FRESNO UNIFIED SCHOOL DISTRICT EMPLOYEE HEALTH CARE PLAN

COMPARISON SUMMARY OF MEDICAL AND PHARMACY BENEFITS
As of January 1, 2017

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

COVERAGE FEATURES	Option Plan A (For all Retirees) Standard Plan (Default)	Option Plan B (For all Retirees) Alternate Plan	Senior Advantage Plan (For all Medicare-Eligible Retirees) Kaiser Permanente Senior Advantage Plan
PLAN MAXIMUMS	Unlimited lifetime Maximum. Unlimited annual Maximum.	Unlimited lifetime Maximum. Unlimited annual Maximum.	Unlimited lifetime Maximum. Unlimited annual Maximum.
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 Permanente facility): No Deductible
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.	$1,500 max per individual $3,000 max per family

[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 all Retirees) Standard Plan (Default)	Option Plan B (For all Retirees) Alternate Plan	Senior Advantage Plan (For all Medicare-Eligible Retirees) Kaiser Permanente Senior Advantage Plan
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 Permanente facility): Covered at 100% after $500 copayment per Admission. At Non-Kaiser Permanente facility: No coverage 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	In Network: 70% of the Anthem Blue Cross Contract Rate. Out of Network: 50% of Usual, Customary and Reasonable Charges	In Network (at Kaiser Permanente facility): Covered at 100% after $500 copayment per Admission copayment. At Non-Kaiser Permanente facility: No coverage.
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.	Outpatient surgery and certain other outpatient procedures is $50 per procedure. Covered at 100% after $50 copayment per procedure for outpatient surgery. From Non-Kaiser Permanente Provider: No coverage 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 Permanente facility): $15 Copayment for each physician office visit includes primary care and specialty visits. Covered at 100% after copayment $0 for routine eye exam, hearing exam, and preventive care. From Non-Kaiser Permanente Provider: No coverage unless prior authorized and referred by Kaiser Permanente physician.
Optical Benefit	Covered Under MES Vision	Covered Under MES Vision	In Network (at Kaiser Permanente facility): $150 allowance for frames/lenses or contacts every 24 months purchased at Kaiser Permanente Medical Offices From Non-Kaiser Permanente Provider: No coverage

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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 all Retirees) Standard Plan (Default)	Option Plan B (For all Retirees) Alternate Plan	Senior Advantage Plan (For all Medicare-Eligible Retirees) Kaiser Permanente Senior Advantage 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 Permanente facility): Preventive Care Lab & X-Ray: No Copayment, Covered at 100%. Most Lab & X-Ray: No Charge From Non-Kaiser Permanente 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 Permanente facility): No Copayment. Covered at 100%. From Non-Kaiser Permanente provider: No coverage for Preventive Services.
Annual Physical Exam Benefit: (Plan Deductible Waived)	In Network: No co-payment. 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 co-payment. 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 Permanente facility): No co-payment. Covered at 100%. From Non-Kaiser Permanente provider: No coverage for Annual Physical exams.
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 Permanente facility): No co-payment. Covered at 100%. From Non-Kaiser Permanente provider: No coverage for Well Baby visits.
	(During the first five years after birth) Childhood immunizations and screening that qualify as preventive care services under PPACA are covered at 100% when a Network provider is used. Please see footnote. 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 Permanente 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 all Retirees) Standard Plan (Default)	Option Plan B (For all Retirees) Alternate Plan	Senior Advantage Plan (For all Medicare-Eligible Retirees) Kaiser Permanente Senior Advantage 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 Permanente facility): Covered at 80% (no annual maximum). Must be in accordance with DME formulary and Medicare guidelines. From non-Kaiser Permanente provider: No coverage for Durable Medical Equipment services.
PRESCRIPTION DRUGS (EnvisionRx *Plus* Medicare Part D)[1] Retail Pharmacy	Envision Rx Pharmacies $10 Copayment Generic $35 Copayment Brand with no Generic equivalent $35 Copayment plus cost difference for Brand with Generic equivalent [2]	Envision Rx Pharmacies $10 Copayment Generic $35 Copayment Brand with no Generic equivalent $35 Copayment plus cost difference for Brand with Generic equivalent [2]	$10 Copayment Generic up to 100 day supply $35 Copayment Brand up to 100 day supply No coverage for Prescriptions filled at non-Kaiser Permanente 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.		
Mail Order Pharmacy	$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]	$10 Copayment Generic for up to 100 day supply $35 Copayment Brand for up to 100 day supply 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		

[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.

[2] Dispense as Written (DAW) Prescriptions written by Physicians – cost difference between Brand and Generic is waived if authorized by EnvisionRx.

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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 all Retirees) Standard Plan (Default)	Option Plan B (For all Retirees) Alternate Plan	Senior Advantage Plan (For all Medicare-Eligible Retirees) Kaiser Permanente Senior Advantage 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 Covered at 100% after $500 copayment per Admission Outpatient Treatment $15 per visit for Individual outpatient treatment $7 per visit for Group outpatient treatment From Non-Kaiser Permanente provider: No coverage for treatment received from non-Kaiser Permanente provider.
Substance Abuse	Pre-authorization by Avante Health is required for all Substance Abuse services All levels of substance abuse care are covered at 100%:		Inpatient Treatment Covered at 100% after $500 copayment per Admission Outpatient Treatment $15 per visit for Individual outpatient treatment $5 per visit for Group outpatient treatment From Non-Kaiser Permanente provider: No coverage for treatment received from non-Kaiser Permanente provider.
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 Permanente facility): No Charge (up to 100 days per benefit period) From non-Kaiser Permanente facility: No coverage for Skilled Nursing Facility services
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 (with Kaiser Permanente provider): No Charge From non-Kaiser Permanente provider: No coverage.

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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 all Retirees) Standard Plan (Default)	Option Plan B (For all Retirees) Alternate Plan	Senior Advantage Plan (For all Medicare-Eligible Retirees) Kaiser Permanente Senior Advantage Plan
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.	No Charge
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 Permanente facility): $15 copayment per visit, covered at 100% after copayment From non-Kaiser Permanente provider: No coverage for Occupational or Speech Therapy 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 Permanente facility): Emergency Room Covered at 100% after $50 copayment. From non-Kaiser Permanente facility or provider: No coverage for Emergency Room services except for as defined under Cost Containment Penalties Section of Evidence of Coverage brochure.
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 Permanente facility): $15 copayment From non-Kaiser Permanente facility or provider: No coverage for Urgent Care services
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 Permanente facility): $50 copayment From non-Kaiser Permanente Ambulatory Surgical Center: No coverage.
Ambulance (Air)	100% with no Copayment.	100% with no Copayment.	As authorized by Kaiser Permanente. 100% Coinsurance $100 copayment per trip,

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COMPARISON SUMMARY OF MEDICAL AND PHARMACY BENEFITS (CONTINUED)

COVERAGE FEATURES	Option Plan A (For all Retirees) Standard Plan (Default)	Option Plan B (For all Retirees) Alternate Plan	Senior Advantage Plan (For all Medicare-Eligible Retirees) Kaiser Permanente Senior Advantage Plan
Ambulance (Ground)	80% after a $100 Copayment.	**70%** after a $100 Copayment.	As authorized by Kaiser Permanente. Covered at 100% after $100 copayment per trip
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 Permanente facility): $50 copayment From a non-Kaiser Permanente facility or 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 Permanente facility): No Charge From a non-Kaiser Permanente facility: No coverage.
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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COMPARISON SUMMARY OF MEDICAL AND PHARMACY BENEFITS (CONTINUED)

COVERAGE FEATURES	Option Plan A (For all Retirees) Standard Plan (Default)	Option Plan B (For all Retirees) Alternate Plan	Senior Advantage Plan (For all Medicare-Eligible Retirees) Kaiser Permanente Senior Advantage Plan
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.		No coverage for Acupuncture Services

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