellness tools and resources

Note: You must register from a computer, not a mobile device, and will need to have your medical record number from your ID card when you register.



Virtual Visits & Knowing Your Care Options

Virtual Visits with Cigna and Kaiser Permanente

Cigna

While some physicians in the Cigna network may offer to meet with their patients virtually, Cigna has partnered with MDLIVE to provide additional virtual care options to their members 24/7. Your cost is the same, or in some cases less, than if you saw a physician in person.

If you wish to make a virtual appointment, logon to mycigna.com and click on "Talk to a Doctor." You can select the type of care you need and review the cost. For primary care or behavioral health care, you can make an appointment, while urgent care and dermatology services you can access on-demand.

Kaiser

Kaiser members can obtain medical advice via video or phone 24/7 for a wide range of minor health concerns. You must be registered on kp.org and be physically present in MD, DC or VA. You can schedule a video visit with your Primary Care Physician for non-urgent concerns, connect with a Kaiser physician on demand for more immediate needs or even request an e-visit or use the chat option to get advice on care. In most cases, there is no out of pocket cost for you.



Knowing Your Care Options

With many options for getting care, how do you choose? Regardless of your insurance coverage, this chart can help you understand where to go for what and how you can save money.

	Option	Overview	Cost and Time
Lower Cost and Time Greater	Virtual Visits	Access video/virtual visits services to treat minor medical conditions. Connect with a board-certified doctor via video or phone when, where, and how it works best for you. Conditions treated include: colds and flu; rashes; sore throat; fever; allergies; UTIs and more.	■ Costs the same or less than a visit with your primary care provider ■ Appointments typically in an hour or less ■ No need to leave home or work
	Convenience Care Clinic	Treats minor medical concerns. Staffed by nurse practitioners and physician assistants. Located in retail stores and pharmacies. Often open nights and weekends. Conditions treated include: colds and flu; rashes/skin conditions; pregnancy testing; sore throat, earache and sinus pain; vaccines and more.	■ Same or lower than doctor's office ■ No appointment needed
	Doctor's Office	The best place to go for routine or preventive care, to keep track of medications, or for a referral to see a specialist. Conditions treated include: general health issues; preventive care; immunizations and screenings; routine checkups and more.	■ May charge copay/coinsurance and/or deductible ■ Usually need appointment ■ Short wait times
	Urgent Care Center	For conditions that aren't life threatening. Staffed by nurses and doctors and usually have extended hours. Conditions treated include: fever and flu symptoms; minor cuts, sprains, burns, rashes; headaches; lower back and joint pain; UTIs and more.	■ Costs lower than ER ■ No appointment needed ■ Wait times vary
	Emergency Room	For immediate treatment of critical injuries or illness. Open 24/7. If a situation seems life-threatening, call 911 or go to the nearest emergency room. Conditions treated include: sudden numbness, weakness; uncontrolled bleeding; chest pain; head injury/major trauma; severe cuts or burns; overdose and more.	■ Highest cost ■ No appointment needed ■ Wait times may be long, averaging over 4 hours

Payroll Deductions: 12-Month Associates

2023 Medical Plan Costs - Per Pay Associate Cost

Payroll deductions will be taken over 24 pays for 12-month associates.

Associates with Salaries Less than \$63,000: Wellness Compliant

	Kaiser HMO	Cigna HMO	Cigna HRA	Cigna Bronze
Individual	\$33.17	\$45.01	\$39.60	\$0.00
Individual + Spouse	\$216.18	\$227.50	\$220.00	\$89.51
Individual + Child(ren)	\$159.20	\$179.95	\$164.78	\$58.45
Family	\$288.67	\$315.00	\$294.47	\$126.59

Associates with Salaries Less than \$63,000: Wellness Non-Compliant

	Kaiser HMO	Cigna HMO	Cigna HRA	Cigna Bronze
Individual	\$93.67	\$105.51	\$100.10	\$51.57
Individual + Spouse	\$276.68	\$288.00	\$280.50	\$150.01
Individual + Child(ren)	\$219.70	\$240.45	\$225.28	\$118.95
Family	\$349.17	\$375.50	\$354.97	\$187.09

Associates with Salaries Greater than \$63,000: Wellness Compliant

	Kaiser HMO	Cigna HMO	Cigna HRA	Cigna Bronze
Individual	\$58.15	\$67.49	\$64.63	\$0.00
Individual + Spouse	\$281.15	\$280.00	\$275.00	\$133.06
Individual + Child(ren)	\$207.84	\$222.77	\$205.74	\$94.14
Family	\$362.40	\$385.37	\$327.50	\$182.72

Associates with Salaries Greater than \$63,000: Wellness Non-Compliant

	Kaiser HMO	Cigna HMO	Cigna HRA	Cigna Bronze
Individual	\$118.65	\$127.99	\$125.13	\$51.57
Individual + Spouse	\$341.65	\$340.50	\$335.50	\$193.56
Individual + Child(ren)	\$268.34	\$283.27	\$266.24	\$154.64
Family	\$422.90	\$445.87	\$388.00	\$243.22

2023 Dental Plan Costs Per Pay Associate Cost

Coverage	DPPO	DMO
Individual	\$8.11	\$3.90
Individual + Spouse	\$16.21	\$7.79
Individual + Child(ren)	\$19.90	\$9.57
Family	\$29.21	\$14.04

2023 Vision Plan Costs Per Pay Associate Cost

Coverage	
Individual	\$3.64
Individual + Spouse	\$7.96
Individual + Child(ren)	\$7.58
Family	\$10.09

Payroll Deductions: 10-Month Associates

2023 Medical Plan Costs - Per Pay Associate Cost

Payroll deductions will be taken over 20 pays for 10-month associates. Deductions will **not** be taken from your paycheck on the following pay dates: 7/11/2023, 7/25/2023, 8/8/2023, and 8/22/2023.

Associates with Salaries Less than \$63,000: Wellness Compliant

	Kaiser HMO	Cigna HMO	Cigna HRA	Cigna Bronze
Individual	\$39.80	\$54.01	\$47.52	\$0.00
Individual + Spouse	\$259.42	\$273.00	\$264.00	\$107.41
Individual + Child(ren)	\$191.04	\$215.94	\$197.74	\$70.14
Family	\$346.40	\$378.00	\$353.36	\$151.91

Associates with Salaries Less than \$63,000: Wellness Non-Compliant

	Kaiser HMO	Cigna HMO	Cigna HRA	Cigna Bronze
Individual	\$112.40	\$126.61	\$120.12	\$61.88
Individual + Spouse	\$332.02	\$345.60	\$336.60	\$180.01
Individual + Child(ren)	\$263.64	\$288.54	\$270.34	\$142.74
Family	\$419.00	\$450.60	\$425.96	\$224.51

Associates with Salaries Greater than \$63,000: Wellness Compliant

	Kaiser HMO	Cigna HMO	Cigna HRA	Cigna Bronze
Individual	\$69.78	\$80.99	\$77.55	\$0.00
Individual + Spouse	\$337.37	\$336.00	\$330.00	\$159.67
Individual + Child(ren)	\$249.40	\$267.32	\$246.88	\$112.96
Family	\$434.88	\$462.44	\$393.00	\$219.26

Associates with Salaries Greater than \$63,000: Wellness Non-Compliant

	Kaiser HMO	Cigna HMO	Cigna HRA	Cigna Bronze
Individual	\$142.38	\$153.59	\$150.15	\$61.88
Individual + Spouse	\$409.97	\$408.60	\$402.60	\$232.27
Individual + Child(ren)	\$322.00	\$339.92	\$319.48	\$185.56
Family	\$507.48	\$535.04	\$465.60	\$291.86

2023 Dental Plan Costs Per Pay Associate Cost

Coverage	DPPO	DMO
Individual	\$9.73	\$4.68
Individual + Spouse	\$19.45	\$9.35
Individual + Child(ren)	\$23.88	\$11.48
Family	\$35.05	\$16.84

2023 Vision Plan Costs Per Pay Associate Cost

Coverage	
Individual	\$4.37
Individual + Spouse	\$9.55
Individual + Child(ren)	\$9.09
Family	\$12.11

Dental - Cigna

Dental coverage is provided by Cigna and allows you to choose from two plans. The plan you select will depend upon your dentist preference, the services you wish to access, and the out-of-pocket costs you can afford. To find a participating provider, visit cigna.com or access your personalized account at mycigna.com.

PPO Plan: Allows you the freedom to visit any licensed dentist. However, you will pay the lowest out-of-pocket cost when you visit an in-network provider in the *Total Cigna DPPO* network. Earn a \$100 annual maximum increase for obtaining preventive care in the preceding year (capped at \$1,800).

DMO Plan: Requires that you select a primary dentist and all services must be from an in-network provider in the *Dental Care Access Plus* network. There are no deductibles or annual maximums and out-of-pocket costs are based on a pre-determined fee schedule. **Please contact the the Benefits department to obtain a copy of the fee schedule showing the costs by type of service.** Adult and child orthodontia is covered, as are other services not covered under the PPO such as occlusal guards, athletic mouthguards or teeth whitening.

Preventive services are covered in full when accessing in-network care under both plans.

The table below summarizes the coverage for the PPO.

Plan Features	In-Network	Out-of-Network
Network	Total Cigna DPPO	N/A
Annual Deductible	\$50 per individual \$150 per family	
Annual Maximum	\$1,500 per person You can add an additional \$100 each year to your annual maximum by having a preventive service in the preceding year. Maximum of \$1,800 in year four.	
Diagnostic and Preventive Care Oral exams, routine cleanings, x-rays, sealants	100% (no deductible)	80% (no deductible)
Basic Restorative Fillings, simple extractions, oral surgery, endodontics and periodontics	80% after deductible	60% after deductible
Major Restorative Single crowns, inlays, onlays, dentures, bridges, implants	50% after deductible	50% after deductible
Orthodontics For eligible dependents to age 19	50% (no deductible)	50% (no deductible)
Orthodontic Maximum	\$1,500 per person lifetime maximum	

Above are only highlights. The specific terms of coverage, exclusions, limitations and maximums are contained in the Summary Plan Description. To the extent there may be differences, the terms of the Summary Plan Description govern.

If you enroll in the DMO plan, you must choose a primary dentist. **If you do not make a selection during the enrollment process, you will be auto-enrolled with a primary dentist in close proximity to your home address.** You can make changes to your primary dentist at any time by contacting Cigna. Please note it can take up to 45 days for the change to be effective, so please ensure you choose a primary dentist in advance of when you need services. Please ensure you have geographic access to a primary dentist before choosing this plan.

ID Cards: If you are enrolled in the PPO dental plan, **you will not receive an ID card.** You can print an ID card from mycigna.com or the mycigna mobile app. If you are enrolled in the DMO plan, you will receive an ID card with your primary dentist listed. If you are a new dental enrollee, you will have access to the mycigna.com website starting January 1, 2023.

Vision - Cigna

NEW

New for 2023, Vision coverage will be provided by Cigna. The overall plan benefits will remain the same but you will now have access to a larger network of providers including Walmart, Sam's Club, Nationwide Vision, Glasses.com, ContactsDirect and LensCrafters. You may receive care from any provider you wish, but your costs are lower when you see a participating Cigna Vision provider.

Locating a Provider

You can locate in-network Vision providers by calling 877-478-7557 or visiting mycigna.com. Under coverage, select "Vision", click on "Visit Cigna Vision", select "Find a Cigna Vision Network Eye Care Professional" to search the EyeMed Directory. Once you choose a provider, call the provider directly to schedule an appointment and identify yourself as a Cigna member.

ID Cards: You will receive a vision ID card or you can download one from mycigna.com starting January 1, 2023.

Vision Benefits Summary

The plan provides benefits for your choice of either glasses OR contacts **every twelve months**, as well as an eye exam once **every twelve months**.

Covered Services	In-Network	Out-of-Network
Exam Copay/Allowance	100% after \$10 copay	Up to \$45
Materials Copay	\$25 copay	N/A
Eyeglass Lens Allowance		
- Single Vision - Lined Bifocal - Lined Trifocal - Lenticular	100% after copay	Up to \$40 Up to \$65 Up to \$75 Up to \$100
Contact Lens Allowance (in lieu of lens/frames)		
- Elective - Therapeutic	Up to \$130 Covered 100%	Up to \$115 Up to \$250
Frames		
Retail Allowance	Up to \$130 + 20% discount on balance	Up to \$71

Additional Savings for Cigna Members

As a Cigna member, you will also receive a minimum of 20% savings on all additional lens enhancements, including but not limited to: scratch/ultraviolet/anti-reflective coatings; polycarbonate (adults); all tints/photochromic (glass or plastic); and lens styles, including Progressive lens upgrades.

Reminder for Kaiser Members

The Kaiser medical plan includes coverage for routine eye exams and provides discounts on glasses and contact lenses. You can also elect the Cigna vision plan if you wish to receive coverage for lenses and/or frames.



Flexible Spending Accounts - TASC

Flexible Spending Accounts (FSAs) are designed to help you take home more of the pay that you earn by allowing you to pay for un-reimbursed medical expenses and expenses associated with the care of a dependent on a **pre-tax basis**. The Y partners with TASC to administer these accounts.

How the Health Care FSA Works

You can set aside up to **\$3,050** annually on a pre-tax basis in the Health Care FSA. You can use this money to pay for eligible expenses you incur during the year that are not covered by your basic plans. If you currently spend money each year on any of the items below, you should consider participating in the Health Care FSA.

- Medical Plan Deductible/Coinsurance
- Dental Plan Deductible/Coinsurance
- Prescription Drug Copays
- Contact Lenses/Eyeglasses/Vision Exams
- Hearing Aids
- Orthodontic (Braces) Fees

Rollover Feature for Health Care FSA

The Health Care FSA plan includes the roll over feature. **This means that if you do not use all your money in your FSA for 2023, you can roll over up to \$610 into the 2024 plan year if you elect the FSA plan for 2024.** You will still need to submit claims for the 2022 calendar year no later than March 31, 2023. Should you roll funds over from one plan year to the next, you will still have the ability to elect up to the annual election amount of \$3,050 in addition to any funds you roll over. This is only available with the Healthcare FSA, not the Dependent care FSA.

NOTE: Any funds rolled over from 2022 will not post in your 2023 FSA account until mid-April.

DID YOU KNOW?

- You must re-enroll in the FSA plans each year during open enrollment. Enrollment will not carry over from year to year.
- If you have \$550 or less in your 2022 Health FSA, it will be credited to your 2023 account once the 2022 run out period has ended. **You must enroll in the FSA plan in 2023 in order to access your 2022 rollover funds.**
- Keep all receipts to document FSA expenses.

How the Dependent Care FSA Works

You can set aside up to \$5,000 (\$2,500 if married filing separately) annually on a pre-tax basis in the Dependent Care FSA. Dependent Care can be for your dependent children, through age 12, and any dependent who is physically or mentally unable to care for him or herself who spends at least eight hours a day in your home and whom you claim as a dependent on your federal income tax return.

You use money in your account to pay for dependent care expenses such as preschool or nursery school expenses, in home childcare, day care center, summer day camp, after-school care, adult day care center or in-home care for an adult dependent. These services must be performed primarily for the well being and protection of a qualified dependent. In addition, to be considered as an eligible expense, **you must be able to provide a tax identification number or Social Security number of the provider** and, if married, your spouse must be employed.

Prior to making Health and/or Dependent Care account elections, there are several important points that must be considered:

- Elections are made each year during open enrollment.
- Dependent Care eligible expenses must be incurred during the plan year to be eligible for reimbursement.
- You may change your election during the year if you have a qualified family status change such as marriage or divorce, the birth of a child, the death of an eligible dependent, or certain changes in employment status.

Dependent Care FSA – Use it or Lose it

You need to plan carefully because you are not able to carry over funds from one year to the next. **For Dependent Care accounts, you forfeit any money remaining in your Dependent Care FSA at the end of the year.**

Supplemental Life & AD&D - New York Life

Supplemental Life and AD&D for Associates, Spouses, and Children

Supplemental Coverage for you or your Dependents

For you: You may purchase additional life and accidental death and dismemberment (AD&D) insurance up to the lesser of 5 times your annual base salary to a maximum benefit of \$500,000. Evidence of Insurability is required for amounts elected in excess of \$150,000.

For your spouse: If you purchase Associate Supplemental Life Insurance, you are also eligible to purchase additional life and AD&D for your spouse. You may purchase supplemental life insurance for your spouse in multiples of \$5,000 up to a maximum benefit of \$100,000 (benefit amount may not exceed 50% of the associates elected amount). Evidence of Insurability will be required if you elect spousal coverage in excess of \$25,000. Coverage ends at age 70.

For your child(ren): You may purchase \$10,000 of supplemental life insurance for your children. The monthly cost of \$2.40 will cover all children in your family, up to age 18, or age 26 if a full-time student. Evidence of Insurability is not required.

Evidence of Insurability

If you wish to purchase supplemental life insurance for you or your spouse, you may be required to complete an Evidence of Insurability (EOI) form.

An EOI is required if:

- 1 You elect an amount of coverage greater than \$150,000 for you and/or coverage for your spouse greater than \$25,000.
- 2 You did not elect supplemental life insurance when you were hired or first eligible but want to elect it later.

Important:

If you plan to elect or increase your supplemental life coverage during Open Enrollment, you will need to complete an EOI form before your coverage can be activated.

Cost for Supplemental Insurance

The cost for you and your spouse are calculated based on your age and amounts of coverage elected.

Formula to calculate monthly premium:

Step 1: Take the coverage amount and divide by \$1,000.

Step 2: Go to the rate table and find the rate that corresponds with your age.

Step 3: Multiply the rate by the result in Step 1. This will equal your Monthly Premium.

Example: An associate who is 35 years old and makes \$30,000 per year wants to purchase \$60,000 in life and AD&D insurance.

Step 1: $\$60,000 / \$1,000 = \$60$

Step 2: 35 years old = \$0.075

Step 3: $\$0.075 \times \$60 = \$4.50$ per month or \$2.25 over 24 pay periods

Age	Monthly Rates per \$1,000 for associate and/or spouse	
	Life	Life and AD&D
<20	\$0.036	\$0.052
20-24	\$0.036	\$0.052
25-29	\$0.036	\$0.052
30-34	\$0.045	\$0.061
35-39	\$0.059	\$0.075
40-44	\$0.089	\$0.105
45-49	\$0.139	\$0.155
50-54	\$0.215	\$0.231
55-59	\$0.323	\$0.339
60-64	\$0.438	\$0.454
65-69	\$0.785	\$0.801
70+	\$1.484	\$1.500

The cost for children is \$0.24 per \$1,000 of voluntary life coverage.

Employer Provided Benefits

As a full-time associate, the Y in Central Maryland provides you with valuable benefits at no cost to you.

Group Term Life

Life and Accidental Death and Dismemberment insurance help protect your family from a sudden loss of income in the event of your death or accidental dismemberment. The Y in Central Maryland pays the full cost for basic coverage. Full-time associates receive a benefit equal to \$20,000. An additional benefit of \$20,000 is payable in the event of accidental death.

Short-Term Disability

The Short-Term Disability (STD) plan replaces a portion of your income if a medical condition or injury forces you to be out of work for a short period of time (up to 13 weeks).

The STD Plan provides you with a weekly benefit on the eighth day after a disabling sickness or injury prevents you from returning to work.

The STD Plan will replace up to 66 2/3% of your pre-disability earnings, up to \$1,385 per week during your approved disability.

You must use any available PTO during the seven day elimination period to continue your salary. If you do not have any remaining PTO, these days will be taken without pay. STD benefits are taxed as ordinary income.

Long-Term Disability

Long Term Disability (LTD) benefits provide protection in the event of an extended illness or injury. LTD benefits begin on the 91st day of disability or at the end of your short-term disability benefit period.

The benefit is 60% of your monthly base salary, up to a maximum benefit of \$6,500 per month. Benefits may be payable up to age 65, or in some cases longer provided that you remain disabled and under a physician's care.

LTD benefits are taxed as ordinary income. LTD benefits under the plan are reduced by the amount of disability benefits you receive from other sources, such as Worker's Compensation, Social Security, or other government disability benefits.

The life, short term and long term disability benefits are provided through New York Life.

Other Value Added Benefits/Services

Money Coaching

- Free access for 30 days
- Assistance with budgeting, saving, getting out of debt and other financial challenges

Veterans Support Line

- Free and available 24/7/365
- Resource for Veterans and their families
- 855-244-6211

Identity Theft Assistance

- Prevention education
- ID Protection Kit
- Assistance with completing an ID theft affidavit and reporting when a theft occurs

Will Preparation

- Online tools to create last will and testament, living will, power of attorney and, medical authorization for minors
- Funeral planning guidebooks and organizer tools

Beneficiary Support Services

- 24/7 free unlimited telephonic bereavement services and two face-to-face counseling sessions
- 30 minutes free telephonic legal and financial advice

Secure Travel

- Worldwide travel assistance > 100 miles from home
- Pre-trip planning
- Emergency evacuation and repatriation

See page 4 for how to access these benefits.

Healthy Lifestyle:

- Free Y Family membership
- Liberty Mutual Home and Auto Insurance Discounts
- Verizon Wireless discounts
- 529 College Savings Plan
- Credit Union Membership with First Financial
- Direct Deposit or Paycard
- Discounts on Y Early Childhood and Youth Development programs

Important Notices

Notice of Health Information Privacy Practices

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

The health plans or options sponsored by Y in Central Maryland (referred to in this Notice as the “**Health Plans**”) may use or disclose health information about participants and their covered dependents as required for purposes of administering the Health Plans. Some of these functions are handled directly by Y in Central Maryland associates who are responsible for overseeing the operation of the Health Plans while other functions may be performed by other companies under contract with the Health Plans (those companies are generally referred to as “service providers”). Regardless of who handles health information for the Health Plans, the Health Plans have established policies that are designed to prevent the misuse or unnecessary disclosure of protected health information.

Please note that the rest of this Notice uses the capitalized word, “**Plan**” to refer to each Health Plan sponsored by Y in Central Maryland, including any Y in Central Maryland associates who are responsible for handling health information maintained by the Health Plans as well as any service providers who handle health information under contract with the Health Plans. This Notice applies to each Health Plan maintained by Y in Central Maryland, including plans or programs that provide medical, vision, prescription drug, dental, long term care and health care flexible spending account benefits. However, if any of the Plan’s health benefits are provided through insurance contracts, you will receive a separate notice, similar to this one, from the insurer and only that notice will apply to the insurer’s use of your health information.

The Plan is required by law to maintain the privacy of certain health information about you and to provide you this Notice of the Plan’s legal duties and privacy practices with respect to that protected health information. This Notice also provides details regarding certain rights you may have under federal law regarding medical information about you that is maintained by the Plan.

You should review this Notice carefully and keep it with other records relating to your health coverage. The Plan is required by law to abide by the terms of this Notice while it is in effect. **This Notice is effective beginning January 1, 2014** and will remain in effect until it is revised.

If the Plan’s health information privacy policies and procedures are changed so that any part of this Notice is no longer accurate, the Plan will revise this Privacy Notice. A copy of any revised Privacy Notice will be available upon request to the Privacy Contact Person indicated later in this Notice. Also, if required under applicable law, the Plan will automatically provide a copy of any revised notice to associates who participate in the Plan. The Plan reserves the right to apply any changes in its health information policies retroactively to all health information maintained by the Plan, including information that the Plan received or created before those policies were revised.

Protected Health Information

This Notice applies to health information possessed by the Plan that includes identifying information about an individual. Such information, regardless of the form in which it is kept, is referred to in this Notice as **Protected Health Information** or “**PHI**”. For example, any health record that includes details such as your name, street address, date of birth or Social Security number would be covered. However, information taken from a document that does not include such obvious identifying details is also Protected Health Information if that information, under the circumstances, could reasonably be expected to allow a person who receives or accesses that information to identify you as the subject of the information. Information that the Plan possesses that is not Protected Health Information is not covered by this

Notice and may be used for any purpose that is consistent with applicable law and with the Plan’s policies and requirements.

How the Plan Uses or Discloses Health Information

Protected Health Information may be used or disclosed by the Plan as necessary for the operation of the Plan. For example, PHI may be used or disclosed for the following Plan purposes:

- **Treatment.** If a provider who is treating you requests any part of your health care records that the Plan possesses, the Plan generally will provide the requested information. (There is an exception for psychotherapy notes. If the Plan possesses any psychotherapy notes, those documents, with rare exceptions, will be used or disclosed only according to your specific authorization.)

For example, if your current physician asks the Plan for PHI in connection with a treatment plan the physician has for you, the Plan generally will provide that PHI to the physician.

- **Payment.** The Plan’s agents or representatives may use or disclose PHI about you to determine eligibility for plan benefits, facilitate payment for services you receive from health care providers, to review claims and to coordinate benefits. This includes, if appropriate, disclosing information to the Plan Sponsor, as needed to facilitate the Plan’s payment function.

For example, if the Plan needs to process a payment to your current physician, but requires additional PHI to process that payment, it may request that PHI from the physician.

- **Other health care operations.** The Plan also may use or disclose PHI as needed for various purposes that are related to the operation of the Plan. These purposes include utilization review programs, quality assurance reviews, contacting providers regarding treatment alternatives, insurance or reinsurance contract renewals and other functions that are appropriate for purposes of administering the Plan. This includes, if appropriate, disclosing information to the Plan Sponsor, as needed to facilitate the Plan’s health care operations function. For example, if the Plan wishes to undertake a review of utilization patterns under the Plan, it may request necessary PHI from your physician.

In addition to the typical Plan purposes described above, PHI also may be used or disclosed as permitted or required under applicable law for the following purposes:

- **Use or disclosure required by law.** If the Plan is legally required to provide PHI to a government agency or anyone else, it will do so. However, the Plan will not use or disclose more information than it determines is required by applicable law.
- **Disclosure for public health activities.** The Plan may disclose PHI to a public health authority that is authorized to collect such information (or to a foreign government agency, at the direction of a public health authority) for purposes of preventing or controlling injury, disease or disability.

The Plan also may disclose PHI to a public health authority or other government agency that is responsible for receiving reports of child abuse or neglect.

In addition, certain information may be provided to pharmaceutical companies or other businesses that are regulated by the Food and Drug Administration (FDA), as appropriate for purposes relating to the quality, safety and effectiveness of FDA-regulated products.

Also, to the extent permitted by applicable law, the Plan may disclose PHI, as part of a public health investigation or intervention, to an individual who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition.

- **Disclosures about victims of abuse, neglect or domestic violence.** (The following does not apply to disclosures

Important Notices

regarding child abuse or neglect, which may be made only as provided under **Disclosure for public health activities.**)

If required by law, the Plan may disclose PHI relating to a victim of abuse, neglect or domestic violence, to an appropriate government agency. Disclosure will be limited to the relevant required information. The Plan will inform the individual if any PHI is disclosed as provided in this paragraph or the next one.

If disclosure is not required by law, the Plan may disclose relevant PHI relating to a victim of abuse, neglect or domestic violence to an authorized government agency, to the extent permitted by applicable law, if the Plan determines that the disclosure is necessary to prevent serious harm to the individual or to other potential victims. Also, to the extent permitted by law, the Plan may release PHI relating to an individual to a law enforcement official, if the individual is incapacitated and unable to agree to the disclosure of PHI and the law enforcement official indicates that the information is necessary for an immediate enforcement activity and is not intended to be used against the individual.

- **Health oversight activities.** The Plan may disclose protected health information to a health oversight agency (this includes federal, state or local agencies that are responsible for overseeing the health care system or a particular government program for which health information is needed) for oversight activities authorized by law. This type of disclosure applies to oversight relating to the health care system and various government programs as well as civil rights laws. This disclosure would not apply to any action by the government in investigating a participant in the Plan, unless the investigation relates to the receipt of health benefits by that individual.

- **Disclosures for judicial and administrative proceedings.** The Plan may disclose protected health information in the course of any judicial or administrative proceeding in response to an order from a court or an administrative tribunal. Also, if certain restrictive conditions are met, the Plan may disclose PHI in response to a subpoena, discovery request or other lawful process. In either case, the Plan will not disclose PHI that has not been expressly requested or authorized by the order or other process.

- **Disclosures for law enforcement purposes.** The Plan may disclose protected health information for a law enforcement purpose to a law enforcement official if certain detailed restrictive conditions are met.

- **Disclosures to medical examiners, coroners and funeral directors following death.** The Plan may disclose protected health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties authorized by law. The Plan also may disclose PHI to a funeral director as needed to carry out the funeral director's duties. PHI may also be disclosed to a funeral director, if appropriate, in reasonable anticipation of an individual's death.

- **Disclosures for organ, eye or tissue donation purposes.**

The Plan may disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

- **Disclosures for research purposes.** If certain detailed restrictions are met, the Plan may disclose protected health information for research purposes.

- **Disclosures to avert a serious threat to health or safety.** The Plan may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, (1) if it believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and the disclosure is made to a

person or persons reasonably able to prevent or lessen the threat, including the target of the threat; or (2) if it believes the disclosure is necessary for law enforcement authorities to identify or apprehend an individual because of a statement by an individual admitting participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to the victim or where it appears that the individual has escaped from a correctional institution or from lawful custody.

- **Disclosures for specialized government functions.** If certain conditions are met, the Plan may use and disclose the protected health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission. Also, the Plan may use and disclose the PHI of individuals who are foreign military personnel to their appropriate foreign military authority under similar conditions.

The Plan may also use or disclose PHI to authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities or for the provision of protective services to the President or other persons as authorized by federal law relating to those protective services.

- **Disclosures for workers' compensation purposes.** The Plan may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

Uses and Disclosures That Are Not Permitted Without Your Authorization

The Plan will not use or disclose Protected Health Information for any purpose that is not mentioned in this Notice, except as specifically authorized by you. If the Plan needs to use or disclose PHI for a reason not listed above, it will request your permission for that specific use and will not use PHI for that purpose except according to the specific terms of your **authorization**.

Any authorization you provide will be limited to specified information, and the intended use or disclosure as well as any person or organization that is permitted to use, disclose or receive the information must be specified in the Authorization Form. Also, an authorization is limited to a specific limited time period and it expires at the end of that period. Finally, you always have the right to revoke a previous authorization by making a written request to the Plan. The Plan will honor your request to revoke an authorization but the revocation will not apply to any action that the Plan took in accord with the authorization before you informed the Plan that you were revoking the authorization.

No Use or Disclosure of Genetic Information for Underwriting

Under applicable law, the Plan generally may not use or disclose genetic information, including information about genetic testing and family medical history, for underwriting purposes. The Plan may use or disclose PHI for underwriting purposes, assuming the use or disclosure is permitted based on the above rules, but any PHI that is used or disclosed for underwriting purposes will not include genetic information.

"Underwriting purposes" is defined under federal law and generally includes any Plan rules relating to (1) eligibility for benefits under the Plan (including changes in deductibles or other cost-sharing requirements in return for activities such as completing a health risk assessment or participating in a wellness program); (2) the computation of premium or contribution amounts under the Plan (including discounts or payments or differences in premiums based on activities such as completing a health risk assessment or participating in a wellness program); (3) the application of any preexisting condition exclusion under the Plan; and (4) other activities related to the creation, renewal, or replacement of a contract for health insurance or health benefits. However, "underwriting purposes" does not include rules relating to

Important Notices

the determination of whether a particular expense or claim is medically appropriate.

Your Health Information Rights

Under federal law, you have the following rights:

- *You may request restrictions with regard to certain types of uses and disclosures.* This includes the uses and disclosures described above for treatment, payment and other health care operations purposes. If the Plan agrees to the restrictions you request, it will abide by the terms of those restrictions. However, under the law, the Plan is not required to accept any restriction. If the Plan determines that a requested restriction will interfere with the efficient administration of the Plan or is otherwise inappropriate, it may decline the restriction. If you want to request a restriction, you should submit a written request describing the restriction to the Privacy Contact Person listed in this Notice.
 - *You may request that certain information be provided to you in a confidential manner.* This right applies only if you inform the Plan in writing (submitted to the Privacy Contact Person listed in this Notice) that the ordinary disclosure of part or all of the information might endanger you. For example, an individual may not want information about certain types of treatment to be sent to his or her home address because someone else who lives there might have access to it. In such a case, the individual could request that the information be sent to an alternate address. The Plan will honor such a request if it is reasonable, but reserves the right to reject a request that would impose too much of an administrative burden or financial risk on the Plan.
 - *You may request access to certain medical records possessed by the Plan and you may inspect or copy those records.* This right applies to all enrollment, claims processing, medical management and payment records maintained by the Plan and also to any other information possessed by the Plan that is used to make decisions about you or your health coverage. However, there are certain limited exceptions. Specifically, the Plan may deny access to psychotherapy notes and to information prepared in anticipation of litigation.
- If you want to request access to any medical records, you should contact the Privacy Contact Person listed in this Notice. If you request copies of any records, the Plan may charge reasonable fees to cover the costs of providing those copies to you, including, for example, copying charges and the cost of postage if you request that copies be mailed to you. You will be informed of any fees that apply before you are charged.
- *You may request that protected health information maintained by the Plan be amended.* If you feel that certain information maintained by the Plan is inaccurate or incomplete, you may request that the information be amended. The Plan may reject your request if it finds that the information is accurate and complete. Also, if the information you are challenging was created by some other person or organization, the Plan ordinarily would not be responsible for amending that information unless you provide information to the Plan to establish that the originator of the information is not in a position to amend it. If you want to request that any medical record maintained by the Plan be amended, you should provide your request in writing to the Privacy Contact Person listed in this Notice. Your request should describe the records that you want to be changed, each change you are requesting and your reasons for believing that each requested change should be made.

The Plan normally will respond to a request for an amendment within 60 days after it receives your request. In certain cases, the Plan may take up to 30 additional days to respond to your request.

If the Plan denies your request, you will have the opportunity to prepare a statement to be included with your health

records to explain why you believe that certain information is incomplete or inaccurate. If you do prepare such a statement, the Plan will provide that statement to any person who uses or receives the information that you challenged. The Plan may also prepare a response to your statement and that response will be placed with your records and provided to anyone who receives your statement. A copy will also be provided to you.

- *You have the right to receive details about certain non-routine disclosures of health information made by the Plan.* You may request an accounting of all disclosures or health information, with certain exceptions. This accounting would not include disclosures that are made for Treatment, Payment and other health plan operations, disclosures made pursuant to an individual authorization from you, disclosures made to you and certain other types of disclosures. Also, your request will not apply to any disclosures made more than 6 years before the date your request is properly submitted to the Plan. You may receive an accounting of disclosures once every 12 months at no charge. The Plan may charge a reasonable fee for any additional requests during a 12 month period.
- *You have the right to request and receive a paper copy of this Privacy Notice.* If the Plan provides this Notice to you in an electronic form, you may request a paper copy and the Plan will provide one. You should contact the Privacy Contact Person identified at the end of this Notice if you want a paper copy.
- *You have the right to be notified of a breach of unsecured PHI.* If unsecured PHI is used or disclosed in a manner that is not permitted under applicable federal law, you will receive a notice about the breach of unsecured PHI, if such a notice is required by applicable law. Unsecured PHI is PHI that is either in paper form or is in an electronic form that is not considered secure.

Privacy Contact Person and Complaint Procedures

After reading this Notice, if you have questions or complaints about the Plan's health information privacy policies or you believe your health information privacy rights have been violated, you should contact:

Privacy Officer
Y in Central Maryland
303 W. Chesapeake Avenue
Baltimore, MD 21204
443-322-9622

To obtain a paper copy of this notice, contact the appropriate business unit contact person listed below:

Privacy Officer
Y in Central Maryland
303 W. Chesapeake Avenue
Baltimore, MD 21204
443-322-9622

In addition to your right to file a complaint with the Plan, you may file a complaint with the U.S. Department of Health & Human Services. (Details are available on the Internet at <http://www.hhs.gov/ocr/privacy>) You will never be retaliated against in any way as a result of any complaint that you file.

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.

Important Notices

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, 2022. Contact your State for more information on eligibility.

ALABAMA – Medicaid
Website: myalhipp.com
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: myakhipp.com
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
Website: myarhipp.com
Phone: 1-855-MyARHIPP (855-692-7447)

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

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: healthfirstcolorado.com
Health First Colorado Member Contact Center: 1-800-221-3943/
State Relay 711
CHP+: colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI):
colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: flmedicaidtplecovery.com/flmedicaidtplecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid
HIPP Website: medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
HIPP Phone: 678-564-1162, Press 1
CHIPRA Website: medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
CHIPRA Phone: 678-564-1162, Press 2

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: in.gov/fssa/hip

Phone: 1-877-438-4479

All other Medicaid
Website: in.gov/medicaid
Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: kancare.ks.gov
Phone: 1-800-792-4884

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPPPROGRAM@ky.gov
KCHIP Website: kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: chfs.ky.gov

LOUISIANA – Medicaid
Website: medicaid.la.gov or ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website: maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003/TTY: Maine relay 711
Private Health Insurance Premium Webpage:
maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740/TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 617-886-8102

MINNESOTA – Medicaid
Website: mn.gov/dhs/people-we-serve/seniors/health-care-programs/programs-and-services/medical-assistance.jsp or
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

MISSOURI – Medicaid
Website: dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
Website: ACCESSNebraska.ne.gov
Phone: 1-855-632-7633/Lincoln: 402-473-7000/
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
state.nj.us/humanservices/dmahs/clients/medicaid
Medicaid Phone: 609-631-2392
CHIP Website: njfamilycare.org
CHIP Phone: 1-800-701-0710

Important Notices

NEW YORK – Medicaid

Website: health.ny.gov/health_care/medicaid
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: medicaid.ncdhhs.gov
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: nd.gov/dhs/services/medicalserv/medicaid
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid

Website: healthcare.oregon.gov/Pages/index.aspx or
oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website:
dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP

Website: eohhs.ri.gov
Phone: 1-855-697-4347 or 401-462-0311
(Direct RItE Share Line)

SOUTH CAROLINA – Medicaid

Website: scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

Website: dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: gethipptexas.com
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Medicaid Website: medicaid.utah.gov
CHIP Website: health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT – Medicaid

Website: greenmountaincare.org
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: coverva.org/en/famis-select or coverva.org/en/hipp
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid

Website: hca.wa.gov
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

Website: dhhr.wv.gov/bms or mywvhipp.com
Medicaid Phone: 304-558-1700
CHIP Toll-free Phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website: dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: 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, 2022, 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.

HIPAA Notice of 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, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage).

However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance. To request special enrollment or obtain more information, contact Human Resources.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as

Important Notices

applicable) following delivery. In any case, a plan may not require a physician or other health care provider to obtain authorization for prescribing a hospital stay in accordance with the NMHPA.

Women's Health and Cancer Rights Act Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; 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. If you have questions, please call the number on your medical plan ID card to speak with a Member Services Representative. If you would like more information on WHCRA benefits, contact Human Resources.

USERRA (The Uniformed Services Employment and Reemployment Rights Act)

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

Patient Protection Disclosure

You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from Y in Central Maryland 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 the participating primary care providers including participating health care professionals who specialize in obstetrics or gynecology, call the customer service phone number on your medical ID card.

Notice Regarding Wellness Program

The Y in Central Maryland's Associate Wellbeing program is a voluntary wellness program available to all associates. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve associate 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 may also be asked to complete a biometric screening, which will include a blood test. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, associates who choose to participate in the wellness program will receive premium reductions on the medical plan by completing the program requirements. You can visit our Associate Wellbeing portal at: member.virginpulse.com/vincentralmaryland. Although you are not required to complete these requirements, only associates who do so will receive premium reductions on the medical plan.

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 LabCorp at 855-913-0578.

Any 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 help to tailor a personal wellness plan to meet your needs. 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 Y in Central Maryland may use aggregate information it collects to design a program based on identified health risks in the workplace, the Associate Wellbeing 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 health providers or others you designate 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 Human Resources.

Important Notices

New Health Insurance Marketplace Coverage Options and Your Health Coverage

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

What is the Health Insurance Marketplace?

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

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer’s health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than the IRS determined % of your household income for the year, or if the coverage your employer provides does not meet the “minimum value” standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

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.

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

¹ An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Nondiscrimination Statement

Discrimination is Against the Law

Y in Central Maryland complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Y in Central Maryland does not exclude people or treat them differently because of race,

color, national origin, age, disability, or sex.

Y in Central Maryland:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - » Qualified sign language interpreters
 - » Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - » Qualified interpreters
 - » Information written in other languages

If you need these services, contact Human Resources.

If you believe that Y in Central Maryland has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Human Resources. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Human Resources is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

To view this notice in another language visit: <http://www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html>.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 443-322-9622.

ATTENTION : Si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez le 443-322-9622.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 443-322-9622.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 443-322-9622.

ATTENZIONE: In caso la lingua parlata sia l’italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 443-322-9622.

注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 443-322-9622。

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 443-322-9622

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 443-322-9622.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 443-322-9622.

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διαθέσιμη σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 443-322-9622.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 443-322-9622.

Important Notices

ملحوظة: إذا كنت تتحدث أذكر اللغة، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل برقم 443-322-9622-1 (رقم هاتف الصم والبكم).

MERK: Hvis du snakker norsk, er gratis språkassistentsetjenester tilgjengelige for deg. Ring 443-322-9622.

PERHATIAN: Jika Anda berbicara dalam Bahasa Indonesia, layanan bantuan bahasa akan tersedia secara gratis. Hubungi 443-322-9622.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 443-322-9622.

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 443-322-9622.

Employee Rights Under the Family and Medical Leave Act

The United States Department of Labor Wage and Hour Division

Leave Entitlements

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered service member's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the service member with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits & Projections

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave. Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and

- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

Requesting Leave

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint contact the U.S. Department of Labor Wage and Hour Division at

1-866-4-USWAGE (1-866-487-9243), TTY: 1-877-889-5627 or www.dol.gov/whd.

The Genetic Information Nondiscrimination Act (GINA)

GINA prohibits a group health plan from adjusting group premium or contribution amounts for a group of similarly situated individuals based on the genetic information of members of the group. GINA prohibits a group health plan from requesting or requiring an individual or a family member of an individual to undergo genetic tests. Genetic information means information about an individual's genetic tests, the genetic tests of family members of the individual, the manifestation of a disease or disorder in family members of the individual or any request for or receipt of genetic services, or participation in clinical research that includes genetic services by the individual or a family member of the individual. The term genetic information includes, with respect to a pregnant woman (or a family member of a pregnant woman) genetic information about the fetus and with respect to an individual using assisted reproductive technology, genetic information about the embryo. Genetic information does not include information about the sex or age of any individual.