INSERT I

FRESNO UNIFIED SCHOOL DISTRICT EMPLOYEE HEALTH CARE PLAN

COMPARISON SUMMARY OF MEDICAL AND PHARMACY BENEFITS
Effective 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.**
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** **(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**
PLAN MAXIMUMS	Unlimited lifetime Maximum. $1,500,000 annual Maximum.	Unlimited lifetime Maximum. $1,500,000 annual Maximum.	Unlimited lifetime Maximum. No annual Maximums
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)	In Network (at Kaiser facility): **$250** per individual (plus any Copayments) **$500** max per family (plus any Copayments) 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: • Emergency services, ambulance services and authorized post-stabilization care • Authorized referrals • Hospice care • 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%. 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%.	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%.
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.	In Network (at Kaiser facility): **80%** Coinsurance after Deductible. At Non-Kaiser facility: No benefits unless for emergencies as defined under Cost Containment Penalties Section.
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	In Network (at Kaiser facility): **80%** Coinsurance after Deductible Covered under Inpatient Hospital (above) At Non-Kaiser facility: No benefits
	(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.		

[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	Option Plan C (For Actives and for Retirees NOT ELIGIBLE for Medicare) Kaiser Permanente Plan
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.	In Network (at Kaiser facility): **$15** per visit for specialty, routine, and urgent care. (deductible does not apply) **$0** for routine eye exam, hearing exam, and preventive care. (deductible does not apply) **80%** Coinsurance after Deductible for outpatient surgery. From Non-Kaiser Provider: Not covered unless prior authorized and referred by Kaiser physician.
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.	In Network (at Kaiser facility): **$15** Copayment for each physician office visit, home, or hospital visit. **80%** Coinsurance after Deductible. From Non-Kaiser Provider: Not covered unless prior authorized and referred by Kaiser physician.
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.	No coverage for care received from a non-Kaiser physician, except for the following: • Emergency services, ambulance services and authorized post-stabilization care • Authorized referrals • Hospice care • 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)

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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.	In Network (at Kaiser facility): Preventive Care Lab & Xray: No Copayment, Covered at 100%. (deductible does not apply) Most Lab & Xray: **$10** Copayment after deductible From Non-Kaiser provider: No coverage for outpatient lab and x-ray services received from non-Kaiser facility.
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.	In Network (at Kaiser facility): No Copayment. Covered at 100%. (deductible does not apply) From Non-Kaiser provider: No coverage for Preventive Services received from non-Kaiser provider.
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.	In Network (at Kaiser facility): No co-payment. Covered at 100%. (deductible does not apply) From Non-Kaiser provider: 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] (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.	In Network (at Kaiser facility): No co-payment. Covered at 100%. (deductible does not apply) From Non-Kaiser provider: No coverage for Well Baby visits received from non-Kaiser provider.
	(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.		(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.) 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.	In Network (at Kaiser facility): **80%** Coinsurance after Deductible per item. (no annual maximum) From non-Kaiser provider: **No coverage** for Durable Medical Equipment received from non-Kaiser provider.
PRESCRIPTION DRUGS (For Actives and Retirees) [2] 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 [3]	**Envision Rx Pharmacies** $10 Copayment Generic $35 Copayment Brand with no Generic equivalent $35 Copayment plus cost difference for Brand with Generic equivalent [3]	**Kaiser Permanente Pharmacies** $10 Copayment Generic $35 Copayment Brand No coverage for Prescriptions filled at non-Kaiser pharmacies, except for the following: • Emergency services • 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)* Retail Pharmacy	1 to 30 days supply at Network Pharmacies. 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 $35 Copayment Brand with no Generic equivalent $35 Copayment plus cost difference for Brand with Generic equivalent [1]	$10 Copayment Generic $35 Copayment Brand with no Generic equivalent $35 Copayment plus cost difference for Brand with Generic equivalent [1]	$10 Copayment Generic $35 Copayment Brand **No coverage** for prescriptions filled at non-Kaiser Mail Order Pharmacy.
	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		$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 **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		**Inpatient Treatment** 80% Coinsurance after Deductible **Outpatient Treatment** $15 per visit for Individual outpatient treatment (Deductible doesn't apply) $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 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).		**Inpatient Treatment** 80% Coinsurance after Deductible **Outpatient Treatment** $15 per visit for Individual outpatient treatment (Deductible doesn't apply) $5 per visit for Group outpatient treatment (Deductible doesn't apply)
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.	In Network (at Kaiser facility): **80%** Coinsurance after Deductible (up to 100 days per benefit period) From non-Kaiser facility: **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 (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
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.	In Network (at Kaiser facility): Covered at **100%** (Deductible does not apply). (up to 100 visits per calendar year) From non-Kaiser provider: **No Home Health Care coverage.**
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.	In Network (at Kaiser facility): Covered at 100% (Deductible does not apply) From non-Kaiser provider: **No Hospice Care coverage.**
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	In Network (at Kaiser facility): $15 copayment per visit, after Deductible. From non-Kaiser provider: **No Occupational or Speech Therapy coverage.**
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).	In Network (at Kaiser facility): **80%** Coinsurance after Deductible. From non-Kaiser facility or provider: **No Emergency Room coverage** except for as defined under Cost Containment Penalties Section of Evidence of Coverage brochure.
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.	In Network (at Kaiser facility): $15 copayment (Deductible does not apply) From non-Kaiser facility or provider: 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 (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
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.	In Network (at Kaiser facility): **80%** Coinsurance after Deductible 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 (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.	In Network (at Kaiser facility): **80%** Coinsurance after Deductible. From a non-Kaiser facility/provider: **No coverage.**
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.	In Network (at Kaiser facility): 80% Coinsurance No charge after Deductible. From a non-Kaiser facility: **No coverage.**

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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
CHIROPRACTIC BENEFITS	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 ONLY the first visit will be covered.		

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FRESNO UNIFIED SCHOOL DISTRICT

Employee Health Care Plan

Preventive Services under Medical Plan Options A and B[1] (Continued)

Topic	The U.S. Preventive Services Task Force (USPSTF) Recommends
Healthy diet counseling	Intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians.
Hearing loss screening: newborns	Screening for hearing loss in all newborn infants.
Hemoglobinopathies screening: newborns	Screening for sickle cell disease in newborns.
Hepatitis B screening: pregnant women	Screening for hepatitis B virus infection in pregnant women at their first prenatal visit.
HIV screening	Clinicians screen for human immunodeficiency virus (HIV) all adolescents and adults at increased risk for HIV infection.
Hypothyrodism screening: newborns	Screening for congenital hypothyroidism in newborns.
* Iron supplementation in children	Routine iron supplementation for asymptomatic children aged 6 to 12 months who are at increased risk for iron deficiency anemia.
Obesity screening and counseling: adults	Clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults.
Obesity screening and counseling: children	Clinicians screen children aged 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.
Osteoporosis screening: women	Women aged 65 and older be screened routinely for osteoporosis, that routine screening begin at age 60 for women at increased risk for osteoporotic fractures.
PKU screening: newborns	Screening for phenylketonuria (PKU) in newborns.
Rh incompatibility screening: first pregnancy visit	Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.
Rh incompatibility screening: 24-28 weeks gestation	Repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24-28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.
STIs counseling	High-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs.
* Tobacco use counseling and interventions: non-pregnant adults and pregnant women (smoking cessation aids)	Clinicians ask about tobacco use and provide tobacco cessation interventions for those who use tobacco products.
Syphilis screening: non-pregnant persons	Clinicians screen persons at increased risk for syphilis infection.
Syphilis screening: pregnant women	Clinicians screen all pregnant women for syphilis infection.
Visual acuity screening in children	Screening to detect amblyopia, strabismus, and defects in visual acuity in children younger than age 5 years.