Yeshiva University

TO	Employees Eligible for Group Health Benefits under the Yeshiva University Health & Welfare Plan
DATE	January 1, 2027
SUBJECT	Required Annual Notices for Group Health Plans

*****Important Information – Action May Be Required*****

To make sure that you have all the information you need to make informed decisions for you and your family, the law requires Yeshiva University to provide you with notice of certain legal rights that you may have and legal obligations that apply to the Yeshiva University Health & Welfare Plan. These rights and obligations are described in more detail in the enclosed notices.

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You should review these notices closely and keep them with other materials that you receive about benefits available under the Plan. If you have any questions about any of the legal rights and obligations described below or the Plan, you should write or call:

Yeshiva University | Human Resources Department

500 West 185th Street | New York, NY 10033

646-592-4340 | benefits@yu.edu

The following notices are not intended to be a description of the benefits offered under the Plan. For more information about specific benefits, refer to the Summary Plan Descriptions for the Plan, which are available by visiting https://www.aetna.com/.

Notice of HIPAA Special Enrollment Rights Under HIPAA and CHIPRA

This notice is being provided to ensure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage

If you are declining coverage 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 toward 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).

In addition, if you have a new dependent resulting from 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 marriage, birth, adoption, or placement for adoption.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

To request special enrollment or obtain more information, please contact:

Yeshiva University | Human Resources Department

646-592-4340 | benefits@yu.edu

ACA Reporting Notice

To reduce waste and promote efficiency, Yeshiva University Health & Welfare Plan is taking advantage of a new law that allows us to make your IRS Form 1095-C or Form 1095-B available to you only upon request. We are required to file this form with the IRS to show whether we offered you healthcare coverage in one or more months of the prior calendar year. If you recall, in the past, this form was mailed to you in the first quarter of the year. However, pursuant to the new law, we will not be mailing the forms this year.

While we are no longer automatically mailing the form to you, you can request a copy of your form at any time. If you are interested in obtaining a copy of your form, you may contact:

Yeshiva University | Human Resources Department

646-592-4340 | benefits@yu.edu

We will provide the form to you within thirty (30) days of your request.

Women's Health and Cancer Rights Act (WHCRA) Notice

Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema?

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. Therefore, the following deductibles and coinsurance apply:

Aetna Choice POS II HDHP
Aetna Choice POS II PPO
Aetna Open Access Aetna Select EPO

If you would like more information on WHCRA benefits, contact your plan administrator:

Yeshiva University | Human Resources Department

646-592-4340 | benefits@yu.edu

Newborns' and Mother's Health Protection Act (NMHPA) Notice

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 applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Michelle's Law Notice

When a dependent child over the age of 26 loses student status under the eligibility policy of Yeshiva University group health plan coverage, as a result of a medically necessary leave of absence from a post-secondary educational institution, the Yeshiva University group health plan will continue to provide coverage during the leave of absence for the earlier end date of up to one year, or until coverage would otherwise terminate under the Yeshiva University group health plan.

To maintain eligibility and continue coverage as a dependent during such leave of absence:

- The Yeshiva University Group Health Plan must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary; and
- The dependent must be established as a disabled dependent as defined by the medical carriers.

To obtain additional information, please contact:

Yeshiva University | Human Resources Department

646-592-4340 | benefits@yu.edu

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

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

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

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

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency Services

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

As of May 2026, the following 18 states had enacted comprehensive Balance Billing Protections: California, Colorado, Connecticut, Florida, Georgia, Illinois, Maine, Maryland, Michigan, New Hampshire, New Jersey, New Mexico, New York, Ohio, Oregon, Texas, Virginia, Washington.

As of May 2026, the following 17 states had enacted limited Balance Billing Protections: Alabama, Arizona, Arkansas, Delaware, Indiana, Iowa, Massachusetts, Minnesota, Mississippi, Missouri, Nebraska, Nevada, North Carolina, Pennsylvania, Rhode Island, Vermont, West Virginia.

Generally, those state passed protections apply to fully insured medical plans governed by the specific state and not self-funded medical plans. Check the state insurance commissioner website for details on specific state laws.

If your state is not listed, check your state commissioner's website as states may adopt a surprising billing mandate at any time.

Certain Services at an In-Network Hospital or Ambulatory Surgical Center

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

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

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

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

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

Generally, your health plan must:

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

If you think you've been wrongly billed, you may contact the US Dept. of Health & Human Services at 1-877-696-6775 or your State Insurance Commissioner.

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depend on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.96% (2026, indexed annually) of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.96% (2026, indexed annually) of the employee's household income.[1, 2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage - is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-25-25.pdf for 2026.

[2] An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

Marketplace-eligible individuals who live in states served by Healthcare.gov and either- submit a new application or update an existing application on Healthcare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit Healthcare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact:

Yeshiva University | Human Resources Department

646-592-4340 | benefits@yu.edu

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.

CREDITABLE COVERAGE –

Aetna Choice POS II HDHP
Aetna Choice POS II PPO
Aetna Open Access Aetna Select EPO

Important Notice about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Yeshiva University and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan.

If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current Creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current Yeshiva University coverage may be affected. If you do decide to join a Medicare drug plan and drop your current Yeshiva University coverage, be aware that you and your dependents will not be able to get this coverage back until the next open enrollment period.

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

You should also know that if you drop or lose your current Yeshiva University coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without Creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage.

For example, if you go nineteen months without Creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Yeshiva University changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	January 1, 2027
Name of Entity/Sender:	Yeshiva University
Contact - Position/Office:	Yeshiva University, Human Resources Department
Address:	500 West 185th Street New York, NY 10033
Phone Number:	646-592-4340

CMS Form 10182-CC Updated April 1, 2011

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**ALASKA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: https://www.dhcs.ca.gov/services/health-insurance-premium-payment-program-cost-avoidance/ Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	ILLINOIS - Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Illinois Medicaid Premium Assistance Information Medicaid application website: https://abe.illinois.gov HIPP Hotline Number: 217-524-8268 HIPP Email: mhfs.boc.hipp@illinois.gov
INDIANA – Medicaid	**IOWA – Medicaid and CHIP (Hawki)**
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584	Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562
KANSAS – Medicaid	**KENTUCKY – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms
LOUISIANA – Medicaid	**MAINE – Medicaid**
Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084	Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP	**MINNESOTA – Medicaid**
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com	Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672

MISSOURI – Medicaid	MONTANA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid	**NEVADA – Medicaid**
Website: http://accessnebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	Medicaid Website: https://www.nj.gov/humanservices/dmahs/individuals-families/familycare/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
NEW YORK – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
NORTH DAKOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid	**PENNSYLVANIA – Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP	**SOUTH CAROLINA – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid	**TEXAS – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP	**VERMONT– Medicaid**
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP	WASHINGTON – Medicaid
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: https://bms.wv.gov/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid	
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269	

To see if any other states have added a premium assistance program since July 31, 2026, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 5/31/2029)

General Notice of COBRA Continuation Coverage Rights

Continuation Coverage Rights Under COBRA

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

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

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

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

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

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Yeshiva University, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified

beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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

Yeshiva University, Human Resources Department

646-592-4340 | benefits@yu.edu

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. You must provide this notice to:

Yeshiva University, Human Resources Department

646-592-4340 | benefits@yu.edu

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

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

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

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

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

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

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

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

To obtain more information about the Plan and COBRA continuation coverage upon request, contact the following person:

Yeshiva University Health & Welfare Plan

Yeshiva University, Human Resources Department

646-592-4340 | benefits@yu.edu

https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start.

Notice of HIPAA Privacy Practices

Effective January 1, 2027, or such later date when this is first published.

PLEASE REVIEW THIS NOTICE CAREFULLY AS IT DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. THIS NOTICE ALSO DIRECTS YOU TO HOW YOU CAN ACCESS YOUR MEDICAL INFORMATION.

Yeshiva University (the "Company") provides this privacy notice so you understand how we use your health information and when we need to disclose your health information to others. For each obligation and right listed within this notice, the term “we” refers to both the Plan Administrator and the claims administrators for the listed coverage options beginning January 1, 2027, under the Yeshiva University Health & Welfare Plan(the "Plan").

The Company is the Plan Administrator for the Plan. The claims administrators for the Plan are listed in the “Claims Administrators” section on the last page of this notice.

This notice is subject to change. You may contact the Company’s HIPAA Privacy Official to request a copy of this notice by mail, phone or email at:

Yeshiva University, Human Resources Department

500 West 185th Street | New York, NY 10033

646-592-4340 | benefits@yu.edu

The Plan is required by law to abide by the terms of this notice, which may be amended from time to time.

Summary of your privacy rights

We may use and give out your health information to:

- Help manage the health care treatment you receive
- Pay for your health services
- Administer the Plan
- Tell you about other health benefits and services
- Help your family and friends involved in your care
- Do research

We may also use and give out health information for:

- Health and safety reasons
- Organ and tissue donation requests
- Military purposes
- Workers’ compensation requests
- Lawsuits
- Law enforcement requests
- National security reasons

- Coroner, medical examiner, or funeral director use
- Such other disclosures as may be required by law or further addressed herein.

You have the right to:

- Get a copy of your medical record.
- Request a change to your medical record if you think it's wrong.
- Ask for an accounting of certain disclosures of your health information.
- Ask us to limit the information we share.
- Ask for a copy of our privacy notice.
- Write a letter of complaint to us if you believe your privacy rights have been violated.

The purpose of this document is to outline and inform you about your privacy rights enacted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This privacy notice describes the privacy practices of the Company under the Plan. You should check with the administrator of the health plans and health care flexible spending accounts for more details on those specific plans. You may receive a Notice of HIPAA Privacy Rights specific to each plan you are enrolled on.

The Company, as the sponsor and administrator of the Plan, and each of the claims administrators that have been hired to administer the Plan's group health plans, are required by law to protect the privacy of your health information.

"Protected health information," as used in this privacy notice, means any individually identifiable health information that is created or received by a health care provider or the Plan relating to:

- Your physical or mental health or condition
- The provision of health care to you
- The payment for health care

"Protected health information" does not include, among other things, any information maintained on the Company's payroll system or records related to an individual's enrollment in or coverage level under a Company group health plan. It also does not include any other information that the Company holds in its capacity as "employer" or in connection with plans other than the Company's group health plans.

The Company reserves the right to change or amend this privacy notice and our privacy practices and to make such changes effective for all protected health information that we maintain, but if we do, we will communicate any material changes to you in a revised privacy notice by the effective date of the material change. We will provide you with the revised notice, or information about the change and how to obtain the revised notice, in the next annual mailing to you. You may contact the Company's HIPAA Privacy Official to request a copy of this notice by mail, phone or email at:

Yeshiva University, Human Resources Department

500 West 185th Street | New York, NY 10033

646-592-4340 | benefits@yu.edu

How we may use or disclose your protected health information

We must use and disclose your protected health information to provide information:

- To you or someone who has the legal right to act for you (your personal representative)

- To the Department of Health and Human Services, if necessary, to make sure your privacy is protected
- When it's required by law

We have the right to use and disclose your protected health information to pay for your health care and to operate and administer the Plan. Some examples of when we may use your protected health information are:

- For payment of claims for services received by you and processed by the claims' administrators for the Plan in which you are enrolled.
- For treatment, so that doctors, hospitals, or both can provide you with medical care.
- For coordination of benefits with other covered health plans.
- For health care operations, to operate and administer the plan and to help manage your health care coverage. For example, the Plan may use your protected health information in connection with:
    - A disease management or wellness program to improve your health
    - Underwriting, including, but not limited to, soliciting bids from potential insurance carriers (genetic information shall not be used for underwriting purposes)
    - Merger and acquisition activities
    - Determining participant contributions
    - Submitting claims to the plans' stop-loss (or excess loss) carrier (if any)
    - Conducting or arranging for medical review
    - Legal services
    - Audit services
    - Fraud and abuse detection programs

The Plan also may use your protected health information for other administrative activities, such as cost management and conducting quality assessment and improvement activities.

- To provide information on health-related programs or products. For example, the claims administrator might talk to your doctor about health-related products and services, or to suggest an alternative medical treatment or program.

Under limited circumstances, we may have to use or disclose your protected health information:

- To people involved with your care, such as a family member, if you are incapacitated, in an emergency, or when permitted by law.
- For public health activities, such as reporting disease outbreaks.
- For reporting victims of abuse, neglect, or domestic violence to government authorities, including a social service or protective service agency.
- For health oversight activities such as governmental audits, fraud, and abuse investigations.
- For judicial or administrative proceedings, such as responding to a court order, search warrant, or subpoena.
- For law enforcement purposes, such as providing limited information to locate a missing person.
- To avoid a serious threat to health or safety, such as disclosing information to public health agencies.

- For specialized government functions, such as military and veteran activities, national security, and intelligence activities.
- For workers' compensation, including disclosures required by state workers' compensation laws for job-related injuries.
- For research purposes, such as research related to the prevention of disease or disability, but only if the research study meets all privacy law requirements.
- To provide information regarding decedents, such as providing protected health information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law, or to funeral directors as necessary to carry out their duties.
- For organ procurement purposes, such as banking or transplantation of organs, eyes, or tissue.

The Plan also may use your protected health information for other administrative activities, such as cost management and conducting quality assessment and improvement activities.

Substance Use Disorder. You have certain additional protections available to you related to substance use disorder treatment records to the extent we receive substance use disorder treatment records from any program or activity relating to substance abuse education, prevention, training, treatment, rehabilitation, or research which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States. We will not use or disclose any of these records without first obtaining your written authorization to disclose such records or without a court order requiring these records to be used or disclosed. We will require that any court order be accompanied by a subpoena or other legal document compelling disclosure before the records will be disclosed. Please note, however, that your written authorization is not required if the records are being provided to public health authorities if the records are de-identified pursuant to the requirements under the Privacy Rule.

If none of the above reasons applies, then your written authorization is needed to use or disclose your protected health information. Specifically, your written authorization is required to use or disclose any psychotherapy notes, if applicable, and to use or disclose any protected health information for marketing purposes or for which the group health plans receive compensation. If applicable, the group health plans also may contact you to raise funds, but you may elect not to receive any such fundraising communications in the future. If a use or disclosure of protected health information is prohibited or materially limited by other applicable laws, then it is our intent to meet the requirements of the more stringent law to protect your privacy.

After we receive authorization from you to release your protected health information, we cannot guarantee that the person to whom the information is provided will not disclose your information. You may revoke your written authorization unless we have already acted based on your authorization. To revoke an authorization, contact the claims administrator for the Plan in which you are enrolled.

Note, any required or permitted disclosures described in this Notice may be subject to redisclosure by the recipient of the disclosure and, at that time, would no longer be protected by the rights and obligations described in this Notice. Further, the Plan does not use or disclose PHI, including substance use disorder information, for purposes of fundraising.

What are your rights to your protected health information?

You have the right to:

- Ask for restrictions on uses or disclosures of your protected health information for treatment, payment, or health care operations. You also can ask to restrict disclosures to family members or to others who are involved in or make payments for your health care. We may also have policies on dependent access that may authorize certain restrictions. We ask you to understand that while we will try to honor your

request and will permit requests consistent with our policies, we are not required to agree to any restriction.

- A covered entity (such as a health care provider) must comply with the requested restriction if the disclosure is to a health plan for purposes of payment or health care operations and the protected health information relates to a health care item or service for which an individual paid in full, out of pocket. For example, if you receive medical care and choose to pay the provider for the entire amount of care in full, out of pocket, you can request that the provider not disclose such information to the Plan, and the provider must agree to such request.
- Choose how we contact you. You have the right to ask that we communicate with you about medical matters in a certain way or even at a certain location. An example of this could be that we only contact you at work or by mail. If you have a preference regarding how we communicate with you, please let us know in writing. We are not required to agree to your request, but, if we do agree to it, we will comply with it.
- See and obtain a copy of your protected health information that may be used to make decisions about you, such as claims and cases or medical management records. You may receive a summary of this health information. If your protected health information is maintained electronically in one or more designated record sets, then you have the right to get a copy of this health information in an electronic format. A written request will be needed to inspect and copy your protected health information. In certain limited circumstances, your request to inspect and copy your protected health information may be denied. An access request should be made to the applicable claims administrators as listed within this privacy notice.
- Ask to amend the protected health information we maintain about you if you believe it is wrong or incomplete. The amendment must be submitted in writing to the claims' administrator for the Plan in which you are enrolled, along with a reason that supports your request. If your request is denied, you may have a statement of your disagreement added to your protected health information.
- Appoint a personal representative You may request that the Plan disclose your protected health information to your personal representative. A "personal representative" is an individual you designate to act on your behalf and make decisions about your medical care. If you want the Plan to disclose your protected health information to your personal representative, submit a written statement giving the Plan permission to release your protected health information to your personal representative and documentation that this individual qualifies as your personal representative under state law, such as a power of attorney authorizing this individual to make health care decisions for you. Submit this request in writing to the applicable claims' administrator.
- Receive an accounting of disclosures of your protected health information made by the Plan during the six years before your request. This accounting will not include disclosures of protected health information made:

    1. For treatment, payment, and health care operations purposes;
    2. To you or pursuant to your authorization;
    3. To correctional institutions or law enforcement officials; and
    4. In connection with other disclosures for which federal law does not require us to provide an accounting.

    Your request should indicate in what format you want the list (for example, on paper or electronically). Submit this request in writing to the applicable claims' administrator. The first list that you request in a 12-month period will be free and we may charge you for responding to any additional requests. We will

notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

You have the right to request a paper copy of this privacy notice anytime by contacting the Company's Privacy Official by mail, phone or email at:

Yeshiva University, Human Resources Department

500 West 185th Street | New York, NY 10033

646-592-4340 | benefits@yu.edu

How to exercise your rights

Contact the claims administrators

If you have any questions about this privacy notice or want to exercise any of your rights, call the claims administrator for the Plan coverage options in which you are enrolled. Contact information is listed in the "Claims administrators" section on the last page of this notice.

Filing a complaint

If you believe your privacy rights have been violated, you may contact the Plan's HIPAA Privacy Official in writing at the following address:

Yeshiva University

Yeshiva University, Human Resources Department

500 West 185th Street | New York, NY 10033

You may also file a complaint with the Secretary of the United States Department of Health and Human Services Office of Civil Rights at: 200 Independence Avenue, SW, Room 509-F HHH Building, Washington, DC 20201, or at the applicable regional office of the HHS Office of Civil Rights, the contact information for which is available at: https://www.hhs.gov/ocr/about-ocr/contact-ocr/index.html

We will not take any action against you for filing a complaint.

The Company's group health plans have policies and procedures in place designed to address breaches of unsecured protected health information. The Company's group health plans are obligated to, consistent with HIPAA, notify you if your unsecured protected health information is breached. If your complaint relates to breach notification procedures of the Company's group health plans or compliance with the policies and procedures of the Company's group health plans in general, send the complaint to the Privacy Official at the address listed above.

Restrictions on protected health information

The Company may not use or disclose protected health information for employment-related actions or decisions. The Company may only use or further disclose protected health information as permitted or required by law and will report any use or disclosure of protected health information that is inconsistent with the permitted uses and disclosures.

Plan Administrator and health plan separation

The Company's team members, classes of team members, or other workforce members listed as "authorized employees" in the Plan's HIPAA policies and procedures will have access to protected health information only to perform the plan administrative functions required of the Plan Administrator to administer the Company's group health plans.

This list includes every team member, class of team member, or other workforce member under the control of the individual who may receive protected health information relating to the ordinary course of business.

The team members, classes of team members, or other workforce members identified above (and any individual under the control of these team members) may be subject to disciplinary action and sanctions for any use or disclosure of protected health information that is in violation of these provisions.

Claims Administrators

Here is the contact information to reach the claims administrator for the Company's group health plans benefits in which you are enrolled, please call the applicable number listed below:

- Self-Funded Administrator: Aetna 855-333-6825
- HCFSA Administrator: Health Equity 866-242-3458
- HRA Administrator: Inspira Financial 888-678-8242