FRESNO UNIFIED SCHOOL DISTRICT

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

FROM: JOINT HEALTH MANAGEMENT BOARD

SUBJECT: EMPLOYEE HEALTH CARE PLAN AMENDMENT 2017-3 – EFFECTIVE JULY 1, 2017

DATE: JANUARY 15, 2018

The Joint Health Management Board of the Fresno Unified School District has modified sections of the Plan Booklet, as described below, to comply with final regulations issued under the Patient Protection and Affordability Act of 2010, and to reflect in a more detailed manner how the Plan is being administered.

1. Under the "Definitions" section, "Rescission" is revised as follows:

"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;

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

4. A cancellation or discontinuance of coverage that is effective retroactively due to the request of the individual (or their representative). The request must be made without any direct or indirect influence from the District or plan, and without any adverse action or retaliation against, interference, coercion, intimidation, or threat to the individual; or

5. A cancellation or discontinuance of coverage that is effective retroactively due to the request of an Exchange.

2. Under the "Internal and External Claims Review Procedures" section: "Vision Service Plan" is deleted from the list of benefit providers.

3. Under the "Internal and External Claims Review Procedures" section: "Medical Eye Services/MES" is added to the list of fully-insured providers in the text box.

4. Under the "Internal and External Claims Review Procedures" section: "Vision Service Plan" is deleted from the Provider Address and Timetable list.

(continued on next page)

5. Under the "Internal and External Claims Review Procedures" section, "Internal Claims Procedures" sub-section, and "Timing of Initial Claims Decision" category, the eighth paragraph is deleted in its entirety, and replaced with the following:

"The Claim Administrator or District's Benefit Department will provide you, automatically and free of charge, with any new or additional evidence or rationale 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. If the Claim Administrator or District's Benefit Office receives the new/additional evidence or rational so late that it would be impossible to provide it to you in time to give you a reasonable opportunity to respond, the period for providing a notice of adverse benefit determination will be paused for 15 days in order to give you an opportunity to respond. As soon as the 15-days have passed the Claim Administrator or the District's Benefit Department will provide the adverse benefit determination notice in a reasonable and prompt manner.

6. Under the "Internal and External Claims Review Procedures" section, "Internal Claims Procedures" sub-section, and "How Your Appeal Will Be Decided" category, the fourth paragraph is deleted in its entirety, and replaced with the following:

"The Reviewer will also provide you, automatically and free of charge, with any new or additional evidence or rationale 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. If the Reviewer receives the new/additional evidence or rational so late that it would be impossible to provide it to you in time to give you a reasonable opportunity to respond, the period for providing the final notice of adverse benefit determination will be paused for 15 days in order to give you an opportunity to respond. As soon as the 15-days has passed the Reviewer will provide the final adverse benefit determination notice in a reasonable and prompt manner."

7. Under the "Internal and External Claims Review Procedures" section, "External Review Procedures", the first paragraph is deleted in its entirety, and replaced with the following:

"Until further guidance is issued, you may only request an external review of claims that involve (1) medical judgement, or (2) rescission of coverage. "Medical judgement" excludes claims that involve only contractual or legal interpretation without any use of medical judgement. "Medical judgment" includes (1) a determination regarding whether a participant or beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program, and (2) a determination of whether a plan is complying with the non-quantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act."