



Jefferson Joint School District 251

Group Health Plan Notices 2026

Annual Required Legal Notices and Disclosures for Plan Participants

The following notices provide important information about your employer provided group health plan. Please read the notices carefully and keep a copy for your records. If you have any questions regarding these notices, please contact Human Resources or the plan administrator at ALords@SD251.org or (208) 745-6693.

Medicare Part D Notice

Important Notice About Your Creditable Prescription Drug Coverage and Medicare

If you or any of your eligible dependents are eligible for Medicare, or will soon become eligible for Medicare, please read this notice. If not, you can disregard this notice.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage 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 prescription 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. Your employer has determined that the prescription drug coverage offered by Blue Cross of Idaho (Preferred Blue PPO \$3,000 Ded & HSA Blue PPO \$6,800 Ded) is expected to pay, on average, 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 prescription drug plan.

Please contact Human Resources for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

Individuals who are eligible for Medicare should compare their current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in their area. Your medical benefits brochure contains a description of your current prescription drug benefits. If you are eligible for Medicare and do decide to enroll in a Medicare prescription drug plan and drop your employer's group health plan prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

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 coverage with your employer and don't join a Medicare prescription 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 Human Resources for further information.

NOTE: You will receive this notice annually, before the next period you can join a Medicare prescription drug plan, and if this coverage through your employer 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 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 the Social Security Administration (SSA) online at www.socialsecurity.gov, or call SSA 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 prescription drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Women's Health and Cancer Rights Act Notice

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

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact the plan administrator.

Newborns' and Mother's Health Protection Act

The Newborns' and Mothers' Health Protection Act (NMHPA) requires that group health plans and health insurance issuers who offer childbirth coverage 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Refer to your plan document for specific information about childbirth coverage or contact your plan administrator.

For additional information about NMHPA provisions and how Self-funded non Federal governmental plans may opt-out of the NMHPA requirements, visit http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/nmhpfa_factsheet.html.

HIPAA Non-Discrimination Requirements

The Health Insurance Portability & Accountability Act (HIPAA) prohibits group health plans and health insurance issuers from discriminating against individuals in eligibility and continued eligibility for benefits and in individual premium or contribution rates based on health factors.

These health factors include health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities), and disability.

Notice of HIPAA Special Enrollment Rights

A federal law called HIPAA requires that we notify you of your right to enroll in the plan under its “special enrollment provision” if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Special Enrollment Provisions

Loss of Other Coverage (Except Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (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).

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

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. 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 new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

Other mid-year election changes may be permitted under your plan (refer to “Permitted Midyear Election Changes” section below).

To request special enrollment or obtain more information, contact Human Resources.

Permitted Midyear Election Changes

Due to Internal Revenue Service (IRS) regulations, in order to be eligible to take your premium contribution using pre-tax dollars, your election generally must be irrevocable for the entire plan year (with the exception of HSA benefit elections, for which prospective election changes generally are allowed). As a result, your enrollment in the medical, dental, and vision plans or declination of coverage when you are first eligible, will generally remain in place until the next open enrollment period, unless you have an approved election change event and certain other conditions are met as outlined in IRS Code Section 125. See your Section 125 premium conversion plan summary plan description (SPD) for further details and a complete listing of permitted change in election events.

Examples of permitted change in election events include:

- Change in legal marital status (e.g., marriage, divorce, annulment, or legal separation)
- Change in number of dependents (e.g., birth, adoption, or death)
- Change in your employment status or your spouse's or covered child's change in employment (e.g., reduction in hours affecting eligibility or change in employment)
- Your child satisfies or ceases to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance as provided in the plan under which you receive coverage
- You and/or your spouse or covered child has a change of residence
- Your spouse or covered child makes an election change during an open enrollment period under his or her employer's cafeteria plan, but only if the change under this Plan is consistent with and on account of your spouse's or covered child's change.
- Enrollment in state-based insurance Exchange
- Medicare Part A or B enrollment

These are just some examples of permitted mid-year change in election events. Consult with Human Resources for other circumstances that may be permissible mid-year change in election events.

You must notify Human Resources within 30 days of the above change in status, with the exception of the loss of eligibility or enrollment in Medicaid or state health insurance programs - which requires notice within 60 days.

HIPAA Privacy Notice

Notice of Health Information Privacy Practices

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

This notice is required by law under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). One of its primary purposes is to make certain that information about your health is handled with special respect for your privacy. HIPAA includes numerous provisions designed to maintain the privacy and confidentiality of your protected health information (PHI). PHI is health information that contains identifiers, such as your name, address, social security number, or other information that identifies you.

Our Pledge Regarding Health Information

- We understand that health information about you and your health is personal.
- We are committed to protecting health information about you.
- This notice will tell you the ways in which we may use and disclose health information about you.
- We also describe your rights and certain obligations we have regarding the use and disclosure of health information.

We are Required by Law to

- Make sure that health information that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to health information about you.
- Follow the terms of the notice that are currently in effect.

The Plan Will Use Your Health Information for

Treatment: The plan may use your health information to assist your health care providers (doctors, pharmacies, hospitals and others) to assist in your treatment. For example, the plan may provide a treating physician with the name of another treating provider to obtain records or information needed for your treatment.

Regular Operations: We may use information in health records to review our claims experience and to make determinations with respect to the benefit options that we offer to employees.

Business Associates: There are some services provided in our organization through contracts with business associates. Business associate agreements are maintained with insurance carriers. Business associates with access to your information must adhere to a contract requiring compliance with HIPAA privacy and security rules.

As Required by Law: We will disclose health information about you when required to do so by federal, state or local law.

Workers' Compensation: We may release health information about you for Workers' Compensation or

similar programs. These programs provide benefits for work-related injuries or illness.

Law Enforcement: We may disclose your health information for law enforcement purposes, or in response to a valid subpoena or other judicial or administrative request.

Public Health: We may also use and disclose your health information to assist with public health activities (for example, reporting to a federal agency) or health oversight activities (for example, in a government investigation).

Your Rights Regarding Your Health Information

Although your health record is the physical property of the entity that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information, where concerning a service already paid for.
- Obtain a paper copy of the Notice of Health Information Practices by requesting it from the plan privacy officer.
- Inspect and obtain a copy of your health information.
- Request an amendment to your health information.
- Obtain an accounting of disclosures of your health information.
- Request communications of your health information be sent in a different way or to a different place than usual (for example, you could request that the envelope be marked "Confidential" or that we send it to your work address rather than your home address);
- Revoke in writing your authorization to use or disclose health information except to the extent that action has already been taken, in reliance on that authorization.

The Plan's Responsibilities

The plan is required to:

- Maintain the privacy of your health information.
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction, amendment or other request.
- Notify you of any breaches of your personal health information within 60 days or 5 days if conducting business in California.
- Accommodate any reasonable request you may have to communicate health information by alternative means or at alternative locations.

The plan will not use or disclose your health information without your consent or authorization, except as provided by law or described in this notice. The plan reserves the right to change our health privacy practices. Should we change our privacy practices in a material way, we will make a new version of our notice available to you.

For More Information or to Report a Problem

- If you have questions or would like additional information, or if you would like to make a request to inspect, copy, or amend health information, or for an accounting of disclosures, contact Human Resources and the plan privacy officer. All requests must be submitted in writing.
- If you believe your privacy rights have been violated, you can file a formal complaint with the plan privacy officer, or with the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

Other Uses of Health Information

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you authorize us to use or disclose health information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the payment activities that we provided to you.

Important Information on How Health Care Reform Impacts Your Plan

Prohibition on Excess Waiting Periods

Group health plans may not apply a waiting period that exceeds 90 days. A waiting period is defined as the period that must pass before coverage for an eligible employee or his or her dependent becomes effective under the Plan.

Prohibition on Preexisting Condition Exclusions

Effective for Plan Years on or after January 1, 2014, Group health plans are prohibited from denying coverage or excluding specific benefits from coverage due to an individual's preexisting condition, regardless of the individual's age. A preexisting condition includes any health condition or illness that is present before the coverage effective date, regardless of whether medical advice or treatment was actually received or recommended.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

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

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

Can I Save Money on my Health Insurance Premiums in the Marketplace? You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace? Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also,

this employer contribution - as well as your employee contribution to employer-offered coverage - is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information? For more information about your coverage offered by your employer, please check your summary plan description or contact the plan administrator. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.healthcare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Employee Rights & Responsibilities under the Family Medical Leave Act (FMLA)

The FMLA only applies to employers that meet certain criteria. A covered employer is a:

- *Private-sector employer with 50 or more employees in 20 or more workweeks in the current or preceding calendar year (including a joint employer or successor in interest).*
- *Public agency (including a local, state, or Federal government agency) regardless of number of employees.*
- *Public or private elementary or secondary school, regardless of number of employees.*

Leave Entitlement

Family Medical Leave Act (FMLA) requires covered employers to provide up to 12 weeks of unpaid, job protected leave in a 12-month period to eligible employees for the following reasons:

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

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

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

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

Benefits & Protections

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

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

Eligibility Requirements

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

- Have worked for the employer for at least 12 months.
- Have at least 1,250 hours of service in the 12 months before taking leave; * and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

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

Requesting Leave

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

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

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

Employer Responsibilities

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

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

Enforcement

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

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

For additional information or to file a complaint:

(866) 4US-WAGE ((866) 487-9243) TTY: (877) 889-5627

www.wagehour.dol.gov

Notice of Right to Continued Coverage under Uniformed Services Employment & Reemployment Rights Act (USERRA)

Right to Continue Coverage

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.

USERRA continuation group health plan coverage is considered alternative group health plan coverage for purposes of COBRA. Therefore, if you elect USERRA continuation coverage, COBRA continuation group health plan coverage will not be available.

Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

How to Continue Coverage

If the conditions are met, you (or your authorized representative) may elect to continue your coverage (and the coverage of your covered dependents, if any) under the Plan by completing and returning an Election Form 60 days after date that USERRA election notice is mailed, and by paying the applicable premium for your coverage as described below.

What Happens if You Do Not Elect to Continue Coverage?

If you fail to submit a timely, completed Election Form as instructed or do not make a premium payment within the required time, you will lose your continuation rights under the Plan, unless compliance with these requirements is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

If you do not elect continuation coverage, your coverage (and the coverage of your covered dependents, if any) under the Plan ends effective the end of the month in which you stop working due to your leave for uniformed service.

Premium for Continuing Your Coverage

The premium that you must pay to continue your coverage depends on your period of service in the uniformed services. Contact Human Resources for more details.

Medicare and Health Savings Accounts (HSAs)

If you are approaching Medicare eligibility and you currently contribute to a Health Savings Account (HSA) that is integrated with a High Deduction Health Plan (HDHP), it is important to understand how HSA eligibility rules and Medicare enrollment interact.

An individual is not eligible to make HSA contributions (nor eligible to have employer contributions made to their HSA) if the individual has other coverage including being enrolled in Medicare. An individual who is enrolled in Medicare is not eligible for continued HSA contributions, however, funds that existed in the HSA prior to Medicare enrollment may continue to be used for ongoing medical expenses.

It is important to be aware that Medicare enrollment based on age or disability cannot be waived by individuals who are receiving Social Security benefits. However, Medicare enrollment may be delayed by delaying the receipt of Social Security benefits. For those that delay applying for Medicare, enrollment is generally retroactive for up to six months (that is, Medicare coverage will begin up to six months prior to the month in which they applied). Because the first month of Medicare enrollment will be retroactive for individuals who delay applying for Medicare, those individuals should use extra care when determining the amount of their HSA contributions to avoid excess contributions and possible adverse tax consequences.

Notice Regarding Wellness Programs

Jefferson Joint School District's wellness program "Healthy Measures" through Blue Cross of Idaho is a voluntary wellness program available to all employees. Spouses are not required to participate. 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 are encouraged to meet with your doctor for a preventative health visit by November 30, 2023 to qualify for the reward. Your wellness exam is covered at 100% when you see an in-network provider. Additional services through the wellness program include access to Blue Cross of Idaho's health coaching, personal trainers, and registered dietitians through the WellConnected wellness portal. You also are encouraged to share your results or concerns with your own doctor.

Employees who choose to participate in the wellness program will be eligible to receive an incentive: Jefferson Joint School District will buy down your individual deductible to \$500 (\$1,000 for family). Additional incentives such as prizes may be available for employees who participate in certain health-related activities such as quarterly health challenges. (Note that some financial incentives will be subject to income tax for the employee who receives this benefit/incentive). Due to the potential changes with wellness regulations in response to the AARP v EEOC case, the incentive limit may change at some point. Please note that we will notify health plan members of any changes and adjust wellness rewards accordingly.

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 Human Resources.

For More Information or to Report a Problem

- If you have questions or would like additional information, or if you would like to make a request to inspect, copy, or amend health information, or for an accounting of disclosures, contact the plan privacy officer. All requests must be submitted in writing.
- If you believe your privacy rights have been violated, you can file a formal complaint with the plan privacy officer, or with the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

Other Uses of Health Information

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you authorize us to use or disclose health information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the payment activities that we provided to you.

Protection from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. The wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed, except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual who will receive your personally identifiable health information is your physician 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. In the event a data breach involving information you provide in connection with the wellness program occurs, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Human Resources.

JEFFERSON JOINT SCHOOL DISTRICT #251



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE:** Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit selecthealth.org or call 800-538-5038. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at selecthealth.org/sbc or call 800-538-5038 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$6,800 person/\$13,600 family per calendar year.	Generally, you must pay all the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of deductible expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes, for in-network <u>providers</u> : <u>preventive</u> care and <u>preventive</u> prescriptions are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$6,800 person/\$13,600 family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billed</u> charges, healthcare this <u>plan</u> doesn't cover, and penalties for failure to obtain <u>preauthorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. To find an in-network <u>provider</u> visit selecthealth.org/find-care or call Member Services at 800-538-5038.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a provider for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness (PCP)	No charge	No charge	A different benefit may apply for major office surgery.
	Specialist visit (SCP)	No charge	No charge	A different benefit may apply for major office surgery.
	Preventive care / screening / immunization	No charge, deductible does not apply.	No charge	You may have to pay for services that aren't preventive . Ask your provider if the services needed are preventive . Then check what your plan will pay for. Frequency limitations apply.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	No charge	-----None-----
	Imaging (CT/PET scans, MRIs)	No charge	No charge	-----None-----
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at selecthealth.org/prescriptions/default.aspx?st=id&plan=select	Standard Tier 1 (generic drugs)	No charge	No charge	Certain limitations apply. Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services. Deductible does not apply to certain prescriptions.
	Standard Tier 2 (preferred brand drugs)	No charge	No charge	
	Standard Tier 3 (non-preferred brand drugs)	No charge	No charge	
	Maintenance Tier 1 (generic drugs)	No charge	No charge	
	Maintenance Tier 2 (preferred brand drugs)	No charge	No charge	
	Maintenance Tier 3 (non-preferred brand drugs)	No charge	No charge	
	Specialty drugs	No charge	No charge	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	-----None-----
	Physician/surgeon fees	No charge	No charge	-----None-----
If you need immediate medical attention	<u>Emergency room services</u>	No charge	No charge	<u>Emergency room services</u> apply to in-network benefits.
	<u>Emergency medical transportation</u>	No charge	No charge	Emergencies only. <u>Emergency medical transportation</u> applies to in-network benefits.
	<u>Urgent care</u>	No charge	No charge	Applies to <u>urgent care</u> facilities only.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	No charge	Benefits may be denied or reduced by 50% for failure to obtain <u>preauthorization</u> for certain services.
	Physician/surgeon fee	No charge	No charge	
If you need mental health, behavioral health, or substance	Outpatient services	No charge	No charge	Benefits may be denied or reduced by 50% for failure to obtain <u>preauthorization</u> for certain services. Additional limitations and exclusions
	Inpatient services	No charge	No charge	
If you are pregnant	Office visits	No charge	No charge	Cost sharing does not apply to <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include test and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	No charge	Hospital stays that extend beyond 48 hours for a normal vaginal delivery or beyond 96 hours for a cesarean section must be pre-authorized at the time the <u>provider</u> recommends the extended stay.
	Childbirth/delivery facility services	No charge	No charge	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	No charge	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	<u>Rehabilitation services</u>	No charge	No charge	Up to 40 days per calendar year for inpatient physical, speech, and occupational therapies combined. Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	<u>Habilitation services</u>	No charge	No charge	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	<u>Skilled nursing care</u>	No charge	No charge	Up to 60 days per calendar year. Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	<u>Durable medical equipment (DME)</u>	No charge	No charge	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	<u>Hospice service</u>	No charge	No charge	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Preventive benefits abide by the ACA and are covered at 100%. One routine eye exam covered per calendar year.
	Children's glasses	Not covered	Not covered	Glasses are not covered.
	Children's dental check-up	Not covered	Not covered	Dental check-ups are not covered.



JEFFERSON JOINT SCHOOL DISTRICT #251



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately.**

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit selecthealth.org or call 800-538-5038. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at selecthealth.org/sbc or call 800-538-5038 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$4,000 person/\$8,000 family per calendar year.	Generally, you must pay all the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes, for in-network <u>providers</u> : <u>preventive</u> care, office visits, prescription drugs, and chiropractic services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	Yes. \$250 per person for prescription drugs. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$5,500 person/\$11,000 family in-network and \$7,000 person/\$14,000 family out-of-network.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billed</u> charges, healthcare this <u>plan</u> doesn't cover, and penalties for failure to obtain <u>preauthorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. To find an in-network <u>provider</u> visit selecthealth.org/find-care or call Member Services at 800-538-5038.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a provider for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness (PCP)	\$30/visit, deductible does not apply	50% co-insurance	A different benefit may apply for major office surgery.
	Specialist visit (SCP)	\$50/visit, deductible does not apply	50% co-insurance	A different benefit may apply for major office surgery.
	Preventive care / screening / immunization	No charge, deductible does not apply	50% co-insurance	You may have to pay for services that aren't preventive . Ask your provider if the services needed are preventive . Then check what your plan will pay for. Frequency limitations apply.
If you have a test	Diagnostic test (x-ray, blood work)	No charge, deductible does not apply	50% co-insurance	-----None-----
	Imaging (CT/PET scans, MRIs)	50% co-insurance	50% co-insurance	-----None-----
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at selecthealth.org/prescriptions/default.aspx?st=id&plan=select	Standard Tier 1 (generic drugs)	\$10/prescription, pharmacy deductible does not apply.	\$10/prescription, pharmacy deductible does not apply.	Certain limitations apply. Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
	Standard Tier 2 (preferred brand drugs)	\$25/prescription	\$25/prescription	
	Standard Tier 3 (non-preferred brand drugs)	\$45/prescription	\$45/prescription	
	Maintenance Tier 1 (generic drugs)	\$10/prescription, pharmacy deductible does not apply.	\$10/prescription, pharmacy deductible does not apply.	
	Maintenance Tier 2 (preferred brand drugs)	\$50/prescription	\$50/prescription	
	Maintenance Tier 3 (non-preferred brand drugs)	\$135/prescription	\$135/prescription	
	Specialty drugs	\$100/prescription	\$100/prescription	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% <u>co-insurance</u>	50% <u>co-insurance</u>	-----None-----
	Physician/surgeon fees	50% <u>co-insurance</u>	50% <u>co-insurance</u>	-----None-----
If you need immediate medical attention	<u>Emergency room services</u>	\$100/visit then 50% <u>co-insurance</u>	\$100/visit then 50% <u>co-insurance</u>	<u>Emergency room services</u> apply to in-network benefits.
	<u>Emergency medical transportation</u>	50% <u>co-insurance</u>	50% <u>co-insurance</u>	Emergencies only. <u>Emergency medical transportation</u> applies to in-network benefits.
	<u>Urgent care</u>	\$50/visit, <u>deductible</u> does not apply	50% <u>co-insurance</u>	Applies to <u>urgent care</u> facilities only.
If you have a hospital stay	Facility fee (e.g., hospital room)	50% <u>co-insurance</u>	50% <u>co-insurance</u>	Benefits may be denied or reduced by 50% for failure to obtain <u>preauthorization</u> for certain services.
	Physician/surgeon fee	50% <u>co-insurance</u>	50% <u>co-insurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 for office visits, 50% <u>co-insurance</u> for outpatient	50% <u>co-insurance</u> for office visits, 50% <u>co-insurance</u> for outpatient	Benefits may be denied or reduced by 50% for failure to obtain <u>preauthorization</u> for certain services. Additional limitations and exclusions apply. <u>Deductible</u> does not apply to in-network office visits and outpatient services.
	Inpatient services	50% <u>co-insurance</u>	50% <u>co-insurance</u>	
If you are pregnant	Office visits	\$30/visit, <u>deductible</u> does not apply	50% <u>co-insurance</u>	Cost sharing does not apply to <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include test and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	50% <u>co-insurance</u>	50% <u>co-insurance</u>	Hospital stays that extend beyond 48 hours for a normal vaginal delivery or beyond 96 hours for a cesarean section must be pre-authorized at the time the <u>provider</u> recommends the extended stay.
	Childbirth/delivery facility services	50% <u>co-insurance</u>	50% <u>co-insurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	50% <u>co-insurance</u>	50% <u>co-insurance</u>	Benefits may be denied or reduced by 50% for failure to obtain <u>preauthorization</u> for certain services.
	<u>Rehabilitation services</u>	\$50/visit for outpatient, 50% <u>co-insurance</u> for inpatient	50% <u>co-insurance</u>	Up to 40 days per calendar year for inpatient physical, speech, and occupational therapies combined. Benefits may be denied or reduced by 50% for failure to obtain <u>preauthorization</u> for certain services.
	<u>Habilitation services</u>	\$50/visit	50% <u>co-insurance</u>	Benefits may be denied or reduced by 50% for failure to obtain <u>preauthorization</u> for certain services.
	<u>Skilled nursing care</u>	50% <u>co-insurance</u>	50% <u>co-insurance</u>	Up to 60 days per calendar year. Benefits may be denied or reduced by 50% for failure to obtain <u>preauthorization</u> for certain services.
	<u>Durable medical equipment (DME)</u>	50% <u>co-insurance</u>	50% <u>co-insurance</u>	Benefits may be denied or reduced by 50% for failure to obtain <u>preauthorization</u> for certain services.
	<u>Hospice service</u>	50% <u>co-insurance</u>	50% <u>co-insurance</u>	Benefits may be denied or reduced by 50% for failure to obtain <u>preauthorization</u> for certain services.
If your child needs dental or eye care	Children's eye exam	\$50/visit, <u>deductible</u> does not apply	50% <u>co-insurance</u>	<u>Preventive</u> benefits abide by the ACA and are covered at 100%. One routine eye exam covered per calendar year.
	Children's glasses	Not covered	Not covered	Glasses are not covered.
	Children's dental check-up	Not covered	Not covered	Dental check-ups are not covered.