Summary of Medical Plan & Prescription Benefits

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.

COVERAGE FEATURES	Option Plan A (For Actives and all Retirees) Standard Plan (Default)	Option Plan B (For Actives and all Retirees) Alternate Plan
PLAN MAXIMUMS	Unlimited lifetime Maximum. $1,500,000 annual Maximum.	Unlimited lifetime Maximum. $1,500,000 annual Maximum.
DEDUCTIBLE (Deductible does not apply to routine preventative care)	In Network: **$250** per individual (plus any Copayments) **$500** max per family (plus any Copayments) Out of Network: **$750** per individual (plus any Copayments) **$1,500** max per family (plus any Copayments)	In Network: **$1,000** per individual (plus any Copayments) **$2,000** max per family (plus any Copayments) Out of Network: **$3,000** per individual (plus any Copayments) **$6,000** max per family (plus any Copayments)
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.	
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%. 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%. 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%.
HOSPITAL SERVICES Inpatient Hospital Room and Board and Ancillary Services	In Network: **80%** of the Anthem Blue Cross Contract Rate. Out of Network: **60%** of Usual, Customary and Reasonable Charges.	In Network: **70%** of the Anthem Blue Cross Contract Rate. Out of Network: **50%** of Usual, Customary and Reasonable Charges.

[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.

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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
Birthing Center	In Network: **80%** of the Anthem Blue Cross Contract Rate. Out of Network: **60%** of Usual, Customary and Reasonable Charges	In Network: **70%** of the Anthem Blue Cross Contract Rate. Out of Network: **50%** of Usual, Customary and Reasonable Charges
	(No coverage is provided when a Dependent Child is the mother.) 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.	
Outpatient Services	In Network: **80%** of the Anthem Blue Cross Contract Rate after a $100 Copayment. Out of Network: **60%** of the Usual, Customary and Reasonable Charges after a $100 Copayment.	In Network: **70%** of the Anthem Blue Cross Contract Rate after a $100 Copayment. Out of Network: **50%** of the Usual, Customary and Reasonable Charges after a $100 Copayment.
PHYSICIAN SERVICES Physician Office, Home, or Hospital Visits All other Physician services and supplies	In Network: $15 Copayment for each physician office, home, or hospital visit. **80%** of the Anthem Blue Cross Contract Rate. Out of Network: **60%** of the Usual, Customary and Reasonable Charges.	In Network: **$25** Copayment for each physician office, home, or hospital visit. **70%** of the Anthem Blue Cross Contract Rate. Out of Network: **50%** of the Usual, Customary and Reasonable Charges.
Non-Authorized Physician Services	In Network: $250 penalty then **80%** of the Anthem Blue Cross Contract Rate. Out of Network: $250 penalty then **60%** of Usual, Customary and Reasonable Charges.	In Network: $250 penalty then **70%** of the Anthem Blue Cross Contract Rate. Out of Network: $250 penalty then **50%** of Usual, Customary and Reasonable Charges.

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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
OUTPATIENT LAB & X-RAY	In Network: **80%** of the Anthem Blue Cross Contract Rate. Out of Network: **60%** of Usual, Customary and Reasonable Charges.	In Network: **70%** of the Anthem Blue Cross Contract Rate. Out of Network: **50%** of Usual, Customary and Reasonable Charges.
PREVENTIVE HEALTH CARE [1] (Routine checkups, immunizations, pap smear, etc.) (Plan Deductible Waived)	In Network: No Copayment. 100% of the Anthem Blue Cross Contract Rate. Out of Network: 100% of Usual, Customary and Reasonable Charges up to a Maximum of $300 per Calendar Year.	In Network: No Copayment. 100% of the Anthem Blue Cross Contract Rate. Out of Network: 100% of Usual, Customary and Reasonable Charges up to a Maximum of $300 per Calendar Year.
Annual Physical Exam Benefit: (Plan Deductible Waived)	In Network: No co-payment. 100% of the Anthem Blue Cross Contract Rate. Out of Network: 100% of Usual, Customary and Reasonable Charges up to a Maximum of $300 per Calendar Year. 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: No co-payment. 100% of the Anthem Blue Cross Contract Rate. Out of Network: 100% of Usual, Customary and Reasonable Charges up to a Maximum of $300 per Calendar Year. 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.
WELL BABY CARE [2] (Plan Deductible Waived)	In Network: 100% of the Anthem Blue Cross Contract Rate. Out of Network: **60%** of Usual, Customary and Reasonable Charges.	In Network: 100% of the Anthem Blue Cross Contract Rate. Out of Network: **50%** of Usual, Customary and Reasonable Charges.

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

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

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

COVERAGE FEATURES	Option Plan A (For Actives and all Retirees) Standard Plan (Default)	Option Plan B (For Actives and all Retirees) Alternate Plan
	(During the first five years after birth) Childhood immunizations and screening that qualify as preventive care services under PPACA are covered at 100% when a Network provider is used. Please see footnote. Includes Immunizations approved by FDA at intervals recommended by the American Pediatric Association. Excludes immunizations required exclusively for travel.	
DURABLE MEDICAL EQUIPMENT	(Purchase or rental in excess of $2,000 must be pre-authorized by Anthem Blue Cross.) In Network: **80%** of the Anthem Blue Cross Contract Rate. Out of Network: **60%** of Usual, Customary and Reasonable Charges.	(Purchase or rental in excess of $2,000 must be pre-authorized by Anthem Blue Cross.) In Network: **70%** of the Anthem Blue Cross Contract Rate. Out of Network: **50%** of Usual, Customary and Reasonable Charges.
PRESCRIPTION DRUGS (For Actives and Retirees) [1] Retail Pharmacy	**Envision Rx Pharmacies** $10 Copayment Generic $35 Copayment Brand with no Generic equivalent $35 Copayment plus cost difference for Brand with Generic equivalent [2]	**Envision Rx Pharmacies** $10 Copayment Generic $35 Copayment Brand with no Generic equivalent $35 Copayment plus cost difference for Brand with Generic equivalent [2]
PRESCRIPTION DRUGS *(continued)* Retail Pharmacy	1 to 30 days supply at Network Pharmacies. Up to 90 days at select pharmacy chains for maintenance and non-maintenance drugs.	
Mail Order Pharmacy	$10 Copayment Generic $35 Copayment Brand with no Generic equivalent $35 Copayment plus cost difference for Brand with Generic equivalent [2]	$10 Copayment Generic $35 Copayment Brand with no Generic equivalent $35 Copayment plus cost difference for Brand with Generic equivalent [2]
	1 to 90 days supply for maintenance and non-maintenance drugs. 91 to 180 days supply for maintenance drugs; requires initial 30-day prescription before 91-180 supply will be allowed	

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

[2] **Dispense as Written (DAW prescriptions written by Physicians – cost difference between Brand and Generic is waived 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
Mental Health	Pre-authorization by Avante Health is required for all mental health services **Inpatient Treatment** Covered at 100% No Inpatient Deductible Inpatient, partial and day treatment – 30 units per Calendar Year (inpatient 1 day = 1 unit, residential 1.5 days = 1 unit, partial day 2 days = 1 unit) **Outpatient Treatment** 45 visits per Calendar Year per member $10 copay per visit	
Substance Abuse	Pre-authorization by Avante Health is required for all mental health services All levels of substance abuse care are covered at 100%: Annual maximum - $1,500,000 (combined with all other eligible Medical expenses paid during Calendar Year).	
SKILLED NURSING FACILITY	In Network: **80%** of the Anthem Blue Cross Contract Rate. Out of Network: **60%** of Usual, Customary and Reasonable Charges.	In Network: **70%** of the Anthem Blue Cross Contract Rate. Out of Network: **50%** of Usual, Customary and Reasonable Charges.
HOME HEALTH CARE (only as a less costly alternative to Inpatient hospitalization)	In Network: **80%** of the Anthem Blue Cross Contract Rate. Out of Network: **60%** of Usual, Customary and Reasonable Charges.	In Network: **70%** of the Anthem Blue Cross Contract Rate. Out of Network: **50%** of Usual, Customary and Reasonable Charges.
HOSPICE CARE (Plan Deductible Waived) The Plan covers charges by hospices that are pre-authorized.	In Network: **100%** of the Anthem Blue Cross Contract Rate. Out of Network: **100%** of Usual, Customary and Reasonable Charges.	In Network: **100%** of the Anthem Blue Cross Contract Rate. Out of Network: **100%** of Usual, Customary and Reasonable Charges.
OCCUPATIONAL AND SPEECH THERAPY **(Requires pre-authorization)**	In Network: **80%** of the Anthem Blue Cross Contract Rate. Out of Network: **60%** of Usual, Customary and Reasonable Charges.	In Network: **70%** of the Anthem Blue Cross Contract Rate. Out of Network: **50%** of Usual, Customary and Reasonable Charges

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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
EMERGENCY, URGENT CARE AND AMBULATORY SERVICES Emergency Room	In Network: **80%** of the Anthem Blue Cross Contract Rate after a $100 Copayment (Copayment waived if admitted). Out of Network: **80%** of Usual, Customary and Reasonable Charges after a $100 Copayment (Copayment waived if admitted).	In Network: **70%** of the Anthem Blue Cross Contract Rate after a $100 Copayment (Copayment waived if admitted). Out of Network: **70%** of Usual, Customary and Reasonable Charges after a $100 Copayment (Copayment waived if admitted).
Urgent Care Facility	In Network: **80%** of the Anthem Blue Cross Contract Rate after a $35 Copayment. Out of Network: **60%** of Usual, Customary and Reasonable Charges after a $35 Copayment.	In Network: **70%** of the Anthem Blue Cross Contract Rate after a $35 Copayment. Out of Network: **50%** of Usual, Customary and Reasonable Charges after a $35 Copayment.
Ambulatory Surgical Center	In Network: **80%** of the Anthem Blue Cross Contract Rate after a $100 Copayment. Out of Network: **60%** of Usual, Customary and Reasonable Charges after a $100 Copayment.	In Network: **70%** of the Anthem Blue Cross Contract Rate after a $100 Copayment. Out of Network: **50%** of Usual, Customary and Reasonable Charges after a $100 Copayment.
Ambulance (Air)	100% with no Copayment.	100% with no Copayment.
Ambulance (Ground)	**80%** after a $100 Copayment.	**70%** after a $100 Copayment.
OTHER		
Voluntary Sterilization (Does not include Dependent Children)	In Network: **80%** of the Anthem Blue Cross Contract Rate. Out of Network: **60%** of Usual, Customary and Reasonable Charges.	In Network: **70%** of the Anthem Blue Cross Contract Rate. Out of Network: **50%** of Usual, Customary and Reasonable Charges.
Blood, Blood Plasma, Blood Derivatives and Blood Factors	In Network: **80%** of the Anthem Blue Cross Contract Rate. Out of Network: **60%** of Usual, Customary and Reasonable Charges.	In Network: **70%** of the Anthem Blue Cross Contract Rate. Out of Network: **50%** of Usual, Customary and Reasonable Charges.

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<table>
<tr><th>COVERAGE FEATURES</th><th>Option Plan A
(For Actives and all Retirees)
Standard Plan (Default)</th><th>Option Plan B
(For Actives and all Retirees)
Alternate Plan</th></tr>
<tr><td>CHIROPRACTIC BENEFITS</td><td colspan="2">Chiropractic benefits are provided through Chirometrics (for Plan Option A, B and C) as follows:

Chiropractic services by ChiroMetrics Provider:
$5 Copayment then 100% of the ChiroMetrics contract rate

Chiropractic services by Non-ChiroMetrics Provider (Outside 100 miles of Fresno ONLY):
Referral must be given by a Physician and also Pre-Certified by ChiroMetrics.
Plans A and C - 60% of Usual, Customary and Reasonable Charges after Plan Deductible.
Plan B - 50% of Usual, Customary and Reasonable Charges after Plan Deductible.

Chiropractic Diagnostic X-Ray Benefit is limited to a $100 per benefit Calendar Year maximum paid at 100% Usual, Customary and Reasonable Charges, or the ChiroMetrics contract rate, after the Plan's Deductible has been satisfied.

28 visits maximum per Calendar Year. 10 visits allowed per month and 1 visit allowed per day. Note: For chiropractic treatment exceeding 12 visits per Calendar year, the chiropractor must submit a "12th visit review" and ChiroMetrics must pre-certify additional visits for the remainder of the Calendar Year.

Massage therapy is excluded unless pre-certification is received from ChiroMetrics.

The following protocol will apply for chiropractic treatment for minor children:
Treatment For Dependents 15 years of age and under requires Special pre-certification by calling ChiroMetrics at (559) 447-3375. All children 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 <u>ONLY</u> the first visit will be covered.</td></tr>
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