HEALTH CARE PLAN NOTICES

This benefit communication includes notices for the Methodist Health System Employee Health Care Plan.

You will find the following notices:

- Special Enrollment Notice
- HIPAA Privacy Notice
- Medicare Part D Notice
- Women's Health and Cancer Rights Act of 1998
- Notice for Employer-Sponsored Wellness Programs

EMPLOYEE HEALTH CARE PLAN

SPECIAL ENROLLMENT NOTICE

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

The Children's Health Insurance Program Reauthorization Act of 2009 ("CHIP") provides that the Methodist Health System Employee Health Care Plan must permit special enrollment arrangements for employees related to eligibility under either Medicaid or CHIP. Specifically, the Methodist Health System Employee Health Care Plan must permit an employee, or his or her dependent, who is eligible, but not enrolled, for coverage under the plan to enroll for coverage if either:

(i) the employee or dependent is covered under a Medicaid plan or state CHIP, (ii) coverage of the employee or dependent is terminated as a result of loss of eligibility, and (iii) the employee requests coverage under the group health plan no later than sixty (60) days after the date coverage terminates; or

(ii) the employee or dependent becomes eligible for assistance under a Medicaid plan or state CHIP (including under any waiver or demonstration project conducted under or in relation to those plans), and (ii) the employee requests coverage under the group health plan no later than 60 days after the date the employee or dependent is determined to be eligible for assistance.

To request special enrollment, or obtain more information, contact Methodist Health System Human Resources at 825 S. 169th Street, Omaha, NE 68118, or (402) 354-2280.

NEBRASKA METHODIST HEALTH SYSTEM
HEALTH CARE, DENTAL CARE, VISION, MEDICAL EXPENSE REIMBURSEMENT AND LIMITED USE MEDICAL EXPENSE REIMBURSEMENT PLANS*
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 pertains only to healthcare coverage provided under the plans.

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 Nebraska Methodist Health System 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 Nebraska Methodist Health System) 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 disenrollments, 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).

<u>Your Rights Regarding Your Protected Health Information</u>

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 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.

Privacy Official
The Plan's Privacy Official, the person responsible for ensuring compliance with this notice, is Anita Patterson, Anita.Patterson@nmhs.org, (402) 354-6863.

Effective Date
The effective date of this notice is: October 9, 2023.

MEDICARE PART D NOTICE

As part of federal legislation, Medicare offers prescription drug benefits. Because the Methodist Health System Employee Health Care Plan offers prescription drug benefits, the following notice is required.

HEALTH CARE PLAN PARTICIPANTS – INCLUDING SPOUSE AND OTHER COVERED DEPENDENTS:

Important Notice from The Methodist Health System Employee Health Care Plan
About Your 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 the Methodist Health System Employee Health Care Plan and prescription drug coverage available for people with Medicare.

This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

Two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Methodist Health System has determined that the prescription drug coverage offered by the Methodist Health System Employee Health Care Plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you join a Medicare drug plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What happens to your current coverage if you decide to join a Medicare drug plan?

If you decide to join a Medicare drug plan, your Methodist Health System Employee Health Care Plan coverage will not be affected. Your Methodist Health System Employee Health Care Plan prescription drug coverage will be primary and will not coordinate with the Medicare drug plan.

AN OVERVIEW – PPO OPTION

An overview of the prescription drug benefits available in the Methodist Health System Employee Health Care Plan is shown below. The plan benefits encourage generic products when these are available. The example shown below outlines the plan benefits when a brand or non-formulary brand is purchased and a generic drug is available.

	Retail*	**Mail Service***
	Up to 30 Day Supply	**Up to 90 Day Supply**
Generic	35%, $10 min., $100 max.	35%, $20 min., $200 max.
Brand Name Formulary	35%, $40 min., $120 max.	35%, $70 min., $230 max.
Non-Formulary Brand Name	50%, $60 min., $150 max.	50%, $120 min., $250 max.
Specialty Mail Service –	-----	35%, $100 min., $200 max.

Mail Service Only, Limit up to 30 day supply.

Retail 90 Day Supply – 3x 30-day co-pay applies

*If a generic drug is available and you opt to have your prescription filled with a brand name or non-formulary drug, the Plan will pay only the cost of the generic. You will be responsible for paying the Brand Name co-pay plus the cost difference between the brand-name or non-formulary and the generic drug.

Example: You have a prescription filled at a retail pharmacy for XYZ drug, and there is a generic available. If the prescription is filled as XYZ drug, it is a brand drug. XYZ drug costs $120; the generic substitution costs $41. Below is an example of your costs for generic substitution compared to brand name:

Brand Name Option	**Generic Substitution Option**
$ 42 Brand Co-pay ($120 * 35% = $42)	$14.35 Generic Co-pay
+ $ 79 ($120 cost of XYZ drug - $41 cost of the generic)	($41 * 35%)
$121 for XYZ drug prescription	

If you do decide to join a Medicare drug plan and drop your current Methodist Health System coverage, be aware that you and your dependents may not be able to get this coverage back.

AN OVERVIEW – HIGH DEDUCTIBLE HEALTH PLAN (HDHP) OPTION

An overview of the prescription drug benefits available in the Methodist Health System Employee Health Care Plan – High Deductible Health Plan option are shown below:

The plan benefits encourage generic products when these are available. The example shown below outlines the plan benefits when a brand or non-formulary brand is purchased and a generic drug is available.

Calendar year deductible applies first, then the coinsurance below applies. The deductible is $1,600 if one person is covered on the plan and $3,200 if more than one person is covered on the plan.

	Retail*	**Mail Service***
	Up to 30 Day Supply	**Up to 90 Day Supply**
Generic	35%, $10 min., $100 max.	35%, $20 min., $200 max.
Brand Name Formulary	35%, $40 min., $120 max.	35%, $70 min., $230 max.
Non-Formulary Brand Name	50%, $60 min., $150 max.	50%, $120 min., $250 max.
Specialty Mail Service –	-----	35%, $100 min., $200 max.

Mail Service Only, Limit up to 30 day supply.

Retail 90 Day Supply – 3x 30-day co-pay applies
Insulin Cap - $50 30-day supply, $150 90-day supply
Preventive Medications – Deductible waived, coinsurance applies

*If a generic drug is available and you opt to have your prescription filled with a brand name or non-formulary drug, the Plan will pay only the cost of the generic. You will be responsible for paying the Brand Name co-pay plus the cost difference between the brand-name or non-formulary and the generic drug.

Example: Calendar Year Deductible: The deductible is $1,600 if one person is covered and $3,200 if more than one person is covered. After you have met your calendar year deductible, you have a prescription filled at a retail pharmacy for XYZ drug, and there is a generic available. If the prescription is filled as XYZ drug, it is a brand drug. XYZ drug costs $120; the generic substitution costs $41. Below is an example of your costs for generic substitution compared to brand name:

Brand Name Option	**Generic Substitution Option**
$ 42 Brand Co-pay ($120 * 35% = $42)	$14.35 Generic Co-pay
+ $ 79 ($120 cost of XYZ drug - $41 cost of the generic)	($41 x 35%)
$121 for XYZ drug prescription	

If you do decide to join a Medicare drug plan and drop your current Methodist Health System coverage, be aware that you and your dependents may not be able to get this coverage back.

When will you pay a higher premium (penalty) to join a Medicare drug plan?

You should also know that if you drop or lose your current coverage with Methodist Health System and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage . . .

Contact Benefits at 402-354-4748 for further information. **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 Methodist Health System changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage . . .

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit 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, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	October 9, 2023
Name of Entity/Sender:	Methodist Health System
Contact – Position/Office:	Benefits
Address:	825 S. 169th Street, Omaha, NE 68118
Number:	(402) 354-2280

WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act of 1998 requires specific health care plan coverage related to mastectomies. Our Health Care Plan has provided this coverage for a number of years and continues to provide the coverage. If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

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

The Nebraska Methodist Health System 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. Therefore, the following deductibles and coinsurance apply:

PPO Option	**Tier 1**	**Tier 2**	**Tier 3**
Individual Deductible	$1,200	$1,200	$3,600
Individual + 1 Deductible	$2,400	$2,400	$6,000
Family Deductible	$3,600	$3,600	$9,000
Coinsurance	85%	80%	40%
HDHP Option	**Tier 1**	**Tier 2**	**Tier 3**
Individual Deductible	$1,600	$2,500	$5,000
Individual + 1 Deductible	$3,200	$5,000	$10,000
Family Deductible	$3,200	$5,000	$10,000
Coinsurance	85%	80%	40%

Services received Out-of-Network, from providers that are not Tier 1, Tier 2 or Tier 1, are not covered. If you would like more information on WHCRA benefits, please contact UMR at 1-800-826-9781.

NOTICE FOR EMPLOYER-SPONSORED WELLNESS PROGRAMS

Nebraska Methodist Health System Wellness Program is a voluntary wellness program available to all MHS Health Care Plan participants and their spouses who are covered on the plan as of August 1, 2023. 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 2024 Wellness Incentive Knowledge Article located in the People Portal.

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 waiver by contacting the Methodist Service Center at (402) 354-2280.

The information from your wellness visit will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as the Wellness Incentive which reduces the amount you pay for Health Plan coverage. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Nebraska Methodist Health System 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 administer the Wellness Incentive or respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individuals who will receive your personally identifiable health information are those designated by the employer to administer the Wellness Incentive and/or to respond to a request from you for a reasonable accommodation needed to participate in the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the Methodist Service Center at (402) 354-2280.