



## Required Notices

### IMPORTANT INFORMATION

### for all Benefit Eligible Employees

The following Notices are required by the laws surrounding health care plans. Please review these notices. If you have any questions, please contact your Treasurer's office.

#### **Evergreen Election**

For those employee benefit programs that allow for employee payroll deductions to be taken on a pre-tax basis, the district's Section 125 Plan allow for such pre-tax deductions. As allowable by law, employee's payroll deductions will be taken on a pre-tax basis unless the employee notifies the Treasurer's office, and completes an election form declining participation. Any change will be effective as of the first day of the new plan year. The salary adjustment amounts will be adjusted automatically to reflect any increase or decrease in the cost of the plans selected. This "evergreen" election applies to all plans as allowable by law to be taken on a pre-tax basis.

#### **USERRA**

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted.

If you do not elect to continue to participate in the Plan during an absence for military duty that is more than 31 days, you and your covered family members will have the opportunity to elect COBRA Continuation Coverage only under the medical insurance policy for the 24-month period (18-month period if you elected coverage prior to December 10, 2004) that begins on the first day of your leave of absence. You must pay the premiums for Continuation Coverage with after-tax funds, subject to the rules that are set out in that plan.

#### **Your Rights After a Mastectomy**

##### ***Women's Health and Cancer Rights Act of 1998***

Under Federal law, Group Health Plans and health insurance issuers providing benefits for mastectomy must also provide, in connection with the mastectomy for which the participant or beneficiary is receiving benefits, coverage for:

- reconstruction of the breast on which the mastectomy has been performed; and
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and physical complications of mastectomy, including lymphedemas;

These services must be provided in a manner determined in consultation between the attending Physician and the patient. Call your Treasurer's office for more information.

#### **Newborns and Mothers Health Protection Act (NMHPA)**

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).

## **HIPAA Special Enrollment Notice**

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing 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 as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact your Treasurer's office.

## **The Affordable Care Act**

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan does provide minimum essential coverage.

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

## **Patient Protection Disclosure**

You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the plan may designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, you may contact the insurance carrier. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the insurance carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, you may contact the insurance carrier.

## **Summary of Benefits and Coverage (SBC)**

As part of the Affordable Care Act, healthcare companies and group health plans must now provide Summary of Benefits and Coverage documents, or SBCs, to help employers, their employees and their families, understand and compare health plans. The SBC and Uniform Glossary are meant to help consumers understand their healthcare coverage, as well as understand common terms used by health plans. Insurance companies and group health plans must provide SBCs in a standard format, and the SBCs can only differ regarding specific plan benefits. This standard format will make it easier for employers and employees to compare plans and shop for a plan that best meets their needs. The Medical & Prescription Drug SBC will be provided to you during open enrollment.

## **Additional Required Notices Are Attached:**

- No Surprise Billing Model Notice
- HIPAA Notice of Privacy Practices
- CHIP Model Notice
- Notice Regarding Wellness Program
- Summary of Benefits and Coverage (SBC) – *PPACA Requirement*

*The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It should not be construed as, nor is it intended to provide, legal advice. Laws may be complex and subject to change. This information is based on current interpretation of the law and is not guaranteed. Questions regarding specific issues should be addressed by legal counsel who specializes in this practice area.*