

September 2026

To: COBRA Participants Enrolled 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.

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>.

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

https://health-access.org/wp-content/uploads/2021/02/No-Surprises-HA-Fact-Sheet_2.8.21.pdf

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