FRESNO UNIFIED SCHOOL DISTRICT EMPLOYEE HEALTH CARE PLAN

COMPARISON SUMMARY OF MEDICAL AND PHARMACY BENEFITS
As of January 1, 2016

Options A and B:	**Refer to applicable sections of the Plan Booklet for complete provisions of the benefits provided under Options A and B.**
Option C:	**Refer to the Kaiser Permanente Evidence of Coverage brochure for complete provisions of the benefits provided under Option C.**

COVERAGE FEATURES	Option Plan A (For Actives and all Retirees) Standard Plan (Default)	Option Plan B (For Actives and all Retirees) Alternate Plan	Option Plan C (For Actives and for Retirees NOT ELIGIBLE for Medicare) Kaiser Permanente Plan
PLAN MAXIMUMS	Unlimited lifetime Maximum. No annual Maximums	Unlimited lifetime Maximum No annual Maximums	Unlimited lifetime Maximum. No annual Maximums
DEDUCTIBLE Does not apply to preventive care, hospice, prescription drugs, chiropractic care, acupuncture or inpatient mental health or substance abuse care.	In Network: **$250** per individual (plus any Copayments) **$500** max per family (plus any Copayments) Out of Network: **$750** per individual (plus any Copayments) **$1,500** max per family (plus any Copayments)	In Network: **$1,000** per individual (plus any Copayments) **$2,000** max per family (plus any Copayments) Out of Network: **$3,000** per individual (plus any Copayments) **$6,000** max per family (plus any Copayments)	In Network (at Kaiser facility): **$250** per individual (plus any Copayments) **$500** max per family (plus any Copayments) Deductible does not apply to doctor's office visits.
COST CONTAINMENT PENALTIES	A $250 penalty will be assessed if pre-authorization for non-emergency medical services is not obtained. Any amount that exceeds Usual, Customary, and Reasonable expenses is the Participant's responsibility and does not apply towards the Out-of-Pocket Maximum.		You must receive all covered care from Kaiser Permanente providers, except for the following: • Emergency services, ambulance services and authorized post-stabilization care • Authorized referrals • Urgent care due to an unforeseen illness, injury, or complication of an existing condition (including pregnancy) while you are temporarily located outside our service area

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FRESNO UNIFIED SCHOOL DISTRICT EMPLOYEE HEALTH CARE PLAN
COMPARISON SUMMARY OF MEDICAL AND PHARMACY BENEFITS (CONTINUED)

COVERAGE FEATURES	Option Plan A (For Actives and all Retirees) Standard Plan (Default)	Option Plan B (For Actives and all Retirees) Alternate Plan	Option Plan C (For Actives and for Retirees NOT ELIGIBLE for Medicare) Kaiser Permanente Plan
OUT-OF-POCKET ANNUAL MAXIMUM [1] No Covered Person will be required to pay more than individual maximums noted on the chart in any Calendar Year for covered expenses. No covered family (employee or retiree and his/her eligible dependents) will be required to pay more than the family maximums noted in the chart in any Calendar Year for covered expenses. Once the out-of-pocket maximum is attained, the remaining Covered Expenses for the balance of the Calendar Year will be paid at 100%.	**In-Network Maximums:** Medical & Mental Health • $4,700 per person; $9,400 per family Prescription Drugs • $900 per person; $1,800 per family **Out-of-Network Maximums (Medical Only):** • $10,000 per person; $20,000 per family • Non-network expenses do not accumulate towards In-Network limits.	**In-Network Maximums:** Medical & Mental Health • $5,700 per person; $11,400 per family Prescription Drugs • $900 per person; $1,800 per family **Out-of-Network Maximums (Medical Only):** • $12,000 per person; $24,000 per family • Non-network expenses do not accumulate towards In-Network limits.	**In-Network Only:** Medical, Mental Health & Prescription Drugs • $5,000 per person; $10,000 per family
HOSPITAL SERVICES Inpatient Hospital Room and Board and Ancillary Services	In Network: **80%** of the Anthem Blue Cross Contract Rate. Out of Network: **60%** of Usual, Customary and Reasonable Charges.	In Network: **70%** of the Anthem Blue Cross Contract Rate. Out of Network: **50%** of Usual, Customary and Reasonable Charges.	In Network (at Kaiser facility): **80%** Coinsurance after Deductible. At Non-Kaiser facility: No benefits unless for emergencies as defined under Cost Containment Penalties Section.
Birthing Center	In Network: **80%** of the Anthem Blue Cross Contract Rate. Out of Network: **60%** of Usual, Customary and Reasonable Charges No coverage is provided when a Dependent Child is the mother.	In Network: **70%** of the Anthem Blue Cross Contract Rate. Out of Network: **50%** of Usual, Customary and Reasonable Charges	In Network (at Kaiser facility): **80%** Coinsurance after Deductible Covered under Inpatient Hospital (above) At Non-Kaiser facility: **No coverage.** (Coverage is provided when a Dependent Child is the mother.)

[1] Plan Penalties, expenses not covered by the plan, and any amount that exceeds Usual, Customary and Reasonable allowances do not apply towards Out-of-Pocket Maximum.

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FRESNO UNIFIED SCHOOL DISTRICT EMPLOYEE HEALTH CARE PLAN
COMPARISON SUMMARY OF MEDICAL AND PHARMACY BENEFITS (CONTINUED)

COVERAGE FEATURES	Option Plan A (For Actives and all Retirees) Standard Plan (Default)	Option Plan B (For Actives and all Retirees) Alternate Plan	Option Plan C (For Actives and for Retirees NOT ELIGIBLE for Medicare) Kaiser Permanente Plan
Outpatient Services	In Network: **80%** of the Anthem Blue Cross Contract Rate after a $100 Copayment. Out of Network: **60%** of the Usual, Customary and Reasonable Charges after a $100 Copayment. Coverage is limited to $1,000 per incident.	In Network: **70%** of the Anthem Blue Cross Contract Rate after a $100 Copayment. Out of Network: **50%** of the Usual, Customary and Reasonable Charges after a $100 Copayment. Coverage is limited to $1,000 per incident.	In Network (at Kaiser facility): **$15** per visit for specialty, routine, and urgent care. (deductible does not apply) **$0** for routine eye exam, hearing exam, and preventive care. (deductible does not apply) **80%** Coinsurance after Deductible for outpatient surgery. From Non-Kaiser Provider: Not covered unless prior authorized and referred by Kaiser physician.
PHYSICIAN SERVICES Physician Office, Home, or Hospital Visits All other Physician services and supplies	In Network: $15 Copayment for each physician office, home, or hospital visit. **80%** of the Anthem Blue Cross Contract Rate. Out of Network: **60%** of the Usual, Customary and Reasonable Charges.	In Network: **$25** Copayment for each physician office, home, or hospital visit. **70%** of the Anthem Blue Cross Contract Rate. Out of Network: **50%** of the Usual, Customary and Reasonable Charges.	In Network (at Kaiser facility): **$15** Copayment for each physician office visit, home, or hospital visit (deductible does not apply). From Non-Kaiser Provider: Not covered unless prior authorized and referred by Kaiser physician.
Non-Authorized Physician Services	In Network: $250 penalty then **80%** of the Anthem Blue Cross Contract Rate. Out of Network: $250 penalty then **60%** of Usual, Customary and Reasonable Charges.	In Network: $250 penalty then **70%** of the Anthem Blue Cross Contract Rate. Out of Network: $250 penalty then **50%** of Usual, Customary and Reasonable Charges.	No coverage for care received from a non-Kaiser physician, except for the following: • Emergency services, ambulance services and authorized post-stabilization care • Authorized referrals • Urgent care due to an unforeseen illness, injury, or complication of an existing condition (including pregnancy) while you are temporarily located outside our service area

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FRESNO UNIFIED SCHOOL DISTRICT EMPLOYEE HEALTH CARE PLAN
COMPARISON SUMMARY OF MEDICAL AND PHARMACY BENEFITS (CONTINUED)

COVERAGE FEATURES	Option Plan A (For Actives and all Retirees) Standard Plan (Default)	Option Plan B (For Actives and all Retirees) Alternate Plan	Option Plan C (For Actives and for Retirees NOT ELIGIBLE for Medicare) Kaiser Permanente Plan
OUTPATIENT LAB & X-RAY	In Network: **80%** of the Anthem Blue Cross Contract Rate. Out of Network: **60%** of Usual, Customary and Reasonable Charges.	In Network: **70%** of the Anthem Blue Cross Contract Rate. Out of Network: **50%** of Usual, Customary and Reasonable Charges.	In Network (at Kaiser facility): Preventive Care Lab & X-ray: No Copayment, Covered at 100%. (deductible does not apply) Most Lab & X-ray: **$10** Copayment after deductible. MRI, most CT and PET scans: $50 Copayment after deductible. From Non-Kaiser provider: **No coverage.**
PREVENTIVE HEALTH CARE [1] Routine annual physical exam, checkups, immunizations, pap smear, etc. (Plan Deductible Waived)	In Network: No Copayment. 100% of the Anthem Blue Cross Contract Rate. Out of Network: 100% of Usual, Customary and Reasonable Charges up to a Maximum of $300 per Calendar Year.	In Network: No Copayment. 100% of the Anthem Blue Cross Contract Rate. Out of Network: 100% of Usual, Customary and Reasonable Charges up to a Maximum of $300 per Calendar Year.	In Network (at Kaiser facility): No Copayment. Covered at 100%. (deductible does not apply) From Non-Kaiser provider: **No coverage.**.
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.			
WELL BABY CARE [2] (Plan Deductible Waived)	In Network: 100% of the Anthem Blue Cross Contract Rate. Out of Network: **60%** of Usual, Customary and Reasonable Charges.	In Network: 100% of the Anthem Blue Cross Contract Rate. Out of Network: **50%** of Usual, Customary and Reasonable Charges.	In Network (at Kaiser facility): No co-payment. Covered at 100%. (deductible does not apply) From Non-Kaiser provider: **No coverage.**
	(During the first five years after birth) Includes Immunizations approved by FDA at intervals recommended by the American Pediatric Association. Excludes immunizations required exclusively for travel.		(During the first 23 months after birth)

[1] Preventive Health Care Services covered under the Patient Protection and Affordable Care Act at Network Providers are covered at 100% and not subject to cost sharing effective July 1, 2011.

[2] Well Baby Preventive Services covered under the Patient Protection and Affordable Care Act at Network Providers and Kaiser Physician visits are covered at 100% and not subject to cost sharing effective July 1, 2011.

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FRESNO UNIFIED SCHOOL DISTRICT EMPLOYEE HEALTH CARE PLAN
COMPARISON SUMMARY OF MEDICAL AND PHARMACY BENEFITS (CONTINUED)

COVERAGE FEATURES	Option Plan A (For Actives and all Retirees) Standard Plan (Default)	Option Plan B (For Actives and all Retirees) Alternate Plan	Option Plan C (For Actives and for Retirees NOT ELIGIBLE for Medicare) Kaiser Permanente Plan
DURABLE MEDICAL EQUIPMENT	(Purchase or rental in excess of $2,000 must be pre-authorized by Anthem Blue Cross.) In Network: **80%** of the Anthem Blue Cross Contract Rate. Out of Network: **60%** of Usual, Customary and Reasonable Charges.	(Purchase or rental in excess of $2,000 must be pre-authorized by Anthem Blue Cross.) In Network: **70%** of the Anthem Blue Cross Contract Rate. Out of Network: **50%** of Usual, Customary and Reasonable Charges.	In Network (at Kaiser facility): **80%** Coinsurance per approved item (deductible does not apply.) From non-Kaiser provider: **No coverage.**.
PRESCRIPTION DRUGS (For Actives and Retirees) [1] Retail Pharmacy	**Envision Rx Pharmacies** $10 Copayment Generic $35 Copayment Preferred Brand-name $50 Copayment Non-preferred Brand-name	**Envision Rx Pharmacies** $10 Copayment Generic $35 Copayment Preferred Brand-name $50 Copayment Non-preferred Brand-name	**Kaiser Permanente Pharmacies** $10 Copayment Generic $35 Copayment Brand No coverage for Prescriptions filled at non-Kaiser pharmacies, except for the following: • Emergency services • Urgent care due to an unforeseen illness, injury, or complication of an existing condition (including pregnancy) while you are temporarily located outside Kaiser's service area
	1 to 30 days supply at Network Pharmacies. Up to 90 days at select pharmacy chains for maintenance and non-maintenance drugs.		$10 Generic/$35 Brand for each 30 day supply to maximum of 100 day supply
Mail Order Pharmacy	$10 Copayment Generic $35 Copayment Preferred Brand-name $50 Copayment Non-preferred Brand-name	$10 Copayment Generic $35 Copayment Preferred Brand-name $50 Copayment Non-preferred Brand-name	$10 Copayment Generic $35 Copayment Brand **No coverage** for prescriptions filled at non-Kaiser Mail Order Pharmacy.
	1 to 90 days supply for maintenance and non-maintenance drugs. 91 to 180 days supply for maintenance drugs; requires initial 30-day prescription before 91-180 supply will be allowed		$10 Generic/$35 Brand up to 30 day supply; 2x copayment $20 Generic/$70 Brand for 31-100 day supply

[1] If you are a Retiree (or a Dependent of a Retiree) who is eligible for Medicare, you will receive the EnvisionRx Plus Drug Plan if you are enrolled in Option Plan A or Plan B.

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COMPARISON SUMMARY OF MEDICAL AND PHARMACY BENEFITS (CONTINUED)

COVERAGE FEATURES	Option Plan A (For Actives and all Retirees) Standard Plan (Default)	Option Plan B (For Actives and all Retirees) Alternate Plan	Option Plan C (For Actives and for Retirees NOT ELIGIBLE for Medicare) Kaiser Permanente Plan
Mental Health	Pre-authorization by Avante Health is required for all mental health services **Inpatient Treatment** Covered at 100% No Inpatient Deductible Inpatient, partial and day treatment – 30 units per Calendar Year (inpatient 1 day = 1 unit, residential 1.5 days = 1 unit, partial day 2 days = 1 unit) **Outpatient Treatment** 45 visits per Calendar Year $10 copay per visit		**Inpatient Treatment** 20% Coinsurance after Deductible **Outpatient Treatment** $15 per visit for Individual outpatient treatment (Deductible doesn't apply) $7 per visit for Group outpatient treatment (Deductible doesn't apply)
Substance Abuse	Pre-authorization by Avante Health is required for all Substance Abuse services All levels of substance abuse care are covered at 100%: Annual maximum - $1,500,000 (combined with all other eligible Medical expenses paid during Calendar Year).		**Inpatient Treatment** 20% Coinsurance after Deductible **Outpatient Treatment** $15 per visit for Individual outpatient treatment (Deductible doesn't apply) $5 per visit for Group outpatient treatment (Deductible doesn't apply)
SKILLED NURSING FACILITY	In Network: **80%** of the Anthem Blue Cross Contract Rate. Out of Network: **60%** of Usual, Customary and Reasonable Charges.	In Network: **70%** of the Anthem Blue Cross Contract Rate. Out of Network: **50%** of Usual, Customary and Reasonable Charges.	In Network (at Kaiser facility): **80%** Coinsurance after Deductible (up to 100 days per benefit period) From non-Kaiser facility: **No coverage.**
HOME HEALTH CARE (only as a less costly alternative to Inpatient hospitalization)	In Network: **80%** of the Anthem Blue Cross Contract Rate. Out of Network: **60%** of Usual, Customary and Reasonable Charges.	In Network: **70%** of the Anthem Blue Cross Contract Rate. Out of Network: **50%** of Usual, Customary and Reasonable Charges.	In Network (at Kaiser facility): Covered at **100%** (Deductible does not apply). (up to 100 visits per calendar year) From non-Kaiser provider: **No coverage.**
HOSPICE CARE (Plan Deductible Waived) The Plan covers charges by hospices that are pre-authorized.	In Network: **100%** of the Anthem Blue Cross Contract Rate. Out of Network: **100%** of Usual, Customary and Reasonable Charges.	In Network: **100%** of the Anthem Blue Cross Contract Rate. Out of Network: **100%** of Usual, Customary and Reasonable Charges.	In Network (at Kaiser facility): Covered at 100% (Deductible does not apply) From non-Kaiser provider: **No coverage.**

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COVERAGE FEATURES	Option Plan A (For Actives and all Retirees) Standard Plan (Default)	Option Plan B (For Actives and all Retirees) Alternate Plan	Option Plan C (For Actives and for Retirees NOT ELIGIBLE for Medicare) Kaiser Permanente Plan
OCCUPATIONAL AND SPEECH THERAPY (Requires pre-authorization)	In Network: **80%** of the Anthem Blue Cross Contract Rate. Out of Network: **60%** of Usual, Customary and Reasonable Charges.	In Network: **70%** of the Anthem Blue Cross Contract Rate. Out of Network: **50%** of Usual, Customary and Reasonable Charges	In Network (at Kaiser facility): $15 copayment per visit, after Deductible. From non-Kaiser provider: **No coverage.**
EMERGENCY, URGENT CARE AND AMBULATORY SERVICES Emergency Room	In Network: **80%** of the Anthem Blue Cross Contract Rate after a $100 Copayment (Copayment waived if admitted). Out of Network: **80%** of Usual, Customary and Reasonable Charges after a $100 Copayment (Copayment waived if admitted).	In Network: **70%** of the Anthem Blue Cross Contract Rate after a $100 Copayment (Copayment waived if admitted). Out of Network: **70%** of Usual, Customary and Reasonable Charges after a $100 Copayment (Copayment waived if admitted).	In Network (at Kaiser facility): **80%** Coinsurance after Deductible. From non-Kaiser facility or provider: Qualified true medical emergencies are covered anywhere in the world – **80%** Coinsurance after Deductible.
Urgent Care Facility	In Network: **80%** of the Anthem Blue Cross Contract Rate after a $35 Copayment. Out of Network: **60%** of Usual, Customary and Reasonable Charges after a $35 Copayment.	In Network: **70%** of the Anthem Blue Cross Contract Rate after a $35 Copayment. Out of Network: **50%** of Usual, Customary and Reasonable Charges after a $35 Copayment.	In Network (at Kaiser facility): $15 copayment (Deductible does not apply) From non-Kaiser facility or provider: No Urgent Care Facility/Provider coverage if inside the Kaiser Service Area. Urgent care is covered outside the Kaiser service area in certain qualified emergency situations.
Ambulatory Surgical Center	In Network: **80%** of the Anthem Blue Cross Contract Rate after a $100 Copayment. Out of Network: **60%** of Usual, Customary and Reasonable Charges after a $100 Copayment. Coverage is limited to $1,000 per incident.	In Network: **70%** of the Anthem Blue Cross Contract Rate after a $100 Copayment. Out of Network: **50%** of Usual, Customary and Reasonable Charges after a $100 Copayment. Coverage is limited to $1,000 per incident.	In Network (at Kaiser facility): **80%** Coinsurance after Deductible From non-Kaiser Ambulatory Surgical Center: **No coverage.**
Ambulance (Air)	100% with no Copayment.	100% with no Copayment.	**80%** Coinsurance $150 copayment per trip, after Deductible
Ambulance (Ground)	**80%** after a $100 Copayment.	**70%** after a $100 Copayment.	As authorized by Kaiser. $150 copayment per trip, after Deductible

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COMPARISON SUMMARY OF MEDICAL AND PHARMACY BENEFITS (CONTINUED)

OTHER			
Voluntary Sterilization (Does not include Dependent Children)	In Network: **80%** of the Anthem Blue Cross Contract Rate. Out of Network: **60%** of Usual, Customary and Reasonable Charges.	In Network: **70%** of the Anthem Blue Cross Contract Rate. Out of Network: **50%** of Usual, Customary and Reasonable Charges.	In Network (at Kaiser facility): Female: No co-payment. Covered at 100%. (deductible does not apply) Male: $15 copayment (deductible does not apply) in office visit setting, otherwise **80%** Coinsurance after Deductible. From a non-Kaiser facility/provider: **No coverage.**
Blood, Blood Plasma, Blood Derivatives and Blood Factors	In Network: **80%** of the Anthem Blue Cross Contract Rate. Out of Network: **60%** of Usual, Customary and Reasonable Charges.	In Network: **70%** of the Anthem Blue Cross Contract Rate. Out of Network: **50%** of Usual, Customary and Reasonable Charges.	In Network (at Kaiser facility): No charge after Deductible. From a non-Kaiser facility: **No coverage.**
ACUPUNCTURE BENEFITS	Acupuncture benefits are provided through Chirometrics (for Options A & B) as follows: **Acupuncture services by ChiroMetrics Provider:** 100% after $20 Copayment (deductible waived). **Acupuncture services by Non-ChiroMetrics Provider:** Up to $20 reimbursement (deductible waived). 20 visits maximum per Calendar Year, 10 visits allowed per month, and 1 visit allowed per day. Note: For acupuncture treatment exceeding 12 visits per Calendar year, the provider must submit a "12th visit review" and ChiroMetrics must pre-certify additional visits for the remainder of the Calendar Year. **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 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.		In Network (at Kaiser facility): $15 copayment (deductible does not apply) From a non-Kaiser facility: **No coverage.**

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CHIROPRACTIC BENEFITS	Chiropractic benefits are provided through Chirometrics (for Plan Option A, B and C) as follows: **Chiropractic services by ChiroMetrics Provider:** 100% after $5 Copayment **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. Plans A and C - 60% of Usual, Customary and Reasonable Charges after Deductible. Plan B - 50% of Usual, Customary and Reasonable Charges after Deductible. **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 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.

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