Joint Health Management Board

Fresno Unified School District

2020 EMPLOYEE BENEFITS INFORMATION GUIDE

Understanding Your Options

HELLO!

Welcome to your 2020 Benefits Information Guide!

Since 2006, Fresno Unified School District's Joint Health Management Board has worked tirelessly to manage and maintain the highest quality health and wellness benefits on behalf of the District's employees. Comprised of members from several District groups, including management and union representatives, the Board promotes informed and proactive health and wellness decisions to ensure that our plan participants are responsible healthcare consumers.

This Benefits Information Guide is your initial resource to understanding and selecting the best benefit options for you and your family. We encourage you to review this booklet in its entirety to learn more about:

- Who is eligible to participate
- How to enroll and how to make changes during the year, if applicable
- Each benefit available to you and a summary of what is covered under the plan
- The carriers who administer our benefits and how to contact them if you need assistance

We appreciate the hard work and dedication you bring to the Fresno Unified School District. If you have any questions about the employee benefits and wellness programs described herein or would like more information, please refer to your plan documents and insurance booklets available at www.JHMBHealthConnect.com/your-benefits.

We're here to help!

If you have any questions at all,
please contact the Benefits Department at 559.457.3520.

In support of your health,

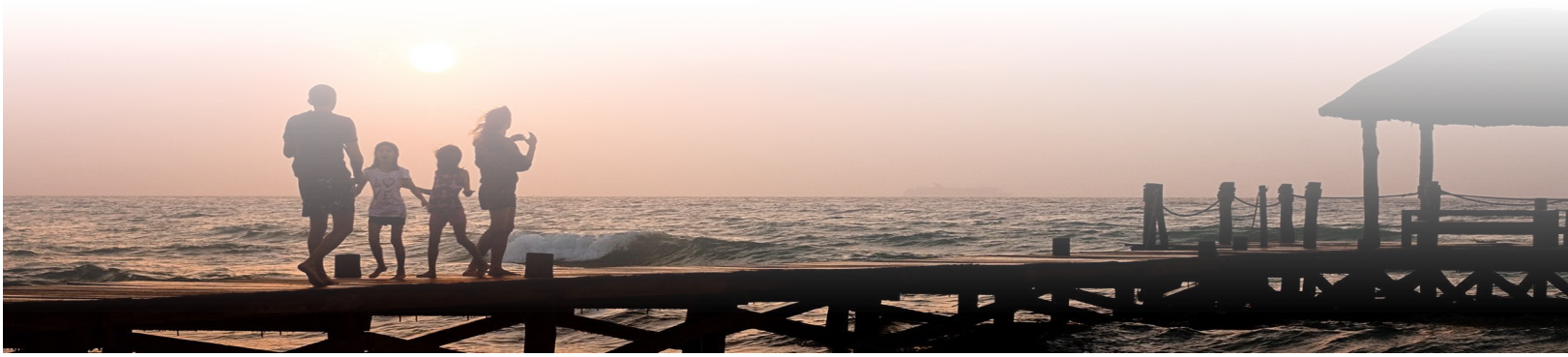
Joint Health Management Board

The rates quoted for these benefits may be subject to change based on final enrollment and/or final underwriting requirements. This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of the plan or program benefits and does not constitute a contract. Consult your plan documents (Schedule of Benefits, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Booklet, Booklet-certificate, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan. All the terms and conditions of your plan or program are subject to applicable laws, regulations and policies. In case of a conflict between your plan document and this information, the plan documents will always govern.

BENEFITS BIRD'S EYE VIEW

At Fresno Unified School District, we offer a range of options to fit your lifestyle.

BENEFITS	PLAN OPTIONS
Medical	• Anthem Blue Cross Medical Plan A (PPO) • Anthem Blue Cross Medical Plan B (PPO) • Prescription Drug Coverage – EnvisionRx • Behavioral Health – Avante/Halcyon (1/1/2020) • Kaiser Permanente Deductible HMO Plan C
Dental	• Delta Dental PPO • UnitedHealthcare Dental HMO
Vision	• MES Vision
Life/AD&D	• Standard Basic Life/AD&D
Voluntary Options	• Standard Voluntary Additional Life
Additional Benefits	• American Fidelity Flexible Spending Account • PhysMetrics Acupuncture/Chiropractic • Claremont Employee Assistance Plan • WellPATH Employee Wellness Program



ENROLLMENT

Who Can Enroll?

Permanent employees working a minimum of 4 hours a day or 20 hours a week are eligible to participate in the benefits program. Eligible employees may also choose to enroll family members, including a legal spouse/state registered domestic partner and/or children.

Children are considered eligible if they are your or your spouse's/state registered domestic partner's:

- Biological child, stepchild or adopted child
- Child subject to a Qualified Medical Child Support Order (QMCCSO)
- Child under permanent legal guardianship up until it ceases due to child's legal age attainment, death, marriage, military enlistment, adoption or any other reason declared by a court
- Child of any age if they are incapable of self-support due to a physical or mental disability that existed prior to such child reaching the age of 26

When Does Coverage Begin?

Your enrollment choices remain in effect through the end of the benefits plan year, January 1, 2020 – December 31, 2020. Benefits for eligible **new hires** will commence as outlined below:

ELIGIBILITY DATE

The first day of the month following your date of hire.

New full-time employees who do not actively make benefit elections during their initial eligibility period will be automatically enrolled with "Employee Only" coverage in Medical Plan A, Delta Dental PPO, MES Vision and Standard Basic Life Insurance plans. Employees must complete enrollment forms to add coverage for dependents, or select alternate plans.

New part-time employees that work less than 20 hours a week may enroll in the UnitedHealthcare Dental HMO and/or MES Vision Plan at their own expense.

BENEFIT PLAN

- Anthem Blue Cross Medical Plan A (PPO)
- Anthem Blue Cross Medical Plan B (PPO)
- Prescription Drug Coverage – EnvisionRx
- Behavioral Health – Avante/Halcyon (1/1/2020)
- Kaiser Permanente Deductible HMO Plan C
- Delta Dental PPO
- UnitedHealthcare Dental HMO
- MES Vision
- Standard Basic Life/AD&D
- Standard Supplemental Life/AD&D
- American Fidelity Flexible Spending Account
- PhysMetrics Acupuncture/Chiropractic
- Claremont Employee Assistance Plan

HOW DO I ENROLL?

Paper Enrollment/Contact Benefits Department

- After reviewing your options, complete the paper enrollment forms and return to the Benefits Department. Forms are located inside your Open Enrollment Benefits' Packet.
- If you have questions when completing your enrollment forms, contact the Benefits Department at 559.457.3520.

Joint Health Management Board
Fresno Unified School District

ANNUAL OPEN ENROLLMENT

Active employees have a passive open enrollment, meaning you **are not required** to take action in order to keep the previous year's coverage. If you would like to migrate from one plan to another, or add/drop dependent(s), you may do so during the Open Enrollment period. Additionally, you must re-elect your contribution amounts each year to the Flexible Spending Account (FSA).

CHANGES DURING THE YEAR

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 contribution), 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. If you are enrolling a new dependent as a result of birth, adoption or placement for adoption, you can also enroll your Spouse or State Registered 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:

- If your dependents experience a loss of eligibility of Medicaid or a State Children's Health Insurance Program ("SCHIP") coverage and you request enrollment within 60 days after that coverage ends; or
- 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 Benefits Department at 559.457.3520.

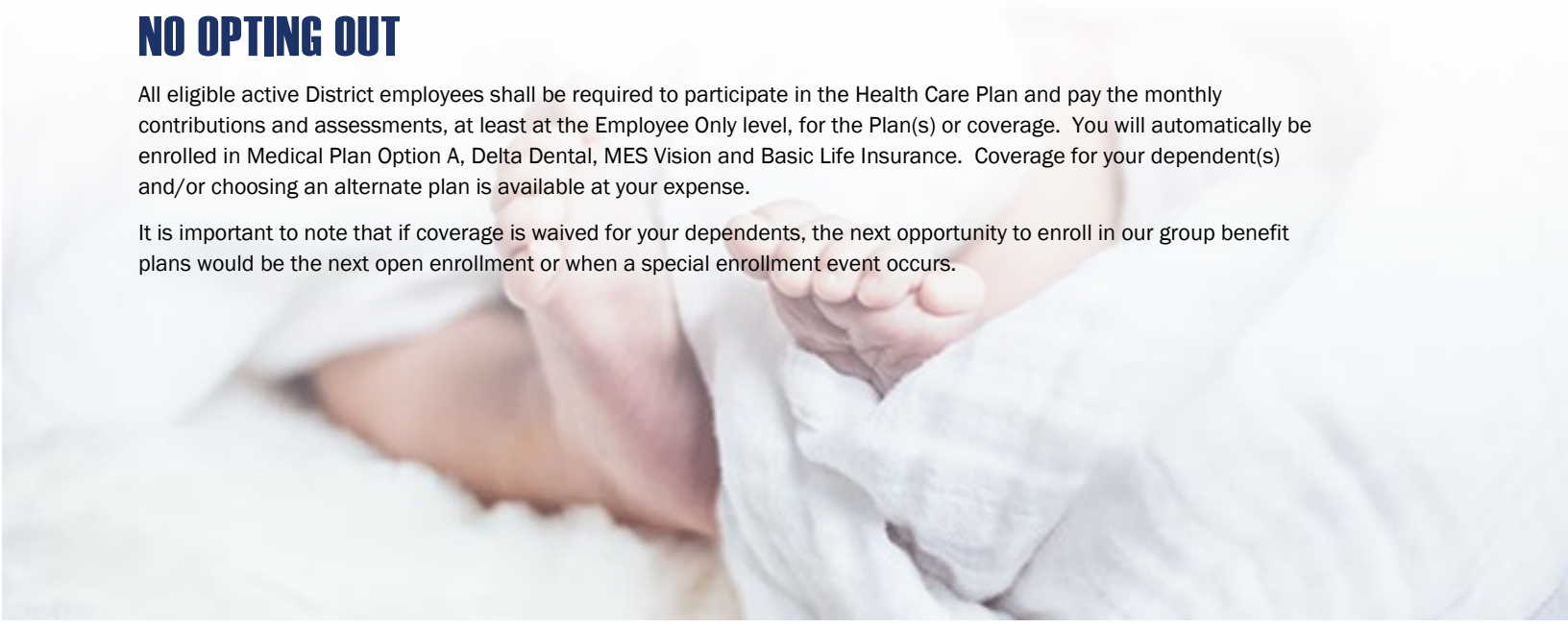
PAYING FOR COVERAGE

Fresno Unified School District and the Joint Health Management Board strives to provide you with a valuable benefits package at a reasonable cost. Based on your benefit selections and coverage level, you may be required to pay for a portion of the cost. The Cost of Coverage section in this guide outlines the rate and frequency of the payroll deduction for each benefit.

NO OPTING OUT

All eligible active District employees shall be required to participate in the Health Care Plan and pay the monthly contributions and assessments, at least at the Employee Only level, for the Plan(s) or coverage. You will automatically be enrolled in Medical Plan Option A, Delta Dental, MES Vision and Basic Life Insurance. Coverage for your dependent(s) and/or choosing an alternate plan is available at your expense.

It is important to note that if coverage is waived for your dependents, the next opportunity to enroll in our group benefit plans would be the next open enrollment or when a special enrollment event occurs.



MEDICAL

What Are My Options?

Fresno Unified School District and the Joint Health Management Board offer two PPO plan options, Medical Plan A and Medical Plan B, administered by Delta Health Systems and utilizing the Anthem Blue Cross provider network, and one Deductible HMO plan, administered by Kaiser Permanente.

To help guide your plan selection, the following pages include details concerning how the plans operate, as well as plan highlights. Please note, if there is a descrepency between the information in this Benefits Information Guide, and the Plan Booklet/Evidence of Coverage (EOC) document, the Plan Booklet and EOC will prevail. For your reference, an illustration of employee contibutions is listed in the Cost of Coverage section of this guide.

Using a PPO plan

With a Preferred Provider Organization (PPO) plan, you have greater flexibility and choice to use both in-network and out-of-network providers. However, you are encouraged to receive services from the Anthem Blue Cross network doctors, specialists and facilities. By doing so, you obtain a higher level of benefit than if services were rendered from an out-of-network provider. Also, claim forms are submitted to the plan on your behalf when services are received from within the network. Additional information regarding use of a PPO plan includes:

- You and any enrolled dependent(s) are permitted to visit any doctor or facility without a referral from a Primary Care Physician (PCP)
- Certain services, such as doctor's visits, may require fixed-dollar payment up front, referred to as a copayment
- Before the plan will pay certain medical expenses, you may be required to pay a plan specific amount, referred to as a deductible
- Once the deductible has been fulfilled, the plan will pay a large percentage of the cost of your care, known as coinsurance. You are then financially responsible for the remaining cost up to the out-of-pocket maximum.

You can find an Anthem provider by going online to www.anthem.com/ca. Click on **Individual & Family**, then select **Find a Doctor** under the **Care** menu. Scroll down to **Search as Guest** and select **Search by Selecting a Plan or Network**. Select the type of care, **California** for your state, and **Blue Cross PPO (Prudent Buyer) - Large Group** as your plan/network. Then click continue, select the type of provider, specialty, provider's name (optional), and location, and click **Search**. From the search results screen, you can find provider contact information, and email or print the results.

Using a Deductible HMO Plan

As a member of the Kaiser Permanente Health Maintenance Organization (HMO), you will receive your medical care from an integrated network of physicians and specialists at a medical office, medical center, or affiliated hospital near you. Additional information regarding use of the Kaiser Permanente HMO Deductible plan includes:

- You may choose a primary care physician for you or your family members at kp.org/chooseyourdoctor, or receive assistance in selecting a doctor or scheduling your first appointment by calling 800.278.3296.
- Initial referrals for most specialty care services will be coordinated by a Kaiser Permanente physician. However, many department such as OB/GYN, Optometry, Psychiatry and Additional Medicine are self-referred
- There is a deductible with the Kaiser Permanente HMO plan; however, there are no claim forms to submit unless you receive emergency services outside of a plan facility
- Preventive care services are covered at 100%

A summary of covered services under the Kaiser Permanente HMO Deductible plan is listed on the following pages. For a complete listing of covered services for each plan, please refer to your Evidence of Coverage (EOC) or Plan Booklet.

MEDICAL (CONTINUED)

Kaiser Permanente – On the Go!

The KP mobile app gives you a suite of tools to use on the go! Use this application with your Kaiser Permanente user ID and password to:

- See your health history at your fingertips.
- Refill prescriptions for yourself or another member.
- Check the status of your prescription order.
- Schedule, view, and cancel appointments.
- Access your message center to email your doctor or another KP department.
- Find KP locations and facilities near you.

Search for Kaiser's mobile app in the App Store or Google Play to get started!

Free Preventive Health Care

The Federal Health Care Reform law requires insurance companies to cover in-network preventive care services in full, saving you money and helping you maintain your health. Such preventive services include:

- Preventive care doctor's visits
- Annual checkups
- Well-baby and child visits
- Several types of immunizations and screenings

To confirm your preventive care services are covered, refer to your Plan Booklet or associated Evidence of Coverage.

Informing You of Health Care Reform

Most U.S. citizens and legal residents are required to have minimum essential health coverage. You can obtain health insurance through our benefits program or purchase coverage elsewhere, such as a State or Federal Health Insurance Exchange.

For information regarding Health Care Reform and the Individual Mandate, please visit www.cciio.cms.gov. You can also visit www.coveredca.com to review information specific to the Covered California State Health Insurance Exchange.

PRESCRIPTION DRUG COVERAGE

Many FDA-approved prescription medications are covered through the benefits program. Important information regarding your prescription drug coverage is outlined below:

PPO Medical Plans A and B:

- Prescription drugs are administered through EnvisionRx using the "Select Formulary"
- The EnvisionRx plan includes a four-tier prescription benefit. Tiered prescription drug plans require varying levels of payment depending on the drug's tier and your copayment or coinsurance will be higher with a higher tier number.
    - **Tier 1** includes generic drugs for high blood pressure, high cholesterol, depression and diabetes.
    - **Tier 2** includes generic drugs. Generic drugs are required by the FDA to contain the same active ingredients as their brand-name counterparts.
    - **Tier 3** includes preferred brand name drugs
    - **Tier 4** includes non-preferred brand name drugs
- If you purchase a brand name prescription when there is a generic equivalent available, you will pay the brand copay plus the difference in cost between the brand name and the generic. Exceptions are available if the brand name medication is authorized as medically necessary by EnvisionRx.
- Up to a 90-day supply available at retail or through mail order.
- Maintenance medication refills are required to be dispensed in a 90-day supply by a pharmacy in the Rx90 network (EnvisionMail, Rite Aid, Walgreens or Costco retail pharmacy). If you are currently taking a maintenance medication, you will need to have your prescription transferred to an Rx90 network pharmacy. For a list of maintenance medications, please visit www.EnvisionRx.com.

Deductible HMO Plan C:

- The Kaiser Rx plan includes a two-tier prescription benefit.
    - **Tier 1** includes generic drugs. Generic drugs are required by the FDA to contain the same active ingredients as their brand-name counterparts.
    - **Tier 2** includes preferred brand name drugs. Non-preferred brand name and specialty drugs are covered under Tier 2 if approved through an exception process.
- Up to a 30-day supply available at retail, and up to a 100-day supply through mail order.
- For a Kaiser formulary prescription drug list(s) or more information on the mail order service, go to www.kp.org/formulary

WHY PAY MORE?

There are a few ways you can save money

Mail Order

Save time and money by utilizing a mail order service for maintenance medications. A 90 or 100-day supply of your medication will be shipped to you, instead of purchasing a typical 30-day supply at a walk-in pharmacy.

Shop Around

Some pharmacies, such as those at warehouse clubs or discount stores may offer less expensive prescriptions than others. By calling ahead, you may determine which pharmacy provides the most competitive price.

Explore Over-the-Counter Options

For common ailments, over-the-counter drugs may provide a less expensive option that serve the same purpose as prescription medications.

PLAN HIGHLIGHTS

	ANTHEM BLUE CROSS PLAN A		ANTHEM BLUE CROSS PLAN B	
	In-network	Out-of-network(1)	In-network	Out-of-network(1)
Annual Calendar Year Deductible				
Individual	$250	$750	$1,000	$3,000
Family	$500	$1,500	$2,000	$6,000
Maximum Calendar Year Out-of-pocket	Medical/Mental Health	Medical Only	Medical/Mental Health	Medical Only
Individual	$2,100	$10,000	$5,700	$12,000
Family	$4,200	$20,000	$11,400	$24,000
Lifetime Maximum	Unlimited		Unlimited	
Professional Services				
Primary Care Physician (PCP)	$15 Copay + 10%	40%	$25 Copay + 30%	50%
Specialist	$15 Copay + 10%	40%	$25 Copay + 30%	50%
Preventive Care Exam	No Charge(2)	Not Available(4)	No Charge(2)	Not Available(4)
Well-baby Care (first 5 years)	No Charge(2)	Not Available(4)	No Charge(2)	Not Available(4)
Diagnostic X-ray and Lab	10%	40%	30%	50%
Complex Diagnostics (MRI/CT Scan)	10%	40%	30%	50%
Therapy(3), including Physical, Occupational and Speech	10%	40%	30%	50%
Hospital Services				
Inpatient(3)	10%	40%	30%	50%
Outpatient Surgery(3)	$100 Copay + 10%	Not Available(4)	$100 Copay + 30%	Not Available(4)
Emergency Room	$100 Copay + 10% (copay waived if admitted)		$100 Copay + 30% (copay waived if admitted)	
Urgent Care	$35 Copay + 10%	$35 Copay + 40%	$35 Copay + 30%	$35 Copay + 50%
Maternity Care	Dependent children are only covered for preventive care services			
Physician Services (prenatal or postnatal)	$15 Copay	40%	$25 Copay	50%
Hospital Services	10%	40%	30%	50%
	Mental Health & Substance Abuse services administered through Avante Health(5)			
Mental Health & Substance Abuse	Pre-Authorization required by Avante Health(5) for all mental health and substance abuse services. See page 12 for more details.			
	Chiropractic & Acupuncture services administered through PhysMetrics			
Chiropractic & Acupuncutre	See page 12 for more details.			
	Prescription Drug Coverage administered through Envision Rx			
Prescription Drug Maximum Calendar Year Out-of-pocket	$400/individual $800/family	N/A	$900/individual $1,800/family	N/A
Retail and Mail Order Prescription Drugs (30-day supply)				
Tier 1 Generic Drugs	$0 Copay	Not Covered	$0 Copay	Not Covered
Tier 2 Generic Drugs	$10 Copay		$10 Copay	
Tier 3 Preferred Brand Name	$35 Copay		$35 Copay	
Tier 4 Non-Preferred Brand Name	$50 Copay		$50 Copay	
Retail and Mail Order Prescription Drugs (90-day supply)				
Tier 1 Generic Drugs	$0 Copay	Not Covered	$0 Copay	Not Covered
Tier 2 Generic Drugs	$20 Copay		$20 Copay	
Tier 3 Preferred Brand Name	$70 Copay		$70 Copay	
Tier 4 Non-Preferred Brand Name	$100 Copay		$100 Copay	

(1) Member pays coinsurance applicable to Usual, Customary and Reasonable (UCR) rate
(2) Plan deductible waived
(3) Requires pre-authorization. For physical therapy services, pre-authorization required exceeding 6 visits.
(4) Plans Not Available for California residents only. Plan A: Non-California residents – 60% UCR. Plan B: Non-California residents – 50% UCR.
(5) Effective January 1, 2020, Mental Health & Substance Abuse services will be administered by Halcyon Behavioral Health.

The above information is a summary only. Please refer to your Evidence of Coverage or Plan Booklet for complete details of Plan benefits, limitations and exclusions.

PLAN HIGHLIGHTS

KAISER DEDUCTIBLE HMO PLAN C

	In-Network Only
Annual Calendar Year Deductible	
Individual	$250
Family	$500
Maximum Calendar Year Out-of-pocket	
Individual	$2,500
Family	$5,000
Lifetime Maximum	
Individual	Unlimited
Professional Services	
Primary Care Physician (PCP)	$15 Copay(1)
Specialist	$15 Copay(1)
Preventive Care Exam	No Charge(1)
Well-baby Care (First 23 months)	No Charge(1)
Diagnostic X-ray and Lab	$10 Copay
Complex Diagnostics (MRI/CT Scan)	$50 Copay
Therapy, including Physical, Occupational and Speech	$15 Copay
Hospital Services	
Inpatient	10%
Outpatient Surgery	10%
Emergency Room	10%
Urgent Care	$15 Copay(1)
Maternity Care	
Physician Services (prenatal or postnatal)	No Charge(1)
Hospital Services	10%
Mental Health & Substance Abuse	
Inpatient	10%
Outpatient	Individual visit: $15 Copay(1) Group visit: $7 Copay (Mental Health)(1) / $5 Copay (Substance Abuse)(1)
Vision Care	
Routine Eye Exams with a Plan Optometrist	No Charge(1)
Eyeglasses or contact lenses every 24 months	Allowance up to $175(1)
Retail Prescription Drugs (Up to a 30-day supply)	
Generic Drugs	$10 Copay
Preferred Brand Name Drugs	$35 Copay
Mail Order Prescription Drugs (Up to a 100-day supply)	
Generic Drugs	$20 Copay
Preferred Brand Name Drugs	$70 Copay

(1) Deductible Waived

The above information is a summary only. Please refer to your Evidence of Coverage or Plan Booklet for complete details of Plan benefits, limitations and exclusions.

SUPPLEMENTAL SERVICES

Mental Health & Substance Abuse

If you are enrolled in Medical Plan Option A or B, your 2019 coverage is through Avante Health (effective January 1, 2020, mental health & substance abuse services will be administered through Halcyon Behavioral Health). Pre-authorization is required for all mental health and substance abuse services. If you are enrolled in Medical Plan Option C, your coverage is through Kaiser.

AVANTE HEALTH PLAN HIGHLIGHTS	MEDICAL PLAN OPTIONS A OR B
Mental Health Services	
Inpatient(1)	Covered at 100% Inpatient, partial and day treatment 45 units/calendar year/ member
Outpatient	$10 Copay per visit 60 visits/calendar year/ member
Substance Abuse Services	
All levels of substance abuse	100%

(1) Deductible Waived

Any questions pertaining to your 2019 mental health and substance abuse coverage can be directed to Avante Health by calling **800.498.9055** or visiting their website at www.fusdmentalhealth.com. Eligible employees will receive vendor contact information for Halcyon Behavioral Health prior to the start of the new plan year.

Chiropractic & Acupuncture

When you're seeking relief from pain caused by an accident, injury, or muscle strain, or just looking for a natural healthcare approach, our Chiropractic and/or Acupuncture Benefits may be able to assist you. These benefits offered by PhysMetrics provide you access to licensed professionals at a discounted rate.

CHIROPRACTIC PLAN HIGHLIGHTS	MEDICAL PLAN OPTIONS A, B & C
Chiropractic Services by PhysMetrics Provider (deductible waived)	$5 Copay then 100% of the PhysMetrics contract rate
Chiropractic Services by Non-PhysMetrics Provider (after deductible) Outside 100 miles of Fresno ONLY Referral must be given by a Physician & Pre-Certified by PhysMetrics	Plan A & C: 60% UCR after $100 deductible Plan B: 50% UCR
Chiropractic Diagnostic X-Ray Benefit (after deductible)	100% UCR Limited to $100 per Benefit Calendar Year
Visits	Up to 28 visits per Calendar Year **Note:** For treatment exceeding 12 visits per calendar year, chiropractor must submit a "twelve visit review" and PhysMetrics must pre-certify additional visits for the remainder of the calendar year.

ACUPUNCTURE PLAN HIGHLIGHTS	MEDICAL PLAN OPTIONS A & B	
	PhysMetrics Provider	**Non-PhysMetrics Provider**
Acupuncture Visit (20 visits per Calendar Year)	$20 Copay Deductible waived	Up to $20 reimbursement Deductible waived

The above are brief benefit summaries only. Please refer to the Plan Booklet (Plans A and B) and the Kaiser Permanente Evidence of Coverage for additional information.

Note: Acupuncture benefits for Plan Option Care covered through Kaiser facilities at a $15 Copay (deductible waived).

Check out PhysMetrics' website at www.fusdchiro.com or contact them at **559.447.3375** to discuss how to use the program and find a participating provider near you.

TELEHEALTH

Telehealth is convenient for diagnosing and treating many non-acute medical conditions using your phone, tablet or computer.

Plushcare (Medical Plan Options A & B)

With Telehealth services provided by Plushcare, you can connect with leading board certified physicians in your state through the internet or telephone, helping you avoid emergency rooms and urgent care centers. Plushcare can assist with prescription medications and with many non-emergency illnesses including:

- Allergies
- Arthritic pain
- Asthma
- Bronchitis
- Colds and flu
- Diarrhea
- Insect bites
- Pharyngitis
- Conjunctivitis (pink eye)
- Rash
- Respiratory infection
- Sinusitis
- Skin inflammation
- Sore throat
- Sprains & strains
- Urinary tract infection
- Sports injuries
- Vomiting

Telehealth services are just $5 per appointment. No deductible applies when using Plushcare. To access this benefit, call Plushcare at 866.460.6205 or go online to www.plushcare.com. You can also download the Plushcare App for further convenience.

Kaiser Permanente (Medical Plan Option C)

As a Plan Option C participant, Kaiser Permanente provides you with a myriad of ways to meet with your physician or schedule an appointment. If you are pressed for time and/or prefer to meet with your physician via video, you can schedule an appointment in minutes by phone or using your mobile phone or computer.

Kaiser recommends that participants download the KP Preventive Care app for the most convenient experience in scheduling appointment and conducting video visits. However, you can also visit their website at kp.org/mydoctor/videovisits for more details on how to use their telehealth services.

WELLNESS PROGRAM

WellPATH Your Path to Better Health
Joint Health Management Board

Healthy, active lifestyles can help reduce the risk of chronic disease and may lower your annual health care costs. Because we care about your total well-being, we're encouraging all employees to engage in our Wellness Program at no-cost to you.

The JHMB's WellPATH Employee Wellness Program is designed for, and by, Fresno Unified School District employees. WellPATH offers a variety of wellness-related educational opportunities and activities throughout the year to help employees along their path to better healing, including:

- Group Fitness Classes
- Personal Training
- Wellness Coaching
- Online Wellness Assessments
- On-site Biometric Screenings
- Flu Vaccinations
- Educational Seminars
- Wellness Newsletters

Employees and their dependents who voluntarily participate and successfully complete certain wellness related activities become eligible to win great prizes. These include gift cards for completing monthly quizzes and annual wellness screenings, as well as raffles for participating in wellness challenges. Visit www.JHMBHealthConnect.com/wellpath for more details about the wellness offerings available to you and your family.

Please note: Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact WellPATH at **833.WELLPATH (935.5728)** or email WellPATH@delapro.com and we will work with you (and, if you wish, your doctor) to find a wellness program with the same reward that is right for you in light of your health status. Some prizes may be taxable to the recipient (e.g., gift cards). Contact WellPATH with any questions.

PLANNED SURGERY BENEFIT PROGRAM

When you need non-emergency surgery, our Planned Surgery Benefit Program offers high quality surgical care covered at 100% from the initial surgeon visit to your final visit after surgery. Top-rated providers may lower your risk for complications, infection and readmission. This benefit, offered by BridgeHealth, provides you access to top-rated hospitals, surgery centers and doctors for your type of procedure.

Planned Surgery Benefit Program

The Planned Surgery Benefit Program is **only available** to those enrolled in Medical Plan Options A and B.

Using the BridgeHealth Planned Surgery Benefit Program

If your doctor recommends surgery, call BridgeHealth before you schedule surgery. A dedicated care coordinator will help you select a top-rated provider for your type of procedure and will handle all the administrative work, approvals, billing and scheduling. If travel is required, BridgeHealth arranges transportation and lodging for the patient and a companion.

Here are some of the procedures covered:

- **Bariatric:** gastric bypass, gastric sleeve, lap band removal
- **Cardiac:** coronary artery bypass graft, valve repair and replacement
- **General:** gall bladder removal, ENT, hernia repair
- **Orthopedic:** carpal tunnel release, ACL repair, hip and knee replacement
- **Spine:** spinal fusion, artificial disc replacement
- **Women's Health:** hysterectomy

MEDICAL PLAN OPTIONS A OR B	COVERAGE
Episode of Care (includes pre-op appointment through post-op appointment)	Covered at 100% No charge for patient
Travel, Lodging & Meals* *only covered if travel of 100 miles or more one way from primary residence is required)	All travel and lodging during Episode of Care are covered at 100%. Meals* Patient: $50 per day meal allowance, and $125 per week after 15 days when not admitted. Companion: $50 per day meal allowance, and $125 per week after 15 days. **Note:** Coverage available for patient and one companion. Travel and lodging must be arranged by BridgeHealth. Coverage includes coach airfare and one double-occupancy hotel room. *Receipts for meals are not required for reimbursement.

Any questions pertaining to your Planned Surgery Benefit Program can be directed to BridgeHealth by calling **844.567.2970**, or visiting their website at www.bridgehealth.com. Register with the company code **FUSD2** for full access to their website.

DENTAL PLAN

Your Dental Plan Options

You and your eligible dependents have the opportunity to enroll in a Dental Health Maintenance Organization (HMO) plan offered by UnitedHealthcare or a Dental Preferred Provider Organization (PPO) plan offered by Delta Dental. We encourage you to review the coverage details and select the option that best suits your needs.

Using the Plan

UnitedHealthcare Dental HMO (Dental Direct) is unique for a DHMO dental plan. You are not required to select a provider as long as you and your dependents go in-network. If you receive services from a provider outside of the approved network, you would be responsible for paying the entire dental bill yourself.

To find a UnitedHealthcare Dental HMO dentist, go to www.myuhc.com and select **Find a Dentist**, or call **800.999.3367**.

The Delta Dental Dental PPO plan is designed to give you the freedom to receive dental care from any licensed dentist of your choice. Keep in mind, you'll receive the highest level of benefit from the plan if you select an in-network PPO dentist versus an out-of-network dentist who has not agreed to provide services at the negotiated rate. Additionally, no claim forms are required when using in-network PPO dentists.

To find an in-network Dental PPO dentist, go to www.deltadentalins.com and search the Provider Network, or call **866.499.3001**.

Note: Part-time employees are eligible to enroll in the UnitedHealthcare Dental HMO plan only.

PLAN HIGHLIGHTS	UNITEDHEALTHCARE DENTAL HMO	DELTA DENTAL DENTAL PPO	
	In-network Only	In-network	Out-of-network
Annual Calendar Year Deductible			
Per Person	N/A	N/A	N/A
Family Maximum	N/A	N/A	N/A
Calendar Year Maximum	N/A	$2,000	$1,000
Preventive Services			
Office Visit	No Charge	100%	50%
X-rays	No Charge	100%	50%
Cleanings	No Charge	100%	50%
Sealants (per tooth)	$5 Copay	100%	50%
Restorative Services			
Amalgam Fillings	No Charge	100%	50%
Composite Fillings	$0 -$10 Copay	100%	50%
Periodontics (gum treatment)			
Scaling & Root Planning	No Charge	100%	50%
Gingivectomy (4+ teeth)	No Charge	100%	50%
Endodontics (root canal theapy)			
Pulpotomy	No Charge	100%	50%
Root Canal	$0 -$60 Copay	100%	50%

The above information is a summary only. Please refer to your Evidence of Coverage or Plan Booklet for complete details of Plan benefits, limitations and exclusions.

DENTAL PLAN (CONTINUED)

PLAN HIGHLIGHTS	UNITEDHEALTHCARE DENTAL HMO	DELTA DENTAL DENTAL PPO	
	In-network Only	In-network	Out-of-network(1)
Oral Surgery			
General Anesthesia	$10 Copay	100%	50%
Simple Extraction	No Charge	100%	50%
Soft Tissue Impaction	$17 Copay	100%	50%
Complete or Partial Bony Impaction	$23 -$30 Copay	100%	50%
Crowns & Inlays			
Inlay / Onlay (2 surfaces)	Copay varies on treatment	100%	50%
Crowns	$7 -$73 Copay(1)	100%	50%
Prosthetics & Bridges			
Bridges	$0 - $80 Copay	50%	50%
Denture Adjustment	$0 - $10 Copay	50%	50%
Complete or Partial Denture	$63 - $93 Copay	50%	50%
Other Services			
Implants	$1,950 Copay	Not Covered	
Orthodontia Services			
Child / Adult Orthodontia Phase 1 & 2	$2,000 maximum out-of-pocket expense for 24-month treatment plan	Not Covered	

(1)Resin, porcelain and any resin to metal or porcelain to metal crowns and pontics are excluded on molar teeth. If titanium, noble or high noble metals are requested for filings, crowns, pontics, bridges or prosthetic devices, there will be an additional charge, based on the amount of the metal used. Flexible base partial dentures are subject to an additional charge based on additional laboratory cost.

The above information is a summary only. Please refer to your Evidence of Coverage or Plan Booklet for complete details of Plan benefits, limitations and exclusions.

VISION PLAN

Your Vision Plan

Vision coverage for members enrolled in Medical Plan A or B is offered by MES Vision as a Preferred Provider Organization (PPO) plan. If you are enrolled in Medical Plan C, your vision coverage is offered by Kaiser Permanente.

Using the Plan

As with a traditional PPO, you may take advantage of the highest level of benefit by receiving services from in-network vision providers and doctors. You would be responsible for a copayment at the time of your service. However, if you receive services from an out-of-network doctor, you pay all expenses at the time of service and submit a claim for reimbursement up to the allowed amount.

Any questions pertaining to your vision coverage can be directed to MES Vision by calling **800.877.6372**, or by visiting their website at www.mesvision.com.

To locate an in-network MES Vision provider, go to www.mesvision.com, click on the Member tab, enter username/password and click on **Login**. Then click on your Group (Company) Name, enter zip code and click **Search**. You can also call MES Vision at **800.877.6372**.

PLAN HIGHLIGHTS	MES VISION PPO	
	In-Network	**Out-of-Network**
Exam – Every 12 months	$5 Copay	Up to $45 Reimbursement
Lenses – Every 12 months		
Single	Covered in Full	Up to $30 Reimbursement
Bifocal	Covered in Full	Up to $50 Reimbursement
Trifocal	Covered in Full	Up to $65 Reimbursement
Frames – Every 24 months	Up to $130 Allowance	Up to $75 Reimbursement
Contacts – Every 12 months, in lieu of lenses & frames		
Medically Necessary	Covered in Full with Authorization	Up to $250 Reimbursement
Cosmetic	Up to $130 Allowance	Up to $130 Reimbursement

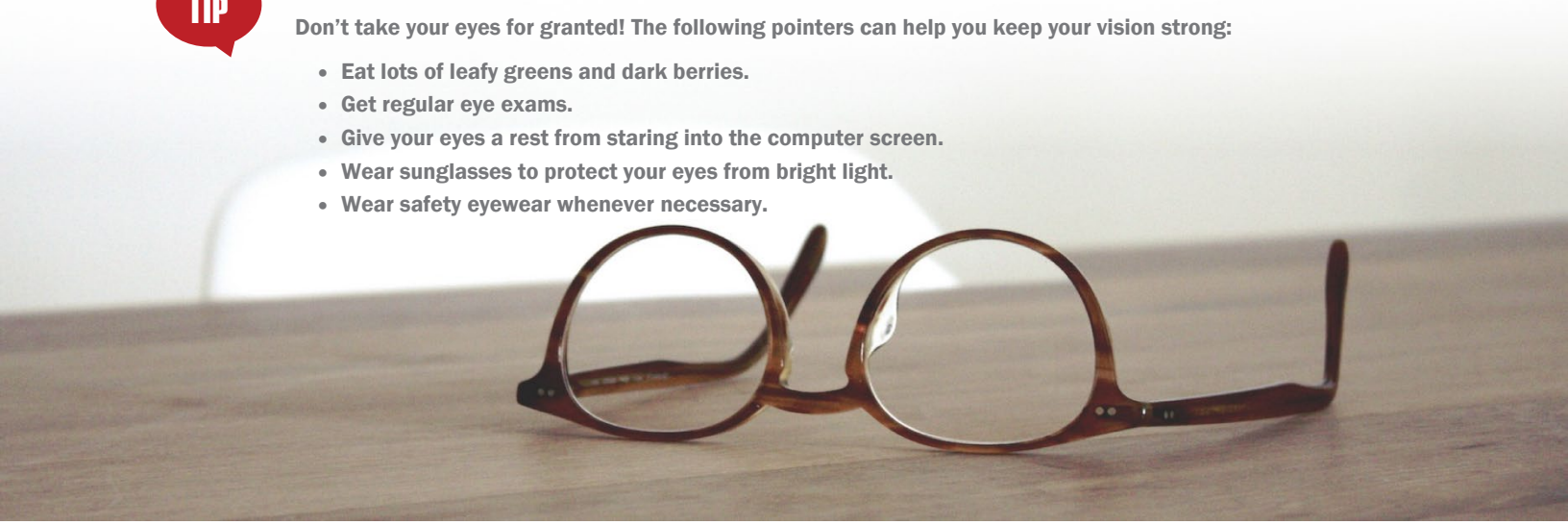
The above information is a summary only. Please refer to the Plan Booklet (Plans A and B) and the MES Vision Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

TIP

Five Tips for Superior Vision

Don't take your eyes for granted! The following pointers can help you keep your vision strong:

- **Eat lots of leafy greens and dark berries.**
- **Get regular eye exams.**
- **Give your eyes a rest from staring into the computer screen.**
- **Wear sunglasses to protect your eyes from bright light.**
- **Wear safety eyewear whenever necessary.**



BASIC LIFE AND AD&D

In the event of your death, Life Insurance will provide your family members or other beneficiaries with financial protection and security. Additionally, if your death is a result of an accident or if you become dismembered, your Accidental Death & Dismemberment (AD&D) coverage may apply.

Your Coverage

Paid for in full by Fresno Unified School District and the Joint Health Management Board, the benefits outlined below are provided by The Standard:

LIFE AND AD&D BENEFIT

Age of Insured	Benefit Amount
Less than 25	$30,000 Regardless of Age
25-29	
30-34	
35-39	
40-44	
45-49	
50-54	
55-59	
60-64	
65-69	
70+	

IRS Regulation: Employees can receive employer paid life insurance up to $50,000 on a tax-free basis and do not have to report the payment as income. However, an amount in excess of $50,000 will trigger taxable income for the "economic value" of the coverage provided to you.

TIP

Required! Are Your Beneficiaries Up to Date?

Beneficiaries are individuals or entities that you select to receive benefits from your policy.

- **You can change your beneficiary designation at any time (Community property rules may apply. Please refer to plan summary or forms for information.)**
- **You may designate a sole beneficiary or multiple beneficiaries to receive payment in the percent allocated.**
- **To select or change your beneficiary, contact the Benefits Department at 559.457.3520.**

VOLUNTARY DEPENDENT LIFE INSURANCE

Voluntary Dependent Life Insurance is available for dependent(s) of employees who qualify for the Employer Paid Basic Life and AD&D. Dependent coverage may be purchased by the employee at a cost of $6.00 per year.

SCHEDULE FOR VOLUNTARY DEPENDENT LIFE INSURANCE

Dependent	Benefit Amount
Spouse Dependent	$1,500
Unmarried Children to age 26	$1,500

VOLUNTARY EMPLOYEE PAID ADDITIONAL LIFE INSURANCE

If you are insured under the Basic Life plan and would like to supplement your employer paid insurance, additional Life coverage for you and/or your dependents is available for purchase through The Standard.

- **For employees:** Increments of $10,000 up to a $300,000 maximum (amount may not exceed 5x annual earnings)
- **For your spouse/state registered domestic partner:** Increments of $5,000 up to a $150,000 maximum
- **For your child(ren):** 14 days old up to 6 months of age, $100; 6 months old up to age 26, $5,000 or $10,000
- **Guarantee Issue Amount:** There are no requirements for a medical questionnaire if you apply for the Guarantee Issue Amount within 31 days after you first become eligible. If you apply within 31 days after you first become eligible for coverage: The Guarantee Issue Amount for you is $50,000, $25,000 for your spouse/state registered domestic partner. The insurance for your child(ren) is all guarantee issue.

Any amounts of insurance over the guarantee issue benefit are subject to review of good health by the insurance company. Insurance amounts subject to review will not be effective until the insurance company approves.

If you do not elect Voluntary Additional Life insurance when you are first eligible, you will be required to submit a health questionnaire, also known as Evidence of Insurability (EOI) to The Standard. An EOI will also be required if you wish to become insured for an amount greater than $50,000 or if you wish to insure a spouse for an amount greater than $25,000. The Benefits Office will supply employees with the proper forms if they are interested.

Please consider the following if you are purchasing Voluntary Additional Life for a dependent:

- You must purchase coverage for yourself in order to purchase coverage for your spouse or child(ren)
- Spouse or Child amount cannot exceed 100% of the employee's additional life benefit
- All children will be insured for the same amount
- For child(ren) coverage, one rate is charged regardless of the number of children in the family

COST OF VOLUNTARY LIFE COVERAGE

Age of Insured	Tenthly Rate per $1,000
Less than 30	$0.072
30–34	$0.084
35–39	$0.108
40–44	$0.204
45–49	$0.312
50–54	$0.468
55–59	$0.732
60–64	$0.972
65+	$1.608

DEPENDENT CHILD COVERAGE

Benefit Amount	Tenthly Premium
$5,000	$1.80
$10,000	$3.60

Please note: Benefits coverage may reduce when you reach age 65. Restrictions may apply if you and/or your dependent(s) are confined in the hospital or terminally ill. Please refer to your Summary Plan Description for exclusions and further detail.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Fresno Unified School District and the Joint Health Management Board understand that you and your family members might experience a variety of personal or work-related challenges. Through the Claremont EAP, you have access to resources, information, and counseling that are fully confidential and no cost to you.

PROGRAM COMPONENT	COVERAGE DETAILS
Who Can Utilize	All employees/retirees, dependents of employees/retirees, and members of your household
Consultations Available for subjects such as:	• Childcare and eldercare assistance • Emotional issues like stress, anxiety and depression • Marital, relationship or family problems • Bereavement or grief counseling • Substance abuse • Identity theft • Financial services to support issues including budgeting, debt management, financial planning and more • Legal services provides one consultation per issue (25% discount) to guide you through a divorce, child custody, real estate issues and other topics • Work/Life services to offer referrals for important matters such as Adoption Assistance or School/College Assistance, among other subjects
Number of Sessions	5 face-to-face sessions per family member per incident

TIP

How to Access:

- By Phone: **800.834.3773**
- Online: **www.claremonteap.com**

FLEXIBLE SPENDING ACCOUNTS (FSA)

A flexible spending account lets you use pre-tax dollars to cover eligible health care and dependent care expenses. There are different types of FSAs that help to reduce your taxable income when paying for eligible expenses for yourself, your spouse, and any eligible dependents, as outlined below:

FSA TYPE	DETAIL
Health Care FSA	• Can reimburse for eligible health care expenses not covered by your medical, dental and vision insurance. • Maximum contribution for 2019 is $2,700. The Maximum contribution for 2020 has yet to be released by the I.R.S.
Dependent Care FSA	• Can be used to pay for qualified child care and/or caregivers for a disabled family member in the household, who is unable to care for themselves. • Maximum contribution for 2019 is $5,000, if you are single or married and filing a joint tax return. If you are married and filing separately, your maximum contribution is $2,500. The Maximum contribution for 2020 has yet to be released by the I.R.S.

Please note: Consult your tax advisor for additional taxation information or advice.

Enrolling and Using an FSA

An annual contribution amount within the maximum limit must be determined at the time of enrollment. Once enrolled, you will have online access to view your FSA balance, check on a reimbursement status, and more. Visit www.americanfidelity.com to access American Fidelity's online portal.

Examples of eligible expenses, as determined by the Internal Revenue Service (IRS), and additional information are below:

ACCOUNT TYPE	EXAMPLES OF ELIGIBLE EXPENSES
Health Care FSA	• Deductibles, copays and coinsurance, as well as out-of-pocket costs for medical, dental and vision services, including chiropractic and acupuncture services • Prescription drugs and over-the-counter medications with a prescription are considered eligible • Explicit guidelines for determining eligible expenses have yet to be provided by the Internal Revenue Service (IRS); for a list of potential eligible expenses that may be covered by a Flexible Spending Account (FSA), review Internal Revenue Code (IRC) section 213(d). IRS Publication 502 (Medical and Dental Expenses) may be used as a guide for what expenses may be considered by the IRS to be for medical care; however, the guidelines should be used with caution when trying to determine what expenses are reimbursable under an FSA(1)
Dependent Care FSA	• Eligible child care, nanny services or residential disabled adult daycare for your dependents • Dependents claimed on your federal income tax return, including those under age 13 and those of any age who are unable to care for themselves, who live with you for more than half of the taxable year and do not provide more than half of his/her own support would be considered eligible dependents for this FSA • To determine potential eligible employment-related expenses, view IRC sections 129 and 21. IRS Publication 502 (Child and Dependent Care Expenses) may also be used as a guide for what expenses may be considered employment-related; however, Publication 502 should be used with caution when trying to determine what expenses are reimbursement under a Dependent Care FSA(1)

[1]**Please note:** This is informational only and not intended to serve as legal, tax or financial advice. Participants in a Health Care FSA or a Dependent Care FSA should consult their tax advisor before making any changed to their plan.

FLEXIBLE SPENDING ACCOUNTS (FSA) (CONTINUED)

Receiving Reimbursements

Keep itemized receipts in a safe place. The IRS or American Fidelity may request a copy to substantiate a claim. If you are required to submit a receipt or some form of claim documentation, and fail to comply, reimbursement may be denied.

You will have until March 31, 2021 to submit a reimbursement request for eligible expenses incurred between January 1 and December 31, 2020. You can submit a manual reimbursement request by:

- **Fax:** 844.319.3668
- **Mail:** American Fidelity Assurance Company, Attn: Flex Account Administration, P.O. Box 161968, Altamonte Springs, FL 32716
- **Online:** www.americanfidelity.com (you must be registered online to process claim)
- **Mobile Device Using AFmobile:** Create an AFmobile account by downloading the app from the Apple App Store or the Google Play Store. Please note, if you already have an OSC account, your username and password will be the same.

You may receive your manual reimbursement either by a mailed check or by direct deposit into your personal Checking or Savings Account.

For more details about using an FSA, be sure to contact American Fidelity's Customer Service at 800.662.1113.

The FSA Health Plan and Termination

If you are a participant in your Health FSA plan and you are terminated, your funds may be preserved and you may have other options available to you. It is important that you check the Plan Booklet or contact the Benefits Department at 559.457.3520 if you have any further questions regarding your FSA health plan fund at the time of termination. Your failure to act in conjunction with your Health FSA plan may cause your fund to be permanently forfeited after your termination.

COST BREAKDOWN

The rates below are effective January 1, 2020 – December 31, 2020.

COVERAGE LEVEL	PAYROLL DEDUCTION	
	Employee Monthly	Employee Tenthly
Medical Plan Option A (Anthem Blue Cross PPO)		
Employee Only	$160	$192
Employee and Spouse/State Registered Domestic Partner	$220	$264
Employee and Child(ren)	$175	$210
Employee and Family	$230	$276
Medical Plan Option B (Anthem Blue Cross PPO)		
Employee Only	$60	$72
Employee and Spouse/State Registered Domestic Partner	$90	$108
Employee and Child(ren)	$70	$84
Employee and Family	$100	$120
Medical Plan Option C (Kaiser Permanente Deductible HMO)		
Employee Only	$160	$192
Employee and Spouse/State Registered Domestic Partner	$220	$264
Employee and Child(ren)	$175	$210
Employee and Family	$230	$276
UnitedHealthcare Dental HMO		
Employee and Family	No Cost	No Cost
Delta Dental PPO		
Employee Only	No Cost	No Cost
Employee + One Dependent	$33.05	$39.66
Employee + Two or more Dependent	$51.57	$61.88
MES Vision		
Employee and Family	No Cost	No Cost

Health Assessment Premiums – All employees enrolled in the District's medical plans will pay, through payroll deduction, an additional $10 or $12 Health Assessment Fee depending on whether you are paid on a monthly or tenthly basis. The funds generated from this assessment shall be placed in a Health Plan Reserve to offset current and future health care cost increases as needed. If the Joint Health Management Board determines such funds are not needed for this purpose, the Board may determine to reduce, rebate or refund such assessment.

AVAILABLE TO PART-TIME EMPLOYEES ONLY	PAYROLL DEDUCTION	
	Employee Monthly	Employee Tenthly
UnitedHealthcare Dental HMO		
Employee and Family	$43.75	$52.49
MES Vision		
Employee and Family	$12.15	$14.58
Employee and Family CSEA Only (Employees with 3 years of service)	$7.59	$9.11

Dual-covered coordination of benefits only applies when both employees elect and pay for cross coverage(s).

PLAN GUIDELINES AND EVIDENCE OF COVERAGE

The benefit summaries listed on the previous pages are brief summaries only. They do not fully describe the benefits coverage for your health and welfare plans. For details on the benefits coverage, please refer to the Plan Booklet and/or Evidence of Coverage. The Evidence of Coverage or Plan Booklet is the binding document between the elected health plan and the member.

A health plan physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat the members' medical condition. These services and supplies must be provided, prescribed, authorized, or directed by the health plan's network physician unless the member enrolls in the PPO plan where the member can use a non-network physician.

The HMO member must receive the services and supplies at a health plan facility or skilled nursing facility inside the service area except where specifically noted to the contrary in the Evidence of Coverage.

For details on the benefit and claims review and adjudication procedures for each plan, please refer to the Plan Booklet and/or Evidence of Coverage. If there are any discrepancies between benefits included in this summary and the Evidence of Coverage or Plan Booklet, the Evidence of Coverage or Plan Booklet will prevail.

MEDICARE PART D NOTICE

Important Notice from the Fresno Unified School District about Your Prescription Drug Coverage and Medicare

2020 CERTIFICATE OF CREDITABLE PRESCRIPTION DRUG COVERAGE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Fresno Unified School District and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare prescription drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Fresno Unified School District has determined that the prescription drug coverage offered by the Fresno Unified School District Employee Health Care Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare prescription drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Prescription Drug Plan?

If you decide to join a Medicare drug plan, your current Fresno Unified School District medical coverage will not be affected. You may keep this coverage if you elect Part D, however, this plan will not coordinate with Part D coverage; will not reimburse you for Part D premiums; nor will it be responsible for any "income-related" monthly adjustment amount (IRMAA) imposed by Medicare. If you do decide to join a Medicare drug plan and drop your current Fresno Unified School District prescription coverage, be aware that you and your dependents will not be able to get this prescription coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Fresno Unified School District and don't join a Medicare prescription drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage…

Contact the Fresno Unified School District Benefits Office listed on page 32 for further information. NOTE: You will receive this notice each year. You will also get it before the next period you can join a Medicare prescription drug plan, and if this coverage through Fresno Unified School District changes. You also may request a copy of this notice at any time.

For More Information about Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help. In California, it is the "Health Insurance Counseling and Advocacy Program" (HICAP) and can be reached (by non-cell phones only) at 1-800-434-0222.
- Call **1-800-MEDICARE (1-800-633-4227).** TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit the Social Security Administration (SSA) online at www.socialsecurity.gov, or call SSA at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: **Keep this Creditable Coverage notice. If you decide to join one of the Medicare prescription drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).**

LEGAL INFORMATION REGARDING YOUR PLANS

Required Notices

Women's Health & Cancer Rights Act of 1998

Under federal law, group health plans, insurers, and HMOs that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery, effective for the first plan year beginning on or after October 21, 1998.

In the case of a participant or beneficiary who is receiving benefits under the plan in connection with a mastectomy and who elects breast reconstruction, federal law requires coverage 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 at all stages of the mastectomy, including lymphedemas.

Each of the medical plan options available through the Fresno Unified School District Health Plan currently covers mastectomies and reconstructive surgery. Coverage is subject to each plan's deductibles, coinsurance and benefit provisions. These provisions are generally described in the Plan Booklet or Explanation of Coverage.

Newborn Mothers Health Protection Act

Under the Newborn and Mothers Health Protection Act, the following language is now included in the Health Plan:

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours for the eligible mother and newborn child following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). The time periods outlined above begin at the birth of the child. The law also prohibits a plan from requiring a health care practitioner to obtain authorization from the Plan for prescribing a length of stay not in excess of those periods.

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 you dependents lose eligibility for that other coverage (because of separation/divorce, termination of employment or reduction in hours, death or cessation of employer contribution), 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 of 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 State Registered 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 of 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.

Mental Health Parity and the Public Health Service Act

Group health plans sponsored by the State and local governmental employers must generally comply with Federal law requirements in title XXVII of the Public Health Service Act (the "PHSA"). However, self-funded group health plans sponsored by state and local governments, including school districts, are permitted to elect to be exempt from some of the PHSA requirements. The benefits provided by Anthem Blue Cross, Avante, EnvisionRx, Claremont EAP, PhysMetrics, and Delta Dental constitute the self-insured portions of the Fresno Unified School District Employee Health Care Plan (the "Plan").

The Plan is administered by the Joint Health Management Board ("JHMB"). The JHMB has elected to exempt the self-insured portion of the Plan from the PHSA requirement to have the same financial requirements and treatment limitations for mental health or substance abuse benefits as for medical and surgical benefits. This exemption will be in effective for the plan year beginning July 1, 2019 and ending June 30, 2020. The election may be renewed for subsequent plan years.

PLEASE NOTE: Even though the JHMB is opting out of the mental health parity protections, **the JHMB is NOT making any changes to your current mental health or substance abuse benefits.** If you have questions regarding your mental health or substance abuse coverage, please contact Avante Health at 800.498.9055.

The JHMB is not opting out of other applicable HIPAA requirements. It is not opting out of the provisions regarding standards relating to benefits for mothers and newborns, coverage for reconstructive surgery following a mastectomy, and coverage of dependent students on medically necessary leaves of absence.

HIPAA Privacy Notice

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

A copy of this Notice can be obtained at any time by writing or calling the Fresno Unified School District Benefit Office and requesting a copy.

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 provide you with notice of its legal duties and privacy practices with respect to your protected health information, and to notify you if there is a breach of your unsecured protected health information.

This notice describes the Plan's legal duties and privacy practices 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, the Plan 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. For example, protected health information may be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.

   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. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensures or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

   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, materials 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

Section 1. Notice of Uses and Disclosures (continued)

i. with applicable law, as necessary to carry out their duties with respect to the decedent.

ii. Organ procurement. The Plan may disclose protected health information to facilitate organ donation and transplantation.

iii. Medical research. The Plan may disclose protected health information for medical research projects, subject to strict legal restrictions.

iv. 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.

v. 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.

vi. 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 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, nor will it use or disclose your genetic information for underwriting purposes.

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. Other uses and disclosures not described in this notices will be made only with your written authorization.

iv. You may revoke an authorization that you previously have given by sending a written request to your 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.

Such requests should be made to the individual identified in Section 5.

b) Right to Receive Confidential Communications of PHI. 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 request should be made to the individual identified in Section 5.

c) 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 "in a designated record set" for as long as the Plan maintains the protected health information.

"Protected health information" includes all individually identifiable health information transmitted or maintained by the Plan regardless of form.

"Designated record set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about individuals. Information used for quality control or peer review analysis and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days. 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.

d) 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 in a designated record set 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 asks 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.

e) 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.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

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.

f) 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. Proof of such authority may take one of the following forms: (1) A power of attorney for health care purposes, notarized by a notary public, (2) A court order of appointment of the person as the conservator or guardian of the individual, or (3) An individual who is the parent of a minor child.

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.

g) Right to Request a Paper Copy. 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.

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 will 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 states 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 of disclosures that are required by law; and

v. Uses and 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 your privacy practices.

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services online at https://ocrportal.hhs.gov/ocr/cp/complaint_frontpage.jsf or by mailing your complaint to the appropriate the HHS Regional office. The list of regional offices can be found at http://www.hhs.gov/ocr/office/about/rgn-hqaddresses.html. If you need help filing a complaint or have a question about the complaint or consent forms, please e-mail OCR at OCRComplaint@hhs.gov.

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
Fresno Unified School District
Benefits & Risk Management
2309 Tulare Ave.
Fresno, CA 93721
559.457.3596

General Notice of COBRA Continuation Coverage Rights

Introduction

You're getting this notice because you recently gained coverage under the Fresno Unified School District Employee Health Care Plan (the "Plan"). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan Booklet or contact the Fresno Unified School District Plan Administrator at (559) 457-3520.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse or domestic partner, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse or domestic partner of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse or domestic partner dies;
- Your spouse or domestic partner's hours of employment are reduced;
- Your spouse or domestic partner's employment ends for any reason other than his or her gross misconduct;
- Your spouse or domestic partner becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse, or your domestic partnership is terminated.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because 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 parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced, legally separated, or terminate their domestic partnership; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the District, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, or domestic partner, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Fresno Unified School District Plan Administrator has been notified that a qualifying event has occurred. The Fresno Unified School District (employer) must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse, the termination of a domestic partnership, or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator via written notice within 30 days after the qualifying event occurs. You must provide this written notice to: Fresno Unified School District, Attn: Benefits Office, 2309 Tulare Street, Fresno, CA 93721. You may be required to provide supporting documentation (e.g. a divorce/legal separation decree).

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children, etc.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. When you call, you may be asked to provide some or all of the following information: (1) Employee's name; (2) 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 Social Security Administration ("SSA") disability determination. In addition, you will be required to provide the District's Benefits 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 Benefits Department by calling (559) 457-3520 within 30 days of any such final determination that the individual is no longer disabled.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Health Flexible Spending Account (FSA) Information

COBRA coverage under the Fresno Unified School District Health FSA will be offered only to Qualified Beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected by the covered employee, reduced by reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for the Fresno Unified School District Health FSA COBRA coverage that will be charged for the remainder of the plan year. COBRA coverage will consist of the Fresno Unified School District Health FSA coverage in force at the time of the qualifying event. The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and the COBRA coverage for the FSA plan will terminate at the end of the plan year. Unless otherwise elected, all qualified beneficiaries who were covered under the Fresno Unified School District Health FSA will be covered together for Health FSA COBRA coverage. However, each qualified beneficiary could alternatively elect separate COBRA coverage to cover that beneficiary only with a separate Health FSA annual limit and a separate premium. If you are interested in this alternative, contact Administrative Solutions, Inc. at (866) 777-1320 during business hours for more information.

Alternate Recipients Under QMCSOs

A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMSCO) received by the Fresno Unified School District during the covered employee's period of employment with Fresno Unified School District is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights, including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans contact the U.S. Department of Health and Human Services at 1-877-267-2323, extension 61565 or www.cciio.cms.gov, or the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Fresno Unified School District
Attn: Plan Administrator
2309 Tulare Street, Fresno, CA 93721
(559) 457-3520

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Part A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy Health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by the Fresno Unified School District.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan, if you are eligible. (Just because you received this notice does not mean you are eligible for the Fresno Unified School District health plan.) However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If your cost for self-only coverage under the Fresno Unified School District health plan is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. An employer sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such cost. The health plan offered by the Fresno Unified School District meets the minimum value standard.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution as well as your employee contribution to employer-offered coverage, is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about the coverage offered by Fresno Unified School District, please contact the Fresno Unified School District Benefits Department at (559) 457-3520. If you are eligible for coverage under the health plan offered by the Fresno Unified School District you can also check your plan booklet.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov or http://www.coveredca.com/ (the website for the California Marketplace) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Part B: Information About Health Coverage Offered by Your Employer

This section contains information about the health coverage offered by the Fresno Unified School District. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name: **Fresno Unified School District**		4. Employer Identification Number (EIN): **94-600220**
5. Employer Address: **2309 Tulare Avenue**		6. Employer Phone Number: **(559) 457-3520**
7. City: **Fresno**	8. State: **CA**	7. City: **Fresno**
10. Who can we contact about employee health coverage at this job? **Fresno Unified School District Benefits Department**		
11. Phone number (if different from above):		12. Email Address: FUSDBenefits@fresnounifited.org

Here is some basic information about health coverage offered by the Fresno Unified School District:

- As your employer, we offer a health plan to:
  - Some employees. Eligible employees are: Permanent employees working 20 or more hours per week who qualify in accordance with Board Policy and respective Collective Bargaining Agreements.
- With respect to dependents:
  - We do offer coverage. Eligible dependents are: a legal spouse, a state registered domestic partner, any child under the age of 26 meeting qualifying criteria (refer to Health Plan Booklet) or an unmarried mentally or physically disabled child meeting qualifying criteria (refer to Health Plan Booklet).
- If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process.

All United States citizens and legal residents are required to maintain a minimum level of medical insurance coverage (known as "Minimum Essential Coverage"). Those failing to maintain adequate medical insurance coverage will be fined. This fine or "tax penalty" will be payable as an additional tax of up to 2.5% of your family's household income (this tax penalty will increase annually).

If you are not eligible for your employer's medical insurance, or it does not meet the minimum value standard (as the above checkbox would indicate), it is not too late to avoid a tax penalty. You have the option of speaking with an MMA MarketLink insurance expert for assistance in obtaining insurance coverage for you or your family.

By Phone: Monday – Friday, 8am – 5pm PST

- For English, call: (844) 861-9458
- For Spanish, call: (844) 861-9458

You may also be eligible for coverage through the public State Exchange, such as "Covered California" for California residents. Note: Many states have their own Exchange Marketplace. An Exchange Marketplace is an additional place to shop for and buy health insurance from a variety of insurance providers. Some individuals and families may qualify for premium subsidies (tax credits), which provide assistance in paying for health insurance purchased through the Exchange Marketplace.

If you would like to review your options directly with your State Exchange, please contact your State Exchange directly by visiting www.coveredca.com if you live in California, otherwise, please visit www.healthcare.gov.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: Medicaid www.medicaid.georgia.gov - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
IOWA – Medicaid	**KANSAS – Medicaid**
Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512

KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll-Free: 1-800-852-3345, ext 5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739 or 651-431-2670	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid and CHIP**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347

SOUTH CAROLINA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://health.wyo.gov/healthcarefin/medicaid/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 12/31/2019)

DIRECTORY & RESOURCES

Below, please find important contact information and resources for Fresno Unified School District.

INFORMATION REGARDING	GROUP / POLICY #	CONTACT INFORMATION	
Enrollment & Eligibility			
Initial Enrollment: • Benefits & Risk Management Department Eligibility / PPO: • Claims: Delta Health Systems Plan Booklet / Forms / SBCs / Policies: • JHMBHealthConnect		559.457.3520 800.807.0820	http://fusd.fresnounified.org/dept/benefits/pages/default.aspx www.deltahealthsystems.com www.jhmbhealthconnect.com
Medical Coverage			
Anthem Blue Cross • Medical Plan Option A • Medical Plan Option B • Pre-Authorizations/Case Management Envision Rx Carve-Out Avante Mental Health/Substance Abuse (for 2019 plan year) **Note:** 2020 MH/SA carrier contact info to be sent out separately	 1866FA 1866FA Rx Bin#009893	 800.807.0820 800.807.0820 800.274.7767 800.361.4542 800.498.9055	 www.anthem.com/ca www.deltahealthsystems.com www.envisionRx.com www.fusdmentalhealth.com
Medical Coverage			
Kaiser Permanente • Medical Plan Option C	 603815	 800.464.4000	 www.kp.org
Chiropractic / Acupuncture Coverage			
PhysMetrics		559.447.3375	www.fusdchiro.com
Dental Coverage			
Delta Dental • Dental PPO UnitedHealthcare Dental • Dental HMO	 00697 711904	 888.335.8227 800.999.3367	 www.deltadentalins.com www.myuhc.com
Vision Coverage			
MES Vision • Vision	 28074	 800.877.6372	 www.MESVision.com
Life, AD&D and Disability			
The Standard • Basic Life/AD&D • Voluntary Additional Life • Travel Assistance Service	 600762 C 600762 B	 559.457.3520 559.457.3520 800.527.0218	 www.standard.com
Flexible Spending Accounts			
American Fidelity Assurance Company • Home Office • Fresno Office • Insurance Claims Fax • FSA Claims Fax	501, 502, 503, 504, 506, 507	800.662.1113 866.504.0010 ext 0 800.818.3453 800.543.3539	www.americanfidelity.com
Employee Assistance Plan			
Claremont EAP		800.834.3773	www.claremonteap.com

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