KAWEAH CARE ABOUT YOUR BENEFITS AND WELLNESS

JANUARY 1 THROUGH DECEMBER 31, 2021

Kaweah Delta

MORE THAN MEDICINE. LIFE.

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Kaweah Delta Health Care District (KDHCD) is recognized for the quality of service we provide and our attention to patient care. To succeed, we remain committed to hiring and retaining the best, most talented people for our hospital.

In return for your hard work and commitment. KDHCD fosters a supportive environment where your contributions can be appreciated and recognized. We want you to grow and accomplish incredible things, make a difference and ultimately build a fulfilling and rewarding career.

This guide focuses on employee benefits. These programs encourage development, self-improvement and well-being. We offer you the opportunity to stay healthy and secure with comprehensive health and wellness programs. We help you achieve financial goals through savings and retirement plans. We provide you and the people you love with peace of mind in the form of survivor, AD&D and disability insurance.

Our goal is to make a difference in your life and career so that you can make a difference in the lives of others. No matter where you happen to be along life's path, KDHCD benefits will be with you every step of the way.

If you have any questions about the contents of this guide, please reach out to us. We are here to help.

ELIGIBILITY

All full-time and part-time (48 or more hours per pay period) employees are eligible for benefits.

Coverage begins the first day of the month following 30 days of employment or a change to an eligible status.

Dependents

If you are an eligible employee, your eligible dependents include:

- Legally married spouse (KDHCD will recognize all marriage licenses valid in the state of issuance)*
- Registered domestic partner (RDP) as recognized by AB 2208, California's domestic partnership law*
- Children: natural, legally adopted or stepchildren up to age 26.

*If spouse or registered domestic partner who participates in the KDHCD Medical Plan and has coverage through his or her own outside employer (not KDHCD); the KDHCD plan will pay only as a secondary insurance. Spouses are required to enroll in their employer's health plan.

OPEN ENROLLMENT

Open Enrollment is your once-a-year opportunity to make changes to your benefit elections and to review which dependents you are including on your health plans.

Decisions made during Open Enrollment are generally in effect for the entire plan year, unless you have a Qualifying Change in Status:

- Marriage, legal separation or divorce
- Birth or adoption of a child
- Dependent becoming ineligible
- Retirement or termination of employment
- Death of a spouse or child
- Change in the status of spouse's employment (becoming employed or losing his/her job)

If one of these Qualifying Changes in Status occurs, you may make adjustments to your benefits within 30 days of the event.

Open Enrollment

All employees must complete an on-line enrollment and authorize their payroll deductions for open enrollment period. Elections will be effective 1/1/2021.

COST OF COVERAGE

Your Share of the Cost: Pre-Tax Premiums

Your health care premium contributions are automatically withheld from your pay as "pre-tax money." This means that payroll deductions listed below are not subject to income, Social Security or Medicare taxes. The trade-off is you can only enroll or drop coverage for yourself or your dependents during initial eligibility, Open Enrollment and "Qualifying Changes in Status." **See "Open Enrollment" on page 3 for more information.**

The deductions listed below are per pay period (2x per month).

MEDICAL	FULL-TIME EMPLOYEE		
POINT OF SERVICE (PSP) FULL TIME	**EE Bi-Weekly Deduction**		**Cobra Premium**
EE Only	$50.00	$0.00	$728.70
EE + Sp	$135.00	$0.00	$1,457.40
EE + CH	$117.50	$0.00	$1,415.46
EE + Family	$175.00	$0.00	$2,277.71
HIGH DEDUCTIBLE HEALTH CARE PLAN (HDHP)		**Kaweah's contribution towards HSA Seed**	
EE Only	$25.00	$10.00	$658.44
EE + Sp	$95.00	$30.00	$1,312.80
EE + CH	$80.00	$30.00	$1,275.04
EE + Family	$105.00	$40.00	$2,051.74

MEDICAL PART-TIME EMPLOYEE

POINT OF SERVICE (PSP) PART TIME	EE Bi-Weekly Deduction				Full Monthly
EE Only	$120.00		$0.00		$728.70
EE + Sp	$255.00		$0.00		$1,457.40
EE + CH	$215.00		$0.00		$1,415.46
EE + Family	$300.00		$0.00		$2,277.71
HIGH DEDUCTIBLE HEALTH CARE PLAN (HDHP)			**Kaweah's contribution towards HSA Seed**		
EE Only	$90.00		$5.00		$658.44
EE + Sp	$200.00		$15.00		$1,312.80
EE + CH	$160.00		$15.00		$1,275.04
EE + Family	$210.00		$20.00		$2,051.74

DENTAL CONTRIBUTIONS

		EE Bi-Weekly Deduction	Cobra Premium
DENTAL PPO	***Dental PPO - Full Time***		
EE Only		$4.00	$32.09
EE + Sp		$14.00	$64.19
EE + CH		$15.00	$87.09
EE + Family		$26.50	$129.88
DENTAL PPO	***Dental PPO - Part Time***		
EE Only		$9.00	$32.09
EE + Sp		$19.00	$61.19
EE + CH		$21.00	$87.09
EE + Family		$32.00	$12.9.88
DENTAL CHOICE	***Dental Choice - Full Time***		
EE Only		$8.00	$40.33
EE + Sp		$22.00	$80.67
EE + CH		$26.00	$109.49
EE + Family		$43.00	$163.23
DENTAL CHOICE	***Dental Choice - Part Time***		
EE Only		$13.00	$40.33
EE + Sp		$27.00	$80.67
EE + CH		$31.50	$109.46
EE + Family		$48.00	$163.23

VISION CONTRIBUTIONS

	EE Bi-weekly Deduction	Cobra Premium
VISION		
EE Only	$5.39	$11.00
EE + Sp	$8.65	$17.65
EE + CH	$8.01	$16.34
EE + Family	$12.80	$26.11

HOSPITAL INDEMNITY

	EE Bi-weekly Deduction
VOYA	
EE Only	$10.51
EE + Sp	$17.58
EE + CH	$17.32
EE + Family	$24.39

VISION

The KDHCD vision plan is designed to provide you with access to quality eye care and coverage for vision materials like frames, lenses and contacts. You can visit any vision care provider but, staying in-network maximizes savings. Vision Service Plan (VSP) is one of the leading vision benefits companies. Through VSP, you will have access to thousands of private practice and retail-affiliated network providers.

Receiving Care Is Easy

1. Select a provider: Find a complete list at www.vsp.com.
   Again, in-network = better benefits.
2. Schedule an appointment. Make sure to let them know about your VSP coverage.
3. Your doctor will take care of the rest. They will contact VSP to verify your benefits and submit a claim for covered services.

Vision Benefits Summary

This is a brief summary of benefits. Please refer to the plan booklet for a complete description of benefits. If there are any discrepancies between the benefits summary and the plan booklet, the plan booklet will prevail.

Discription	IN-NETWORK	OUT-OF-NETWORK
Exam once every 12 months	$25	Up to $50 allowance
Lenses once every 12 months		
Single Lenses	No charge	Up to $50 allowance
Bifocal Lenses	No charge	Up to $75 allowance
Trifocal Lenses	No charge	Up to $100 allowance
Frames once every 24 months	Up to $150 allowance	Up to $70 allowance
Contact Lenses once every 12 months	Up to $150 allowance	Up to $105 allowance

The Importance of Vision Care

More than half of vision problems may be prevented by regular examinations.

- **Over 177 million people are in need of some form of corrective eyewear.**
- **One of every four children has a vision problem. Early detection can enhance a child's growth and development.**
- **Eye exams can detect diabetes, multiple sclerosis, high blood pressure, cancer, brain tumors and high cholesterol.**

DENTAL

Dental PPO Highlights

- No referrals necessary
- No copayments for most diagnostic and preventive services.
- In-network dentists have agreed to provide services at negotiated rates.

Dental Choice Highlights

- No referrals necessary.
- No charges for most diagnostic and preventive services, plus savings on covered services after the annual plan maximum.

Dental Plan Summary and Comparison

Talk to your dentist about out-of-pocket costs prior to receiving services. The percentages listed below are the coinsurance levels the plan will pay for covered services. The summary information on this page does not include all exclusions and limitations. Please refer to the plan booklet for a complete description of benefits. If there are any discrepancies between the benefits summary and the plan booklet, the plan booklet will prevail.

Description	PPO Option		Choice Option	
	IN-NETWORK	NON-NETWORK	IN-NETWORK	NON-NETWORK
Annual Deductible	$50 Individual	$50 individual	$50 individual	$50 individual
AnnualPlan Maximum	$1,500	$1,500	$1,500	$1,500
Diagnostic and Preventive Services				
Periodic OralExams	No charge	No charge	No charge	No charge
X-Rays, Prophylaxis	No charge	No charge	No charge	No charge
Basic Services				
	90%	80%	80%	80%
Major Service				
	60%	50%	50%	50%
Orthodontia				
	50%	50%	50%	50%
	Lifetime Maximum $1,000		Lifetime Maximum $1,000	

HEALTH AND WELLNESS

Most of us spend almost as much time with our work family as we do with our own family. We are attached to, invested in and care about each other. Our wish for every member of the Kaweah Delta Health Care District employee family is to be happy and healthy.

In addition, your well-being has direct benefits to KDHCD beyond how much we care about you as a person. When you are at the top of your game you help our District enjoy a level of energy and drive that help us to be a center of achievement and excellence.

KNOW YOUR NUMBERS

How: A yearly health screening by your PCP, or other medical provider that can indicate your risk for certain disease and medical conditions. (Include any additional annual exams such as Mammo, Pap, prostate check and colorectal as appropriate).

Dental, Vision and annual Flu shots are valuable wellness checks for continued great health.

HEALTHY EATING

In coordination with our Food and Nutrition services, healthy meals will be available at all our cafeterias, restaurants and cafes. Nutritional information and menus will also be available.

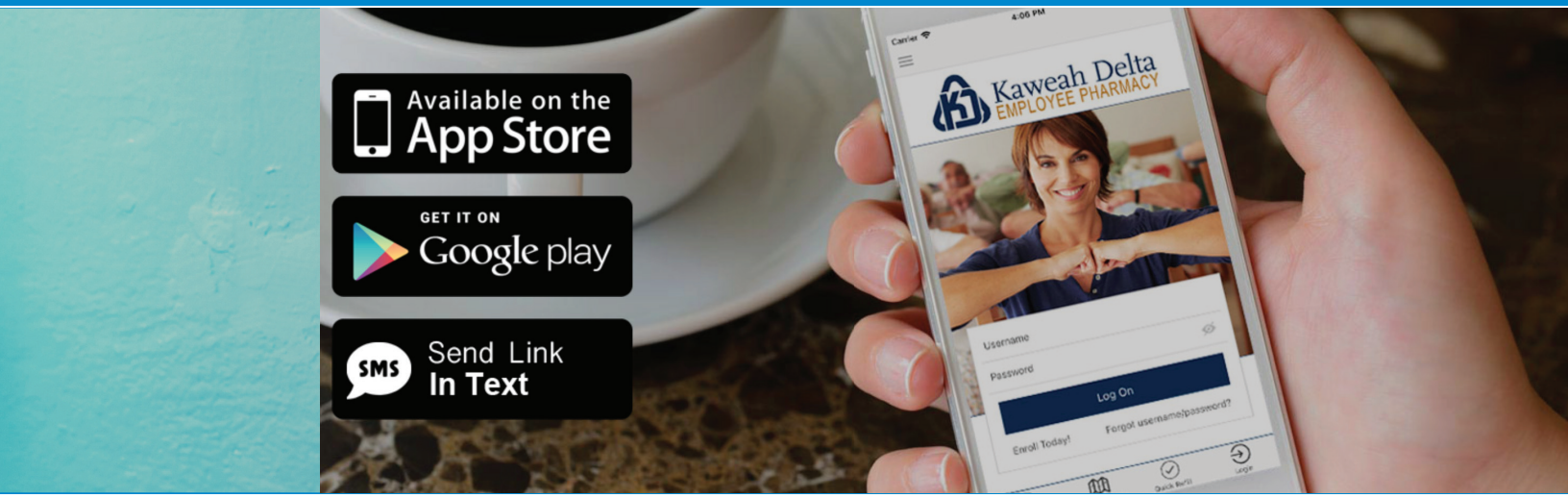
HEALTHY LIVING PROGRAMS

- Smoking Cessation Programs
- Weight Loss Programs
- Stretching instructions online for desk bound jobs
- Chair yoga- YouTube video on- line

AN OUNCE OF PREVENTION

If you're living an active, healthy lifestyle and taking good care of yourself, you may think a trip to the doctor is the last thing you need. Remember, doctor visits are for healthy people, too.

It's important to think about preventive health - catching problems before they start. Proper immunizations can help prevent serious diseases for children and adults. Regular screenings for high blood pressure and cholesterol, diabetes and other conditions can identify a problem before it becomes worse.



REFILLING PRESCIPTIONS JUST GOT EASIER

REASONS TO REFILL ONLINE:

- It's FREE
- Refill in the comfort of your own home or office
- Access your account 24/7
- Check the status of your prescriptions
- Pick up when ready
- Identify pills and search drug information
- View/refill family's prescriptions from one account

IT'S EASY

Access and refill your prescriptions directly from your Apple or Android device using our pharmacy mobil app.

kdemployeepharmacy.org

HOW DO I REGISTER?

1: Go to - kdemployeepharmacy.org

2: Click "Sign up Today"

3: Complete registration form

4: Create a username and password

5: Login to start accessing your account

Kaweah Delta
EMPLOYEE PHARMACY

602 W. Willis Ave. Suite B
Visalia, CA 93291

(559) 624-2920
kdemployeepharmacy.org

Employee Wellness Specialty Programs

Kaweah Delta has implemented voluntary wellness programs for a variety of conditions as part of our overall wellness initiative. These programs focus on improving the health of employees and covered dependents while saving you money.

If you, your spouse, or adult dependent covered under Kaweah Delta's Foundation insurance have been diagnosed with certain conditions, you/they may be eligible to participate in this program.

Eligible conditions include:

- Diabetes
- Chronic infectious disease
- Certain rheumatologic conditions

Program Benefits include:

- Access to a health care team who, in collaboration with your primary care provider and/or specialist, will evaluate and monitor your medication regimen to ensure safe and effective therapy.
- Access to a dedicated team who will coordinate prescription authorizations and manage refills.
- Waived copays on specific medications evaluated and managed by the Chronic Disease Management Center (CDMC) health care team.
- Waived copays for visits at the CDMC.

Contact us with any questions and to apply!

Kaweah Delta Chronic Disease Management Center
325 S. Willis St. Visalia, CA 93291
Phone: 559-624-4586 | Fax: 559-625-7661

Diabetes Wellness Program for Pregnant Women & Non-Adult Participants

The Diabetes Wellness Program includes 2 additional programs:

- Pregnant/gestational diabetes
- Non-adult diabetes (<18 years of age)

Benefits and requirements of each program are summarized below:

- Enrollment forms and instructions for these programs can be obtained from the Foundation for Medical Care.
- Participants will have their copays waived for specific diabetes medications and visits to the Chronic Disease Management Center (CDMC), as applicable.
- Copays will only be waived at the Kaweah Delta **Employee Pharmacy** located at 602 W. Willow St, Suite B.
- Participation in this program is strictly voluntary and participants may opt out of the program at any time and resume paying standard copays.

DIABETES WELLNESS PROGRAM for NON-ADULT PARTICIPANTS (under 18 years of age)

Participation Requirements:
PCP OR ENDOCRINOLOGIST: at least 1 visit per year
LABS: A1c at least 2 times per year
IMMUNIZATIONS: Annual flu shot and up-to-date on pneumonia (Prevnar/Pneumovax)
DIABETES EDUCATION: Enrollee agrees to attend formal diabetes education with an approved provider in the first year of participation in this program. Not required if member has attended the education within the previous three years.

DIABETES WELLNESS PROGRAM for PREGNANT/GESTATIONAL

Participation Requirements:
Participation in the Sweet Success Program at Kaweah Delta's Diabetes Clinic in the Chronic Disease Management Center

To Enroll in a Diabetes Wellness Program:

- Contact the Foundation for Medical Care at 559-735-3892 Option 2.
  - Adult, Non-Adult or Pregnant/Gestational Program
- Have your primary care physician sign the agreement, if applicable
- Return the agreement to the Foundation for Medical Care of Tulare and Kings Counties
- For adult participants, once your agreement has been reviewed and processed, staff at CDMC will contact you to schedule your first consultation

2021 POINT OF SERVICE (PSP) PLAN

	Kaweah	In-Network	Out-Of-Network
GENERAL ATTRIBUTES			
Deductible - EE / FAM	$0	$1,000 / $2,000	$1,000 / $2,000
Coinsurance	0%	20%	50%
Out of Pocket Max - EE / FAM	$4,000 / $8,000	$4,000 / $8,000	$6,000 / $12,000
Aggregate vs Embedded Deductible		Embedded	
Aggregate vs Embedded OOP Max		Embedded	
HOSPITAL		**You pay:**	
Inpatient			
Admission Deductible/Copay	No charge*	20% after deductible	$100/confinement + 50% after deductible
Pre-authorization Required?		Yes	
Outpatient Surgery	No charge*	20% after deductible	50% after deductible
Urgent Care****	$20/visit	$30/visit + 20% after deductible	$30/visit + 50% after deductible
Emergency Room	$200/visit	$200/visit	$200/visit
PHYSICIAN'S SERVICES		**You pay:**	
Office Visits	Not Available at Kaweah	$20/visit	$30/visit
Specialist Office Visit	Not Available at Kaweah	$40/visit	$60/visit
Preventive Care	No charge*	No charge*	50% after deductible
Diagnostic Test/Lab/X-ray (Outpatient)	No charge*	20% after deductible	50% after deductible
Advanced Imaging (Outpatient)	No charge*	20% after deductible	50% after deductible
Diagnostic Test/Lab/X-ray (Inpatient)	No charge*	20% after deductible	50% after deductible
Advanced Imaging (Inpatient)	No charge*	20% after deductible	50% after deductible
Prenatal Care	Not Available at Kaweah	$20/visit*	50% after deductible
Postnatal Care	Not Available at Kaweah	$20/visit*	50% after deductible
PRESCRIPTION DRUGS**			
Retail (30 days)		**You pay:**	
Generic	$5/Rx	$20/Rx	
Preferred brand drugs	$35/Rx	$45/Rx	
Non-preferred brand drugs	$60/Rx	$70/Rx	
Specialty			
Mail Order (90 days)			
Generic	$10/Rx	$60/Rx	
Preferred brand drugs	$70/Rx	$135/Rx	
Non-preferred brand drugs	$120/Rx	$210/RX	
Specialty			

**Limited to ER and office visits.

Kaweah Delta has recently negotiated excellent reduced rates with USC and Valley Children's Hospital. If you are unable to use Kaweah Facilities, USC or Valley Children's Hospital will save you the most money when seeking services at an In-Network provider. You may still use Stanford, but we suggest you compare the overall costs between USC and Stanford first, to see how you can save yourself money on out of pocket costs when you select USC.

Choosing USC or Valley Children's Hospital will mean a smaller overall bill when you pay your 20% coinsurance share.

2021 HIGH DEDUCTIBLE HEALTH PLAN (HDHP) PLAN

	Kaweah	In-Network	Out-Of-Network
GENERAL ATTRIBUTES			
Deductible - EE / FAM	$1,400 / $2,800	$1,400 / $2,800	$2,800 / $5,600
Coinsurance	10%	30%	50%
Out of Pocket Max - EE / FAM	$4,000 / $8,000	$4,000 / $8,000	$6,000 / $12,000
Aggregate vs Embedded Deductible	Aggregate		
Aggregate vs Embedded OOP Max	Embedded		
HOSPITAL	**You pay:**	**You pay:**	**You pay:**
Inpatient			
Admission Deductible/Copay	10% after deductible	30% after deductible	50% after deductible
Pre-authorization Required?		Yes	
Outpatient Surgery	10% after deductible	30% after deductible	50% after deductible
Urgent Care****	10% after deductible	30% after deductible	50% after deductible
Emergency Room	10% after deductible	10% after deductible	10% after deductible
PHYSICIAN'S SERVICES	**You pay:**		**You pay:**
Office Visits	Not Available at Kaweah	30% after deductible	50% after deductible
Specialist Office Visit	Not Available at Kaweah	30% after deductible	50% after deductible
Preventive Care	No charge	No charge	50% after deductible
Diagnostic Test/Lab/X-ray (Outpatient)	10% after deductible	30% after deductible	50% after deductible
Advanced Imaging (Outpatient)	10% after deductible	30% after deductible	50% after deductible
Diagnostic Test/Lab/X-ray (Inpatient)	10% after deductible	30% after deductible	50% after deductible
Advanced Imaging (Inpatient)	Not Available at Kaweah	30% after deductible	50% after deductible
PRESCRIPTION DRUGS**	**You pay:**		
Retail (30 days)	All copays apply after the plan deductible has been satisfied		
Generic	$5/Rx	$20/Rx	
Preferred brand drugs	$35/Rx	$45/Rx	
Non-preferred brand drugs	$60/Rx	$70/RX	
Specialty	No difference, see above		
Mail Order (90 days)			
Generic	$10/Rx	$60/Rx	
Preferred brand drugs	$70/Rx	$135/Rx	
Non-preferred brand drugs	$120/Rx	$210/Rx	
Specialty	No difference, see above		

**Limited to ER and office visits.

Kaweah Delta has recently negotiated excellent reduced rates with USC and Valley Children's Hospital. If you are unable to use Kaweah Facilities, USC or Valley Children's Hospital will save you the most money when seeking services at an In-Network provider. You may still use Stanford, but we suggest you compare the overall costs between USC and Stanford first, to see how you can save yourself money on out of pocket costs when you select USC.

Choosing USC or Valley Children's Hospital will mean a smaller overall bill when you pay your 20% coinsurance share.

HEALTH SAVINGS ACCOUNT (HSA)

The High Deductible Health Plan is designed to work with a Health Savings Account (HSA) to give you more control over how your health care dollars are spent. Kaweah is offering HSA's through myCafeterPlan.

Federal legislation allows you to contribute to your HSA on a pre-tax basis and then use these funds to pay for qualified health expenses. If you do not use all of the money in your HSA in a given calendar year, the remaining money "rolls over" for us in future years.

The Triple Tax Advantage

1. Access to a health care team who, in collaboration with your primary care provider and/or specialist, will evaluate and monitor your medication regimen to ensure safe and effective therapy.
2. Access to a dedicated team who will coordinate prescription authorizations and manage refills.
3. Waived copays on specific medications evaluated and managed by the Chronic Disease Management Center (CDMC) health care team.

2021 Annual IRS HSA Contribution Limits:

- Individual: $3,600
- Catch up contribution (Age 55+): $1,000
- Family: $7,200
- Catch up contribution (Age 55+): $1,000

	Full Time Seed* (Employer Contribution)	Part Time Annual Seed* (Employer Contribution)
Employee Only	$240	$120
Employee + Spouse	$720	$360
Employee + Child(ren)	$720	$360
Employee + Family	$960	$480

*Kaweah will contribute to your HSA on a monthly basis.

FLEXIBLE SPENDING ACCOUNTS (FSA's)

The medical and dependent care reimbursement accounts allow you to set aside pre-tax funds via convenient payroll deductions. You can use this money for eligible health care and/or dependent care expenses.

FSA Healthcare Account

You may contribute up to $2,750 annually* to the FSA Healthcare Account to pay for eligible expenses like:

- Medical and dental copays, deductibles, coinsurance, etc.
- Non-reimbursed expenses for orthodontia
- Non-reimbursed expenses for vision and chiropractic care
- $550 maximum limit turnover
- Many other eligible expenses. You can view the list of eligible expenses on the myCafeteriaPlan.com website

What if there is money left in my account at the end of plan year 2020?

Any eligible claims incurred between January 1, 2020 and March 15, 2021, can be reimbursed out of contributions that are made during the plan year. You have another sixteen(16) days to gather documentation and get them submitted. To qualify for reimbursement, all claims must be submitted by March 31, 2021. At the end of the plan year, after all eligible reimbursements have been made, any unused funds are ***forfeited .***

In order to prevent the loss of funds, it is important to plan carefully so that your annual election matches your actual expenses as closely as possible.

Dependent Care Reimbursement Account

You may contribute up to $5,000 if you are married and file a joint tax return or file single/head of household. If you are married and file a separate tax return, the contribution limit is $2,500.* Eligible expenses must be related to dependent care that enables you (and your spouse, if married) to remain gainfully employed, look for work or attend school full-time. Examples of eligible expenses include those for:

- Care of a dependent child under the age of 13 (e.g., babysitters, after-school programs, nursery school or preschool, registration fees for child care, etc.)
- Adult care or senior day care for dependent family member who lives with you
- Care for someone you can claim on your taxes and who is physically or mentally incapable of caring for himself or herself

For a complete list of eligible reimbursable expenses, go to: www.irs.gov, Publications 502 and 503.

*$2,750 is the Healthcare FSA contribution maximum. At the time of printing this document the 2020 Healthcare FSA contribution maximum has not been released.

VOLUNTARY BENEFITS

Hospital Indemnity Plan

- New voluntary benefit offering from Voya that will pair nicely with the new PSP or HDHP option.
- This plan pays an admission benefit when a member hospitalized.
- Maternity claims are included.
- Wellness benefit pays members a small amount for receiving preventive care services.

VB-Hospital Indemnity	Voya
Coverage	$150 per day
Policy Features and Charges	
Hospital Admission Benefit	$1,500 for first day of confinement
Admission Maxmium	8 per year
Hospital Confinement Benefits	$150 per day limited to 10 days, beginning day 2
Critical Care Unit	$300 per day limited to 10 days, beginning day 2
Rehabilitation Facility	$75 per day limited to 10 days, beginning day 2
Wellness Benefit	$50 for EE & SP. $25 for Child, limits $100 for all Children
Dependent Coverage	Matches EE Benefit
Maternity	Included
Pre-Ex	None
Waiting Period	None
Portability	Included

Hospital Indemnity	EE Bi-weekly Deduction
Employee Only	$10.51
EE + Sp	$17.58
EE + CH	$17.32
EE + Family	$24.39

For employees enrolled in a medical plan, we are offering additional benefits to help when there has been an accident or a diagnosis of a critical illness.

Accident Insurance

Accident Insurance pays benefits for specific injuries and events resulting from a covered accident that occurs while you are not at work. The benefit amount depends on the type of injury and care received. Accident Insurance is not health insurance and is only available to those enrolled in health insurance.

How can Accident Insurance help?

Accident Insurance benefits can be used for:

- Medical expenses, such as deductibles and copays
- Home healthcare costs
- Everyday expenses like utilities and groceries

Cost per pay period			
Employee	Employee + Spouse	Employee + Children	Family
$4.86	$8.08	$9.57	$12.80

Critical Illness Insurance

Critical Illness insurance pays a lump sum payment to you at the first diagnosis of a covered illness or condition after your coverage effective date. Critical Illness insurance is not health insurance and is only available to those enrolled in health insurance.

The Critical Illness plan also includes a Wellness Benefit. This provides an annual benefit payment of $100 for completing a health screening test.

Cost per pay period/Coverage Amt $15,000			
Employee		Spouse	
Under Age 30	$3.48	Under Age 30	$3.48
Age 30-39	$4.68	Age 30-39	$4.68
Age 40-49	$8.65	Age 40-49	$8.65
Age 50-59	$18.48	Age 50-59	$18.48
Age 60-64	$26.80	Age 60-64	$26.80
Age 65-69	$34.30	Age 65-69	$34.30
Age 70+	$47.73	Age 70+	$47.73
Children	Coverage Amt $5,000	Cost per pay period $0.98	

Plan Summary Document and Details

Please visit https://presents.voya.com/EBRC/Kaweah for VOYA's
Employee Benefits Resource Center and review plan summary documents.

- Hospital Indemnity
- Life Insurance
- Accident Insurance
- Disability Insurance
- Critical Illness Insurance

LIFE AND AD&D

Life insurance is an important part of your comprehensive benefits package. It provides financial protection to your family in the event of your death.

All full-time and part-time benefit eligible employees can participate in the Basic Life and AD&D, Voluntary Life and AD&D, and Long-Term Disability plans. All you have to do is enroll!

Basic Life and AD&D

For full-time and part-time benefit eligible employees, Basic Life and AD&D insurance is offered through Voya, and KDHCD pays 100% of this premium for you. You must provide your beneficiary information during the enrollment process.

* Do not forget to update your beneficiary information when you experience a change in family status (marriage, divorce, new baby, etc.).

Basic Life and AD&D Insurance Summary

Description	Benefit
Basic Life and AD&D	I x base salary up to $150,000
Age Reduction Schedule	70-74 years old: 65% 75 years old and above: 50% Terminates at retirement
Premium Cost to You	No cost to you (I00% paid by KDHCD)

Voluntary Life and AD&D

In addition to the basic life and AD&D benefit provided by KDHCD, eligible employees may purchase voluntary life and AD&D insurance, as well as other supplemental benefits. See "Voluntary Benefits" on page 21 for more information.

LONG-TERM DISABILITY

Kaweah Delta Health Care District will also pay the full cost of long-term disability insurance for eligible employees. This valuable benefit through Voya can help provide you with an important source of income in the event of a disability.

All full-time and part-time benefit eligible employees are provided the core benefit.

Long-Term Disability Summary

Description	Benefit
Elimination Period	Benefits begin 120 days after the onset of a disabling injury or illness. With in 240 calendar days
Core Benefit	60% of before-tax monthly earnings up to $10,000 for up to 24 months
Premium Cost to You	No cost to you (I00% paid by KDHCD) or pay this insurance yourself and the benefit will be tax-free when used
Buy-Up	You may purchase additional coverage up to Social Security normal retirement age

VOLUNTARY BENEFITS

In addition to all of the benefits and programs sponsored by KDHCD, eligible employees may choose to participate in one or more of the available voluntary insurance plans. Participants pay the full cost of these coverages at reduced group rates through regular payroll deductions.

The following descriptions are high-level summaries. Please refer to carrier materials for more information. If there are any discrepancies between the following descriptions and the plan documents, the plan documents will prevail. These voluntary benefits are provided by Voya.

VOLUNTARY LIFE AND AD&D INSURANCE

Voluntary term life insurance is an affordable way to ensure you and your family have the financial protection you need in the case of death. The Accidental Death and Dismemberment (AD&D) benefit pays more money if you die in a covered accident. If you survive a serious accident, it can pay you money for certain severe injuries, such as loss of vision, hearing and limbs. The plan also includes such features as portability and conversion as well as an accelerated death benefit. The following is a summary of features and available coverages:

- As a reminder, KDHCD provides basic life and AD&D insurance of 1x annual earnings to a maximum of $150,000. For more information, please see page 20.
- You can purchase additional voluntary life and AD&D coverage; maximum amount is the lesser of a total of 5x annual earnings or $300,000 for life and $500,000 for AD&D.
- Voluntary life coverage can also be purchased for your spouse in increments of $10,000; maximum amount $50,000 and you must purchase Voluntary Life of equal value or more.
- Voluntary child coverage can also be purchased in the life amount of $10,000, you must purchase Voluntary Life of equal value or more.
- AD & D Employee Only or Employee plus Family can also be purchased in increments of 2, 4, 6, 8x your annual salary up to $500,000.

VOLUNTARY SHORT-TERM DISABILITY INSURANCE

Short term disability (STD) insurance can replace a portion of your weekly income if you are unable to work for a few weeks or months due to an illness, injury or childbirth. The amount of benefit you receive from the plan may be reduced or offset by income from other sources. Contact Voya, see page 30 for contact information.

VOLUNTARY LONG-TERM DISABILITY INSURANCE

Long term disability (LTD) insurance protects a portion of your income if you can't work for an extended period of time due to a covered injury or illness. LTD insurance can pay a benefit as long as you are considered disabled according to your policy. The amount of benefit you receive from the plan may be reduced or offset by income from other sources such as Social Security Disability Insurance. The length of time you can receive benefits is based on your age when you become disabled. Disability benefits will begin after a period of 120 days of disability. If purchased, Voluntary Long-Term Disability Insurance allows you to continue to receive disability payment after the benefit duration of your employer-paid Long Term Disability plan ends up until Social Security Normal Retirement Age. **See "Long-Term Disability" on page 20 for more information about the employer-paid basic benefit.**

legalzoom lifeplan™

LegalZoom LifePlan™ is a comprehensive employee benefit that provides integrated legal, financial, tax and insurance services to help members confidently navigate the major and daily life events their families face including marriage, home purchase, childbirth, retirement and end of life planning.

Just a call, tap, or a click away

Mobile and web

Members can view and schedule legal advice sessions real time. Also schedule Tax, Financial, and Insurance advice sessions with a click of a button.

Email us lifeplan@legalzoom.com

Membership Advisors

Membership Advisors help members navigate their major and daily life events by providing information, instruction, and considerations around the areas of Legal, Tax, Finance, and Insurance

Call a Membership Advisor (888) 556-0888
Monday - Friday: 7:00am - 7:00pm CT

Here's what you get

An Estate Plan for two

Last Will and Testament or Living Trust and Living Will (Advance Healthcare Directive) and Financial Power(s) of Attorney

Document Review

Legal document and contract review

Legal Library

Access to 160+ legal forms and agreements

Unlimited Cloud File Storage

Save, manage and share any of your files from one convenient place

Advisory Services

Legal, Insurance†‡, Financial†‡, Tax†
Family law, bankruptcy, debt, homeownership, property damage,

10% Off products & services

Business Services
Intellectual Property
Personal Services

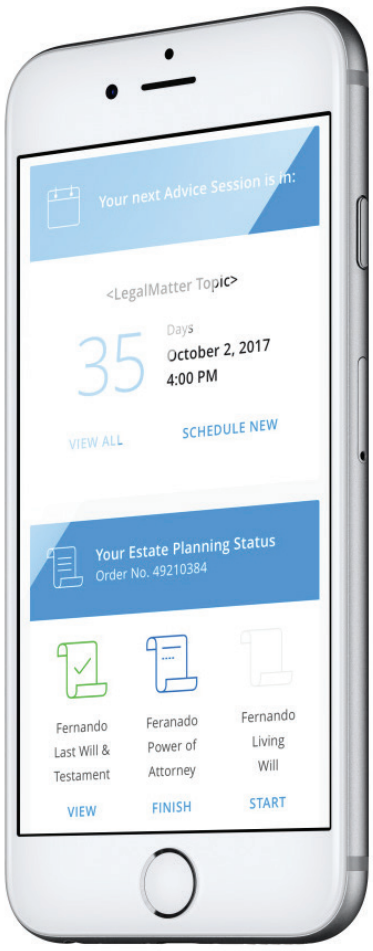
Annual Check Up

Assessment of legal profile update of a previous Legal Check-Up

Identity Theft Protection

Full service ID restoration, Internet/ dark web surveillance, Lost wallet protection, 1 Bureau credit monitoring, $1M identity theft insurance, Stolen funds reimbursement

COST $6.95 every pay period



Coverage

- Primary Member
- The Primary Member's spouse or domestic partner;
- Any dependent who is under the age of 26;
- Any dependent child, regardless of age, who is incapable of sustaining employment by reason of mental or physical disability; and
- Any dependent individuals living in the Primary Member's home such as a parent or grandparent.

† All legal, financial, tax, and insurance services are from independent advisors.

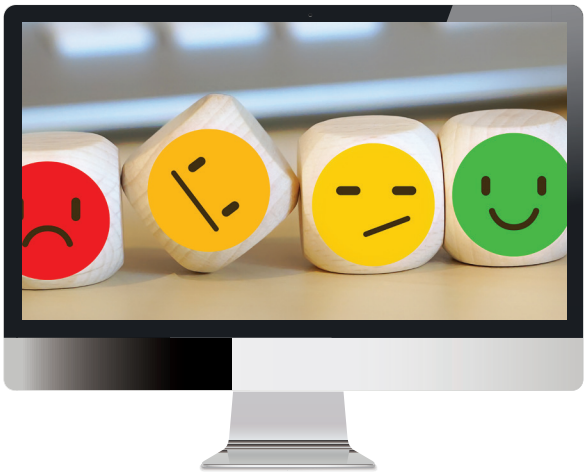
This is a general overview and is for illustrative purposes only. Plans and services vary state to state. See our plan contract for your state of residence for complete terms, coverage, amounts, conditions, and exclusions. LegalZoom is not a law firm or a substitute for an attorney or law firm and does not provide legal advice or services.

EMPLOYEE ASSISTANCE PLAN (EAP)

The Kaweah Delta Employee Assistance Program (EAP) can help you maintain an optimum quality of life. Available to you and your household members, the EAP is a free, confidential resource offering counseling, support, information and planning, as well as professional referrals.

EAP Services

Kaweah Delta Employee Assistance Program is one of the best benefits you and your family can have. It provides assistance to employees and their families for everyday life problems. Sooner or later, we are all overwhelmed by the complexity of our lives. Balancing work and family demands can take an extraordinary toll on our overall sense of health and well being. Fortunately, help is available for a wide range of problems and issues.



Access Is Easy

For a free/confidential appointment:
Call (877) 533-2363

The program offers someone to talk to and resources to consult whenever and wherever you need them.

24/7 SUPPORT, RESOURCES & INFORMATION

CALL: 877.533.2363

Sometimes You Just Need Someone To Talk To

Highly trained clinicians will listen to your concerns and quickly refer you to in-person counseling and other resources for:

- Anxiety, depression, stress
- Grief, loss and life adjustments
- Relationship/marital conflicts

Online Support

Through VOYA and ComPsych®, GuidanceResources® Online, you have a 24/7 link to vital information, tools and support. Log on for:

- Articles, podcasts, videos, slideshows
- On-demand trainings
- "Ask the Expert" personal responses to your questions
- Direct 24/7 access to a GuidanceConsultant, who will answer your questions and, if needed, refer you to a counselor or other resources.
- Log on today to connect directly with a GuidanceConsultant about your issue or to consult articles, podcasts, videos and other helpful tools.

NEW EAP SERVICES

Call: 877.533.2363
TTY: 800.697.0353

Online:

guidanceresources.com

App:

GuidanceResources®

Now Web ID:

My5848i

VOYA®

No-cost, confidential solutions to life's challenges.

RETIREMENT PLAN

A consistent savings plan throughout your career is the foundation for security during your retirement years. According to financial experts, employer-sponsored plans - like the Kaweah Delta Health Care District 401(k) and 457 (b) Plans - may provide approximately two thirds of your necessary retirement income.

Regardless of where you decide to live or what you choose to do in retirement, saving in the plan can help you get closer to achieving your goals. This program is one of the most important benefits KDHCD offers. Discover the advantages:

- **It's convenient:** All contributions are conveniently taken out of your paycheck each pay period, before you have a chance to spend it. Start small if you have to, just start. Even saving as little as $20-$30 a pay period can make a big difference over 10, 20 or 30 years.
- **It's flexible:** You can adjust your contribution amount at any time to meet your personal budget needs and reach your retirement goals. You can even stop contributions temporarily if you have to.
- **You save money on taxes:** All of your contributions to the plan will reduce your taxable income. If you contribute $50.00 per paycheck, it may cost you only $39.20, because the money is deducted directly from your paycheck before you pay any taxes.

* Take-home savings calculated based on example of a single California resident making $40,000 with no other federal or state exemptions. The impact to your take-home pay will vary on your tax rate.

Three Easy Ways for you to take action:

1) **Over the Phone:** (800) 234-3500
2) **On-Line:** www.lincolnfinancial.com
2) **In Person:** Lincoln Retirement Consultant by Appointment:
https://www.lfq.com/kaweahdeltaschedule or bobcowsert@lfg.com (916) 292-1031

All employees are immediately eligible to participate! Upon completing 1 year of service, KDHCD may provide an employer contribution based on years of service: for those who work 1,000 hours during the plan year and are employeed on December 31st:

1-2 Year of Service	3%
3-5 Years of Service	4%
6-10 Years of Service	5%
11+ Years of Service	6%

* The above matching contributions are made only with respect to the amount of your contributions as defined by the plan.
Five year vesting schedule applies.
At the time of printing this document, Kaweah Delta may not make an employer contribution for 2020.

Lincoln Financial Group®

Kaweah Delta KAWEAHDELTA.ORG

Retirement Plan Services

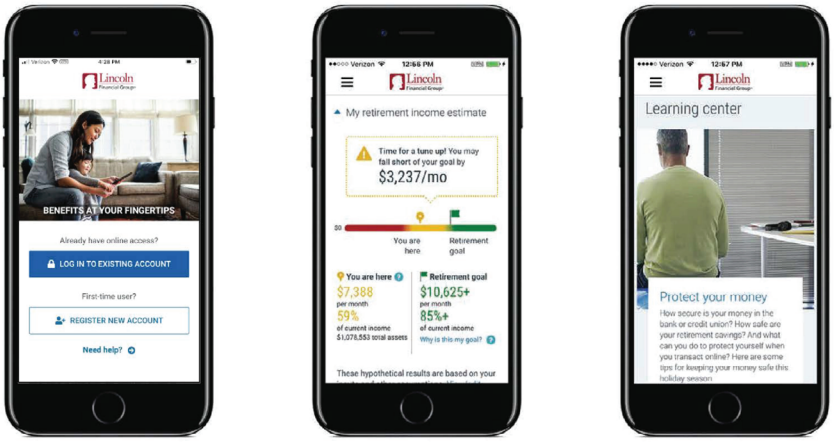
Check out the tools and resources on our mobile app

MY ACCOUNTS

Accessing your Lincoln account information is easier than ever with our mobile app, Lincoln Financial Mobile.

The app includes a retirement income estimator that helps you see if you're on track for the retirement you envision, as well as other cool tools and insights to help you get where you want to be.

Not registered for online access? No problem. You can sign up for online access either through the app or by logging in directly to the registration page at **LincolnFinancial.com/Register**.



Get it now in the App Store or at Google Play!

Download on the App Store

GET IT ON Google Play

For a more comprehensive experience, visit our mobile-optimized website, LincolnFinancial.com/Retirement.

LincolnFinancial.com/Retirement

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

Affiliates are separately responsible for their own financial and contractual obligations.

LCN-3146727-063020
POD 6/20 **Z03**
Order code: DC-APP-FLI001

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Insurance products issued by:
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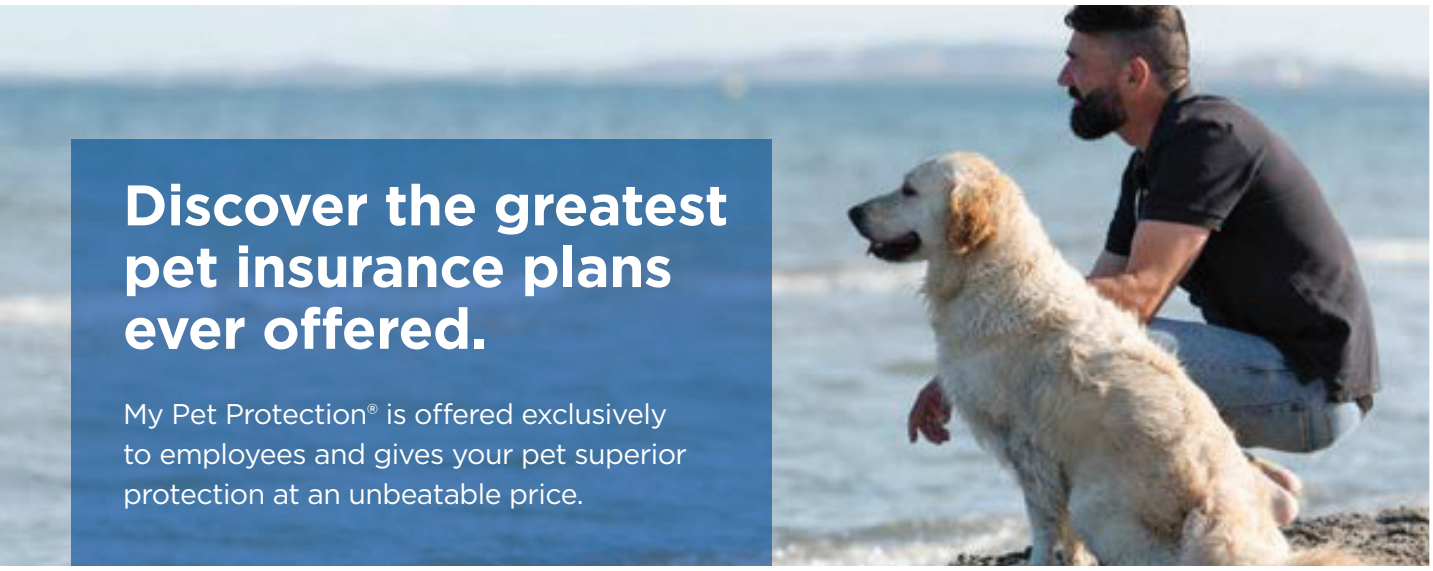
Lincoln Life & Annuity Company of New York



Discover the greatest pet insurance plans ever offered.

My Pet Protection® is offered exclusively to employees and gives your pet superior protection at an unbeatable price.

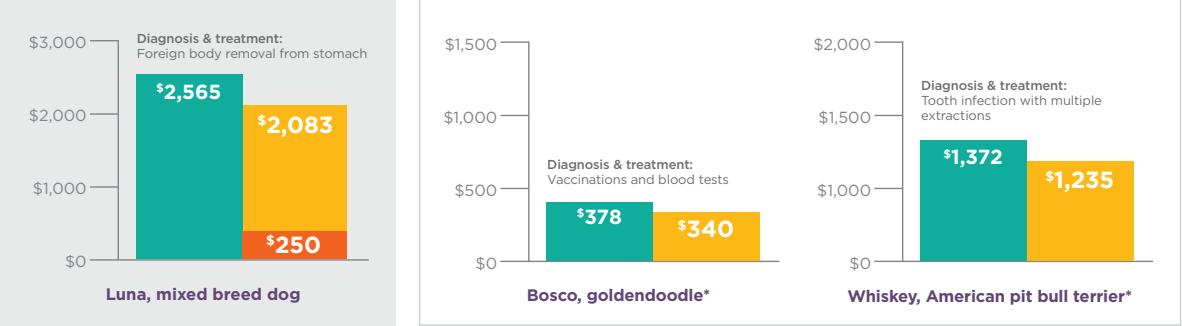
my pet protection® with wellness

my pet protection®

- ✓ 90% back on vet bills[1]
- ✓ Exclusive to employees, not available to the general public
- ✓ Same price for pets of all ages
- ✓ Best deal: average savings of 30% over similar plans from other pet insurers[2]
- ✓ Wellness plan option that includes spay/neuter, vaccinations and more

Here's how My Pet Protection helped Nationwide® pet parents

Between big-ticket emergency vet bills and basic preventive care, My Pet Protection coverage helped keep these pet parents' bank accounts in the black.



*Annual deductible met on previous claim

Claim amount | Reimbursement by Nationwide | Annual deductible

Sample reimbursements are based on actual claims but have been edited for clarity. Coverage for wellness services only available on My Pet Protection with Wellness®.

Sign up multiple pets with individual plans and receive a discount[3] for even more savings.

Get a free, no-obligation quote today at

www.petinsurance.com/kaweahdelta

Nationwide® is on your side

Choose a plan that's as unique as your pet.

Get back 90% of the vet bill for these items **and more**.[1]

Visit any vet, anywhere

	my pet protection® with wellness	my pet protection®
Accidents, including poisonings and allergic reactions	✓	✓
Injuries, including cuts, sprains and broken bones	✓	✓
Common illnesses, including ear infections, vomiting and diarrhea	✓	✓
Serious/chronic illnesses, including cancer and diabetes	✓	✓
Hereditary and congenital conditions	✓	✓
Surgeries and hospitalization	✓	✓
X-rays, MRIs and CT scans	✓	✓
Prescription medications and therapeutic diets	✓	✓
Wellness exams	✓	
Vaccinations	✓	
Spay/neuter	✓	
Flea and tick prevention	✓	
Heartworm testing and prevention	✓	
Routine blood tests	✓	

Just like all other pet insurers, we don't cover **pre-existing conditions.*** However, we go above and beyond with extra features such as **emergency boarding, lost pet advertising and more**. Plus, both plans have a low $250 annual deductible and a generous $7,500 maximum annual benefit.

*Any illness or injury that your pet had prior to the start of your policy will be considered a pre-existing condition.

Easy enrollment

1 Select the species (dog or cat)** → 2 Provide your zip code → 3 Pick your plan

**To enroll your bird, rabbit, reptile or other exotic pet, please call 888-899-4874.

vethelpline®

Available to all pet insurance members. Unlimited, 24/7 access to a veterinary professional ($150 value). Only from Nationwide®.

Get your pet insurance reimbursements deposited directly to your bank.

Submit claims right from your smartphone with the free VitusVet app.

Download from the App Store | Download from Google Play

Email, fax and snail mail claim submissions also available.

Learn more today. **www.petinsurance.com/kaweahdelta**

[1]Some exclusions may apply. Certain coverages may be subject to pre-existing exclusion. See policy documents for a complete list of exclusions. [2]Average based on similar plans from top competitors' websites for a 4-year-old Labrador retriever in Calif., 90631. Data provided using information available as of December 2017. [3]Pet owners receive a 5% multiple-pet discount by insuring two to three pets or a 10% discount on each policy for four or more pets.

TRANSITIONS BENEFIT GROUP

Transitions Benefit Group supports all employees and your families through a variety of services, which include:

- Understanding Medicare and Enrollment
- Retirement Preparedness & Planning
- Life Insurance & Expense Planning
- Maximizing Social Security
- COBRA Options & Portability of Benefits
- VA Benefits
- Assisted living Services
- Caregiver Support
- Eldercare Resources
- Long Term Care & Chronic Needs Planning
- Prescription Planning

Transitions is available to you and your family members. Contact them at 800-936-1405 and let them know you are a Kaweah Delta employee. From there, you will have access to the group's services and a national network of providers.

Announcement: New Employee Benefit

We are so excited to announce our partnership with Transitions Benefit Group. This organization specializes in helping our employees plan for tomorrow. This service is available to all of our employees and their loved ones! Please click the camera icon below to watch the introductory video to learn more.

These consultations are available to all of our employees, with a focus on planning for life after retirement through Social Security Planning and understanding how to protect your finances after retirement. They work to assist with a retirement readiness strategy. For employees that are working past Medicare eligibility, we encourage scheduling a call to confirm proper Medicare enrollment and coordination to avoid penalties or other delays in coverage. This is a phenomenal service for employees and their loved ones to utilize. They will be able to discuss your own unique situation as well as help you learn the best way to cover your needs.

Their services are not only for employees that are Medicare eligible, if you have loved ones that you help with their Medicare services, they are available to assist them as well. They offer a program that you can share with your family and friends, it is called the Caregiver Assistance Program. This program assists in a variety of ways that you can learn more about in our member hub area.

This benefit has been provided to you at no charge, we strive to listen to our employees and the services they need. Please utilize Transitions Benefit Group as a trusted resource. If you receive an email, text or call from them, it has been approved from our team. Please respond as needed. Below are a few links that you can follow to learn more or book an appointment.

Introduction video

Member Hub

Schedule a Personal Consultation

We hope you are as excited as we are about this new benefit offering! The Transitions team is looking forward to meeting and helping you with questions and support.

Please feel free to reach out to them directly at: 800-936-1405 or go to their website at www.transitionsrbg.com to learn more.

HR Online

Employee Suite – User Name: your first initial & last name. Password can be obtained by calling ext. 2280. Here you can view the benefits options you have chosen, your beneficiaries, your leave accruals, paycheck stubs, & other employee information about yourself. (Available on KD Intranet Only)

Kaweah COMPASS

Human Resources > HR Forms. While here at work you can view on the Intranet your benefits documents and other resources. (Available on Compass Only)

www.myCafeteriaPlan.com

Click on "ACCOUNT LOGIN" link located on the home page. Click on "Create your new username and password" for ongoing access. Here you can see your account balance, submit an Online Claim as well as view all the payments made using your Flexible Spending and Health Savings Account with your healthcare Benny™ Benefits Card. 1-800-865-6543

www.tkfmc.org

Here you can view the provider lists for Foundation for Medical Care of Tulare-Kings County. Currently there are three PDF Files. Be sure to select the appropriate file for your need.

www.cfmcnet.org

To locate a network physician with California Foundation for Medical Care

www.stratose.com

Here you can view the provider lists for out of state physicians with Foundation for Medical Care. Click find a physician > click Coalition America/nppn 1-800-557-1656

www.Legalzoom.com

Here you can sign in to your account and access the full suite of LifePlan resources.

You can also call a Member Advisor at (888) 556-0888
Monday - Friday 5am - 5pm
Website: Lifeplan.legalzoom.com
Email: lifeplan@legalzoom.com

Voya

VOYA – Group number 700622 – Policy Name: Kaweah Delta Health Care District
The website Employee Benefits Resource Center **https://presents.voya.com/EBRC/Kaweah**

- To submit claims online visit: www.voya.com/claims or you may call the numbers below.
- Please have name of insured, date of birth, social security number when calling to submit a claim -
- Hospital Indemnity claim number 1-877-236-7564
- Short Term Disability Claim number 1-866-228-8742 or online
- Long Term Disability Claim number 1-888-305-0602 or online
- Life Insurance Claim number 1-888-238-4840 or online
- Accident and Critical Illness Insurance Claim number 1-888-238-4840 or online
- Wellness Benefit Credit 1-888-238-4840 or online
- Funeral Planning and Concierge Services 1-800-913-8318 or online www.everestfunelal.com/voya
- Travel Assistance 1-800-859-2821

Dental
www.kernfmc.com

To locate a network dentist with the California Foundation for Medical Care

www.healthsmart.com

To locate a network hospital Healthsmart/Interplan Network 1-800-613-1124 customer service

Vision

Click on Registration for a www.VSP.com account if this is the first time on website. Here you can see any vision claims for yourself or covered dependents as well as what options are available to you.

Prescription
www.medimpact.com

Click on member portal sign in to register or sign in. You will need your insurance card when you go on for the first time. Here you can view the formulary of preferred drugs for our plans. Medimpact is our pharmacy benefit manager.

Nationwide Pet Insurance

1 (888) 899-4874
www.petinsurance.com/kaweahdelta

Foundation for Medical Care

Authorizations

735-3892 or 1-800-662-5502

Medical & Dental Claims

734-1321 or 1-800-662-5502
press option 3 - selffunded then
option 1- for Medical or
option 3- for Dental

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You've arrived at the best home and auto insurance savings.

Mylo can help you find the right insurance for your home or ride, while holding onto more of your money too. And you'll save even more when you bundle both policies together.

The expert who knows the way to the right insurance, fast.

The right coverage at the best rate for YOU.

You've made a home for yourself. Nicely done! Naturally you want to protect it. You also want peace of mind behind the wheel when you're heading to work, hitting the highway or chauffeuring the kids to their million (and one) activities.

Count on Mylo to make it happen.

Why Mylo?

We're part of Lockton, the world's largest independent insurance expert, connecting people to top-rated coverage for 50+ years. We have an amazing bench of carriers and coverage most companies don't. That allows us to:

- Pre-select top policies from **40+ carriers**
- Find **the most** affordable choice for you
- Add on **extra** discounts and savings you may not know about!

Expert answers. From real experts.

Mylo's licensed agents untangle the terminology and give you clear answers to questions like:

- Should I value my house at Replacement Cost or Actual Cash Value?
- Does homeowners insurance pay for an appliance breakdown?
- What happens if my car is totaled — and I owe more on my loan than it's worth?

The right coverage is no accident.

Whether you live in a house, condo or apartment ... or drive a car, motorcycle, boat, ATV, RV or other favorite ride ... we'll find the coverage you need from top carriers.

- **Building and Personal Property** covers your home and belongings from damages
- **Personal Liability** helps cover legal costs if someone is injured (or their property damaged) in or near your home
- **Collision and Comprehensive** covers damage to your car if it's stolen or damaged ... or hits another car or object
- **Bodily Injury and Property Damage Liability** covers damages your car may cause to others or their property
- **And many more options** that could be right for you!

Driving home additional savings.

- **Bundling home & auto.** Save by managing two important policies in one place
- **Home safety discounts.** Get a nice break for having smoke detectors and security systems
- **Good student & safe driver.** Save good money for your good behavior
- **And many more.** Ask a licensed Mylo agent!

Liberty Mutual INSURANCE

MetLife

TRAVELERS

Safeco Insurance™
A Liberty Mutual Company

ASI

PROGRESSIVE

Ready to start saving?

Visit ChooseMylo.com/CA1 or call 844-893-9886.

HOME AUTO

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Kaweah Delta Health Care District

HEALTH PLAN NOTICES

IMPORTANT NOTICE
This packet of notices related to our health care plan includes a notice regarding how the plan's prescription drug coverage compares to Medicare Part D. If you or a covered family member is also enrolled in Medicare Parts A or B, but not Part D, you should read the Medicare Part D notice carefully. It is titled, "Important Notice From Kaweah Delta Health Care District About Your Prescription Drug Coverage and Medicare."

IMPORTANT NOTICE FROM KAWEAH DELTA HEALTH CARE DISTRICT ABOUT YOUR CREDITABLE PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Kaweah Delta Health Care District and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or your dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

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. Kaweah Delta Health Care District has determined that the prescription drug coverage offered by the Kaweah Delta Health Care District Employee Health Care Plan ("Plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

Enrolling in Medicare—General Rules
As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty
If you decide to *wait* to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period you go **63 continuous days or longer without "creditable" prescription drug coverage** (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1 percent of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go 19 months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. *However, there are some important exceptions to the late enrollment penalty.*

Special Enrollment Period Exceptions to the Late Enrollment Penalty
There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage
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. See the Kaweah Delta Health Care District Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting us at the telephone number or address listed below.

Coordinating Other Coverage With Medicare Part D
Generally speaking, if you decide to join a Medicare drug plan while covered under the Kaweah Delta Health Care District Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the Kaweah Delta Health Care District Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed below.

If you do decide to join a Medicare drug plan and drop your Kaweah Delta Health Care District prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

For More Information About This Notice or Your Current Prescription Drug Coverage…
Contact the person listed below for further information, or call 559-624-2482. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Kaweah Delta Health Care District changes. You also may request a copy.

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 Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date:	January 1, 2021
Name of Entity/Sender:	Kaweah Delta Health Care District
Contact—Position/Office:	Carmen Rodriguez
Address:	400 W. Mineral King Ave. Visalia, CA 93291
Phone Number:	559-624-2482

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

HIPAA COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

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KAWEAH DELTA HEALTH CARE DISTRICT
IMPORTANT NOTICE
COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

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

This notice is provided to you on behalf of:**Kaweah Delta Health Care District***

* This notice pertains only to healthcare coverage provided under the plan.

The Plan's Duty to Safeguard Your Protected Health Information
Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered "Protected Health Information" ("PHI"). The Plan is required to extend certain protections to your PHI, and to give you this notice about its privacy practices that explains how, when, and why the Plan may use or disclose your PHI. Except in specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

The Plan is required to follow the privacy practices described in this notice, though it reserves the right to change those practices and the terms of this notice at any time. If it does so, and the change is material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other fashion. This notice, and any material revisions of it, will also be provided to you in writing upon your request (ask your Human Resources representative, or contact the Plan's Privacy Official, described below), and will be posted on any website maintained by Kaweah Delta Health Care District that describes benefits available to employees and dependents.

You may also receive one or more other privacy notices from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI and your rights with respect to the PHI they maintain.

How the Plan May Use and Disclose Your Protected Health Information
The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative (e.g., a person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the Plan's uses and disclosures of your PHI.

- **Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.**
  - **Treatment:** Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists, and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it's important for your treatment team to know your blood type, the Plan could disclose that PHI to the team in order to allow it to more effectively provide treatment to you.
  - **Payment:** Of course, the Plan's most important function, as far as you are concerned, is that it *pays for* all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan receives a substantial amount of PHI about you. For example, doctors, hospitals, and pharmacies that provide you care send the Plan detailed information about the care they provided, so that they can be paid for their services. The Plan may also share your PHI with other plans in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this Plan and your spouse's plan or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.
  - **Health care Operations:** The Plan may use and disclose your PHI in the course of its "health care operations." For example, it may use your PHI in evaluating the quality of services you received or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverages. However, the Plan will not disclose, for underwriting purposes, PHI that is genetic information.
- **Other Uses and Disclosures of Your PHI Not Requiring Authorization.** The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:
  - **To the Plan Sponsor:** The Plan may disclose PHI to the employers (such as Kaweah Delta Health Care District) who sponsor or maintain the Plan for the benefit of employees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and dis-enrollments, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage, and other disputes related to the Plan's provision of benefits.
  - **To the Plan's Service Providers:** The Plan may disclose PHI to its service providers ("business associates") who perform claim payment and plan management services. The Plan requires a written contract that obligates the business associate to safeguard and limit the use of PHI.
  - **Required by Law**: The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect, or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities that monitor compliance with these privacy requirements.
  - **For Public Health Activities:** The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.
  - **For Health Oversight Activities:** The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.

- **Relating to Decedents:** The Plan may disclose PHI relating to an individual's death to coroners, medical examiners, or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
- **For Research Purposes:** In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research.
- **To Avert Threat to Health or Safety:** In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
- **For Specific Government Functions:** The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.

- **Uses and Disclosures Requiring Authorization:** For uses and disclosures beyond treatment, payment, and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. For example, uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI would require your authorization. Your authorization can be revoked at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.
- **Uses and Disclosures Requiring You to Have an Opportunity to Object:** The Plan may share PHI with your family, friend, or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

Your Rights Regarding Your Protected Health Information

You have the following rights relating to your protected health information:

- **To Request Restrictions on Uses and Disclosures:** You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request, but it is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.
- **To Choose How the Plan Contacts You:** You have the right to ask that the Plan send you information at an alternative address or by an alternative means. To request confidential communications, you must make your request in writing to the Privacy Official. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.
- **To Inspect and Copy Your PHI:** Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.
- **To Request Amendment of Your PHI:** If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors you may request in writing that the record be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its vendor and/or not part of the Plan's or vendor's records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.
- **To Find Out What Disclosures Have Been Made:** You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

How to Complain About the Plan's Privacy Practices

If you think the Plan or one of its vendors may have violated your privacy rights, or if you disagree with a decision made by the Plan or a vendor about access to your PHI, you may file a complaint with the person listed in the section immediately below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

Notification of a Privacy Breach

Any individual whose unsecured PHI has been, or is reasonably believed to have been used, accessed, acquired or disclosed in an unauthorized manner will receive written notification from the Plan within 60 days of the discovery of the breach.

If the breach involves 500 or more residents of a state, the Plan will notify prominent media outlets in the state. The Plan will maintain a log of security breaches and will report this information to HHS on an annual basis. Immediate reporting from the Plan to HHS is required if a security breach involves 500 or more people.

Contact Person for Information, or to Submit a Complaint

If you have questions about this notice please contact the Plan's Privacy Official or Deputy Privacy Official(s) (see below). If you have any complaints about the Plan's privacy practices, handling of your PHI, *or breach notification process*, please contact the Privacy Official or an authorized Deputy Privacy Official. **Ben Cripps Compliance and Privacy Officer 559-624-5006**

Effective Date

The effective date of this notice is: January 1, 2021.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

KAWEAH DELTA HEALTH CARE DISTRICT EMPLOYEE HEALTH CARE PLAN

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 later 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).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (e.g., divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of eligibility under Medicaid or CHIP, you must request enrollment within *30 days* after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within ***60 days*** of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy toward this plan, you may request enrollment under this plan within ***60 days*** after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

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: Carmen Rodriguez 559-624-2482

**** This notice is relevant for healthcare coverages subject to the HIPAA portability rules.***

NOTICE OF RIGHT TO DESIGNATE PRIMARY CARE PROVIDER AND OF NO OBLIGATION FOR PRE-AUTHORIZATION FOR OB/GYN CARE

Kaweah Delta Health Care District Employee Health Care Plan generally allows the designation of a primary care provider. 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. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator at 559-734-1321 option 3.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Kaweah Delta Health Care District Employee Health Care Plan 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, contact the Plan Administrator at 559-734-1321 option 3.

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

Kaweah Delta Health Care District Employee Health Care Plan is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections 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 lymphedemas.

The Kaweah Delta Health Care District Employee Health Care Plan provide(s) medical coverage for mastectomies and the related procedures listed above, 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, please refer to your Summary Plan Description/Policy booklet or contact the Plan Administrator at 559-734-1321 option 3.

NOTICE FOR EMPLOYER-SPONSORED WELLNESS PROGRAMS

EEOC regulations under the Americans with Disabilities Act (ADA) require employers that offer wellness programs ***that include medical examinations or disability-related inquiries*** *(such as typical health risk assessments, including biometric examinations) and collect employee health information to* ***provide a notice to employees*** *informing them what information will be collected, how it will be used, who will receive it, and what will be done to keep it confidential. The EEOC has published a sample notice to help employers comply with the ADA.*

Kaweah Delta Health Care District Wellness Program is a voluntary wellness program available to All Benefit Eligible 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 (ADA), the Genetic Information Nondiscrimination Act of 2008 (GINA), and the Health Insurance Portability and Accountability Act, as applicable, among others.

Details about the wellness program, including criteria and incentives, can be found in the Kaweah Delta Benefit Guide.

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 Carmen Rodriguez 559-624-2482.

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 Kaweah Delta Health Care District may use aggregate information it collects to design a program based on identified health risks in the workplace, 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.

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 Carmen Rodriguez 559-624-2482 .

Model General Notice of COBRA Continuation Coverage Rights
**** Continuation Coverage Rights Under COBRA****

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 30 after the qualifying event occurs. You must provide this notice in writing to the Plan Administrator. Any notice you provide must state the name of the plan or plans under which you lost or are losing coverage, the name and address of the employee covered under the plan, the name(s) and address(es) of the qualified beneficiary(ies), and the qualifying event and the date it happened. The Plan Administrator will direct you to provide the appropriate documentation to show proof of the event.

How is COBRA continuation coverage provided?

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

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

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

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

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

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

Keep your Plan informed of address changes

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

Plan contact information

For additional information regarding your COBRA continuation coverage rights, please contact the Plan Administrator below:
Dana Ramos Foundation for Medical Care of Tulare and Kings Counties 333 S. Fairway St. Visalia, CA 93277 559-734-0393 dramos@tkfmc.org

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

Kaweah Delta Health Care District
HEALTH PLAN NOTICES

AVISO IMPORTANTE
Este paquete de avisos relacionados con nuestro plan médico incluye un aviso sobre cómo se compara la cobertura de medicamentos con prescripción del plan y la Parte D de Medicare. Si usted, o un miembro de su familia con cobertura, también está inscrito en las Partes A o B de Medicare, pero no en la Parte D, debe leer con detenimiento el aviso de la Parte D de Medicare. Se titula "Aviso importante de Kaweah Delta Health Care District sobre su cobertura de medicamentos con prescripción y Medicare".

MEDICARE PART D CREDITABLE COVERAGE NOTICE (En Espanol)
AVISO IMPORTANTE DE KAWEAH DELTA HEALTH CARE DISTRICT SOBRE SU COBERTURA DE MEDICAMENTOS CON PRESCIPCIÓN Y MEDICARE

Lea este aviso con detenimiento y guárdelo donde pueda encontrarlo. Este aviso contiene información sobre su cobertura actual de medicamentos con prescripción con Kaweah Delta Health Care District y sobre sus opciones amparadas por la cobertura de medicamentos con prescripción de Medicare. Esta información puede ayudarlo a decidir si desea inscribirse en un plan de medicamentos de Medicare. La información sobre dónde puede obtener ayuda para tomar decisiones sobre su cobertura de medicamentos con prescripción se encuentra al final de este aviso.

Si ni usted ni sus dependientes cubiertos son elegibles ni tienen Medicare, este aviso no aplica ni para usted ni para sus dependientes, según sea el caso. Sin embargo, igual debe conservar una copia de este aviso en caso de que usted o un dependiente califiquen para cobertura de Medicare en el futuro. Tenga en cuenta, sin embargo, que los avisos posteriores pueden reemplazar este aviso.
Hay dos cosas importantes que usted necesita saber sobre su cobertura actual de Medicare y la cobertura de medicamentos recetados:

1. La cobertura de medicamentos con prescripción de Medicare estuvo disponible en 2006 para todas las personas que tenían Medicare. Puede obtener esta cobertura si se inscribe en un Plan de Medicamentos con Prescripción de Medicare o en un Plan Medicare Advantage (como una Organización para el Mantenimiento de la Salud [Health Maintenance Organization, HMO] o una Organización de Proveedores Preferidos [Preferred Provider Organization, PPO]) que ofrecen cobertura de medicamentos con prescripción. Todos los planes de medicamentos de Medicare brindan, al menos, un nivel estándar de cobertura establecido por Medicare. Algunos planes también pueden ofrecer más cobertura por una prima mensual más alta.
2. Kaweah Delta Health Care District ha determinado que se prevé que la cobertura de medicamentos con prescripción ofrecida por el Plan de Salud del Empleado ("Plan") de Kaweah Delta Health Care District pague, en promedio para todos los participantes del plan, tanto como paga la cobertura estándar de medicamentos con prescripción de Medicare, y que se considere como una cobertura "acreditable" de medicamentos con prescripción. Esto es importante por los motivos que se describen a continuación.

Debido a que su cobertura actual es, en promedio, al menos tan buena como la cobertura estándar de medicamentos con prescripción de Medicare, puede mantener esta cobertura y no pagar una prima más alta (una penalización) si posteriormente decide inscribirse en un plan de medicamentos de Medicare, siempre que lo haga dentro de períodos específicos.

Inscribirse en Medicare — Normas generales
A modo de contexto, puede inscribirse en un plan de medicamentos de Medicare si primero ha sido elegible para Medicare. Si califica para Medicare debido a su edad, puede inscribirse en un plan de medicamentos de Medicare durante un período de inscripción inicial de siete meses. Ese período comienza tres meses antes de que cumpla 65 años, incluyendo el mes en que los cumple, y continúa durante los siguientes tres meses. Si califica para Medicare debido a discapacidad o a enfermedad renal en fase terminal, su período inicial de inscripción en la Parte D de Medicare depende de la fecha en la que comenzó su discapacidad o tratamiento. Para obtener más información, debe comunicarse con Medicare al número de teléfono o a la dirección web que aparecen más adelante.

Inscripción tardía y penalización por inscripción tardía
Si decide *esperar* para inscribirse en un plan de medicamentos de Medicare, puede hacerlo posteriormente durante el período de inscripción anual de la Parte D de Medicare, el cual se abre cada año del 15 de octubre al 7 de diciembre. Pero como norma general, si difiere su inscripción en la Parte D de Medicare después de haber sido elegible para inscribirse, es posible que deba pagar una prima más alta (una penalización).

Si después de su período inicial de inscripción de la Parte D de Medicare usted pasa **63 días continuos o más sin cobertura "acreditable" de medicamentos con prescripción** (es decir, una cobertura de medicamentos con prescripción que sea, al menos, tan buena como la cobertura de medicamentos con prescripción de Medicare), su prima mensual de la Parte D puede subir en, al menos, 1% de la prima que habría pagado si se hubiera inscrito oportunamente por cada mes que no tuvo cobertura acreditable.

Por ejemplo, si después de su período inicial de inscripción de la Parte D de Medicare usted pasa 19 meses sin cobertura, su prima puede ser, al menos, 19% más alta que la prima que de otro modo hubiera pagado. Es posible que tenga que pagar esta prima más alta durante el tiempo que tenga cobertura de medicamentos con prescripción de Medicare. *Sin embargo, hay algunas excepciones importantes a la penalización por inscripción tardía.*

Excepciones del período especial de inscripción a la penalización por inscripción tardía
Existen "períodos especiales de inscripción" que le permiten agregar cobertura de la Parte D de Medicare meses o incluso años después de que sea elegible para hacerlo, sin una penalización. Por ejemplo, si después de su período inicial de inscripción de la Parte D de Medicare pierde o decide abandonar la cobertura médica patrocinada por el empleador o por el sindicato que incluye cobertura "acreditable" de medicamentos con prescripción, será elegible para inscribirse en un plan de medicamentos de Medicare en ese momento.

Además, si de otro modo pierde otra cobertura acreditable de medicamentos con prescripción (como en el caso de una póliza individual) sin que sea su culpa, podrá inscribirse nuevamente en un plan de medicamentos de Medicare sin penalización. Estos períodos especiales de inscripción finalizan dos meses después del mes en el que finaliza su otra cobertura.

Compare coberturas
Debe comparar su cobertura actual, incluidos cuáles medicamentos están cubiertos a qué costo, con la cobertura y los costos de los planes que ofrecen cobertura de medicamentos con prescripción de Medicare en su área. Consulte el resumen del Plan de Kaweah Delta Health Care District para obtener una síntesis de la cobertura de medicamentos con prescripción del plan. Si no tiene una copia, puede obtener una al comunicarse con nosotros al número de teléfono o a la dirección que se encuentran más adelante.

Coordinación de otra cobertura con la Parte D de Medicare
En términos generales, si decide inscribirse en un plan de medicamentos de Medicare mientras está cubierto por el plan de Kaweah Delta Health Care District debido a su empleo (o al empleo de otra persona, como su cónyuge o alguno de sus padres), su cobertura amparada por el Plan de Kaweah Delta Health Care District no resultará afectada. Para la mayoría de las personas cubiertas por el Plan, el Plan pagará primero los beneficios de medicamentos con prescripción, y Medicare determinará sus pagos en segundo lugar. Para obtener más información acerca de este tema sobre qué programa paga primero y qué programa paga en segundo lugar, consulte el resumen del Plan o comuníquese con Medicare al número de teléfono o a la dirección web que figuran más adelante.

Si decide inscribirse en un plan de medicamentos de Medicare y cancelar su cobertura de medicamentos con prescripción de Kaweah Delta Health Care District, tenga en cuenta que es posible que usted y sus dependientes no puedan recuperar esta cobertura. Para recuperar la cobertura, deberá volver a inscribirse en el Plan, conforme a las normas de elegibilidad e inscripción del Plan. Debe revisar el resumen del Plan para determinar si le está permitido agregar cobertura y cuándo.

Para obtener más información sobre este aviso o sobre su cobertura actual de medicamentos con prescripción:
Comuníquese con la persona que figura más adelante para obtener más información, o llame al 858-314-7334. **NOTA:** Recibirá este aviso cada año. También lo recibirá antes del próximo período en el que puede inscribirse en un plan de medicamentos de Medicare, y si esta cobertura a través de Kaweah Delta Health Care District cambia. También puede solicitar una copia.

Para obtener más información sobre sus opciones amparadas por la cobertura de medicamentos con prescripción de Medicare:
Puede encontrar información más detallada sobre los planes de Medicare que ofrecen cobertura de medicamentos con prescripción en el manual "Medicare & You" (Medicare y usted). Obtendrá una copia del manual por correo cada año de parte de Medicare. También es posible que los planes de medicamentos de Medicare se comuniquen directamente con usted.

Para obtener más información sobre la cobertura de medicamentos con prescripción de Medicare:
- Visite www.medicare.gov.
- Llame a su Programa Estatal de Asistencia de Seguros Médicos (consulte la contraportada interior de su copia del manual "Medicare y usted" para obtener su número de teléfono) para obtener ayuda personalizada.
- Llame al 1-800-MEDICARE (1-800-633-4227). Los usuarios de TTY deben llamar al 1-877-486-2048.

Si tiene ingresos y recursos limitados, hay disponible ayuda adicional para pagar la cobertura de medicamentos con prescripción de Medicare. Para obtener información sobre esta ayuda adicional, visite el sitio web del Seguro Social en www.socialsecurity.gov o llame al 1-800-772-1213 (los usuarios de TTY deben llamar al 1-800-325-0778).

Recuerde: Conserve este aviso de cobertura acreditable. Si decide inscribirse en uno de los planes de medicamentos de Medicare, es posible que deba proporcionar una copia de este aviso cuando se lo haga para mostrar si ha mantenido o no una cobertura acreditable y si debe o no pagar una prima más alta (una penalización).

Fecha:	January 1, 2021
Nombre de la entidad/del remitente:	Kaweah Delta Health Care District
Contacto — Cargo/oficina:	Carmen Rodriguez
Dirección:	400 W. Mineral King Ave. Visalia, CA 93291
Número de teléfono:	559-624-2482

AVISO INTEGRAL DE LA HIPAA SOBRE POLÍTICAS Y PROCEDIMIENTOS DE PRIVACIDAD

KAWEAH DELTA HEALTH CARE DISTRICT
AVISO IMPORTANTE
AVISO INTEGRAL DE LA HIPAA SOBRE POLÍTICAS Y PROCEDIMIENTOS DE PRIVACIDAD

ESTE AVISO DESCRIBE CÓMO SE PUEDE USAR Y DIVULGAR SU INFORMACIÓN MÉDICA Y CÓMO PUEDE TENER ACCESO A ESTA INFORMACIÓN. REVÍSELO CON DETENIMIENTO.

Este aviso se le proporciona a usted en nombre de: **Kaweah Delta Health Care District**

El deber del plan de proteger su información médica protegida
La información individualmente identificable sobre su salud o condición pasada, presente o futura, la provisión de atención médica para usted o el pago por la atención médica se consideran "Información Médica Protegida" (Protected Health Information, PHI). Se requiere que el Plan amplíe ciertas protecciones a su PHI y que se le proporcione este aviso sobre sus prácticas de privacidad que explican cómo, cuándo y por qué el Plan puede usar o divulgar su PHI. Excepto en circunstancias específicas, el Plan puede usar o divulgar solo la PHI mínima necesaria para lograr el propósito del uso o la divulgación.

El Plan debe seguir las prácticas de privacidad descritas en este aviso, aunque se reserva el derecho de cambiarlas, así como de cambiar los términos de este aviso en cualquier momento. Si lo hace, y el cambio es importante, recibirá una versión revisada de este aviso, ya sea a través de entrega directa, envío por correo a su última dirección conocida o de alguna otra manera. Este aviso, y cualquier revisión importante del mismo, también se le proporcionará por escrito cuando lo solicite (pregúntele a su representante de Recursos Humanos o comuníquese con el Funcionario de Privacidad del Plan, descritos más adelante) y será publicado en cualquier sitio web mantenido por Kaweah Delta Health Care District que describa los beneficios disponibles para empleados y dependientes.

También puede recibir uno o más avisos de privacidad de compañías de seguros que brinden beneficios de acuerdo al Plan. Esos avisos describirán cómo las compañías de seguros usan y divulgan la PHI y sus derechos con respecto a la PHI que conservan.

Cómo el plan puede usar y divulgar su información médica protegida
El Plan usa y divulga PHI por una variedad de motivos. Para sus usos y divulgaciones de rutina, no requiere su autorización, pero para otros usos y divulgaciones, se puede requerir su autorización (o la autorización de su representante personal [por ejemplo, una persona que es su custodio, tutor o tiene un poder notarial]). A continuación, se ofrecen más descripción y ejemplos de los usos y divulgaciones de su PHI por parte del Plan.

- **Usos y divulgaciones relacionadas con tratamiento, pago u operaciones de atención médica.**
  - **Tratamiento:** en general, y como usted lo esperaría, se le permite al Plan divulgar su PHI para fines de su tratamiento médico. Por lo tanto, puede divulgar su PHI a médicos, personal de enfermería, hospitales, técnicos de emergencias médicas, farmacéuticos y otros profesionales de la salud cuando la divulgación es para su tratamiento médico. Por ejemplo, si se lesiona en un accidente y es importante que su equipo de tratamiento conozca su tipo de sangre, el Plan podría divulgar esa PHI al equipo para permitirle que le brinden un tratamiento más eficaz.
  - **Pago:** por supuesto, la función más importante del Plan, en lo que a usted respecta, es que *pague por* la totalidad o parte de la atención médica que recibe (siempre que la atención esté cubierta por el Plan). En el transcurso de sus operaciones de pago, el Plan recibe una cantidad sustancial de PHI sobre usted. Por ejemplo, médicos, hospitales y farmacias que le brindan atención le envían al Plan información detallada sobre la atención que brindan, de modo que se les pueda pagar por sus servicios. El Plan también puede compartir su PHI con otros planes en ciertos casos. Por ejemplo, si está cubierto por más de un plan de atención médica (p. ej., cubierto por este Plan y el plan de su cónyuge o cubierto por los planes que cubren a su padre y a su madre), podemos compartir su PHI con los otros planes para coordinar el pago de sus reclamos.
  - **Operaciones de atención médica:** el Plan puede usar y divulgar su PHI en el curso de sus "operaciones de atención médica". Por ejemplo, puede usar su PHI para evaluar la calidad de los servicios que recibió o divulgar su PHI a un contador o abogado para propósitos de auditoría. En algunos casos, el Plan puede divulgar su PHI a compañías de seguro con el propósito de obtener varias coberturas de seguro. Sin embargo, el Plan no divulgará, con fines de suscripción, PHI que sea información genética.
- **Otros usos y divulgaciones de su PHI que no requieren autorización.** La ley establece que el Plan puede usar y divulgar su PHI sin autorización en las siguientes circunstancias:
  - **Al patrocinador del plan:** el plan puede divulgar su PHI a los empleadores (como Kaweah Delta Health Care District) que patrocinan o mantienen el Plan en beneficio de empleados y dependientes. Sin embargo, la PHI solo se puede usar con propósitos limitados, y no se puede usar para propósitos de medidas o decisiones relacionadas con el empleo o en conexión con cualquier otro beneficio o plan de beneficios para empleados de los empleadores. La PHI se puede divulgar al: Departamento de Recursos Humanos o de Beneficios para Empleados a los efectos de inscripciones y desafiliaciones, censos, resoluciones de reclamos y otros asuntos relacionados con la administración del Plan; Departamento de Nómina a los efectos de garantizar deducciones de nómina apropiadas y otros pagos de las personas cubiertas por su cobertura; Departamento de Tecnología de la Información, según sea necesario para preparación de compilaciones de datos e informes relacionados con la administración del Plan; Departamento de Finanzas a los efectos de reconciliar pagos apropiados de la prima y beneficios del Plan y otros asuntos relacionados con la administración del Plan; Asesor Jurídico interno para ayudar con la resolución de reclamos, cobertura y otras disputas relacionadas con la provisión de beneficios del Plan.
  - **A los proveedores de servicios del Plan:** el plan puede divulgar la PHI a sus proveedores de servicios ("socios comerciales") que llevan a cabo pago de reclamos y servicios de administración del plan. El Plan requiere un contrato por escrito que obligue al socio comercial a salvaguardar y limitar el uso de PHI.
  - **Exigido por la ley**: el Plan puede divulgar la PHI cuando una ley exige que presente información sobre presuntos maltratos, abandono o violencia doméstica, que esté relacionada con una sospecha de actividad delictiva o en respuesta a una orden judicial. También debe divulgar PHI a las autoridades que supervisan el cumplimiento de estos requisitos de privacidad.
  - **Para actividades de salud pública:** el Plan puede divulgar PHI cuando sea necesario para recopilar información sobre enfermedades o lesiones o para informar estadísticas vitales a la autoridad de salud pública.
  - **Para actividades de supervisión de la salud:** el plan puede divulgar PHI a agencias o departamentos responsables de supervisar el sistema de atención médica a efectos tales como informar sobre incidentes inusuales o investigarlos.
  - **Relativo a los difuntos:** el Plan puede divulgar PHI relacionada con la muerte de una persona a médicos forenses, examinadores médicos o directores de funerarias y a organizaciones de obtención de órganos relacionadas con donaciones o trasplantes de órganos, ojos o tejidos.

- **Para propósitos de investigación:** en ciertas circunstancias, y bajo estricta supervisión de una junta de privacidad, el Plan puede divulgar PHI para ayudar a la investigación médica y psiquiátrica.
- **Para evitar amenazas a la salud o a la seguridad:** para evitar una amenaza grave a la salud o a la seguridad, el Plan puede divulgar PHI según sea necesario a fuerzas del orden público o a otras personas que razonablemente pueden prevenir o disminuir la amenaza de daño.
- **Para funciones específicas del Gobierno:** el Plan puede divulgar PHI de personal militar y veteranos en ciertas situaciones a instituciones correccionales en ciertas situaciones, a programas gubernamentales relacionados con elegibilidad e inscripción y por motivos de seguridad nacional.

- **Usos y divulgaciones que requieren autorización:** para usos y divulgaciones que van más allá de tratamiento, pago y propósitos de operaciones, y por motivos que no están incluidos en una de las excepciones descritas anteriormente, se requiere que el Plan tenga su autorización por escrito. Por ejemplo, usos y divulgaciones de notas de psicoterapia, usos y divulgaciones de PHI para fines comerciales y divulgaciones que constituyen una venta de PHI requerirían su autorización. Su autorización puede revocarse en cualquier momento para detener usos y divulgaciones futuras, excepto en la medida en que el Plan ya haya emprendido una acción sobre la base de su autorización.
- **Usos y divulgaciones que requieren que usted tenga la oportunidad de oponerse:** el plan puede compartir PHI con su familia, amigo u otra persona involucrada en su atención o en el pago de su atención. También podemos compartir PHI con estas personas para notificarles sobre su ubicación, condición general o fallecimiento. Sin embargo, el Plan puede divulgar su PHI solo si le informa sobre la divulgación por adelantado y usted no se opone (pero si hay una situación de emergencia y no se le puede dar la oportunidad de objetar, se puede llevar a cabo la divulgación si es consistente con cualquier deseo expresado anteriormente y se determina que la divulgación es lo mejor para usted; usted debe estar informado y se le debe dar la oportunidad de oponerse a una divulgación posterior tan pronto como sea posible).

Sus derechos con respecto a su información médica protegida

Usted tiene los siguientes derechos relacionados con su información médica protegida:

- **Solicitar restricciones sobre usos y divulgaciones:** tiene derecho a solicitar que el Plan limite cómo usa o divulga su PHI. El Plan considerará su solicitud, pero no está legalmente obligado a aceptar la restricción. En la medida en la que acepte cualquier restricción sobre su uso o divulgación de su PHI, pondrá el acuerdo por escrito y lo cumplirá, excepto en situaciones de emergencia. El Plan no puede aceptar limitar usos o divulgaciones que exige la ley.
- **Elegir cómo se el Plan se comunica con usted:** tiene derecho a solicitar que el Plan le envíe información a una dirección alternativa o por medios alternativos. Para solicitar comunicaciones confidenciales, debe hacer su solicitud por escrito al Funcionario de Privacidad. No le preguntaremos el motivo de su solicitud. Su solicitud debe especificar cómo o dónde desea que nos comuniquemos con usted. El Plan debe aceptar su solicitud siempre que sea razonablemente fácil atender la solicitud.
- **Inspeccionar y copiar su PHI:** a menos que su acceso esté restringido por motivos de tratamiento claros y documentados, tiene derecho a ver su PHI en posesión del Plan o sus proveedores si presenta su solicitud por escrito. El Plan, o alguien en nombre del Plan, responderá a su solicitud, normalmente dentro de los 30 días. Si su solicitud es denegada, recibirá los motivos de la denegación por escrito y una explicación de cualquier derecho a que se revise la denegación. Si desea copias de su PHI, se puede imponer un cargo por la copia, pero puede eximirse, dependiendo de sus circunstancias. Tiene derecho a elegir qué partes de su información quiere copiar y recibir, a pedido, previa información sobre el costo de copiado.
- **Solicitar modificaciones de su PHI:** si cree que hay un error o falta información en un registro de su PHI en poder del Plan o de uno de sus proveedores, puede solicitar por escrito que se corrija o complemente el registro. El Plan, o alguien en nombre del Plan, responderá normalmente dentro de los 60 días posteriores a la recepción de su solicitud. El Plan puede denegar la solicitud si se determina que la PHI: (i) es correcta y completa; (ii) no es creada por el Plan o su proveedor o no es parte de los registros del proveedor o del Plan; o (iii) no se permite ser divulgada. Cualquier denegación indicará los motivos de la misma y le explicará sus derechos para solicitar que se adjunte a su PHI la solicitud y la denegación, junto con cualquier declaración en respuesta que usted proporcione. Si se aprueba la solicitud de enmienda, el Plan o el proveedor, según sea el caso, cambiará la PHI y así se lo informará, y le dirá a otras personas que necesiten saber sobre el cambio en la PHI.
- **Averiguar qué divulgaciones se han realizado:** tiene derecho a obtener una lista de cuándo, a quién, con qué propósito y qué parte de su PHI ha sido divulgada por el Plan y sus proveedores, a excepción de las instancias de divulgación para las que proporcionó la autorización, o instancias en las que la divulgación fue hecha a usted o a su familia. Además, la lista de divulgación no incluirá divulgaciones para tratamiento, pago u operaciones de atención médica. La lista tampoco incluirá ninguna divulgación hecha con fines de seguridad nacional a funcionarios del orden público o a instituciones correccionales o antes de la fecha en la que normas de privacidad federales se aplicaron al Plan. Normalmente recibirá una respuesta a su solicitud por escrito de dicha lista dentro de los 60 días después de que realice la solicitud por escrito. Su solicitud puede relacionarse con divulgaciones que se remontan a seis años. No se cobrarán cargos por hasta una de esas listas cada año. Puede haber un cargo por solicitudes más frecuentes.

Cómo presentar quejas sobre las prácticas de privacidad del Plan

Si cree que el Plan o uno de sus proveedores puede haber violado sus derechos de privacidad, o si no está de acuerdo con una decisión tomada por el Plan o un proveedor sobre el acceso a su PHI, puede presentar una queja con la persona que se indica en la sección inmediata siguiente. También puede presentar una queja por escrito ante el Secretario del Departamento de Salud y Servicios Humanos de EE. UU. La ley no permite que nadie tome medidas de represalia contra usted si presenta dichas quejas.

Notificación de una violación de privacidad

Cualquier persona cuya PHI no asegurada ha sido, o se cree razonablemente que ha sido, usada, accedida, adquirida o divulgada de manera no autorizada, recibirá una notificación por escrito del Plan dentro de los 60 días posteriores al descubrimiento de la violación.

Si la violación involucra a 500 o más residentes de un estado, el Plan notificará a los medios de comunicación importantes en el estado. El Plan mantendrá un registro de violaciones de seguridad y presentará esta información al Departamento de Salud y Servicios Humanos (Health and Human Services, HHS) anualmente. Se requieren informes inmediatos del Plan al HHS si una violación de seguridad involucra a 500 o más personas.

Persona de contacto para obtener información o presentar una queja

Si tiene preguntas sobre este aviso, comuníquese con el Funcionario de Privacidad del Plan o el(los) Funcionario(s) Adjunto(s) de Privacidad (consulte a continuación). Si tiene alguna queja sobre las prácticas de privacidad del Plan, el manejo de su PHI, *o el proceso de notificación de una violación*, comuníquese con el Funcionario de Privacidad o con un Funcionario Adjunto de Privacidad autorizado: **Ben Cripps Compliance and Privacy Officer 559-624-5006** **Fecha de entrada en vigor:** La fecha de entrada en vigor de este aviso es: January 1, 2021.

AVISO DE DERECHOS ESPECIALES DE INSCRIPCIÓN

PLAN DE SALUD DEL EMPLEADO DE KAWEAH DELTA HEALTH CARE DISTRICT
AVISO DE DERECHOS ESPECIALES DE INSCRIPCIÓN

Si rechaza la inscripción para usted o sus dependientes (incluido su cónyuge) debido a otro seguro de salud o a un plan colectivo de cobertura médica, puede inscribirse posteriormente a sí mismo y a sus dependientes en este plan si usted o sus dependientes pierden la elegibilidad para esa otra cobertura (o si el empleador deja de contribuir a su otra cobertura o a la de sus dependientes).

La pérdida de elegibilidad incluye, entre otros:

- Pérdida de elegibilidad para la cobertura como consecuencia de dejar de cumplir con los requisitos de elegibilidad del plan (p. ej., divorcio, cese de la situación de dependiente, fallecimiento de un empleado, terminación del empleo, reducción en el número de horas de empleo).
- Pérdida de la cobertura de una HMO porque la persona ya no reside o no trabaja en el área de servicio de la HMO y no hay otra opción de cobertura disponible a través del patrocinador del plan de la HMO.
- Eliminación de la opción de cobertura en la que se inscribió una persona, y no se ofrece otra opción en su lugar.
- No regresar de un permiso de ausencia de la Ley de Ausencia Familiar y Médica (Family and Medical Leave Act, FMLA).
- Pérdida de elegibilidad de acuerdo a Medicaid o al Programa de Seguro Médico Infantil (Children's Health Insurance Program, CHIP).

A menos que el evento que da lugar a su derecho especial de inscripción sea una pérdida de elegibilidad de acuerdo a Medicaid o al CHIP, debe solicitar la inscripción dentro de los *30 días* después de que finalice su otra cobertura o la de sus dependientes (o después de que el empleador que patrocina esa cobertura deje de contribuir a la cobertura).

Si el evento que da lugar a su derecho especial de inscripción es una pérdida de cobertura de acuerdo a Medicaid o al CHIP, puede solicitar la inscripción en este plan dentro de ***60 días*** después de la fecha en la que usted o sus dependientes pierden dicha cobertura de acuerdo a Medicaid o al CHIP. Del mismo modo, si usted o su(s) dependiente(s) se vuelven elegibles para un subsidio de primas otorgado por el estado a este plan, puede solicitar la inscripción en este plan dentro de los ***60 días*** después de la fecha en la que Medicaid o el CHIP determinen que usted o el(los) dependiente(s) califican para el subsidio.

Además, si tiene un nuevo dependiente producto de un matrimonio, nacimiento, adopción o colocación para adopción es posible que pueda inscribirse usted y sus dependientes. Sin embargo, debe solicitar la inscripción dentro de los *30 días* después del matrimonio, del nacimiento, de la adopción o de la colocación para adopción.

Para solicitar una inscripción especial u obtener más información, comuníquese con: Carmen Rodriguez 559-624-2482

**** Este aviso es pertinente para coberturas de atención médica sujetas a las normas de transferencia de la Ley de Transferencia y Responsabilidad de Seguro Médico (Health Insurance Portability and Accountability Act, HIPAA).***

MODELO DE AVISO GENERAL DE LOS DERECHOS DE LA COBERTURA DE CONTINUACIÓN DE COBRA

(para que usen los planes de salud grupales de un solo empleador)
****Derechos de la cobertura de continuación conforme a la ley COBRA****

Le enviamos este aviso porque recientemente obtuvo la cobertura de un plan de salud grupal (el Plan). Este aviso contiene información importante acerca de su derecho a recibir la cobertura de continuación de COBRA, que es una extensión temporal de la cobertura del Plan. **Este aviso explica la cobertura de continuación de COBRA, el momento en el que usted y su familia pueden recibirla, y lo que usted puede hacer para proteger su derecho a obtenerla.** Al ser elegible para la cobertura de COBRA, también puede ser elegible para otras opciones que pueden costarle menos que la cobertura de continuación de COBRA.

El derecho a recibir la cobertura de continuación de COBRA se originó gracias a una ley federal, la Ley Ómnibus Consolidada de Reconciliación Presupuestaria (COBRA, por sus siglas en inglés) de 1985. Usted y otros familiares suyos pueden disponer de la cobertura de continuación de COBRA cuando se termine la cobertura de salud grupal. Para obtener más información acerca de sus derechos y obligaciones conforme al Plan y a la ley federal, debe revisar el resumen de la descripción del Plan o comunicarse con el administrador del Plan.

Al perder la cobertura de salud grupal, puede haber otras opciones disponibles. Por ejemplo, puede ser elegible para comprar un plan individual a través del mercado de seguros médicos. Al inscribirse en la cobertura a través del mercado de seguros médicos, puede cumplir con los requisitos para tener menores costos en las primas mensuales y gastos propios más bajos. Asimismo, puede tener derecho a un período de inscripción especial de 30 días en otro plan de salud grupal para el cual sea elegible (como un plan del cónyuge), aunque ese plan generalmente no acepte afiliados de último momento.

¿Qué es la cobertura de continuación de COBRA?

La cobertura de continuación de COBRA es la continuación de la cobertura del Plan cuando esta debería terminar debido a un evento determinado de la vida. Este acontecimiento también se conoce como "evento específico". Los eventos específicos se incluyen más abajo en este aviso. Después de un evento específico, la cobertura de continuación de COBRA debe ofrecerse a cada persona considerada un "beneficiario que cumple con los requisitos". Usted, su cónyuge y sus hijos dependientes podrían convertirse en beneficiarios que cumplan con los requisitos si la cobertura del Plan se pierde debido al evento específico. Según el Plan, los beneficiarios que cumplan con los requisitos y que elijan la cobertura de continuación de deben pagar la cobertura de continuación de COBRA.

Si usted es un empleado, se convertirá en un beneficiario que cumple con los requisitos si pierde la cobertura del Plan debido a estos eventos específicos:

- sus horas de empleo se reducen; o
- su empleo termina por un motivo que no sea una falta grave de su parte.

Si usted es el cónyuge del empleado, se convertirá en un beneficiario que cumple con los requisitos si pierde la cobertura del Plan debido a estos eventos específicos:

- su cónyuge muere;
- las horas de empleo de su cónyuge se reducen;
- el empleo de su cónyuge termina por un motivo que no sea una falta grave por parte de su cónyuge;
- su cónyuge adquiere el derecho a recibir los beneficios de Medicare (Parte A, Parte B o ambas); o
- se divorcia o se separa legalmente de su cónyuge.

Sus hijos dependientes se convertirán en beneficiarios que cumplen con los requisitos si pierden la cobertura del Plan debido a estos eventos específicos:

- el empleado cubierto muere;
- las horas de empleo del empleado cubierto se reducen;
- el empleo del empleado cubierto termina por un motivo que no sea una falta grave por parte del empleado cubierto;
- el empleado cubierto adquiere el derecho a recibir los beneficios de Medicare (Parte A, Parte B o ambas);
- los padres se divorcian o se separan legalmente; o el hijo deja de ser elegible para la cobertura del Plan como "hijo dependiente".

¿Cuándo está disponible la cobertura de continuación de COBRA?

El Plan ofrecerá la cobertura de continuación de COBRA a los beneficiarios que cumplan con los requisitos solamente después de que se le informe al administrador del Plan que ha ocurrido un evento específico. El empleador debe notificar los siguientes eventos habilitantes al administrador del Plan:

- la terminación del empleo o la reducción de las horas de empleo;
- la muerte del empleado;
- el hecho de que el empleado adquiera el derecho a recibir los beneficios de Medicare (Parte A, Parte B o ambas).
  Para todos los otros eventos específicos (divorcio o separación legal del empleado y el cónyuge, o hijo dependiente que pierde la elegibilidad para la cobertura como hijo dependiente), debe avisarle al administrador del Plan en los 60 días 30 posteriores a que se produzca el evento habilitante. Debe proporcionarle este aviso a: administrador del Plan). Informe al administrador del plan si tiene preguntas sobre elegir la cobertura de continuación de COBRA.

¿Cómo se proporciona la cobertura de continuación de COBRA?

Después de que el administrador del Plan recibe el aviso de que se ha producido un evento específico, la cobertura de continuación de COBRA se ofrecerá a cada uno de los beneficiarios que cumplan con los requisitos. Cada beneficiario que cumpla con los requisitos tendrá su propio derecho a elegir la cobertura de continuación de COBRA. Los empleados cubiertos pueden elegir la cobertura de continuación de COBRA en nombre de su cónyuge y los padres pueden elegir la cobertura de continuación de COBRA en nombre de sus hijos.

La cobertura de continuación de COBRA es la continuación temporal de la cobertura debido a la terminación del empleo o a la reducción de las horas de trabajo, y en general dura 18 meses. Determinados eventos específicos, o un segundo evento específico durante el período inicial de cobertura, pueden permitir que el beneficiario reciba un máximo de 36 meses de cobertura.

También hay otros motivos por los cuales este período de 18 meses de la cobertura de continuación de COBRA puede prolongarse:

Extensión por discapacidad del período de 18 meses de la cobertura de continuación de COBRA
Si el Seguro Social determina que usted o alguien de su familia que esté cubierto por el Plan tiene una discapacidad y usted le avisa al respecto al administrador del Plan en el plazo correspondiente, usted y toda su familia pueden recibir una extención adicional de hasta 11 meses de cobertura de continuación de COBRA, por un máximo de 29 meses. La discapacidad debe haber comenzado en algún momento antes de los 60 días de la cobertura de continuación de COBRA y debe durar al menos hasta el final del período de 18 meses de la cobertura de continuación de COBRA. (*Agregue la descripción de cualquier procedimiento adicional del Plan para este aviso, incluida la descripción de toda documentación o información obligatoria, el nombre de la persona a quien enviarle este aviso y el período válido para enviar el aviso*).
Extensión por un segundo evento específico del período de 18 meses de la cobertura de continuación de COBRA
Si su familia sufre otro evento específico durante los 18 meses de la cobertura de continuación de COBRA, su cónyuge y sus hijos dependientes pueden recibir hasta 18 meses adicionales de cobertura de continuación de COBRA, por un máximo de 36 meses, si se le avisa al Plan como corresponde acerca del segundo evento específico. Esta extensión puede estar disponible para el cónyuge y cualquier hijo dependiente que reciba la cobertura de continuación de COBRA en el caso de que el empleado o exempleado muera, adquiera el derecho a recibir los beneficios de Medicare (Parte A, Parte B o ambas), se divorcie o se separe legalmente, o si el hijo dependiente deja de ser elegible en el Plan como hijo dependiente. Esta extensión solo está disponible en el caso de que el segundo evento específico hubiese hecho que el cónyuge o el hijo dependiente pierda la cobertura del Plan si no se hubiese producido el primer evento específico.

¿Hay otras opciones de cobertura además de la cobertura de continuación de COBRA?

Sí. En lugar de inscribirse en la cobertura de continuación de COBRA, puede haber otras opciones de cobertura para usted y su familia a través del mercado de seguros médicos, Medicaid u otras opciones de un plan de salud grupal (por ejemplo, el plan de su cónyuge) mediante lo que se denomina un "período de inscripción especial". Es posible que algunas de estas opciones cuesten menos que la cobertura de continuación de COBRA. Puede encontrar más información sobre muchas de estas opciones en **www.healthcare.gov**.

¿Puedo inscribirme en Medicare, en caso de ser elegible, después de que finalice la cobertura de mi plan de salud colectivo?

En general, después del período de inscripción inicial, hay un período de inscripción especial de 8 meses[1] para inscribirse en Medicare Parte A o B, que comienza cuando ocurre lo primero de lo siguiente:

- El mes posterior a la finalización del empleo.

[1] www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-period.

- El mes posterior a la finalización de la cobertura del plan de salud colectivo basada en el empleo actual.

Si elige la Ley Ómnibus Consolidada de Reconciliación Presupuestaria (COBRA) y desea inscribirse en Medicare Parte B después de que finalice su cobertura de continuación, es posible que tenga que pagar una penalidad por inscripción tardía. Si se inscribe inicialmente en Medicare Parte A o B después de elegir la cobertura de continuación COBRA, el plan puede terminar su cobertura de continuación (sin embargo, si Medicare Parte A o B entra en vigencia en la fecha de la elección de COBRA o antes de esta fecha, la cobertura de COBRA no se puede descontinuar debido al derecho a Medicare, incluso si la persona se inscribe en la otra parte de Medicare después de la fecha de la elección de la cobertura de COBRA).

Si está inscrito tanto en COBRA como en Medicare, Medicare será generalmente el pagador principal. Es posible que algunos planes "disminuyan" el monto que Medicare pagaría en caso de ser el pagador principal, incluso si usted no está inscrito.

Para obtener más información, visite www.medicare.gov/medicare-and-you

Si tiene preguntas

Las preguntas acerca de su Plan o de sus derechos a recibir la cobertura de continuación de COBRA deben enviarse al contacto o los contactos identificados abajo. Para obtener más información sobre sus derechos según la Ley de Seguridad de los Ingresos de Jubilación de los Empleados (ERISA, por sus siglas en inglés), incluida la ley COBRA, la Ley de Atención Médica (de bajo costo) y la Protección al Paciente, y otras leyes que afectan a los planes de salud grupales, comuníquese con la oficina regional o de distrito más cercana de la Administración de Seguridad de Beneficios para Empleados (EBSA, por sus siglas en inglés) del Departamento de Trabajo de Estados Unidos en su área, o visite www.dol.gov/ebsa. (Las direcciones y los números de teléfono de las oficinas regionales y de distrito de EBSA están disponibles en el sitio web de EBSA). Para obtener más información acerca del mercado de seguros médicos, visite www.HealthCare.gov.

Informe a su plan si cambia de dirección

Para proteger los derechos de su familia, informe al administrador del Plan sobre cualquier cambio en las direcciones de sus familiares. También debe conservar una copia, para su registro, de todos los avisos que le envíe al administrador del Plan.

Información de contacto del Plan

(*Ingrese el nombre del Plan y el nombre (o el puesto), la dirección y el número de teléfono de la persona o las personas a las que se les puede solicitar información sobre el Plan y la cobertura de continuación de COBRA*). *Carmen Rodriguez 559-624-2482*

AVISO DEL DERECHO A DESIGNAR UN PROVEEDOR DE ATENCIÓN PRIMARIA Y DE LA NO OBLIGACIÓN DE UNA AUTORIZACIÓN PREVIA PARA ATENCIÓN DE OBSTETRICIA Y GINECOLOGÍA

Para planes y emisores que exijan o permitan la designación de proveedores de cuidados primarios por participantes o beneficiarios, insertar:]

Por lo general, el Plan de Atención Médica del Empleado de Kaweah Delta Health Care District allows la designación de un Proveedor de Atención Primaria. Tiene derecho a designar cualquier Proveedor de Atención Primaria que participe en nuestra red y que esté disponible para aceptarlo a usted o a los miembros de su familia. Para obtener información sobre cómo seleccionar un Proveedor de Atención Primaria y una lista de proveedores de atención primaria participantes, comuníquese con plan administrator: 559-734-1321 opcion 3.
Para planes y emisores que exijan o permitan la designación de un proveedor de cuidados primarios para un menor, añada:]

Para los niños, puede designar un pediatra como Proveedor de Atención Primaria.
Para planes y emisores que provean cobertura para atención obstétrica o ginecológica y exijan que el participante o el beneficiario designe un proveedor de cuidados primarios, añada:]

No necesita autorización previa del Plan de Atención Primaria del Empleado de Kaweah Delta Health Care District o de cualquier otra persona (incluye un Proveedor de Atención Primaria) con el fin de obtener acceso a atención obstétrica o ginecológica de parte de un profesional de atención médica de nuestra red que se especializa en obstetricia o ginecología. Sin embargo, es posible que se le exija al profesional de atención médica que cumpla con ciertos procedimientos, como obtención de autorización previa para ciertos servicios, cumplimiento de un plan de tratamiento aprobado previamente o procedimientos para hacer remisiones. Para obtener una lista de profesionales de atención médica participantes que se especializan en obstetricia o ginecología, comuníquese con el Plan de Atención Médica del Empleado de Kaweah Delta Health Care District al: 559-734-1321 opcion 3.

AVISO SOBRE DERECHOS DE SALUD Y CÁNCER DE LAS MUJERES

La ley exige que el Plan de Atención Médica del Empleado de Kaweah Delta Health Care District le proporcione el siguiente aviso:

La Ley de Derechos de Salud y Cáncer de las Mujeres (Ley de Salud de la Mujer y Derechos del Cáncer, WHCRA) brinda ciertas protecciones para personas que reciben beneficios relacionados con la mastectomía. La cobertura se proporcionará de una manera determinada en consulta con el médico tratante y el paciente para:

- Todas las etapas de reconstrucción del seno en el que se realizó la mastectomía.
- Cirugía y reconstrucción del otro seno para producir una apariencia simétrica.
- Prótesis.
- Y tratamiento de complicaciones físicas de la mastectomía, incluidos linfedemas.

El Plan de Atención Médica del Empleado de Kaweah Delta Health Care District brinda cobertura médica para mastectomías y procedimientos relacionados enumerados anteriormente, sujetos a los mismos deducibles y coaseguros aplicables a otros beneficios médicos y quirúrgicos provistos en este plan.

Si desea obtener más información sobre los beneficios de la WHCRA, consulte su o comuníquese con su Administrador del Plan 559-734-1321 opcion 3 o el folleto de la póliza del plan de seguro medico.

AVISO DE LOS PROGRAMAS DE BIENESTAR PATROCINADOS POR EL EMPLEADOR

Kaweah Delta Health Care District Wellness Program es un programa de bienestar voluntario disponible para All Benefit Eligible Employees. El programa es administrado de acuerdo con las normas federales que permiten los programas de bienestar patrocinados por el empleador que buscan mejorar la salud de los empleados o prevenir enfermedades, incluye la Ley sobre Estadounidenses con Discapacidades de 1990 (Americans with Disabilities Act, ADA), la Ley de No Discriminación por Información Genética de 2008 (Genetic Information Nondiscrimination Act, GINA) y Ley de Portabilidad y Responsabilidad de Seguros Médicos, según sea el caso, entre otras.

Los detalles sobre el programa de bienestar, que incluyen criterios e incentivos, se pueden encontrar en el Kaweah Delta Benefit Guide.

Si no puede participar en alguna de las actividades con relación a su salud o no obtiene algunos de los resultados médicos necesarios para merecer un incentivo, es posible que tenga derecho a una adaptación razonable o una norma alternativa. Puede solicitar una adaptación razonable o una norma alternativa, comunicándose con al o al.

La información de se utilizará con el fin de brindarle información que lo ayude a comprender su condición médica actual y los posibles riesgos. Asimismo, se puede utilizar para ofrecerle servicios a través del programa de bienestar, como. También le recomendamos que comparta sus resultados o preocupaciones con su médico de cabecera

Protecciones contra la divulgación de información médica

Por ley, debemos mantener la privacidad y seguridad de su información médica personal e identificable. Aunque el programa de bienestar y Kaweah Delta Health Care District pueden utilizar información adicional recopilada para diseñar un programa con base en los riesgos para la salud que se presentan en su lugar de trabajo, el programa de bienestar nunca divulgará su información personal ni al público ni al empleador, a menos que sea necesario para responder una solicitud de su parte sobre una adaptación razonable que se necesita para participar en el programa de bienestar o conforme a la ley permita. La información médica que lo identifica de forma personal y se proporciona con relación a el programa de bienestar no se divulgará ni a los directores o gerentes y no se utilizará para tomar decisiones con respecto a su empleo.

Se prohíbe la venta, intercambio, transferencia y divulgación de su información médica, conforme a la ley lo permita, a menos que sea para realizar determinadas actividades relacionadas al programa de bienestar y no se le pedirá o exigirá que renuncie al derecho de la confidencialidad de su información médica como condición para participar en el programa de bienestar o para obtener un intensivo. Cualquier persona que reciba su información con la finalidad de brindarle servicios, como parte del programa de bienestar, cumplirá con los mismos requisitos de confidencialidad. La(s) única(s) personas que recibirán su información médica personal e identificable es(son) a fin de brindarle servicios bajo el programa de bienestar.

Además, toda la información médica que se obtenga a través del programa de bienestar se mantendrá separada de sus registros personales, la información almacenada de manera electrónica se codificará y la información que proporcione, como parte del programa de bienestar, se utilizará para tomar una decisión sobre su empleo. Se tomarán las precauciones necesarias para evitar cualquier filtración de información y en caso de que se filtre alguna información que incluya información que proporcionó con relación al programa de bienestar, le notificaremos de inmediato.

No puede ser discriminado en su empleo a causa de la información médica que proporciona como parte de participar en el programa de bienestar, ni se deben tomar represalias en su contra si decide no participar.
Si tiene alguna pregunta o preocupación sobre este aviso o sobre las protecciones contra la divulgación y represalias, comuníquese con al o al.
Dana Ramos Foundation for Medical Care of Tulare and Kings Counties 333 S. Fairway St. Visalia, CA 93277 559-734-0393 dramos@tkfmc.org

NOTES:

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KAWEAH CARE

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Excellence is our FOCUS.
Compassion is our PROMISE.

Kaweah Delta

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