# Summary of Medical Plan & Prescription Benefits And Kaiser Permanente Zip Code List

# FRESNO UNIFIED SCHOOL DISTRICT EMPLOYEE HEALTH CARE PLAN

## COMPARISON SUMMARY OF MEDICAL AND PHARMACY BENEFITS
## As of April 1, 2012

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

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

NOTE: This is only a brief summary of Plans available. Please refer to the Plan Booklet (Plans A and B) and the Kaiser Evidence of Coverage brochure for additional information.

# FRESNO UNIFIED SCHOOL DISTRICT EMPLOYEE HEALTH CARE PLAN

## COMPARISON SUMMARY OF MEDICAL AND PHARMACY BENEFITS (CONTINUED)

| COVERAGE FEATURES | Option Plan A (For Actives and all Retirees) Standard Plan (Default) | Option Plan B (For Actives and all Retirees) Alternate Plan | Option Plan C (For Actives and for Retirees NOT ELIGIBLE for Medicare) Kaiser Permanente Plan |
|---|---|---|---|
| **OUT-OF-POCKET ANNUAL MAXIMUM** [1] **(In Network)** | No Covered Person will be required to pay more than **$5,000** in any Calendar Year toward the percentage share of expenses which are not paid by the Plan. Once a Covered Person has paid **$5,000**, Eligible Expenses for the balance of the Calendar Year will be paid at 100%.<br><br>No covered family (Employee or retiree and his/her eligible Dependents) will be required to pay more than **$10,000** in any Calendar Year toward their percentage share of expenses not paid by the Plan**.** Once the family has paid **$10,000**, the remaining Covered Expenses for the balance of the Calendar Year will be paid at 100%. | No Covered Person will be required to pay more than **$6,000** in any Calendar Year toward the percentage share of expenses which are not paid by the Plan. Once a Covered Person has paid **$6,000**, Eligible Expenses for the balance of the Calendar Year will be paid at 100%.<br><br>No covered family (Employee or retiree and his/her eligible Dependents) will be required to pay more than **$12,000** in any Calendar Year toward their percentage share of expenses not paid by the Plan. Once the family has paid **$12,000**, the remaining Covered Expenses for the balance of the Calendar Year will be paid at 100%. | No Covered Person will be required to pay more than **$5,000** in any Calendar Year toward the percentage share of expenses which are not paid by the Plan. Once a Covered Person has paid **$5,000**, Eligible Expenses for the balance of the Calendar Year will be paid at 100%.<br><br>No covered family (Employee or retiree and his/her eligible Dependents) will be required to pay more than **$10,000** in any Calendar Year toward their percentage share of expenses not paid by the Plan. Once the family has paid **$10,000**, the remaining Covered Expenses for the balance of the Calendar Year will be paid at 100%. |
| **HOSPITAL SERVICES**<br>Inpatient Hospital Room and Board and Ancillary Services | In Network:<br>**80%** of the Anthem Blue Cross Contract Rate.<br><br>Out of Network: **60%** of Usual, Customary and Reasonable Charges. | In Network:<br>**70%** of the Anthem Blue Cross Contract Rate.<br><br>Out of Network:<br>**50%** of Usual, Customary and Reasonable Charges. | In Network (at Kaiser facility):<br>**80%** Coinsurance after Deductible.<br><br>At Non-Kaiser facility:<br>No benefits unless for emergencies as defined under Cost Containment Penalties Section. |
| Birthing Center | In Network:<br>**80%** of the Anthem Blue Cross Contract Rate.<br><br>Out of Network:<br>**60%** of Usual, Customary and Reasonable Charges | In Network:<br>**70%** of the Anthem Blue Cross Contract Rate.<br><br>Out of Network:<br>**50%** of Usual, Customary and Reasonable Charges | In Network (at Kaiser facility):<br>**80%** Coinsurance after Deductible Covered under Inpatient Hospital (above)<br><br>At Non-Kaiser facility:<br>No benefits |
| | (No coverage is provided when a Dependent Child is the mother.)<br>After the birth, the infant and mother are examined and remain in recovery from four (4) to twenty-four (24) hours and then are permitted to return home. Emergency transportation services are also available in case an unforeseen complication arises either with the infant or the mother and an immediate transfer to a Hospital becomes necessary. | | |

[1] Deductibles, Copayments and any Plan Penalties do not apply towards Out-of-Pocket Maximum. Out of Network Out-of-Pocket Maximum is two times the In Network amounts shown. Any amount that exceeds Usual, Customary, and Reasonable expenses does not apply towards the Out of Network Out-of-Pocket Maximum.

NOTE: This is only a brief summary of Plans available. Please refer to the Plan Booklet (Plans A and B) and the Kaiser Evidence of Coverage brochure for additional information.

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

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

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# FRESNO UNIFIED SCHOOL DISTRICT EMPLOYEE HEALTH CARE PLAN

## COMPARISON SUMMARY OF MEDICAL AND PHARMACY BENEFITS (CONTINUED)

| COVERAGE FEATURES | Option Plan A<br>(For Actives and all Retirees)<br>Standard Plan (Default) | Option Plan B<br>(For Actives and all Retirees)<br>Alternate Plan | Option Plan C<br>(For Actives and for Retirees NOT ELIGIBLE for Medicare)<br>Kaiser Permanente Plan |
|---|---|---|---|
| **OUTPATIENT LAB & X-RAY** | In Network:<br>**80%** of the Anthem Blue Cross Contract Rate.<br><br>Out of Network:<br>**60%** of Usual, Customary and Reasonable Charges. | In Network:<br>**70%** of the Anthem Blue Cross Contract Rate.<br><br>Out of Network:<br>**50%** of Usual, Customary and Reasonable Charges. | In Network (at Kaiser facility):<br>Preventive Care Lab & Xray: No Copayment, Covered at 100%. (deductible does not apply)<br><br>Most Lab & Xray: **$10** Copayment after deductible<br><br>From Non-Kaiser provider:<br>No coverage for outpatient lab and x-ray services received from non-Kaiser facility. |
| **PREVENTIVE HEALTH CARE** [1]<br>(Routine checkups, immunizations, pap smear, etc.)<br><br>(Plan Deductible Waived) | In Network:<br>No Copayment. 100% of the Anthem Blue Cross Contract Rate.<br><br>Out of Network:<br>100% of Usual, Customary and Reasonable Charges up to a Maximum of $300 per Calendar Year. | In Network:<br>No Copayment. 100% of the Anthem Blue Cross Contract Rate.<br><br>Out of Network:<br>100% of Usual, Customary and Reasonable Charges up to a Maximum of $300 per Calendar Year. | In Network (at Kaiser facility):<br>No Copayment. Covered at 100%. (deductible does not apply)<br><br>From Non-Kaiser provider:<br>No coverage for Preventive Services received from non-Kaiser provider. |
| Annual Physical Exam Benefit:<br><br>(Plan Deductible Waived) | In Network:<br>No co-payment. 100% of the Anthem Blue Cross Contract Rate.<br><br>Out of Network:<br>100% of Usual, Customary and Reasonable Charges up to a Maximum of $300 per Calendar Year.<br><br>Routine Annual Physical Examination. This benefit provides coverage for expenses relating to periodic health evaluations for preventive health services to promote healthy lifestyles and to detect unknown diseases or conditions. Examples of types of services covered under this benefit: (a) routine annual physical examinations and laboratory tests, including PSA testing for prostate cancer, when no medical condition exists; (b) routine annual visit to a Dermatologist to determine if skin lesions, moles, etc are cancerous; (c) immunizations. | In Network:<br>No co-payment. 100% of the Anthem Blue Cross Contract Rate.<br><br>Out of Network:<br>100% of Usual, Customary and Reasonable Charges up to a Maximum of $300 per Calendar Year.<br><br>Routine Annual Physical Examination. This benefit provides coverage for expenses relating to periodic health evaluations for preventive health services to promote healthy lifestyles and to detect unknown diseases or conditions. Examples of types of services covered under this benefit: (a) routine annual physical examinations and laboratory tests, including PSA testing for prostate cancer, when no medical condition exists; (b) routine annual visit to a Dermatologist to determine if skin lesions, moles, etc are cancerous; (c) immunizations. | In Network (at Kaiser facility):<br>No co-payment. Covered at 100%. (deductible does not apply)<br><br>From Non-Kaiser provider:<br>No coverage for Annual Physical exams received from non-Kaiser provider. |

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

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

| COVERAGE FEATURES | Option Plan A (For Actives and all Retirees) Standard Plan (Default) | Option Plan B (For Actives and all Retirees) Alternate Plan | Option Plan C (For Actives and for Retirees NOT ELIGIBLE for Medicare) Kaiser Permanente Plan |
|---|---|---|---|
| **WELL BABY CARE** [1]<br>(Plan Deductible Waived) | In Network:<br>100% of the Anthem Blue Cross Contract Rate.<br><br>Out of Network:<br>**60%** of Usual, Customary and Reasonable Charges. | In Network:<br>100% of the Anthem Blue Cross Contract Rate.<br><br>Out of Network:<br>**50%** of Usual, Customary and Reasonable Charges. | In Network (at Kaiser facility):<br>No co-payment. Covered at 100%. (deductible does not apply)<br><br>From Non-Kaiser provider:<br>No coverage for Well Baby visits received from non-Kaiser provider. |
| | (During the first five years after birth)<br><br>Childhood immunizations and screening that qualify as preventive care services under PPACA are covered at 100% when a Network provider is used. Please see footnote.<br><br>Includes Immunizations approved by FDA at intervals recommended by the American Pediatric Association. Excludes immunizations required exclusively for travel. | | (During the first 23 months after birth) |
| **DURABLE MEDICAL EQUIPMENT** | (Purchase or rental in excess of $2,000 must be pre-authorized by Anthem Blue Cross.)<br><br>In Network:<br>**80%** of the Anthem Blue Cross Contract Rate.<br><br>Out of Network:<br>**60%** of Usual, Customary and Reasonable Charges. | (Purchase or rental in excess of $2,000 must be pre-authorized by Anthem Blue Cross.)<br><br>In Network:<br>**70%** of the Anthem Blue Cross Contract Rate.<br><br>Out of Network:<br>**50%** of Usual, Customary and Reasonable Charges. | In Network (at Kaiser facility):<br>**80%** Coinsurance after Deductible per item. (no annual maximum)<br><br>From non-Kaiser provider:<br>**No coverage** for Durable Medical Equipment received from non-Kaiser provider. |
| **PRESCRIPTION DRUGS**<br>(For Actives and Retirees) [2]<br>Retail Pharmacy | **Envision Rx Pharmacies**<br><br>$10 Copayment Generic<br>$35 Copayment Brand with no Generic equivalent<br>$35 Copayment plus cost difference for Brand with Generic equivalent [3] | **Envision Rx Pharmacies**<br><br>$10 Copayment Generic<br>$35 Copayment Brand with no Generic equivalent<br>$35 Copayment plus cost difference for Brand with Generic equivalent [3] | **Kaiser Permanente Pharmacies**<br><br>$10 Copayment Generic<br>$35 Copayment Brand<br><br>No coverage for Prescriptions filled at non-Kaiser pharmacies, except for the following:<br>• Emergency services<br>• Urgent care due to an unforeseen illness, injury, or complication of an existing condition (including pregnancy) while you are temporarily located outside Kaiser's service area |

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

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

[3] **Dispense as Written (DAW prescriptions written by Physicians – cost difference between Brand and Generic is waived only if Physician writes "DAW".**

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# FRESNO UNIFIED SCHOOL DISTRICT EMPLOYEE HEALTH CARE PLAN

## COMPARISON SUMMARY OF MEDICAL AND PHARMACY BENEFITS (CONTINUED)

| COVERAGE FEATURES | Option Plan A (For Actives and all Retirees) Standard Plan (Default) | Option Plan B (For Actives and all Retirees) Alternate Plan | Option Plan C (For Actives and for Retirees NOT ELIGIBLE for Medicare) Kaiser Permanente Plan |
|---|---|---|---|
| **PRESCRIPTION DRUGS** *(continued)*<br>Retail Pharmacy | 1 to 30 days supply at Network Pharmacies.<br>Up to 90 days at select pharmacy chains for maintenance and non-maintenance drugs. | | $10 Generic/$35 Brand for each 30 day supply to maximum of 100 day supply |
| Mail Order Pharmacy | $10 Copayment Generic<br>$35 Copayment Brand with no Generic equivalent<br>$35 Copayment plus cost difference for Brand with Generic equivalent [1] | $10 Copayment Generic<br>$35 Copayment Brand with no Generic equivalent<br>$35 Copayment plus cost difference for Brand with Generic equivalent [1] | $10 Copayment Generic<br>$35 Copayment Brand<br><br>**No coverage** for prescriptions filled at non-Kaiser Mail Order Pharmacy. |
| | 1 to 90 days supply for maintenance and non-maintenance drugs.<br>91 to 180 days supply for maintenance drugs; requires initial 30-day prescription before 91-180 supply will be allowed | | $10 Generic/$35 Brand up to 30 day supply; 2x copayment $20 Generic/$70 Brand for 31-100 day supply |
| **Mental Health** | Pre-authorization by Avante Health is required for all mental health services<br><br>**Inpatient Treatment**<br>Covered at 100%<br>No Inpatient Deductible<br><br>Inpatient, partial and day treatment – 30 units per Calendar Year (inpatient 1 day = 1 unit, residential 1.5 days = 1 unit, partial day 2 days = 1 unit)<br><br>**Outpatient Treatment**<br>45 visits per Calendar Year per member<br>$10 copay per visit | | **Inpatient Treatment**<br>20% Coinsurance after Deductible<br><br>**Outpatient Treatment**<br>$15 per visit for Individual outpatient treatment (Deductible doesn't apply)<br>$7 per visit for Group outpatient treatment (Deductible doesn't apply) |
| **Substance Abuse** | Pre-authorization by Avante Health is required for all mental health services<br><br>All levels of substance abuse care are covered at 100%:<br>Annual maximum - $1,500,000 (combined with all other eligible Medical expenses paid during Calendar Year). | | **Inpatient Treatment**<br>20% Coinsurance after Deductible<br><br>**Outpatient Treatment**<br>$15 per visit for Individual outpatient treatment (Deductible doesn't apply)<br>$5 per visit for Group outpatient treatment (Deductible doesn't apply) |
| **SKILLED NURSING FACILITY** | In Network:<br>**80%** of the Anthem Blue Cross Contract Rate.<br><br>Out of Network:<br>**60%** of Usual, Customary and Reasonable Charges. | In Network:<br>**70%** of the Anthem Blue Cross Contract Rate.<br><br>Out of Network:<br>**50%** of Usual, Customary and Reasonable Charges. | In Network (at Kaiser facility):<br>**80%** Coinsurance after Deductible<br>(up to 100 days per benefit period)<br><br>From non-Kaiser facility:<br>**No Skilled Nursing Facility coverage** at non-Kaiser facility. |

[1] **Dispense as Written (DAW prescriptions written by Physicians – cost difference between Brand and Generic is waived only if Physician writes "DAW".**

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

| COVERAGE FEATURES | Option Plan A<br>(For Actives and all Retirees)<br>Standard Plan (Default) | Option Plan B<br>(For Actives and all Retirees)<br>Alternate Plan | Option Plan C<br>(For Actives and for Retirees NOT ELIGIBLE for Medicare)<br>Kaiser Permanente Plan |
|---|---|---|---|
| **HOME HEALTH CARE (only as a less costly alternative to Inpatient hospitalization)** | In Network:<br>**80%** of the Anthem Blue Cross Contract Rate.<br><br>Out of Network:<br>**60%** of Usual, Customary and Reasonable Charges. | In Network:<br>**70%** of the Anthem Blue Cross Contract Rate.<br><br>Out of Network:<br>**50%** of Usual, Customary and Reasonable Charges. | In Network (at Kaiser facility):<br>Covered at **100%**<br>(Deductible does not apply).<br>(up to 100 visits per calendar year)<br><br>From non-Kaiser provider:<br>**No Home Health Care coverage.** |
| **HOSPICE CARE** (Plan Deductible Waived)<br>The Plan covers charges by hospices that are pre-authorized. | In Network:<br>**100%** of the Anthem Blue Cross Contract Rate.<br><br>Out of Network:<br>**100%** of Usual, Customary and Reasonable Charges. | In Network:<br>**100%** of the Anthem Blue Cross Contract Rate.<br><br>Out of Network:<br>**100%** of Usual, Customary and Reasonable Charges. | In Network (at Kaiser facility):<br>Covered at 100%<br>(Deductible does not apply)<br><br>From non-Kaiser provider:<br>**No Hospice Care coverage.** |
| **OCCUPATIONAL AND SPEECH THERAPY (Requires pre-authorization)** | In Network:<br>**80%** of the Anthem Blue Cross Contract Rate.<br><br>Out of Network:<br>**60%** of Usual, Customary and Reasonable Charges. | In Network:<br>**70%** of the Anthem Blue Cross Contract Rate.<br><br>Out of Network:<br>**50%** of Usual, Customary and Reasonable Charges | In Network (at Kaiser facility):<br>$15 copayment per visit, after Deductible.<br><br>From non-Kaiser provider:<br>**No Occupational or Speech Therapy coverage.** |
| **EMERGENCY, URGENT CARE AND AMBULATORY SERVICES**<br>Emergency Room | In Network:<br>**80%** of the Anthem Blue Cross Contract Rate after a $100 Copayment (Copayment waived if admitted).<br><br>Out of Network:<br>**80%** of Usual, Customary and Reasonable Charges after a $100 Copayment (Copayment waived if admitted). | In Network:<br>**70%** of the Anthem Blue Cross Contract Rate after a $100 Copayment (Copayment waived if admitted).<br><br>Out of Network:<br>**70%** of Usual, Customary and Reasonable Charges after a $100 Copayment (Copayment waived if admitted). | In Network (at Kaiser facility):<br>**80%** Coinsurance after Deductible.<br><br>From non-Kaiser facility or provider:<br>**No Emergency Room coverage** except for as defined under Cost Containment Penalties Section of Evidence of Coverage brochure. |
| Urgent Care Facility | In Network:<br>**80%** of the Anthem Blue Cross Contract Rate after a $35 Copayment.<br><br>Out of Network:<br>**60%** of Usual, Customary and Reasonable Charges after a $35 Copayment. | In Network:<br>**70%** of the Anthem Blue Cross Contract Rate after a $35 Copayment.<br><br>Out of Network:<br>**50%** of Usual, Customary and Reasonable Charges after a $35 Copayment. | In Network (at Kaiser facility):<br>$15 copayment (Deductible does not apply)<br><br>From non-Kaiser facility or provider:<br>No Urgent Care Facility/Provider coverage. |

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# FRESNO UNIFIED SCHOOL DISTRICT EMPLOYEE HEALTH CARE PLAN

## COMPARISON SUMMARY OF MEDICAL AND PHARMACY BENEFITS (CONTINUED)

| COVERAGE FEATURES | Option Plan A<br>(For Actives and all Retirees)<br>Standard Plan (Default) | Option Plan B<br>(For Actives and all Retirees)<br>Alternate Plan | Option Plan C<br>(For Actives and for Retirees NOT ELIGIBLE for Medicare)<br>Kaiser Permanente Plan |
|---|---|---|---|
| Ambulatory Surgical Center | In Network:<br>**80%** of the Anthem Blue Cross Contract Rate after a $100 Copayment.<br><br>Out of Network:<br>**60%** of Usual, Customary and Reasonable Charges after a $100 Copayment. | In Network:<br>**70%** of the Anthem Blue Cross Contract Rate after a $100 Copayment.<br><br>Out of Network:<br>**50%** of Usual, Customary and Reasonable Charges after a $100 Copayment. | In Network (at Kaiser facility):<br>**80%** Coinsurance after Deductible<br><br>From non-Kaiser Ambulatory Surgical Center: No facility/provider coverage. |
| Ambulance (Air) | 100% with no Copayment. | 100% with no Copayment. | **80%** Coinsurance $150 copayment per trip, after Deductible |
| Ambulance (Ground) | **80%** after a $100 Copayment. | **70%** after a $100 Copayment. | As authorized by Kaiser. $150 copayment per trip, after Deductible |
| **OTHER** | | | |
| **Voluntary Sterilization**<br>(Does not include Dependent Children) | In Network:<br>**80%** of the Anthem Blue Cross Contract Rate.<br><br>Out of Network:<br>**60%** of Usual, Customary and Reasonable Charges. | In Network:<br>**70%** of the Anthem Blue Cross Contract Rate.<br><br>Out of Network:<br>**50%** of Usual, Customary and Reasonable Charges. | In Network (at Kaiser facility):<br>**80%** Coinsurance after Deductible.<br><br>From a non-Kaiser facility/provider:<br>**No coverage.** |
| **Blood, Blood Plasma, Blood Derivatives and Blood Factors** | In Network:<br>**80%** of the Anthem Blue Cross Contract Rate.<br><br>Out of Network:<br>**60%** of Usual, Customary and Reasonable Charges. | In Network:<br>**70%** of the Anthem Blue Cross Contract Rate.<br><br>Out of Network:<br>**50%** of Usual, Customary and Reasonable Charges. | In Network (at Kaiser facility):<br>80% Coinsurance No charge after Deductible.<br><br>From a non-Kaiser facility:<br>**No coverage.** |

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| COVERAGE FEATURES | Option Plan A<br>(For Actives and all Retirees)<br>Standard Plan (Default) | Option Plan B<br>(For Actives and all Retirees)<br>Alternate Plan | Option Plan C<br>(For Actives and for Retirees NOT ELIGIBLE for Medicare)<br>Kaiser Permanente Plan |
|---|---|---|---|
| **CHIROPRACTIC BENEFITS** | Chiropractic benefits are provided through Chirometrics (for Plan Option A, B and C) as follows:<br><br>**Chiropractic services by ChiroMetrics Provider:**<br>$5 Copayment then 100% of the ChiroMetrics contract rate<br><br>**Chiropractic services by Non-ChiroMetrics Provider (Outside 100 miles of Fresno ONLY):**<br>Referral must be given by a Physician and also Pre-Certified by ChiroMetrics.<br>Plans A and C - 60% of Usual, Customary and Reasonable Charges after Plan Deductible.<br>Plan B - 50% of Usual, Customary and Reasonable Charges after Plan Deductible.<br><br>**Chiropractic Diagnostic X-Ray Benefit** is limited to a $100 per benefit Calendar Year maximum paid at 100% Usual, Customary and Reasonable Charges, or the ChiroMetrics contract rate, after the Plan's Deductible has been satisfied.<br><br>28 visits maximum per Calendar Year. 10 visits allowed per month and 1 visit allowed per day. Note: For chiropractic treatment exceeding 12 visits per Calendar year, the chiropractor must submit a "12th visit review" and ChiroMetrics must pre-certify additional visits for the remainder of the Calendar Year.<br><br>Massage therapy is excluded unless pre-certification is received from ChiroMetrics.<br><br>**The following protocol will apply for chiropractic treatment for minor children:**<br>Treatment For Dependents 15 years of age and under requires Special pre-certification by calling ChiroMetrics at (559) 447-3375. All children fifteen (15) years of age and under must have a written precertification for treatment before any claims will be paid. In the case of an Emergency or where authorization was unable to be obtained on the first visit, then ONLY the first visit will be covered. | | |

NOTE: This is only a brief summary of Plans available. Please refer to the Plan Booklet (Plans A and B) and the Kaiser Evidence of Coverage brochure for additional information.

# NORTHERN CALIFORNIA SERVICE AREA
# ZIP CODE RANGES
# FOR KAISER PERMANENTE

The Service Area is that portion of Alameda, Amador, Contra Costa, El Dorado, Fresno, Kings, Madera, Marin, Mariposa, Napa, Placer, Sacramento, San Francisco, San Joaquin, San Mateo, Santa Clara, Solano, Sonoma, Stanislaus, Sutter, Tulare, Yolo, and Yuba counties within the following ZIP codes:

93230
93232
93238
93242
93261
93601-02
93604
93606-07
93609
93611-14
93616
93618-19
93623-27
93630-31
93636-39
93643-46
93648-54
93656-57
93660
93662
93666-69
93673
93675
93701-12
93714-18
93720-30
93737
93741
93744-45
93747
93750
93755
93760-61
93764-65
93771-79
93786
93790-94
93844
93888
94002
94005
94010-11
94014-28
94030
94035
94037-44
94060-66
94070
94074
94080
94083
94085-89
94101-05
94107-12
94114-34
94137
94139-47
94151
94156
94158-64
94172
94177
94188
94199
94203-09
94211
94229-30
94232
94234-37
94239-40
94244
94246-50
94252
94254
94256-59
94261-63
94267-69
94271
94273-74
94277
94279-80
94282-91
94293-98
94301-06
94309
94401-04
94497
94501-03
94505-31
94533-53
94555-66
94567*
94568-83
94585-92
94595-99
94601-15
94617-24
94649
94659-62
94666
94701-10
94712
94720
94801-08
94820
94850
94901
94903-04
94912-15
94920
94922-31
94933
94937-42
94945-57
94960
94963-66
94970-79
94999
95002
95008-09
95011
95013-15
95020-21
95026
95030-33
95035-38
95042
95044
95046
95050-56
95070-71
95076
95101
95103
95106
95108-13
95115-36
95138-41
95148
95150-61
95164
95170
95172-73
95190-94
95196
95201-13
95215
95219-20
95227
95230-31
95234
95236-37
95240-42
95253
95258
95267
95269
95296-97
95304
95307
95313
95316
95319-20
95323
95326
95328-30
95336-37
95350-58
95360-61
95363
95366-68
95376-78
95380-82
95385-87
95391
95397
95401-07
95409
95416
95419
95421
95425
95430-31
95433
95436
95439
95441-42
95444
95446
95448
95450
95452
95462
95465
95471-73
95476
95486-87
95492
95602-05
95607-21
95623-26
95628
95630
95632-35
95638-41
95645
95648
95650-52
95655
95658-64
95667-74
95676-78
95680-83
95686-88
95690-98
95703
95722
95736
95741-42
95746-47
95757-59
95762-63
95765
95776
95798-99
95811-38
95840-43
95851-53
95860
95864-67
95894
95899
95903
95961

*Knoxville is not in the Service Area.

## SOUTHERN CALIFORNIA SERVICE AREA ZIP CODE RANGES FOR KAISER PERMANENTE

The Service Area is that portion of Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, and Ventura counties within the following ZIP codes:

90001-84
90086-91
90093-96
90101
90103
90189
90201-02
90209-13
90220-24
90230-33
90239-42
90245
90247-51
90254-55
90260-67
90270
90272
90274-75
90277-78
90280
90290-96
90301-12
90401-11
90501-10
90601-10
90620-24
90630-33
90637-40
90650-52
90660-62
90670-71
90680
90701-03
90706-07
90710-17
90720-21
90723
90731-34
90740
90742-49
90755
90801-10
90813-15
90822
90831-35
90840
90842
90844
90846-48
90853
90895
91001
91003
91006-12
91016-17
91020-21
91023-25
91030-31
91040-43
91046
91066
91077
91101-10
91114-18
91121
91123-26
91129
91182
91184-85
91188-89
91199
91201-10
91214
91221-22
91224-26
91301-11
91313
91316
91319-22
91324-31
91333-35
91337
91340-46
91350-62
91364-65
91367
91371-72
91376-77
91380-81
91383-87
91390
91392-96
91401-13
91416
91423
91426
91436
91470
91482
91495-96
91499
91501-08
91510
91521-23
91601-12
91614-18
91701-02
91706
91708-11
91714-16
91722-24
91729-35
91737
91739-41
91743-50
91752
91754-56
91758-59
91761-73
91775-76
91778
91780
91784-86
91788-93
91795
91801-04
91896
91901-03
91908-17
91921
91931-33
91935
91941-47
91950-51
91962-63
91976-80
91987
92007-11
92013-14
92018-27
92029-30
92033
92037-40
92046
92049
92051-52
92054-58
92064-65
92067-69
92071-72
92074-75
92078-79
92081-85
92091-93
92096
92101-24
92126-32
92134-40
92142-43
92145
92147
92149-50
92152-55
92158-79
92182
92184
92186-87
92190-94
92195-99
92201-03
92210-11
92220
92223
92230
92234-36
92240-41
92247-48
92252-56
92258
92260-64
92268
92270
92274-78
92282
92284-86
92292
92305
92307-08
92313-18
92320-22
92324-26
92329
92331
92333-37
92339-41
92344-46
92350
92352
92354
92357-59
92369
92371-78
92382
92385-86
92391-95
92397
92399
92401-08
92410-15
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92423-24
92427
92501-09
92513-19
92521-22
92530-32
92543-46
92548
92551-57
92562-64
92567
92570-72
92581-87
92589-93
92595-96
92599
92602-07
92609-10
92612
92614-20
92623-30
92637
92646-63
92672-79
92683-85
92688
92690-94
92697-98
92701-08
92711-12
92728
92735
92780-82
92799
92801-09
92811-12
92814-17
92821-23
92825
92831-38
92840-46
92850
92856-57
92859-61
92863
92865-71
92877-83
92885-87
92899
93001-07
93009-12
93015-16
93020-22
93030-36
93040-44
93060-66
93094
93099
93203
93205-06
93215-16
93220
93222
93224-26
93240-41
93243
93249-52
93263
93268
93276
93280
93285
93287
93301-09
93311-14
93380
93383-90
93501-02
93504-05
93510
93518-19
93531-32
93534-36
93539
93543-44
93550-53
93560-61
93563
93581
93584
93586
93590-91
93599

# FRESNO UNIFIED SCHOOL DISTRICT

2309 Tulare Street Fresno, CA 93721 (559) 457-3520 Fax No. (559) 457-3760

## Open Enrollment Form

EFFECTIVE: JANUARY 1, 2013

**Active and Non-Medicare (under Age 65) Retired Employees**

## EMPLOYEE INFORMATION

| LAST NAME | FIRST NAME | EMPLOYEE ID OR SSN NUMBER | ☐ SINGLE ☐ MARRIED<br>☐ DOMESTIC PARTNERSHIP<br>☐ LEAVE ☐ COBRA |
|---|---|---|---|
| MAILING ADDRESS | | BIRTHDATE / TELEPHONE NO. | ☐ MALE<br>☐ FEMALE |
| CITY STATE ZIP CODE | | DEPT./SITE | |

Is your spouse employed? ☐ YES ☐ NO IF YES, WHERE ____________________

Are you or any family members covered by another group plan? ☐ NO ☐ YES ____________________
GROUP NAME

## MEDICAL PLAN OPTION A ☐ CHECK BOX IF NO CHANGE IS REQUIRED

### DISTRICT MEDICAL PLAN

| Premiums | 12 Month | 10 Month |
|---|---|---|
| Employee Only | $160 | $192 |
| Employee, Child/Children | $175 | $210 |
| Employee & Spouse/Domestic Partner | $220 | $264 |
| Employee & Family | $230 | $276 |

**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 10 or 12 monthly payments.

Office Visit Co Pay $15.00

***Usual, Customary and Reasonable**

| | PPO Providers | Non PPO |
|---|---|---|
| Covered Services | 80% of Blue Cross Rate | 60% of UCR* |
| Calendar Year Deductible | $250 Individual<br>$500 Family | $750 Individual<br>$1,500 Family |
| Annual Out-Of Pocket Maximum | $5,000 Individual<br>$10,000 Family | $10,000 Individual<br>$20,000 Family |

☐ Employee Only ☐ Add Dependent(s) ☐ Add Family ☐ Delete Employee ☐ Delete Dependent(s) ☐ Delete Family

## MEDICAL PLAN OPTION B ☐ CHECK BOX IF NO CHANGE IS REQUIRED

### ALTERNATE MEDICAL PLAN

| Premiums | 12 Month | 10 Month |
|---|---|---|
| Employee Only | $60 | $72 |
| Employee, Child/Children | $70 | $84 |
| Employee & Spouse/Domestic Partner | $90 | $108 |
| Employee & Family | $100 | $120 |

**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 10 or 12 monthly payments.

Office Visit Co Pay $25.00

***Usual, Customary and Reasonable**

| | PPO Providers | Non PPO |
|---|---|---|
| Covered Services | 70% of Blue Cross Rate | 50% of UCR* |
| Calendar Year Deductible | $1,000 Individual<br>$2,000 Family | $3,000 Individual<br>$6,000 Family |
| Annual Out-Of Pocket Maximum | $6,000 Individual<br>$12,000 Family | $12,000 Individual<br>$24,000 Family |

☐ Employee Only ☐ Add Dependent(s) ☐ Add Family ☐ Delete Employee ☐ Delete Dependent(s) ☐ Delete Family

 Continue on reverse side

## MEDICAL PLAN OPTION C ☐ CHECK BOX IF NO CHANGE IS REQUIRED

### ALTERNATE MEDICAL PLAN — KAISER PERMANENTE HEALTH PLAN

| **Premiums** | **12 Month** | **10 Month** |
|---|---|---|
| **Employee Only** | **$160** | **$192** |
| **Employee, Child/Children** | **$175** | **$210** |
| **Employee & Spouse/Domestic Partner** | **$220** | **$264** |
| **Employee & Family** | **$230** | **$276** |

**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 10 or 12 monthly payments.

**If you are choosing Kaiser Permanente Health Plan for your coverage, you must also complete the KAISER ENROLLMENT FORM (California Region Group Enrollment/Change Form)**

Office Visit Co-Pay $15.00

**Covered services for care must be obtained at a Kaiser facility (Except in emergencies)**

| | | |
|---|---|---|
| Covered Services | 80% after Deductible | |
| Calendar Year Deductible | $250 Individual | $500 Family |
| Annual Out-Of Pocket Maximum | $5,000 Individual | $10,000 Family |

Kaiser Permanente enrolled participants will continue to use the Plan's Chiropractic benefits provided through ChiroMetrics and the Plan's Employee Assistance Program (EAP) benefits through Claremont EAP. The Kaiser Permanente Health Plan will include Mental Health service benefits as noted on the comparison.

☐ Employee Only ☐ Add Dependent(s) ☐ Add Family ☐ Delete Employee ☐ Delete Dependent(s) ☐ Delete Family

## DENTAL PLANS ☐ CHECK BOX IF NO CHANGE IS REQUIRED

### DELTA DENTAL PPO (DISTRICT PLAN)

#### ACTIVES

Family coverage is available at the rates listed.

**Cross Coverage is not available**

| **Monthly Cost:** | **12 Month** | **10 Month** |
|---|---|---|
| Employee ……………… | No Cost | |
| One Dependent | $33.05 | $39.66 |
| Two or more | $51.57 | $61.88 |

| Maximums | PPO | NON-PPO |
|---|---|---|
| Per patient per calendar year ……….. | $2,000 | $1,000 |
| Dental Accident per calendar year …... | $1,000 | $1,000 |
| Orthodontic lifetime maximum …….. | N/A | N/A |

#### RETIREES UNDER AGE 65

**Monthly Premiums**

| | |
|---|---|
| **RETIREE** | **$ 51.00** |
| **RETIREE/SPOUSE** | **$102.00** |
| **RETIREE/FAMILY** | **$149.00** |

**Employee and Family**
**MUST USE PPO PROVIDER FOR PPO COVERAGE**

☐ Employee Only ☐ Add Dependent(s) ☐ Add Family
☐ Delete Employee ☐ Delete Dependent(s) ☐ Delete Family

### UHC/PACIFIC UNION

#### ACTIVES

**Employee and Family ……………………. No Cost**

**Includes Orthodontic coverage for dependents between ages 10 and 19. Some procedures may require co-payments.**

**Plan coverage includes:**
**Office Exam, X-Rays, and**
**(2) Cleanings Annually**

#### RETIREES UNDER AGE 65

**Monthly Premiums**

| | |
|---|---|
| **RETIREE** | **$31.00** |
| **RETIREE/SPOUSE** | **$62.00** |
| **RETIREE/FAMILY** | **$87.00** |

**Employee and Family**
**MUST USE UHC/PACIFIC UNION Provider**

☐ Employee Only ☐ Add Dependent(s) ☐ Add Family
☐ Delete Employee ☐ Delete Dependent(s) ☐ Delete Family

## VISION PLAN ☐ CHECK BOX IF NO CHANGE IS REQUIRED

**MEDICAL EYE SERVICES (MES)**

## ACTIVES

**Employee Only…………………….. No Cost**

**NO ADDITIONAL COST TO EMPLOYEE FOR FAMILY COVERAGE**

**Plan coverage:**
**Exam, Once every 12 months $5. Co-pay - Lenses, Once every 12 months… (If Rx changes) - Frames, Once every 24 months $0 (frames or Lenses)**

☐ Employee Only ☐ Add Dependent(s) ☐ Add Family ☐ Delete Employee ☐ Delete Dependent(s) ☐ Delete Family

## RETIREES UNDER AGE 65

**Monthly Premiums**

| | |
|---|---|
| **RETIREE** | **$ 7.00** |
| **RETIREE/SPOUSE** | **$ 11.00** |
| **RETIREE/FAMILY** | **$ 17.00** |

**Plan coverage:**
**Exam - Once every 12 months …… $5. Co-pay**
**Lenses - Once every 12 months …… (If Rx changes)**
**Frames - Once every 24 months …… $0 (frames or Lenses)**

☐ **ADD Coverage**

☐ Retiree Only
☐ Retiree/Spouse Coverage
☐ Retiree/Family Coverage
☐ Dependent or Spouse

☐ **DROP Coverage**

☐ Delete Retiree Coverage
☐ Delete Dependent Coverage
☐ Delete Family Coverage

**FAMILY INFORMATION – LIST DEPENDENTS AND PROVIDE COPIES OF:**
**BIRTH CERTIFICATES / MARRIAGE OR DOMESTIC PARTNER CERTIFICATES / SS# COPY**

| FIRST NAME | LAST NAME | GENDER | AGE | BIRTHDATE | SOCIAL SECURITY |
|---|---|---|---|---|---|
| ☐ DOMESTIC PARTNER<br>☐ SPOUSE | | F / M | | | |
| ☐ SON<br>☐ DAUGHTER | | F / M | | | |
| ☐ SON<br>☐ DAUGHTER | | F / M | | | |
| ☐ SON<br>☐ DAUGHTER | | F / M | | | |
| ☐ SON<br>☐ DAUGHTER | | F / M | | | |
| ☐ SON<br>☐ DAUGHTER | | F / M | | | |
| ☐ SON<br>☐ DAUGHTER | | F / M | | | |

- **The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides for continued group health care coverage for employees and family members at their own expense. Contact the Benefits Office for continuation of coverage due to a qualifying event.**
- **Please notify the Benefits Office of any change in Health Coverage within 31 days of event.**

| Verified by: | Effective Date: |
|---|---|
| | |

**EMPLOYEE SIGNATURE**___________________________________ **Date** ___________

# California Region Group Enrollment/Change Form

**Please print or type in black ink only. See instructions on reverse before completing this form. Make a copy for your records.**

| Company name FRESNO UNIFIED SCHOOL DISTRICT | | Hire date (mm/dd/yyyy) |
|---|---|---|
| Group number 603815 | Enrollment unit 0000 | Effective enrollment/ change date |

**A. ENROLLMENT/CHANGE REASON** (see Change Table for assistance) New group: ☒ Yes ☐ No

☒ New Hire (complete sections A, B, C, D) ☐ Open Enrollment (complete sections A, B, C, D)

Health Plan (Check one) ☐ HMO Plan ☒ Deductible Plan ☐ Other

**B. EMPLOYEE** Have you ever been a Kaiser Permanente member? ☐ Yes ☐ No

Medical Record No. (if known) Social Security No.

Name (Last, First, MI) Birth Date (mm/dd/yyyy) Gender ☐ M ☐ F

Home Address City State ZIP

Work Phone Home Phone Email

Ethnicity Preferred Language

**C. FAMILY** For additional dependents, attach a separate sheet with employee's name at top. (Last, First, MI)

| | |
|---|---|
| ☐ Add ☐ Delete ☐ Spouse ☐ Domestic partner Gender ☐ M ☐ F<br>Spouse/domestic partner name:<br>Former last name (if any): | Social Security No.<br>Birth Date (mm/dd/yyyy)<br>Medical Record No. |
| ☐ Add ☐ Delete ☐ Child Gender ☐ M ☐ F<br>Dependent name:<br>Relationship: | Social Security No.<br>Birth Date (mm/dd/yyyy)<br>Medical Record No. |
| ☐ Add ☐ Delete ☐ Child Gender ☐ M ☐ F<br>Dependent name:<br>Relationship: | Social Security No.<br>Birth Date (mm/dd/yyyy)<br>Medical Record No. |
| ☐ Add ☐ Delete ☐ Child Gender ☐ M ☐ F<br>Dependent name:<br>Relationship: | Social Security No.<br>Birth Date (mm/dd/yyyy)<br>Medical Record No. |

Do any of dependents above live at another address? : ☐ Yes ☐ No If yes, complete the following:

Name (Last, First, MI): Address:

Do any of dependents above live at another address? : ☐ Yes ☐ No If yes, complete the following:

Name (Last, First, MI): Address:

**D. Kaiser Foundation Health Plan, Inc., and Kaiser Permanente Insurance Company Arbitration Agreement***

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation (29 CFR 2560.503-1), certain benefit-related disputes*) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), Kaiser Permanente Insurance Company (KPIC), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP or coverage by KPIC, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage and in the Certificate of Insurance.

*Disputes arising from any of the following KPIC products are not subject to binding arbitration: 1) Tiers 2 & 3 of the Point of Service (POS) Plans; 2) the Preferred Provider Organization (PPO) and Out of Area Indemnity (OOA) Plans; and 3) the KPIC Dental plans.

Signature Required for all Kaiser Permanente Plans Date
(Excluding KPIC PPO, KPIC OOA, and KPIC Dental Plans)

Note: Once the form is complete (including employer section), the subscriber should make a copy for his or her records, and to use as a temporary ID card, after the effective date.