FRESNO UNIFIED SCHOOL DISTRICT

TO: PARTICIPANTS OF THE FRESNO UNIFIED SCHOOL DISTRICT EMPLOYEE HEALTH CARE PLAN

FROM: JOINT HEALTH MANAGEMENT BOARD

SUBJECT: EMPLOYEE HEALTH CARE PLAN AMENDMENT 2014-4

DATE: JULY 1, 2014

The Joint Health Management Board of the Fresno Unified School District has modified the Plan Document regarding requirements under the Patient Protection and Affordability Care Act (Affordable Care Act), for Plan Options 'A' and 'B'. This notice defines changes to the Fresno Unified School District Employee Health Care Plan **EFFECTIVE JULY 1, 2014.**

I. **Coverage for Individuals Participating in Approved Clinical Trials**

Coverage of Routine Patient Costs for items and services furnished in connection with participation in an Approved Clinical Trial, subject to all applicable Deductibles, Copayments and Coinsurance amounts that are consistent with the cost-sharing requirements that apply to other benefits under the Plan.

a. The member must be considered eligible to participate in the Approved Clinical Trial according to the applicable protocol for the treatment of cancer or other Life-Threatening Disease or Condition, and either, 1) a Network provider has referred the individual to the Approved Clinical Trial and concludes that participation would be appropriate, or 2) the member provides medical and scientific information establishing that their participation would be appropriate and consistent with the applicable protocol.
b. An Approved Clinical Trial is a Phase I, Phase II, Phase III or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition. The trial must be approved or funded by one of the number of federal agencies set forth under Patient Protection and Affordable Care Act Section 2709(d)(1)(A), including, but not limited to the National Institutes of Health, Centers for Medicare & Medicaid Services, and the Food and Drug Administration.
c. A Life Threatening Disease or Condition is a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
d. Routine Patient Costs include all items and services consistent with the Plan's coverage for a member who is not enrolled in an Approved Clinical Trial.
e. Routine Patient Costs exclude the investigational item, device, or service itself, items and services provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management of the patient, and services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
f. If one or more Network providers is participating in an Approved Clinical Trial a member eligible to participate in the Approved Clinical Trial must participate through such a participating Network provider if the Network provider will accept the member as a participant in the Approve Clinical Trial.
g. Notwithstanding the above, a member eligible to participate in an Approved Clinical Trial will be permitted to participate in such Clinical Trial if it is conducted outside of the state in which the member resides. The Plan does not have Network providers outside of the state of California. Routine patient costs provided outside of the Plan's Network will be processed at the non-network benefit level.

II. **Limitation On Member Cost-Share ("Out of Pocket Annual Maximum")**

The Network Out-of-Pocket Annual Maximum now includes Network Deductibles, Copayments, and Coinsurance and applies only to Essential Health Benefits ("EHBs").

a. EHBs include the following ten categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.
b. The Network Out-of-Pocket Annual Maximum applies to the Plan's Major Medical Benefit only.
c. Non-Network Deductibles, Copayments, Plan Penalties and amounts exceeding Usual, Customary, and Reasonable (UCR) do not apply towards the Non-Network Out-of-Pocket Annual Maximum.
d. Network Services and items which are <u>not</u> Essential Health Benefits do not apply towards the Network Out-of-Pocket Annual Maximum.