FRESNO UNIFIED SCHOOL

DISTRICT

EMPLOYEE HEALTH CARE PLAN

PLAN BOOKLET

BENEFIT CHANGES EFFECTIVE APRIL 1, 2012

(Including all Plan Clarifications through August 1, 2012

PLAN YEAR: July 1 – June 30

Benefit Year: January 1 – December 31

This is your Plan Booklet

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

This booklet primarily describes the benefits applicable to individuals enrolled in Medical Plan Options A and B offered by Anthem Blue Cross; however, it also describes important information for all participants, such as Contact Information, Employee Assistance Program, Chiropractic Care, Dental Benefits, Life Insurance, and General Plan Provisions relating to contributions and eligibility including termination of benefit provisions. Participants in Plan Option C, Kaiser Permanente option, should review a separate Evidence of Coverage brochure describing benefits offered through Kaiser Permanente and applicable sections of this Plan Booklet to familiarize yourself with all provisions of the plan of benefits offered through the District.

Binding the Plan: As a courtesy to you, the Benefits Administrator (Delta Health Systems) and the Fresno Unified School District's Benefit Department may respond informally to oral questions. However, oral information and answers are not binding upon the Fresno Unified School District Health Care Plan and cannot be relied on in any dispute concerning your benefits. Binding information may be obtained only through written request to Delta Health Systems (Benefits Administrator).

The Benefits Administrator, the JHMB Board of Directors, the District's Benefit Department, and any Claim Administrator retain full discretionary authority to: (a) determine all facts relevant to any claim; (b) to construe the terms of the Plan and all other documents relevant to the Plan; and (c) to determine which benefits are payable from the Plan.

INTRODUCTION TO YOUR BENEFIT PLAN OPTIONS A, B AND C

The Joint Health Management Board (JHMB) is pleased to provide you with this new and updated Fresno Unified School District Employee Health Care Plan Booklet. This Plan Booklet has been updated to include the most current benefit and vendor information under the three Medical Plan Options that became effective April 1, 2012 including Plan clarifications up to August 1, 2012. These plans are referred to as:

- Option A - Standard Plan, using Anthem Blue Cross
- Option B – Alternate Plan using Anthem Blue Cross
- Option C – using Kaiser Permanente

A comparison of these Plan Options is included in the back of this booklet. Eligible Participants may change to either Option during the Plan's regular Open Enrollment Period, as defined on page 14.

This Plan Booklet also includes applicable benefit and dependent eligibility provisions required under Health Care Reform, as signed into Federal law on March 23, 2010, under the Patient Protection and Affordable Care Act (PPACA), and as amended by the Health Care and Education Affordability Reconciliation Act of 2010 (Reconciliation Act) on March 30, 2010. These Acts required benefit modifications and eligibility changes for health care plans such as the Fresno Unified School District Employee Health Care Plan. These changes have been included in this restated Plan Booklet. Note: In accordance with PPACA this Plan is not considered a "grandfathered" plan.

Since the Rules and Regulations under the above Health Care Reform Acts have not been finalized, and in some cases only general guidelines have been given, the Plan will administer changes in good faith with guidance from its professional benefit consultants and legal counsel as new regulations are issued.

The Plan Booklet is used to explain certain medical, employee assistance, behavioral health, chiropractic, prescription drug, dental, vision care, and life insurance benefits for Eligible Employees, Eligible Retirees, and their Eligible Dependents. This document should be considered a "living document;" that is, it will be periodically updated to include clarifications and modifications approved by the JHMB.

The Plan became effective on January 1, 1981 and the Plan Booklet is hereby amended and restated in its entirety to include benefit changes and clarifications as of August 1, 2012 and Plan clarifications concerning updated Health Insurance Privacy and Protection and Health Care Reform requirements. The Plan is subject to all of the terms, provisions and conditions recited on the following pages. The Plan is not in lieu of, and does not affect, any requirement for coverage by any worker's compensation law or similar legislation.

MISSION STATEMENT[1]

The Fresno Unified School District's Joint Health Management Board's (JHMB) purpose is to continually:

- Share responsibility and build unity between the District and the participating Employee Labor Units;
- Manage and maintain the highest quality health benefits possible on behalf of Active and Retired Employees;
- Promote informed and proactive decisions regarding health benefits in the most cost-effective, innovative and efficient manner;
- Develop and promote wellness education;
- Enable participants to become informed and responsible health care consumers.

[1] Approved by JHMB at September 21, 2005 meeting.

IMPORTANT INFORMATION AND CONTACT NUMBERS FOR BENEFIT PLAN OPTIONS A, B AND C

Binding the Plan: As a courtesy to you, the Benefits Administrator (Delta Health Systems) and the Fresno Unified School District's Benefit Department may respond informally to oral questions. However, oral information and answers are not binding upon the Fresno Unified School District Employee Health Care Plan and cannot be relied on in any dispute concerning your benefits. Binding information may be obtained only through written request to Delta Health Systems (Benefits Administrator).

The Benefits Administrator, the full JHMB Board of Directors, the District's Benefit Department, and any Claim Administrator retain full discretionary authority to: (a) determine all facts relevant to any claim; (b) to construe the terms of the Plan and all other documents relevant to the Plan; and (c) to determine which benefits are payable from the Plan.

Plan Options referenced below mean: Plan A (Standard Plan), or Plan B (Alternate Plan), or Plan C (Kaiser Permanente Plan) which are compared on Insert I in the back of this booklet.

If you have Questions about:	Contact Name and Telephone Number	Web Site
• **Initial Enrollment** • **Employee Contributions** • **Termination of Benefits** • **Continuation of Coverage (COBRA and Ed Code 7000)** • **Life Insurance** • **Flexible Spending Account information**	**District's Benefit Department** 559-457-3520	www.fresnounified.org Go to Quick Links. Click on Department Directory, locate Benefits Department and click on the website link
ALL Medical Plan Options A, B and C: • Eligibility	Delta Health Systems (Benefits Administrator) 1-800-807-0820	www.deltahealthsystems.com
Anthem Blue Cross Medical Plan Options A and B: • ID Cards • Find Network Providers • Claims Administration • Forms • Benefit Questions	Delta Health Systems (Benefits Administrator) 1-800-807-0820	www.deltahealthsystems.com
Anthem Blue Cross Medical Plan Options A and B: • Receive Pre-Authorization • Find Network providers	Anthem Blue Cross Pre-Authorization or Case Management 1-800-274-7767	www.anthem.com/ca www.deltahealthsystems.com
Prescription Benefits Plan Options A and B: • **Retail** • **Mail Order** • **Specialty Pharmacy** • **EnvisionRx Plus Plan**	EnvisionRx Options Help Desk 1-800-361-4542 Orchard Pharmaceuticals 1-866-909-5170 Costco Specialty Pharmacy 1-866-443-0060 EnvisionRx Plus 1-866-250-2005	www.envisionRx.com

If you have Questions about:	Contact Name and Telephone Number	Web Site
Kaiser Permanente Medical Plan Option C (including Prescription Drug, Behavioral Health and Vision Benefits) • Benefit Questions • ID Cards • Claims Administration • Forms	Kaiser Permanente 1-800-464-4000	www.kp.org Must register to obtain benefit information, make appointments, view lab results, order Prescription refills, etc.
Preventive Care Benefits under the Patient Protection and Affordable Care Act ALL Medical Plan Options A, B and C	U.S. Preventive Services Task Force Recommendations	Regulations: http://www.uspreventiveservicestaskforce.org Overview: http://www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations
Employee Assistance Program (EAP) Plan ALL Medical Plan Options A, B and C	Claremont EAP 1-800-834-3773	www.claremonteap.com
Behavioral Health Benefits Plan Options A and B: • Find Network Providers • Claims Administration • Forms • Benefit Questions	Avante Health 1-800-498-9055 1-559-261-9060	www.fusdmentalhealth.com
Chiropractic Benefits ALL Medical Plan Options A, B and C: • Find Network Providers • Claims Administration • Forms • Benefit Questions	ChiroMetrics 1-559-447-3375	www.fusdchiro.com
Dental Benefits ALL Medical Plan Options • Find Network Providers • Claims Administration • Benefit Questions • Pre-Treatment Review	Delta Dental PPO Plan 1-888-335-8227 Pacific Union Dental Napa Plan 1-800-999-3367	www.deltadentalca.org www.myuhc.com
Vision Benefits Plan Options A and B • Find Network Providers • Benefit Questions	MES Vision 1-800-877-6372	www.MESVision.com

HealthConnect website: www.jhmbhealthconnect.com

HealthConnect is the communication publication and website of the Fresno Unified School District's Joint Health Management Board (JHMB). You can access this Plan Booklet online, including past issues of Employee communications, HealthConnect newsletters, and other information regarding the Plan's benefits.

You may send feedback about HealthConnect to jhmbhealthconnect@yahoo.com, or contact your JHMB Board Members listed at www.jhmbhealthconnect.com. Go to Staying Connected. Click on JHMB info, and then JHMB Members.

WHAT TO DO IF YOU NEED MEDICAL CARE

Please read your Plan Booklet and familiarize yourself with the benefits provided through the Fresno Unified School District Health Care Plans. Make sure you understand the benefits under the Medical Plan you are enrolled: Anthem Blue Cross Option A (Standard Plan), Option B (Alternate Plan), or Kaiser Permanente Plan Option C as each plan has different benefit features and out-of-pocket expenses.

The Table of Contents in the front of this booklet and the Index in the back, are designed to help you find information quickly and assist you in understanding the Plan's benefits, provisions, and eligibility requirements. There is also an Index in the back of this Plan Booklet to assist you as a quick reference. Becoming familiar with your Plan prior to accessing health care services will assist you in receiving maximum benefits payable under the Plan.

Should you require Medical Care, follow the procedures outlined below. These procedures are applicable whether you are enrolled in Plan Option A or Option B. Note: If you are enrolled in Kaiser Permanente Plan Option C you should carefully read your Evidence of Coverage booklet in order to understand how to obtain routine and emergency medical, behavioral health, prescription drug, and vision services. Only covered services received from Kaiser Permanente or authorized by Kaiser Permanente are covered by Kaiser Permanente. Plan C members are eligible to receive Chiropractic benefits of the Plan outlined on page 34.

ANTHEM BLUE CROSS BENEFIT PLAN OPTIONS A AND B

EMERGENCY

If you are experiencing a medical emergency i.e., a life threatening condition, injury, or serious condition requiring immediate treatment:

1. Call your Physician or 911 as appropriate, OR

2. Go directly to the emergency room, outpatient clinic or similar provider for needed service.

NON-EMERGENCY

1. Obtain routine care from your Network Physician or Specialist. You may obtain services **without** obtaining prior authorization except for those services or treatments listed under Authorizations by Anthem Blue Cross (for California residents) or Delta TeamCare (for non-California residents) on page 4.

2. Obtain care from a Network Hospital or Free Standing facility. **Services require pre-authorization by Anthem Blue Cross.** Please refer to page 4 for additional information.

3. For Behavioral Health Care, contact Avante Health for pre-authorization. – refer to page 31 to 33 for further information.

4. For care under the Employee Assistance Program (EAP) contact Claremont EAP – refer to page 30 for additional information.

5. For Chiropractic Care, contact ChiroMetrics for pre-certification – refer to page 34 for more information.

PROCEDURES TO SAVE YOU MONEY UNDER ANTHEM BLUE CROSS MEDICAL PLANS

Option A (Standard Plan) or Option B (Alternate Plan)

The information contained on pages 2 through 5, and the Questions and Answers outlined on pages 6 and 7, is provided to help you understand and receive maximum benefits payable under the Plan. It is important that you take a moment to review them.

ANTHEM BLUE CROSS PREFERRED PROVIDER ORGANIZATION (PPO)

Your Plan has contracted with Anthem Blue Cross, an organization providing the Network of health care providers. When obtaining health care services, you have a choice of using providers who are participating in that Network or any other Covered Providers of your choice (Non-Network Providers). Network Providers are located throughout California. Use of the Anthem Blue Cross Network will result in lowered health care costs for Participants and lower costs for the Plan. You can find a current listing of Anthem Blue Cross Network providers at www.anthem.com/ca or by contacting the Benefits Administrator.

Medical Plan Option A (Standard Plan) and Option B (Alternate Plan) both use the same Network Provider listing and have the same rules and requirements for Network and Non-Network services, HOWEVER, the benefits provided by Option A are greater than Option B benefits as compared beginning on pages 18 to 22.

Please review the Schedule of Benefits contained herein in order to understand the benefits paid to Network and Non-Network Providers.

HOW TO USE THE PLAN IN WHICH YOU ARE ENROLLED

To take full advantage of the cost-saving features of your Plan, you will need to carefully read and fully understand this explanation of how your Plan works. This Plan Booklet will explain how your claims are paid according to Option A and Option B, and the Hospital, Physician and health care providers you use.

SPECIAL TERMS

Network Providers have a Participation Agreement in effect with Anthem Blue Cross at the time services are rendered. They agree to a payment rate which has been negotiated on behalf of the Plan. The Covered Individual will have no additional charges from the Network Provider for covered benefits other than the Copayment, Deductible and/or coinsurance specified in the Schedule of Benefits.

The amount of the Allowable Expenses differs according to the type of provider and circumstances:

1. When referring to a Network Provider, the Allowable Expenses under the Plan is the rate at which the Network Provider has contracted to accept as payment for covered services.

2. When referring to a Non-Network Provider, the Allowable Expenses under the Plan is limited to the Usual, Customary and Reasonable Charge (defined on pages 8 and 17).

MANDATORY COST CONTAINMENT REQUIREMENTS

The cost containment requirements of the Plan are designed to maintain its benefits, assist the patient in making more informed decisions and establish a procedure to eliminate unnecessary costs.

Neither Option A nor Option B Medical Plans restrict your choice of Physicians, Hospitals or other healthcare providers.

Benefits will be reduced under Option A and Option B if Anthem Blue Cross (for California residents) or Delta TeamCare (for non-California residents) determines the Covered Person failed to follow the required pre-authorization procedure and/or entered the Hospital earlier than Medically Necessary (any expense relating to hospitalization that is not Medically Necessary will not be covered and is the Participant's responsibility).

You can find a current listing of Anthem Blue Cross Network Providers at www.anthem.com/ca. If there is any question regarding the status of any provider or their participation in the Anthem Blue Cross Network, Anthem Blue Cross should be contacted at (800) 274-7767 prior to obtaining services.

AUTHORIZATIONS REQUIRED BY ANTHEM BLUE CROSS (FOR CALIFORNIA RESIDENTS) OR DELTA TEAMCARE (FOR NON-CALIFORNIA RESIDENTS)

Under Option A (Standard Plan) or Option B (Alternate Plan)

The decision or choice of treatment is made by the patient and the patient's health care provider.

Pre-service review and authorization is not a guarantee of coverage. The Anthem Blue Cross (for California residents) and Delta TeamCare (for non-California residents) Pre-Authorization Programs are designed ONLY to determine whether or not a proposed setting and course of treatment is Medically Necessary and appropriate. Benefits under the Plan will depend upon the person's eligibility for coverage and the Plan's limitations and exclusions. Nothing in the Pre-Authorization Programs will increase benefits to cover any confinement or service that is not Medically Necessary or that is otherwise not covered under the Plan. The decision or choice of treatment is made by the patient and the patient's health care provider.

Penalty for Non-Compliance – If the pre-authorization requirements are not completed in any of the below instances, a penalty of $250 will be applied.

REMINDER: Behavioral Health, Chiropractic Care services and certain prescription drugs for Specialty Medications require preauthorization by Avante Health, ChiroMetrics or EnvisionRx Options as noted on page 5.

EMERGENCY SERVICES

In the event of an Emergency Hospital admission, authorization by Anthem Blue Cross (for California residents) or Delta TeamCare (for non-California residents) must be obtained within 72 hours of Hospital admission.

PRE-AUTHORIZATION REQUIRED BY ANTHEM BLUE CROSS (FOR CALIFORNIA RESIDENTS) AND DELTA TEAMCARE (FOR NON-CALIFORNIA RESIDENTS) FOR NON-EMERGENCY MEDICAL SERVICES

1. Proposed Inpatient, Outpatient hospitalizations (including ambulatory surgery centers), surgeries, including Bariatric Surgery, regardless of location.

2. Maternity hospital stays exceeding 48 hours for normal vaginal delivery, or 96 hours for Cesarean Section delivery.

3. Transplants.

4. Home Health Care, Home Infusion Therapy, or Skilled Nursing Facility.

5. Physical Therapy exceeding six visits.

6. Durable Medical Equipment over $2,000.

7. Prosthetics / Braces over $500 including replacements.

8. Occupational and Speech Therapy.

9. Specialty Medications not obtained through the prescription drug program (EnvisionRx Options). Specialty Medications ordered for administration and use at home or in a physician's office should be attempted to be obtained through the prescription drug program with EnvisionRx Options first.

ADDITIONAL PLAN BENEFITS REQUIRING PRE-AUTHORIZATION

1. **Behavioral Health -** Inpatient services and Outpatient counseling services are **NOT** part of the Plan's Pre-Authorization Review Program, however, such services are subject to coverage limits specified in this Plan Booklet. **Behavioral Health services require prior authorization by calling Avante Health at (800) 498-9055 or (559) 261-9060**. For additional information, please refer to pages 31 to 33.

2. **Chiropractic Care services** are **NOT** part of the Plan's Pre-Authorization Review Program, however, such services are subject to coverage limits specified in this Plan Booklet. **Chiropractic services require prior pre-certification by calling ChiroMetrics at (559) 447-3375**. For additional information, please refer to page 34.

3. **Prescription Drugs** are **NOT** part of the Plan's Pre-Authorization Review Program, however, such services are subject to coverage limits specified in this Plan Booklet. **Certain prescription drug services require prior authorization by calling EnvisionRx Options at (800) 361-4542.** For additional information, please refer to pages 35 to 43.

VOLUNTARY CASE MANAGEMENT

Anthem Blue Cross (for California residents) or Delta TeamCare (for non-California residents) provides case management for catastrophically ill or injured covered persons who require extensive medical services and who have exceptional or complex needs. Case managers are responsible for evaluating and monitoring the efficiency, appropriateness and qualifying all aspects of health care for covered persons who have been accepted into the case management program. To achieve this objective, the case management program works in collaboration with the covered person's team of health care professionals to provide feedback, support and assistance during the utilization and case management process.

Once a covered person is identified for potential case management, the covered person is contacted for program enrollment; the case manager will introduce and describe the program. The covered person can ask questions and agree or decline to participate. If the covered person declines to participate, a case manager may work with the health care treatment team to monitor progress through the healthcare continuum.

IMPORTANT: Case Management is **voluntary**. There are no reductions in benefits or penalties if the patient chooses not to participate. Also, each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis. *Note: There may be some situations in which Case Management is required (i.e., transplant services); you will be notified by Anthem Blue Cross (for California residents) or Delta TeamCare (for non-California residents) in these situations.*

PRE-AUTHORIZATION AND NETWORK PROVIDER QUESTIONS AND ANSWERS

Applicable to Option A (Standard Plan) and Option B (Alternate Plan)

The following Questions and Answers pertain to the Medical Plan. Please note that the Employee Assistance Program (EAP), the Behavioral Health Plan, and Chiropractic Care Plan have different Network Providers and require pre-authorization as described in this Plan Booklet.

1. Q. What Is Pre-Authorization?

A. Unnecessary medical care and hospital stays, or stays that last longer than necessary cause medical costs to increase. Sometimes, individuals are hospitalized for procedures that can be performed safely, effectively and more comfortably in an alternate setting, such as a hospital's outpatient department or physician's office. As a result, the Plan has contracted with an independent organization to provide **Pre-Authorization** to certify medical necessity when you or your dependent requires certain care or services (as listed on the previous pages) or if you need to continue a stay beyond the period initially certified.

PLEASE READ THE MEDICAL PRE-AUTHORIZATION PROCEDURES ON PAGES 4 and 5.

2. Q. What is a "Network Provider"?

A. A Network Provider in this Plan is a Physician, Hospital or other health care provider, which has entered into a participation agreement with Anthem Blue Cross.

3. Q. What if I need help in locating or choosing a Network Provider?

A. You can find a current listing of Anthem Blue Cross Network of Providers at www.anthem.com/ca or by contacting Delta Health Systems at (800) 807-0820.

4. Q. Do I need to select an Anthem Blue Cross Network Provider?

A. No, but to ensure maximum benefits under the Plan, you should select an Anthem Blue Cross Network provider.

5. Q. What if the Doctor refers me to a Non-Network laboratory or radiology service?

A. Referrals to a Non-Network Provider are covered at the Non-Network benefit. It is your responsibility to ensure services to be rendered are performed by a Network Provider.

6. Q. What if I reside outside of the state of California?

A. Benefits will be covered at the Non-Network benefit level, subject to the Usual, Customary and Reasonable Charge provisions outlined on page 17 of the Definition section of this booklet.

7. Q. What if I am temporarily out of state or not within distance of Anthem Blue Cross Network providers?

A. If you reside in the State of California and you must use a Non-Network provider because the necessary services are available **only** at a Non-Network provider, or if a Network provider is not available within a thirty (30) miles radius of your residence, then the Non-Network provider expenses will be covered at the Network benefit levels, subject to the Usual, Customary and Reasonable charge provisions outlined on page 17 of the Definition section of this Plan Booklet.

8. Q. What if I have questions about specific coverage provisions, deductibles, claims payment, eligibility, or other such matters?

A. Please refer to page iii, Anthem Blue Cross, which outlines Important Information and Contact Numbers regarding specific questions you may have in the Plan benefit categories noted.

DEFINITIONS

As used in this Plan, the following terms shall have the meanings specified below. Note: Words in the masculine gender shall connote the feminine gender as well.

"Allowable Expense" means the amount of an eligible charge that may be used as the basis of a claim.

1. For providers who are:

   (a) under contract with the Plan, or

   (b) Network Providers who have contracted with the Preferred Provider Organizations,

   the Allowable Expense is the contract rate. In no event shall these providers bill the covered Person an amount in excess of the Allowable Expense (see definition of Balance Billing below).

2. For all other providers, the Allowable Expense is the Usual, Customary and Reasonable Charge. The Covered Person is responsible for Expenses in excess of Usual, Customary and Reasonable (UCR) charges.

"Ambulatory Surgical Center" means a facility licensed in the jurisdiction in which it is located that:

1. has an organized medical staff of Physicians;

2. has permanent facilities equipped and operated primarily for the purpose of performing Surgical Procedures;

3. offers continuous Physician services and registered professional nursing services whenever the patient is in the facility; and

4. generally, does not provide accommodations for patients to stay overnight, except that a Hospital Outpatient department will be considered an Ambulatory Surgical Center.

"Anthem Blue Cross Contract Rate" means the rate at which a Network Provider has contracted with Anthem Blue Cross to accept as payment for covered services.

"Balance Billing" means the requirement, with respect to the providers shown below, that any amount above the Allowable Expenses shall not be payable by a Covered Person.

The providers subject to this provision are those providers who are:

1. under contract with the Plan; or

2. Network Providers who have contracted with the Preferred Provider Organizations with which the District contracts.

"Benefits Administrator" means Delta Health Systems.

"Benefits" means those services and supplies that are covered under the terms of this Plan.

"Birthing Center" means a Hospital unit or center, or free-standing facility, licensed in the jurisdiction in which it is located that provides a home-like setting under a controlled environment for the purpose of childbirth.

"Calendar Year" means any one (1) year period commencing on January 1 and ending on December 31. However, when a person first becomes covered by the Plan, the first Calendar Year begins for him or her on the effective date of his or her coverage and ends on the following December 31.

"Chiropractic Care" means Chiropractic treatment from a licensed chiropractor (D.C.) for a musculoskeletal disorder (bone, muscle, tendon and joint) and for related diagnostic x-rays performed and billed by the chiropractor.

"Claim Administrator" means:

1. For the Hospital and Medical Expense Benefits portion of the Plan Options A and B: Anthem Blue Cross and Delta Health Systems. For Plan Option C benefits, the Claim Administrator is Kaiser Permanente Plan.

2. For the Prescription Drug Benefits portion of the Plan: EnvisionRx Options.

3. For the Behavioral Health Benefits portion of the Plan: Avante Health.

4. For the Chiropractic Benefits portion of the Plan: ChiroMetrics.

5. For the Vision Care Expense Benefits portion of the Plan: Vision Service Plan and Safeguard Vision Plan.

6. For the Dental Expense Benefits portion of the Plan: Delta Dental Plan of California and Pacific Union Dental.

"Code" means the Internal Revenue Code of 1986 as amended from time to time.

"Coinsurance" (%) means the amount the Plan pays after the satisfaction of the Deductible each Calendar Year unless otherwise stated.

"Copayment" means the amount of money that each Covered Person may be required to pay for services and supplies. The Schedule of Benefits shows which benefits require Copayment under Option A and Option B. Copayments do not apply towards the Out-of-Pocket maximum or to satisfy any Deductible under either Option.

"Covered Charges" means the Allowable Expense for the Medically Necessary treatment of conditions covered under the Plan.

"Covered Dependent" means any Dependent who is covered under the Plan.

"Covered Person" means a covered Employee, a covered Retiree, or a covered Dependent.

"Cross Coverage or Dual Coverage" means that if an Employee and/or Retiree is covered under this Plan as an Eligible Employee and/or Eligible Retiree and as an Eligible Dependent spouse or Domestic Partner, the Plan shall pay based on the Coordination of Benefits provision for Plan Options A and B as outlined on page 79 of this Plan Booklet. Surviving spouses of Cross Covered or Dual Covered Employee or Retiree are eligible for the same level of benefits that the Coordination of Benefits provision provides.

There are different provisions for Dual Covered Employees under the Kaiser Permanente Plan. Please refer to the Kaiser Permanente Plan Evidence of Coverage booklet.

"Custodial Care" means care that provides a level of routine maintenance for the purpose of meeting personal needs and assisting with the activities of daily living. It is care that can be provided by a lay person who does not have professional qualifications, skills or training. Custodial Care includes, but is not limited to: help in walking and getting into or out of bed, a chair or a wheelchair; help in bathing, dressing, and eating (whether from a receptacle [such as a plate or cup] or by feeding tube or intravenously); help in other functions of daily living of a similar nature; administration of or help in using or applying medications, creams and ointments; routine administration of medical gasses after a regimen of therapy has been set up; routine care of a patient, including functions such as changes of dressings; diapers and protective sheets and periodic turning and positioning in bed; routine care and maintenance in connection with casts, braces and other similar devices, or other equipment and supplies used in treatment of a patient, such as colostomy and ileostomy bags and indwelling catheters; routine tracheotomy care; general supervision of exercise programs including carrying out of maintenance programs of repetitive exercises that do not need the skills of a therapist and are not skilled rehabilitation services.

"Dentist" means a duly licensed Doctor of Dental Surgery (D.D.S.) or Doctor of Medical Dentistry (D.M.D.) legally entitled to practice dentistry at the time and place services are performed.

"Deductible" means the amount of Allowable Expenses that each Covered Person or Family must incur and pay in each Calendar Year before benefits under the Plan will be paid.

Any expenses applied against the Deductible during the last three (3) months of the Calendar Year will reduce the Deductible applicable in the following Calendar Year. Also, when two or more Covered Persons in a Family are injured in the same accident, eligible charges for those Injuries will be combined, in each Calendar Year, to meet one Calendar Year Deductible for all such Covered Persons.

Deductibles do not apply towards Non-Network expenses in excess of Usual, Customary and Reasonable (UCR) allowances, expenses that become the Covered Person's responsibility for failure to comply with the pre-authorization requirements or the Out-of-Pocket maximum.

"Dependent" means:

1. a legal spouse;

2. a Domestic Partner as defined on page 11;

3. any child under the age of 26. For these purposes a "child" will include:

   (a) an Employee's, Domestic Partner's or Retirees[1] natural child,

   (b) a legally adopted child on the date the child is placed in the physical custody of the Employee or Retiree[1];

   (c) a stepchild of an Employee or Retiree[1],

   (d) a child of an Employee or Retiree[1] subject to a Qualified Medical Child Support Order (QMCSO), and

[1] Some but <u>not</u> all Retirees may enroll dependent children under the Plan. For example, Dependent child coverage is not provided under the Education Code 7000 Retiree Continuation Coverage provisions of the Plan noted on page 18.

(e) a child placed in the permanent legal guardianship of the covered Employee or Retiree[1] by court order. A child placed in the permanent legal guardianship becomes an eligible Dependent on the latter of the date the child is placed in the physical custody of the Employee/Retiree or the date the court awards legal guardianship to the Employee/Retiree.

4. an unmarried mentally or physically Disabled child beyond the maximum age (see #3 above), provided the child is incapable of self-sustaining employment and is dependent upon the Employee/Retiree for support and maintenance and further provided that the condition existed prior to such child reaching the age of 26. Proof of any mental or physical disability shall be required 60 days prior to such child's 26th birthday and the District's Benefit Department may require additional proof from time to time.

An eligible Dependent does not include:

1. a spouse who is legally separated or divorced from the Employee or Retiree; or

2. an individual whose Domestic Partnership with the Employee or Retiree has terminated; or

3. a child who is on active duty in any military, naval or air forces of any country; or

4. any child who is covered as an Employee under this Plan.

"Disabled Child" means a Dependent child who is physically or mentally disabled and incapable of self-sustaining employment and is dependent upon the Employee/Retiree for support and maintenance, and further, provided that the condition existed prior to such Disabled child reaching the age of 26. Proof of physical or mental disability shall be required prior to 60 days of such child's 26th birthday and the District's Benefit Department may require additional proof from time to time.

"Disabled Employee" means the incapacity of an Eligible Employee by reason of bodily Injury or Sickness that prevents the Eligible Employee from performing the material duties of his or her job with the Employer.

"District" means Fresno Unified School District.

"District's Benefit Department" means the Fresno Unified School District's Benefit Office.

"Doctor, Physician, or Surgeon" is a person acting within the scope of his or her license and holding the degree of Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.M.), Doctor of Dental Surgery (DDS), Doctor of Podiatry (D.P.M.), Doctor of Optometry (D.O.), Psychologist (Ph.D.), or Doctor of Chiropractic Medicine (D.C.) and is not a person who is related to the Covered Person by blood, marriage, Domestic Partnership, or law or resides in the same residence as the Covered Person.

"Domestic Partner" means same-sex partner, or opposite-sex partner where at least one of the partners is age 62 or older and qualifies for certain Social Security benefits, as defined under California Family Code 297 and has filed a Declaration of Domestic Partnership with the California Secretary of State, or by validly forming a legal union in a jurisdiction other than California consistent with the requirements of Family Code Section 299.2.

"Durable Medical Equipment" means equipment that is:

1. designed for repeated use;

2. mainly and customarily used for medical purposes; and

3. not generally of use to a person in the absence of a disease or Injury.

Durable medical equipment includes, but is not limited to, such items as: hospital bed, wheelchair, iron lung, traction apparatus, intermittent positive pressure breathing machine, brace, and crutch.

"Educational" means that the primary purpose of a service or supply is to provide the patient with any of the following: training in the activities of daily living; instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities.

"E.O.B." means Explanation of Benefits. The form explains how your claim was processed and should be saved for tax purposes and other future reference.

"Eligible Employee" means an Employee who meets the eligibility requirements of the Plan.

"Eligible Retiree" means a Retiree who meets the eligibility requirements of the Plan.

"Emergency" means a sudden onset of a condition requiring immediate treatment for an Emergency Medical Condition.

"Emergency Medical Condition" means a Sickness or Injury which, if not immediately treated, is likely to result in any of the following: death, permanent disability, prolonged temporary disability or unwarranted prolongation of treatment; increased risk by requiring more complex or hazardous treatment; development of chronic illness; or inordinate physical or psychological suffering.

"Employee" means an Employee of the Employer who is eligible for participation in the Plan as determined by Board Policy or negotiated agreements.

"Employer" means the District.

"Essential Health Benefits," as defined by the Affordable Care Act, means the following general categories and the items and services covered within the 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 dental and vision services.

"Expenses or Charges Incurred" means that an expense shall be deemed to be incurred on the date the purchase is made or on the day the service is rendered for which the charge is made.

"Experimental or Investigational" means any portion or part of any procedure, device, drug, treatment, or medicine, or the use thereof, which falls within any of the following categories:

1. Which is considered Experimental or Investigational by any governmental agency or subdivision, including but not limited to the Food and Drug Administration, the Office of Health Technology Assessment; or

2. Which is not commonly and customarily recognized by the medical profession in the state where treatment is rendered as appropriate for the condition being treated in that:

    (a) The medical procedure, equipment, treatment or course of treatment, or drug or medicine is under investigation or is limited to research; and

    (b) The techniques are restricted to use at centers which are capable of carrying out disciplined clinical efforts and scientific studies; and

    (c) The procedures are not proven in an objective way to have therapeutic value or benefit; and

    (d) The procedure's or treatment's effectiveness is medically questionable.

"Family" means an Eligible Employee, or Eligible Retiree, and his or her Eligible Covered Dependents.

"Fiduciary" means the District, or other entity that assumes responsibilities of the District, with respect to the management of the Plan or the disposition of its assets.

"HIPAA" means the federal Health Insurance Portability and Accountability Act of 1996 as amended from time to time.

"Home Health Care" means a program, prescribed in writing by a person's Physician and administered by a Home Health Care Agency, that provides for the care and treatment of a person's Sickness or Injury in the Covered Person's home.

"Home Health Care Agency" means an organization that has been licensed or authorized as a home health agency in the state where the Home Health Care is given or is a home health agency as defined in Medicare.

"Hospice" means a facility that provides short periods of stay for a Terminally Ill Person in a home-like setting for either direct care or respite. The facility can be free-standing or affiliated with a Hospital. If such a facility is required by a state to be authorized, it must also meet that requirement.

"Hospice Care Program" means a formal program directed by a Physician to help care for a Terminally Ill Person.

"Hospice Team" means a team of professionals and volunteer workers who provide care to:

1. reduce or abate pain or other symptoms of mental or physical distress, and

2. meet the special needs arising out the stresses of the terminal illness and dying.

The Hospice Team must include a Physician and a registered graduate nurse.

The team may also include one or more of the following: a social worker, a clergyman/counselor, volunteers, a clinical psychologist, a physiotherapist, an occupational therapist.

"Hospital" means an institution which is engaged primarily in providing medical care and treatment of a sick or injured person on an in-patient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides, on the premises, 24-hour-a-day nursing services by or under the supervision of Registered Nurses (RNs); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" also includes the following:

1. A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

2. A facility operating primarily for the treatment of substance abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour-a-day nursing services by a Registered Nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of substance abuse.

"Injury" shall mean accidental bodily Injury that occurs while the Eligible Employee, Eligible Retiree, or Eligible Dependent is covered under this Plan excluding work-related injuries. All injuries sustained in connection with any accident shall be considered one Injury.

"Inpatient" means a Hospital stay for which at least one (1) day's room and board is charged.

"JHMB" means the Board of Directors of the Joint Health Management Board.

"Medical Review Organization" means Anthem Blue Cross as retained by the District in connection with the operation of the Medical Review Program portion of the Plan, whose medical specialists consult with an Eligible Employee, Eligible Retiree, or Eligible Dependent and their Physician with regard to recommended medical care and treatment.

"Medically Necessary (or medical necessity)" means services or supplies, which are:

1. appropriate and necessary for the symptoms, diagnosis or direct care and treatment of the medical condition,

2. within standards of good medical practice within the organized medical community,

3. not Educational, Experimental or Investigational in nature,

4. not provided primarily for medical or other research,

5. not primarily for the convenience of the patient or provider, and

6. determined by the Plan to be the most appropriate level of service and type of facility in which the patient receives care.

"Medicare" means the basic hospital portion (Part A), voluntary supplemental medical portion (Part B), and prescription drug (Part D) of Title XVIII of the Social Security Act, ("Federal Health Insurance for the Aged Act"), including any amendments as may be adopted from time to time.

"Nervous/Mental Disorder" means a mental or nervous condition as defined by the American Psychiatric Association that shall include but shall not be limited to a neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

"Network Provider" means a "Doctor", "Physician", "Surgeon", Hospital, urgent care center, laboratory, or x-ray facility rendering services at reduced rates in accordance with the agreement between the Claim Administrator and the Fresno Unified School District.

"Non-Emergency Admission" means an Inpatient admission not related to an Emergency Medical Condition.

"Open Enrollment Period" means the period of time when an Eligible Employee may enroll himself or herself and/or the Employee's Eligible Dependents in the Plan other than during the 31 days immediately following original eligibility. Open Enrollment Period will be a 60 day period beginning October 1 of each Calendar Year for a January 1 effective change in benefits. The Open Enrollment Period is also the period of time when a Covered Employee or Covered Retiree may change coverage where coverage options are available under the Medical, Dental and Vision Plans. A Special Open Enrollment Period may be held if the Plan's eligibility, benefits or provisions change or if an individual experiences a Special Enrollment Event (see page 67).

"Outpatient" means treatment not requiring Inpatient confinement and not involving a charge for Room and Board.

"Outpatient Surgery" means a Surgical Procedure performed in a Doctor's office or any Outpatient surgical facility.

"Participant" means an Employee Retiree, or their eligible Dependent(s), of the Fresno Unified School District who meets the eligibility requirements of the Plan and elects to participate in the Plan.

"Participating Pharmacy" means a licensed and registered pharmacy that has an agreement with EnvisionRx Options.

"PHSA" means the Public Health Service Act of 1944, as amended from time to time.

"Physician" means a person who is licensed to administer medical care and treatment so long as he or she is acting within the scope of his or her practice and such license. A Physician includes a Surgeon and Assistant Surgeon.

"Plan" means the Fresno Unified School District Employees Health Care Plan, as amended from time to time.

"Plan Administrator" means the Joint Health Management Board (JHMB) of the Fresno Unified School District.

"Plan Year" means the period of time which starts on July 1 each year and ends June 30 the following year.

"PPACA" or "Affordable Care Act" means the Patient Protection and Affordable Care Act of 2010, as amended from time to time.

"Preferred Providers" means the group of Hospitals, Physicians and other health care providers of medical care that have agreed, through contracts with the District or the Preferred Provider Organization, to provide medical care to Covered Persons under this Plan.

"Preferred Provider Organization" means, for all chiropractic and medical services, a provider organization which is signatory to an agreement with the District providing for charges at a prevailing negotiated fee.

"Preventive Benefits or Services" under "Essential Benefits" means specific services and testing required for Children (from birth up to age 18) and for Adults (age 18 and older) under the Patient Protection and Affordable Care Act (PPACA). Preventive Services are covered without a Copayment, Deductible, or co-insurance ONLY if a Network Provider is used. Non-Network benefits may be covered at higher out-of-pocket costs pursuant to the benefits described on page 18 to 22. Benefits under the Act may be subject to change.

"Registered Nurse" means a graduated and licensed Registered Nurse who is not related to a Covered Person by blood, marriage, domestic partnership, or law or who does not reside in the same residence as the Covered Person.

"Rescission" means a cancellation or discontinuance of coverage under the Plan that has a retroactive effect. The Plan will not rescind coverage with respect to an individual after the individual is covered under the Plan unless:

1. The individual or a person seeking coverage on behalf of the individual performs an act, practice, or omission that constitutes fraud, or

2. The individual makes an intentional misrepresentation of material fact in relation to Plan coverage.

Rescission does not include:

1. A cancellation or discontinuance of coverage that only has a prospective effect; or

2. A cancellation or discontinuance of coverage that is effective retroactively to the extent that it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage; or

3. Termination of eligibility under the terms of the Plan after termination of employment due to a delay in administrative record-keeping.

"Retiree" means a Retiree of the District who is eligible for participation in the Plan as determined by District's Board Policy or, if applicable, by a negotiated bargaining agreement.

"Sickness" means a disorder of the body or mind of a Covered Person that is not an Injury or work related. Pregnancy for female Employees or an Employee's wife is considered a Sickness.

"Skilled Nursing Facility" means an institution that meets all of these tests:

1. It is legally operated.

2. It mainly provides short-term nursing and rehabilitation services for persons recovering from Sickness or Injury. The services are provided for a fee from the Plan and include both:

   a. Room and board; and

   b. 24-hour a day skilled nursing service.

3. It provides the services under the full-time supervision of a Physician or registered graduate nurse (R.N.). If full-time supervision by a Physician is not provided, it has the services of a Physician available under a fixed agreement.

4. It keeps adequate medical records.

"Skilled Nursing Facility" does not include an institution or part of one that is used mainly as a place for rest or for the aged.

"Surgical Procedure" shall mean but is not limited to cutting, suturing, treatment of burns, correction of fracture, reduction of dislocation, manipulation of joint under general anesthesia, electrocauterization, laser surgery, taping, application of plaster casts, and administration of pneumothorax, endoscopy or injection of sclerosing solution.

"Terminally Ill Person" means a Covered Person who has an anticipated life expectancy of six (6) months or less as determined by the Covered Person's Physician.

"Total Disability" as it applies to an Employee means all periods of disability arising from the same cause, including any and all complications, except that if the Employee completely recovers or returns to active employment or is available for employment, any subsequent period of disability from the same cause shall be considered a new disability.

The term **"Total Disability"** as it applies to a Retired Employee or Dependent means all periods of disability arising from the same cause including all complications, except that if a Retired Employee or Dependent recovers for a period of three months and throughout such period also resumes normal activities of a person of like age and sex in good health, any subsequent period of disability from the same cause shall be considered as a new period of disability.

"Unnecessary Service and Supply" means services or supplies, including tests and check-up exams, to the extent that they are not needed for (i) the diagnosis of a Sickness or Injury, or (ii) the medical care of a diagnosed Sickness or Injury. To be considered "needed", a service or supply must meet all of the "Medically Necessary" requirements defined on page 14.

"Usual, Customary and Reasonable Charges" means charges made for services or supplies essential to the care of the Covered Person. Such charges will be considered Usual, Customary and Reasonable if they are the amount normally charged by most providers of comparable services and supplies and do not exceed the amount ordinarily charged by most providers of comparable services and supplies in the locality where the services or supplies are provided for Sicknesses and Injuries comparable in severity and nature to the Sickness or Injury being treated. The amount of Usual, Customary and Reasonable Charges hereunder shall be determined by the Plan.

"Waiting Period" means the period of time an Employee must wait before benefits under the Plan can become effective. The period of time begins on the date the Employee is hired and ends on the first day of the month following such date.

MEDICAL PLAN SCHEDULE OF BENEFITS
OPTION A (STANDARD PLAN) AND OPTION B (ALTERNATE PLAN)

PENALTY MESSAGE

The Plan requires pre-authorization for certain Specialists and services. Please review pages 3 to 5 of this Plan Booklet to familiarize yourself with these pre-authorization provisions. Should services not be pre-authorized, and/or if you do not utilize Network Providers, benefits will be substantially reduced as set forth in the Plan's Schedule of Benefits below. Referrals to a Non-Network Provider are covered at the Non-Network benefit. It is the responsibility of the Participant to ensure services to be rendered are performed by a Network Provider.

THIS SCHEDULE IS A SUMMARY ONLY. PLEASE REFER TO THE SECTIONS ON ELIGIBLE MEDICAL EXPENSES AND LIMITATIONS AND EXCLUSIONS SECTIONS FOR MORE COMPLETE INFORMATION.

COVERAGE FEATURES	Option Plan A Standard Plan (Default)	Option Plan B Alternate Plan
PLAN MAXIMUMS (Plan A or B) **Lifetime Maximum** **Annual Limit Per Individual**	Unlimited Lifetime Maximum. **Effective July 1, 2011 there is a $1.5 million annual limit on Medical Benefits. The annual maximum on Medical Benefits will be $2 million beginning on July 1, 2013. There will be no annual limit on and after January 1, 2014.**	
DEDUCTIBLE [1]	**Network:** **$250** per individual (plus any Copayments) **$500** max per Family (plus any Copayments) **Non-Network:** **$750** per individual (plus any Copayments) **$1,500** max per Family (plus any Copayments)	**Network:** **$1,000** per individual (plus any Copayments) **$2,000** max per Family (plus any Copayments) **Non-Network:** **$3,000** per individual (plus any Copayments) **$6,000** max per Family (plus any Copayments)
COST CONTAINMENT PENALTIES (Plan A or B)	A $250 penalty will be assessed if authorization is not obtained for non-emergency medical services (see page 4). Any amount that exceeds Usual, Customary, and Reasonable expenses is the Participant's responsibility and does not apply towards the Out-of-Pocket maximum.	

[1] Deductible: In no event will the Calendar Year Deductible be more than $750 per Individual or $1,500 per Family under Plan Option A, or $3,000 per Individual or $6,000 per Family under Plan Option B for use of Network and Non-Network services. Deductibles, Copayments, Plan Penalties and amounts exceeding Usual, Customary, and Reasonable (UCR) do not apply towards the Out-of-Pocket Maximum.

- **"Deductible"** means the amount of Allowable Expenses that each Covered Person or Family must incur in each Calendar Year before benefits under the Plan will be paid. Any expenses applied against the Deductible during the last three (3) months of the Calendar Year will reduce the Deductible applicable in the following Calendar Year. Also, when two or more Covered Persons in a Family are injured in the same accident, eligible charges for those Injuries will be combined, in each Calendar Year, to meet one Calendar Year Deductible for all such Covered Persons.

- Deductibles do not apply towards Non-Network expenses in excess of Usual, Customary and Reasonable (UCR) allowances, expenses that become the Covered Person's responsibility for failure to comply with the pre-authorization requirements or the Out-of-Pocket maximum.

Note: Benefits Not Subject to Deductible or Co-Insurance
Effective July 1, 2011, Preventive Services for Children and Adults as defined under the Patient Protection and Affordable Care Act (PPACA) will be covered under the Plan as noted on Insert III in the back of this Plan Booklet.

COVERAGE FEATURES	Option Plan A Standard Plan (Default)	Option Plan B Alternate Plan
OUT-OF-POCKET ANNUAL MAXIMUM [1] **Non-Network Out-of-Pocket Maximum is two times the Network amounts shown.**	**Network:** No Covered Person will be required to pay more than **$5,000** in any Calendar Year toward the percentage share of expenses which are not paid by the Plan. Once a Covered Person has paid **$5,000**, Allowable Expenses for the balance of the Calendar Year will be paid at 100%. No covered family (Employee or Retiree and his/her eligible Dependents) will be required to pay more than **$10,000** in any Calendar Year toward their percentage share of expenses which are not paid by the Plan. Once the family has paid **$10,000**, Allowable Expenses for the balance of the Calendar Year will be paid at 100%.	**Network:** No Covered Person will be required to pay more than **$6,000** in any Calendar Year toward the percentage share of expenses which are not paid by the Plan. Once a Covered Person has paid **$6,000**, Allowable Expenses for the balance of the Calendar Year will be paid at 100%. No covered family (Employee or Retiree and his/her eligible Dependents) will be required to pay more than **$12,000** in any Calendar Year toward their percentage share of expenses which are not paid by the Plan. Once the Family has paid **$12,000**, the remaining Allowable Expenses for the balance of the Calendar Year will be paid at 100%.
	COINSURANCE [2]	**COINSURANCE** [2]
HOSPITAL SERVICES		
Inpatient Hospital Room and Board and Ancillary Services	**Network:** **80%** of the Anthem Blue Cross Contract Rate **Non-Network:** **60%** of Usual, Customary and Reasonable Charges	**Network:** **70%** of the Anthem Blue Cross Contract Rate **Non-Network:** **50%** of Usual, Customary and Reasonable Charges
Birthing Center	**Network:** **80%** of the Anthem Blue Cross Contract Rate **Non-Network:** **60%** of Usual, Customary and Reasonable Charges	**Network:** **70%** of the Anthem Blue Cross Contract Rate **Non-Network:** **50%** of Usual, Customary and Reasonable Charges
	(No coverage is provided when a Dependent Child is the mother) After the birth, the infant and mother are examined and remain in recovery from four (4) to twenty-four (24) hours and then are permitted to return home. Emergency transportation services are also available in case an unforeseen complication arises either with the infant or the mother and an immediate transfer to a Hospital becomes necessary.	
Outpatient Services	**Network:** **80%** of the Anthem Blue Cross Contract Rate after a $100 Copayment **Non-Network:** **60%** of the Usual, Customary and Reasonable Charges after a $100 Copayment	**Network:** **70%** of the Anthem Blue Cross Contract Rate after a $100 Copayment **Non-Network:** **50%** of the Usual, Customary and Reasonable Charges after a $100 Copayment

[1] Deductibles, Copayments, Plan Penalties and amounts exceeding Usual, Customary and Reasonable (UCR) do not apply towards the Out-of-Pocket Maximum.

[2] Co-Insurance Percentage: The Plan pays Allowable Expenses at the percentages indicated after the satisfaction of the Deductible each Calendar Year unless otherwise stated.

Note: Benefits Not Subject to Deductible or Co-Insurance
Effective July 1, 2011, Preventive Services for Children and Adults as defined under the Patient Protection and Affordable Care Act (PPACA) will be covered under the Plan as noted on Insert III in the back of this Plan Booklet.

COVERAGE FEATURES	Option Plan A Standard Plan (Default)	Option Plan B Alternate Plan
EMERGENCY, URGENT CARE AND AMBULATORY SERVICES		
Emergency Room	**Network:** **80%** of the Anthem Blue Cross Contract Rate after the $100 Copayment (Copayment waived if admitted) **Non-Network:** **80%** of Usual, Customary and Reasonable charges after $100 copayment (copayment waived if admitted)	**Network:** **70%** of the Anthem Blue Cross Contract Rate after the $100 Copayment (Copayment waived if admitted) **Non-Network:** **70%** of Usual, Customary and Reasonable charges after $100 copayment (copayment waived if admitted)
Urgent Care Facility	**Network:** **80%** of the Anthem Blue Cross Contract Rate after the $35 Copayment **Non-Network:** **60%** of Usual, Customary and Reasonable Charges after the $35 Copayment	**Network:** **70%** of the Anthem Blue Cross Contract Rate after the $35 Copayment **Non-Network:** **50%** of Usual, Customary and Reasonable Charges after the $35 Copayment
Ambulatory Surgical Center	**Network:** **80%** of the Anthem Blue Cross Contract Rate after a $100 copayment **Non-Network:** **60%** of Usual, Customary and Reasonable Charges after a $100 copayment	**Network:** **70%** of the Anthem Blue Cross Contract Rate after a $100 copayment **Non-Network:** **50%** of Usual, Customary and Reasonable Charges after a $100 copayment
PHYSICIAN SERVICES		
Physician Office, Home, or Hospital visits	**Network:** **$15** copayment for each physician office, home, or hospital visit.	**Network:** **$25** copayment for each physician office, home, or hospital visit.
Other Physician services and supplies	**80%** of the Anthem Blue Cross Contract Rate **Non-Network:** **60%** of the Usual, Customary and Reasonable Charges	**70%** of the Anthem Blue Cross Contract Rate **Non-Network:** **50%** of the Usual, Customary and Reasonable Charges
PREVENTIVE SERVICES (Plan Deductible Waived)		
Annual Physical Exam Benefit (Plan Deductible Waived)	This benefit provides coverage for expenses relating to periodic health evaluations for preventive health services to promote healthy lifestyles and to detect unknown diseases or conditions. Examples of types of services covered under this benefit: (a) routine annual physical examinations and laboratory tests, including PSA testing for prostate cancer, when no medical condition exits; (b) routine annual visit to a Dermatologist to determine if skin lesions, moles, etc. are cancerous; (c) Immunizations.	
	Network: **100%** of Anthem Blue Cross Contract Rate **Non-Network:** **100%** of Usual, Customary and Reasonable Charges to a maximum of $300 per calendar year	**Network:** **100%** of Anthem Blue Cross Contract Rate **Non-Network:** **100%** of Usual, Customary and Reasonable Charges to a maximum of $300 per calendar year

Note: Benefits Not Subject to Deductible or Co-Insurance
Effective July 1, 2011, Preventive Services for Children and Adults as defined under the Patient Protection and Affordable Care Act (PPACA) will be covered under the Plan as noted on Insert III in the back of this Plan Booklet.

COVERAGE FEATURES	Option Plan A Standard Plan (Default)	Option Plan B Alternate Plan
Women's Annual Health Benefit (Plan Deductible Waived):	Routine mammograms and Pap smears will be provided under the Women's Annual Health benefit. Note: Expenses relating to diagnosis and treatment of an Injury or Sickness are covered under Medical and X-Ray and Laboratory benefits of the Plan.	
Women's Annual Health Benefit (continued)	**Network:** **100%** of Anthem Blue Cross Contract Rate **Non-Network:** **100%** of Usual, Customary and Reasonable Charges to a maximum of $300 per calendar year	**Network:** **100%** of Anthem Blue Cross Contract Rate **Non-Network:** **100%** of Usual, Customary and Reasonable Charges to a maximum of $300 per calendar year
Well Baby Care (Plan Deductible Waived)	During the first 5 years after birth includes immunizations approved by FDA at intervals recommended by the American Pediatric Association. Excludes immunizations required exclusively for travel.	
	Network: **100%** of Anthem Blue Cross Contract Rate **Non-Network:** **60%** of Usual, Customary and Reasonable Charges to a maximum of $300 per calendar year	**Network:** **100%** of Anthem Blue Cross Contract Rate **Non-Network:** **50%** of Usual, Customary and Reasonable Charges to a maximum of $300 per calendar year
OUTPATIENT LAB & X-RAY	**Network:** **80%** of the Anthem Blue Cross Contract Rate. **Non-Network:** **60%** of Usual, Customary and Reasonable Charges	**Network:** **70%** of the Anthem Blue Cross Contract Rate. **Non-Network:** **50%** of Usual, Customary and Reasonable Charges
DURABLE MEDICAL EQUIPMENT Purchase or rental in excess of $2,000 requires Pre-authorization from Anthem Blue Cross	**Network:** **80%** of the Anthem Blue Cross Contract Rate. **Non-Network:** **60%** of Usual, Customary and Reasonable Charges	**Network:** **70%** of the Anthem Blue Cross Contract Rate. **Non-Network:** **50%** of Usual, Customary and Reasonable Charges
PRESCRIPTION DRUGS[1]		
Retail Pharmacy (Provided through EnvisionRx Options)	**$10** copayment generic **$35** copayment brand with no generic equivalent **$35** copayment plus cost difference for brand with generic equivalent [2]	
Refer to page 40 regarding Specialty Drugs	1 to 30 days supply at Network Pharmacies. Up to 90 days at select pharmacy chains for maintenance and non-maintenance drugs.	
Mail Order Pharmacy (Provided by Orchard Mail Order Pharmacy-Affiliate of EnvisionRx Options)	**$10** copayment generic **$35** copayment brand with no generic equivalent **$35** copayment plus cost difference for brand with generic equivalent [2]	**$10** copayment generic **$35** copayment brand with no generic equivalent **$35** copayment plus cost difference for brand with generic equivalent [2]
	1 to 90 days supply for non-maintenance drugs. 91 to 180 days supply for maintenance drugs – Requires initial 30-day prescription before 91-180 day supply will be allowed.	

1 Prescription Drugs for stomach-related conditions (Proton Pump Inhibitors) and allergy (non-sedating antihistamine) are subject to Step Therapy provisions outlined in Plan Booklet.

2 Cost difference between Brand and Generic is waived if the Physician writes "DAW" (Dispense as Written).

Note: Benefits Not Subject to Deductible or Co-Insurance
Effective July 1, 2011, Preventive Services for Children and Adults as defined under the Patient Protection and Affordable Care Act (PPACA) will be covered under the Plan as noted on Insert III in the back of this Plan Booklet.

COVERAGE FEATURES	Option Plan A Standard Plan (Default)	Option Plan B Alternate Plan
SKILLED NURSING FACILITY (Maximum of 120 days per calendar year)	**Network:** **80%** of the Anthem Blue Cross Contract Rate. **Non-Network:** **60%** of Usual, Customary and Reasonable Charges	**Network:** **70%** of the Anthem Blue Cross Contract Rate. **Non-Network:** **50%** of Usual, Customary and Reasonable Charges
HOME HEALTH CARE (Only as a less costly alternative to Inpatient hospitalization) Requires Pre-authorization	**Network:** **80%** of the Anthem Blue Cross Contract Rate **Non-Network:** **60%** of Usual, Customary and Reasonable Charges	**Network:** **70%** of the Anthem Blue Cross Contract Rate **Non-Network:** **50%** of Usual, Customary and Reasonable Charges
HOSPICE CARE (Plan Deductible Waived) Requires Pre-authorization	**Network:** **100%** of the Anthem Blue Cross Contract Rate. **Non-Network:** **100%** of Usual, Customary and Reasonable Charges	**Network:** **100%** of the Anthem Blue Cross Contract Rate. **Non-Network:** **100%** of Usual, Customary and Reasonable Charges
OCCUPATIONAL AND SPEECH THERAPY Requires Pre-authorization	**Network:** **80%** of the Anthem Blue Cross Contract Rate. **Non-Network:** **60%** of Usual, Customary and Reasonable Charges	**Network:** **70%** of the Anthem Blue Cross Contract Rate. **Non-Network:** **50%** of Usual, Customary and Reasonable Charges
AMBULANCE SERVICES		
Ambulance (Air)	**Network:** **100%** of Usual, Customary and Reasonable Charges **Non-Network:** **100%** of Usual, Customary and Reasonable Charges	**Network:** **100%** of Usual, Customary and Reasonable Charges **Non-Network:** **100%** of Usual, Customary and Reasonable Charges
Ambulance (Ground)	**Network:** **80%** of Usual, Customary and Reasonable Charges after $100 Copayment **Non-Network** **80%** of Usual, Customary and Reasonable Charges after $100 Copayment	**Network:** **70%** of Usual, Customary and Reasonable Charges after $100 Copayment **Non-Network** **70%** of Usual, Customary and Reasonable Charges after $100 Copayment
OTHER		
Voluntary Sterilization (No coverage for Dependent Children)	**Network:** **80%** of the Anthem Blue Cross Contract Rate. **Non-Network:** **60%** of Usual, Customary and Reasonable Charges	**Network:** **70%** of the Anthem Blue Cross Contract Rate. **Non-Network:** **50%** of Usual, Customary and Reasonable Charges
Blood, Blood Plasma, Blood Derivatives and Blood Factors	**Network:** **80%** of the Anthem Blue Cross Contract Rate **Non-Network:** **60%** of Usual, Customary and Reasonable Charges	**Network:** **70%** of the Anthem Blue Cross Contract Rate **Non-Network:** **50%** of Usual, Customary and Reasonable Charges

Note: Benefits Not Subject to Deductible or Co-Insurance
Effective July 1, 2011, Preventive Services for Children and Adults as defined under the Patient Protection and Affordable Care Act (PPACA) will be covered under the Plan as noted on Insert III in the back of this Plan Booklet.

The charges for the following **do not** apply toward the 100% benefit payment and **are never covered at 100%:**

1. Behavioral Health treatment for Mental Health and Substance Abuse benefits;
2. Chiropractic;
3. Prescription Drugs;
4. Vision Plan; except as required for pediatric preventive services under the Affordable Care Act effective July 1, 2011; and
5. Dental Plan except as required for pediatric oral health services, under the Affordable Care Act effective July 1, 2011.

COMPREHENSIVE MEDICAL BENEFITS FOR PLAN OPTIONS A AND B

COVERED MEDICAL EXPENSES

Allowable Expense means either: (a) Network Anthem Blue Cross Contract Rates; or (b) Non-Network Usual, Customary and Reasonable (UCR) expenses incurred by or on behalf of a Covered Person for Hospital or other medical services listed below which are:

1. Administered or ordered by a Physician; and

2. Medically necessary for the treatment of an Injury or Sickness; and

3. Not of a luxury or personal nature; and

4. Not otherwise excluded or reduced under the Exclusions and Limitations sections of this Plan or in the Medical Plan Schedule of Benefits, or subject to inclusion under the Affordable Care Act legislation effective July 1, 2011.

DEDUCTIBLE AMOUNT

The Deductible, if applicable, will be applied to covered expenses only once each Calendar Year regardless of the number of accidents or Sicknesses the Covered Person may have.

FAMILY LIMIT ON DEDUCTIBLE

If an amount equal to two (2) Deductibles is met by any total of Family members during the same 12 month period beginning January 1 of each year, all eligible medical expenses incurred during that 12 month period by covered members of such Family shall be considered as being in excess of their Deductible amount.

DEDUCTIBLE CARRYOVER PROVISION

Any expense incurred in October, November and December, which is used to satisfy the Deductible for that year, will also be applied to the Deductible for the following year.

ANNUAL MAXIMUM AMOUNT PAYABLE

The maximum amount payable for all covered expenses incurred annually is as noted on the Schedule of Benefits. The word “annual” is the 12 month period beginning January 1 of each year.

COVERED MEDICAL BENEFITS FOR PLAN OPTIONS A AND B MEDICAL EXPENSES

(Please refer to pages 58 – 62 for General Exclusions and Limitations)

Benefits are payable under the Plan for the following services at the percentages set forth in the Schedule of Benefits:

HOSPITAL BENEFITS

1. The room and board, medical services, and supplies furnished by a Hospital, Ambulatory Surgical Center, or a Birthing Center.

2. Other Hospital Expenses: The actual charges made by the Hospital for necessary services and supplies used in the Hospital, such as drugs, dressings, blood plasma, anesthetic fees, operating room, etc. This does not include special nursing fees. Charges for the cost of unreplaced blood and blood plasma, and blood processing. Charges for autologous blood donation will be covered.

3. Hospital Outpatient care is provided for non-confining disabilities. Outpatient Hospital care is covered when Medically Necessary to perform covered dental services and pre-authorized by Anthem Blue Cross.

Services rendered by a Non-Network Hospital based Physician (such as a radiologist, pathologist or anesthesiologist) in a Network Hospital are covered at the Network benefit level when the Covered Person has no choice of provider.

If a private room is used, the average semi-private room rate will be used unless confinement in a private room is deemed Medically Necessary. Charges for an Intensive Care Unit or other special care unit such as Coronary Care (but not for the concurrent use of any other Hospital room) are also covered.

Medically necessary Outpatient services and supplies furnished by a Hospital while being treated on an Outpatient basis.

Emergency Care – If a Covered Person is admitted to a Non-Network Hospital on an Emergency basis, as defined by this Plan, Allowable Expenses will be covered at the Network benefit levels until patient's condition has been stabilized to the point that he or she can be transferred to the Network provider (at Plan's expense); otherwise Non-Network benefits will commence.

AMBULANCE EXPENSE BENEFITS

Ground or Inter-Facility
Professional ground ambulance service when used to transport the Covered Person directly from the place where he or she is injured or becomes ill to the nearest Hospital qualified to give treatment. When Medically Necessary, inter-facility ambulance expense is also covered.

Air
Professional air ambulance services when used to transport the Covered Person directly from the place where he or she is injured or becomes ill to the nearest Hospital qualified to give treatment.

HOSPITAL BASED PHYSICIAN BENEFITS

This benefit provides payment for charges for Doctors' visits as often as needed, including charges for extra time and consultations. In-Hospital Physician's visits provided in connection with Substance Abuse and Behavioral Health have separate limitations as noted on pages 31 to 33.

Services rendered by a Non-Network Hospital-based Physician (such as a radiologist, pathologist or anesthesiologist or an Emergency Room Physician) in a Network Hospital are covered at the Network benefit level when the Covered Person has no choice of providers.

Professional anesthesiologist benefits are provided when a Covered Person is entitled to surgical care and when anesthesia is administered by a licensed Physician, C.R.W.A., or Certified Nurse Anesthesiologist.

SKILLED NURSING FACILITY BENEFITS

Room and board (at the semi-private rate), medical services, physical therapy and supplies are covered provided care is ordered by a Physician and is Medically Necessary. *No benefits for convalescent care shall be payable for Custodial Care, or for services or conditions attributed to or caused by mental illness or functional nervous disorders, or for services primarily for the convenience of the patient or provider, or because the Covered Person has nowhere else to go.*

HOME HEALTH CARE

Home Health Care Agency services and supplies when authorized by Anthem Blue Cross.

HOSPICE BENEFITS

The Plan covers a wide range of services provided by Hospices to control physical symptoms and to provide emotional and spiritual support during the last six months of life. Covered services include home visits by nurses and other health care professionals in addition to Hospital Inpatient and Outpatient care when needed. The Plan covers Charges by Hospices that are licensed as authorized Home Health Agencies in the state.

SURGICAL BENEFITS

The surgical fee incurred when a Covered Person has undergone a surgical operation by a legally qualified Physician or Surgeon because of bodily Injury or Sickness.

PREVENTIVE SERVICES

Preventive Care Services are covered without your having to meet your Deductible, as noted on Insert III in the back of this Plan Booklet.

Note: These benefits are subject to change under the Affordable Care Act; the most up-to-date information is available online; see the website address listed under Important Numbers and Website Addresses on page iv, Preventive Care Benefits. Keep in mind:

1. Your doctor may provide a Preventive Service, such as a cholesterol screening test, as part of an office visit. Be aware that your Plan can require you to pay some costs of the office visit, if the preventive service is not the **primary** purpose of the visit, or if your doctor bills you for the preventive services separately from the office visit

2. Frequency Limitations

   (a) Routine Exam: Once each calendar year, or as required by your physician according to age and Affordable Care Act preventive care guidelines.

   (b) Diagnostic Test: Based on the nature of the diagnostic test or screening, as determined by Affordable Care Act preventive care guidelines.

A chart outlining the Preventive Care benefits offered by the Plan is included as an insert in the back of this Plan Booklet.

DIAGNOSTIC X-RAY AND LABORATORY

The Plan covers charges for laboratory tests and x-ray examinations for diagnosis of an Injury or Sickness with the recommendation and approval of a legally qualified Physician or Surgeon.

Limitation:
These Diagnostic Laboratory and x-ray Benefits do not cover any expense incurred for dental x-rays.

MASTECTOMY BENEFITS

The Plan complies with the Women's Health and Cancer Rights Act of 1998, after a covered mastectomy, the Hospital and Physician benefits of the Plan will cover the following expenses:

1. Reconstruction of the breast on which the mastectomy has been performed; and

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. Prostheses (implants, special bras, etc.) and physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes) in a manner determined appropriate in consultation with the attending Physician and the patient.

If a Participant had a mastectomy prior to the effective date of coverage under this Plan and is not presently receiving benefits in connection with a mastectomy, the Plan does not provide coverage for a symmetrical appearance. However, if a Participant is receiving follow-up care related to the mastectomy that occurred before the Participant became covered under the Plan, then the Participant may have rights to a symmetrical appearance procedure under the statute.

Coverage for breast reconstruction and related services will be subject to all applicable Deductibles, Copayments and coinsurance amounts that are consistent with those that apply to other benefits under the Plan.

Please see pages 103 to 104 for more information regarding HIPAA standards with which the Plan voluntarily complies.

MATERNITY BENEFITS

Expenses incurred by a female Employee, Retiree, Dependent spouse or Domestic Partner as a result of pregnancy will be considered on the same basis as illness-related expenses. All Plan provisions and limitations will apply to pregnancy claims in the same manner as claims incurred as a result of illness. Expenses incurred by a female Employee, Retiree, Dependent spouse or Domestic Partner as a result of pre-natal screening will be considered on the same basis as illness related expenses. No maternity benefits are provided to Dependent Children.

The Plan complies with the HIPAA standard which prohibits restrictions on benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. HIPAA generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or the newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

OTHER SERVICES AND SUPPLIES

1. Physical therapy rendered by a licensed physical therapist.

2. Services of an acupuncturist who is a medical Doctor.

3. Services performed for the purpose of cardiac rehabilitation.

4. Professional services rendered by a Dentist for treatment of accidental Injury to natural teeth for an Injury occurring while the individual is covered under the Plan and only during the one hundred eighty (180) day period immediately following the date of Injury. Teeth damaged as a result of chewing or biting shall not be deemed an accidental Injury.

5. Treatment of Temporomandibular Joint Disorder (TMJ). Covered services include only x-rays, surgery splints and/or palliative procedures. Charges for orthodontic braces are not covered.

6. Insulin, needles, syringes, lancets, clinitest, glucose strips and chemstrips for diagnosed diabetes.

7. Rental of Hospital beds, wheelchairs and similar Durable Medical Equipment determined to be Medically Necessary and used solely by the Covered Person. In no event shall rental charges exceed the Usual, Reasonable and Customary purchase price of such equipment.

8. Rental of dialysis equipment and all necessary services and supplies required for hemodialysis treatment, excluding the purchase of dialysis equipment.

9. Oxygen and rental of equipment for its administration.

10. Artificial limbs and eyes as well as replacement of, when medically necessary.

11. Newborn expenses for the following paid as part of the mother's claim:

    (a) Hospital nursery expenses;

    (b) Routine pediatric care for a healthy newborn child;

    (c) Circumcision.

    If the baby is sick, suffers an Injury, premature birth, congenital abnormality or requires care other than routine care, benefits will be provided on the same basis as for any other eligible expense.

12. Occupational therapy rendered by a duly qualified occupational therapist only if referred by a Physician and only for treatment following a Surgical Procedure, a stroke and/or accidental Injury, surgery, or trauma subject to the Plan’s Exclusions and Limitations.

13. Human to human organ or tissue transplant procedures for kidney, cornea, heart, heart/lung, liver, lung, bone marrow (including autologous bone marrow transplants) or pancreas. The procedure must be due to a Sickness or accidental Injury occurring while the individual is covered under the Plan.

Benefits are provided for services and supplies for the procedure including the following expenses:

(a) Organ and tissue procurement consisting of removing, preserving and transporting the donated part, subject to the following:

i. When both the recipient and donor are covered by this Plan, services will be covered for each patient.

ii. When only the recipient is covered by this Plan, benefits are provided for services for both the recipient and donor, provided benefits to the donor are not furnished under any other plan.

iii. When the recipient is not covered by this Plan and the donor is covered, expenses will not be covered for either the recipient or the donor.

(b) Transportation of the recipient and a companion to and from the site of the transplant and lodging and meal costs incurred in the interim by such companions. If the recipient is a minor, transportation of two (2) persons who travel with the minor is included.

(c) Private duty nursing care by a registered graduate nurse (RN.) or a licensed practical nurse (L.P.N.).

14. X-ray, radium, radioactive isotope therapy, and chemotherapy.

15. Elective sterilization. No benefits for Dependent Children.

16. Diabetes Education. Services of a Physician or other professionals who are knowledgeable about the treatment of diabetes (such as a registered nurse, registered pharmacist or registered dietitian) for the purpose of enabling a diabetic and his/her family to understand and practice daily management of diabetes.

17. Cochlear Implants. The surgically implanted electronic device that provides a sense of sound to a person who is profoundly deaf or severely hard of hearing.

18. Infusion Therapy. Professional services of an appropriate provider for the intravenous or aerosol administration of prescription drugs or other prepared or compounded substances. Infusion therapy may be administered in a Covered Person's home, Physician's office, or at a facility/hospital.

EMPLOYEE ASSISTANCE PROGRAM (EAP) BENEFITS FOR PLAN OPTIONS A, B AND C

The Plan has contracted with Claremont EAP to provide an Employee Assistance Program for all Plan Participants regardless of which Medical Plan Option you are enrolled. To address the services provided by this program, you must call Claremont EAP at 800-834-3773.

What Is an Employee Assistance Program (EAP)?

The EAP can support you and your family in confidentially dealing with the stresses and strains of daily living. This program has resources available to help with a wide variety of concerns. We encourage you to take advantage of this service. Claremont EAP offers the following services to all employees and family members:

COUNSELING
Five (5) free visits per incident, per year. Counseling can address any personal issue such as marital/family conflicts, parenting concerns, substance abuse, work stress, depression, and other issues that affect your quality of life.

For Plan Option A and B participants: Visits in excess of five (5) per incident per year, please refer to benefits payable under the Behavioral Health section of this Plan Booklet on page 32.

For Kaiser Permanente Plan Option C participants: Visits in excess of five (5) per incident per year, please contact your Kaiser Permanente physician for continued treatment.

LEGAL CONSULTATION
Up to 30-minutes of consultation is provided at no cost. A 25% discount is available for any service beyond the initial consultation. Attorneys have expertise in areas such as family law, consumer issues, traffic violations and personal injury, etc. Free “Simple Will” kits are available.

FINANCIAL SERVICES
An initial 30-60 minute consultation is available at no cost. Financial specialists are able to assist employees/family members with budgeting, retirement planning, debt consolidation, financial planning, auto and real estate purchasing, etc., and provides free credit reports and reviews.

ELDER/ADULT/CHILD CARE
Nationwide referrals for elder/child care. A work/life specialist consults with each employee/family member to generate a customized report, which provides a listing of available and appropriate agencies/services and other helpful written information.

SCHOOL/COLLEGE ASSISTANCE
This nationwide program helps parents choose an appropriate elementary or secondary education and provides assistance with the college search process for both college-bound children and the working individual in search of furthering his/her educational needs.

DAILY LIVING/CONVENIENCE REFERRALS
Referrals for daily living such as pet care, home repair, errand services, travel, entertainment and apartment locator services.

WELLNESS REFERRALS
Help with physician searches, medical support groups, fitness centers, diet & nutrition resources, alternative medicine and other resources.

BEHAVIORAL HEALTH BENEFITS
MENTAL HEALTH AND SUBSTANCE ABUSE PLAN
SCHEDULE OF BENEFITS FOR PLAN OPTIONS A AND B

All **Inpatient and Outpatient Services** must be pre-authorized by Avante Health at (800) 498-9055 or (559) 261-9060 or they are **NOT** covered by the Plan. Only Avante Health approved services are covered at Network Practitioners. Non-Network Providers are not covered.

The Plan has contracted with Avante Health to provide the **Behavioral Health benefits for Mental Health and Substance Abuse Treatment.**

How do I access services?
Call (800) 498-9055 or (559) 261-9060, 24-hours a day, seven days a week. The phone counselor will listen carefully to your concern or issue and help you assess the situation, and then suggest ways to help. A Directory of Network behavioral health professionals, hospitals and substance abuse facilities is available and can be found on Avante's website www.fusdmentalhealth.com.

Your phone counselor may refer you to a licensed counselor who will help to resolve your issue. You may also be referred to community resources, such as a support group. If a health problem may be contributing to your situation, you could be referred to a medical professional.

Who is eligible?
You and any covered Dependent may call (800) 498-9055 or (559) 261-9060 for Behavioral Services.

Are these services confidential?
Yes, all services are strictly confidential. Your identity is protected at all stages of the program.

Is Pre-Authorization Always Necessary?
Yes. All Behavioral Health services must be pre-authorized by Avante Health. You may be responsible for all or a portion of any services provided without pre-authorization unless in an Emergency.

In an Emergency, go to a treatment center, and then as soon as possible (or within 24 hours of admission) call Avante Health for authorization.

How can Avante Health help?
Avante Health's clinical staff is available to help with many types of personal concerns including those shown below.

WHAT DO BEHAVIORAL HEALTH BENEFITS COVER?

Behavioral Health benefits include outpatient counseling visits with a licensed provider and help with problems such as:

Behavioral Health

- Depression
- Drug/alcohol abuse
- Marriage/family issues
- Treatment centers/detox services
- Stress and anxiety
- Eating disorders
- Support groups

Mental Health Benefits

- Pre-authorization by Avante Health required for all mental health services
- Available to you and your eligible Dependents

Outpatient Treatment

- 45 visits per Calendar Year per member
- $10 copay per visit

Inpatient Treatment

- No Inpatient Deductible
- Inpatient, partial and day treatment[1] – 30 days per Calendar Year covered at 100% after any applicable admission fee

Substance Abuse Benefits

- Pre-authorization by Avante Health required for all Substance Abuse services
- Available to you and your eligible Dependents
- All levels of Substance Abuse care including detox – covered at 100% with $0 copay

Annual maximum - $1,500,000 (combined with all other eligible Medical expenses paid during a Calendar Year)

Please refer to page 103 regarding the Plan's election under HIPAA (a Federal law) which exempts the Plan from providing the same benefits for treatment of Behavioral Health as for medical and surgical benefits.

Please remember that all services except Emergency services, require pre-authorization through Avante Health in order to be covered by the Plan. Please call Avante Health at (800) 498-9055 or (559) 261-9060 for preauthorization.

[1] Days to be determined based on the following ratios:

Inpatient treatment – 1 day
Residential treatment – 66.7% of 1 day (1.5 residential days to 1 Inpatient day)
Day treatment – 50% of 1 day (2 day treatment days to 1 Inpatient day)

BEHAVIORAL HEALTH EXCLUSIONS AND LIMITATIONS

1. Services not specifically included in this Plan Document.

2. Services provided by a Non-Network Provider unless certified by Avante Health.

3. Services that are not pre-certified (except for Emergency Services).

4. Services that exceed the maximum coverage for the benefit year.

5. Medical Detoxification.

6. Treatment for addiction to smoking or pathological gambling.

7. Any expense the eligible member or eligible dependent incurs in excess of Plan benefits.

8. Charges for a missed appointment or completion of claims forms.

9. All court ordered services and testing, including, but not limited to, legal reports, court testimony, and custody evaluations.

10. Advanced Behavioral Therapy for the treatment of Autism, non-verbal learning disabilities, and other learning or behavioral disorders.

11. Biofeedback, hypnosis and any goal oriented behavioral modification such as to quit smoking, weight loss or services related to pain management and pain management centers.

12. Any service to the extent the patient is covered by any other primary insurance plan (Medicare, etc.).

13. Services which are not medically necessary.

14. Neurological services and tests including, but not limited to, EEGs, brain scans, beam scans, MRIs, CAT Scans, skull X-Rays, and lumbar punctures.

The fact that a procedure or level of care is prescribed by a Network Provider does not mean that it is a Covered Charge under the Plan and shall not bind the Plan in determining covered services under the Plan. Services which are not reasonable and necessary shall include, but are not limited to:

1. procedures that are Experimental, of unproven value or of questionable current usefulness;

2. procedures that tend to be redundant when performed in combination with other procedures;

3. procedures that are unlikely to provide a provider with additional information when they are used repeatedly; and

4. procedures that can be performed with equal efficiency at a lower level of care.

CHIROPRACTIC CARE PLAN
SCHEDULE OF BENEFITS
FOR ALL PLAN OPTIONS A, B AND C

The Plan covers Chiropractic Care in coordination with ChiroMetrics. Please review the benefits under this Chiropractic Care Plan. It is to your advantage to use a ChiroMetrics Network Provider to receive the best benefits for you and your Dependents. Please contact ChiroMetrics at (559) 447-3375; www.fusdchiro.com to locate a Provider near you.

<table>
<tr><th colspan="3">SUMMARY OF CHIROPRACTIC SERVICES</th></tr>
<tr><td>Chiropractic services by ChiroMetrics Provider (Deductible waived)</td><td colspan="2">$5 Copayment then 100% of the ChiroMetrics contract rate</td></tr>
<tr><td>Chiropractic services by Non-ChiroMetrics Provider
Outside 100 miles of Fresno ONLY
Referral must be given by a Physician and also Pre-Certified by ChiroMetrics.</td><td>Plan A and Plan C
60% of Usual, Customary and Reasonable Charges after deductible</td><td>Plan B
50% of Usual, Customary and Reasonable Charges after deductible</td></tr>
<tr><td colspan="3">Chiropractic Diagnostic X-Ray Benefit is limited to a $100 per benefit Calendar Year maximum paid at 100% Usual, Customary and Reasonable Charges, or the ChiroMetrics contract rate, after the Plan's Deductible has been satisfied.
28 visits maximum per Calendar Year 10 visits allowed per month and 1 visit allowed per day. Note: For chiropractic treatment exceeding 12 visits per Calendar year, the chiropractor must submit a "12th visit review" and ChiroMetrics must pre-certify additional visits for the remainder of the Calendar Year.
Massage therapy is excluded unless pre-certification is received from ChiroMetrics.
The following protocol will apply for chiropractic treatment for minor children:
Treatment For Dependents 15 years of age and under requires Special pre-certification by calling ChiroMetrics at (559) 447-3375. All children fifteen (15) years of age and under must have a written precertification for treatment before any claims will be paid. In the case of an Emergency or where authorization was unable to be obtained on the first visit, then ONLY the first visit will be covered.</td></tr>
</table>

"Chiropractic Care" means chiropractic treatment from a licensed Chiropractor (D.C.) for a musculoskeletal disorder (bone, muscle, tendon and joint) and for related diagnostic x-rays performed and billed by the chiropractor.

A ChiroMetrics chiropractic doctor must be used within one hundred (100) miles of Fresno; when outside 100 miles, services for any non-Preferred Provider Organization chiropractic doctor must be referred by a Physician and pre-certified by ChiroMetrics.

PRESCRIPTION DRUG PLAN
SCHEDULE OF BENEFITS
FOR PLAN OPTIONS A AND PLAN B
(Kaiser Permanente Plan Participants Must Use Kaiser Permanente Plan Pharmacies)

EnvisionRx Options administers the Prescription Drug Program for the Fresno Unified School District. If you fail to use the EnvisionRx Options program and its provider Pharmacies there will be NO benefit to you. For a complete list of participating pharmacies, please register online and visit www.envisionrx.com or call EnvisionRx Options Help Desk at (800) 361-4543.

Each eligible Employee, Retiree and Dependent will be charged the copayments outlined on the insert in the back of this Plan Booklet.

ENVISIONRX PLUS PLAN

If you are a Retiree currently enrolled in Medicare Parts A (hospital) and/or B (medical) coverage, or you become eligible for Parts A and/or B of Medicare at a later date, or you are awarded Medicare through Social Security Disability benefits after 24 months of being disabled, you will automatically be enrolled in the EnvisionRx Plus Plan unless you notify the District's Benefits Office that you wish to "Opt Out' and decline Prescription Drug coverage. You will be required to complete an Opt Out election form (available through EnvisionRx Plus or the District's Benefit Department). Your Medicare-eligible Dependents will also automatically be enrolled in this plan; however if your Dependents are not eligible for Medicare, they will not be enrolled in EnvisionRx Plus Plan and will continue to be covered the same as for Non-Medicare Dependents.

- The EnvisionRx Plus Plan provides the same benefits as you currently receive. Note that effective April 1, 2012 copayments will apply to all Retirees and Dependents whether dual coverage exists or not.

- You are not required to be enrolled in EnvisionRx Plus Plan if you are eligible for Medicare Parts A and/or B. **However if you choose to Opt Out, you will lose all prescription drug coverage under the Envision Rx Options plans (outlined herein) AND you will not be allowed to elect coverage in the future. You understand that if you leave this EnvisionRx Plus plan and do not have or obtain other Medicare prescription drug coverage that is at least as good as Medicare's Part D coverage, you may have to pay a Medicare late enrollment penalty in addition to your premium for Medicare Part D prescription coverage in the future.**

  Note: In January 2012, the Social Security Administration implemented specific rules on how they calculate monthly Medicare Part D (prescription drug) premiums for higher-income beneficiaries. High-income beneficiaries pay an "income related" monthly adjustment amount (IRMAA). Social Security uses your most recent federal tax return to determine if you will be required to pay higher Medicare premiums for an income-related monthly adjustment amount.

- EnvisionRx Plus Plan is a Medicare drug plan and is in addition to your coverage under Medicare; therefore, you will need to maintain your Medicare coverage. It is your responsibility to inform EnvisionRx Plus of any other prescription drug coverage that you have or may get in the future. Medicare only allows one Medicare prescription drug plan at a time, therefore, if you are currently enrolled in a Medicare prescription drug plan, your automatic enrollment in EnvisionRx Plus will end that enrollment.

- If you have a Medigap (Medicare Supplement) policy that **includes prescription drug coverage**, you must contact your Medigap Issuer to let them know that you have joined the EnvisionRx Plus Plan offered through this Plan. Your Medigap Issuer will remove the prescription drug coverage portion of the policy and adjust your premium. Call your Medigap issuer for details.

- You may leave this plan only at certain times of the year by sending a request to EnvisionRx Plus or by calling 1-800-Medicare. Please notify the District's Benefit Department if you choose to leave this plan as well.

- **Additional information for Medicare-eligible Retirees and Dependents**: When you enroll in this plan, you will receive an Evidence of Coverage brochure from EnvisionRx Plus which will provide additional information including your right to Claim Appeals relating to payment or services. It is your responsibility to read the EnvisionRx Plus Evidence of Coverage brochure. By joining the Plan's EnvisionRx Plus Medicare prescription drug plan, EnvisionRx Plus is required to release your information to Medicare and other plans as is necessary for treatment, payment and health care operations, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.

If you have additional questions regarding the EnvisionRx Plus Plan, please call EnvisionRx Plus at (866) 250-2005 24-hours a day, 7 days a week. TTY users should call 711.

ENVISIONRX OPTIONS RETAIL, MAIL AND SPECIALTY PLAN

The prescription program contains the following parts; in addition, there is important benefit information relating to:

- **Brand and Generic drugs, (see chart on page 38)**
- **Quantity Limits on specified drugs (page 38)**
- **Over the Counter (OTC) drugs for stomach-related and allergy conditions (pages 41)**
- **Step Therapy requirements for Sleep Agents, Cholesterol, Antidepressants and Osteoporosis medications (pages 41 to 42)**
- **Clinical Prior Authorization for specified medications, (page 39)**
- **Prescription Drug, Adherence Program for Chronic Diseases (page 39)**

1. **Retail Pharmacy Benefit** – Choose from thousands of EnvisionRx Options participating pharmacies nationwide.

2. **Retail - up to 90 Day Supply for Maintenance and Non-Maintenance Benefit** – Choose from EnvisionRx Options retail pharmacies to dispense your maximum 90 day supply.

3. **Orchard Mail Order – Up to 180 Days Pharmacy Benefits (an affiliate of EnvisionRx Options)** – Order your long-term maintenance medications and have them delivered right to your door. Note: In order to receive more than a 90-day supply (91-180 days) the Plan requires an initial 30-day prescription be filled. Mail Order is an excellent way to receive prescriptions you will be taking for a long time with fewer worries about availability at the local retail pharmacy. Mail order services offer the convenience of home delivery or to another specified address. In order to use this program, please refer to page 40.

4. **Specialty Pharmacy Program** – EnvisionRx Options retains Costco Specialty Pharmacy Programs in order to provide convenient, dependable access to medications for people living with complex health conditions. The programs and services focus on injectables and medication therapies involving strict compliance requirements, special storage/handling/delivery, complex administration methods, and education/monitoring/ongoing support. Drugs that fall under this program can only be dispensed at a Costco retail pharmacy, some retail pharmacies or via a home delivery method through the mail order program. These drugs are limited to a 30-day supply regardless if dispensed at a retail pharmacy or at a mail service pharmacy. Retail copays will also apply at retail/mail.

Your Cost: Retail, Mail-Order and Specialty Pharmacy

When your covered prescriptions are filled under these pharmacy programs, you will share a portion of the cost; the Plan pays the rest. If the cost of the drug is less than the Copayments, OR if the Copayment plus the difference in cost between the Brand-name and Generic drug is less than the actual cost of the Brand-name drug, you will only be responsible for the actual cost of the drug. Your costs for the prescription program are summarized on the following page.

Exception: Preventive Services coverage for Prescription Drugs noted by an asterisk on Insert III, in the back of this Plan Booklet, are covered at 100% with no Copayment provided a physician writes a prescription, even if they can be bought over the counter. The physician's prescription and the receipt must be submitted with the Over the Counter (OTC) Preventive Prescription Drug at an EnvisionRx Options pharmacy in order to be covered by the Plan and to receive reimbursement.

PRESCRIPTION DRUG SCHEDULE OF BENEFITS
PLAN OPTIONS A AND PLAN B

	EnvisionRx Options 30-Day Retail Pharmacy	EnvisionRx Options Maintenance Retail[1]	Orchard Mail Order (North Canton, Ohio)	Costco Specialty Pharmacy Program[2]
Prescription Plan				
Days Supply Allowed	1 to 30 days	Up to 90 days	Up to 180 days	1 to 30 days[2]
Generic Drug Co-Pay	$10 copay	$10 copay	$10 copay	$10 copay
Brand Drug Copay with No Generic Drug Equivalent	$35 copay	$35 copay	$35 copay	$35 copay
Brand Drug Copay with Generic Drug Equivalent	$35 copay plus difference in cost between Generic and Brand UNLESS the Physician writes "DAW" (Dispense as Written).			

IMPORTANT NOTES:

A. **Quantity Limitations: Certain Prescribed Medications are Subject to the Quantity Limit Program**

(For a list of medications with quantity limitation, please contact EnvisionRx Options at (800) 361-4582.) Quantity limits for certain medications will automatically be enforced at the pharmacy level. There is nothing for you to do if your prescription(s) are for quantities **less** than the amount for fill period, and prior authorization is **not** required in order to receive your prescription. However, if your prescription(s) are for quantifies **more** than the approved quantities for a fill period, prior authorization from your physician will be required.

What Should I Do if I am Taking One of the Listed Medications which Exceeds the Quantity Limit?

The Plan recognizes that there may be reasons where quantities exceeding those listed may be required in order to treat certain medical conditions. If you are taking a medication that exceeds the quantity limit of the Plan, you may begin the prior authorization process by contacting the EnvisionRxOptions Helpdesk at (800) 361-4542.

B. **Step Therapy: Certain Prescribed Medications are Subject to Step Therapy Provisions**

Prescription Drugs for stomach-related conditions (Proton Pump Inhibitors) and allergy (non-sedating antihistamine) are subject to the Step Therapy provisions outlined on page 41.

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[1] Your Doctor must prescribe the days supply of medication noted in order to receive quantities and copayments noted. Some medications may not be available in 90-day/180-day supplies under applicable law.

[2] See Specialty Pharmacy Program parameters under the Costco Specialty Pharmacy Programs section of this Plan Booklet on page 41.

C. **Clinical Prior Authorization (CPA)**

Certain prescriptions require "clinical prior authorization" before they will be covered. The categories/medications that require clinical prior authorization include, but are not limited to:

1. Proton Pump Inhibitors

2. Non-Sedating Antihistamines

3. Topical Acne over age 24

4. ADHD/Narcolepsy medications over age 19

5. Butorphanol exceeding 2 bottles/25 days

6. Impotency medications, Clinical Prior Authorization on first fill. If approved, maximum quantity of 6 tablets per 30 day fill is allowed

7. Oral/Topical/Intravaginal, and injectable Contraceptives, Clinical Prior Authorization required for *Dependents only*. Only approved if Medically Necessary

8. Obesity medications

9. Narcotic Pain Medication: Actiq®, Fentora® and generic fentanyl oral transmucosal tablets will require a prior authorization while Duragesic®/fentanyl and OxyContin®/oxycodone ER/CR will require prior authorization when the usual quantity limits are exceeded.

D. **Prescription Drug Adherence Program for participants with chronic disease.**

1. Drug Therapy Management (DTM) and Medication Therapy Management (MTM) programs:

   a. The goals of the DTM/MTM program are to identify and enroll at risk patients in order to achieve appropriate therapeutic outcome goals for targeted patients through improved medication use and to reduce the incidence of adverse medication events. These goals are achieved through services which are designed to: (1) enhance patient understanding of individual disease states and steps they can take towards better management of such conditions; (2) increase adherence to prescribed medication courses, and (3) detect adverse drug events and patterns of over- and under- utilization.

   b. DTM/MTM program services are designed with specific patient populations in mind. These services are intended to:

      i. Improve disease awareness, symptom recognition, and diagnosis and treatment through patient education and referral to disease management programs and through provider notification,

      ii. Mitigate or eliminate symptoms, minimize health-related problems, and prevent disease occurrences; and

      iii. Track and document outcomes through monitoring of drug utilization and patient interaction.

To request approval for Step Therapy, Clinical Prior Authorization, and for the Prescription Drug Adherence programs, the pharmacy, your Physician or participant must call EnvisionRx Options at (800) 361-4542. Have available the name of your medication, Physician's name, phone (and fax number, if available), and your Plan ID number.

FILLING PRESCRIPTIONS AT A RETAIL PHARMACY

For a complete list of participating pharmacies, please visit www.envisionrx.com or call (800) 361-4542. You may also call EnvisionRx Options Customer Service Help Desk at (800) 361-4542 with questions regarding refills.

Refill Prescriptions at Retail Pharmacy

1. If you have a current prescription(s) with valid refills, you will not need to obtain a new prescription(s).

2. Present your Health Plan ID card to the pharmacist at the time the prescription(s) is filled to ensure that your prescription insurance information is updated to process through EnvisionRx Options.

3. The pharmacist will process and fill the prescription(s), send it to EnvisionRx Options, and collect the appropriate Copayments from you.

New Prescriptions at Retail Pharmacy

1. Present your new prescription(s) and Health Plan ID card to the pharmacist. The pharmacist will process and fill the prescription(s), send it to EnvisionRx Options, and collect the appropriate Copayments from you.

2. The **Retail Maintenance** program will require a new prescription for each prescription (up to a 90-day quantity) at retail pharmacies. Be sure to ask your Doctor to write your prescription for the correct quantity (90-day maximum) if it is a maintenance drug.

FILLING PRESCRIPTIONS THROUGH THE MAIL SERVICE PHARMACY **(provided through Orchard Pharmaceutical Services an EnvisionRx Options affiliate.)**

Through the Mail Order Prescription Drug Program, you can take advantage of convenient delivery of your covered maintenance medications to your home or other specified address. Orchard Pharmaceutical Services Brochures are available by going online at www.orchardrx.com, requesting an Orchard Pharmaceutical Customer Services Representative to mail you one or through the District's Benefits Department.

You will need to obtain NEW 90 day supply prescriptions from your physician. Mail the original prescription(s) written for a 90 - 180 day supply of your medication (plus refills, if applicable) with the mail order brochure, along with your first payment or payment information. **Note: Prescriptions for a 91-180 day supply requires initial 30-day prescription before 91-180 day supply will be allowed.**

Ways to Register for Orchard Pharmaceutical Services Program Mail Service:

Fill out a new Orchard Pharmaceutical Mail Order registration form. Before you mail in a new prescription, you must REGISTER your information with Orchard Mail Order Pharmacy. You may use any of the following three easy registration options:

1. **Online: (Recommended method)** Visit www.orchardrx.com and select ***Not registered? Click to Register.*** Your account will activate within 24 hours. By registering online, members and can also track the progress of their orders.

2. **Phone:** Call Orchard Pharmaceutical Services Customer Service at (866) 909-5170 to speak with a representative.

3. **Mail: Complete the Registration and Prescription Order Form and mail it to Orchard Pharmaceutical Services.**

Once registered, your Physician can fax your prescription(s) to Orchard at (866) 909-5171. Only faxes sent from a physician's office will be valid.

SPECIALTY PHARMACY PROGRAM – EnvisionRx Options uses Costco Specialty Pharmacy Program as your preferred provider for specialty medications.

What this means is that you and your family will receive the personalized care and expertise of Costco Specialty Pharmacy's dedicated pharmacies, which is essential to successful therapy. This is because Costco Specialty Pharmacy goes beyond traditional retail pharmacy, helping you get the most from your specialty medication therapy.

Because specialty medications can be more difficult to manage, Costco Specialty Pharmacy offers the following patient support services at no charge:

1. Personalized support to help you achieve the best results from your prescribed therapy

2. Convenient delivery to your home or prescriber's office

3. Easy access to a Care Team who can answer medication questions, provide educational materials about your condition, help you manage any potential medication side effects, and provide confidential support – all with one toll-free phone call

4. Assistance with your specialty medication refills

As a convenience, you can choose to receive your first specialty prescription through the mail or pick it up at retail Costco location. After that first fill you will be required to use Costco Specialty Pharmacy for all of your specialty medication needs. If you have any questions, or to begin taking advantage of these complimentary patient support services, please call Costco Specialty Pharmacy toll free at (866) 443-0060.

HOW YOU CAN MINIMIZE OUT-OF-POCKET COSTS?

Make sure you ask your Doctor and Pharmacist to dispense a Generic equivalent drug if one is available. If you are unsure if you have been prescribed a Brand-Name Drug, ask your Pharmacist. You can request that your Pharmacist substitutes a Brand-Name Drug with a Generic equivalent at any time unless it is Medically Necessary and your Physician has specified "DAW" (Dispense as Written).

Step Therapy for Over the Counter "OTC" Drugs

There are more and more drugs that can now be purchased OTC that previously required a Physician's written prescription. Two such drugs that now have OTC equivalents are:

Prilosec OTC or Omeprazole (Generic Name)	Also known as Proton Pump Inhibitors (PPI): treats stomach-related conditions, including heartburn. (Brand-Name Prescription Drugs include: Aciphex, Nexium, Prevacid, or Protonix.)
Claritin OTC or Loratadine (Generic Name)	Non-Sedating Antihistamine: treats allergy symptoms. (Brand-Name Prescription Drugs include: Allegra, Allegra-D, Clarinex, Clarinex-D, Clarinex RediTab, Zyrtec and Zyrtec- D.)

With certain exceptions, **the Plan will require:** Step Therapy for Brand-Name Prescription Drugs prescribed for Proton Pump Inhibitors and Non-Sedating Antihistamines in order to be covered by the Plan and to promote proper utilization of these medications.

How Do I Receive "OTC" Step Therapy?
Your Physician should discuss Step Therapy with EnvisionRx Options Help Desk at (800) 361-4542. Generally, Step Therapy requires that the patient try one of the OTC/Generic drugs listed above *before* a Brand-Name Prescription Drug will be authorized. Note: There are certain medical conditions where the patient will not have to obtain Step Therapy in order to receive medication. EnvisionRx Options will discuss these exceptions with you and your Physician during the authorization process.

In order for the Plan to cover any of the Brand-Name Prescription Drugs noted above, you or your Physician must receive PRIOR authorization/approval from EnvisionRx Options by calling the Help Desk to begin the prior authorization process:

EnvisionRx Options	7 days per week
(800) 361-4542	24 hours per day

Make sure you (or your Physician) have available: the name of your medication, the Physician's name and phone number (and fax number, if possible), and your member ID number..

Step Therapy For Brand Sleep Agents, Cholesterol/Statins, Antidepressants, and Biphosphonates

How Do I Receive Step Therapy for the Above Medications?
In step therapy, medications are grouped into categories.

- 1st Step – First Line medications: mostly generic medications proven safe, effective, and affordable. These medications should be tried first.

- 2nd Step – Second Line medications: mostly higher brand name medications

Step therapy is a process to ensure you are receiving a cost effective therapy. Under this program, you will be required to first try a recognized First Line medication (Step 1) before approval of a more costly and complex therapy is approved (Step 2). If the Step 1 therapy does not provide you with the therapeutic benefit desired, your physician may write a prescription for a Second Line medication. Generally, Second Line medications require the usage and failure of a First Line medication before coverage is authorized. The step therapy approach to care is a way to provide you with savings without compromising your quality of care.

What Medications have Step Therapy?
The following medications are subject to Step Therapy:

REQUIRED STEP THERAPY REGIMENS

If you've been prescribed Second Line Medication/Class	**Criteria for Coverage and First Line Medications**
Branded Sleep Agents **Ambien** **Lunesta** **Sonata** **Edular** **Zolpimist**	*Must have tried and failed a generic agent prior to use of branded agent* *First Line Generic Medications:* Zaleplon Zolpidem
Cholesterol/Statin **Crestor** **Lipitor** **Lescol** **Vytorin** **Altoprev**	*Must have tried and failed statin therapy prior to use of branded agent.* *First Line Generic Medications:* Pravastatin Simvastatin Lovastatin
Antidepressants **Lexapro** **Pristiq** **Cymbalta** **Effexor**	*Must have tried and failed a generic product prior to coverage of a branded Antidepressant.* *First Line Generic Medications:* Nortriptyline Bupropion Paroxetine Amitriptyline Sertraline Citalopram Trazodne Fluoxetine Venlafaxine
Bisphosponates **Boniva/Actonel**	Must have tried and failed Alendronate prior to coverage of branded Boniva or Actonel. *First Line Generic Medications:* Alendronate

Note: The above medications requiring Step Therapy will be updated from time to time. You will be advised of future changes prior to the required implementation date.

What Should I do if I Take a Medication that is Part of the Step Therapy Program?
It's easy – if your physician writes a new prescription for a medication that is part of the Step Therapy Program, he/she will need to write you a prescription for a First Line medication. You may request that your pharmacist call the doctor for you and ask him to change to a First Line medication; or have your physician submit a prior authorization request for your current prescription before you can continue to receive coverage for the medication. A prior authorization is a request to the physician to document why you cannot take a First Line medication and must use a Second Line medication. You or your physician can begin the prior authorization process by contacting the EnvisionRx Options Help desk at (800) 361-4542.

IMPORTANT: Always talk to your doctor before discontinuing or changing any medication. As your pharmacist or doctor about First Line mMedications and discuss the Step Therapy medications on your benefit plan.

Remember:

1. Ask your Doctor to write a prescription for one of the over the counter or generic medications listed above, and you will only be charged a $10 Copayment.

2. If you use a Brand-name drug and have received a Clinical Prior Authorization from EnvisionRx Options, your Copay will be $35 and the Plan will cover the remaining cost.

3. If you use a Brand-name Drug and DO NOT receive EnvisionRx Options Clinical Prior Authorization, you will be responsible for the full cost of the drug and the Plan will NOT cover any portion of it.

GLUCOMETER REPLACEMENT PROGRAM

EnvisionRx Options has a program available to members that allows them to receive a free glucometer. Call (866) 224-8892 for an Abbott Diabetes Care Glucometer (FreeStyle and the Precision Xtra® Blood Glucose & Katona Monitoring System) or (877-229-3777 for a Bayer Healthcare, Diabetes Care Glucometer (Ascensia® CONTOUR® and Ascensia BREEZE). **Please identify EnvisionRx Options as your pharmacy benefit administrator** and Abbott or Bayer will take care of the rest. There is a limit of one glucometer per member.

ASSISTANCE OR APPEALS

If you need assistance, please call our EnvisionRx Options Customer Service Help Desk at (800) 361-4542. Please refer to page 86 of this Plan Booklet for instructions on how to file a grievance with your Plan or appeal a coverage determination.

VISION PLAN BENEFITS
FOR PLAN OPTIONS A AND B
(Kaiser Permanente Plan Participants Must Use Kaiser Permanente Plan Facilities; Benefits Outlined in Evidence of Coverage Brochure)

The Plan offers two separate Vision Plans. One through VSP and the other through Safeguard. The summary of benefits is listed below. Once you have enrolled in a vision plan, you and all of your enrolled Dependents[1] must remain in that Vision Plan until the next Open Enrollment. If you require further clarification of vision benefits, contact VSP at (800) 877-7195 (or visit www.vsp.com), or Safeguard at (800) 880-1800 (or visit www.safeguard.net).

BENEFIT	VISION SERVICE PLAN	SAFEGUARD
Examinations	Once each 12 months	Once each 12 months
Spectacle Lenses	One each 12 months if prescription has changed	One each 12 months if prescription has changed
Frames	Once each 24 months	Once each 24 months
Medically Necessary Contacts (in lieu of other benefits)	Once each 12 months	Once each 24 months
Elective Contacts (in lieu of other benefits)	Once each 12 months	Once each 24 months
Sunglasses	Paid accordingly in lieu of regular glasses	Paid accordingly in lieu of regular glasses
Copayment	$5 total copay, plus any amount over allowance or for cosmetic options. Medically necessary contacts are covered in full, less the copay. Cosmetic contacts are covered up to $105.	$5 exam plus any amount over allowance or for cosmetic options. Medically necessary contacts are covered in full, less the co-pay. Cosmetic contacts are covered up to $50 exam and $100 materials.
How to Obtain Services (Contracted providers only)	(800) 877-7195. The participating Doctor will obtain authorization.	(800) 880-1800. The participating Doctor will obtain authorization.
Frame Allowance	Frames of your choice every 24 months covered up to $115 plus 20% of any out-of-pocket over $115	$35 Maximum Wholesale Allowance If you wish to purchase a frame not fully covered by the plan, you will be responsible for the difference between the allowance and the wholesale cost of the more expensive frame, plus an additional service fee.
Non-Medically Necessary Contact Lens Allowance	$105 Allowance: The allowance applies to the cost of your contacts and the contact lens exam (fitting and evaluations). Contacts are available in lieu of frames and lenses.	$120 Maximum Retail Allowance The above coverage applies to prescriptions for contact lenses that are not Medically Necessary. (Contact lenses are offered in lieu of frames and lenses.)

[1] The cost to add Dependents for Vision benefits may vary. Contact the District's Benefit Department for further explanation of benefits and costs.

BENEFIT	VISION SERVICE PLAN	SAFEGUARD
Medically Necessary Contact Lens Allowance	Covered in full.	$250 Maximum Allowance Participating Providers have agreed to limit their charges to a reduced amount that is 80% of their usual charge. The allowance applies to all costs associated with obtaining contact lenses. You are responsible for any charges in excess of the allowance plus any applicable Copayments. (Contact lenses are offered in lieu of frames and lenses.)

VSP LIMITATIONS AND EXCLUSIONS
This Plan is designed to cover your visual needs rather than cosmetic eyewear. You are responsible for additional costs if you choose extras, including:

1. Blended or oversized lenses;

2. Progressive multifocal lenses;

3. Photochromic or tinted lenses other than Pink 1 or 2;

4. Coated, laminated or UV protected lenses;

5. Cosmetic lenses or processes unless specifically covered on page 44; and

6. A frame that exceeds your allowance.

You are not covered for the following services or eyewear:

1. Orthoptics or vision training and supplemental training;

2. Plano lenses (non-prescription);

3. Two pairs of glasses instead of bifocals;

4. Replacement of lost or broken glasses, except at the normal intervals when services are otherwise available;

5. Medical or surgical treatment of the eyes; and

6. Corrective vision services, treatments and eyewear of an Experimental nature.

SAFEGUARD LIMITATIONS AND EXCLUSIONS
No benefits are payable under this Plan for any expenses incurred for:

1. Any procedures not specifically listed as a covered benefit in the Schedule of Benefits.

2. Services and supplies provided by a provider who is not a Participating Vision Provider, except as specifically described in the section entitled “Emergency Vision Care” in the Evidence of Coverage.

3. Charges for services and materials that the Participating Vision Provider determines to be (1) not Medically Necessary, (2) beyond the maximum material allowance for frames and contact lenses indicated in the Schedule of Benefits, or (3) non-basic, are excluded.

4. Hospital and medical charges of any kind, medical transportation, vision services rendered in a Hospital, prescriptions or medications, and medical or surgical treatment of the eyes are excluded.

5. Prescriptions from non-Participating Vision Providers.

6. Replacement due to loss, theft or destruction is excluded, except when replacement is at the regular time intervals of coverage under the vision plan.

7. Orthoptics and vision training and any associated testing, subnormal vision aids, plano (non-prescription) lenses are excluded.

8. A second pair of glasses in lieu of bifocals.

9. Services that cannot be performed because of the general health, physical, emotional, mental or behavioral limitations of the patient.

10. Services and supplies considered Experimental in nature.

11. Services and supplies rendered by a person who resides in the Member's home, or by an immediate relative of the Member.

12. Services or supplies provided for or paid by a federal or state government agency or authority, political subdivision, or other public program.

13. Any expenses paid by any Workers' Compensation law or act, Employers' Liability law or by any governmental program, law or agency, except for Medicare or Medicaid.

14. Any services or materials as a condition of employment (e.g., safety glasses).

15. Charges associated with copying or transferring vision records.

DENTAL PLANS
ALL PLAN OPTIONS A, B, OR C

The Plan offers two separate Dental Plans for active Employees working four (4) or more hours per day and to self-paid Retirees. Retirees must elect Dental coverage at retirement and may not enroll at a later date if dental coverage is initially declined. Dependents of Actives and Retirees are eligible to participate provided the Employee or Retiree contributes 100% of the appropriate Dependent premiums. Contact the District's Benefit Department for Dependent premium information.

An active Employee may enroll himself or herself and/or the Employee's Eligible Dependents in either Dental Plan during the 31 days immediately following original eligibility. Once you choose your plan, you will not be allowed to change dental plans until the next Open Enrollment Period unless you have a Special Enrollment event. There is an Open Enrollment Period each year for a 60 day period beginning on October 1st for any changeover date effective January 1.

The Dental Plan selected by the Employee or Retiree also applies to his or her eligible Dependents.

The two Dental programs provided by the Plan are:

Delta Dental PPO Plan
Pacific Union Dental

A description of these programs can be found on pages 49 to 54 for Delta Dental and pages 54 through 57 for Pacific Union Dental.

DELTA DENTAL PPO PLAN BENEFITS
Effective January 1, 2012

THESE RULES APPLY SOLELY TO PARTICIPANTS WHO ARE ENROLLED IN THE DELTA DENTAL PPO PLAN. If You Are Enrolled with Pacific Union Dental, please see page 54 to 57.

Delta Dental PPO benefits are provided to Active Employees, self-paid Retirees, and Dependents as specified on page 65. This program covers several categories of benefits when the services are provided by a licensed Dentist and are necessary and customary under the generally accepted standards of dental practice.

Delta Dental will pay Delta Dental PPO dentists 100% of the Covered Fees for the Diagnostic, Preventive, Basic, Crown and Restorative Benefits and 50% of Prosthodontic covered fees up to a maximum benefit of $2,000 per calendar year per Covered person.

Dental Accident Benefit of $1,000 is also provided at 100% per Calendar year.

How Do I Know if My Dentist is a Delta Dental PPO Dentist?
Your current dentist may be a Delta Dental PPO dentist. If so, you won't need to change dentists to enjoy additional savings through reduced PPO fees. We recommend that you verify your current dentist's participation in the Delta Dental PPO network. Simply asking if a dentist "accepts Delta Dental" **does not** guarantee he or she is a PPO dentist. Make sure you specifically ask if he or she is a **contracted Delta Dental PPO dentist**. We also recommend that you verify your dentist's participation before each dental appointment. For the most current list of Delta Dental PPO and Premier dentists, visit Delta Dental's website at deltadentalins.com, or call (800) 756-6003.

Non-PPO Dentists (all other dentists who are not Delta Dental dentists) are paid at 50% of Covered Fees and have a $1,000 maximum benefit per calendar year per Covered person.

DELTA DENTAL SCHEDULE OF PPO BENEFITS

BENEFIT	PPO Dentist	Non-PPO Dentist
Preventive and Diagnostic Procedures (exam, x-rays and prophylaxis – teeth cleaning)	100%	50%
Basic Procedures (fillings, single crowns & oral surgery)	100%	50%
Major Procedures (bridges, partials & dentures)	50%	50%
Orthodontics	Not covered	Not covered
Yearly Maximum per Member	$2,000	$1,000
Accident Benefit	$1,000	$1,000

PREDETERMINATIONS
After an examination, your dentist will talk to you about treatment you may need. The cost of the treatment is something you may want to consider. If the service is extensive and involves crowns or bridges, or if the service will cost more than $300, we encourage you to ask your dentist to request a predetermination.

A predetermination does not guarantee payment. It is an estimate of the amount Delta Dental will pay if you are eligible and meet all the requirements of your plan at the time the treatment you have planned is completed.

In order to receive predetermination, your dentist must send a claim form listing the proposed treatment. Delta Dental will send your dentist a notice of predetermination which estimates how much you will have to pay. After you review the estimate with your dentist and decide to go ahead with the treatment plan, your dentist returns the form to Delta Dental for payment when treatment has been completed.

Computations are estimates only and are based on what would be payable on the date the Notice of predetermination is issued if the individual is eligible. Payment will depend on the individual's eligibility and the remaining annual Maximum when completed services are submitted to Delta Dental.

Predetermining treatment helps prevent any misunderstanding about your financial responsibilities. If you have any concerns about the predetermination, let us know before treatment begins so your questions can be answered before you incur any charges.

DELTA DENTAL PPO PLAN BENEFITS

THESE RULES APPLY SOLELY TO PARTICIPANTS WHO ARE ENROLLED IN THE DELTA DENTAL PPO PLAN. If You Are Enrolled in Pacific Union Dental, please refer to pages 54 to 57, or call (800) 999-3367 for a complete Summary of your Benefits.

COVERED SERVICES

The Plan's dental benefits cover the following services when a licensed Dentist provides them and when necessary and customary as determined by the standards of generally accepted dental practice. The Plan covers only the cost of the Dentist's services as specified on page 49. In addition, please also refer to "Service Limitations" and "Exclusions" on pages 51 and 53. You and your Dependents will receive maximum Plan benefits by using a Delta Dental PPO Dentist.

PREVENTIVE AND BASIC PROCEDURES

Diagnostic — Procedures to assist the Dentist in determining required dental treatment (examinations, x-rays, diagnostic costs, palliative emergency treatment, specialist consultation).

Preventive — Prophylaxis (cleaning), not more often than twice in any Calendar Year; fluoride treatment; space maintainers; sealants for Dependent children up to age 14.

Oral Surgery — Extractions and certain other surgical procedures, including pre- and post-operative care.

General Anesthesia — When administered by a Dentist for a covered oral surgery procedure.

Restorative — Treatment of tooth decay or fracture by use of silver or plastic restoration. Cast restorations and crowns will be provided only when silver or plastic restorations will not suffice.

Endodontic — Treatment of the tooth pulp.

Periodontic — Treatment of gums and bones and supporting teeth.

MAJOR PROCEDURES

PROSTHODONTIC SERVICES

Procedures for construction or repair of fixed bridges, partial or complete dentures are payable at 50%.

DENTAL ACCIDENT BENEFITS

Covered Basic and Prosthodontic services are those rendered within 180 days following the date of an accident for conditions caused, directly and independently of all other causes, by external, violent and accidental means. Services rendered more than 180 days after the date of the accident or otherwise outside of the Dental Accident Benefit coverage may be provided as Basic or Prosthodontic benefits, subject to all of the conditions, limitations and exclusions applicable thereto. The dental accident benefit shall pay 100% of covered services, not to exceed $1,000.

COVERED FEES
The term "Covered Fees" means only expenses incurred for necessary treatment received by the eligible Employee, Retiree, and his/her Dependent from a Dentist, which, in the geographical area where treatment is rendered, is the usual and customary procedure for the condition being treated. However, the amount considered as Covered Fees, will not exceed the fees and prices regularly and customarily charged for the treatment generally furnished for cases of comparable nature and severity in such geographical area.

EXTENSION OF BENEFITS
If within 60 days after the Employee, self-paid Retiree or Dependent ceases to be covered under the Plan, a covered expense is incurred for services or supplies furnished in connection with a dental procedure which began prior to the date the coverage ceased, benefits will be payable for such expense, provided that the services or supplies are still covered by the Plan on the date such expense occurred.

SERVICE LIMITATIONS
Dental benefits are subject to the following limitations:

1. An oral examination twice in a Calendar Year.

2. Full-mouth x-rays once in a three-year period.

3. Bitewing x-rays are provided on request by the Dentist, but no more than twice in any Calendar Year.

4. Only the first two cleanings, fluoride treatments, or single procedures which include cleaning, or combination thereof, in a Calendar Year.

5. Sealant is limited to eligible Dependent children under age 14. Sealant benefits include the application of sealants only to permanent posterior molars without caries (decay), without restorations and with the occlusal surface intact. Sealant Benefits do not include the repair or replacement of a sealant on a tooth within three years of its application.

6. Crowns, Inlays, Onlays and Cast Restorations on the same tooth only once every five years, unless Delta Dental determines that replacement is required because the restoration is unsatisfactory as a result of poor quality of care, or because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues since the restoration.

7. Prosthodontic appliances only once every five years, while eligible under any Delta Dental Plan, unless Delta Dental determines that there has been such an extensive loss of remaining teeth or a change in supporting tissues that the existing appliance cannot be made satisfactory. Replacement of a prosthodontic appliance not provided under a Delta plan will be made if it is unsatisfactory and cannot be made satisfactory.

8. Delta Dental will pay the applicable percentage of the Dentist's fee for a standard partial or complete denture. A standard partial or complete denture is defined as a removable prosthetic appliance provided to replace missing natural, permanent teeth, which is made from accepted materials and by conventional methods.

9. Implants (appliances inserted into bone or soft tissue in the jaw, usually to anchor a denture) are not covered by your plan. However, if implants are provided along with a covered prosthodontic appliance, Delta Dental will allow the cost of a standard partial or complete denture toward the cost of the implants and the prosthodontic appliances when the prosthetic appliance is completed. If Delta Dental makes such an allowance, Delta Dental will not pay for any replacement for five years following the completion of the service.

10. If you select a more expensive plan of treatment than is customarily provided or specialized techniques, an allowance will be made for the least expensive, professionally acceptable, alternative treatment plan. Delta Dental will pay the applicable percentage of the lesser fee for the customary or standard treatment and you are responsible for the remainder of the Dentist's fee.

    For example: a crown where an amalgam filling would restore the tooth; or a precision denture where a standard denture would suffice.

11. Delta Dental will pay Dental Accident Benefits when services are provided within 180 days following the date of accident and shall not include any services for conditions caused by an accident occurring before your eligibility date.

DELTA DENTAL PPO PLAN EXCLUSIONS

THESE RULES APPLY SOLELY TO PARTICIPANTS WHO ARE ENROLLED IN DELTA DENTAL PPO PLAN.

If You Are Enrolled in Pacific Union Dental, please refer to pages 54 to 57, or at (800) 999-3367 for a complete Summary of your Benefits.

Delta Dental benefits are subject to the following exclusions:

1. Services for injuries covered by Workers' Compensation or Employer's Liability Laws.

2. Services which are provided to the Enrollee by any Federal or State Governmental Agency or are provided without costs to the Enrollee by any municipality, county or other political subdivision, except Medi-Cal benefits.

3. Services for cosmetic purposes for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel.

4. Services for restoring tooth structure lost from wear (abrasion, erosion, attrition, or abfraction), for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Examples of such treatment are equilibration and periodontal splinting.

5. Any procedure, bridge, denture or other prosthodontic service which was started before the Enrollee was covered by this plan.

6. Prescribed drugs, or applied therapeutic drugs, premedication or analgesia.

7. Experimental procedures.

8. Charges by any Hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.

9. Anesthesia, except for general anesthesia given by a Dentist for covered oral surgery procedures.

10. Grafting tissues from outside the mouth to tissues inside the mouth ("extraoral grafts").

11. Implants (materials implanted into or on bone or soft tissue) or the repair or removal of implants, except as provided under LIMITATIONS.

12. Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joints or associated muscles, nerves or tissues (TMJ).

13. Replacement of existing restoration for any purpose other than active tooth decay.

14. Intravenous sedation, occlusal guards and complete occlusal adjustment.

15. Orthodontic services (treatment of mal-alignment of teeth and/or jaws).

PACIFIC UNION DENTAL (PUD) DENTAL PLAN

THESE RULES APPLY SOLELY TO PARTICIPANTS WHO ARE ENROLLED IN THE PACIFIC UNION DENTAL (PUD) PLAN.

If You Are Enrolled in the Delta Dental PPO Plan, please refer to pages 49 to 53, or call (888) 335-8227 for a complete Summary of your Benefits.

Pacific Union Dental (PUD) Plan benefits are provided to active Employees, self-paid Retirees, and Dependents as specified on page 64.

Under the Pacific Union Dental Plan, dental services are provided through a network of Participating Dental Offices. When you enroll, you select the Participating Dental Office most convenient for you. You and your Dependents will receive dental services only at that office, except in the case of Emergency.

For as long as you are enrolled in the Pacific Union Dental Plan, the plan will pay the Participating Dental Office a monthly amount on your behalf. The monthly rate entitles you to all the benefits under the plan. **Once you choose this plan, you will not be allowed to change dental plans until the next Open Enrollment Period**.

There are No Claim Forms, No Deductibles, and No Maximums (other than those noted under Limitations and Exclusions). Some dental services are provided to you on a "Co-Pay," (share the cost) basis. You arrange payment of the Copayment (your portion of the charge), directly with your Participating Dental Office.

ORTHODONTIC BENEFITS

In addition, the Pacific Union Dental Plan offers a discounted orthodontic benefit (Phase II as defined by the plan) with a standard 24 month full banded service for a Copayment from you of $1,500, approximately 40% of Usual, Customary and Reasonable Charges plus an additional charge of no more than:

$350.00 for start-up fees
$150.00 for one set of retainers (with retention limited to 12 consecutive months, if necessary)

Participant's payment schedule shall be as follows unless otherwise agreed upon between the Participant and the orthodontist:

$500.00 at the inception of care (the placement of bands)
$100.00 per month for 10 months

If you are covered under Pacific Union Dental Plan and are currently undergoing orthodontic treatment (e.g. banding, etc.), you will not be eligible for the orthodontic benefit if you decide to switch to the Delta Dental Plan.

Due to the capitated nature of the Pacific Union Dental Plan, there is no coordination of benefits.

PACIFIC UNION DENTAL PLAN LIMITATIONS
Set forth below are the limitations that are applicable to the plan.

1. Prophylaxis is limited to one treatment each six month period (includes periodontal maintenance following active therapy);

2. Crowns, bridges and dentures (including immediate dentures) are not to be replaced within a five-year period from initial placement;

3. Partial dentures are not to be replaced within a five year period from initial placement, unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible;

4. Denture relines are limited to one per denture during any 12 consecutive months;

5. Replacement will be provided for an existing denture, partial denture or bridge only if it is unsatisfactory and cannot be made satisfactory by reline or repair;

6. Treatment for conditions is generally limited to conventional techniques and does not include splinting, hemisection implants, overdentures, grafting, precision attachments, duplicate dentures and bruxating appliances;

7. The plan allows up to five units of crown or bridgework per arch. Upon the sixth unit, the Plan considers the treatment to be full mouth reconstruction. The patient is responsible for fees incurred for anything beyond the fifth unit;

8. Periodontal treatments (root planning/subgingival curettage) are limited to four quadrants during any 12 consecutive months;

9. Full mouth debridement (gross scale) is limited to one treatment in any 24 consecutive month period;

10. Bitewing x-rays are limited to four quadrants during any 12 consecutive months;

11. Full mouth x-rays and/or panographic type films are limited to one set every 24 consecutive months. A full mouth x-ray is defined as a minimum of 6 periapical films plus bitewing x-rays;

12. Sealant benefits include the application of sealants only to permanent first and second molars with no decay, with no restorations and with the occlusal surface intact, for the first molars up to age nine and second molars and bicuspids up to age fourteen. Sealant benefits do not include the repair or replacement of a sealant on any tooth within three years of its application;

13. Single unit cast metal and/or ceramic restorations and crowns are covered only when the tooth cannot be adequately restored with other restorative materials. Crown build-ups including pins are only allowable as separate procedures in the exceptional instance where extensive tooth structure is lost and the need for a substructure can be demonstrated by written report and x-rays;

14. Cosmetic dental care is limited to composite restorations on posterior teeth distal to canines when a Pacific Union Dental Plan Dentist determines treatment to be appropriate dental care. Composite restorations will be covered on premolar facial surfaces.

PACIFIC UNION DENTAL PLAN EXCLUSIONS
The following dental procedures and services are not included under the plan:

1. General anesthesia and the services of a special anesthesiologist, intravenous and inhalation sedation and prescription drugs;

2. Dental conditions arising out of and due to enrollee's employment or for which Worker's Compensation is payable. Services that are provided to the enrollee by state government or agency thereof, or are provided without cost to the enrollee by any municipality, county or other subdivision, except as provided in Section 1373 (a) of the California Health and Safety Code;

3. Treatment required by reason of war;

4. Dental services performed in a Hospital and related Hospital fees;

5. Treatment of fractures and dislocations;

6. Loss or theft of fixed and removable prosthetics (crowns, bridges, full or partial dentures);

7. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage; and dental expenses incurred for treatment in progress prior to Member's eligibility with the Plan (e.g., teeth prepared for crowns, root canals in progress, fixed and removable prosthetics);

8. Any service that is not specifically listed as a covered expense;

9. Procedures, appliances or restorations to correct congenitally and/or developmentally missing teeth or other congenital and/or developmental conditions, developmental malformations (including but not limited to cleft palate, enamel hypoplasia, fluorosis, jaw malformations, and odontia) and supernumerary teeth;

10. Treatment/removal of malignancies, cysts over 1.25 centimeters, tumors or neoplasms;

11. Dispensing of drugs not normally supplied in a dental office;

12. Treatment as a result of accidental Injury. Accidental Injury is defined as damage to the hard and soft tissues of the oral cavity resulting from external forces to the mouth.

13. Cases which in the professional opinion of the plan's attending Dentist determines that a satisfactory result cannot be obtained or where the prognosis is poor or guarded;

14. Dental services received from any dental office other than a Pacific Union Dental Plan's dental office, unless expressly authorized in writing by the Plan or as cited under "Out of Area Emergency Treatment";

15. Prophylactic removal of asymptomatic, nonpathological impacted teeth, extractions for orthodontic purposes; surgical orthognatic procedures and crown exposure with ligation;

16. Implant placement or removal, appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment;

17. Crown lengthening procedures;

18. Replacement of long standing missing tooth/teeth in an otherwise stable dentition;

19. Dental services and treatments for restoring tooth structure loss from wear, bruxism, attrition and/or erosion, changing or restoring vertical dimension, and full mouth reconstruction to enhance occlusion, diagnosis and/or treatment of the temporomandibular joint (TMJ);

20. Dental services that cannot be performed in a Pacific Union Dental Plan's general dental office because of physical, medical or behavioral limitations of eligible Dependents over the age of six years.

MEDICAL AND VISION BENEFIT LIMITATIONS UNDER PLAN OPTIONS A AND B, AND DENTAL BENEFIT LIMITATIONS UNDER ALL PLAN OPTIONS

GENERAL EXCLUSIONS AND LIMITATIONS APPLICABLE TO THE PLAN

Benefits are not payable for:

1. Any services rendered by a person related to the Covered Person by blood, marriage or law or any person who resides in the same house.

2. Any expenses covered under a Workers Compensation Act or similar legislation, or which is due to Injury or illness arising out of or in the course of any occupation or employment for wages or profit.

3. Services for care or treatment provided or furnished by any governmental agency of any country, unless the Covered Person is legally required to pay without regard to the existence of coverage. A government agency includes federal, state, or local governmental agencies, whatever they may be called, in any country.

4. Any service for which a charge would not have been made in the absence of coverage.

5. Any condition, disability, or expense resulting from or sustained as a result of being engaged in an illegal occupation, commission of or attempted commission of an illegal act charged as a felony including driving under the influence.

6. Any condition, disability, or expense resulting from or sustained as a result of being engaged in participation in a civil insurrection or a riot.

7. Any condition, disability, or expense resulting from or sustained as a result of being engaged in duty as a member of the Armed Forces of any state or country, or war or act of war whether declared or undeclared.

8. Any charges incurred prior to the effective date of coverage under the Plan or subsequent to the date of termination of coverage under the Plan.

9. Services, supplies, and treatment not prescribed by a legally qualified Physician or Surgeon; services, supplies, or treatment not Medically Necessary for treatment of an Injury or Sickness, including vitamins and dietary supplements.

10. Charges in excess of the Usual, Customary and Reasonable guidelines utilized by the Plan.

11. Charges that the Covered Person is not legally required to pay, or would not be required to pay in absence of the Plan.

12. Charges for the completion of claim forms, prescriptions (except as provided for under the Prescription Drug program described on pages 35 to 43), missed or broken appointments or finance charges.

13. Procedures that are considered Experimental or Investigational.

14. Services rendered outside the United States, which would not have been covered if provided in the United States.

15. Orthoptics and vision training (unless pre-authorization is obtained in writing through Anthem Blue Cross).

16. Charges incurred in connection with cosmetic surgery, except where:

    a. Accidental injuries occurred while covered, and only if performed while still covered and incurred within a period of 90 days subsequent to the date the Injury was sustained; or

    b. Reconstructive Surgery. Surgery performed to reshape abnormal structures of the body is covered when it is necessary to improve functional impairment. Examples include congenital defects, such as cleft-lip or palate, which impede functional ability.

    c. Reconstructive cosmetic surgery which does not improve a functional impairment is only covered when;

        (i) it is incident to a several stage treatment plan following a trauma for which Medically Necessary reconstructive surgery was necessary to improve functional impairment if the trauma occurred during the Participant's enrollment, or

        (ii) when it is necessary to restore and achieve symmetry for the Covered Person incident to a Medically Necessary mastectomy, or

        (iii) where it is necessary to repair a congenital defect which is disfiguring, requires surgery, and treatment would be likely to lead to substantial improvement of the defect.

17. Treatment of obesity for any Covered Person who is not morbidly obese.

18. Charges for surgical treatment of obesity except for the Medically Necessary treatment of **morbid obesity for Gastric Restrictive Procedure with Gastric Bypass with Roux-en-Y Gastroenterostomy**. To be eligible for this procedure, the patient must:

    a. Be more than 100 pounds over ideal body weight, or has a body mass index exceeding 40 kg/m, or has a body mass index over 35 kg/m and a clinically serious condition (e.g., obesity hypoventilation, sleep apnea, diabetes, hypertension, cardiomyopathy, or musculoskeletal dysfunction); and

    b. Have demonstrated an inability to control weight because the patient (all of the following must apply):

        1. has failed to significantly lose weight or has regained weight despite compliance with a multidisciplinary nonsurgical program, including low or very low-calorie diet, supervised exercise, behavior modification, and support; and

        2. has full growth; and

        3. has no correctable cause for obesity (e.g., endocrine disorder); and

4. is receiving treatment in a surgical program experienced in obesity surgery, characterized by Surgeons experienced with Roux-en-Y gastric bypass and a multidisciplinary approach including (all of the following):

    i) preoperative medical consultation and approval; and
    ii) preoperative psychiatric consultation and approval; and
    iii) nutritional counseling; and
    iv) exercise counseling; and
    v) psychological counseling; and
    vi) support group meetings.

19. Any other treatment of obesity including but not limited to appetite or weight control drugs, dietary supplements, special foods or food supplements primarily for weight loss or control unless necessitated as the direct result of a specifically identified and diagnosed endogenous (caused within the body) condition and pre-authorized by Anthem Blue Cross.

20. Nutritional counseling, unless (a) prescribed in writing by the attending Physician, (b) provided by a registered dietician, (c) performed for treatment of a condition of disease origin, and (d) pre-authorized by Anthem Blue Cross.

21. In-vitro fertilization, artificial insemination, infertility treatment or any charges associated with the direct inducement of pregnancy (however, necessary services and supplies to diagnose infertility are covered).

22. Reversal of sterilization procedures.

23. Professional services, except as specifically provided herein, rendered for behavioral or marriage counseling, or study of behavioral characteristics, or vocational testing or counseling.

24. Testing or treatment for learning or behavioral disorders including but not limited to attention deficit disorder (ADD), Autism, Non-Verbal Learning Disorders, Childhood Disintegrative Disorder, Rhett's Disorder, Asperger's Disorder, Pervasive Development Disorder or mental retardation.

25. Treatment for attention deficit/hyperactivity disorder (ADHD) unless authorized by Avante Health.

26. Therapy or surgery for sexual dysfunction or inadequacies or psychiatric admissions.

27. Treatment for substance abuse or alcoholism other than that described under the substance abuse benefit of the Plan.

28. Charges for foot care (except surgery or foot orthotics), to include but not limited to any condition resulting from weak, unstable, or flat feet, fallen arches, pronated foot metatarsalgia, foot strain or bunions; any treatment of corns, calluses, or toenails unless at least part of the nail root is removed, unless for specifically diagnosed diabetic foot care.

29. Myofunctional therapy following illness or Injury incurred while covered under the Plan.

30. Confinement in a Hospital owned or operated by the federal government, except Usual, Customary and Reasonable Charges otherwise payable and incurred at a Veteran's Administration Facility or by a Covered Person as an armed services Retiree for services or supplies unrelated to military service.

31. Travel expenses, whether or not recommended by a Physician, except for ambulance service as specifically provided.

32. Charges incurred for services or supplies, which constitute personal comfort, personal hygiene, or convenience and beautification items such as but not limited to air conditioners, personal hygiene, bathing/toilet accessories, and Physician fitness equipment for home use.

33. Charges incurred for hospitalization primarily for x-ray, laboratory, diagnostic study, physio-therapy, hydrotherapy, medical observation, convalescent or rest cure or any medical examination or test not connected with an actual illness or Injury.

34. Charges incurred for the replacement of an initial prosthesis unless medical necessity is proven in writing.

35. Charges incurred for injuries sustained as the result of the misuse of a controlled substance.

36. Charges for organ or tissue transplants except as specified in the Plan.

37. Charges for maternity care for a Dependent child, including abortions and complications thereof.

38. Charges for biofeedback, hypnosis, sleep apnea, and services relating to pain management centers unless authorized by a Physician as required for the necessary medical treatment of an illness, Injury or pregnancy.

39. Complications arising from a service or treatment which is excluded from coverage.

40. Treatment of mandible for correction of a bite problem or treatment of jaw joint problems, including temporomandibular joint syndrome and craniomandibular disorders, or other conditions of the joint linking the jaw bone and skull and a complex of muscle, nerve and other tissue related to that joint, except when any of the following criteria is met:

    a. There is radiological evidence of bone deterioration in the jaw or joint.

    b. There are significant nutritional problems from the inability to masticate food properly, which cannot be managed through variations in diet.

    c. The associated respiratory problems would endanger life.

    d. The disability treated was the result of an accident.

41. Prescriptions obtained outside the USA not approved by the Federal Food and Drug Administration and EnvisionRx Options.

42. Services, supplies or medications associated with sex transformations and resulting complications.

43. Charges for Custodial Care, domiciliary care, rest cures, services that are primarily Educational in nature, or any maintenance-type care which is not reasonably expected to improve the patient's condition, except that Custodial Care provided in conjunction with Home Health Care, Hospice Care and Skilled Nursing care when these services are provided as a less costly alternative to Inpatient hospitalization shall be considered a Covered Medical Expense under the Plan.

44. Charges for benefits other than specifically provided or in excess of the benefits specified in the Plan.

45. Charges for or related to physical examinations, except as specified.

46. Charges for artificial insemination, invitro fertilization, or treatment of sexual dysfunctions not related to organic disease, or treatment relating to the inability to conceive.

47. Charges for any device, drug or procedure (except for injectable birth control administered during a medical office visit or elective sterilization, as specified) used for the direct purpose of birth control. Oral contraceptives are covered under the Prescription Drug Expense Benefit Plan.

48. Charges for hearing examinations, hearing aids or for fitting them, except as required under Patient Protection and Affordable Care Act (PPACA).

49. Charges for dental care, treatment, or x-rays, except as specified in the Plan.

50. Charges for private duty nursing.

51. Charges incurred through the use of a nurse's aide or licensed vocational nurse (L.V.N.).

52. Charges of an occupational therapist, except as specified in the Plan.

53. Charges for the purchase of dialysis equipment.

54. Charges related to conception, pregnancy delivery or any other health condition related to a surrogacy arrangement. For the purposes of this exclusion, a surrogacy arrangement is defined as one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child. If the Plan Participant or the Participant's Spouse or Domestic Partner enters into a surrogacy arrangement, the Plan will not pay for any charges for services related to conception, pregnancy, delivery or any other health condition related with that arrangement for either the mother or the child(ren).

    Within 30 days of entering into a surrogacy arrangement, the Plan Participant must send to Delta Health Systems written notice of the arrangement, including the names and addresses of the other parties to the arrangement, and a copy of any contracts or other documents explaining the arrangement.

55. Charges for genetic testing.

56. Charges for massage therapy.

57. Charges for or related to exercise equipment, or health club dues or fees, hair restoration.

58. Charges for Holistic, Homeopathic, Naturopathic Medicine, Vitamins and Dietary Supplements.

59. Refractive Eye Surgery.

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE FOR ACTIVE EMPLOYEES AND RETIREES

EFFECTIVE DATE OF COVERAGE
Your coverage will be effective on the first day of the month following the date your completed enrollment form is received by the District's Benefit Department.

TERMINATION OF COVERAGE
Insurance will continue as long as you and your Dependents remain eligible through the District, who continues to pay the premiums, and the Contract is not terminated. Coverage for your Dependents will terminate when your coverage terminates, or when they no longer qualify under the Plan.

BENEFICIARY
You may name any beneficiary or beneficiaries you wish. If you purchase coverage for your family, you are automatically your Dependents' beneficiary for loss of life.

LIFE INSURANCE

Life Insurance is provided to Fresno Unified School District Employees, Retirees, and Dependents. Active Employees insurance coverage is paid for by the District. Elective Dependent insurance coverage and Retiree insurance coverage require a contribution by the Employee or Retiree. All additional Life Insurance coverage is available through Standard Insurance Company and information is available through the District.

For additional information, please refer to your Group Insurance certificate issued by Standard Insurance Company, as provided by the District, or contact Standard Insurance at(800) 628-8600.

Fresno Unified School District provides Basic Life and Accidental Death & Dismemberment Insurance for all active eligible Employees working at least four hours a day, 20 hours a week, at no cost to the Employee, as follows:

The amount of your term life insurance is determined from the following table:

Attained Age at Nearest Birthday	Amount
Under 25	$ 56,784
25 – 29	49,686
30 – 34	42,588
35 – 39	36,555
40 – 44	29,102
45 – 49	21,826
50 – 54	14,196
55 – 59	11,357
60 – 64	9,582
65 – 69	6,229
70 or over	4,049

For further information, please refer to your life insurance certificate.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

Fresno Unified School District also provides Accidental Death and Dismemberment through Prudential to Active Employees and elective AD&D coverage to Dependents.

Eligible Participants will be protected 24 hours a day, 365 days a year, for covered accidents occurring anywhere in the world, on or off the job, at home or while traveling (subject to the Exclusions and Limitations of the contract). Benefits are paid in a lump sum.

For additional information, or information regarding the amount of your AD&D insurance benefit, please refer to your Group Insurance certificate issued by Prudential, as provided by the District, or contact Prudential at (800) 524-0524.

ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT (You may only be covered under one option below)

100% of the Benefit Amount	50% of the Full Benefit Amount	25% of the Full Benefit Amount
Loss of life or Loss of two or more members or Loss of speech and hearing of both ears	Loss of one member or Loss of speech or hearing of both ears	Loss of hearing of one ear or Loss of thumb and index finger of the same hand

Member means hand, foot or eye.
Loss must occur within 365 days of the date of the covered accident.

PARALYSIS BENEFIT

100% of the Benefit Amount	75% of the Full Benefit Amount	50% of the Full Benefit Amount
Quadriplegia (total paralysis of both upper and lower limbs.)	Paraplegia (total paralysis of both lower limbs.)	Hemiplegia (total paralysis of upper and lower limbs on one side of the body.)

LOSS DUE TO EXPOSURE AND DISAPPEARANCE
Loss due to exposure to the elements is considered an accidental loss. Also, if the insured's body is not found within a year of a certain disappearance, that person will be presumed to have died.

MONTHLY COMA BENEFIT
If a covered insured is injured in a covered accident, which results in a coma for at least 31 consecutive days, the Plan will begin payment of a Monthly Coma Benefit. Payment of this benefit will continue each month as long as the Covered Person remains in a coma, up to a maximum of 100 months. This benefit will be paid at a rate of 1% of the Benefit Amount less any benefits paid as a result of the same covered accident.
"Coma" means being in a profound state of unconsciousness from which the person cannot be aroused, even by powerful stimulation, as determined by the person's Doctor.

SEAT BELT BENEFIT
Because of the added protection seat belts bring to drivers and passengers every day, this special benefit is provided for you. If, while insured for this benefit, you suffer accidental death due to a covered accident in which you were seated in an automobile with a seat belt properly fastened, the Plan will pay an additional **10%** of the entitled Amount.

GENERAL PLAN PROVISIONS

PLAN CONTRIBUTIONS AND HEALTH PLAN RESERVE ASSESSMENT CONTRIBUTIONS

Active Employees and Eligible Retirees (Under Age 65)[1]
Contributions are required for Health Benefit Plan coverage and are outlined in the Health Plan Contribution and Reserve Assessment Insert II contained in the back of this booklet. There are separate rates for the Employee/Retiree only and for Employees/Retirees with Dependents.

Health Plan Reserve Assessment
Employees and Retirees (Age 65 and Older but Under Age 75) [1]
In addition to the monthly contributions, all eligible active Employees and Retirees (under age 75) who retired on and after August 31, 2006 shall contribute a Health Plan Reserve Assessment as outlined in the Health Plan Contribution and Reserve Assessment Insert II contained in the back of this booklet.

The monthly contribution and Health Plan Reserve Assessment shall continue only until the Retiree and/or Dependent reaches age 75, at which time the Post-75 year-old Retiree/Dependent shall not be required to make any monthly contributions.

EMPLOYEE ELIGIBILITY AND EFFECTIVE DATES

EMPLOYEE ELIGIBILITY
An eligible Employee who is employed by the Fresno Unified School District is eligible to participate in the Plan as determined by Board Policy or the Collective Bargaining Agreements between the District and the Employee organizations representing bargaining unit members.

No Opting Out
All eligible District active Employees shall be required to participate in the Health Care Plan and shall be required to pay the monthly contributions and assessments, at least at the Employee only level, for the Plan(s) or coverage**.**

Employees – Effective Date
Medical coverage by the Plan is provided on a contributory basis (that is, the Employee pays a portion of the cost of coverage). An eligible Employee's coverage is effective upon the first of next the month following date of hire (or on the first day of the month if the Employee is hired on the first of any month).

Rehire
An Employee who returns to work with the District within thirty-nine (39) months of termination from the Plan shall be eligible for Plan coverage effective upon the first of the next month following date of re-employment.

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[1] Retirees Exempt from Plan Contributions and Assessments: FURA Retirees who retired prior to April 17, 2006, and any Retiree who retired after April 17, 2006 but before August 31, 2006 who met and signed the "Agreement for the Provisions of District-Paid Health Benefits" are not required to pay contributions for Health Benefit Plan coverage nor a Health Plan Reserve Assessment.

Changes in monthly Contribution and Health Plan Reserve Assessment amounts are subject to the Collective Bargaining Agreement language between the District and the Employee organization representing bargaining unit members.

RETIRED EMPLOYEE ELIGIBILITY

Certain Retired Employees are also eligible to participate as a Retiree in the Plan. The conditions of eligibility, and any Retiree contributions, are determined by the District's Board Policies, or if applicable, by a negotiated Collective Bargaining Agreement. A Retired Employee may Opt Out of Retiree Benefits by completing an Opt Out form and submitting it to the District Benefits Department. Once a Retiree Opts Out of Retiree benefits he or she, and his or her eligible dependents, WILL NOT be allowed to enroll in the Plan at a later date.

In order to be eligible for the Plan's Medical and Prescription Drug benefits under Plan Options A and B, all Retiree Plan Participants age 65 and over and all Retired disabled Plan Participants who are eligible for Medicare Parts A & B based on age or disability, regardless of age, must enroll in Parts A and B of Medicare as their primary insurance coverage. Please see Coordination of Benefits for more information.

DEPENDENT ELIGIBILITY

An eligible Dependent of an Employee or Retiree is:

1. a legal spouse;

2. a Domestic Partner[1];

3. any child under the age of 26[2]. For these purposes a "child" will include:

   (a) an Employee's, Domestic Partner's[1] or Retiree's[3] natural child,

   (b) a Legally adopted child on the date the child is placed in the physical custody of the Employee/Retiree[3],

   (c) a stepchild of the Employee/Retiree[3],

   (d) a child of the Employee/Retiree[3] subject to a Qualified Medical Child Support Order (QMCSO) as noted on page 69; and

   (e) a child placed in the permanent legal guardianship of the covered Employee/Retiree[3] by court order. A child placed in the permanent legal guardianship becomes an eligible Dependent on the latter of the date the child is placed in the physical custody of the Employee/Retiree[3] or the date the court awards legal guardianship to the Employee/Retiree[3].

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[1] A Domestic Partner will be covered under the Fresno Unified School District's Health Plan provided a Participant is a same-sex partner, or opposite-sex partner where at least one of the partners is age 62 or older and qualifies for certain Social Security benefits, as defined under California Family Code 297 and has filed a Declaration of Domestic Partnership with the California Secretary of State, or by validly forming a legal union in a jurisdiction other than California consistent with the requirements of Family Code Section 299.2.

[2] **Important Note:** If a Dependent child is born after the effective date of an Employee's coverage hereunder, benefits will only be available for Allowable Expenses of the child, provided the newborn child is **enrolled** within 31 days following the date of birth. After the 31-day period, coverage for the child will be available **only** if the Employee has notified the District's Benefit Department of the birth and has enrolled the child under the "Open Enrollment" provisions of the Plan.

[3] Some but not all Retirees may enroll dependent children under the Plan. For example, Dependent child coverage is not provided under the Retiree Continuation Coverage provisions, of the Plan Ed Code 7000, noted on per page 78.

4. an unmarried mentally or physically Disabled child beyond the maximum age (pursuant to 3 on the previous page) provided the child is incapable of self-sustaining employment and is dependent upon the Employee/Retiree for support and maintenance and further provided that the condition existed prior to such child reaching the age of 26. Proof of any mental or physical disability shall be required within 31 days of such child's 26th birthday and the Benefits Administrator or District's Benefit Department may require additional proof from time to time.

An eligible Dependent **does not** include:

1. a spouse who is legally separated or divorced from the Employee/Retiree; or

2. an individual whose Domestic Partnership with the Employee/Retiree has terminated; or

3. a child who is on active duty in any military, naval or air forces of any country; or

4. any child who is covered as an Employee under this Plan.

DEPENDENTS EFFECTIVE DATE

Coverage for Dependents who are eligible and enrolled concurrently with the Employee will be effective on the Employee's effective date. Coverage for Dependents acquired later will be effective as follows, provided the Dependent is enrolled within 31 days of eligibility:

1. for a newly acquired Dependent spouse or Domestic Partner, coverage is effective on the date of marriage or Domestic Partnership;

2. for a newly acquired Dependent child including newborns, coverage is effective on the date the child was acquired. See also "Newborn Children…" on page 65, under "Important Note" at the bottom of the page.

If a new Dependent is not enrolled within 31 days of his or her eligibility, s/he can be enrolled later only in accordance with the "Open Enrollment" provision.

HIPAA SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll your dependents in this Plan if your dependents lose eligibility for that other coverage (because of separation/divorce, termination of employment or reduction in hours, death or cessation of employer contributions), or if your dependents were receiving COBRA coverage and their eligibility for COBRA has expired. However, you must request enrollment within 30 days after your dependents' other coverage ends.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. If you are enrolling a new dependent as a result of birth, adoption, or placement for adoption, you can also enroll your Spouse or Domestic Partner if he or she was not previously enrolled in the Plan, but only if he or she is otherwise eligible to participate in the Plan.

Special enrollment rights may also exist in the following circumstances:

1. If your dependents experience a loss of eligibility for Medicaid or a State Children's Health Insurance Program ("SCHIP") coverage and you request enrollment within 60 days after that coverage ends; or

2. If your dependents become eligible for a state premium assistance subsidy through Medicaid or a SCHIP program with respect to coverage under this Plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

To request Special Enrollment or to obtain more information, contact the District's Benefit Department at (559) 457-3520.

OPEN ENROLLMENT

The 60-day period beginning October 1 of each Calendar Year, for a January 1 changeover date in benefits beginning the following year, will be the beginning of the Plan's Open Enrollment period. This is the period of time when an eligible Employee may enroll himself and/or his or her eligible Dependents in the Plan other than during the 60 day period immediately following original eligibility.

Note: Each Dependent must be identified with a Social Security number. A Dependent's coverage will not become effective prior to the Employee's effective date.

CROSS (DUAL) COVERAGE

"Cross Coverage or Dual Coverage" means that if an Employee and/or Retiree is covered under this Plan as an Eligible Employee and/or Eligible Retiree and as an Eligible Dependent spouse or Domestic Partner, the Plan shall pay based on the Coordination of Benefits provision for Plan Options A and B as outlined on page 79 of this Plan Booklet. Surviving spouses of Cross Covered or Dual Covered Employee or Retiree are eligible for the same level of benefits that the Coordination of Benefits provision provides.

There are different provisions for Dual Covered Employees under the Kaiser Permanente Plan. Please refer to the Kaiser Permanente Plan Evidence of Coverage.

When both spouses or Domestic Partners are employed by the District, the Plan's Options A and B will coordinate benefits as noted under the Coordination of Benefits provision outlined on page 79 of the booklet. The Kaiser Permanente Plan has different Dual Coverage provisions. Please refer to Kaiser Permanente Plan's Evidence of Coverage booklet for more information.

PORTABILITY UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The following information is provided as required under HIPAA. You should be advised that the Plan does not impose any pre-existing condition exclusion.

Any Medical or Dental pre-existing condition exclusion indicated in this Plan booklet is reduced by the individual's "creditable coverage" for up to 12 months. Creditable coverage is the total number of days on which the individual had health coverage from all sources. The individual must demonstrate creditable coverage by providing a certificate from the previous plan, or, if a certificate is not available, by presenting evidence to corroborate his/her statement that he/she had other coverage and cooperating with the Plan's efforts to verify it.

For individuals already covered by the Plan, the foregoing rules will apply to a spouse and/or children subsequently acquired through marriage and their "enrollment date" would be the date of marriage.

NOTE: If an individual has gone 63 days or more without any health coverage, any (medical or dental) pre-existing condition exclusionary period is not reduced and the individual is subject to the previously stated pre-existing condition exclusions.

Under certain conditions, an individual and Dependents may be allowed a "special enrollment" period of at least 30 days under any pre-existing condition provision stated above if:

1. The individual or Dependents had originally declined coverage because they:

    a. Had other coverage, which they later lost because of separation/divorce, termination of employment or reduction in hours, death or the cessation of employer contributions for their coverage (unless it was for cause or failure to pay contributions on time), or
    b. Were on COBRA, but their COBRA eligibility has expired.

2. If an individual who did not initially enroll later marries or has or adopts a child, the individual is entitled to a special enrollment along with the child.

NOTICE OF RIGHT TO RECEIVE A CERTIFICATE OF CREDITABLE COVERAGE

Under the Health Insurance Portability and Accountability Act of 1996, an individual has the right to receive a certificate of prior health coverage, called a "certificate of creditable coverage" or "certificate of group health plan coverage," from the Plan Sponsor or its delegate. If Plan coverage or COBRA continuation coverage terminates, the Plan Sponsor will automatically provide a certificate of creditable coverage. The certificate is provided at no charge and will be mailed to the person at the most current address on file. A certificate of creditable coverage will also be provided on request, in accordance with the law (i.e., a request can be made at any time while coverage is in effect and within twenty-four (24) months after termination of coverage). Written procedures for requesting and receiving certificates of creditable coverage are available from the Benefit Administrator.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

If a QMCSO issued in a divorce or legal separation proceeding requires you to provide medical coverage to a child who is not in your custody, you may do so. To be considered qualified, a medical child support order must include:

- Name and last known address of the parent who is covered under this Plan;
- Name and last known address of each child to be covered under this Plan;
- Type of coverage to be provided to each child; and
- Period of time the coverage is to be provided.

QMCSOs should be sent to the District's Benefit Department. Upon receipt, the Plan's Administrative Office will notify you and describe the Plan's procedures for determining if the order is qualified. If the order is qualified, you may cover your children under the Plan. As a beneficiary covered under the Plan, your child will be entitled to information that the Plan provides to other beneficiaries.

TERMINATION OF COVERAGE

EMPLOYEE COVERAGE TERMINATION

Coverage under the Plan shall terminate for an Employee or Retiree on the earliest of the following dates:

(a) the date the Employee or Retiree fails to pay any required contributions when due;

(b) the date the Plan terminates;

(c) the date the person is no longer an eligible Employee because his or her coverage terminates prior to retirement eligibility. However, in this instance, coverage will continue to the end of the Plan Year (June 30) provided the Employee works for the District until the end of the school year. For Employees who do not work for the District until the end of the school year, the date coverage terminates will be determined on a Prorated basis; as determined by District's Board Policy or, if applicable, by a negotiated bargaining agreement.

(d) the date the Employee becomes a full-time member of the armed forces of any country for more than one (1) month in any Calendar Year.

DEPENDENT COVERAGE TERMINATION

A Dependent's coverage under the Plan will terminate upon the earliest of the following dates:

(a) the date the Employee or Retiree ceases to make any required contributions for Dependent coverage;

(b) the date the Employee or Retiree ceases to be covered under the Plan, except that Dependents of an Employee who is recalled to active duty as a member of the National Guard or military reserves shall be considered a Dependent for purposes of the Plan;

(c) the date the Dependent ceases to meet the eligibility requirements of the Plan;

(d) the date the Plan ends;

(e) the date the Dependent becomes a full-time member of the armed forces of any country for more than one (1) month in any Calendar Year.

RESCISSION OF COVERAGE

Beginning on July 1, 2011, coverage under the Plan can only be "rescinded," which means that the coverage can be cancelled retroactively, when a participant has committed fraud or has intentionally misrepresented a material fact (see the definition of "Rescission" on page 15. When coverage is cancelled retroactively it means that coverage will be cancelled back to the first day of enrollment in the Plan.

Enrolling an individual in the Plan who you know is not an "eligible Dependent" under the Plan is an example of fraud and an intentional misrepresentation of a material fact. Coverage will be retroactively cancelled back to the first day the individual was fraudulently enrolled in the Plan, and you will be responsible for repaying the Plan for any health costs incurred on the individual's behalf. In addition, when coverage is cancelled retroactively because of fraud or intentional misrepresentation the individual will not have the right to COBRA continuation.

If the Plan cancels coverage retroactively it will provide 30 calendar days advance written notice explaining the reasons for the retroactive cancellation of coverage, information regarding appealing the retroactive cancellation of coverage, and the contact information of the individual available to answer your questions. You will have the right to appeal the rescission of coverage (see "Claims Procedures" beginning on page 85).

The Plan can still cancel coverage prospectively, or cancel coverage retroactively if the cancellation is based on the individual's failure to timely pay required contributions (if you fail to pay COBRA contributions, for example). If coverage is cancelled prospectively, or for failure to timely pay required contributions, the Plan is not required to provide you with 30 calendar days advance written notice.

CONTINUATION OF BENEFITS

FAMILY AND MEDICAL LEAVE ACT (FMLA)

Under the Family and Medical Leave Act of 1993 (FMLA), an active Employee may be entitled to family or medical leave.

1. If an Employee is eligible to take and elects FMLA leave, coverage under this Plan will continue until the earlier of:

    a. The date the Employee notifies the District's Benefit Department that he or she does not intend to return to work at the end of the FMLA leave; or

    b. The end of the FMLA leave.

2. Contributions will continue to be paid by the District on the Employee's behalf while he or she is on FMLA leave.

3. The Employee must contact the District to determine his or her eligibility for FMLA leave.

CONTINUATION OF COVERAGE – TOTAL DISABILITY

Loss of eligibility under this Plan will immediately terminate all benefits. However, if an Employee or a Dependent were totally Disabled on the date coverage terminated, and if expenses are thereafter incurred directly related to the Injury or Sickness causing the disability, then benefits will be continued with respect to such expenses until the first of the following events occur:

1. On the 101st day following the month of the date of disability; or

2. The date the maximum amount of benefits has been paid; or

3. The date the Employee or the Dependent ceases to be totally Disabled; or

4. The date coverage for the Employee or the Dependent becomes effective under any replacement policy without limitations as to the disabling condition.

Benefits under this provision will not be payable with respect to any other Injuries or Sicknesses.

CONTINUATION OF COVERAGE UNDER FEDERAL LAW – COBRA

As required by a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Plan offers Employee's and each of your eligible Dependents the opportunity for a temporary extension of health coverage at group rates in certain instances when Plan coverage would otherwise end. Qualified beneficiaries must pay for this continuation coverage (called "COBRA coverage") by sending premiums directly to the District's Benefit Department. (See Section 10 and 11 beginning on page 75 regarding the Cost of COBRA Coverage and Payment Rules for COBRA Coverage.) **Both you and your spouse or Domestic Partner should take the time to read this section carefully.**

1. Benefits Available Under COBRA Coverage

Those of you who are entitled to choose COBRA (i.e., you and separately your spouse or Domestic Partner and eligible Dependents) are known under COBRA as "qualified beneficiaries."

COBRA coverage is the same coverage and benefits you had immediately prior to becoming eligible for COBRA. It is the same Plan provided to other Plan Participants who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA coverage will have the same rights under the Plan as other Plan Participants, including open enrollment and special enrollment rights. If the Plan changes its benefits levels or health coverage for all Participants, your health coverage will be changed in the same manner. COBRA qualified beneficiaries are not, however, considered Plan "Participants" during COBRA coverage.

When you initially enroll in COBRA Coverage, you will be offered a choice between two levels of coverage: (1) a Core Plan of Benefits, which consists of Medical and Prescription Drug coverage; and (2) a Non-Core Plan of Benefits, which consists of Medical, Prescription Drug, Vision and Dental coverage. Each qualified beneficiary need not elect the same level of coverage. You are not eligible to continue benefits under COBRA if you were not eligible prior to the Qualifying Event.

2. How COBRA Coverage Becomes Available

a. For an Employee

If you are an Employee, you have a right to choose COBRA coverage for yourself if you lose your coverage under the Plan due to any of the following "Qualifying Events."

- Your hours of employment are reduced; or

- Your employment ends for any reason (such as layoff or retirement) other than your gross misconduct.

b. For the Spouse or Domestic Partner of an Employee

If you are the spouse or Domestic Partner of an Employee, you have a right to choose COBRA coverage for yourself if you lose your coverage under the Plan due to any of the following "Qualifying Events."

- The Employee dies;
- The Employee's hours of employment are reduced;
- The Employee' employment ends for any reason other than his or her gross misconduct;
- You become divorced or legally separated from the Employee; or
- Your Domestic Partnership with the Employee is terminated, dissolved, or nullified.

c. For the Dependent Children of an Employee

Your Dependent children have the right to choose COBRA coverage for themselves if they lose coverage under the Plan due to any 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 parents become divorced or legally separated;
- The parents' Domestic Partnership is terminated, dissolved, or nullified); or
- The child stops being eligible for Plan coverage because the child no longer qualifies as a "Dependent" as defined by the Plan.

d. For Retirees in the Event the District files for Bankruptcy

If you are a Retiree covered under this Plan, you will have a right to choose COBRA coverage if your Plan coverage is lost on account of the District filing for bankruptcy under Title 11 of the United States Code. Your spouse or Domestic Partner, and Dependent children will also have the right to choose COBRA coverage if the bankruptcy results in their loss of Plan coverage.

3. Notifying the District's Benefit Department of a Qualifying Event

The Plan will offer COBRA coverage to each qualified beneficiary only after the District's Benefit Department has been notified that a Qualifying Event has occurred.

YOU MUST NOTIFY THE DISTRICT'S BENEFIT DEPARTMENT OF CERTAIN QUALIFYING EVENTS:

You or a Dependent (or a representative of either) must notify the District's Benefit Department by calling (559) 457-3520 within 60 days after the date Plan coverage is lost due to a Qualifying Event that is the result of the Employee's divorce or legal separation, the termination, dissolution or nullification of the Employee's Domestic Partnership, or a child's loss of eligibility under the Plan as a Dependent child. When you call, you may be asked to provide some or all of the following information: (1) the Employee's name; (2) the Employee's social security number; (3) the name(s) and social security number(s) of all qualified beneficiaries; (4) relevant mailing addresses; and (5) the date and nature of the Qualifying Event. You may be required to provide supporting documentation (e.g., a divorce decree) to the District's Benefit Department.

COBRA coverage will be denied if you fail to give notice to the District's Benefit Department of a divorce, legal separation, termination or dissolution of a Domestic Partnership or child's loss of eligibility as a Dependent child under the Plan within 60 days after the date Plan coverage is lost due to one of these Qualifying Events.

4. Electing COBRA Coverage and Notice of Denial of COBRA Coverage

After the District's Benefit Department is timely notified of a Qualifying Event, it will send each qualified beneficiary a "Notice of Right to Continue Health Coverage under Federal Law (COBRA) and Election Form" (the "Election Form") within 14 days of the date Plan coverage ends due to a Qualifying Event.

If you would like to elect COBRA coverage, you must return the completed and signed Election Form to the District's Benefit Department within 60 days after the later of: (1) the date Plan coverage ends due to a Qualifying Event; or (2) the date the District's Benefit Department mailed you an Election Form. An election is considered to be made on the date you send the completed and signed Election Form to the District's Benefit Department.

Each qualified beneficiary has a separate right to elect COBRA coverage. For example, the Employee's spouse or Domestic Partner may elect COBRA coverage, even if the Employee does not. COBRA coverage may be elected for only one, several, or for all Dependent children. Employees may elect COBRA coverage on behalf of their spouses or Domestic Partners, and parents may elect COBRA coverage on behalf of their children. The Employee or the Employee's spouse or Domestic Partner can elect COBRA coverage on behalf of all of the qualified beneficiaries.

If you reject COBRA coverage before the date the Election Form is due, you may change your mind as long as you send the completed and signed Election Form to the District's Benefit Department before the due date. However, if you change your mind after first rejecting COBRA coverage, your COBRA coverage will begin on the date you send your completed and signed Election Form to the District's Benefit Department.

Please note that the Plan is required by law to make a complete disclosure of your COBRA eligibility and election status to any health care provider, such as a Doctor, Hospital, or pharmacy, that requests information about your coverage during such a period.

If the District's Benefit Department receives a notice relating to a Qualifying Event or disability determination regarding an Employee, Dependent or other person and determines that such person is not entitled to COBRA coverage, the District's Benefit Department will, within 14 days of receiving such notice, send such person a Notice of Denial of COBRA Coverage containing the reason for such denial.

IMPORTANT:
In considering whether to elect COBRA coverage, you should be aware that a failure to continue your group health coverage will affect your future rights under federal law. First, pre-existing condition exclusions in other group health plans may apply if you have more than a 63 day gap in health coverage. Election of COBRA coverage may help you avoid such a 63 day gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition exclusions if you do not receive COBRA coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan, if available, for which you are otherwise eligible (such as a plan sponsored by your spouse's or Domestic Partner's employer) within 30 days after your group health coverage ends because of a Qualifying Event. You will also have the same special enrollment right at the end of COBRA coverage.

5. How Long COBRA Coverage Lasts

COBRA coverage is a temporary continuation of coverage.

- When the Qualifying Event is the Employee's death, divorce or legal separation, or the loss of Dependent child status under the terms of the Plan, COBRA coverage lasts for up to a total of 36 months.

- When the Employee becomes entitled to Medicare benefits less than 18 months before the Qualifying Event and the Qualifying Event is the end of employment or reduction of the Employee's hours of employment, COBRA coverage for qualified beneficiaries other than the Employee lasts up until 36 months after the date of the Employee's Medicare entitlement. For example, if an Employee becomes entitled to Medicare 8 months before the date on which his or her employment terminates, COBRA coverage for his or her Dependent spouse or Domestic Partner and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).

- When the Qualifying Event is the end of employment or reduction of the Employee's hours of employment, COBRA coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA coverage can be extended (see Section 6 below).

6. Extending an 18-Month Period of COBRA Coverage

a. Disability Extension of 18-Month Period of COBRA Coverage
An 11-month extension of COBRA coverage (for a total maximum of 29 months) may be available if the Social Security Administration (SSA) determines any qualified beneficiary to be Disabled. The disability must have started at any time before the 60th day of COBRA coverage and must last at least until the end of the 18-month COBRA coverage period. Each qualified beneficiary who has elected COBRA coverage will be eligible for the disability extension if one of them qualifies. COBRA premiums are higher for the extra 11 months of coverage.

To obtain this extension, you must notify the District's Benefit Department by calling (559) 457-3520 within 60 days after the date of the SSA disability determination (or if the qualified beneficiary is already Disabled, within 60 days after the date Plan coverage is lost due to the Qualifying Event), but before the end of the initial 18-month period of COBRA coverage. When you call, you may be asked to provide some or all of the following information: (1) the Employee's name; (2) the Employee's social security number; (3) the name(s) and social security number(s) of all qualified beneficiaries; (4) relevant mailing addresses; and (5) the date of the SSA disability determination. In addition, you will be required to provide the District's Benefit Department with a copy of

the SSA determination letter.

The disability extension will terminate early if the SSA determines that the individual is no longer Disabled before the end of the 11-month extension. You or your Dependent must notify the District's Benefit Department by calling (559) 457-3520 within 30 days of any such final determination that the individual is no longer Disabled.

b. Second Qualifying Event Extension of 18-Month Period of COBRA Coverage

An 18-month period of COBRA coverage may be extended for a period of up to 36 months for an Employee's spouse, Domestic Partner or Dependent child, if a second Qualifying Event occurs during the first 18-month period. This extension may be available to the spouse, Domestic Partner and any Dependent child receiving COBRA coverage if the Employee or former Employee dies, gets divorced or legally separated, the Employee's Domestic Partnership is terminated, dissolved, or nullified, or if the child stops being eligible under the Plan as a Dependent child, **but only if the second event would have caused the spouse, Domestic Partner or child to lose coverage under the Plan had the first Qualifying Event not occurred.** For example, if an Employee's spouse or Domestic Partner is on COBRA coverage for 18 months due to the termination of the Employee's employment, and during the 18-month period, the spouse or Domestic Partner and the former Employee get divorced, the spouse or Domestic Partner will be eligible to maintain his or her COBRA coverage for up to 36 months from the date coverage ended due to the first Qualifying Event. However, in no event will COBRA coverage extend beyond 36 months from the date coverage ends due to the first Qualifying Event, and it may end before the 18, or 36-month period expires, as explained under "When COBRA Coverage Terminates" (see Section 8 below).

In order to obtain an extension because of a second Qualifying Event, you must notify the District's Benefit Department by calling (559) 457-3520 within 60 days following the later of the date of the second Qualifying Event or the termination of the initial 18-month COBRA coverage period. When you call, you may be asked to provide some or all of the following information: (1) the Employee's name; (2) the Employee's social security number; (3) the name(s) and social security number(s) of all qualified beneficiaries; (4) relevant mailing addresses; and (5) the date and nature of the Qualifying Event. The District's Benefit Department may require that supporting documentation (such as a divorce decree) be submitted.

7. When COBRA Coverage Begins

COBRA coverage begins on the date Plan coverage ends due to a Qualifying Event. If you received extended Plan coverage due to Total Disability, as described on page 104, your COBRA coverage will begin on the first day of the month after the end of such period of extended coverage. In other words, months of extended Plan coverage due to Total Disability will not count against or reduce the 18-, 29-, or 36-month maximum COBRA coverage period.

8. When COBRA Coverage Terminates

COBRA coverage will end before the expiration of the 18-, 29-, or 36-month maximum COBRA coverage period if:

- The District's Benefit Department does not receive timely payment of the required COBRA premium;
- The Plan no longer provides group health coverage;
- A qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of a qualified beneficiary;

- The 11-month disability extension terminates early because the SSA determines that the Disabled qualified beneficiary is no longer Disabled;

- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA coverage (COBRA coverage for family members not covered by Medicare will not be affected), or

- The District ceases to make contributions to the Plan and provides other group health plan coverage for its Employees.

COBRA coverage may also be terminated for any of the reasons the Plan would terminate coverage of a Participant not receiving COBRA coverage (such as fraud).

Termination of COBRA coverage will be effective on the first day of the month following the month in which any of the above-listed events occur. Once COBRA coverage ends for any reason, it will not be reinstated. Furthermore, any medical expenses incurred after the COBRA coverage termination date will not be paid by the Plan.

If your COBRA coverage is terminated early, the District's Benefit Department will send you a Notice of Early Termination of COBRA Coverage as soon as reasonably practicable after it determines that your COBRA coverage will end. This notice will contain the reason for such termination and the termination date.

9. Adding Dependents to COBRA Coverage

You may add a spouse, Domestic Partner or a Dependent child who is newly acquired during a period of COBRA coverage for the balance of your COBRA coverage period. To enroll your new eligible Dependent for COBRA coverage, you must submit written proof of their dependency to the District's Benefit Department at the address shown on page 104 within 30 days of the date the Dependent(s) was acquired. There may be an increase in your COBRA premium to cover the new Dependent.

A child born to, or placed for adoption with, the Employee while receiving COBRA coverage will become a qualified beneficiary in his or her own right. Such child will have the right, for example, to elect a different medical plan, if available, than the qualified beneficiary parent during the next Open Enrollment period and will be eligible for extended COBRA coverage if a second Qualifying Event or disability occurs during an initial 18-month maximum COBRA coverage period.

10. The Cost of COBRA Coverage

Each qualified beneficiary must pay the entire cost of COBRA coverage, which may not exceed 102 percent (or, if the case of an extension of COBRA coverage due to a disability, 150 percent) of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly-situated Plan Participant who is not receiving COBRA coverage. Neither the District nor the Plan will pay for any part of your COBRA coverage.

The cost of COBRA coverage is determined once a year. You should contact the District's Benefit Department to obtain current rates.

11. Payment Rules for COBRA Coverage

a. First Payment for COBRA Coverage

If you elect COBRA coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA coverage not later than 45 days after the date of your election. (This is the date your completed and signed Election Form is post-marked, if mailed.) If you do not make your first payment for COBRA coverage in full within this 45-day period, you will lose all COBRA coverage rights under the Plan.

You are responsible for making sure that the amount of your first payment is correct and includes premiums due for all calendar months between the date Plan coverage terminated and the calendar month ending immediately before the initial premium is paid. You may contact the District's Benefits Department to confirm the correct amount of your first payment. COBRA coverage will not be effective until your payment is received.

b. Periodic Payments for COBRA Coverage

After you make your first payment for COBRA coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary will be provided to you with the Election Form. The periodic payments must be made on a monthly basis and are due on the tenth (10^{th}) day of the month of coverage. For example, the payment for COBRA coverage for the month of January is due on January 10^{th}. If you make a periodic payment on or before the first day of the coverage period to which it applies, your COBRA coverage under the Plan will continue for that coverage period without any break. **The District's Benefit Department will not send monthly bills or warning notices of payments due for these coverage periods. It is the responsibility of you or your Dependents to send the required payments when due.**

c. Grace Period for Periodic Payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 31 days after the first day of the coverage period to make each periodic payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. For example, you have until January 31^{st} to pay for coverage effective January 1^{st}. **If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to COBRA coverage under the Plan.**

d. Where Should I Send My Payments?

All payments for COBRA coverage must be sent to the District's Benefit Department at the address shown in this Plan Booklet on page 104.

12. If You Have Questions

Questions concerning the Plan or your COBRA coverage rights can be answered by the District's Benefit Department at (559) 457-3520.

For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

13. Keep the District's Benefit Department Informed of Any Changes

In order to protect you and your family's rights, you must keep the District's Benefit Department informed of any change in your address and the addresses of family members. Also, you must inform the District's Benefit Department of any change in marital or Domestic Partnership status. You should also keep a copy, for your records, of any notices you send to the District's Benefit Department.

CONTINUATION OF COVERAGE UNDER USERRA – MILITARY SERVICE

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) established requirements that employers and health plans must meet for certain Employees who have left employment due to service in the uniformed services. With one important exception, your rights under COBRA and USERRA are essentially the same. Any election that you make pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to the continuation coverage elected. But in contrast to COBRA, which provides you and your Dependents up to 18 months of coverage, USERRA provides you and your Dependents up to 24 months of coverage.

COBRA and USERRA coverage are concurrent for up to the first 18 months of coverage. This means that COBRA coverage and USERRA coverage begin at the same time. As with COBRA, you are responsible for paying for USERRA coverage. The monthly premiums are the same. The cost of the USERRA premium is the same as it would be under COBRA.

Your USERRA coverage will terminate if one of the following events takes place before the end of the 24 months:

(1) You fail to make a premium payment within the required time;

(2) You do not return to work within the time required under USERRA following the completion of your service in the uniformed services (the time for returning varies, please contact the District for more details); or

(3) You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

You may lose coverage under COBRA and USERRA for different reasons. You could, therefore, lose coverage under COBRA but retain it under USERRA, or vice versa. For example, if you lose coverage under USERRA due to a dishonorable discharge, your COBRA coverage would continue as long as you were within the 18-month time limit (plus any extensions, if applicable) for COBRA.

RETIREE VOLUNTARY CONTINUATION OF COVERAGE:

- **FOR RETIRED CERTIFICATED EMPLOYEES AND SPOUSES OR DOMESTIC PARTNERS (ED. CODE 7000/AB 528), AND**

- **FOR CLASSIFIED EMPLOYEES AND SPOUSES OR DOMESTIC PARTNERS WHO RETIRED AFTER JANUARY 1, 2009**[1]

Upon retirement, and following any extended coverage under COBRA elected by the Retiree, a Retired Employee and eligible Spouse or Domestic Partner will have the option of continuing Medical, Dental and Vision coverage provided under this Plan if the Retiree was an Employee of the Fresno Unified School District prior to his or her retirement dates and the Employee:

1. Retired under any public Employee retirement system;

2. Gained permanent status while in the employment of the District;

3. Would currently be eligible for health and welfare benefits in the District if they were employed under the current conditions and in the same capacity as when permanency was gained;

4. Otherwise meet the requirements of Education Code Section 7000; and

[1] Classified Employees are required to satisfy 1, 2, 3, and 5.

5. Enrolls in the Plan's Education Code Section 7000 plan within 30 days after losing active Employee or other Plan coverage.

If an individual is the surviving Spouse or Domestic Partner of a retired Employee, he or she is also eligible to continue coverage. **Note: These Retiree Voluntary Continuation of Coverage benefits do not cover Dependent children of the Retiree.**

Coverage will be provided at the individual's own expense, and premiums, as set by the Plan, must be paid by the individual for a minimum of three months coverage. **A Retiree or spouse (or Domestic Partner) who has elected Retiree Voluntary Continuation Coverage, and who subsequently voluntarily terminates said coverage for any reason, will be excluded from enrolling for coverage at any later date.**

COORDINATION OF BENEFITS (COB)

ORDER OF BENEFIT DETERMINATION

The benefits of another plan will be ignored for the purpose of determining the benefits under this Plan if the rules set forth in the paragraphs below would require the Plan to determine its benefits before such other plan.

The rules establishing the order of benefit determination are as follows:

1. The plan that covers the person as other than a Dependent is the plan that pays first. This plan is called the "primary" plan. The plan that covers the person as a Dependent is the plan that pays second. This plan is called the "secondary" plan.

2. If the person is a Dependent child, the primary plan is the plan of the parent whose birthdate (month and day), excluding year of birth, occurs earlier in a Calendar Year.

3. When the parents are separated or divorced: If there is a court decree that establishes financial responsibility for the medical, dental or other health care expense with respect to a Dependent child, the benefits are determined in agreement with the court decree. Otherwise, if the parent with custody has not remarried, the plan of the parent with custody is primary; if the parent with custody has remarried, the plan of the parent with custody is primary, the stepparent's plan pays second, and the plan of the parent without custody pays third.

4. If the above rules do not establish an order of benefit determination, the plan that has covered the person for the longer period of time shall be primary except that the benefits of a plan covering the person as laid-off or retired Employee or as a Dependent of such person, shall be determined after the benefits of any plan covering the person as an Employee.

5. Any plan, other than a health maintenance organization (HMO), that does not contain a coordination of benefits provision is automatically primary. Primary coverage by an HMO is determined by numbers 2 and 3 above. When part of a Plan coordinates benefits and a part does not, each part shall be treated like a separate plan.

COORDINATION WITH OTHER MEDICAL PLANS

Effect of Coverage Under Another Medical Plan

If an individual covered under this Plan is also covered under one or more other group health benefit plans, the benefits payable under this Plan may be reduced by the benefits payable under all other plans so that the total payment under this Plan and under all other plans does not exceed 100% of the Allowable Expenses. In no event will the payment under this Plan be larger than it would have been in the absence of this coordination with other plans' provisions. Benefits payable under all other plans include the benefits that would have been payable had a claim been properly made for them.

Definition of "Plan"
Any plan providing benefits or services for or by reason of medical care which services or supplies are provided by:

1. group, blanket or franchise insurance coverage;

2. service plan contracts, group practice, individual practice or other prepayment coverage other than health maintenance organizations;

3. any coverage under labor-management trusteed plans, union welfare plans, employer organization plans or Employee benefit organization plans;

4. any coverage under governmental programs, and any coverage required or provided by any statute.

In no event shall the term "plan" mean a plan which provides benefits or services for or by reason of dental, vision or prescription drug care.

Participants Covered as a Dependent under a Spouse's or Domestic Partner's HMO
If the Participant is covered as a Dependent under a Spouse's or Domestic Partner's HMO, and uses the services of that HMO, the Plan's liability will be limited to the Copayments, Deductible, and any Coinsurance required under said HMO (but not to exceed any benefits that would have been payable by the Plan). If the Participant does not use the Spouse's or Domestic Partner's HMO, for which they are eligible and, instead, receives services from a provider not associated with the HMO, the Plan will not pay as primary.

Spouse or Domestic Partner who is Covered Under his or her Own HMO
The Spouse's or Domestic Partner's HMO Plan will be considered primary for the Spouse or Domestic Partner, and the Plan will only reimburse Copayments, Deductibles, and any Coinsurance required under the HMO (but not to exceed any benefits that would have been payable by the Plan).

Effect on Benefits
Benefits under this Plan will be paid as follows if:

1. this Plan is the primary plan, it shall pay its benefits as if there were no other coverage;

2. an Employee and/or Retiree is covered under this Plan as an Eligible Employee and/or Eligible Retiree and as an Eligible Dependent spouse or Domestic Partner, this Plan shall pay up to 100% of the total Allowable Expenses including annual Deductibles for each of the above parties and their other Eligible Dependents;

3. this Plan is the secondary plan, it shall limit the benefit it pays so that the sum of its benefits and all other benefits payable by the primary plan will not exceed the total Allowable Expenses payable under this Plan;

4. this Plan is the secondary plan, it shall limit the benefits it pays so that the amount of benefits this Plan pays as the secondary plan will not exceed the amount of benefits this Plan would have paid (the "normal claim liability") had it been the primary plan.

5. In order to be eligible for the Plan's Medical and Prescription Drug benefits under Plan Options A and B, all Retiree Plan participants age 65 and over an all Retired disabled Plan participants who are eligible for Medicare Parts A & B based on age or disability, regardless of age, must enroll in Parts A and B of Medicare as their primary insurance coverage. If the Retired Plan participant does not enroll in Medicare when they become eligible for Medicare) regardless of whether they enroll in Medicare or not, the benefits of this Plan will be coordinated as if Medicare is the Primary provider, resulting in a reduction in Plan payment as the secondary payor.

6. In all instances where the individual is eligible for Medicare, this plan is the secondary plan and Medicare is the primary plan. This Plan shall pay physician benefits for doctors who have Opted Out of Medicare and will estimate what Medicare would have paid as the primary payer. The Plan will then pay its benefits as secondary payer, based on Usual, Customary and Reasonable fees.

7. the above provisions operate to reduce the total amount of benefits otherwise payable as to a Covered Person under this Plan during any Claim Determination Period, each benefit that would be payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit maximum of this Plan.

Right to Receive and Release Information
For the purposes of determining the applicability of and implementing the terms of the above provisions of this Plan or any similar provision of another plan, the Benefits Administrator may release to, or obtain from, any other insurance company, organization or individual any information, concerning any individual, that the Benefits Administrator considers to be necessary for those purposes. Any individual claiming benefits under this Plan shall furnish to the Benefits Administrator the information that may be necessary to implement the above provisions.

THIRD PARTY LIABILITY AND SUBROGATION

Subrogation and Right of Recover
This provision shall apply to all benefits provided under any section of this Plan.

When This Provision Applies
A Covered Person may incur medical or other charges related to Injuries or Illness caused by the act or omission of another person; or Another Party may be liable or legally responsible for payment of charges incurred in connection with the Injuries or Illness. If so, the Covered Person may have a claim against that other person or Another Party for payment of the medical or other charges. In that event, the Plan will be secondary, not primary, and the Plan will be Subrogated to all rights the Covered Person may have against that other person or Another Party and will be entitled to Reimbursement. In addition, the Plan shall have the first lien against any Recovery to the extent of benefits paid or to be paid and expenses incurred by the Plan in enforcing this provision. The Plan's first lien supersedes any right that the Covered Person may have to be "made whole." In other words, the Plan is entitled to the right of first Reimbursement out of any Recovery the Covered Person procures or may be entitled to procure regardless of whether the Covered Person has received compensation for any of his or her damages or expenses, including any of his or her attorneys' fees or costs. Additionally, the Plan's right of first Reimbursement may not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. As a condition to receiving benefits under the Plan, the Covered Person agrees that acceptance of benefits is constructive notice of this provision.

The Covered Person must:

1. Execute and deliver a Subrogation and Reimbursement Agreement;

2. Authorize the Plan to sue, compromise and settle in the Covered Person's name to the extent of the amount of medical or other benefits paid for the Injuries or Illness under the Plan and the expenses incurred by the Plan in collecting this amount, and assign to the Plan the Covered Person's rights to Recovery when this provision applies;

3. Within 10 business days, reimburse the Plan, out of any Recovery made from Another Party, 100% of the amount of medical or other benefits paid for the Injuries or Illness under the Plan and expenses (including attorneys' fees and costs of suit, regardless of an action's outcome) incurred by the Plan in collecting this amount (without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise);

4. Notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and

5. Cooperate fully with the Plan in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan.

When a right of recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for other Illnesses or Injuries), the Covered Person will execute and deliver all required instruments and papers, including a Subrogation and Reimbursement Agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other benefits will be paid by the Plan for the Injuries or Illness. However, failure or refusal on the Covered Person's part to execute such agreements or furnish information does not preclude the Plan from exercising its right to Subrogation or obtaining full reimbursement. In addition, the Covered Person will do nothing to prejudice the Plan's right to Subrogation and Reimbursement and acknowledges that the Plan precludes operation of the made-whole and common-fund doctrines.

The District's Benefit Department has maximum discretion to interpret the terms of this provision and to make changes, as it deems necessary.

Amount Subject to Subrogation or Reimbursement

Any amounts recovered will be subject to Subrogation or Reimbursement. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or other benefits paid for the Injuries or Illness under the Plan and the expenses incurred by the Plan in collecting this amount. The Plan has a right to recover in full, without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise, even if the Covered Person does not receive full compensation for all of his or her charges and expenses.

"Covered Person"
Anyone covered under the Plan, including minor Dependents.

"Another Party"
"Another Party" shall mean any individual or organization, other than the Plan, who is liable or legally responsible to pay expenses, compensation or damages in connection with a Covered Person's Injuries or Illness.

"Another Party" shall include the party or parties who caused the Injuries or Illness; the insurer, guarantor or other indemnifier of the party or parties who caused the Injuries or Illness; a Covered Person's own insurer, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; and any other individual or organization that is liable or legally responsible for payment in connection with the Injuries or Illness.

"Recovery"
"Recovery" shall mean any and all monies paid to the Covered Person by way of judgment, settlement or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the Injuries or Illness. Any Recovery shall be deemed to apply, first, for Reimbursement.

"Reimbursement"
"Reimbursement" shall mean repayment to the Plan for medical or other benefits that it has paid toward care and treatment of the Injury or Illness and for the expenses incurred by the Plan in collecting this benefit amount.

"Subrogation"
Subrogation" shall mean the Plan's right to pursue the Covered Person's claims for medical or other charges paid by the Plan against Another Party.

When a Covered Person Retains an Attorney
If the Covered Person retains an attorney, that attorney must sign the Subrogation and Reimbursement Agreement as a condition to any payment of benefits and as a condition to any payment of future benefits for other Illnesses or Injuries. Additionally, the Covered Person's attorney must recognize and consent to the fact that the Plan precludes the operation of the "made-whole" and "common fund" doctrines, and the attorney must agree not to assert either doctrine in his or her pursuit of Recovery. The Plan will neither pay the Covered Person's attorneys' fees and costs associated with the recovery of funds, nor reduce its reimbursement pro rata for the payment of the Covered Person's attorneys' fees and costs. Attorneys' fees will be payable from the Recovery only after the Plan has received full Reimbursement.

A Covered Person or his or her attorney who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the Recovery to the Plan under the terms of this provision. Furthermore, a Covered Person agrees to direct his or her attorney who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) that he or she has an absolute obligation to immediately tender the Recovery to the Plan under the terms of this provision. A Covered Person or his or her attorney who receives any such Recovery and does not immediately tender the Recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan, because the Covered Person or his or her attorney is not the rightful owner of the Recovery and should not be in possession of the Recovery until the Plan has been fully reimbursed.

When the Covered Person is a Minor or is Deceased
These provisions apply to the parents, trustee, guardian or other representative of a minor Covered Person and to the heir or personal representative of the estate of a deceased Covered Person, regardless of applicable law and whether or not the minor's representative has access or control of the Recovery.

When a Covered Person Does Not Comply
When a Covered Person does not comply with the provisions of this section, the Benefits Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) under the Plan by the amount due as Reimbursement to the Plan. The reductions will equal the amount of the required Reimbursement. If the Plan must bring an action against a Covered Person to enforce this provision, then that Covered Person agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

When Recovery includes the Cost of Past or Future Expenses
In certain circumstances, a Covered Person may receive a Recovery that includes amounts intended to be compensation for past and future expenses for treatment of the Illness or Injury, which is the cause of the Recovery. This Plan will not cover any expenses for which compensation was provided through a previous Recovery. This exclusion will apply to the full extent of such Recovery or the amount of the expenses submitted to the Plan for payment, whichever is less. The Plan also precludes operation of the made-whole and common-fund doctrines in applying this provision.

It is the responsibility of the Covered Person to inform the Benefits Administrator when expenses are incurred related to an Illness or Injury for which a Recovery has been made. Acceptance of benefits under this Plan for which the Covered Person has received a Recovery will be considered fraud, and the Covered Person will be subject to any sanctions determined by the Plan, in its sole discretion, to be appropriate. The Covered Person is required to submit full and complete documentation of any such Recovery in order for the Plan to consider eligible expenses that exceed the Recovery

EFFECT OF PLAN BENEFITS FOR PARTICIPANTS ELIGIBLE FOR MEDICARE

EFFECT OF MEDICARE FOR ACTIVE EMPLOYEES

Federal law requires that the District offer to active Employees and the Covered Dependents who are age 65 or more the same health benefits as are available to active Employees and Covered Dependents less than age 65. Further, if such Covered Person chooses to be covered under the District's group medical Plan, Medicare will become the secondary provider of benefits. The Plan will determine what benefits are covered under this Plan; the remainder of the expenses may then be submitted to Medicare by the Covered Person for reimbursement.

If the active Employee chooses to be covered under Medicare, then the benefits described in this Plan will be paid separately to Medicare.

EFFECT OF MEDICARE FOR RETIREES

A retired Employee and covered Dependents must enroll in Medicare Parts A (Hospital) and Medicare Part B (Medical) upon becoming eligible for Part A (Hospital) coverage under Social Security. If you are a Retired member or an eligible Dependent of a Retired member and are eligible for Medicare, regardless of whether you are enrolled or not, the benefits of this Plan will be paid secondary and Medicare will be the primary. This means that if you are eligible for Medicare, your benefits under this Plan (as secondary payor) will be reduced by what Medicare would have paid.

If you are a Retired member or an eligible Dependent of a Retired member and are not eligible for Medicare, the benefits of this Plan will be paid the same as for active Employees and their Dependents.

Medicare Part A (Hospital) benefits are covered at no cost provided you enroll for such coverage when you first qualify under Social Security. Medicare Part B (Medical) benefits require a contribution from Participants. The District will not reimburse Retirees for the Medicare Part B premium(s).

Medicare Part D (Prescription Drug)

The Plan offers at least as much as the Standard Medicare Part D coverage so Employees, Retirees and Dependents are urged **NOT** to enroll in an individual Part D plan. The federal Medicare Part D prescription drug program does not allow enrollment in more than one prescription drug plan. Therefore, enrollment in an individual Part D prescription drug plan may risk permanent loss of your current prescription drug coverage. The Plan will not be reimburse for Part D premiums, nor will it be responsible for any "income-related" monthly adjustment amount (IRMAA) imposed by Medicare, pursuant to page 35.

Please refer to this Plan Booklet beginning on page 35 which describes Prescription Drug Benefits for Eligible Active Employees, and Retirees, and for Eligible Dependents.

INTERNAL AND EXTERNAL CLAIMS REVIEW PROCEDURES

The information in this section applies to the following benefit providers who have contracted to provide services under the Fresno Unified School District Employees Health Plan (the "Plan"):

Anthem Blue Cross Network Provider
Avante Health Mental Health and Substance Abuse Program
ChiroMetrics Chiropractic Plan
Claremont Employee Assistance Plan
EnvisionRx Options Prescription Drug Plan
Delta Dental Plan
Vision Service Plan

If you participate in the Kaiser Permanente Plan, Pacific Union Dental Plan, the Safeguard Vision Plan, the Standard Life Insurance Plan, and/or the Prudential Accidental Death & Disability Plan, and a claim for benefits is denied you must follow the appeals procedures of that plan. Only that plan is able to extend or modify any time limits set forth in that plan's appeal procedures. If you do not agree with the result obtained under the insured plan's procedure you may make a written request to the JHMB (the Joint Health Management Board of Fresno Unified School District) to intervene. If the JHMB determines that the position of the Participant is correct, the JHMB shall contact the insured plan and request that the plan change its decision. The JHMB, however, is limited to this role. The insurer is the ultimate decision maker for these plans.

FILING A CLAIM

NOTICE OF CLAIM
The Plan does not generally require Participants or Dependents to file any claim forms as long as:

- Itemized claims are submitted by the provider directly to the Claims Administrator.
- Payment is assigned to the provider of service.

If your provider does not submit the claim on your behalf (for example, if you are billed directly by an Out-of-Network provider), written notice of a claim must be given to the appropriate Claim Administrator within the timeframe noted in the chart below. Any claim for services not submitted within the timeframe indicated below will be ineligible for payment unless a written appeal is approved by the Joint Health Management Board, which approval must be based on proof of special circumstances which made timely filing of the claim unfeasible.

PROVIDER ADDRESS AND TIMETABLE FOR SUBMISSION OF CLAIMS

Claims Administrator and Address	Claims Must be Submitted within Months of Date Incurred Noted Below
Anthem Blue Cross Network Provider Grievances and Appeals P.O. Box 54159 Los Angeles, California 90054	12 months
Avante Health Mental Health and Substance Abuse Program 1111 E. Herndon Ave, Suite 308 Fresno, California 93720	12 months
ChiroMetrics Chiropractic Plan 4678 N. First Street Fresno, California 93726	90 Days
Claremont Employee Assistance Plan Claims Department Claremont Behavioral Services 1050 Marina Village Parkway, Suite 203 Alameda, California 94501	12 months
Delta Dental Plan Delta Dental of California P.O. Box 997330 Sacramento, California 95899-7330	12 months
Delta Health Systems Appeals Department P.O. Box 1931 Stockton, California 95201	12 months
EnvisionRx Options Prescription Drug Plan Attn: Clinical Services/Appeals 2181 E. Aurora Road Twinsburg, Ohio 44087	12 months
Vision Service Plan VSP Appeals P.O. Box 2350 Rancho Cordova, California 95741	12 months

EXTENSION OF COVERAGE DUE TO DISABILITY

You or your authorized representative WILL need to submit claims for an extension of coverage based on Disability to the District's Benefit Department, in writing, using the appropriate claims form (see page 70 of this Plan Booklet for more information regarding extensions of coverage based on Disability). Disability claims should be submitted within 60 days of the date on which the employee's or dependent's coverage will end.

RESCISSION OF ELIGIBILITY FOR COVERAGE

You will have 30 calendar days from the date you receive notice of a rescission of coverage to file an appeal with the District's Benefit Department.

USING AN AUTHORIZED REPRESENTATIVE

An authorized representative, such as your Spouse, may complete a claim or receive claim information for you if you previously designated the individual to be your authorized representative (you can obtain a form from the District's Benefit Department or the Benefits Administrator). Additional information may be required from you to verify that this person is authorized to act on your behalf.

In the case of an urgent care claim, a Physician with knowledge of your condition may act on your behalf even without written authorization.

INTERNAL CLAIMS PROCEDURES

TYPES OF CLAIMS FOR BENEFITS

For the purposes of these Claims Review Procedures, "claim for benefits" means a request for benefits under the Plan. This term includes, *pre-service claims*, *urgent care claims*, *concurrent care claims*, *post-service claims*, *disability claims*, and an appeal from a *rescission of coverage*.

Pre-service claims: A pre-service claim is a request for authorization of care or treatment that requires approval in whole or in part before the care or treatment is obtained (also called "prior authorization"). These are the types of claims that will generally be submitted by your Provider.

Please see pages 3 to 5 of this Plan Booklet or contact the Claim Administrator for a list of services for which pre-service approval (prior authorization or certification) is required. If you fail to obtain prior approval for these services, your benefits may be denied or reduced.

Urgent care claims: Your request for a required prior authorization will be considered an *urgent care claim* if it needs expedited handling. In other words, your pre-service claim will be considered "urgent" if applying the time frames allowed for a *pre-service claim* (generally 15 - 30 days for a request submitted with sufficient information):

- Could seriously jeopardize your life or health or your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that could not be adequately managed without the care or treatment that is' the subject of the claim.

The applicable urgent care claim reviewer, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, will determine whether your claim is an urgent care claim. Alternatively, any claim that a physician with knowledge of your medical condition determines is an urgent care claim within the meaning above will be treated as an urgent care claim.

Concurrent care (ongoing treatment) claim: A concurrent care claim is a decision to reconsider a benefit after an initial approval was made resulting in a reduction, termination, or extension of a benefit. (For example, an inpatient hospital stay originally approved for 5 days is subjected to concurrent review at 3 days to determine if the full 5 days are appropriate.) In this situation, a decision to reduce, terminate, or extend treatment is made concurrently with the provision of treatment. This category also includes requests by you or your provider to extend care or treatment approved as an urgent care claim.

Post-service claims: Any other type of health care claim is considered a post-service claim, such as a claim submitted for payment after health care services and treatment have been obtained.

Disability claims: A disability claim is a claim that requires a finding of total disability as a condition of eligibility. Under the terms of this Plan, a *disability claim* is any claim for an extension of eligibility due to disability arising prior to the date that coverage would otherwise terminate. (See page 71 of this Plan Booklet or contact the District's Benefits Department for further information about extensions of eligibility based on disability.)

Rescission of Coverage. A rescission of coverage occurs when a Participant or Dependent's coverage under the Plan is cancelled *retroactively* because a Participant has committed fraud or has intentionally misrepresented a material fact (contact the District's Benefits Department regarding the definition of "Rescission"). When coverage is cancelled retroactively, it means that coverage will be cancelled back to the first day of enrollment in the Plan.

Situations That do NOT Constitute a "Claim for Benefits"

The following are not considered claims and are therefore not subject to the requirements and time frames described in this section:

- Simple inquiries about this Plan's provisions that are unrelated to any specific benefit claim.
- A request for an advance determination regarding this Plan's coverage of a treatment or service that does not require prior authorization.
- A prescription you present to a pharmacy to be filled. (However, if your request for a prescription is denied, in whole or in part, you may file a claim and appeal regarding the denial by using the procedures in this section.)
- Simple requests for a determination regarding whether an individual is eligible for coverage under the Plan.
- Simple requests for a diagnosis code (and its corresponding meaning) or a treatment code (and its corresponding meaning).

Change in Claim Type
Generally, the claim type is determined at the time the initial claim is filed. However, if the nature of your claim changes as it proceeds through the claims procedures, the claim may be re-characterized. For example, a claim that was initially characterized as an *urgent care claim* may be re-characterized as a *pre-service claim* if the urgency subsides.

NOTIFICATION THAT YOUR PRE-SERVICE OR URGENT CARE CLAIM HAS NOT BEEN PROPERLY FILED
If your *pre-service claim* has not been properly filed, the applicable Claim Administrator will notify you as soon as possible but no later than 5 days after receipt of the claim of the proper procedures to be followed in filing a claim.

If your *urgent care claim* has not been properly filed, the applicable Claim Administrator will notify you as soon as possible but no later than 24 hours after receipt of the claim of the proper procedures to be followed in filing a claim.

Unless the claim is re-filed properly, it will not constitute a claim. You or your Provider will receive notice that you have improperly filed your claim only if the claim includes your name, your specific condition or symptom, and a specific treatment, service, or product for which approval is requested.

TIMING OF INITIAL CLAIMS DECISION
A determination on your initial claim will be made within the following time frames:

Pre-service claims. If your pre-service claim has been properly filed, the applicable Claim Administrator will notify you of its decision within 15 days from the date your claim is received, unless additional time is needed. The time for response may be extended by up to 15 days if necessary due to matters beyond the control of the Claim Administrator. If an extension is necessary, you will be notified before the end of the initial 15-day period of the circumstances requiring the extension and the date by which a decision is expected to be made.

If an extension is needed because the Claim Administrator needs additional information from you, the Claim Administrator will notify you as soon as possible, but no later than 15 days after receipt of the claim, of the specific information necessary to complete the claim. In that case you and/or your provider will have 45 days from receipt of the notification to respond. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or the date you respond to the request (whichever is earlier). The Claim Administrator then has 15 days to make a decision and notify you of the determination.

Urgent care claim. You will be notified of a determination by telephone as soon as possible, taking into account the exigencies of your situation, but no later than 72 hours after receipt of the claim by the Claim Administrator. The plan will defer to the attending provider with respect to the decision as to whether a claim constitutes "urgent care." The determination will also be confirmed in writing. If your urgent care claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, the Claim Administrator will notify you as soon as possible, but no later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. You and/or your provider must respond to this request within 48 hours. Notice of a decision will be provided no later than 48 hours after the Claim Administrator receives your response, but only if it is received within the required time frame.

Concurrent care decision. A reconsideration that involves the termination or reduction of payment for a treatment in progress (other than by Plan amendment or termination) will be made by the Claim Administrator as soon as possible, but in any event early enough to allow you to have an appeal decided before the benefit is reduced or terminated. A request by you to extend approved urgent care treatment will be acted upon by the Claim Administrator within 72 hours of receipt of the claim, provided the claim is received at least 24 hours prior to the expiration of the approved treatment. The Plan is required to provide continued coverage pending the outcome of your internal concurrent claim appeal.

Post-service claims. Ordinarily, you will be notified of the decision on your post-service health care claim within 30 days of the date the Claim Administrator receives the claim. This period may be extended one time by up to 15 days if the extension is necessary due to matters beyond the control of the Claim Administrator. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension and the date by which the Claim Administrator expects to make a decision. If an extension is needed because the Benefits Administrator or Claim Administrator needs additional information from you, the Claim Administrator will notify you as soon as possible, but no later than 30 days after receipt of the claim, of the specific information necessary to complete the claim. You and/or your provider will have 45 days from receipt of the notification to respond. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days have passed or the date you respond to the request (whichever is earlier). The Claim Administrator then has 15 days to make a decision on your post-service claim and notify you of the determination.

Extension of Coverage for Disability claims. The District's Benefit Department will ordinarily make a decision on the claim and notify you of the decision within 45 days of receipt of the claim. This period may be extended by up to 30 days if the extension is necessary due to matters beyond the control of the District's Benefit Department. If an extension is necessary, you will be notified before the end of the initial 45-day period of the circumstances requiring the extension and the date by which the District's Benefit Department expects to make a decision. A decision will then be made within 30 days of the date the District's Benefit Department notifies you of the delay. The period for making a decision may be extended an additional 30 days, provided the District's Benefit Department notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date by which the District's Benefit Department expects to render a decision. If an extension is needed because the District's Benefit Department needs additional information from you, the District's Benefit Department will notify you as soon as possible, but no later than 45 days after receipt of the claim, of the specific information necessary to complete the claim. You will have 45 days from receipt of the notification to respond. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the

extension notice until either 45 days have passed or the date you respond to the request (whichever is earlier). District's Benefit Department then has 30 days to make a decision on your claim and notify you of the determination.

Rescissions of Coverage. The District's Benefit Department will provide you with a decision on your initial appeal of a rescission of coverage. For the purposes your initial claim, *rescissions of coverage* will be subject to the same time frames which apply to *post-service claims*.

The Claim Administrator or District's Benefit Department will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim while it is under review. You will be provided with the new or additional rationale sufficiently in advance of the date on which the Claim Administrator, or the District's Benefit Department is required to provide you with an adverse benefit determination. This is to give you time to respond to the new or additional rationale.

NOTICE OF AN ADVERSE BENEFIT DETERMINATION

You will be provided with written notice of a determination denying your claim, whether your claim is denied in whole or in part. This notice will include the following:

- Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount (if applicable). You have the right to request the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning. These will be provided to you free of charge upon your request.
- The specific reason(s) for the denial.
- The denial code and its corresponding meaning.
- A reference to the specific Plan provision(s) on which the determination is based.
- A description of any additional material or information needed to process your claim, as well as an explanation of why the additional material or information is needed.
- A description of the Plan's review procedures and the time limits that are applicable to them if you appeal and the claim denial is upheld at the initial level, as well as a description of the external review process and information regarding when and how to initiate an external appeal.
- Information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge, along with a discussion of the claims denial decision.
- Information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment, or about your right to request this explanation free of charge, along with a discussion of the claims denial decision.
- In the case of a final adverse benefit determination following your appeal of the initial adverse benefit determination, a discussion of the reasons for the decision.
- The contact information for the District's Benefit Department and the Department of Health and Human Services Insurance Assistance Team (1-888-393-2789).

For *urgent/concurrent* claims:

- The Claim Administrator's notice will also include a description of the applicable urgent/concurrent review process; and
- The Claim Administrator may notify you or your authorized representative within 72 hours orally and then furnish a written notification.
- For *pre-service* and *urgent care claims*, you will receive notice of the determination even when the claim is approved.

HOW TO APPEAL AN ADVERSE BENEFIT DETERMINATION
You have the right to appeal an adverse benefit determination (claim denial). You or your authorized representative must file your appeal within 180 calendar days after you are notified of the denial. You will have the opportunity to submit written comments, documents, records, and other information supporting your claim. The review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

The time frame allowed for the Claim Administrator, or the JHMB Board of Directors to complete its review of your appeal is dependent upon the type of review involved (*e.g*. pre-service, concurrent, post-service, urgent, disability, or rescission).

Pre-Service Claims, Urgent Care Claims, Concurrent Care Claims, Post-Service Claims
The Plan offers one level of appeal which will be heard by the applicable Claim Administrator. You will not be charged any fees to file an appeal.

For *pre-service claims* involving urgent/concurrent care, you may obtain an expedited appeal. You or your authorized representative may request it orally or in writing. All necessary information, including the Claim Administrator's decision, can be sent between the Benefit Administrator or Claim Administrator and you by telephone, facsimile or other similar method. To file an appeal for a claim involving urgent/concurrent care, you or your authorized representative must contact the Claim Administrator by phone and provide at least the following information:

- The identity of the claimant;
- The date (s) of the medical service;
- The specific medical condition or symptom;
- The provider's name;
- The service or supply for which approval of benefits was sought; and
- Any reasons why the appeal should be processed on a more expedited basis.

All other requests for appeals should be submitted in writing by you or your authorized representative, except where the acceptance of oral appeals is otherwise required by the nature of the appeal (*e.g*. urgent care).

Appeals of Disability Extension of Coverage
If your disability claim is denied by the District's Benefit Department, the JHMB Board of Directors will offer a single mandatory level of appeal.

You or your authorized representative must submit a written request for an appeal to the JHMB Board of Directors at the following address:

Attn: JHMB Board Administrator
Post Office Box 2330
Stockton, CA 95201

Appeals of Rescission of Coverage
If your initial appeal of a rescission of coverage is denied by the District's Benefit Department, the JHMB Board of Directors will offer a single mandatory level of appeal.

You or your authorized representative must submit a written request for an appeal to the JHMB Board of Directors at the following address:

Attn: JHMB Board Administrator
Post Office Box 2330
Stockton, CA 95201

HOW YOUR APPEAL WILL BE DECIDED
When the Claim Administrator, or the JHMB Board of Directors, (the "Reviewer") considers your appeal, it will not rely upon the initial benefit determination. The review will be conducted by persons who did not make the initial determination and who do not work for the person who made the initial determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not medically necessary, the Reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination. Upon your request, the Reviewer will identify the health care professional whose advice was obtained in connection with the initial determination, whether or not it was relied on.

Upon request, the Reviewer will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. "Relevant" means that the document, record, or other information:

- Was relied on in making the benefit determination; or
- Was submitted, considered, or produced in the course of making the benefit determination; or
- Demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the plan, applied consistently for similarly-situated claimants; or
- Is a statement of the plan's policy or guidance concerning the treatment or benefit relative to your diagnosis.

The Reviewer will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. You will be provided with the new or additional rationale sufficiently in advance of the date on which the Reviewer is required to provide you with the final adverse benefit determination. This is to give you time to respond to the new or additional rationale.

You do not have the right to personally appear before the Reviewer unless the Reviewer, in its sole discretion, concludes that such an appearance would be of value in enabling it to review the initial adverse determination.

NOTIFICATION OF THE OUTCOME OF THE APPEAL
If you appeal a *pre-service claim*, the Reviewer will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal.

If you appeal a claim involving *urgent/concurrent care*, the Reviewer will notify you of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of your request for appeal.

If you appeal a *post-service claim*, the Reviewer will notify you of the outcome of the appeal within 60 days after receipt of your request for appeal.

If you appeal the initial decision of your extension of coverage due to a *disability claim*, the JHMB Board of Directors will notify you of the outcome of the appeal within 45 days after receipt of your request for appeal. This period can be extended for an additional 45 days if it determined that special circumstances exist. If an extension is needed you will be notified in writing of the need for an extension prior to the expiration of the first 45 day period, of the circumstances requiring the extension, and the date by which the District's Benefit Department expects to reach a decision.

If you are appealing the District's Benefit Department initial decision of your *rescission of coverage*, the JHMB Board of Directors will notify you of the outcome of the appeal within 60 days after the receipt of your request for appeal.

DENIAL OF YOUR APPEAL
If your appeal is denied, that denial will be considered an adverse benefit determination. The notification from the Reviewer will include all of the information set forth in the above subsection entitled "Notice of Adverse Benefit Determination."

You may have reasonable access to all records relevant to your claim and may receive copies at no charge upon written request. If an internal rule, guideline, protocol, or other similar criterion was used in the appeal denial, you will be told about it and may receive a copy of it. If the denial is based on medical necessity or the treatment's being experimental or investigational or the like, you may have a copy of whatever scientific or clinical explanation was used in the determination.

If you waive your right to appeal or receive a final adverse benefit determination, such waiver or the final adverse benefit determination is final and binding upon all parties, subject only to the External Review Procedures described immediately below or any civil action you may bring following such external review. Following issuance of the written final adverse benefit determination there is no further right of internal appeal. Please note that if your claim is eligible for external review you are required to exhaust the External Review Procedures immediately below before you may file a legal claim in state or federal court.

EXTERNAL REVIEW PROCEDURES

Until further guidance is issued, you may only request an external review of claims that involve (1) medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment), as determined by the external reviewer, or (2) a rescission of coverage.

If your claim involved a medical judgment or a rescission of coverage, and the outcome of the final internal appeal is adverse to you, you may be eligible for an external review pursuant to federal law. This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above; it is voluntary. Your decision to seek external review will not affect your rights to any other benefits under this Plan. There is no charge for you to initiate an independent external review. The external review decision is final and binding on all parties except for any relief available through applicable state or federal laws. If your claim is denied following an independent external review, no lawsuit or legal action of any kind may be filed by you in a court of law or in any other forum, unless it is commenced within three years of the external review decision on the claim.

REQUEST FOR EXTERNAL REVIEW
You or your authorized representative must submit your request for external review within four (4) months of the notice of your final internal adverse benefit determination. A request for an external review must be in writing and must be sent to the Department of Health and Human Services ("HHS"):

Via Email:	**Via Fax:**	**Via Mail:**
disputedclaim@opm.gov	(202) 606-0036	P.O. Box 791 Washington, DC 20044

The HHS examiner who reviews your External Review request will be an independent third party with clinical and legal expertise and with no financial or personal conflicts with the Plan. If you have any questions or concerns during the external review process you can call HHS at the following toll-free number: (877) 549-8152.

You do not have to resend the information that you submitted for your internal appeal. However, you are encouraged to submit any additional information that you think is important for review to the mailing address above. Any additional information you submit to the HHS will be shared with the Plan in order to give the Plan an opportunity to reconsider the denial.

When the HHS examiner receives your request for external review the review will contact the Plan. Within five (5) business days of the HHS examiner's request, the Plan must provide the following documents to HHS:

- The Certificate of Coverage;
- A copy of the adverse benefit determination;
- A copy of the final internal adverse benefit determination;
- A summary of the claim;
- An explanation of the Plan's adverse benefit determination and final internal adverse benefit determination; and
- All documents and information considered in making the adverse benefit determination or final internal adverse benefit determination including any additional information that may have been provided to the Plan or relied upon by the Plan during the internal appeals process.

The HHS examiner will make a preliminary review of your request for external review following the receipt of your request. This review will determine whether:

- You have exhausted the Plan's internal claims procedures;
- The denial of benefits relates to your failure (or the failure of your Dependent) to meet the Plan's eligibility requirements;
- You are or were covered under the Plan at the time the initial claim for health care was requested; and
- You have provided all information and forms needed to process the external review.

If your request is complete, but not eligible for external review, the HHS examiner will notify you and the Plan in writing. If your request is not complete, the notice will describe the information you or the Plan need to provide to make your request complete.

THE REVIEW PROCESS

The HHS examiner will review all the information and documents timely received. In reaching a decision, the HHS examiner will review the claim "de novo" ("afresh") and will not be bound by any decisions or conclusions reached during the internal claims and appeals process.

Reconsideration by the Plan

The HHS examiner will forward any documents submitted directly to the HHS examiner by the claimant to the Plan within one (1) business day of their receipt. Upon the receipt of such information the Plan may reconsider its adverse benefit determination or final internal adverse benefit determination, however this reconsideration will not delay the external review. The external review will only be terminated as a result of the Plan's reconsideration if the Plan decides to reverse its adverse benefit determination or final adverse benefit determination. Within one (1) business day of making its decision to reverse, the Plan must provide written notification of its decision to you and the HHS examiner. The HHS examiner will terminate the external review upon receipt of this notice.

The Decision of the HHS Examiner

The HHS examiner must provide written notice to you and the Plan of the final external review decision within 45 days after the HHS examiner receives the request for the external review.

The HHS examiner's final external review decision will contain:

- A general description of the reason for the request for external review, including information sufficient to identify the claim (the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and the corresponding meaning). If the notice involves a denial unrelated to a specific claim, only the name and the ID number will be provided;
- The date the HHS examiner received assignment to conduct the external review and the date of the HHS examiner's decision;
- References to the evidence or the documentation, including the specific coverage provisions and evidenced-based standards, considered in reaching its decision;
- A discussion of the principal reason or reasons for the decision, including the rationale and any evidence-based standards that were relied on;
- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either you or the Plan;
- A statement that judicial review may be available to you; and
- The current contact information for any applicable ombudsman.

After the final external review decision, the HHS examiner will maintain records of all claims and notices associated with the external review process for six (6) years. The HHS examiner must make such records available for examination by you and the Plan upon request.

Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

REQUEST FOR AN EXPEDITED EXTERNAL REVIEW

You may make a written or oral request to HHS for an expedited external review if you receive:

- An adverse benefit determination or final adverse benefit determination which involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal (*i.e.*, and *urgent* claim); or
- An adverse benefit determination or final adverse benefit determination concerning an admission, availability of care, continued stay, or health care item or service for which you receive services, but have not been discharged from a facility, and you have filed a request for an expedited internal appeal (*i.e.*, a *concurrent* claim).

A request for an expedited external review can be made by calling HHS at the following toll-free number: (877) 549-8152.

The HHS examiner will contact the Plan immediately upon your request for an expedited external review. Immediately upon request of the HHS Examiner, the Plan must provide the information detailed above under "Request for External Review." If the HHS examiner determines that you are not eligible for an expedited external review, the HHS examiner will notify you and the Plan as soon as possible.

The Review Process

The review process detailed above will be followed by the HHS examiner. However, the HHS examiner will provide you and the Plan with notice of the final external review decision within 72 hours of receipt of the request for an expedited external review. This notice can be provided orally, but will be followed by written notice within 48 hours.

In the event that the Plan makes the decision to reverse its adverse benefit denial upon reconsideration, the notice of the Plan's decision can be provided to you and the HHS examiner orally, but must be followed by written notice with 48 hours.

OTHER IMPORTANT INFORMATION

REQUIREMENT TO FILE A REQUEST FOR EXTERNAL REVIEW BEFORE FILING A LAWSUIT

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced within three years of a final external review decision on the claim or other request for benefits. You must exhaust the Plan's internal and external claims and appeals procedure before filing a lawsuit or taking other legal action of any kind against the Plan.

If the Plan fails to adhere to the internal claims process described above, the Plan's claims and appeals procedure will be deemed exhausted and you can seek immediate review by a court or request external review, unless the failure was: de minimis; non-prejudicial; attributable to good cause or matters beyond the Plan's control; in the context of an ongoing good-faith exchange of information; and not reflective of a pattern or practice of non-compliance. You are entitled, upon written request, to an explanation of the Plan's basis for asserting that it meets the foregoing standard so that you can make an informed decision about whether to seek immediate review. If the external reviewer or the court rejects your request for immediate review on the basis that the Plan meets the foregoing standard you have the right to resubmit and pursue the internal appeal of the claim.

If the Plan decides an internal appeal is untimely (*e.g.*, you do not appeal with 180 calendar days of being notified of the adverse benefit determination), the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date.

LEGAL STANDARD OF REVIEW

The Benefits Administrator, the JHMB Board of Directors, the District's Benefit Department and any applicable Claim Administrator retain full discretionary authority to (a) determine all facts relevant to any claim (b) to construe the terms of the Plan and all other documents relevant to the Plan, and (c) to determine which benefits are payable from the Plan.

Any decision made by the Benefits Administrator, the JHMB Board of Directors, the District's Benefit Department or any applicable Claim Administrator shall be binding on all persons affected to the fullest extent permitted by law.

No decision made by the Benefits Administrator, the JHMB Board of Directors, the District's Benefit Department or any applicable Claim Administrator shall be revised, changed or modified by court unless the party seeking such action is able to show by clear and convincing evidence that that decision made by the Benefits Administrator, JHMB Board of Directors, the District's Benefit Department or applicable Claim Administrator on appeal was an abuse of discretion in light of the information actually available to it at the time of its decision.

PLAN RECORDS

The Plan's Benefits Administrator will maintain records designed to ensure and verify that determinations are made in accordance with the Plan documents and applicable law, and that where appropriate, the Plan provisions have been followed and applied consistently with respect to similarly situated claimants. Your privacy will be protected in accordance with applicable state and federal law.

The JHMB Board of Directors reserves the right to modify the policies, procedures and timeframes in this section. Furthermore, if these procedures are ambiguous or do not provide an explicit procedure for a specific circumstance, the JHMB Board of Directors reserves the right to adopt such rules as it in its discretion deems necessary and appropriate to provide claimants with appropriate initial determinations and an opportunity for a full and fair review of any adverse benefit determination.

PLAN'S PRIVACY PRACTICES

NOTICE OF PRIVACY PRACTICES

Effective April 1, 2012

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

GENERAL PRIVACY RULES

The Joint Health Management Board ("JHMB"), as the sponsor of the Fresno Unified School District Employee Health Care Plan (the "Plan"), is required by law to maintain the privacy of protected health information and to inform you with notice of its legal duties and privacy practices with respect to your protected health information, including:

- The Plan's uses and disclosures of protected health information;
- Your privacy rights with respect to such information;
- The Plan's duties with respect to such information;
- The person or office to contact for further information about the Plan's privacy practices.

Section 1. Notice of Uses and Disclosures

(a) Required Uses and Disclosures. Upon your request, the Plan is required to give you access to certain protected health information, which includes all individually identifiable health information in order to inspect and copy it. Use and disclosure of your protected health information may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

(b) Uses and disclosures to carry out treatment, payment and health care operations without your consent or authorization. The Plan and its business associates will use protected health information without your consent, authorization or opportunity to agree or object to carry out "treatment, payment and health care operations" as defined below.

(i) *Treatment* is the provision, coordination or management of health care and related services. For example, your pharmacy may contact your treating physician to refill your prescription for medication.

(ii) *Payment* includes but is not limited to actions to make coverage determinations and to provide payment for the treatment you receive. For example, we may use and disclose your protected health information to pay and manage your claims, coordinate your benefits and review health care services provided to you.

(iii) *Health care operations* include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts and related business services. For example, the Plan may use information about your claims to refer you to a disease management program, project future benefit costs and audit the accuracy of its claims processing functions.

(c) Other uses and disclosures for which consent, authorization or opportunity to object is not required. Use and disclosure of your protected health information is allowed without your consent, authorization or request under the following circumstances:

(i) When required by law. The Plan may use and disclose your protected health information when required by law, and when the use or disclosure complies with and is limited to the relevant requirement of such law.

(ii) When permitted for purposes of public health activities.

(iii) Reports about victims of abuse, neglect or domestic violence to government entities. The Plan will disclose your protected health information in these reports only if the Plan is required or authorized to do so by law, or if you otherwise agree.

(iv) To a public health oversight agencies. The Plan will provide protected health information as requested to government agencies that have the authority to audit our operations.

(v) When required for judicial or administrative proceedings, provided certain conditions are met. Those conditions include that satisfactory assurances are given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.

(vi) When required for law enforcement purposes. The Plan may release protected health information if asked to do so by a law enforcement official in the following circumstances: (1) to respond to a court order, subpoena, warrant, summons or similar process; (2) to identify or locate a suspect, fugitive, material witness or missing person, (3) to assist the victim of a crime if, under certain limited circumstances, the Plan is unable to obtain the person's agreement, (4) to investigate a death the Plan believes may be due to criminal conduct, (5) to investigate criminal conduct, and (6) to report a crime, its location or victims or the identity, description or location of the person who committed the crime (in emergency circumstances).

(vii) When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

(viii) Organ procurement. The Plan may disclose protected health information to facilitate organ donation and transplantation.

(ix) Medical research. The Plan may disclose protected health information for medical research projects, subject to strict legal restrictions.

(x) When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

(xi) Special government functions. The Plan may disclose protected health information to various departments of the government such as the U.S. military or U.S. Department of State.

(xii) When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

(d) Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or disclosure. Disclosure of your protected health information to family members, other relatives and your close personal friends is allowed if the information is directly relevant to the family or friend's involvement with your care or payment for that care and you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

(e) Uses and disclosures that require your written authorization or consent.

(i) In general, the Plan will obtain a written authorization before using or disclosing your protected health information whenever it is required to do so under the privacy rules. For example, we will not supply confidential information to another company for its marketing purposes (unless it is for Health Care Operations), for sale (unless under strict legal restrictions), or to a potential employer with whom you are seeking employment without your signed authorization. Your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you from your psychotherapist. The Plan may use and disclose psychotherapy notes when needed by the Plan to defend against litigation filed by you. The Plan will not disclose to third parties the results of genetic testing in a manner which includes individually identifying characteristics without your written authorization.

(ii) The Plan may require your consent to disclose protected health information, even to carry out treatment, payment or health care operations, to certain individuals or organizations. For example, if your union representative is helping you with a claim the Plan may require you to sign a consent form before it will disclose protected health information to that person.

(iii) You may revoke an authorization that you previously have given by sending a written request to the Plan's Privacy Officer, but not with respect to any actions the Plan has already taken.

Section 2. Rights of Individuals

(a) Right to Request Restrictions on Protected Health Information Uses and Disclosures. You may request the Plan to restrict uses and disclosures of your protected health information to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. While the Plan will consider all requests for restrictions carefully, the Plan is not required to agree to your request. However, the Plan must comply with your request to restrict disclosure of your protected health information for payment or health care operations purposes if you paid for these services in full, out of pocket.

The Plan will accommodate reasonable requests to receive communications of protected health information by alternative means or at alternative locations. The Plan must agree to your request if you state that disclosure of the information will put you in danger. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your protected health information. Such requests should be made to the individual identified in Section 5.

If you agree to receive this Privacy Notice electronically, you have the right to obtain a paper copy of this Privacy Notice upon request from the individual identified in Section 5.

(b) Right to Inspect and Copy Protected Health Information. Except under certain circumstances limited by law, you have a right to inspect and obtain a copy of your protected health information for as long as the Plan maintains the protected health information. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the information you request is in an electronic health record, you may request that these records be transmitted electronically to yourself or a designated individual. If you request copies of your protected health information, the Plan may charge a reasonable fee to cover the cost.

You or your personal representative will be required to complete a form to request access to the protected health information. Requests for access to protected health information should be made to the individual identified in Section 5. If access is denied, you and your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise rights to review and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

(c) Right to Amend Protected Health Information. You have the right to request that the individual identified in Section 5 amend your protected health information or a record about you for as long as the protected health information is maintained by the Plan. You or your personal representative will be required to complete a form to request amendment of the protected health information. The Plan may deny your request if you ask us to amend information that: (i) was not created by the Plan, unless the person who created the information is no longer available to make the amendment, (ii) is not part of the protected health information we keep about you, (iii) is not part of the protected health information that you would be allowed to see or copy, or, (iv) is determined by the Plan to be accurate and complete.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your protected health information.

(d) The Right to Receive an Accounting of Protected Health Information Disclosures. You have the right to request a list of protected health information disclosures, which is also referred to as an accounting.

The list will not include disclosures the Plan has made as authorized by law. For example, the accounting will not include disclosures made for treatment, payment, and health care operation purposes (except as noted in the last paragraph of this subsection (d)). Also, no accounting will be made for disclosures made directly to you or under an authorization that you provided or those made to your family or friends. The list will not include disclosures the Plan has made for national security purposes or law enforcement personnel or disclosures made before April 14, 2003.

The list provided by the Plan will include disclosures made within the last six years (subject to the April 14, 2003 beginning date) unless you specify a shorter period. The first list you request within a 12 month period will be free. You may be charged a reasonable fee for providing any additional lists within a 12-month period.

You may also request and receive an accounting of disclosures made for payment, treatment, or health care operations during the prior three years for disclosures made as of January 1, 2014 for electronic health records acquired before January 1, 2009, or January 1, 2011 for electronic health records acquired on or after January 1, 2009.

(e) Personal Representatives. You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your protected health information or allowed to take any action for you. The Plan retains discretion to deny access to your protected health information to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Section 3. The Plan's Duties

(a) General Duty. The Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any protected health information received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this notice will be provided to all past and present participants and beneficiaries for whom the Plan still maintains protected health information. The revised notice will be mailed to all active and retired plan participants. Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.

(b) Minimum Necessary Standard. When using or disclosing protected health information or when requesting protected health information from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the Limited Data Set, or if necessary, the minimum necessary information necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

(i) Disclosures to or requests by a health care provider for treatment;

(ii) Uses or disclosures made to the participant or beneficiary;

(iii) Disclosures made to the Secretary of the U.S. Department of Health and Human Services;

(iv) Uses or disclosures that are required by law; and

(v) Uses or disclosures that are required for the Plan's compliance with legal regulations.

(c) De-Identified Information. This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify the individual.

In addition, the Plan may use or disclose "summary health information" for obtaining premium bids or modifying, amending or terminating the group health plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and from which identifying information has been deleted in accordance with HIPAA.

Section 4. Your Right to File A Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may file a complaint with the Privacy Officer named in Section 5 below, or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the Plan, put your complaint in writing and address it to the Privacy Officer named in Section 5 below. The Plan will not retaliate against you for filing a complaint. You may also contact the Privacy Officer if you have questions or comments about our privacy practices.

Section 5. Whom to Contact at the Plan for More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact:

Andrew De La Torre
2309 Tulare Street
Fresno, California 93721
(559) 457-3520
(559) 457-3797 (fax)

THE PLAN'S VOLUNTARY COMPLIANCE WITH CERTAIN HIPAA STANDARDS

Group health plans sponsored by State and local governmental employers, such as the Plan, must generally comply with the Health Insurance Portability and Accountability Act ("HIPAA") standards found under Title XXVII of the Public Health Service Act ("PHSA"). However employers such as the Fresno Unified School District are permitted to elect to exempt their Plan from some of the HIPAA standards for any part of the Plan that is "self-funded," rather than provided through an insured health insurance policy. The benefits provided by Anthem Blue Cross, Avante, EnvisionRx, Claremont EAP, Chirometrics, Delta Dental, and VSP constitute the self-insured portions of the Plan.

Federal law permits the self-insured benefits of the Plan to be exempt from the following HIPAA standards: (1) Mental Health Parity; (2) Standards Relating to Benefits for Mothers and Newborns; (3) Standards Relating to Reconstructive Surgery following a Mastectomy; and, (4) Coverage Of Dependent Students On Medically Necessary Leaves Of Absence.

The JHMB (which has been given authority by the District to administer the Plan) elects on an annual basis to exempt the self-insured benefits from certain HIPAA standards, and to voluntarily comply with other HIPAA standards. When the JHMB chooses to opt-out of certain HIPAA standards the exemption is effective for the duration of the Plan Year (from July 1st to June 30th), and is renewed for subsequent Plan Years on an annual basis. As required by law, you will receive an annual notice describing the HIPAA standards the JHMB has elected to "opt-out" before the beginning of the Plan Year.

HIPAA Standards the Plan Has Elected to "Opt-Out" Of

1. Mental Health Parity Standards:

   Until such time that you are provided with notice to the contrary, the JHMB elects on an annual basis to exempt the Plan from the HIPAA standard which prohibits benefits for mental health and substance use disorders from being subject to more restrictions than apply to medical and surgical benefits covered by the plan. If you have questions regarding your mental health or substance abuse coverage, please contact Avante Health at (800) 498-9055.

HIPAA Standards That the Plan Voluntarily Complies With

Until such time that you are provided with notice to the contrary, the Plan will voluntarily comply with the following HIPAA standards:

1. HIPAA Standards Relating To Benefits For Mothers And Newborns:

   The Plan voluntarily complies with the HIPAA standard which prohibits restrictions on benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. HIPAA generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or the newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours). For more information, please see page 27 of this Booklet.

2. HIPAA Standards Relating To Reconstructive Surgery Following Mastectomies:

The Plan voluntarily complies with the HIPAA standard which entitles you to certain benefits under the Women's Health and Cancer Rights Act ("WHCRA"). For individuals receiving mastectomy-related benefits, coverage will provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. For more information, please see page 27 of this Booklet.

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If you have any questions regarding the JHMB's right to opt-out of select HIPAA standards, or about any of the HIPAA standards with which the Plan voluntarily complies, please contact Delta Health Systems at (800) 807-0820.

PLAN INFORMATION

Binding the Plan: As a courtesy to you, the Benefits Administrator (Delta Health Systems) and the Fresno Unified School District's Benefit Department may respond informally to oral questions. However, oral information and answers are not binding upon the Fresno Unified School District Employee Health Care Plan and cannot be relied on in any dispute concerning your benefits. Binding information may be obtained only through written request to Delta Health Systems (Benefit Administrator). The Benefits Administrator, the full JHMB Board of Directors, the District's Benefit Department, and any Claim Administrator retain full discretionary authority to (a) determine all facts relevant to any claim, (b) to construe the terms of the Plan and all other documents relevant to the Plan, and (c) determine which benefits are payable from the Plan.

Binding the Plan: As a courtesy to you, the Benefits Administrator (Delta Health Systems) and the Fresno Unified School District's Benefit Department may respond informally to oral questions. However, oral information and answers are not binding upon the Fresno Unified School District Employee Health Care Plan and cannot be relied on in any dispute concerning your benefits. Binding information may be obtained only through written request to Delta Health Systems (Benefits Administrator).

The Benefits Administrator, the full JHMB Board of Directors, the District's Benefit Department, and any Claim Administrator retain full discretionary authority to: (a) determine all facts relevant to any claim; (b) to construe the terms of the Plan and all other documents relevant to the Plan; and (c) to determine which benefits are payable from the Plan.

PLAN NAME AND AFFILIATION

Fresno Unified School District Employee Health Care Plan

BENEFITS ADMINISTRATOR

Delta Health Systems
3244 Brookside Road 2nd Floor
Stockton, California 95219
Phone: (800) 807-0820

District's Benefit Department
2309 Tulare Street
Fresno, California 93721
Phone: (559) 457-3520

PLAN ADMINISTRATION

The Plan is administered by the JHMB Board consisting of three Directors from each Union representing Employees and six Directors representing the District, whose names are as follows:

JOINT HEALTH MANAGEMENT BOARD OF DIRECTORS (as of July 1, 2012)

Voting Directors:

Fresno Unified School District
Dan Boyd
Mike Darling
Andrew De La Torre
Vincent Harris
Kim Kelstrom
Ruth Quinto (Co-Chair)
Ronald Sheppard (Alternate)

Fresno Teachers Association
Brenda Emerson (Alternate Co-Chair)
Michael Friend
Viola Melella
Bill Swanson

California Schools Employees Association
Chapter 125 – White Collar Unit
Elizabeth Guzman
Kathy Johnson
John Stallsmith (Co-Chair)
Mattie Thomas

California Schools Employees Association
Chapter 143 – Food Services Unit
Janice Gardner
Tomasina Kelzer

Services Employees International Union
Local No. 521
Andy Christiansen
Gwyn Harshaw
Richard Marquez
Chris Norman
Pat Riley (Alternate)

Building Trades Council of Fresno, Madera, Kings, & Tulare Counties
AFL/CIO Unions
Drone Jones
Don Redfern
Tom Rotella

Non-Voting Member:

Association of California School Administrators (ACSA)
Roz Bessard, PhD.

CONSULTANT
Rael & Letson

LEGAL COUNSEL
Saltzman & Johnson Law Corporation

The index is provided to help you find the primary section(s) where a term is discussed.
It is for quick reference only and is not intended to be all-inclusive.

INDEX

INDEX (Continued)

INDEX (Continued)

U

V

W

X