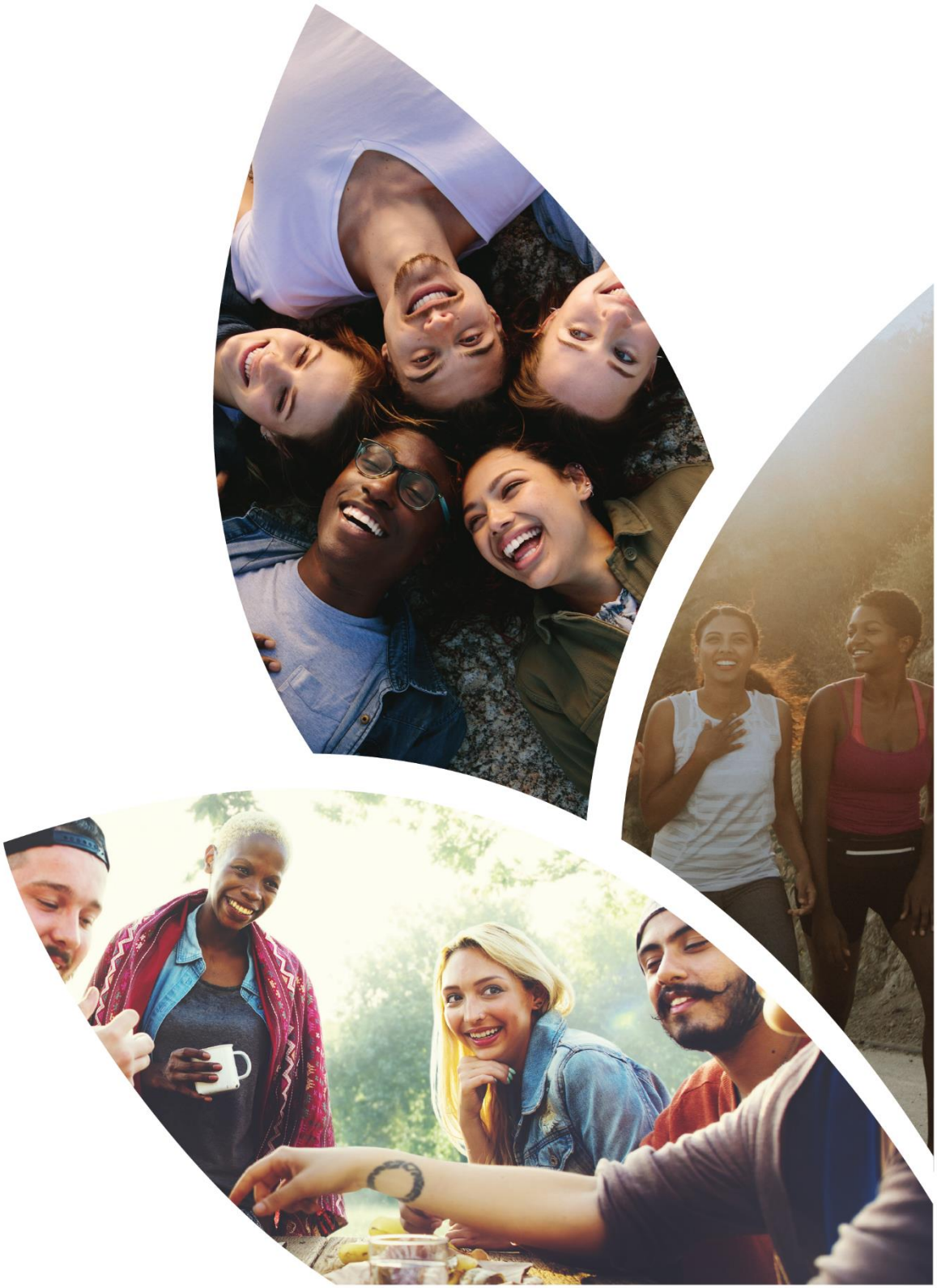
BENEFITS

2022 INFORMATION GUIDE

UNDERSTANDING YOUR OPTIONS

Joint Health Management Board

Fresno Unified School District



Guidelines/Evidence of Coverage

The benefit summaries listed on the following 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.

All rights reserved. No part of this document may be reproduced or transmitted in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without prior written permission of Marsh & McLennan Insurance Agency LLC.

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.

Discover Your Benefits

Welcome to your 2022 Benefits Plan Year! 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 eligibility, how to enroll or make changes when applicable, each benefit available to you as an eligible employee, summaries of covered benefits and how to contact each insurance carrier if you need assistance.

We appreciate the hard work and dedication you bring to Fresno Unified School District. For more information about the employee benefits and wellness programs described herein, please refer to your plan documents and insurance booklets available at http://www.jhmbhealthconnect.com/your-benefits. If you have any questions, please contact the Benefits Department at 559.457.3520.

Section	Page #
Eligibility & Enrollment	4
Medical	7
Prescription Drug Coverage	10
Supplemental Services	13
Wellness Program	16
Dental	18
Vision	21
Flexible Spending Accounts	23
Life and AD&D	26
Employee Assistance Program	29
Costs & Required Notices	31
Directory & Resources	43

Eligibility & Enrollment

Eligibility & Enrollment

Time to answer some questions…

Who can enroll?

Permanent employees working a minimum of 4 hours a day or 20 hours a week are eligible and are required 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 (QMCSO)
- 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?

Benefits for eligible **new hires** commence on the first day of the month following your date of hire. Eligible employees must complete their benefit enrollment forms and submit to the Benefits Department within 31 days of benefit eligibility.

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.

Your enrollment choices remain in effect through the end of the benefits plan year, January 1, 2022 – December 31, 2022.

TIP

If you miss the enrollment deadline, and are automatically enrolled in benefits as described above, you will not be able to change your benefits coverage until the next Open Enrollment period unless you have a change in status during the plan year. Please review details on HIPAA Special Enrollment Rights qualified change in status events for more information.

How do I get started with my enrollment?

Joint Health Management Board
Fresno Unified School District

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 or available at www.JHMBHealthConnect.com.
- If you have questions when completing your enrollment forms, contact the Benefits Department at 559.457.3520.

Annual Open Enrollment – October 1 – November 30, 2021

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. Please note, if you currently participate in the District's Flexible Spending Account (FSA) plan offered by American Fidelity, the FSA **DOES NOT** automatically renew each year. If you wish to contribute to an FSA plan in 2022, review the FSA section on page 24 and contact American Fidelity to enroll for the upcoming year.

What if my needs change 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 31 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 if you don't make an election within 31 days of benefit eligibility. 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

Medical

Which plan type is right for you?

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 Aetna 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 discrepancy 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 Aetna 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.

More information about how to find a provider in the Aetna network will be communicated during Open Enrollment.

NOTE: You should continue to utilize the Anthem provider network for PPO Plan Options A & B through December 31, 2021. The Aetna network of providers will be effective as of January 1, 2022.

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 www.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 departments 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

California 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, please visit www.cciio.cms.gov. For information regarding the Individual Mandate in the state of California, please refer to the State of California Franchise Tax Board or visit their website at https://www.ftb.ca.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 Elixir using the "Select Formulary"
- The Elixir 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 Elixir.
- 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 (Elixir Pharmacy, 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.ElixirSolutions.com.

Deductible HMO Plan C:

- The Kaiser prescription 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 for prescriptions?

Use 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 a typical 30-day supply from a walk-in pharmacy.

Shop Around

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

Over-the-Counter Options

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

Plan Highlights	Aetna Plan A		Aetna 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 + 5%	40%	$25 Copay + 25%	50%
Specialist	$15 Copay + 5%	40%	$25 Copay + 25%	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	5%	40%	25%	50%
Complex Diagnostics (MRI/CT Scan)	5%	40%	25%	50%
Therapy[3], including Physical, Occupational and Speech	5%	40%	25%	50%
Hospital Services				
Inpatient[3]	5%	40%	25%	50%
Outpatient Surgery[3]	$100 Copay + 5%	Not Available[4]	$100 Copay + 25%	Not Available[4]
Emergency Room	$100 Copay + 5% (copay waived if admitted)		$100 Copay + 25% (copay waived if admitted)	
Urgent Care	$35 Copay + 5%	$35 Copay + 40%	$35 Copay + 25%	$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	5%	40%	25%	50%
	Mental Health & Substance Abuse services administered through Halcyon Behavioral Health			
Mental Health & Substance Abuse	Pre-Authorization required by Halcyon Behavioral Health for all mental health and substance abuse services. See page 14 for more details.			
	Chiropractic & Acupuncture services administered through PhysMetrics			
Chiropractic & Acupuncture	See page 14 for more details.			
	Prescription Drug Coverage administered through Elixir			
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.

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)	5% up to $50 Copay per procedure
Therapy, including Physical, Occupational and Speech	$15 Copay
Hospital Services	
Inpatient	5%
Outpatient Surgery	5%
Emergency Room	5%
Urgent Care	$15 Copay(1)
Maternity Care	
Physician Services (prenatal or postnatal)	No Charge(1)
Hospital Services	5%
Mental Health & Substance Abuse	
Inpatient	5%
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

Supplemental Services

Mental Health & Substance Abuse

If you are enrolled in Medical Plan Option A or B, your mental health & substance abuse coverage is 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.

Halcyon Behavioral Health Plan Highlights	Medical Plan Options A or B
Mental Health Services	
Inpatient(1)	Covered at 100% as certified medically necessary 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	Covered at 100% as certified medically necessary

(1) Deductible Waived

Any questions pertaining to your mental health and/or substance abuse coverage can be directed to Halcyon Behavioral Health by calling **888.425.4800**, emailing info@halcyonbehavioral.com or visiting their website at www.fusdmhsa.com.

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 after $100 deductible
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 C are covered through Kaiser facilities at a $15 Copay (deductible waived).

Check out PhysMetrics' website at www.fusdchiro.com or contact them at **877.519.8839** to discuss how to use the program and find a participating provider near you.

Need to see a doctor on demand?

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

Teladoc (Medical Plan Options A & B) – Available starting January 1, 2022

As of January 1, 2022, Teladoc will provide telehealth services for PPO Plan Options A & B. With Teladoc, 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. Teladoc 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 Teladoc.

To get started (on or after January 1, 2022), you can:

- Call **800.TELADOC (835.2362)**
- Download the Teladoc App (from the Apple App Store or Google Play Store)
- Go online to www.Teladoc.com

**$5 telehealth copay is waived on a temporary basis during the COVID-19 national emergency period.*

NOTE: PlushCare remains the covered telehealth service for PPO Plan Options A & B through December 31, 2021. Continue to use this service through the end of the year (2021) for your telehealth needs. For more information regarding this service, please visit www.JHMBHealthConnect.com/telehealth-at-your-fingertips.

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 www.kp.org/mydoctor/videovisits for more details on how to use their telehealth services.

Wellness Program

Wellness Program

A healthier you starts here – mind and body!

Healthy, active lifestyles can help reduce the risk of chronic disease and may lower your annual healthcare costs. We care about your total well-being and encourage all employees to engage in our wellness resources at no-cost.

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:

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

WellPATH
Your Path to Better Health
Joint Health Management Board

Employees and their dependents 18 years of age and older 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.

Dental

Dental Plan

A smile is the nicest thing you can wear.

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

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 Delta Dental PPO dentist, go to www.deltadentalins.com and search the Provider Network, or call **866.499.3001**.

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**.

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

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

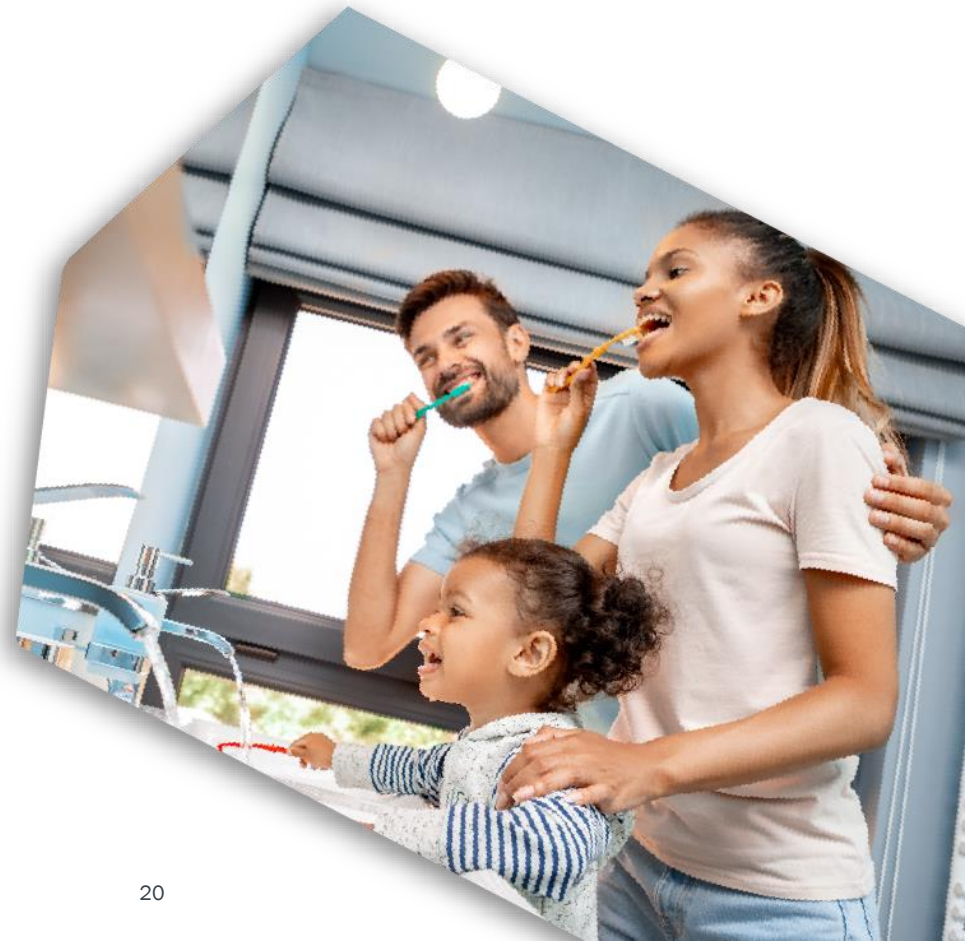
The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Dental Plan (Continued)

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

[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

Vision Plan

Keep a clear focus on your sight.

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 your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Flexible Spending Accounts

Flexible Spending Accounts (FSA)

Make your money work for you.

The District, in partnership with American Fidelity, offers flexible spending account plans that let you use pre-tax dollars to cover eligible healthcare 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
Healthcare FSA	• Can reimburse for eligible healthcare expenses not covered by your medical, dental, and vision insurance. • Maximum contribution for **2022 is $2,750.**
Dependent Care FSA	• Can be used to pay for a child's (up to the age of 13) childcare expenses and/or care for a disabled family member in the household, who is unable to care for themselves. • Maximum contribution for **2022 is $5,000.**

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

Enrolling and Using an FSA

Your annual contribution amount, within the maximum limit, must be determined at the time of enrollment each year. FSA plans do not automatically renew each year. If you currently participate in the District's FSA plan, you must re-enroll and set your annual contribution amount for the upcoming year. 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. For more information regarding how a Section 125 Plan works, please watch the following video: https://americanfidelity.com/support/videos/section-125/

Examples of eligible expenses, as determined by the Internal Revenue Service (IRS), and additional information are below. Visit https://americanfidelity.com/claims/fsa-hsa-eligibility-list/ to view a more comprehensive list of eligible expenses.

Account Type	Examples of Eligible Expenses
Healthcare 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 Healthcare 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, 2023, to submit a reimbursement request for eligible expenses incurred between January 1 and December 31, 2022. 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.

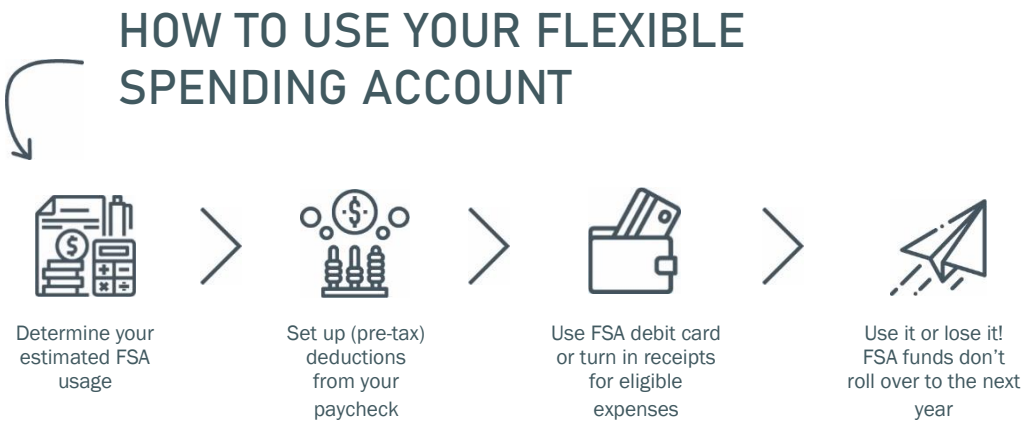
Healthcare FSA Plan Debit Card

Upon enrollment in the Healthcare FSA Plan, you will have the option to request a Healthcare FSA Plan Debit Card through American Fidelity. You can use this debit card to pay your provider for eligible healthcare expenses rather than paying out of pocket, or to purchase eligible healthcare FSA plan products within the FSA plan year. Your Healthcare FSA Plan account will be automatically deducted for the eligible expense amount, and you will not have to wait for reimbursement from American Fidelity. Although payment will come directly from your Healthcare FSA Plan account, you must save all receipts, as proof of the eligibility of the expense is required by the Internal Revenue Code (IRC) regulations. For more information on using the Healthcare FSA Plan Debit Card, visit: https://americanfidelity.com/support/benefits-debit-card/

The Healthcare FSA Plan and Termination

If you are a participant in your Healthcare FSA plan and you are terminated, your funds may be preserved and you may have other options available to you. Please note that your termination date becomes the last day of your FSA plan year. You can only submit reimbursement for eligible expenses that are incurred prior to your termination date.

It is important that you contact the Benefits Department at 559.457.3520 if you have any further questions regarding your FSA healthcare plan fund at the time of termination. Your failure to act in conjunction with your Healthcare FSA plan may cause your fund to be permanently forfeited after your termination. If you have a balance in your Healthcare FSA plan approaching the end of the plan year or upon termination, you may purchase eligible healthcare FSA plan items through the FSA Store: www.fsastore.com.



Life and AD&D

Life and AD&D

Protection for your loved ones.

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 the Joint Health Management Board, the benefits outlined below are provided by The Standard:

Basic 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

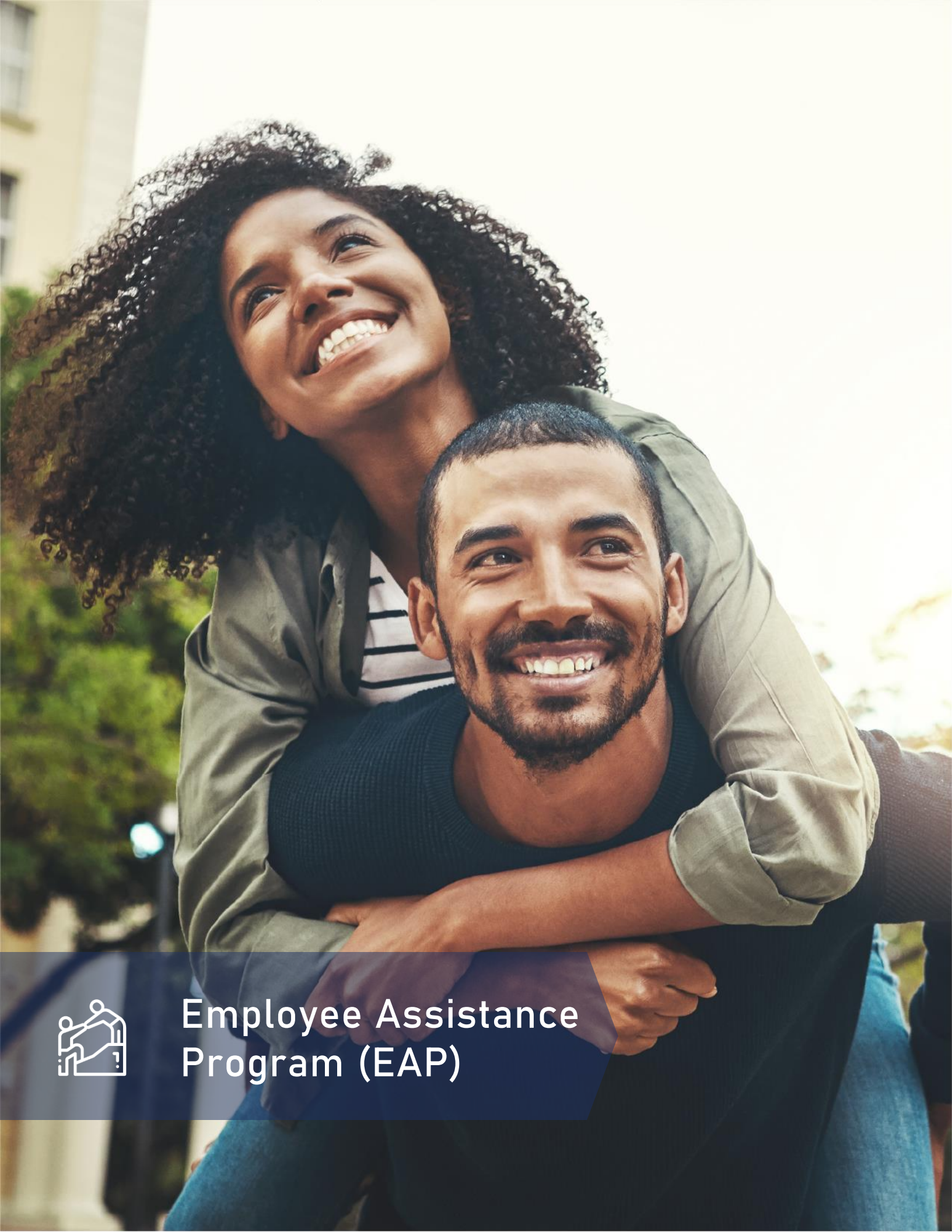
Cost of Voluntary Life Coverage

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 Plan Booklet for exclusions and further detail.



Employee Assistance Program (EAP)

Employee Assistance Program (EAP)

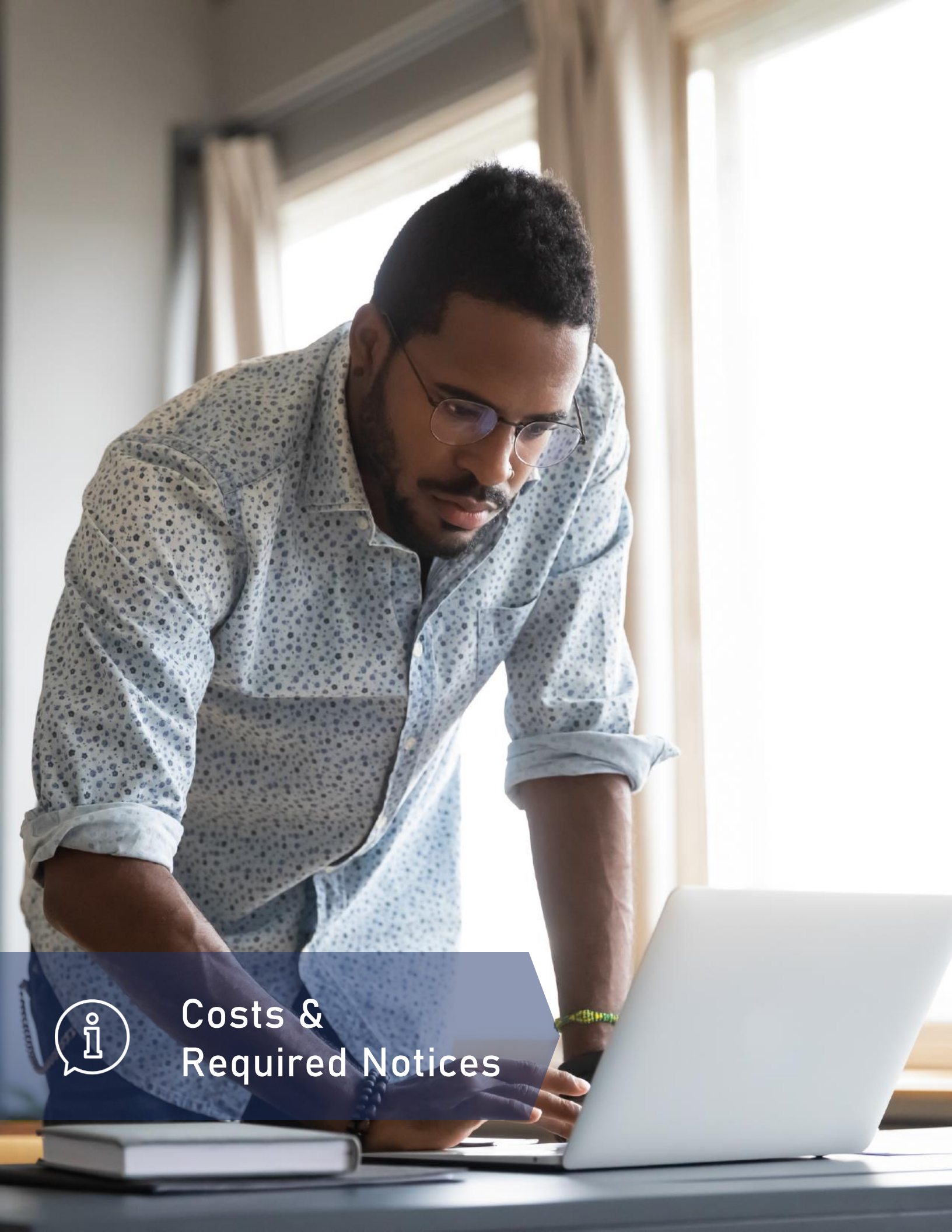
Your free and confidential go-to resource.

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 year per family member per incident

How to Access:

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



Costs & Required Notices

Cost Breakdown

All of your rates in one place.

Joint Health Management Board
Fresno Unified School District

The rates below are effective January 1, 2022 – December 31, 2022

Coverage Level	Payroll Deduction	
	Employee Monthly	Employee Tenthly
Medical Plan Option A (Aetna 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 (Aetna 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).

Medicare Part D Notice

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

2022 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 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 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?

Individuals who are eligible for Medicare should compare their current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in their area.

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.

Please contact the Benefits Office for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

Your medical benefits brochure contains a description of your current prescription drug benefits.

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 Fresno Unified School District Benefits Office listed on page 43 for further information. NOTE: You will receive this notice annually, before the next period you can join a Medicare prescription drug plan, and if this coverage through your employer 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
- 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

The Women's Health and Cancer Rights Act (WHCRA) requires group health plans to make certain benefits available to participants who have undergone or who are going to have a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Each of the medical plan options available through 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 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 the 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.

Health Insurance Portability & Accountability Act Non-discrimination Requirements

Health Insurance Portability & Accountability Act (HIPAA) prohibits group health plans and health insurance issuers from discriminating against individuals in eligibility and continued eligibility for benefits and in individual premium or contribution rates based on health factors.

These health factors include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities), and disability.

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, HIPAA Special Enrollment Rights require your plan to allow you and/or your dependents to enroll in Fresno Unified School District's plans (except dental and vision plans elected separately from your medical plans) if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days (60 days if the lost coverage was Medicaid or Healthy Families) after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Other midyear election changes may be permitted under your plan (refer to "Change in Status" section). To request special enrollment or obtain more information, contact the Benefits Office.

"HIPAA Special Enrollment Opportunities" include:

- COBRA (or state continuation coverage) exhaustion
- Loss of other coverage [1]
- Acquisition of a new spouse or dependent through marriage [1], adoption [1], placement for adoption [1] or birth [1]
- Loss of state Children's Health Insurance Program coverage (e.g., Healthy Families) (60-day notice) [1]
- Employee or dependents become eligible for state Premium Assistance Subsidy Program (60-day notice)

"Change in Status" Permitted Midyear FSA Election Changes

Due to the Internal Revenue Service (IRS) regulations, in order to be eligible to take your premium contribution using pre-tax dollars, your election must be irrevocable for the entire plan year. As a result, your enrollment in the medical, dental, and vision plans or declination of coverage when you are first eligible, will remain in place until the next Open Enrollment period. Flexible Spending Account election(s) will also remain in place, unless you have an approved "change in status" as defined by the IRS.

Examples of permitted "change in status" events include:

- Change in legal marital status (e.g., marriage [2], divorce or legal separation)
- Change in number of dependents (e.g., birth [2], adoption [2] or death)
- Change in eligibility of a child
- Change in your / your spouse's / your registered domestic partner's employment status (e.g., reduction in hours affecting eligibility or change in employment)
- A substantial change in your / your spouse's / your registered domestic partner's benefits coverage
- A relocation that impacts network access
- Enrollment in state-based insurance Exchange
- Medicare Part A or B enrollment
- Qualified Medical Child Support Order or other judicial decree
- A dependent's eligibility ceases resulting in a loss of coverage [3]
- Loss of other coverage [2]

You must notify the Benefits Office within 31 days of the above change in status, with the exception of the following which requires notice within 60 days:

- Loss of eligibility or enrollment in Medicaid or state health insurance programs (e.g., Healthy Families)

Mental Health Parity and the Public Health Service Act

Group health plan 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 Aetna, Halcyon Behavioral Health, Elixir, 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 effective for the plan year beginning July 1, 2021 and ending June 30, 2022. The election may be renewed for subsequent plan years.

If you have questions regarding your mental health or substance abuse coverage, please contact Halcyon Behavioral Health at 888.425.4800.

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 absences.

IMPORTANT INFORMATION ON HOW HEALTH CARE REFORM AFFECTS YOUR PLAN

Primary Care Provider Designations

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries:

- Your HMO generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Human Resources office

For plans and issuers that require or allow for the designation of a primary care provider for a child:

- For children, you may designate a pediatrician as the primary care provider

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider:

- You do not need prior authorization from your insurance provider or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Human Resources office.

Prohibition on Excess waiting Periods

Group health plans may not apply a waiting period that exceeds 90 days. A waiting period is defined as the period that must pass before coverage for an eligible employee or his or her dependent becomes effective under the Plan.

Preexisting Condition Exclusion

Effective for Plan Years on or after January 1, 2014, Group health plans are prohibited from denying coverage or excluding specific benefits from coverage due to an individual's preexisting condition, regardless of the individual's age. A PCE includes any health condition or illness that is present before the coverage effective date, regardless of whether medical advice or treatment was actually received or recommended

[1] Indicates that this event is also a qualified "Change in Status"
[2] Indicates this event is also a HIPAA Special Enrollment Right
[3] Indicates that this event is also a COBRA Qualifying Event

CONTINUATION COVERAGE RIGHTS UNDER COBRA

You're getting this notice because you recently gained coverage under a group health 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, 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 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 dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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 or legally separated; 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 Fresno Unified School 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, 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 Plan Administrator has been notified that a qualifying event has occurred. The Fresno Unified School District 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 or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 31 days after the qualifying event occurs. You must provide this 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.

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 also 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.

How is COBRA continuation coverage provided? (Continued)

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 31 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 extensions of COBRA Continuation Coverage?

If you are a covered employee or qualified beneficiary in California receiving federal COBRA continuation coverage, California extended "Cal-COBRA" coverage may apply to you.

After your federal COBRA continuation coverage period ends, under Cal-COBRA you may be eligible to receive up to 18 months of additional continuation coverage for a maximum total continuation coverage period of up to 36 months of combined federal COBRA and Cal-COBRA coverage. This 36-month period is measured from the original commencement date of your federal COBRA coverage. You must exhaust your federal COBRA continuation coverage in order to be eligible for Cal-COBRA coverage. Cal-COBRA coverage is not available to employees and qualified beneficiaries who receive 36 months of federal COBRA coverage.

Cal-COBRA applies to medical care plans, but not dental or vision care plans. Cal-COBRA coverage only applies to coverage under an insured plan or HMO, and not under a self-insured plan. Generally, premiums for Cal-COBRA coverage is 110% of the applicable premium under the group health plan (150% for disability coverage).

You will receive additional information from Kaiser prior to your scheduled end-date for federal COBRA coverage.

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, Children's Health Insurance Program (CHIP), 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.

Alternative Recipients Under QMCSOs

A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) 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.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period [1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you

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 under COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, 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.

For More Information

This notice doesn't fully describe continuation coverage or other rights under the plan. More information about continuation coverage and your rights under the plan is available in your plan booklet or from the Plan Administrator.

If you have questions about the information in this notice, your rights to coverage, or if you want a copy of your plan booklet, contact your Plan Administrator.

Plan contact information

Fresno Unified School District
Attn: Plan Administrator
2309 Tulare Street, Fresno, CA 93721
559.457.3520

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods

EMPLOYEE RIGHTS & RESPONSIBILITIES UNDER THE FAMILY MEDICAL LEAVE ACT

Basic Leave Entitlement

Family Medical Leave Act (FMLA) requires covered employers to provide up to 12 weeks of unpaid, job protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, child or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness [1]; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness. [1]

Benefits & Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months [2], and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days' notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider; or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information: (866) 4US-WAGE ((866) 487-9243) TYY: (877) 889-5627 www.wagehour.dol.gov

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.
[2] The FMLA definitions of "serious injury or illness" for current service members and veterans are distinct from the FMLA definition of "serious health condition"
[3] Special hours of service eligibility requirements apply to airline flight crew employees

UNIFORMED SERVICES EMPLOYMENT & REEMPLOYMENT RIGHTS ACT NOTICE OF 1994, NOTICE OF RIGHT TO CONTINUED COVERAGE UNDER USERRA

Right to Continue Coverage

Under the Uniformed Services Employment & Reemployment Rights Act of 1994 (USERRA), you (the employee) have the right to continue the coverage that you (and your covered dependents, if any) had under the Company Medical Plan if the following conditions are met:

- You are absent from work due to service in the uniformed services (defined below);
- You were covered under the Plan at the time your absence from work began; and
- You (or an appropriate officer of the uniformed services) provided your employer with advance notice of your absence from work (you are excused from meeting this condition if compliance is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances).

How to Continue Coverage

If the conditions are met, you (or your authorized representative) may elect to continue your coverage (and the coverage of your covered dependents, if any) under the Plan by completing and returning an Election Form 60 days after date that USERRA election notice is mailed, and by paying the applicable premium for your coverage as described below.

What Happens if You do not Elect to Continue Coverage?

If you fail to submit a timely, completed Election Form as instructed or do not make a premium payment within the required time, you will lose your continuation rights under the Plan, unless compliance with these requirements is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

If you do not elect continuation coverage, your coverage (and the coverage of your covered dependents, if any) under the Plan ends effective the end of the month in which you stop working due to your leave for uniformed service.

Premium for Continuing Your Coverage

The premium that you must pay to continue your coverage depends on your period of service in the uniformed services. Contact Human Resources for more details.

Length of Time Coverage Can Be Continued

If elected, continuation coverage can last 24 months from the date on which employee's leave for uniformed service began. However, coverage will automatically terminate earlier if one of the following events takes place:

- A premium is not paid in full within the required time;
- You fail to return to work or apply for reemployment within the time required under USERRA (see below) following the completion of your service in the uniformed services; or
- You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

Reporting to Work / Applying for Reemployment

Your right to continue coverage under USERRA will end if you do not notify Human Resources of your intent to return to work within the timeframe required under USERRA following the completion of your service in the uniformed services by either reporting to work (if your uniformed service was for less than 31 days) or applying for reemployment (if your uniformed service was for more than 30 days). The time for returning to work depends on the period of uniformed service, as follows:

Period of Uniformed Service	Report to Work Requirement
Less than 31 days	The beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, then as soon as is possible
31–180 days	Submit an application for reemployment within 14 days after completion of your service or, if that is unreasonable or impossible through no fault of your own, then as soon as is possible
181 days or more	Submit an application for reemployment within 90 days after completion of your service
Any period if for purposes of an examination for fitness to perform uniformed service	Report by the beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, as soon as is possible
Any period if you were hospitalized for or are convalescing from an injury or illness incurred or aggravated as a result of your service	Report or submit an application for reemployment as above (depending on length of service period) except that time periods begin when you have recovered from your injuries or illness rather than upon completion of your service. Maximum period for recovering is limited to two years from completion of service but may be extended if circumstances beyond your control make it impossible or unreasonable for you to report to work within the above time periods

Definitions

For you to be entitled to continued coverage under USERRA, your absence from work must be due to "service in the uniformed services."

- "Uniformed services" means the Armed Forces, the Army National Guard, and the Air National Guard when an individual is engaged in active duty for training, inactive duty training, or full-time National Guard duty (i.e., pursuant to orders issued under federal law), the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency
- "Service in the uniformed services" or "service" means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active and inactive duty for training, National Guard duty under federal statute, a period for which a person is absent from employment for an examination to determine his or her fitness to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain service by intermittent disaster response appointees of the National Disaster Medical System (NDMS)

HIPAA PRIVACY NOTICE

Notice of Health Information Privacy Practices

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

This notice is EFFECTIVE: October 2021

The Joint Health Management Board ("JHMB"), as sponsor of the Fresno Unified School District Employee Health Care Plan (the "Plan") is required by law under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) to maintain the privacy of protected health information and 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. HIPAA includes numerous provisions that are designed to maintain the privacy and confidentiality of your Protected Health Information (PHI). PHI is health information that contains identifiers (such as your name, address, social security number, or other information that identifies you) and information related to your past, present or future health condition and treatments.

This notice is for participants in the Company Health & Welfare Plan (referred to as the "Plan"), including its component plans.

Required by Law

- The Plan must make sure that health information that identifies you is kept private.
- The Plan must give you this notice of our legal duties and privacy practices with respect to health information about you.
- The Plan must obtain written authorization from you for the use and disclosure of your PHI related to psychotherapy notes; when for purposes of marketing; and/or for disclosures constituting a sale of PHI.
- The Plan must follow the terms of the notice that are currently in effect.

Permitted Plan use of Your Health Information

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, contact the Plan Privacy Officer.

You have both the right and choice to tell us to: share information with your family, close friends, or others involved in payment for your care; share information in a disaster relief situation; and contact you for fundraising efforts.

If you are not able to tell us your preference, for example if you are unconscious, the Plan may go ahead and share your information if it believes it is in your best interest. The Plan may also share your information when needed to lessen a serious and imminent threat to health or safety.

The Plan will never share your information unless you give us written permission for: marketing purposes and the sale of your information.

Treatment: The Plan may use your health information to assist your health care providers (doctors, pharmacies, hospitals and others) to assist in your treatment. For example, the Plan may provide a treating physician with the name of another treating provider to obtain records or information needed for your treatment.

Regular Operations: We may use information in health records to review our claims experience and to make determinations with respect to the benefit options that we offer to employees. We may also use and disclose your information to run our organization and contact you when necessary. If PHI is used or disclosed for underwriting purposes, the Plan is prohibited from using or disclosing any of your PHI that is genetic information for such purposes. The Plan is also not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Payment for Health Services and Administration of the Plan: The Plan can use and disclose your health information when paying for your health services. For example, the Plan may share information about you with your dental plan to coordinate payment for your dental work. The Plan may disclose your health information to your health plan sponsor for plan administration. For example, where your company contracts with an insurer to provide a health plan, and the Plan provides your company with certain statistics to explain the premiums charged.

Business Associates: There are some services provided in our organization through contracts with business associates. Business associates with access to your information must adhere to a contract requiring compliance with HIPAA privacy rules and HIPAA security rules.

As Required by Law: We will disclose health information about you when required to do so by federal, state or local law (this includes the Department of Health and Human Services if it wants to see that the Plan is complying with federal privacy law).

To Respond to Organ and Tissue Donation Requests and Work with a Medical Examiner or Funeral Director: We may share health information about you with organ procurement organizations; and may share health information with a coroner, medical examiner, or funeral director when an individual dies.

Workers' Compensation: We may release health information about you for workers' compensation programs or claims or similar programs. These programs provide benefits for work-related injuries or illness.

Law Enforcement and other Government Requests: We may disclose your health information for law enforcement purposes or with a law enforcement official, in response to a valid subpoena or other judicial or administrative request/order, with health oversight agencies for activities authorized by law, or for special government functions such as military, national security, and presidential protective services.

Public Health and Research: We may also use and disclose your health information to assist with public health activities (for example, reporting to a federal agency) or health oversight activities (for example, in a government investigation). Additionally we may share health information about you when: preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; preventing or reducing a serious threat to anyone's health or safety or for purposes of health research.

Your Rights Regarding Your Health Information

Although your health record is the physical property of the entity that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information where concerning a service already paid for.
- Obtain a paper copy of the notice of health information practices promptly (even if you have agreed to receive the notice electronically) by requesting it from the Plan Privacy Officer.
- Ask to see or get a copy of your health and claims records and other health information we have about you. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Inspect and obtain a copy of your PHI contained in a "designated record set." A designated records set includes medical and billing records; enrollment, payment, billing, claims adjudication and case or medical management record systems; or other information used in whole or in part by or for the covered entity to make decisions about individuals. A written request to access your PHI must be submitted to your company Privacy Officer. Requested information will be provided within 30 days if maintained on site or 60 days if maintained off site.
- Request an amendment/correction to your health information: you can ask us to correct your health and claims records if you think they are incorrect or incomplete. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Ask us to limit what we use or share. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- Obtain an accounting of disclosures of your PHI during the preceding six years, who we shared it with, and why, with the exception of disclosures made for purposes of treatment, payment or health care operations, and certain other disclosures (such as any you asked us to make); made to individuals about their own PHI; or, made through use of an authorization form. A reasonable fee may be charged for more than one request per year.
- Request confidential communications of your health information be sent in a different way (for example, home, office or phone) or to a different place than usual (for example, you could request that the envelope be marked "confidential" or that we send it to your work address rather than your home address). We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
- Revoke in writing your authorization to use or disclose health information except to the extent that action has already been taken, in reliance on that authorization.
- Receive notification within 60 days (5 day for California residents) for any breaches of your unsecured PHI.
- Assign someone as your medical power of attorney or your legal guardian, who can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

Plan Responsibilities

The Plan is required to maintain the privacy of PHI and to comply with the terms of this notice. The Plan reserves the right to change our health privacy practices. Should we change our privacy practices in a material way, we will make a new version of our notice available to you within 60 days of the effective date of any material change to the rights and duties listed in this notice. The Plan is required to:

- Maintain the privacy and security of your health information.
- Make reasonable efforts not to use, share, disclose or request more than the minimum necessary amount of PHI needed to accomplish the intended purpose, unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- Follow the duties and privacy practices described in this notice with respect to information we collect and maintain about you and provide you a copy of the notice.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction, amendment or other request.
- Notify you of any breaches of your protected health information that may have compromised the privacy or security of your information within 60 days (5 days for California residents).
- Accommodate any reasonable request you may have to communicate health information by alternative means or at alternative locations.

The Plan will not use or disclose your health information without your consent or authorization, except as provided by law or described in this notice. The Plan may use or disclose "summary health information" to the plan sponsor 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. The plan is prohibited from using or disclosing PHI that is genetic information of an individual for any purposes, including underwriting.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Your Right to File a Complaint

If you believe your privacy rights have been violated, you can file a formal complaint with the Plan Privacy Officer; or with the U.S. Department of Health and Human Services (by mail or email). We will not retaliate against you and you will not be penalized for filing a complaint.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Contact Person

If you have questions or would like additional information, or if you would like to make a request to inspect, copy, or amend health information, or for an accounting of disclosures, contact the Plan Privacy Officer. All requests must be submitted in writing to the address shown below.

Fresno Unified School District Benefit Office
Attention: Andrew De La Torre
Benefits & Risk Management
2309 Tulare Street
Fresno, CA 93721
559.457.3596

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 July 31, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – 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: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov	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: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**MONTANA – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	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
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2021, 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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

Notes

Notes

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: • 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			
Aetna • Medical Plan Option A • Medical Plan Option B Elixir Prescription Benefit Halcyon Behavioral Health	 891049 891049 Rx Bin#009893 	 800.807.0820 800.807.0820 833.640.2849 888.425.4800	 www.deltahealthsystems.com www.ElixirSolutions.com www.fusdmhsa.com
Medical Coverage			
Kaiser Permanente • Medical Plan Option C	 603815	 800.464.4000	 www.kp.org
Chiropractic / Acupuncture Coverage			
PhysMetrics		877.519.8839	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

Prepared by: Marsh & McLennan Insurance Agency LLC
www.MarshMMA.com | CA Insurance Lic: 0H18131