

**September 2026**

**To: All Active and Retired Employees Eligible for Benefits under the Fresno Unified School District's Employee Health Care Plan**

**Re: Required Legal Notices**

### **WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998**

Under federal law, group health plans, insurers, and HMOs that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery, effective for the first plan year beginning on or after October 21, 1998.

In the case of a participant or beneficiary who is receiving benefits under the plan in connection with a mastectomy and who elects breast reconstruction, federal law requires coverage 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 at all stages of the mastectomy, including lymphedemas.

Each of the medical plan options available through the Fresno Unified School District Health Plan currently covers mastectomies and reconstructive surgery. Coverage is subject to each plan's deductibles, coinsurance and benefit provisions. These provisions are generally described in the Plan Booklet or Explanation of Coverage.

### **NEWBORN MOTHERS HEALTH PROTECTION ACT**

Under the Newborn and Mothers Health Protection Act, the following language is now included in the Health Plan:

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 for the eligible mother and newborn child 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). The time periods outlined above begin at the birth of the child. The law also prohibits a plan from requiring a health care practitioner to obtain authorization from the Plan for prescribing a length of stay not in excess of those periods.

### **HIPAA SPECIAL ENROLLMENT RIGHTS**

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll your new dependents. The District also allows you to enroll a child placed in your permanent legal guardianship outside of open enrollment, subject to the Special Enrollment requirements. If you are enrolling a new dependent as a result of birth, adoption, placement for adoption, or permanent legal guardianship, you can also enroll your Spouse or State Registered Domestic Partner if he or she was not previously enrolled in the Plan, but only if he or she is otherwise eligible to participate in the Plan. Part-time employees are only eligible to enroll in dental and/or vision insurance if they experience a special enrollment event.

Other midyear election changes may be permitted under your plan. To request special enrollment or obtain more information, contact the Benefits Office.

“HIPAA Special Enrollment Opportunities” include:

- ☐ COBRA (or state continuation coverage) exhaustion
- ☐ Loss of other coverage
- ☐ Acquisition of a new spouse or dependent through marriage, adoption, placement for adoption, or birth, or a child placed in your permanent legal guardianship
- ☐ Loss of state Children’s Health Insurance Program coverage (e.g., Healthy Families) (60-day notice)
- ☐ Employee or dependents become eligible for state Premium Assistance Subsidy Program (60-day notice)

## **AVAILABILITY OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION**

The Joint Health Management Board (“JHMB”), as the sponsor of the Fresno Unified School District Employee Health Care Plan (the “Plan”), is required by law to inform you of how you can obtain a copy of the Plan’s **NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION** (“Notice”). This Notice has previously been provided to all Plan participants.

The Notice informs you about your rights and the Plan’s legal duties and privacy practices with respect to your protected health information, and to notify you if there is a breach of your unsecured protected health information.

A copy of the full Notice can be obtained at any time by writing or calling the Fresno Unified School District Benefit Office and requesting a copy. It can also be viewed or downloaded from the JHMB HealthConnect website at: <http://www.jhmbhealthconnect.com>.

## **EEOC WELLNESS PROGRAM NOTICE**

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

However, employees who choose to participate in the wellness program will receive an incentive of a \$25 gift card for completing the health screening requirements. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive a \$25 gift card. This gift card may be reportable income. Please consult a tax professional for further information.

Additional incentives of up to \$100 may be available for employees who participate in certain health-related activities, such as the successful completion of a WellPATH Wellness Challenge. 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 WellPATH at [WellPATH@delapro.com](mailto:WellPATH@delapro.com).

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as enrollment in personal training, behavior modification and/or health coaching. 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 Fresno Unified School District may use aggregate information it collects to design a program based on identified health risks in the workplace, WellPATH 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 a Pinnacle Training Systems health coach or your Primary Care Physician (only upon your request) 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 WellPATH at [WellPATH@delapro.com](mailto:WellPATH@delapro.com).

## **YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS**

When you receive emergency care (other than ground ambulance services) 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.

### What is “balance billing” (sometimes called “surprise billing”)?

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

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

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

### **You are protected from balance billing for:**

#### Emergency services

When you receive emergency care (other than ground ambulance services) or are 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.

If you have an emergency medical condition and get emergency services (other than ground ambulance services) from an out-of-network provider or facility, or air ambulance, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency 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 balance billed for these post-stabilization services.

Thirty-three states have enacted laws to protect enrollees from balance billing and the scope of these protections varies by state. Congress enacted the No Surprises Act in 2020 to protect most people who are not currently protected under this patchwork of state laws. This federal law went into effect on January 1, 2022. Visit the National Conference of State Legislatures to see if your state has consumer protections at <https://www.ncsl.org/>.

In 2009 a California Supreme Court unanimously ruled that non-contracting emergency room doctors and hospitals cannot send the balance of a bill to consumers with Department of Managed Health Care (DMHC) regulated coverage. This ruling excluded balance billing protections for self-funded plans. Under the No Surprises Act, self-funded plans are now protected from receiving balance billing for emergency services.

#### Certain services at an in-network hospital or ambulatory surgical center

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

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

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

Thirty-three states have enacted laws to protect enrollees from balance billing and the scope of these protections varies by state. Congress enacted the No Surprises Act in 2020 to protect most people who are not currently protected under this patchwork of state laws. This federal law went into effect on January 1, 2022, to offer consumers protection against balance billing for non-emergency services rendered by a non-network provider at a participating health care facility, provided the participant has not validly waived the applicability of the NSA; and covered non-network air ambulance services. Visit the National Conference of State Legislatures to see if your state has consumer protections at <https://www.ncsl.org/>.

In 2009 a California Supreme Court unanimously ruled that non-contracting emergency room doctors and hospitals cannot send the balance of a bill to consumers with Department of Managed Health Care (DMHC) regulated coverage. This ruling excluded balance billing protections for self-funded plans. Under the No Surprises Act, self-funded plans are now protected from receiving balance billing for emergency services. <https://dmhc.ca.gov/portals/0/healthcareincalifornia/factsheets/fsab72.pdf>

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

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.
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**If you believe you've been wrongly billed, you may contact:**

- The Department of Health and Human Services (HHS) at 1-800-985-3059 or visit <https://www.cms.gov/nosurprises/consumers> for more information about your rights under federal law.
- Department of Managed Healthcare at 1-888-466-2219 or visit [www.HealthHelp.ca.gov](http://www.HealthHelp.ca.gov)

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[https://health-access.org/wp-content/uploads/2021/02/No-Surprises-HA-Fact-Sheet\\_2.8.21.pdf](https://health-access.org/wp-content/uploads/2021/02/No-Surprises-HA-Fact-Sheet_2.8.21.pdf)

<https://www.ncsl.org/>