FRESNO UNIFIED SCHOOL DISTRICT

EMPLOYEE HEALTH CARE PLAN

PLAN BOOKLET

EFFECTIVE JULY 1, 2005

(RESTATED DECEMBER 1, 2007)

Updated providers 0309

This is your Plan Booklet

The Joint Health Management Board (JHMB) is pleased to provide you with the new and updated Fresno Unified School District Employee Health Care Plan Booklet. The Plan Booklet is used to determine certain medical, dental, vision care, and prescription drug benefits for Eligible Employees, Eligible Retirees, and their Dependents. This document should be considered a "living document;" that is, it will be periodically updated to include clarifications and modifications approved by the JHMB. This booklet has been prepared to provide you with a summary of the most current benefits as of December 1, 2007.

The effective date of the Plan is January 1, 1981. The Plan is hereby amended and restated in its entirety as of December 1, 2007. The Plan is subject to all of the terms, provisions and conditions recited on the following pages. The Plan is not in lieu of, and does not affect, any requirement for coverage by any worker's compensation law or similar legislation.

Mission Statement[1]

The Fresno Unified School District's Joint Health Management Board's (JHMB) purpose is to continually:

- Share responsibility and build unity between the District and the participating Employee Labor Units;
- Manage and maintain the highest quality health benefits possible on behalf of Active and Retired Employees;
- Promote informed and proactive decisions regarding health benefits in the most cost-effective, innovative and efficient manner;
- Develop and promote wellness education;
- Enable participants to become informed and responsible health care consumers.

Binding the Plan: As a courtesy to you, the Benefit's Administration Office (Delta Health Systems) and the Fresno Unified School District's Benefit Department may respond informally to oral questions. However, oral information and answers are not binding upon the Fresno Unified School District Health Care Plan and cannot be relied on in any dispute concerning your benefits. Binding information may be obtained only through written request to Delta Health Systems.

[1] Approved by JHMB at September 21, 2005 meeting

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BENEFITS ADMINISTRATOR

Delta Health Systems
(800) 807-0820
Website: www.deltahealthsystems.com

MANAGED CARE VENDORS

Anthem Blue Cross of California
Anthem Blue Cross Prudent Buyer PPO Network
(800) 274-7767
Website: www.bluecrossca.com

Call Anthem Blue Cross for pre-authorization of hospitalization, Home Healthcare, Skilled Nursing Facility, Outpatient Surgery, and Durable Medical Equipment in excess of $2,000.

Failure to pre-authorize Non-Emergency services outlined on pages 4 and 5 of this booklet will result in a $250 penalty. Failure to use the Anthem Blue Cross Prudent Buyer PPO Network will result in a 20% penalty in your benefit payment as described on page 17 through 19.

Avante Health
Mental Health and Substance Abuse Services
(800) 498-9055 or (559) 261-9060
Website: www.fusdmentalhealth.com

Claremont EAP
800-834-3773
Website: www.claremonteap.com.

Walgreens Health Initiatives (WHI)
Prescription Drug Benefit
(800) 745-6298
Website: www.mywhi.com

Delta Dental
Delta Preferred Option (DPO) Program
(888) 335-8227
Website: www.deltadentalca.org

Pacific Union Dental (PUD)
Napa Plan
(800) 999-3367
Website: www.pdbi.com

Vision Service Plan (VSP)
(800) 877-7195
Website: www.vsp.com

SafeGuard
Vision Plan
(800) 880-1800
Website: www.safeguard.net

ChiroMetrics
(559) 447-3375
www.fusdchiro.com

WHAT TO DO IF YOU NEED MEDICAL CARE

Please read your Plan Booklet and familiarize yourself with the benefits provided through the Fresno Unified School District Health Care Plan. The Table of Contents is designed to help you find information quickly and assist you in understanding the Plan's benefits, provisions, and eligibility requirements. There is also an Index in the back of this Plan Booklet to assist you as a quick reference. Becoming familiar with your Plan prior to accessing health care services will assist you in receiving maximum benefits payable under the Plan.

As a quick reference, should you require Medical Care follow the procedures outlined below:

EMERGENCY

1. Call Patient's Network Provider Physician or 911 as appropriate, OR

2. Go directly to emergency room, Outpatient clinic or similar provider for needed service.

If you are admitted to the Hospital as an Inpatient **--** Within 72 hours of admission, someone **MUST CALL** either of the following numbers to obtain authorization.

Medical Conditions: Anthem Blue Cross (800) 274-7767

OR

Mental Health Conditions: Avante Health (800) 498-9055 or (559) 261-9060

If ongoing care (follow-up visit) is required, you may be required to obtain authorization for certain Non-Emergency services (outlined below). Failure to obtain necessary pre-authorization will result in a $250 penalty if you use a Non-Network provider.

NON-EMERGENCY

1. Obtain Routine Care from Patient's Network Provider Physician. **You may use Anthem Blue Cross Specialists for Outpatient services without obtaining prior-authorization except for the following services or treatments:**

    * **All Inpatient Admissions**
    * **All Outpatient Surgeries**
    * **Skilled Nursing Facility**
    * **Home Health Care**
    * **Diagnostic Services over $2,000**
    * **All Durable Medical Equipment, expected to exceed $2,000**
    * **Physical Therapy over six visits**

2. **Inpatient or Outpatient Hospital Services require pre-authorization by Anthem Blue Cross.**

3. **Chiropractic** – please refer to page 28.

4. **Mental Health** – page 25, please call Avante Health for routine Mental Health Care – **(800) 498-9055 or (559) 261-9060.**

PROCEDURES TO SAVE YOU MONEY

The information contained on pages 16 through 19, and the Questions and Answers outlined on pages 6 and 7, is provided to help you understand and receive maximum benefits payable under the Plan. It is important that you take a moment to review them.

PREFERRED PROVIDER ORGANIZATION (PPO)

You can find a current listing of Anthem Blue Cross Prudent Buyer Network providers at www.bluecrossca.com.

Your Plan is designed to give you control of your own health care. Members have freedom of choice in choosing the Hospital and Physician they wish to use. However, the Plan offers considerable financial advantage to you if the provider you have selected has contracted with Anthem Blue Cross and is used by you and your eligible Dependents.

Your Plan has established a network of participating Hospitals and Physicians called Network Providers. **Please review the Schedule of Benefits contained herein in order to understand the benefits paid to Network and Non-Network Providers**. Network Providers are located throughout the area. Use of the Anthem Blue Cross Prudent Buyer Network will result in lowered health care costs for Participants and lower costs for the Plan.

HOW TO USE THE PLAN
To take full advantage of the cost-saving features of the Plan, you will need to carefully read and fully understand this explanation of how the Plan works. This Plan Booklet will explain how your claims are paid according to the Hospital and Physician you use.

SPECIAL TERMS
Network Providers have a Participation Agreement in effect with Anthem Blue Cross at the time services are rendered. They agree to a payment rate which has been negotiated on behalf of the Plan. The Covered Individual will have no additional charges from the Network Provider for covered benefits other than the Copayment and Deductible specified in the Schedule of Benefits. A list of Network Providers will be provided to you. **You can also find a current listing of Anthem Blue Cross Network Providers at www.bluecrossca.com.** If there is any question regarding the status of any Hospital or Physician or their participation with Anthem Blue Cross, Anthem Blue Cross should be contacted at (800) 274-7767 prior to obtaining services.

The amount of the Allowable Charge differs according to the type of provider and circumstances:

1. When referring to a Network Provider, the Allowable Charge under the Plan is the rate at which the Network Provider has contracted to accept as payment for covered services.

2. When referring to Non-Network Providers the Allowable Charge is limited to the Usual, Customary and Reasonable Charge (defined on page 15).

MANDATORY COST CONTAINMENT REQUIREMENTS
The cost containment requirements of this Plan are not intended to reduce in any way the benefits under the Plan, but are designed to maintain those benefits, assist the patient in making more informed decisions and establish a procedure to eliminate unnecessary costs.

The programs do not restrict choice of Physicians, Hospitals or other medical providers nor are they applicable when a medical Emergency exists.

Benefits will be reduced if Anthem Blue Cross determines the Covered Person failed to follow the required pre-authorization procedure and/or entered the Hospital earlier than Medically Necessary (any expense relating to hospitalization that is not Medically Necessary will not be covered and is the Participant's responsibility).

AUTHORIZATIONS REQUIRED BY ANTHEM BLUE CROSS

Anthem Blue Cross' pre-authorization for certain treatment and procedures DOES NOT APPROVE or DENY BENEFIT payments. Benefit payments are based on Eligibility and the Schedule of Benefits payable under the Plan at the time of service, and are subject to all Limitations and Exclusions of the Plan in addition to these pre-authorization requirements. Pre-authorization does not determine treatment. The decision or choice of treatment is made by the patient and the patient's health care provider.

Should you need assistance or information regarding available services, call the Anthem Blue Cross Review Department at (800) 274-7767.

REMINDER: Mental Health and Chiropractic Care services require authorization by Avante Health and ChiroMetrics (CHIROMETRICS), as noted on page 5.

I. EMERGENCY SERVICES

In the event of an Emergency Hospital admission, authorization by Anthem Blue Cross must be obtained within 72 hours of Hospital admission.

II. PRE-AUTHORIZATION REQUIRED BY ANTHEM BLUE CROSS FOR NON-EMERGENCY MEDICAL SERVICES

1. Proposed Inpatient or Outpatient hospitalizations, regardless of location other than maternity.

2. Home Health Care, Skilled Nursing Facility, or Durable Medical Equipment expected to exceed $2,000.

3. Services of the following: Inpatient or Outpatient surgeries or procedures; Physical Therapy exceeding six visits and Diagnostic Services over $2000.

Penalty for Non-Compliance – If the pre-authorization requirements are not completed in any of the above instances, a penalty of $250 will be applied.

III. MEDICAL SERVICES NOT REQUIRING ANTHEM BLUE CROSS PRE-AUTHORIZATION

1. Services by the patient's Physician, except those indicated in II above. For maximum Plan coverage, the Physician should be a Network Provider.

2. Routine laboratory tests and radiology.

3. Routine mammograms and Pap smears will be provided under a Women's Annual Health Benefit. One routine Physician's visit, Pap smear, and mammogram will be covered.

4. Durable medical equipment and supplies costing less than $2,000 and authorized by a Physician. For maximum benefits, the provider should be a Network Provider.

IV. ADDITIONAL BENEFITS REQUIRING PRE-AUTHORIZATION

1. **Mental Health and Substance Abuse -** Inpatient services and Outpatient counseling **services** are **NOT** part of Anthem Blue Cross' pre-authorization review program; however, such services are subject to coverage limits specified in the benefit Plan. **These services require prior authorization by calling Avante Health at (800) 498-9055 or (559) 261-9060**. For additional information, please refer to pages 25 to 27.

2. **Chiropractic Care services** are **NOT** part of Anthem Blue Cross' medical review program, however, **services for all children fifteen (15) years of age and under must be pre-authorized by calling ChiroMetrics** (559) 447-3375. . For additional information, please refer to page 28.

PRE-AUTHORIZATION AND NETWORK PROVIDER QUESTIONS AND ANSWERS

1. Q What Is Pre-Authorization?

A. Pre-Authorization is a requirement in which specified services, in order to have maximum coverage under the Plan, must be approved in advance. Nurses and Physicians conduct medical review. A pre-authorization review for medical services is initiated by contacting Anthem Blue Cross at (800) 274-7767. As stated on page 4 of this Plan Booklet, pre-authorization review does not determine eligibility for Plan Benefits – for example, obtaining pre-authorization approval does not assure coverage, and failure to obtain pre-authorization approval does not necessarily mean the Plan will deny coverage for the services. Plan benefits are determined by following the claim procedures set forth on page 65 of this Plan Booklet. Plan benefits are payable in accordance with the Schedule of Benefits and the terms of this Plan Booklet. All treatment decisions remain between the patient and the patients' health care provider.

PLEASE READ THE MEDICAL PRE-AUTHORIZATION PROCEDURES ON PAGES 4 and 5.

2. Q What is a "Network Provider"?

A. A Network Provider in this Plan is a Physician, Hospital or other health care provider, which has entered into a participation agreement with Anthem Blue Cross.

3. Q What if I need help in locating or choosing a Network Provider Physician?

A. You may call Anthem Blue Cross for assistance at (800) 274-7767. **You can also find a current listing of Anthem Blue Cross Prudent Buyers Network of Physicians at www.bluecrossca.com.**

4. Q Do I need to select an Anthem Blue Cross Network Provider Network Provider Physician?

A. No, but to ensure maximum benefits under the Plan, select an Anthem Blue Cross Network provider.

5. Q What if the Doctor refers me to a Non-Network laboratory or radiology service?

A. You should remind your Doctor of the contracting labs and radiology services. If your Doctor feels that Non-Network Providers are needed for your care, Anthem Blue Cross should still be contacted and Anthem Blue Cross may pre-authorize if medically indicated based on the particular situation.

6. Q What if I reside outside of the state of California?

A. Benefits will be reimbursed without penalty reduction for using Non-Network providers, subject to the Usual, Customary and Reasonable Charge provisions outlined on page 15 of the Definition section of this booklet.

7. Q What if I am temporarily out of state or not within distance of Anthem Blue Cross Prudent Buyer Network providers?

A. If Emergency care is needed, see Emergency services provisions in this Plan. If not an Emergency, you must obtain pre-authorization.

8. Q What if I have questions about specific coverage provisions, Deductibles, claims payment, eligibility, or other such matters?

A. Contact Delta Health Systems at (800) 807-0820 or visit their website at www.deltahealthsystems.com for answers to these questions.

DEFINITIONS

As used in this Plan, the following terms shall have the meanings specified below:

"Allowable Charge" means the amount of an eligible charge that may be used as the basis of a claim.

1. For providers who are:

   a. under contract with the Plan, or
   b. Preferred Providers who have contracted with the Preferred Provider Organizations,

   the Allowable Charge is the contract rate. In no event shall these providers bill the covered Person an amount in excess of the Allowable Charge (see definition of Balance Billing below).

2. For all other providers, the Allowable Charge is the Usual, Reasonable and Customary Charge.

"Ambulatory Care Center" means a facility licensed in the jurisdiction in which it is located that:

1. has an organized medical staff of Physicians;

2. has permanent facilities equipped and operated primarily for the purpose of performing Surgical Procedures;

3. offers continuous Physician services and registered professional nursing services whenever the patient is in the facility; and

4. generally, does not provide accommodations for patients to stay over night, except that a Hospital Outpatient department will be considered an Ambulatory Care Center.

"Balance Billing" means the requirement, with respect to the providers shown below, that any amount above the Allowable Charges shall not be payable by a Covered Person.

The providers subject to this provision are those providers who are:

1. under contract with the Plan; or

2. Preferred Providers who have contracted with the Preferred Provider Organizations with which the District contracts.

"Benefit Administrator" means Delta Health Systems.

"Benefits" means those services and supplies that are covered under the terms of this Plan.

"Birthing Center" means a Hospital unit or center, or free-standing facility, licensed in the jurisdiction in which it is located that provides a home-like setting under a controlled environment for the purpose of childbirth.

"Anthem Blue Cross Contract Rate" means the rate at which a Network Provider has contracted with Anthem Blue Cross to accept as payment for covered services.

"Calendar Year" means any one (1) year period commencing on January 1 and ending on December 31. However, when a person first becomes covered by the Plan, the first Calendar Year begins for him or her on the effective date of his or her coverage and ends on the following December 31.

"Chiropractic Care" means Chiropractic treatment from a licensed chiropractor (D.C.) for a musculoskeletal disorder (bone, muscle, tendon and joint) and for related diagnostic x-rays performed and billed by the chiropractor.

"Claim Administrator" means:

1. For the Medical Expense Benefits portion of the Plan: Delta Health Systems.

2. For the Prescription Drug Benefits portion of the Plan: Walgreens Health Initiative (WHI).

3. For the Vision Care Expense Benefits portion of the Plan: Vision Service Plan and Safeguard Health Plans.

4. For the Dental Expense Benefits portion of the Plan: Delta Dental Plan of California and Pacific Union Dental.

5. For the Mental Health Benefits portion of the Plan: Avante Health.

"Code" means the Internal Revenue Code of 1986 as amended from time to time.

"Copayment" means the amount of money that each Covered Person may be required to pay for services and supplies. The Schedule of Benefits shows which benefits require Copayment. Copayments do not apply towards the Out-of-Pocket maximum.

"Covered Charges" means the Allowable Charge for the Medically Necessary treatment of conditions covered under the Plan.

"Covered Dependent" means any Dependent who is covered under the Plan.

"Covered Person" means a covered Employee, a covered Retiree, or a covered Dependent.

"Cross Coverage or Dual Coverage" means that if an Employee and/or Retiree is covered under this Plan as an Eligible Employee and/or Eligible Retiree and as an Eligible Dependent spouse or Domestic Partner, the Plan shall pay up to 100% of the total Allowable Expenses for Covered Persons.

"Custodial Care" means care that provides a level of routine maintenance for the purpose of meeting personal needs and assisting with the activities of daily living. It is care that can be provided by a lay person who does not have professional qualifications, skills or training. Custodial Care includes, but is not limited to: help in walking and getting into or out of bed, a chair or a wheelchair; help in bathing, dressing, and eating (whether from a receptacle [such as a plate or cup] or by feeding tube or intravenously); help in other functions of daily living of a similar nature; administration of or help in using or applying medications, creams and ointments; routine administration of medical gasses after a regimen of therapy has been set up; routine care of a patient, including functions such as changes of dressings; diapers and protective sheets and periodic turning and positioning in bed; routine care and maintenance in connection with casts, braces and other similar devices, or other equipment and supplies used in treatment of a patient, such as colostomy and ileostomy bags and indwelling catheters; routine tracheotomy care; general supervision of exercise programs including carrying out of maintenance programs of repetitive exercises that do not need the skills of a therapist and are not skilled rehabilitation services.

"Dentist" means a duly licensed Doctor of Dental Surgery (D.D.S.) or Doctor of Medical Dentistry (D.M.D.) legally entitled to practice dentistry at the time and place services are performed.

"Deductible" means the amount of eligible charges that each Covered Person or Family must incur in each Calendar Year before benefits under the Plan will be paid.

Any expenses applied against the Deductible during the last three (3) months of the Calendar Year will reduce the Deductible applicable in the following Calendar Year. Also, when two or more Covered Persons in a Family are injured in the same accident, eligible charges for those Injuries will be combined, in each Calendar Year, to meet one Calendar Year Deductible for all such Covered Persons. Deductibles do not apply towards the Out-of-Pocket maximum.

"Dependent" means:

1. a legal spouse;

2. a Domestic Partner as defined on page 53;

3. any unmarried child under the age of 19 who is Dependent on the Employee for support and maintenance. For these purposes a "child" will include: (a) an Employee's natural child, (b) an adopted child; (c) a stepchild and (d) a child subject to a Qualified Medical Child Support Order (QMCSO);

4. an unmarried student age 19 but less than 25, if such child meets the requirements of the preceding paragraph, except for the ages, is in full-time school attendance at an accredited institution of learning and is claimed as a Dependent on the Employee's federal income tax return;

5. an unmarried mentally or physically Disabled child beyond the maximum age, provided the child is incapable of self-sustaining employment and is Dependent upon the Employee for support and maintenance and further provided that the condition existed prior to such child reaching the age of nineteen (19) or age twenty-five (25) whichever is applicable. Proof of any mental or physical disability shall be required within thirty-one (31) days of such child's nineteenth (19^{th}) or twenty-fifth (25^{th}) birthday and the Benefit Administrator may require additional proof from time to time.

An eligible Dependent does not include:

1. a spouse who is legally separated or divorced from the Employee; or

2. an individual whose Domestic Partnership with the Employee has terminated; or

3. a child who is on active duty in any military, naval or air forces of any country; or

4. any child who is covered as an Employee under this Plan.

"Disabled" means the incapacity of an Eligible Employee by reason of bodily Injury or Sickness that prevents the Eligible Employee from performing the material duties of his or her job with the Employer.

"District" means Fresno Unified School District.

"Doctor, Physician, or Surgeon" is a person acting within the scope of his or her license and holding the degree of Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.M.), Doctor of Dental Surgery (DDS), Doctor of Podiatry (D.P.M.), Doctor of Optometry (D.O.), Psychologist (Ph.D.), or Doctor of Chiropractic Medicine (D.C.) and is not a person who is related to the Covered Person by blood, marriage, Domestic Partnership, or law or resides in the same residence as the Covered Person.

"Domestic Partner" means same-sex partner, or opposite-sex partner where at least one of the partners is age 62 or older and qualifies for certain Social Security benefits, as defined under California Family Code 297 and has filed a Declaration of Domestic Partnership with the California Secretary of State, or by validly forming a legal union in a jurisdiction other than California consistent with the requirements of Family Code Section 299.2.

"Durable Medical Equipment" means equipment that is:

1. designed for repeated use;

2. mainly and customarily used for medical purposes; and

3. not generally of use to a person in the absence of a disease or Injury.

Durable medical equipment includes, but is not limited to, such items as: hospital bed, wheelchair, iron lung, traction apparatus, intermittent positive pressure breathing machine, brace, and crutch.

"Educational" means that the primary purpose of a service or supply is to provide the patient with any of the following: training in the activities of daily living; instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities.

"E.O.B." means Explanation of Benefits. The form explains how your bill was processed and should be saved for tax purposes and other future reference.

"Eligible Employee" means an Employee who meets the eligibility requirements of the Plan.

"Eligible Retiree" means a Retiree who meets the eligibility requirements of the Plan.

"Emergency" means a sudden onset of a condition requiring immediate treatment for an Emergency Medical Condition.

"Emergency Medical Condition" means a Sickness or Injury which, if not immediately treated, is likely to result in any of the following: death, permanent disability, prolonged temporary disability or unwarranted prolongation of treatment; increased risk by requiring more complex or hazardous treatment; development of chronic illness; or inordinate physical or psychological suffering.

"Employee" means an Employee of the Employer who is eligible for participation in the Plan as determined by Board Policy or negotiated agreements.

"Employer" means the District.

"Expenses or Charges Incurred" means that an expense shall be deemed to be incurred on the date the purchase is made or on the day the service is rendered for which the charge is made.

"Experimental or Investigational" means any portion or part of any procedure, device, Drug, treatment, or medicine, or the use thereof, which falls within any of the following categories:

1. Which is considered Experimental or Investigational by any governmental agency or subdivision, including but not limited to the Food and Drug Administration, the Office of Health Technology Assessment; or

2. Which is not commonly and customarily recognized by the medical profession in the state where treatment is rendered as appropriate for the condition being treated in that:

   (a) The medical procedure, equipment, treatment or course of treatment, or Drug or medicine is under investigation or is limited to research; and

   (b) The techniques are restricted to use at centers which are capable of carrying out disciplined clinical efforts and scientific studies; and

   (c) The procedures are not proven in an objective way to have therapeutic value or benefit; and

   (d) The procedure's or treatment's effectiveness is medically questionable.

"Family" means an Eligible Employee, or Eligible Retiree, and his or her Covered Dependents.

"Fiduciary" means the District, or other entity that assumes responsibilities of the District, with respect to the management of the Plan or the disposition of its assets.

"Home Health Care" means a program, prescribed in writing by a person's Physician and administered by a Home Health Care Agency, that provides for the care and treatment of a person's Sickness or Injury in the Covered Person's home.

"Home Health Care Agency" means an organization that has been licensed or authorized as a home health agency in the state where the Home Health Care is given or is a home health agency as defined in Medicare.

"Hospice" means a facility that provides short periods of stay for a Terminally Ill Person in a home-like setting for either direct care or respite. The facility can be free-standing or affiliated with a Hospital. If such a facility is required by a state to be authorized, it must also meet that requirement.

"Hospice Care Program" means a formal program directed by a Physician to help care for a Terminally Ill Person.

"Hospice Team" means a team of professionals and volunteer workers who provide care to:

1. reduce or abate pain or other symptoms of mental or physical distress, and

2. meet the special needs arising out the stresses of the terminal illness and dying.

The Hospice Team must include a Physician and a registered graduate nurse.

The team may also include one or more of the following: a social worker, a clergyman/counselor, volunteers, a clinical psychologist, a physiotherapist, an occupational therapist.

"Hospital" means an institution which is engaged primarily in providing medical care and treatment of a sick or injured person on an in-patient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides, on the premises, 24-hour-a-day nursing services by or under the supervision of Registered Nurses (RNs); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" also includes the following:

1. A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

2. A facility operating primarily for the treatment of substance abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour-a-day nursing services by a Registered Nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of substance abuse.

"Injury" shall mean accidental bodily Injury that occurs while the Eligible Employee, Eligible Retiree, or Covered Dependent is covered under this Plan excluding work-related injuries. All injuries sustained in connection with any accident shall be considered one Injury.

"Inpatient" means a Hospital stay for which at least one (1) day's room and board is charged.

"JHMB" means the Board of Directors of the Joint Health Management Board.

"Medical Review Organization" means Anthem Blue Cross as retained by the District in connection with the operation of the Medical Review Program portion of the Plan, whose medical specialists consult with an Eligible Employee, Eligible Retiree, or Covered Dependent and their Physician with regard to recommended medical care and treatment.

"Medically Necessary (or medical necessity)" means services or supplies, which are:

1. appropriate and necessary for the symptoms, diagnosis or direct care and treatment of the medical condition,

2. within standards of good medical practice within the organized medical community,

3. not Educational, Experimental or Investigational in nature,

4. not provided primarily for medical or other research,

5. not primarily for the convenience of the patient or provider, and

6. determined by the Plan to be the most appropriate level of service and type of facility in which the patient receives care.

"Medicare" means the basic hospital portion (Part A), voluntary supplemental medical portion (Part B), and prescription drug (Part D) of Title XVIII of the Social Security Act, ("Federal Health Insurance for the Aged Act"), including any amendments as may be adopted from time to time.

"Nervous/Mental Disorder" means a mental or nervous condition as defined by the American Psychiatric Association that shall include but shall not be limited to a neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

"Network Provider" means a Doctor, Hospital, urgent care center, laboratory, or x-ray facility rendering services at reduced rates in accordance with the agreement between Anthem Blue Cross and the Fresno Unified School District.

"Non-Emergency Admission" means an Inpatient admission not related to an Emergency Medical Condition.

"Open Enrollment Period" means the period of time when an Eligible Employee may enroll himself or herself and/or the Employee's Eligible Dependents in the Plan other than during the 31 days immediately following original eligibility. Open Enrollment Period will be a 60 day period beginning January 10 of each Calendar Year. The Open Enrollment Period is also the period of time when a Covered Employee may change coverage where coverage options are available under the Dental and Vision Plans.

"Outpatient" means treatment not requiring Inpatient confinement and not involving a charge for Room and Board.

"Outpatient Surgery" means a Surgical Procedure performed in a Doctor's office or any Outpatient surgical facility.

"Participant" means an Employee or Retiree of the Fresno Unified School District who meets the eligibility requirements of the Plan and elects to participate in the Plan.

"Participating Pharmacy" means a licensed and registered pharmacy that has an agreement with Walgreens Health Initiatives.

"Physician" means a person who is licensed to administer medical care and treatment so long as he or she is acting within the scope of his or her practice and such license. A Physician includes a Surgeon and Assistant Surgeon.

"Plan" means the Fresno Unified School District Health Care Plan, as amended from time to time.

"Plan Administrator" means the Joint Health Management Board (JHMB) of the Fresno Unified School District.

"Plan Year" means the period of time which starts on July 1 each year and ends June 30 the following year.

"Preferred Providers" means the group of Hospitals, Physicians and other health care providers of medical care that have agreed, through contracts with the District or the Preferred Provider Organization, to provide medical care to Covered Persons under this Plan.

"Preferred Provider Organization" means, for all chiropractic and medical services, a provider organization which is signatory to an agreement with the District providing for charges at a prevailing negotiated fee.

"Registered Nurse" means a graduated and licensed Registered Nurse who is not related to a Covered Person by blood, marriage, domestic partnership, or law or who does not reside in the same residence as the Covered Person.

"Retiree" means a Retiree of the District who is eligible for participation in the Plan as determined by District's Board Policy or, if applicable, by a negotiated bargaining agreement.

"Sickness" means a disorder of the body or mind of a Covered Person that is not an Injury or work related. Pregnancy for female Employees or an Employee's wife is considered a Sickness.

"Skilled Nursing Facility" means an institution that meets all of these tests:

1. It is legally operated.

2. It mainly provides short-term nursing and rehabilitation services for persons recovering from Sickness or Injury. The services are provided for a fee from the Plan and include both:

   a. Room and board; and

   b. 24-hour a day skilled nursing service.

3. It provides the services under the full-time supervision of a Physician or registered graduate nurse (R.N.). If full-time supervision by a Physician is not provided, it has the services of a Physician available under a fixed agreement.

4. It keeps adequate medical records.

"Skilled Nursing Facility" does not include an institution or part of one that is used mainly as a place for rest or for the aged.

"Surgical Procedure" shall mean but is not limited to cutting, suturing, treatment of burns, correction of fracture, reduction of dislocation, manipulation of joint under general anesthesia, electrocauterization, laser surgery, taping, application of plaster casts, and administration of pneumothorax, endoscopy or injection of sclerosing solution.

"Terminally Ill Person" means a Covered Person who has an anticipated life expectancy of six (6) months or less as determined by the Covered Person's Physician.

"Total Disability" as it applies to an Employee means all periods of disability arising from the same cause, including any and all complications, except that if the Employee completely recovers or returns to active employment or is available for employment, any subsequent period of disability from the same cause shall be considered a new disability.

The term **"Total Disability"** as it applies to a Retired Employee or Dependent means all periods of disability arising from the same cause including all complications, except that if a Retired Employee or Dependent recovers for a period of three months and throughout such period also resumes normal activities of a person of like age and sex in good health, any subsequent period of disability from the same cause shall be considered as a new period of disability.

"Unnecessary Service and Supply" means services or supplies, including tests and check-up exams, to the extent that they are not needed for (i) the diagnosis of a Sickness or Injury, or (ii) the medical care of a diagnosed Sickness or Injury. To be considered "needed", a service or supply must meet all of the "Medically Necessary" requirements on page 13.

"Usual, Customary and Reasonable Charges" means charges made for services or supplies essential to the care of the Covered Person. Such charges will be considered Usual, Customary and Reasonable if they are the amount normally charged by most providers of comparable services and supplies and do not exceed the amount ordinarily charged by most providers of comparable services and supplies in the locality where the services or supplies are provided for Sicknesses and Injuries comparable in severity and nature to the Sickness or Injury being treated. The amount of Usual, Customary and Reasonable Charges hereunder shall be determined by the Plan.

"Waiting Period" means the period of time an Employee must wait before benefits under the Plan can become effective. The period of time begins on the date the Employee is hired and ends on the first day of the month following such date.

Note: Words in the masculine gender shall connote the feminine gender as well.

MEDICAL PLAN SCHEDULE OF BENEFITS

PENALTY MESSAGE

The Plan requires pre-authorization for certain Specialists and services. Please review pages 4 and 5 of this Plan Booklet to familiarize yourself with these pre-authorization provisions. For services and procedures requiring pre-authorization, call Anthem Blue Cross at (800) 274-7767.

Should services not be pre-authorized, and/or if you do not utilize Network Providers, benefits will be substantially reduced as set forth in the Plan's Schedule of Benefits below. Referrals to a Non-Network Provider are covered at the Non-Network rate. It is the responsibility of the Participant to assure services to be rendered are performed by a Network Provider.

Lifetime Maximums

Per Individual — **$1,500,000** All medical benefits of the Plan are subject to the individual Lifetime Maximum. Please refer to pages 25 to 27 for maximum benefits payable under Substance Abuse, Mental Health and Chiropractic Benefits.

Deductible Per Calendar Year

	In-Network	Out-of-Network
Per Individual	$100 (plus any Copayments)	$500 (plus any Copayments)
Maximum Per Family	$200 (plus any Copayments)	$1,000 (plus any Copayments)

In no event will the Calendar Year Deductible be more than $500 per Individual or $1,000 per family for use of In-Network and Out-of-Network services.

"Deductible" means the amount of eligible charges that each Covered Person or Family must incur in each Calendar Year before benefits under the Plan will be paid. Any expenses applied against the Deductible during the last three (3) months of the Calendar Year will reduce the Deductible applicable in the following Calendar Year. Also, when two or more Covered Persons in a Family are injured in the same accident, eligible charges for those Injuries will be combined, in each Calendar Year, to meet one Calendar Year Deductible for all such Covered Persons. Deductibles do not apply towards the Out-of-Pocket maximum.

Co-Insurance Percentage — The Plan pays Covered Charges at the percentages indicated on pages 17 – 19 after the satisfaction of your Deductible each Calendar Year unless otherwise stated.

Cost Containment Penalties

A $250 penalty will be assessed if pre-authorization is not obtained in accordance with page 4. 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" Maximum Protection per Calendar Year

No Covered Person will be required to pay more than $1,000 in any Calendar Year toward the percentage share of expenses which are not paid by the Plan. Once a Covered Person has paid $1,000, Eligible Expenses for the balance of the Calendar Year will be paid at 100%.

No covered family (Employee and his/her eligible Dependents) will be required to pay more than $2,000 in any Calendar Year toward their percentage share obligations. Once the family has paid $2,000, the remaining Covered Expenses for the balance of the Calendar Year will be paid at 100%.

NOTE: Deductibles, Copayments and Penalties do not apply towards the Out-of-Pocket maximum.

MEDICAL PLAN SCHEDULE OF BENEFITS

THIS SCHEDULE IS A SUMMARY ONLY. PLEASE REFER TO THE SECTIONS ON ELIGIBLE MEDICAL EXPENSES AND LIMITATIONS AND EXCLUSIONS SECTIONS FOR MORE COMPLETE INFORMATION.

SUMMARY OF SERVICE	Network Provider Benefits	Non-Network Provider Benefits
HOSPITAL SERVICES		
NOTE: Pre-authorization for admission is required except in emergencies. The Plan will pay pre-authorized services rendered by a Non-Network Hospital-based Physician (such as a radiologist, pathologist or anesthesiologist) in a Network Hospital at the Network benefit level when the Covered Person has no choice of providers.		
Inpatient Hospital Room and Board and Ancillary Services	100% of the Anthem Blue Cross Contract Rate	80% of Usual, Customary and Reasonable Charges
Birthing Center (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.	100% of the Anthem Blue Cross Contract Rate	80% of Usual, Customary and Reasonable Charges
Outpatient Services (Copayment of $100 required for Outpatient surgery in a facility)	100% after the Copayment of $100	80% of Usual, Customary and Reasonable charges
PHYSICIAN SERVICES		
Physician Office, Home, or Hospital visits	**100%** of the Anthem Blue Cross Contract Rate after a $15 Copayment	**80%** of the Usual, Customary and Reasonable Charges
Other Physician services and supplies	**100%** of the Anthem Blue Cross Contract Rate	**80%** of the Usual, Customary and Reasonable Charges
Non-Authorized Physician Services	$250 penalty then **100%** of the Anthem Blue Cross Contract Rate	$250 penalty then **80%** of the Usual, Customary and Reasonable Charges

SUMMARY OF SERVICE	Network Provider Benefits	Non-Network Provider Benefits
Annual Physical Examination Benefit and Women's Annual Health Benefit (Plan Deductible Waived) *Annual Physical Exam Benefit:* Plan allows for Employees, Retirees and Eligible Dependents to receive a 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 not to exceed $300. 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. Annual Physical Exams exceeding $300 per Calendar year are Participant's responsibility. *Women's Annual Health Benefit* In addition to the above Annual Physical Benefit, routine mammograms and Pap smears will be provided under the Women's Annual Health Benefit. One routine Physician's visit, Pap smear, and mammogram will be covered under this benefit. Expenses under the Women's Annual Health Benefit are separate from and not subject to the $300 Annual Physical Benefit noted above. Note: Expenses relating to diagnosis and treatment of an Injury or Sickness are covered under Medical and X-Ray and Laboratory benefits of the Plan.	100% of Anthem Blue Cross Contract Rate	100% of Usual, Customary and Reasonable Charges
Well Baby Care (Plan Deductible Waived) During the first 5 years after birth Includes Immunizations approved by FDA at intervals recommended by the American Pediatric Association. Excludes immunizations required exclusively for travel.	100% of Anthem Blue Cross Contract Rate	80% of Usual, Customary and Reasonable Charges
X-RAY AND LABORATORY SERVICES		
Outpatient X-Ray and Laboratory Services	100% of the Anthem Blue Cross Contract Rate	80% of Usual, Customary and Reasonable Charges
EMERGENCY, URGENT CARE AND AMBULATORY SERVICES		
Emergency Room	100% of the Anthem Blue Cross Contract Rate after the $100 Copayment (Copayment waived if admitted)	80% of Usual, Customary and Reasonable Charges after the $100 Copayment (Copayment waived if admitted)
Urgent Care Facility	100% of the Anthem Blue Cross Contract Rate after the Copayment of $35	80% of Usual, Customary and Reasonable Charges after the Copayment of $35
Ambulatory Surgical Center	100% of the Anthem Blue Cross Contract Rate	80% of Usual, Customary and Reasonable Charges
Ambulance		
Ground	90% after $100 Copayment	90% after $100 Copayment
Air	100% with no Copayment	100% with no Copayment

SUMMARY OF SERVICE	Network Provider Benefits	Non-Network Provider Benefits
SKILLED NURSING FACILITY		
Skilled Nursing Facility Room and Board and Ancillary Services	100% of the Anthem Blue Cross Contract Rate	80% of Usual, Customary and Reasonable Charges
HOME HEALTH CARE		
Home Health Care Expenses (only as a less costly alternative to Inpatient hospitalization)	100% of the Anthem Blue Cross Contract Rate	80% of Usual, Customary and Reasonable Charges
HOSPICE CARE		
Hospice Care (Plan Deductible Waived) The Plan covers Charges by Hospices that are pre-authorized (see page 4 and 22)	100% of the Anthem Blue Cross Contract Rate	100% of Usual, Customary and Reasonable Charges
OCCUPATIONAL THERAPY		
Occupational Therapy	100% of Usual, Customary and Reasonable charges	100% of Usual, Customary and Reasonable Charges
DURABLE MEDICAL EQUIPMENT		
Durable Medical Equipment Purchase or rental in excess of $2,000 must be pre-authorized by Anthem Blue Cross.	100% of Anthem Blue Cross Contract Rate	80% of Usual, Customary and Reasonable Charges
OTHER		
Voluntary Sterilization (Does not include Dependent Children)	100% of the Anthem Blue Cross Contract Rate	80% of Usual, Customary and Reasonable Charges
Blood, Blood Plasma, Blood Derivatives and Blood Factors	100% of the Anthem Blue Cross Contract Rate	80% of Usual, Customary and Reasonable Charges

The charges for the following **do not** apply toward the 100% benefit payment and **are never covered at 100%:**

1. Mental Health and Substance Abuse treatment;
2. Chiropractic;
3. Prescription Drugs;
4. Vision Plan services;
5. Dental

Failure to use a Network Provider will result in a reduction in your benefit payment.

COMPREHENSIVE MEDICAL BENEFITS

COVERED EXPENSES

Covered/Eligible medical expense means either: (a) Network Anthem Blue Cross Contract Rates; or (b) Non-Network Usual, Customary and Reasonable (UCR) expenses incurred by or on behalf of a Covered Person for the Hospital or other medical services listed below which are:

1. Administered or ordered by a Physician; and

2. Medically necessary for the treatment of an Injury or Sickness; and

3. Not of a luxury or personal nature; and

4. Not otherwise excluded or reduced under the Exclusions and Limitations sections of this Plan or in the Medical Plan Schedule of Benefits.

DEDUCTIBLE AMOUNT

The Deductible will be applied to covered expenses only once each Calendar Year regardless of the number of accidents or Sicknesses the Covered Person may have.

FAMILY LIMIT ON DEDUCTIBLE

If an amount equal to 2 Deductibles is met by any total of family members during the same 12 month period beginning January 1 of each year, all eligible medical expenses incurred during that 12 month period by covered members of such family shall be considered as being in excess of their Deductible amount.

DEDUCTIBLE CARRYOVER PROVISION

Any expense incurred in October, November and December, which is used to satisfy the Deductible for that year, will also be applied to the Deductible for the following year.

LIFETIME MAXIMUM AMOUNT PAYABLE

The maximum amount payable for all covered expenses incurred during each Covered Person's lifetime is as noted on the Schedule of Benefits. The word "lifetime" as used herein, means the duration of participation in this Plan.

COVERED MEDICAL EXPENSES

(Please refer to pages 45 – 49 for General Exclusions and Limitations)

Benefits are payable under the Plan for the following services at the percentages set forth in the Schedule of Benefits:

1. **HOSPITAL BENEFITS**

   a. The room and board, medical services, and supplies furnished by a Hospital, Ambulatory Surgical Center, or a Birthing Center.

   b. Other Hospital Expenses: The actual charges made by the Hospital for necessary services and supplies used in the Hospital, such as drugs, dressings, blood plasma, anesthetic fees, operating room, etc. This does not include special nursing fees. Charges for the cost of unreplaced blood and blood plasma, and blood processing. Charges for autologous blood donation will be covered.

   c. Hospital Outpatient care is provided for non-confining disabilities. Outpatient Hospital care is covered when Medically Necessary to perform covered dental services and pre-authorized by Anthem Blue Cross.

   Pre-authorized services rendered by a Non-Network Hospital based Physician (such as a radiologist, pathologist or anesthesiologist) in a Network Hospital are covered at the Network benefit level when the Covered Person has no choice of provider.

   If a private room is used, the average semi-private room rate will be used unless confinement in a private room is deemed Medically Necessary. Charges for an Intensive Care Unit or other special care unit such as Coronary Care (but not for the concurrent use of any other Hospital room) are also covered.

   Medically necessary Outpatient services and supplies furnished by a Hospital while being treated on an Outpatient basis.

2. **AMBULANCE EXPENSE BENEFITS**

   Ground or Inter-Facility
   Professional ambulance service when used to transport the Covered Person directly from the place where he or she is injured or becomes ill to the nearest Hospital qualified to give treatment by ground is covered at 90% after $100 Copayment. When Medically Necessary, inter-facility ambulance expense is also covered at 90% after a $100 Copayment to transport from one facility to the next. Both are subject to UCR until the Covered Person's Out-of-Pocket Maximum is reached, then all ambulance fees are covered at 100%.

   Air
   All professional air ambulance services when used to transport the Covered Person directly from where he or she is injured or becomes ill to the nearest Hospital qualified to give treatment is fully covered by the Plan and does not require a Copayment. This also applies to air ambulance services for interfacility transportation.

3. **HOSPITAL BASED PHYSICIAN BENEFITS**
This benefit provides payment for charges for Doctors' visits as often as needed, including charges for extra time and consultations. In-Hospital Physician's visits provided in connection with Substance Abuse and Mental Health have separate limitations as noted on pages 25 to 27.

Pre-authorized services rendered by a Non-Network Hospital-based Physician (such as a radiologist, pathologist or anesthesiologist or an Emergency Room Physician) in a Network Hospital are covered at the Network benefit level when the Covered Person has no choice of providers.

Professional anesthesiologist benefits are provided when a Covered Person is entitled to surgical care and when anesthesia is administered by a licensed Physician, C.R.W.A., or Certified Nurse Anesthesiologist.

4. **SKILLED NURSING FACILITY BENEFITS**
Room and board (at the semi-private rate), medical services, physical therapy up to 120 days per incident (if ordered by a Physician and pre-authorized by Anthem Blue Cross) and supplies furnished by or in a Skilled Nursing Facility are covered provided care is ordered by a Physician and is Medically Necessary. *No benefits for convalescent care shall be payable for Custodial Care, or for services or conditions attributed to or caused by mental illness or functional nervous disorders, or for services primarily for the convenience of the patient or provider, or because the Covered Person has nowhere else to go.*

5. **HOME HEALTH CARE**
Home Health Care Agency services and supplies when authorized by Anthem Blue Cross.

6. **HOSPICE BENEFITS**
The Plan covers a wide range of services provided by Hospices to control physical symptoms and to provide emotional and spiritual support during the last six months of life. Covered services include home visits by nurses and other health care professionals in addition to Hospital Inpatient and Outpatient care when needed. The Plan covers Charges by Hospices that are licensed as authorized Home Health Agencies in the state.

7. **SURGICAL BENEFITS**
The surgical fee incurred when a Covered Person has undergone a surgical operation by a legally qualified Physician or Surgeon because of bodily Injury or Sickness.

8. **DIAGNOSTIC X-RAY AND LABORATORY**
The Plan covers charges for laboratory tests and x-ray examinations for diagnosis of an Injury or Sickness with the recommendation and approval of a legally qualified Physician or Surgeon.

Limitation:
These Diagnostic Laboratory and x-ray Benefits do not cover any expense incurred for dental x-rays.

9. **MASTECTOMY BENEFITS**
In accordance with the Women's Health and Cancer Rights Act of 1998, after a covered mastectomy, the Hospital and Physician benefits of the Plan will cover the following expenses:

a. Reconstruction of the breast on which the mastectomy has been performed; and

b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

c. Prostheses (implants, special bras, etc.) and physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes) in a manner determined appropriate in consultation with the attending Physician and the patient.

If a Participant had a mastectomy prior to the effective date of coverage under this Plan and is not presently receiving benefits in connection with a mastectomy, the Plan does not provide coverage for a symmetrical appearance. However, if a Participant is receiving follow-up care related to the mastectomy that occurred before the Participant became covered under the Plan, then the Participant may have rights to a symmetrical appearance procedure under the statute.

Coverage for breast reconstruction and related services will be subject to all applicable Deductibles, Copayments and coinsurance amounts that are consistent with those that apply to other benefits under the Plan.

10. **MATERNITY BENEFITS**

Expense incurred by a female Employee, Retiree, Dependent spouse or Domestic Partner as a result of pregnancy will be considered on the same basis as illness-related expenses. All Plan provisions and limitations will apply to pregnancy claims in the same manner as claims incurred as a result of illness. Expense incurred by a female Employee, Retiree, Dependent spouse or Domestic Partner as a result of pre-natal screening will be considered on the same basis as illness related expenses. No maternity benefits are provided to Dependent Children.

11. **OTHER SERVICES AND SUPPLIES**

a. Physical therapy rendered by a licensed physical therapist.

b. Services of an acupuncturist who is a medical Doctor.

c. Services performed for the purpose of cardiac rehabilitation.

d. Professional services rendered by a Dentist for treatment of accidental Injury to natural teeth for an Injury occurring while the individual is covered under the Plan and only during the one hundred eighty (180) day period immediately following the date of Injury. Teeth damaged as a result of chewing or biting shall not be deemed an accidental Injury.

e. Treatment of Temporomandibular Joint Disorder (TMJ). Covered services include only x-rays, surgery splints and/or palliative procedures. Charges for orthodontic braces are not covered.

f. Insulin, needles, syringes, lancets, clinitest, glucose strips and chemstrips for diagnosed diabetes.

g. Rental of Hospital beds, wheelchairs and similar Durable Medical Equipment determined to be Medically Necessary by the Medical Expense Benefits Administrator and used solely by the Covered Person. In no event shall rental charges exceed the Usual, Reasonable and Customary purchase price of such equipment.

h. Rental of dialysis equipment and all necessary services and supplies required for hemodialysis treatment, excluding the purchase of dialysis equipment.

i. Oxygen and rental of equipment for its administration.

j. Artificial limbs and eyes as well as replacement of, when medically necessary.

k. Newborn expenses for the following paid as part of the mother's claim:

(1) Hospital nursery expenses;

(2) Routine pediatric care for a healthy newborn child;

(3) Circumcision.

If the baby is sick, suffers an Injury, premature birth, congenital abnormality or requires care other than routine care, benefits will be provided on the same basis as for any other eligible expense.

l. Occupational therapy rendered by a duly qualified occupational therapist only if referred by a Physician and only for treatment following a Surgical Procedure, a stroke and/or accidental Injury.

m. Human to human organ or tissue transplant procedures for kidney, cornea, heart, heart/lung, liver, lung, bone marrow (including autologous bone marrow transplants) or pancreas. The procedure must be due to a Sickness or accidental Injury occurring while the individual is covered under the Plan.

Benefits are provided for services and supplies for the procedure including the following expenses:

(1) Organ and tissue procurement consisting of removing, preserving and transporting the donated part, subject to the following:

(a) When both the recipient and donor are covered by this Plan, services will be covered for each patient.

(b) When only the recipient is covered by this Plan, benefits are provided for services for both the recipient and donor, provided benefits to the donor are not furnished under any other plan.

(c) When the recipient is not covered by this Plan and the donor is covered, expenses will not be covered for either the recipient or the donor.

(2) Transportation of the recipient and a companion to and from the site of the transplant and lodging and meal costs incurred in the interim by such companions. If the recipient is a minor, transportation of two (2) persons who travel with the minor is included.

(3) Private duty nursing care by a registered graduate nurse (RN.) or a licensed practical nurse (L.P.N.).

n. X-ray, radium, radioactive isotope therapy, and chemotherapy.

o. Elective sterilization. No benefits for Dependent Children.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The Plan has arranged with Claremont EAP to provide an Employee Assistance Program for all plan members. Insert more Claremont info and contact info here…

WHAT IS AN EMPLOYEE ASSISTANCE PROGRAM (EAP)?

The EAP is a free, brief confidential counseling and referral service designed to help you and your household members resolve personal problems that may be interfering with your work or home life. You can access your EAP services by calling 800-834-3773.

Face-to-Face Counseling
Your EAP provides 24/7, year-round access to prompt face-to-face assessment and counseling with licensed/certified therapists.

Employee Assistance Program Benefits

- 1-5 sessions per incident; $0 copay (visits in excess of five, please refer to benefits payable under Mental Health and Chemical Dependency on page 27).
- 24-hour toll-free access
- Available to Employees, Retirees and eligible Dependents, and other household members

EAP services for:

Emotional Well-Being

- Stress and depression
- Family matters
- Domestic violence
- Grief and loss

Work Issues

- Co-worker relationships
- Job burnout
- Career planning
- Performance concerns

Parenting and Child Care

- Becoming a parent/exploring adoption
- Child care options and referrals
- Parenting skills
- Strategies for working parents

Resources for Seniors

- Elder care options and referrals
- The aging process
- Long-distance caregiving
- Community programs and services

Education

- Private versus public school selection
- College searches/applications/scholarships
- Tutoring
- School performance
- Special needs

Legal Assistance

- Divorce
- Landlord/tenant conflicts
- Wills/consumer issues
- 30-minute consultation, at no extra charge

Money Management

- Debt management
- Budgeting
- Dealing with delinquent payments

MENTAL HEALTH AND CHEMICAL DEPENDENCY SCHEDULE OF BENEFITS

All **Inpatient and Outpatient Services** must be pre-authorized by Avante Health at (800) 498-9055 or (559) 261-9060 or they are **NOT** covered by the Plan. Only Avante Health approved services are covered at Network Practitioners. Non-Network Providers are not covered.

The Plan has arranged with Avante Health to provide the **Mental Health and Chemical Dependency benefits.**

How do I access services?
Call (800) 498-9055 or (559) 261-9060, 24-hours a day, seven days a week. The phone counselor will listen carefully to your concern or issue and help you assess the situation, and then suggest ways to help.

Your phone counselor may refer you to a licensed counselor who will help to resolve your issue. You may also be referred to community resources, such as a support group. If a health problem may be contributing to your situation, you could be referred to a medical professional.

Who is eligible?
You and any covered Dependent may call (800) 498-9055 or (559) 261-9060 for behavioral health services.

Are these services confidential?
Yes, all services are strictly confidential. Your identity is protected at all stages of the program.

Is Pre-Authorization Always Necessary?
Yes. All behavioral health services including Substance Abuse and EAP benefits must be pre-authorized by Avante Health. You may be responsible for all or a portion of any services provided without pre-authorization unless in an Emergency.

In an Emergency, go to a treatment center, and then as soon as possible (or within 24 hours of admission) call Avante Health for authorization.

How can Avante Health help?
Avante Health's clinical staff is available to help with many types of personal concerns including those shown below.

WHAT DO MENTAL HEALTH AND CHEMICAL DEPENDENCY BENEFITS COVER?

Mental health and chemical dependency benefits include Outpatient counseling visits with a licensed provider and help with problems such as:

Mental Health and Chemical Dependency

- Depression
- Drug/alcohol abuse
- Marriage/family issues
- Treatment centers/detox services
- Stress and anxiety
- Eating disorders
- Support groups

Mental Health Benefits

- Pre-authorization by Avante Health required for all mental health services
- Available to you and your eligible Dependents

Outpatient Treatment

- 45 visits per Calendar Year per member
- $10 copay per visit

Inpatient Treatment

- No Inpatient Deductible
- Inpatient admission fee – same as medical Plan
- Inpatient, partial and day treatment[1] – 30 days per Calendar Year covered at 100% after any applicable admission fee

Chemical Dependency Benefits

- Pre-authorization by Avante Health required for all chemical dependency services
- Available to you and your eligible Dependents
- All levels of chemical dependency care including detox – covered at 100% with $0 copay
- Annual maximum - $25,000
- Lifetime maximum - $35,000

Please remember that all services but Emergency services, require preauthorization through Avante Health in order to be covered by the Plan. Please call Avante Health at (800) 498-9055 or (559) 261-9060 for preauthorization.

[1] Days to be determined based on the following ratios:

Inpatient treatment – 1 day
Residential treatment – 66.7% of 1 day (1.5 residential days to 1 Inpatient day)
Day treatment – 50% of 1 day (2 day treatment days to 1 Inpatient day)

CHIROPRACTIC CARE SCHEDULE OF BENEFITS

The Plan covers Chiropractic Care in coordination with ChiroMetrics. It is to your advantage to use an ChiroMetrics Network Provider to receive the best benefits to you and your Dependents. Please contact ChiroMetrics at (559) 447-3375; www.fusdchiro.com **to locate a Provider near you.**

SUMMARY OF CHIROPRACTIC SERVICES	
Chiropractic services by ChiroMetrics Provider (Deductible waived)	$5 Copayment then 100% of the ChiroMetrics contract rate
Chiropractic services by Non-ChiroMetrics Provider Within 100 miles of Fresno	80% of the Usual, Customary and Reasonable Charge contract rate after the Deductible
Chiropractic services by Non-ChiroMetrics Provider Outside 100 miles of Fresno	Authorization must be given by a Physician and also authorized by ChiroMetrics.
LIMITATIONS: Chiropractic Diagnostic X-Ray Benefit is limited to a $100 per year maximum paid at 100% of Usual, Customary and Reasonable Charges or the ChiroMetrics contract rate after the Plan's Deductibles. 28 visits maximum per Calendar Year; 10 visits allowed per month and 1 visit allowed per day. **The following protocol will apply for chiropractic treatment for minor children:** Treatment For Dependents 15 years of age and under requires Special Prior Approval By Calling ChiroMetrics at (559) 447-3375 . No pre-authorization with Anthem Blue Cross required. All children fifteen (15) years of age and under must have either written or verbal authorization 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.	

"Chiropractic Care" means Chiropractic treatment from a licensed chiropractor (D.C.) for a musculoskeletal disorder (bone, muscle, tendon and joint) and for related diagnostic x-rays performed and billed by the chiropractor.

A ChiroMetrics chiropractic Doctor must be used within one hundred (100) miles of Fresno; when outside 100 miles, services for any non-Preferred Provider Organization chiropractic Doctor must be referred by a Physician and approved by ChiroMetrics.

PRESCRIPTION DRUG PLAN SCHEDULE OF BENEFITS

Walgreens Health Initiatives (WHI) administers the Prescription Drug Program for the Fresno Unified School District. If you fail to use a WHI Participating Pharmacy there will be no benefit to you. WHI is not only limited to Walgreens pharmacies. For a complete list of participating pharmacies, please visit www.mywhi.com or call (800) 745-6298.

The prescription program has four parts as follows. In addition, there are important benefit changes relating to Brand and Generic drugs as well as Over the Counter (OTC) drugs for stomach-related and allergy conditions noted below and on page 30.

1. **Retail Pharmacy Benefit** – Choose from thousands of WHI participating pharmacies nationwide.

2. **Retail Advantage 90™ Benefit** – Choose from select pharmacy chains to dispense your 90-180 day supply of long-term/maintenance medications. You may call WHI at (800) 745-6298 or visit www.mywhi.com to obtain a list of Retail Advantage90™ pharmacies.

3. **Mail Service Pharmacy Benefit** – Order your long-term maintenance medications and have them delivered right to your door.

4. **Specialty Pharmacy Program** - Walgreens Specialty Pharmacy Programs provide convenient, dependable access to medications for people living with complex health conditions. The programs and services focus on injectables and medication therapies involving strict compliance requirements, special storage/handling/delivery, complex administration methods, and education/monitoring/ongoing support. Drugs that fall under this program can only be dispensed at a Walgreens retail pharmacy or via a home delivery method through the Walgreens mail service pharmacy. These drugs are limited to a 30-day supply regardless if dispensed at a retail pharmacy or at a mail service pharmacy. Retail copays will also apply at retail/mail.

Your Cost: Retail, Advantage90™, Mail-Order and Specialty Pharmacy
When your covered prescriptions are filled under this program, you will share a portion of the cost; the Plan pays the rest. If the cost of the drug is less than the Copayments, OR if the Copayment plus the difference in cost between the Brand-name and Generic drug is less than the actual cost of the Brand-name drug, you will only be responsible for the actual cost of the drug. Your costs for the prescription program are summarized on the following page.

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

	Retail Pharmacy (All Pharmacies in WHI Network)	Advantage 90™ Program[1] (select retail locations only)	Walgreens Mail Service Pharmacy (Portland, OR)	Walgreens Specialty Pharmacy Program[2]
Prescription Plan – Non-Maintenance Medications*				
Days Supply Allowed	1 to 30 days	Minimum 84 days up to 90 days	1 to 90 days	1 to 30 days[2]
Non-Maintenance Generic Drug Co-Pay	$5	$5	$5	$5
Non-Maintenance Brand Drug Copay with No Generic Drug Available	$20	$20	$20	$20
Non-Maintenance Brand Drug Copay with Generic Drug Available (effective April 1, 2007)	$20 plus difference in cost between Generic and Brand UNLESS Brand-name is Medically Necessary and Physician writes "DAW" (Dispense as Written)			
Prescription Plan – Maintenance Medications*				
Days Supply Allowed	1 to 30 days	Minimum 84 days up to 180 days	1 to 180 days	1 to 30 days[2]
Maintenance Generic Drug Co-Pay	$5	$5	$5	$5
Maintenance Brand Drug Copay with No Generic Drug Available	$20	$20	$20	$20
Maintenance Brand Drug Copay with Generic Drug Available (effective April 1, 2007)	$20 plus difference in cost between Generic and Brand UNLESS Brand-name is Medically Necessary and Physician write "DAW" (Dispense as Written)			
IMPORTANT NOTE: Effective April 1, 2007 Prescription Drugs for stomach-related conditions (Proton Pump Inhibitors) and allergy (non-sedating antihistamine) are subject to Step Therapy provisions outlined on page 31 (effective April 1, 2007).				

1 Your Doctor must prescribe the days supply of medication noted in order to receive the Advantage 90 copays. Some medications may not be available in 90-day/180-day supplies under applicable law.

2 See Specialty Rx program parameters under the WHI Specialty Pharmacy Programs section of this document on page 32.

FILLING PRESCRIPTIONS AT A RETAIL PHARMACY

For a complete list of participating pharmacies, please visit www.mywhi.com or call (800) 745-6298. From the website go to the pharmacy locator link, and enter 512319 which is your six-digit RxGrp number (found on your ID card) and your zip code or city and state.

Effective January 1, 2007, if you receive a Brand name drug when a Generic equivalent drug is available you will be required to pay the $20 Copayment plus the difference in cost between the Brand name and the Generic drug unless it is Medically Necessary for you to use a Brand name drug.

How You Can Minimize Out-of-Pocket Costs On and After January 1, 2007?

Make sure you ask your Doctor and Pharmacist to dispense a Generic equivalent drug if one is available. If you are unsure if you have been prescribed a Brand-Name Drug, ask your Pharmacist. You can request that your Pharmacist substitutes a Brand-Name Drug with a Generic equivalent at any time unless it is Medically Necessary and your Physician has specified "DAW" (Dispense as Written).

Effective April 1, 2007 Step Therapy for Over the Counter "OTC" Drugs

There are more and more drugs that can now be purchased OTC that previously required a Physician's written prescription. Two such drugs that now have OTC equivalents are:

Prilosec OTC or Omeprazole (Generic Name)	Also known as Proton Pump Inhibitors (PPI): treats stomach-related conditions, including heartburn. (Brand-Name Prescription Drugs include: Aciphex, Nexium, Prevacid, or Protonix.)
Claritin OTC or Loratadine (Generic Name)	Non-Sedating Antihistamine: treats allergy symptoms. (Brand-Name Prescription Drugs include: Allegra, Allegra-D, Clarinex, Clarinex-D, Clarinex RediTab, Zyrtec and Zyrtec- D.)

Effective April 1, 2007: with certain exceptions, **the Plan will require:**

Step Therapy for Brand-Name Prescription Drugs prescribed for Proton Pump Inhibitors and Non-Sedating Antihistamines in order to be covered by the Plan and to promote proper utilization of these medications.

How Do I Receive Step Therapy?

Your Physician should discuss Step Therapy with the WHI Clinical Call Center. Generally, Step Therapy requires that the patient try one of the OTC/Generic drugs listed above *before* a Brand-Name Prescription Drug will be authorized. Note: There are certain medical conditions where the patient will not have to obtain Step Therapy in order to receive medication. The WHI Clinical Call Center will discuss these exceptions with you and your Physician during the authorization process.

In order for the Plan to cover any of the Brand-Name Prescription Drugs noted above, you or your Physician must receive PRIOR authorization/approval from Walgreens Health Initiatives (WHI) by calling the WHI Clinical Call Center to begin the prior authorization process:

WHI Clinical Call Center 1-877-665-6609	Monday through Friday 8:00 a.m. – 8:00 p.m. Central Standard Time

Make sure you (or your Physician) have available: your member ID number, medication prescription information, and Physician's name and phone number (and fax number, if possible).

Remember:

1. Ask your Doctor to write a prescription for one of the over the counter or generic medications listed above, and you will only be charged a $5 Copayment.

2. If you use a Brand-name drug and have received a Clinical Prior Authorization from WHI, your Copayment will be $20 and the Plan will cover the remaining cost.

3. If you use a Brand-name Drug and DO NOT receive WHI Clinical Prior Authorization, you will be responsible for the full cost of the drug and the Plan will NOT cover any portion of it.

Refill Prescriptions at Retail Pharmacy

1. If you have a current prescription(s) with valid refills, you will not need to obtain a new prescription(s).

2. Present your Health Plan ID card to the pharmacist at the time the prescription(s) is filled to ensure that your prescription insurance information is updated to process through WHI.

3. The pharmacist will process and fill the prescription(s), send it to WHI, and collect the appropriate Copayments from you.

New Prescriptions at Retail Pharmacy

1. Present your new prescription(s) and Health Plan ID card to the pharmacist. The pharmacist will process and fill the prescription(s), send it to WHI, and collect the appropriate Copayments from you.

2. The Advantage90™ program will require a new prescription for the 90 or 180 day quantity at the select retail pharmacies. Be sure to ask your Doctor to write your prescription for a 90 or 180 day supply if it is a maintenance drug.

FILLING PRESCRIPTIONS AT THE MAIL SERVICE PHARMACY

Through the Prescription Drug Program, you can take advantage of convenient delivery of your covered maintenance medications to your home or other specified address. Please allow 7-10 business days for mailing and processing time.

Ways to Register at the Walgreens Mail Service Pharmacy – Portland, Oregon

1. Fill out a new Walgreens Mail Service registration form, which will be provided with your benefit packet; **OR**

2. You may visit the WHI website at www.mywhi.com to complete and submit the Online Registration Form. This form allows for online registration only. Your registration will be active within 48 hours. Be sure to select the form for the Portland Walgreens Mail Service Pharmacy.

WHI Specialty Pharmacy Programs

Specialty Pharmacy (injectables and complex medications): Per 30-day supply – no greater than a 30-day supply will be dispended at a Walgreens Pharmacy only or via home delivery through Walgreens Mail Service. *See copays that apply to this program on the chart listed under the Your Cost on page 30*.

Drugs include the following, but are not limited to: Cystic Fibrosis medications, Enzyme replacement medications, Viral Hepatitis medications, Multiple Sclerosis medications, Growth Hormones, and all other biotech injectables. Call WHI toll free at (888) 782-8443 to pre-enroll in this program.

Clinical Prior Authorization (CPA)
Certain prescriptions require "clinical prior authorization" before they will be covered. The categories/medications that require clinical prior authorization include, but are not limited to:

- Proton Pump Inhibitors
- Non-Sedating Antihistamines
- Topical Acne over age 24
- ADHD/Narcolepsy medications over age 19
- Butorphanol exceeding 2 bottles/25 days
- Impotency medications, Clinical Prior Authorization on first fill. If approved, maximum quantity of 8 per 25 days is allowed
- Oral/Topical/Intravaginal, and injectable Contraceptives, Clinical Prior Authorization for *Dependents only*. Only approved if Medically Necessary
- Obesity medications
- Narcotic Pain Medication: Actiq®, Fentora® and generic fentanyl oral transmucosal tablets will require a prior authorization while Duragesic®/fentanyl and OxyContin®/oxycodone ER/CR will require prior authorization when the usual quantity limits are exceeded.

To request approval, the pharmacy, the Physician or you must call WHI at (877) 665-6609. Have available the name of your medication, Physician's name, phone (and fax number, if available), your ID number, and your Rx Group number of 512319.

VISION PLAN

The Plan offers two separate vision plans. One through VSP and the other through Safeguard. The summary of benefits is listed below. Once enrolled in a vision plan you and all of your Dependents must remain in that vision plan until the next Open Enrollment. For a further explanation contact VSP at (800) 877-7195 or visit www.vsp.com or Safeguard at (800) 880-1800.

BENEFIT	VISION SERVICE PLAN	SAFEGUARD
Examinations	Once each 12 months	Once each 12 months
Spectacle Lenses	One each 12 months if prescription has changed	One each 12 months if prescription has changed
Frames	Once each 24 months	Once each 24 months
Medically Necessary Contacts (in lieu of other benefits)	Once each 12 months	Once each 24 months
Elective Contacts (in lieu of other benefits)	Once each 12 months	Once each 24 months
Sunglasses	Paid accordingly in lieu of regular glasses	Paid accordingly in lieu of regular glasses
Copayment	$5 total copay, plus any amount over allowance or for cosmetic options. Medically necessary contacts are covered in full, less the copay. Cosmetic contacts are covered up to $105.	$5 exam plus any amount over allowance or for cosmetic options. Medically necessary contacts are covered in full, less the co-pay. Cosmetic contacts are covered up to $50 exam and $100 materials.
How to Obtain Services (Contracted providers only)	(800) 877-7195. The participating Doctor will obtain authorization.	(800) 880-1800. The participating Doctor will obtain authorization.
Frame Allowance	Frames of your choice every 24 months covered up to $115 plus 20% of any out-of-pocket over $115	$35 Maximum Wholesale Allowance If you wish to purchase a frame not fully covered by the plan, you will be responsible for the difference between the allowance and the wholesale cost of the more expensive frame, plus an additional service fee.
Non-Medically Necessary Contact Lens Allowance	$105 Allowance: The allowance applies to the cost of your contacts and the contact lens exam (fitting and evaluations). Contacts are available in lieu of frames and lenses.	$120 Maximum Retail Allowance The above coverage applies to prescriptions for contact lenses that are not Medically Necessary. (Contact lenses are offered in lieu of frames and lenses.)
Medically Necessary Contact Lens Allowance	Covered in full.	$250 Maximum Allowance Participating Providers have agreed to limit their charges to a reduced amount that is 80% of their usual charge. The allowance applies to all costs associated with obtaining contact lenses. You are responsible for any charges in excess of the allowance plus any applicable Copayments. (Contact lenses are offered in lieu of frames and lenses.)

Dependents can be added to either vision plan. The cost to add Dependents for vision benefits may vary. Contact the Benefit Administrator for further explanation of benefits and costs.

VSP LIMITATIONS AND EXCLUSIONS
This Plan is designed to cover your visual needs rather than cosmetic eyewear. You are responsible for additional costs if you choose extras, including:

1. Blended or oversized lenses;

2. Progressive multifocal lenses;

3. Photochromic or tinted lenses other than Pink 1 or 2;

4. Coated, laminated or UV protected lenses;

5. Cosmetic lenses or processes unless specifically covered on page 34; and

6. A frame that exceeds your allowance.

You are not covered for the following services or eyewear:

1. Orthoptics or vision training and supplemental training;

2. Plano lenses (non-prescription);

3. Two pairs of glasses instead of bifocals;

4. Replacement of lost or broken glasses, except at the normal intervals when services are otherwise available;

5. Medical or surgical treatment of the eyes; and

6. Corrective vision services, treatments and eyewear of an Experimental nature.

SAFEGUARD LIMITATIONS AND EXCLUSIONS
No benefits are payable under this Plan for any expenses incurred for:

1. Any procedures not specifically listed as a covered benefit in the Schedule of Benefits.

2. Services and supplies provided by a provider who is not a Participating Vision Provider, except as specifically described in the section entitled “Emergency Vision Care” in the Evidence of Coverage.

3. Charges for services and materials that the Participating Vision Provider determines to be (1) not Medically Necessary, (2) beyond the maximum material allowance for frames and contact lenses indicated in the Schedule of Benefits, or (3) non-basic, are excluded.

4. Hospital and medical charges of any kind, medical transportation, vision services rendered in a Hospital, prescriptions or medications, and medical or surgical treatment of the eyes are excluded.

5. Prescriptions from non-Participating Vision Providers.

6. Replacement due to loss, theft or destruction is excluded, except when replacement is at the regular time intervals of coverage under the vision plan.

7. Orthoptics and vision training and any associated testing, subnormal vision aids, plano (non-prescription) lenses are excluded.

8. A second pair of glasses in lieu of bifocals.

9. Services that cannot be performed because of the general health, physical, emotional, mental or behavioral limitations of the patient.

10. Services and supplies considered Experimental in nature.

11. Services and supplies rendered by a person who resides in the Member's home, or by an immediate relative of the Member.

12. Services or supplies provided for or paid by a federal or state government agency or authority, political subdivision, or other public program.

13. Any expenses paid by any Workers' Compensation law or act, Employers' Liability law or by any governmental program, law or agency, except for Medicare or Medicaid.

14. Any services or materials as a condition of employment (e.g., safety glasses).

15. Charges associated with copying or transferring vision records.

DENTAL PLANS

Fresno Unified School District provides two Dental Plans for active Employees working 4 or more hours per day and to self-paid Retirees. Retirees must elect Dental coverage at retirement and may not enroll at a later date if dental coverage is initially declined. Dependents of Actives and Retirees are eligible to participate provided the Employee or Retiree contributes 100% of the appropriate Dependent premiums. Contact the Plan's Benefit Administrator for Dependent premium information.

An active Employee may enroll himself or herself and/or the Employee's Eligible Dependents in either Dental Plan during the 31 days immediately following original eligibility. Once you choose your plan, you will not be allowed to change dental plans until the next Open Enrollment Period. There is an Open Enrollment Period each year for a 60 day period beginning on January 10th.

The Dental Plan selected by the Employee or Retiree also applies to his or her eligible Dependents.

The two Dental programs provided by the Plan are:

Delta Dental
Pacific Union Dental

A description of these programs can be found on pages 38 through 41 for Delta Dental and pages 42 through 44 for Pacific Union Dental.

DELTA DENTAL PLAN

THESE RULES APPLY SOLELY TO PARTICIPANTS WHO ARE ENROLLED IN THE DELTA DENTAL PLAN. If You Are Enrolled with Pacific Union Dental, please see page 42.

Delta Dental benefits are provided to Active Employees, self-paid Retirees, and Dependents as specified on page 37. This program covers several categories of benefits when the services are provided by a licensed Dentist and are necessary and customary under the generally accepted standards of dental practice.

Delta will pay 70% of the Covered Fees for the Diagnostic, Preventive, Basic, Crown and Restorative Benefits during the first Calendar Year of eligibility. This percentage increases 10% each consecutive year you visited your Dentist, up to a maximum benefit of 100%. If you do not use your program, the percentage remains at the level you reached the previous year. It drops back to 70% if you lose eligibility or had a break in coverage and then become eligible again.

The percentage for Prosthodontic and Dental Accident Benefits do not change each year you visit your Dentist.

Benefits are limited to the applicable percentage of Dentist's fees of allowances specified below. You are required to pay the balance of any such fee or allowance known as the "patient Copayment." If the Dentist discounts, waives or rebates any portion of the patient Copayment to the Enrollee, Delta Dental only provides as benefits the applicable allowances reduced by the amount that such fees or allowances are discounted, waived or rebated.

SCHEDULE OF BENEFITS

BENEFIT	
Preventive and Diagnostic Procedures (exam, x-rays and prophylaxis – teeth cleaning)	70/80/90/100[1]
Basic Procedures (fillings, single crowns & oral surgery)	70/80/90/100[1]
Major Procedures (bridges, partials & dentures)	50%
Orthodontics	Not covered
Yearly Maximum per Member	$1,500
Choice of Provider	Any licensed provider

[1] Coverage begins at 70% of the approved fees and increases 10% each year to a maximum 100%, provided that person visits the Dentist at least once during the year. If you do not use the program during a Calendar Year, the percentage remains at the level you reached the previous year. Any break in coverage may result in a reduction in percentage of payment.

DELTA DENTAL BENEFITS

THESE RULES APPLY SOLELY TO PARTICIPANTS WHO ARE ENROLLED IN THE DELTA DENTAL PLAN. If You Are Enrolled in Pacific Union Dental, please refer to page 42, or call (800) 999-3367 for a complete Summary of your Benefits.

COVERED SERVICES

The Plan's dental benefits cover the following services when a licensed Dentist provides them and when necessary and customary as determined by the standards of generally accepted dental practice. The Plan covers only the cost of the Dentist's services as specified on page 38. In addition, please also refer to "Service Limitations" and "Exclusions" on pages 40 and 41.

PREVENTIVE AND BASIC PROCEDURES

Diagnostic	Procedures to assist the Dentist in determining required dental treatment.
Preventive	Prophylaxis (cleaning), not more often than twice in any Calendar Year; fluoride treatment; space maintainers; sealants for Dependent children up to age 14.
Oral Surgery	Extractions and certain other surgical procedures, including pre- and post-operative care.
General Anesthesia	When administered by a Dentist for a covered oral surgery procedure.
Restorative	Treatment of tooth decay or fracture by use of silver or plastic restoration. Cast restorations and crowns will be provided only when silver or plastic restorations will not suffice.
Endodontic	Treatment of the tooth pulp.
Periodontic	Treatment of gums and bones and supporting teeth.

MAJOR PROCEDURES

PROSTHODONTIC SERVICES

Procedures for construction or repair of fixed bridges, partial or complete dentures are payable at 50%.

DENTAL ACCIDENT BENEFITS

Covered Basic and Prosthodontic services are those rendered within 180 days following the date of an accident for conditions caused, directly and independently of all other causes, by external, violent and accidental means. Services rendered more than 180 days after the date of the accident or otherwise outside of the Dental Accident Benefit coverage may be provided as Basic or Prosthodontic benefits, subject to all of the conditions, limitations and exclusions applicable thereto. The dental accident benefit shall pay 100% of covered services, not to exceed $1,000.

COVERED FEES

The term "Covered Fees" means only expenses incurred for necessary treatment received by the eligible Employee, Retiree, and his/her Dependent from a Dentist, which, in the geographical area where treatment is rendered, is the usual and customary procedure for the condition being treated. However, the amount considered as Covered Fees, will not exceed the fees and prices regularly and customarily charged for the treatment generally furnished for cases of comparable nature and severity in such geographical area.

EXTENSION OF BENEFITS
If within 60 days after the Employee, self-paid Retiree or Dependent ceases to be covered under the Plan, a covered expense is incurred for services or supplies furnished in connection with a dental procedure which began prior to the date the coverage ceased, benefits will be payable for such expense, provided that the services or supplies are still covered by the Plan on the date such expense occurred.

SERVICE LIMITATIONS
Dental benefits are subject to the following limitations:

1. An oral examination twice in a Calendar Year.

2. Full-mouth x-rays once in a three-year period.

3. Bitewing x-rays are provided on request by the Dentist, but no more than twice in any Calendar Year.

4. Only the first two cleanings, fluoride treatments, or single procedures which include cleaning, or combination thereof, in a Calendar Year.

5. Sealant is limited to eligible Dependent children under age 14. Sealant benefits include the application of sealants only to permanent posterior molars without caries (decay), without restorations and with the occlusal surface intact. Sealant Benefits do not include the repair or replacement of a sealant on a tooth within three years of its application.

6. Crowns, Inlays, Onlays and Cast Restorations on the same tooth only once every five years, unless Delta Dental determines that replacement is required because the restoration is unsatisfactory as a result of poor quality of care, or because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues since the restoration.

7. Prosthodontic appliances only once every five years, unless Delta Dental determines that there has been such an extensive loss of remaining teeth or a change in supporting tissues that the existing appliance cannot be made satisfactory. Replacement of a prosthodontic appliance not provided under a Delta plan will be made if it is unsatisfactory and cannot be made satisfactory.

8. Delta Dental will pay the applicable percentage of the Dentist's fee for a standard partial or complete denture. A standard partial or complete denture is defined as a removable prosthetic appliance provided to replace missing natural, permanent teeth, which is made from accepted materials and by conventional methods.

9. Implants (appliances inserted into bone or soft tissue in the jaw, usually to anchor a denture) are not covered by your plan. However, if implants are provided along with a covered prosthodontic appliance, Delta Dental will allow the cost of a standard partial or complete denture toward the cost of the implants and the prosthodontic appliances when the prosthetic appliance is completed. If Delta Dental makes such an allowance, Delta Dental will not pay for any replacement for five years following the completion of the service.

10. If you select a more expensive plan of treatment than is customarily provided or specialized techniques, an allowance will be made for the least expensive, professionally acceptable, alternative treatment plan. Delta Dental will pay the applicable percentage of the lesser fee for the customary or standard treatment and you are responsible for the remainder of the Dentist's fee.

    For example: a crown where an amalgam filling would restore the tooth; or a precision denture where a standard denture would suffice.

11. Delta Dental will pay Dental Accident Benefits when services are provided within 180 days following the date of accident and shall not include any services for conditions caused by an accident occurring before your eligibility date.

DELTA DENTAL EXCLUSIONS

THESE RULES APPLY SOLELY TO PARTICIPANTS WHO ARE ENROLLED IN DELTA DENTAL PLAN.

If You Are Enrolled in Pacific Union Dental, please refer to page 42, or at (800) 999-3367 for a complete Summary of your Benefits.

Delta Dental benefits are subject to the following exclusions:

1. Services for injuries covered by Workers' Compensation or Employer's Liability Laws.

2. Services which are provided to the Enrollee by any Federal or State Governmental Agency or are provided without costs to the Enrollee by any municipality, county or other political subdivision, except Medi-Cal benefits.

3. Services for cosmetic purposes for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel.

4. Services for restoring tooth structure lost from wear (abrasion, erosion, attrition, or abfraction), for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Examples of such treatment are equilibration and periodontal splinting.

5. Any procedure, bridge, denture or other prosthodontic service which was started before the Enrollee was covered by this plan.

6. Prescribed drugs, or applied therapeutic drugs, premedication or analgesia.

7. Experimental procedures.

8. Charges by any Hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.

9. Anesthesia, except for general anesthesia given by a Dentist for covered oral surgery procedures.

10. Grafting tissues from outside the mouth to tissues inside the mouth ("extraoral grafts").

11. Implants (materials implanted into or on bone or soft tissue) or the repair or removal of implants, except as provided under LIMITATIONS.

12. Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joints or associated muscles, nerves or tissues (TMJ).

13. Replacement of existing restoration for any purpose other than active tooth decay.

14. Intravenous sedation, occlusal guards and complete occlusal adjustment.

15. Orthodontic services (treatment of mal-alignment of teeth and/or jaws).

PACIFIC UNION DENTAL (PUD) BENEFITS

THESE RULES APPLY SOLELY TO PARTICIPANTS WHO ARE ENROLLED IN THE PACIFIC UNION DENTAL (PUD).

If You Are Enrolled in Delta Dental, please refer to page 38, or call (888) 335-8227 for a complete Summary of your Benefits.

Pacific Union Dental (PUD) benefits are provided to active Employees, self-paid Retirees, and Dependents as specified on page 37.

Under Pacific Union, dental services are provided through a network of Participating PUD Dental Offices. When you enroll, you select the Participating Dental Office most convenient for you. You and your Dependents will receive dental services only at that office, except in the case of Emergency.

For as long as you are enrolled in PUD, PUD will pay the Participating Dental Office a monthly amount on your behalf. The monthly rate entitles you to all the benefits under the PUD plan. **Once you choose this plan, you will not be allowed to change dental plans until the next Open Enrollment Period**.

There are No Claim Forms, No Deductibles, and No Maximums (other than those noted under Limitations and Exclusions). Some dental services are provided to you on a "Co-Pay," (share the cost) basis. You arrange payment of the Copayment (your portion of the charge), directly with your Participating Dental Office.

ORTHODONTIC BENEFITS

In addition, the PUD Plan offers a discounted orthodontic benefit (Phase II as defined by PUD) with a standard 24 month full banded service for a Copayment from you of $1,500, approximately 40% of Usual, Customary and Reasonable Charges plus an additional charge of no more than:

$350.00 for start-up fees
$150.00 for one set of retainers (with retention limited to 12 consecutive months, if necessary)

Participant's payment schedule shall be as follows unless otherwise agreed upon between the Participant and the orthodontist:

$500.00 at the inception of care (the placement of bands)
$100.00 per month for 10 months

If you are covered under PUD and are currently undergoing orthodontic treatment (e.g. banding, etc.), you will not be eligible for the orthodontic benefit if you decide to switch to the Delta Dental Plan.

Due to the capitated nature of PUD, there is no coordination of benefits.

PACIFIC UNION DENTAL (PUD) LIMITATIONS
Set forth below are the limitations that are applicable to the PUD Plan.

1. Prophylaxis is limited to one treatment each six month period (includes periodontal maintenance following active therapy);

2. Crowns, bridges and dentures (including immediate dentures) are not to be replaced within a five-year period from initial placement;

3. Partial dentures are not to be replaced within a five year period from initial placement, unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible;

4. Denture relines are limited to one per denture during any 12 consecutive months;

5. Replacement will be provided for an existing denture, partial denture or bridge only if it is unsatisfactory and cannot be made satisfactory by reline or repair;

6. Treatment for conditions is generally limited to conventional techniques and does not include splinting, hemisection implants, overdentures, grafting, precision attachments, duplicate dentures and bruxating appliances;

7. The PUD plan allows up to five units of crown or bridgework per arch. Upon the sixth unit, the Plan considers the treatment to be full mouth reconstruction. The patient is responsible for fees incurred for anything beyond the fifth unit;

8. Periodontal treatments (root planning/subgingival curettage) are limited to four quadrants during any 12 consecutive months;

9. Full mouth debridement (gross scale) is limited to one treatment in any 24 consecutive month period;

10. Bitewing x-rays are limited to four quadrants during any 12 consecutive months;

11. Full mouth x-rays and/or panographic type films are limited to one set every 24 consecutive months. A full mouth x-ray is defined as a minimum of 6 periapical films plus bitewing x-rays;

12. Sealant benefits include the application of sealants only to permanent first and second molars with no decay, with no restorations and with the occlusal surface intact, for the first molars up to age nine and second molars and bicuspids up to age fourteen. Sealant benefits do not include the repair or replacement of a sealant on any tooth within three years of its application;

13. Single unit cast metal and/or ceramic restorations and crowns are covered only when the tooth cannot be adequately restored with other restorative materials. Crown build-ups including pins are only allowable as separate procedures in the exceptional instance where extensive tooth structure is lost and the need for a substructure can be demonstrated by written report and x-rays;

14. Cosmetic dental care is limited to composite restorations on posterior teeth distal to canines when a PUD Dentist determines treatment to be appropriate dental care. Composite restorations will be covered on premolar facial surfaces.

PACIFIC UNION DENTAL (PUD) EXCLUSIONS
The following dental procedures and services are not included under the PUD Plan:

1. General anesthesia and the services of a special anesthesiologist, intravenous and inhalation sedation and prescription drugs;

2. Dental conditions arising out of and due to enrollee's employment or for which Worker's Compensation is payable. Services that are provided to the enrollee by state government or agency thereof, or are provided without cost to the enrollee by any municipality, county or other subdivision, except as provided in Section 1373 (a) of the California Health and Safety Code;

3. Treatment required by reason of war;

4. Dental services performed in a Hospital and related Hospital fees;

5. Treatment of fractures and dislocations;

6. Loss or theft of fixed and removable prosthetics (crowns, bridges, full or partial dentures);

7. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage; and dental expenses incurred for treatment in progress prior to Member's eligibility with the Plan (e.g., teeth prepared for crowns, root canals in progress, fixed and removable prosthetics);

8. Any service that is not specifically listed as a covered expense;

9. Procedures, appliances or restorations to correct congenitally and/or developmentally missing teeth or other congenital and/or developmental conditions, developmental malformations (including but not limited to cleft palate, enamel hypoplasia, fluorosis, jaw malformations, and odontia) and supernumerary teeth;

10. Treatment/removal of malignancies, cysts over 1.25 centimeters, tumors or neoplasms;

11. Dispensing of drugs not normally supplied in a dental office;

12. Treatment as a result of accidental Injury. Accidental Injury is defined as damage to the hard and soft tissues of the oral cavity resulting from external forces to the mouth.

13. Cases which in the professional opinion of the PUD's attending Dentist determines that a satisfactory result cannot be obtained or where the prognosis is poor or guarded;

14. Dental services received from any dental office other than a PUD's dental office, unless expressly authorized in writing by the Plan or as cited under "Out of Area Emergency Treatment";

15. Prophylactic removal of asymptomatic, nonpathological impacted teeth, extractions for orthodontic purposes; surgical orthognatic procedures and crown exposure with ligation;

16. Implant placement or removal, appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment;

17. Crown lengthening procedures;

18. Replacement of long standing missing tooth/teeth in an otherwise stable dentition;

19. Dental services and treatments for restoring tooth structure loss from wear, bruxism, attrition and/or erosion, changing or restoring vertical dimension, and full mouth reconstruction to enhance occlusion, diagnosis and/or treatment of the temporomandibular joint (TMJ);

20. Dental services that cannot be performed in a PUD's general dental office because of physical, medical or behavioral limitations of eligible Dependents over the age of six years.

MEDICAL, VISION AND DENTAL BENEFIT LIMITATIONS

GENERAL EXCLUSIONS AND LIMITATIONS APPLICABLE TO THE PLAN

Benefits are not payable for:

1. Any services rendered by a person related to the Covered Person by blood, marriage or law or any person who resides in the same house.

2. Any expenses covered under a Workers Compensation Act or similar legislation, or which is due to Injury or illness arising out of or in the course of any occupation or employment for wages or profit.

3. Services for care or treatment provided or furnished by any governmental agency of any country, unless the Covered Person is legally required to pay without regard to the existence of coverage. A government agency includes federal, state, or local governmental agencies, whatever they may be called, in any country.

4. Any service for which a charge would not have been made in the absence of coverage.

5. Any condition, disability, or expense resulting from or sustained as a result of being engaged in an illegal occupation, commission of or attempted commission of an illegal act charged as a felony including driving under the influence.

6. Any condition, disability, or expense resulting from or sustained as a result of being engaged in participation in a civil insurrection or a riot.

7. Any condition, disability, or expense resulting from or sustained as a result of being engaged in duty as a member of the Armed Forces of any state or country, or war or act of war whether declared or undeclared.

8. Any charges incurred prior to the effective date of coverage under the Plan or subsequent to the date of termination of coverage under the Plan.

9. Services, supplies, and treatment not prescribed by a legally qualified Physician or Surgeon; services, supplies, or treatment not Medically Necessary for treatment of an Injury or Sickness, including vitamins and dietary supplements.

10. Charges in excess of the Usual, Customary and Reasonable guidelines utilized by the Plan.

11. Charges that the Covered Person is not legally required to pay, or would not be required to pay in absence of the Plan.

12. Charges for the completion of claim forms, prescriptions, missed or broken appointments or finance charges.

13. Procedures that are considered Experimental or Investigational.

14. Services rendered outside the United States, which would not have been covered if provided in the United States.

15. Orthoptics and vision training (unless pre-authorization is obtained in writing through Anthem Blue Cross).

16. Charges incurred in connection with cosmetic surgery, except where:

    a. Accidental injuries occurred while covered, and only if performed while still covered and incurred within a period of 90 days subsequent to the date the Injury was sustained; or

    b. Reconstructive Surgery. Surgery performed to reshape abnormal structures of the body is covered when it is necessary to improve functional impairment. Examples include congenital defects, such as cleft-lip or palate, which impede functional ability.

    c. Reconstructive cosmetic surgery which does not improve a functional impairment is only covered when;

        (i) it is incident to a several stage treatment plan following a trauma for which Medically Necessary reconstructive surgery was necessary to improve functional impairment if the trauma occurred during the Participant's enrollment, or

        (ii) when it is necessary to restore and achieve symmetry for the Covered Person incident to a Medically Necessary mastectomy, or

        (iii) where it is necessary to repair a congenital defect which is disfiguring, requires surgery, and treatment would be likely to lead to substantial improvement of the defect.

17. Treatment of obesity for any Covered Person who is not morbidly obese.

18. Charges for surgical treatment of obesity except for the Medically Necessary treatment of **morbid obesity, when pre-authorized by Anthem Blue Cross, for Gastric Restrictive Procedure with Gastric Bypass with Roux-en-Y Gastroenterostomy**. To be eligible for this procedure, the patient must:

    a. Be more than 100 pounds over ideal body weight, or has a body mass index exceeding 40 kg/m, or has a body mass index over 35 kg/m and a clinically serious condition (e.g., obesity hypoventilation, sleep apnea, diabetes, hypertension, cardiomyopathy, or musculoskeletal dysfunction); and

    b. Have demonstrated an inability to control weight because the patient (all of the following must apply):

        1. has failed to significantly lose weight or has regained weight despite compliance with a multidisciplinary nonsurgical program, including low or very low-calorie diet, supervised exercise, behavior modification, and support; and

        2. has full growth; and

        3. has no correctable cause for obesity (e.g., endocrine disorder); and

        4. is receiving treatment in a surgical program experienced in obesity surgery, characterized by Surgeons experienced with Roux-en-Y gastric bypass and a multidisciplinary approach including (all of the following):

            i) preoperative medical consultation and approval; and
            ii) preoperative psychiatric consultation and approval; and

iii) nutritional counseling; and
iv) exercise counseling; and
v) psychological counseling; and
vi) support group meetings.

19. Any other treatment of obesity including but not limited to appetite or weight control drugs, dietary supplements, special foods or food supplements primarily for weight loss or control unless necessitated as the direct result of a specifically identified and diagnosed endogenous (caused within the body) condition and pre-authorized by Anthem Blue Cross.

20. Nutritional counseling, unless (a) prescribed in writing by the attending Physician, (b) provided by a registered dietician, (c) performed for treatment of a condition of disease origin, and (d) pre-authorized by Anthem Blue Cross.

21. In-vitro fertilization, artificial insemination, infertility treatment or any charges associated with the direct inducement of pregnancy (however, necessary services and supplies to diagnose infertility are covered).

22. Reversal of sterilization procedures.

23. Professional services, except as specifically provided herein, rendered for behavioral or marriage counseling, or study of behavioral characteristics, or vocational testing or counseling.

24. Treatment for learning disabilities or educational problems; behavioral problems; therapy or surgery for sexual dysfunction or inadequacies or psychiatric admissions, which are primarily to control or change the patient's environment.

25. Treatment for attention deficit/hyperactivity disorder unless authorized by Avante Health.

26. Treatment for chemical dependency or alcoholism other than that described under the substance abuse benefit of the Plan.

27. Charges for foot care (except surgery or foot orthotics), to include but not limited to any condition resulting from weak, unstable, or flat feet, fallen arches, pronated foot metatarsalgia, foot strain or bunions; any treatment of corns, calluses, or toenails unless at least part of the nail root is removed, unless for specifically diagnosed diabetic foot care.

28. Myofunctional therapy; occupational therapy, speech therapy, except to restore speech following illness or Injury incurred while covered under the Plan.

29. Confinement in a Hospital owned or operated by the federal government, except Usual, Customary and Reasonable Charges otherwise payable and incurred at a Veteran’s Administration Facility or by a Covered Person as an armed services Retiree for services or supplies unrelated to military service.

30. Travel expenses, whether or not recommended by a Physician, except for ambulance service as specifically provided.

31. Charges incurred for services or supplies, which constitute personal comfort, personal hygiene, or convenience and beautification items such as but not limited to air conditioners, personal hygiene, bathing/toilet accessories, and Physician fitness equipment for home use.

32. Charges incurred for hospitalization primarily for x-ray, laboratory, diagnostic study, physio-therapy, hydrotherapy, medical observation, convalescent or rest cure or any medical examination or test not connected with an actual illness or Injury.

33. Charges incurred for the replacement of an initial prosthesis unless medical necessity is proven in writing, and pre-authorized by Anthem Blue Cross.

34. Charges incurred for injuries sustained as the result of the misuse of a controlled substance.

35. Charges for organ or tissue transplants except as specified in the Plan.

36. Charges for maternity care for a Dependent child, including abortions and complications thereof.

37. Charges for biofeedback, hypnosis, sleep apnea, and services relating to pain management centers unless authorized by a Physician as required for the necessary medical treatment of an illness, Injury or pregnancy, and pre-authorized by Anthem Blue Cross.

38. Complications arising from a service or treatment which is excluded from coverage.

39. Treatment of mandible for correction of a bite problem or treatment of jaw joint problems, including temporomandibular joint syndrome and craniomandibular disorders, or other conditions of the joint linking the jaw bone and skull and a complex of muscle, nerve and other tissue related to that joint, except when any of the following criteria is met – Note: Pre-authorization must be obtained from Anthem Blue Cross.

    a. There is radiological evidence of bone deterioration in the jaw or joint.

    b. There are significant nutritional problems from the inability to masticate food properly, which cannot be managed through variations in diet.

    c. The associated respiratory problems would endanger life.

    d. The disability treated was the result of an accident.

40. Prescriptions obtained outside the USA not approved by the Federal Food and Drug Administration.

41. Services, supplies or medications associated with sex transformations and resulting complications.

42. Charges for Custodial Care, domiciliary care, rest cures, services that are primarily Educational in nature, or any maintenance-type care which is not reasonably expected to improve the patient's condition, except that Custodial Care provided in conjunction with Home Health Care, Hospice Care and Skilled Nursing care when these services are provided as a less costly alternative to Inpatient hospitalization shall be considered a Covered Medical Expense under the Plan.

43. Charges for benefits other than specifically provided or in excess of the benefits specified in the Plan.

44. Charges for or related to physical examinations, except as specified.

45. Charges for artificial insemination, invitro fertilization, or treatment of sexual dysfunctions not related to organic disease, or treatment relating to the inability to conceive.

46. Charges for any device, drug or procedure (except elective sterilization, as specified) used for the direct purpose of birth control. Oral contraceptives are covered under the Prescription Drug Expense Benefit Plan.

47. Charges for hearing examinations, hearing aids or for fitting them.

48. Charges for dental care, treatment, or x-rays, except as specified in the Plan.

49. Charges for private duty nursing unless authorized by Anthem Blue Cross.

50. Charges incurred through the use of a nurse's aide or licensed vocational nurse (L.V.N.) unless authorized by Anthem Blue Cross.

51. Charges of an occupational therapist, except as specified in the Plan.

52. Charges for the purchase of dialysis equipment.

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE FOR ACTIVE EMPLOYEES AND RETIREES

EFFECTIVE DATE OF COVERAGE
Your coverage will be effective on the first day of the month following the date your completed enrollment form is received by the District.

TERMINATION OF COVERAGE
Insurance will continue as long as you and your Dependents remain eligible through the District, who continues to pay the premiums, and the Contract is not terminated. Coverage for your Dependents will terminate when your coverage terminates, or when they no longer qualify under the Plan.

BENEFICIARY
You may name any beneficiary or beneficiaries you wish. If you purchase coverage for your family, you are automatically your Dependents' beneficiary for loss of life.

LIFE INSURANCE

Life Insurance is provided to Fresno Unified School District Employees, Retirees, and Dependents. Active Employees insurance coverage is paid for by the District. Elective Dependent insurance coverage and Retiree insurance coverage require a contribution by the Employee or Retiree. All additional Life Insurance coverage is available through Standard Insurance Company and information is available through the District.

For additional information, please refer to your Group Insurance certificate issued by Standard Insurance Company, as provided by the District, or contact Standard Insurance at (559) 457-3515.

Fresno Unified School District provides Basic Life and Accidental Death & Dismemberment Insurance for all active eligible Employees working at least four hours a day, 20 hours a week, at no cost to the Employee, as follows:

The amount of your term life insurance is determined from the following table:

Attained Age at Nearest Birthday	Amount
Under 25	$ 56,784
25 – 29	49,686
30 – 34	42,588
35 – 39	36,555
40 – 44	29,102
45 – 49	21,826
50 – 54	14,196
55 – 59	11,357
60 – 64	9,582
65 – 69	6,229
70 or over	4,049

For further information, please refer to your life insurance certificate.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

Fresno Unified School District also provides Accidental Death and Dismemberment through Prudential to Active Employees and elective AD&D coverage to Dependents.

Eligible Participants will be protected 24 hours a day, 365 days a year, for covered accidents occurring anywhere in the world, on or off the job, at home or while traveling (subject to the Exclusions and Limitations of the contract). Benefits are paid in a lump sum.

For additional information, or information regarding the amount of your AD&D insurance benefit, please refer to your Group Insurance certificate issued by Prudential, as provided by the District, or contact Prudential at (800) 524-0524.

ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT (You may only be covered under one option below)

100% of the Benefit Amount	50% of the Full Benefit Amount	25% of the Full Benefit Amount
Loss of life or Loss of two or more members or Loss of speech and hearing of both ears	Loss of one member or Loss of speech or hearing of both ears	Loss of hearing of one ear or Loss of thumb and index finger of the same hand

Member means hand, foot or eye.
Loss must occur within 365 days of the date of the covered accident.

PARALYSIS BENEFIT

100% of the Benefit Amount	75% of the Full Benefit Amount	50% of the Full Benefit Amount
Quadriplegia (total paralysis of both upper and lower limbs.)	Paraplegia (total paralysis of both lower limbs.)	Hemiplegia (total paralysis of upper and lower limbs on one side of the body.)

LOSS DUE TO EXPOSURE AND DISAPPEARANCE
Loss due to exposure to the elements is considered an accidental loss. Also, if the insured's body is not found within a year of a certain disappearance, that person will be presumed to have died.

MONTHLY COMA BENEFIT
If a covered insured is injured in a covered accident, which results in a coma for at least 31 consecutive days, the Plan will begin payment of a Monthly Coma Benefit. Payment of this benefit will continue each month as long as the Covered Person remains in a coma, up to a maximum of 100 months. This benefit will be paid at a rate of 1% of the Benefit Amount less any benefits paid as a result of the same covered accident.
"Coma" means being in a profound state of unconsciousness from which the person cannot be aroused, even by powerful stimulation, as determined by the person's Doctor.

SEAT BELT BENEFIT
Because of the added protection seat belts bring to drivers and passengers every day, this special benefit is provided for you. If, while insured for this benefit, you suffer accidental death due to a covered accident in which you were seated in an automobile with a seat belt properly fastened, the Plan will pay an additional **10%** of the entitled Amount.

GENERAL PROVISIONS

EMPLOYEE CONTRIBUTIONS

Active Employees and Eligible Pre-65 Year Old Retirees
Effective July 1, 2005, contributions are required for Health Benefit Plan coverage and are outlined in the Health Plan Contribution and Reserve Assessment Exhibit contained in the back of this booklet. There are separate rates for Employee/Retiree only and for Employee/Retiree with Dependents.

Health Plan Reserve Assessment

Employees and Retirees Pre-75
In addition to the monthly contributions, all eligible active Employees and Pre-75 Retirees shall contribute a Health Plan Reserve Assessment as outlined in the Health Plan Contribution and Reserve Assessment Exhibit contained in the back of this booklet.

However, the monthly contribution and Health Plan Reserve Assessment shall continue only until the Retiree and/or Dependent reaches age 75, at which time the Post-75 year-old Retiree/Dependent shall not be required to make any monthly contributions.

NOTE: Changes in monthly Contribution and Health Plan Reserve Assessment amounts are subject to the Collective Bargaining Agreement language between the District and the Employee organization representing bargaining unit members.

ELIGIBILITY AND EFFECTIVE DATES

EMPLOYEE ELIGIBILITY
An eligible Employee who is employed by the Fresno Unified School District is eligible to participate in the Plan as determined by Board Policy or the Collective Bargaining Agreements between the District and the Employee organizations representing bargaining unit members.

No Opting Out
All eligible District active Employees shall be required to participate in the Health Care Plan and shall be required to pay the monthly contributions and assessments, at least at the Employee only level, for the Plan(s) or coverage**.**

Employees – Effective Date
Medical coverage by the Plan is provided on a contributory basis (that is, the Employee pays a portion of the cost of coverage). An eligible Employee's coverage is effective upon the first of next the month following date of hire (or on the first day of the month if the Employee is hired on the first of any month).

Rehire
An Employee who returns to work with the District within thirty-nine (39) months of termination from the Plan shall be eligible for Plan coverage effective upon the first of the next month following date of re-employment.

RETIRED EMPLOYEE - ELIGIBILITY

Certain Retired Employees are also eligible to participate as a Retiree in the Plan. The conditions of eligibility, and any Retiree contributions, are determined by the District's Board Policies, or if applicable, by a negotiated bargaining agreement.

All Retiree Plan Participants age 65 and over who are eligible for Medicare Parts A & B must designate Medicare as their primary insurance coverage.

DEPENDENT ELIGIBILITY

An eligible Dependent of an Employee is:

1. a legal spouse;

2. a Domestic Partner;

3. any unmarried child under the age of 19* who is Dependent on the Employee for support and maintenance. For these purposes a "child" will include: (a) an Employee's natural child, (b) a Legally adopted child placed in the lawful custody of adopted parents, (c) a stepchild, and (d) a child subject to a Qualified Medical Child Support Order (QMCSO) as noted on page 55;

4. an unmarried student age 19 but less than 25, if such child meets the requirements of the preceding paragraph, except for the ages, is in full-time school attendance at an accredited institution of learning and can be claimed as a Dependent on the Employee's federal income taxes;

5. an unmarried mentally or physically Disabled child beyond the maximum age provided the child is incapable of self-sustaining employment and is Dependent upon the Employee for support and maintenance and further provided that the condition existed prior to such child reaching the age of nineteen (19) or age twenty-five (25) whichever is applicable. Proof of any mental or physical disability shall be required within thirty-one (31) days of such child's nineteenth (19th) or twenty-five (25th) birthday and the Administrator may require additional proof from time to time.

*** Note: Newborn Children – Limited Automatic 31-Day Benefit Period**

If a Dependent child is born after the effective date of an Employee's coverage hereunder, benefits will be available for Eligible Expenses of the child, which are incurred within the first 31 days after birth. Payment for services received after the 31 days will be denied until the newborn is enrolled. Benefits for such child will be available for the 31-day period only. After the 31-day period, coverage for the child will be available only if within the 31 days after the child's birth, the Employee has notified the Plan Sponsor or the Plan Administrator of the birth and has enrolled the child. Otherwise, the "Open Enrollment" provision will apply.

An eligible Dependent does not include:

1. a spouse who is legally separated or divorced from the Employee; or

2. an individual whose Domestic Partnership with the Employee has terminated; or

3. a child who is on active duty in any military, naval or air forces of any country; or

4. any child who is covered as an Employee under this Plan.

A Domestic Partner will be covered under the Fresno Unified School District's Health Plan provided a Participant is a same-sex partner, or opposite-sex partner where at least one of the partners is age 62 or older and qualifies for certain Social Security benefits, as defined under California Family Code 297 and has filed a Declaration of Domestic Partnership with the California Secretary of State, or by validly forming a legal union in a jurisdiction other than California consistent with the requirements of Family Code Section 299.2.

Effective Date - Dependents
Coverage for Dependents who are eligible and enrolled concurrently with the Employee will be effective on the Employee's effective date. Coverage for Dependents acquired later will be effective as follows, provided the Dependent is enrolled within 31 days of eligibility:

1. for a newly acquired Dependent spouse or Domestic Partner, coverage is effective on the date of marriage or Domestic Partnership;

2. for a newly acquired Dependent child, coverage is effective on the date the child was acquired. See also "Newborn Children…" above.

If a new Dependent is not enrolled within 31 days of his or her eligibility, s/he can be enrolled later only in accordance with the "Open Enrollment" provision.

OPEN ENROLLMENT
The 60-day period beginning January 10 of each Calendar Year will be an Open Enrollment period. This is the period of time when an eligible Employee may enroll himself and/or his or her eligible Dependents in the Plan other than during the 31 days immediately following original eligibility.

NOTE: Each Dependent must be identified with a Social Security number. A Dependent's coverage will not become effective prior to the Employee's effective date.

CROSS (DUAL) COVERAGE
When both spouses or Domestic Partners are employed by the District, the Plan shall pay up to 100% of the total Allowable expenses including annual Deductibles and co-pays for each person and their Eligible Dependents.

PORTABILITY UNDER THE FEDERAL HEALTH INSURANCE PROTABILITY AND ACCOUNTABILITY ACT (HIPAA)
Any Medical or Dental pre-existing condition exclusion indicated in this Plan booklet is reduced by the individual's "creditable coverage" for up to 12 months. Creditable coverage is the total number of days on which the individual had health coverage from all sources. The individual must demonstrate creditable coverage by providing a certificate from the previous plan, or, if a certificate is not available, by presenting evidence to corroborate his/her statement that he/she had other coverage and cooperating with the Plan's efforts to verify it.

For individuals already covered by the Plan, the foregoing rules will apply to a spouse and/or children subsequently acquired through marriage and their "enrollment date" would be the date of marriage.

NOTE: If an individual has gone 63 days or more without any health coverage, any (medical or dental) pre-existing condition exclusionary period is not reduced and the individual is subject to the previously stated pre-existing condition exclusions.

Under certain conditions, an individual and Dependents may be allowed a "special enrollment" period of at least 30 days under any pre-existing condition provision stated above if:

1. The individual or Dependents had originally declined coverage because they:

    a. Had other coverage, which they later lost because of separation/divorce, termination of employment or reduction in hours, death or the cessation of employer contributions for their coverage (unless it was for cause or failure to pay contributions on time), or
    b. Were on COBRA, but their COBRA eligibility has expired.

2. If an individual who did not initially enroll later marries or has or adopts a child, the individual is entitled to a special enrollment along with the child.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)
If a QMCSO issued in a divorce or legal separation proceeding requires you to provide medical coverage to a child who is not in your custody, you may do so. To be considered qualified, a medical child support order must include:

- Name and last know address of the parent who is covered under this Plan;
- Name and last know address of each child to be covered under this Plan;
- Type of coverage to be provided to each child; and
- Period of time the coverage is to be provided.

QMCSOs should be sent to the Plan's Administrative Office. Upon receipt, the Plan's Administrative Office will notify you and describe the Plan's procedures for determining if the order is qualified. If the order is qualified, you may cover your children under the Plan. As a beneficiary covered under the Plan, your child will be entitled to information that the Plan provides to other beneficiaries.

TERMINATION OF COVERAGE

EMPLOYEE COVERAGE TERMINATION
Coverage under the Plan shall terminate for an Employee on the earliest of the following dates:

(a) the date the Employee fails to pay any required contributions when due;

(b) the date the Plan terminates;

(c) the date the person is no longer an eligible Employee because his or her coverage terminates prior to retirement eligibility. However, in this instance, coverage will continue to the end of the Plan Year (June 30) provided the Employee works for the District until the end of the school year. For Employees who do not work for the District until the end of the school year, the date coverage terminates will be determined on a Prorated basis; as determined by District's Board Policy or, if applicable, by a negotiated bargaining agreement.

(d) the date the Employee becomes a full-time member of the armed forces of any country for more than one month in any Calendar Year.

DEPENDENT COVERAGE TERMINATION
A Dependent's coverage under the Plan will terminate upon the earliest of the following dates:

(a) the date the Employee ceases to make any required contributions for Dependent coverage;

(b) the date the Employee ceases to be covered under the Plan, except that Dependents of an Employee who is recalled to active duty as a member of the National Guard or military reserves shall be considered an Dependent for purposes of the Plan;

(c) the date the Dependent ceases to meet the eligibility requirements of the Plan;

(d) the date the Plan ends;

(e) the date the Dependent becomes a full-time member of the armed forces of any country for more than one (1) month in any Calendar Year.

CONTINUATION OF BENEFITS

FAMILY AND MEDICAL LEAVE ACT (FMLA)
Under the Family and Medical Leave Act of 1993 (FMLA), an active Employee may be entitled to family or medical leave.

1. If an Employee is eligible to take and elects FMLA leave, coverage under this Plan will continue until the earlier of:

    a. The date the Employee notifies the District that he or she does not intend to return to work at the end of the FMLA leave; or

    b. The end of the FMLA leave.

2. Contributions will continue to be paid by the District on the Employee's behalf while he or she is on FMLA leave.

3. The Employee must contact the District to determine his or her eligibility for FMLA leave.

CONTINUATION OF COVERAGE – TOTAL DISABILITY
Loss of eligibility under this Plan will immediately terminate all benefits. However, if you or a Dependent were totally Disabled on the date coverage terminated, and if expenses are thereafter incurred directly related to the Injury or Sickness causing the disability, then benefits will be continued with respect to such expenses until the first of the following events occur:

1. On the 101st day following the month of the date of disability; or

2. The date the maximum amount of benefits has been paid; or

3. The date you or your Dependents cease to be totally Disabled; or

4. The date coverage for you or your Dependents become effective under any replacement policy without limitations as to the disabling condition.

Benefits under this provision will not be payable with respect to any other Injuries or Sicknesses.

CONTINUATION OF COVERAGE UNDER FEDERAL LAW – COBRA
As required by a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Plan offers you and each of your eligible Dependents the opportunity for a temporary extension of health coverage at group rates in certain instances when Plan coverage would otherwise end. Qualified beneficiaries must pay for this continuation coverage (called "COBRA coverage") by sending premiums directly to the Benefit Administrator. (See Section 10 and 11 on page 61.) **Both you and your spouse or Domestic Partner should take the time to read this section carefully.**

1. Benefits Available Under COBRA Coverage
Those of you who are entitled to choose COBRA (i.e., you and separately your spouse or Domestic Partner and eligible Dependents) are known under COBRA as "qualified beneficiaries."

COBRA coverage is the same coverage that the Plan gives to other Plan Participants who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA coverage will have the same rights under the Plan as other Plan Participants, including open enrollment and special enrollment rights. If the Plan changes its benefits levels or health coverage for all Participants, your health coverage will be changed in the same manner. COBRA qualified beneficiaries are not, however, considered Plan "Participants" during COBRA coverage.

When you initially enroll in COBRA Coverage, you will be offered a choice between two levels of coverage: (1) a Core Plan of Benefits, which consists of Medical and Prescription Drug coverage; and (2) a Non-Core Plan of Benefits, which consists of Medical, Prescription Drug, Vision and Dental coverage. Each qualified beneficiary need not elect the same level of coverage. You are not eligible to continue benefits under COBRA if you were not eligible prior to the Qualifying Event.

2. How COBRA Coverage Becomes Available

a. For an Employee

If you are an Employee, you have a right to choose COBRA coverage for yourself if you lose your coverage under the Plan due to any of the following "Qualifying Events."

- Your hours of employment are reduced; or
- Your employment ends for any reason (such as layoff or retirement) other than your gross misconduct.

b. For the Spouse or Domestic Partner of an Employee

If you are the spouse or Domestic Partner of an Employee, you have a right to choose COBRA coverage for yourself if you lose your coverage under the Plan due to any of the following "Qualifying Events."

- The Employee dies;
- The Employee's hours of employment are reduced;
- The Employee' employment ends for any reason other than his or her gross misconduct;
- You become divorced or legally separated from the Employee; or
- Your Domestic Partnership with the Employee is terminated, dissolved, or nullified.

c. For the Dependent Children of an Employee

Your Dependent children have the right to choose COBRA coverage for themselves if they lose coverage under the Plan due to any of the following "Qualifying Events:"

- The parent-Employee dies;
- The parent-Employee's hours of employment are reduced;
- The parent-Employee's employment ends for any reason other than his or her gross misconduct;
- The parents become divorced or legally separated;
- The parents' Domestic Partnership is terminated, dissolved, or nullified); or
- The child stops being eligible for Plan coverage because the child no longer qualifies as a "Dependent" as defined by the Plan.

d. For Retirees in the Event of Bankruptcy

If you are a Retiree covered under this Plan, you will have a right to choose COBRA coverage if your Plan coverage is lost on account of the District filing for bankruptcy under Title 11 of the United States Code. Your spouse or Domestic Partner, and Dependent children will also have the right to choose COBRA coverage if the bankruptcy results in their loss of Plan coverage.

3. Notifying the Benefit Administrator of a Qualifying Event

The Plan will offer COBRA coverage to each qualified beneficiary only after the Benefit Administrator has been notified that a Qualifying Event has occurred.

The District must notify the Benefit Administrator within 30 days of the occurrence of the following Qualifying Events: (1) the end of employment or reduction of hours of employment; (2) death of the Employee; or (3) commencement of a bankruptcy proceeding by the District.

YOU MUST NOTIFY THE BENEFIT ADMINISTRATOR OF CERTAIN QUALIFYING EVENTS:

You or a Dependent (or a representative of either) must notify the Benefit Administrator by calling (800) 807-8820 within 60 days after the date Plan coverage is lost due to a Qualifying Event that is the Employee's divorce or legal separation, the termination, dissolution of nullification of the Employee's Domestic Partnership, or a child's loss of eligibility under the Plan as a Dependent child. When you call, you may be asked to provide some or all of the following information: (1) the Employee's name; (2) the Employee's social security number; (3) the name(s) and social security number(s) of all qualified beneficiaries; (4) relevant mailing addresses; and (5) the date and nature of the Qualifying Event. You may be required to provide supporting documentation (e.g., a divorce decree) to the Benefit Administrator.

COBRA coverage will be denied if you fail to give notice to the Benefit Administrator of a divorce, legal separation, termination or dissolution of a Domestic Partnership or child's loss of eligibility as a Dependent child under the Plan within 60 days after the date Plan coverage is lost due to one of these Qualifying Events.

4. Electing COBRA Coverage and Notice of Denial of COBRA Coverage

After the Benefit Administrator is timely notified of a Qualifying Event, it will send each qualified beneficiary a "Notice of Right to Continue Health Coverage under Federal Law (COBRA) and Election Form" (the "Election Form") within 14 days of the date Plan coverage ends due to a Qualifying Event.

If you would like to elect COBRA coverage, you must return the completed and signed Election Form to the Benefit Administrator within 60 days after the later of: (1) the date Plan coverage ends due to a Qualifying Event; or (2) the date the Benefit Administrator mailed you an Election Form. An election is considered to be made on the date you send the completed and signed Election Form to the Benefit Administrator.

Each qualified beneficiary has a separate right to elect COBRA coverage. For example, the Employee's spouse or Domestic Partner may elect COBRA coverage, even if the Employee does not. COBRA coverage may be elected for only one, several, or for all Dependent children. Employees may elect COBRA coverage on behalf of their spouses or Domestic Partners, and parents may elect COBRA coverage on behalf of their children. The Employee or the Employee's spouse or Domestic Partner can elect COBRA coverage on behalf of all of the qualified beneficiaries.

If you reject COBRA coverage before the date the Election Form is due, you may change your mind as long as you send the completed and signed Election Form to the Benefit Administrator before the due date. However, if you change your mind after first rejecting COBRA coverage, your COBRA coverage will begin on the date you send your completed and signed Election Form to the Benefit Administrator.

Please note that the Plan is required by law to make a complete disclosure of your COBRA eligibility and election status to any health care provider, such as a Doctor, Hospital, or pharmacy, that requests information about your coverage during such a period.

If the Benefit Administrator receives a notice relating to a Qualifying Event or disability determination regarding an Employee, Dependent or other person and determines that such person is not entitled to COBRA coverage, the Benefit Administrator will, within 14 days of receiving such notice, send such person a Notice of Denial of COBRA Coverage containing the reason for such denial.

IMPORTANT:
In considering whether to elect COBRA coverage, you should be aware that a failure to continue your group health coverage will affect your future rights under federal law. First, pre-existing condition exclusions in other group health plans may apply if you have more than a 63 day gap in health coverage. Election of COBRA coverage may help you avoid such a 63 day gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition exclusions if you do not receive COBRA coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan, if available, for which you are otherwise eligible (such as a plan sponsored by your spouse's or Domestic Partner's employer) within 30 days after your group health coverage ends because of a Qualifying Event. You will also have the same special enrollment right at the end of COBRA coverage.

5. How Long COBRA Coverage Lasts

COBRA coverage is a temporary continuation of coverage.

- When the Qualifying Event is the Employee's death, divorce or legal separation, or the loss of Dependent child status under the terms of the Plan, COBRA coverage lasts for up to a total of 36 months.

- When the Employee becomes entitled to Medicare benefits less than 18 months before the Qualifying Event and the Qualifying Event is the end of employment or reduction of the Employee's hours of employment, COBRA coverage for qualified beneficiaries other than the Employee lasts up until 36 months after the date of the Employee's Medicare entitlement. For example, if an Employee becomes entitled to Medicare 8 months before the date on which his or her employment terminates, COBRA coverage for his or her Dependent spouse or Domestic Partner and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).

- When the Qualifying Event is the end of employment or reduction of the Employee's hours of employment, COBRA coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA coverage can be extended (see Section 6 below).

6. Extending an 18-Month Period of COBRA Coverage

a. Disability Extension of 18-Month Period of COBRA Coverage

An 11-month extension of COBRA coverage (for a total maximum of 29 months) may be available if the Social Security Administration (SSA) determines any qualified beneficiary to be Disabled. The disability must have started at any time before the 60th day of COBRA coverage and must last at least until the end of the 18-month COBRA coverage period. Each qualified beneficiary who has elected COBRA coverage will be eligible for the disability extension if one of them qualifies. COBRA premiums are higher for the extra 11 months of coverage.

To obtain this extension, you must notify the Benefit Administrator by calling 1-800-382-6278 within 60 days after the date of the SSA disability determination (or if the qualified beneficiary is already Disabled, within 60 days after the date Plan coverage is lost due to the Qualifying Event), but before the end of the initial 18-month period of COBRA coverage. When you call, you may be asked to provide some or all of the following information: (1) the Employee's name; (2) the Employee's social security number; (3) the name(s) and social security number(s) of all qualified beneficiaries; (4) relevant mailing addresses; and (5) the date of the SSA disability determination. In addition, you will be required to provide the Benefit Administrator with a copy of the SSA determination letter.

The disability extension will terminate early if the SSA determines that the individual is no longer Disabled before the end of the 11-month extension. You or your Dependent must notify the Benefit Administrator by calling 1-800-382-6278 within 30 days of any such final determination that the individual is no longer Disabled.

b. Second Qualifying Event Extension of 18-Month Period of COBRA Coverage

An 18-month period of COBRA coverage may be extended for a period of up to 36 months for an Employee's spouse, Domestic Partner or Dependent child, if a second Qualifying Event occurs during the first 18-month period. This extension may be available to the spouse, Domestic Partner and any Dependent child receiving COBRA coverage if the Employee or former Employee dies, gets divorced or legally separated, the Employee's Domestic Partnership is terminated, dissolved, or nullified, or if the child stops being eligible under the Plan as a Dependent child, **but only if the second event would have caused the spouse, Domestic Partner or child to lose coverage under the Plan had the first Qualifying Event not occurred.** For example, if an Employee's spouse or Domestic Partner is on COBRA coverage for 18 months due to the termination of the Employee's employment, and during the 18-month period, the spouse or Domestic Partner and the former Employee get divorced, the spouse or Domestic Partner will be eligible to maintain his or her COBRA coverage for up to 36 months from the date coverage ended due to the first Qualifying Event. However, in no event will COBRA coverage extend beyond 36 months from the date coverage ends due to the first Qualifying Event, and it may end before the 18, or 36-month period expires, as explained under "When COBRA Coverage Terminates" (see Section 8 below).

In order to obtain an extension because of a second Qualifying Event, you must notify the Benefit Administrator by calling (800) 807-0820 within 60 days following the later of the date of the second Qualifying Event or the termination of the initial 18-month COBRA coverage period. When you call, you may be asked to provide some or all of the following information: (1) the Employee's name; (2) the Employee's social security number; (3) the name(s) and social security number(s) of all qualified beneficiaries; (4) relevant mailing addresses; and (5) the date and nature of the Qualifying Event. The Benefit Administrator may require that supporting documentation (such as a divorce decree) be submitted.

7. When COBRA Coverage Begins

COBRA coverage begins on the date Plan coverage ends due to a Qualifying Event. If you received extended Plan coverage due to Total Disability, as described on page 56, your COBRA coverage will begin on the first day of the month after the end of such period of extended coverage. In other words, months of extended Plan coverage due to Total Disability will not count against or reduce the 18-, 29-, or 36-month maximum COBRA coverage period.

8. When COBRA Coverage Terminates

COBRA coverage will end before the expiration of the 18-, 29-, or 36-month maximum COBRA coverage period if:

- The Benefit Administrator does not receive timely payment of the required COBRA premium;
- The Plan no longer provides group health coverage;

- A qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of a qualified beneficiary;

- The 11-month disability extension terminates early because the SSA determines that the Disabled qualified beneficiary is no longer Disabled;

- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA coverage (COBRA coverage for family members not covered by Medicare will not be affected), or

- The District ceases to make contributions to the Plan and provides other group health plan coverage for its Employees.

COBRA coverage may also be terminated for any of the reasons the Plan would terminate coverage of a Participant not receiving COBRA coverage (such as fraud).

Termination of COBRA coverage will be effective on the first day of the month following the month in which any of the above-listed events occur. Once COBRA coverage ends for any reason, it will not be reinstated. Furthermore, any medical expenses incurred after the COBRA coverage termination date will not be paid by the Plan.

If your COBRA coverage is terminated early, the Benefit Administrator will send you a Notice of Early Termination of COBRA Coverage as soon as reasonably practicable after it determines that your COBRA coverage will end. This notice will contain the reason for such termination and the termination date.

9. Adding Dependents to COBRA Coverage

You may add a spouse, Domestic Partner or a Dependent child who is newly acquired during a period of COBRA coverage for the balance of your COBRA coverage period. To enroll your new eligible Dependent for COBRA coverage, you must submit written proof of their dependency to the Benefit Administrator at the address shown on page 74 within 30 days of the date the Dependent(s) was acquired. There may be an increase in your COBRA premium to cover the new Dependent.

A child born to, or placed for adoption with, the Employee while receiving COBRA coverage will become a qualified beneficiary in his or her own right. Such child will have the right, for example, to elect a different medical plan, if available, than the qualified beneficiary parent during the next Open Enrollment period and will be eligible for extended COBRA coverage if a second Qualifying Event or disability occurs during an initial 18-month maximum COBRA coverage period.

10. The Cost of COBRA Coverage

Each qualified beneficiary must pay the entire cost of COBRA coverage, which may not exceed 102 percent (or, if the case of an extension of COBRA coverage due to a disability, 150 percent) of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly-situated Plan Participant who is not receiving COBRA coverage. Neither the District nor the Plan will pay for any part of your COBRA coverage.

The cost of COBRA coverage is determined once a year. You should contact the Benefit Administrator to obtain current rates.

11. Payment Rules for COBRA Coverage

a. First Payment for COBRA Coverage

If you elect COBRA coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA coverage not later than 45 days after the date of your election. (This is the date your completed and signed Election Form is post-marked, if mailed.) If you do not make your first payment for COBRA coverage in full within this 45-day period, you will lose all COBRA coverage rights under the Plan.

You are responsible for making sure that the amount of your first payment is correct and includes premiums due for all calendar months between the date Plan coverage terminated and the calendar month ending immediately before the initial premium is paid. You may contact the Benefit Administrator to confirm the correct amount of your first payment. COBRA coverage will not be effective until your payment is received.

b. Periodic Payments for COBRA Coverage

After you make your first payment for COBRA coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary will be provided to you with the Election Form. The periodic payments must be made on a monthly basis and are due on the tenth (10^{th}) day of the month of coverage. For example, the payment for COBRA coverage for the month of January is due on January 10^{th}. If you make a periodic payment on or before the first day of the coverage period to which it applies, your COBRA coverage under the Plan will continue for that coverage period without any break. **The Benefit Administrator will not send monthly bills or warning notices of payments due for these coverage periods. It is the responsibility of you or your Dependents to send the required payments when due.**

c. Grace Period for Periodic Payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 31 days after the first day of the coverage period to make each periodic payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. For example, you have until January 31^{st} to pay for coverage effective January 1^{st}. **If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to COBRA coverage under the Plan.**

d. Where Should I Send My Payments?

All payments for COBRA coverage must be sent to the Benefit Administrator at the address shown in this Plan Booklet on page 74.

12. If You Have Questions

Questions concerning the Plan or your COBRA coverage rights can be answered by the Benefit Administrator at (800) 807-0820.

For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

13. Keep the Benefit Administrator Informed of Any Changes

In order to protect you and your family's rights, you must keep the Benefit Administrator informed of any change in your address and the addresses of family members. Also, you must inform the Benefit Administrator of any change in marital or Domestic Partnership status. You should also keep a copy, for your records, of any notices you send to the Benefit Administrator.

CONTINUATION OF COVERAGE UNDER USERRA – MILITARY SERVICE

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) established requirements that employers and health plans must meet for certain Employees who have left employment due to service in the uniformed services. With one important exception, your rights under COBRA and USERRA are essentially the same. Any election that you make pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to the continuation coverage elected. But in contrast to COBRA, which provides you and your Dependents up to 18 months of coverage, USERRA provides you and your Dependents up to 24 months of coverage.

COBRA and USERRA coverage are concurrent for up to the first 18 months of coverage. This means that COBRA coverage and USERRA coverage begin at the same time. As with COBRA, you are responsible for paying for USERRA coverage. The monthly premiums are the same. The cost of the USERRA premium is the same as it would be under COBRA.

Your USERRA coverage will terminate if one of the following events takes place before the end of the 24 months:

(1) You fail to make a premium payment within the required time;

(2) You do not return to work within the time required under USERRA following the completion of your service in the uniformed services (the time for returning varies, please contact the District for more details); or

(3) You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

You may lose coverage under COBRA and USERRA for different reasons. You could, therefore, lose coverage under COBRA but retain it under USERRA, or vice versa. For example, if you lose coverage under USERRA due to a dishonorable discharge, your COBRA coverage would continue as long as you were within the 18-month time limit (plus any extensions, if applicable) for COBRA.

CERTIFICATED RETIREE CONTINUATION OF COVERAGE UNDER STATE LAW – FOR ONLY RETIRED CERTIFICATED EMPLOYEES AND SPOUSES OR DOMESTIC PARTNERS (ED. CODE 7000/AB 528)

Upon retirement, a Retired Certificated Employee and eligible spouse or Domestic Partner will have the option of continuing medical and dental coverage provided under this Plan if the Employee was a certificated Employee of the Fresno Unified School District prior to retirement and the Employee:

1. Retired under any public Employee retirement system;

2. Gained permanent status while in the employment of the District;

3. Would currently be eligible for health and welfare benefits in the District if they were employed under the current conditions and in the same capacity as when permanency was gained;

4. Otherwise meet the requirements of Education Code Section 7000; and

5. Enrolls in the Plan's Ed. Code Section 7000 plan within 30 days after losing active Employee or other Plan coverage.

If an individual is the surviving spouse or Domestic Partner of a retired certificated Employee, he or she is also eligible to continue coverage.

Coverage will be provided at the individual's own expense, and premiums, as set by the Plan, must be paid by the individual for a minimum of three months coverage. **A Retiree or spouse (or Domestic Partner) who has elected coverage under Education Code Section 7000, and who subsequently voluntarily terminates that coverage for any reason, will be excluded from enrolling for coverage at any later date.**

CLAIMS PROCEDURES

HOW TO FILE A "CLAIM"

This Plan does not require any claim forms from Participants or Dependents as long as:

1. Itemized claims are submitted by the provider directly to the Benefit Administrator.

2. The Benefit Administrator must have current (less than 1 year old) "Other Insurance Information" on file.

3. Payment is assigned to the provider of service.

Providers must submit itemized statements showing:

1. Participant's Name

2. Participant's Social Security Number

3. Patient's Name

4. Dates of Services

5. List of Services and charges provided by CPT code

6. Provider's name, address and Tax ID Number

NOTICE OF CLAIM

Written notice of a claim must be given to the Benefit Administrator within 60 calendar days after the date services are rendered that are covered by the Plan, or as soon thereafter as is reasonably possible. Any claim not submitted within 12 months of the date services are rendered is ineligible for payment unless a written appeal is approved by the Joint Health Management Board, which approval must be based on proof of special circumstances which prohibited timely filing of the claim.

HOW TO APPEAL A DENIED CLAIM

APPEALS PROCEDURE FOR ALL PLANS EXCLUDING PACIFIC UNION DENTAL (PUD)

A. Scope of Appeals Procedure

The District provides some benefits on a self-funded basis. Any dispute concerning eligibility, including eligibility of Dependents, can be appealed under the appeals procedure. Any dispute concerning benefits under the Fresno Unified School District Health Care self-funded medical plan can be appealed under this appeal procedure.

B. Joint Health Management Board

A Participant shall attempt to resolve any dispute concerning eligibility or benefits with the Benefit Administrators, Delta Health Systems administrative office. If the Participant is not satisfied with the decision of the Benefits Administrator, the Participant shall file an appeal with the Joint Health Management Board following the procedures set forth in Section C of this policy.

C. Appeal to Joint Health Management Board (JHMB)

1. The Participant must file a written appeal with the JHMB within sixty (60) days after the event giving rise to the appeal.

2. The appeal must state the reasons why the Participant disagrees with the notice of denial. It is recommended that the Participant include with the appeal, any evidence the Participant wishes the JHMB to consider.

3. The JHMB may consider a late appeal if the JHMB concludes that the delay was due to reasonable cause.

4. The JHMB shall fully and fairly review each appeal.

5. The JHMB shall issue a written notice of decision which shall include the specific reasons for the decision.

6. The JHMB will normally render a decision within sixty (60) days after receipt of the appeal. If the JHMB notifies the Participant in writing that additional time is needed, the sixty (60) day period will be automatically extended to one hundred twenty (120) days. If the JHMB fails to respond within the applicable time period, the appeal shall be deemed denied.

7. The JHMB possesses full discretion to decide appeals properly coming within this section and to interpret the terms of the JHMB bylaws, the Plan Booklet, and other documents relevant to a claim.

D. Post-JHMB Review

1. This section sets forth the sole and exclusive methods by which a dissatisfied Participant may seek review of a JHMB decision on the Participant’s appeal.

2. If the Participant's claim is for less than the jurisdictional limit of small claims court (which is $5,000 as of January 1, 2006), then the Participant's exclusive remedy is to file an action in small claims court.

3. If a Participant disagrees with the decision of the JHMB and if the Participant's claim is greater than the jurisdictional limit of small claims court, a Participant's exclusive remedy shall be **binding arbitration**. A Participant may request arbitration by making a written demand for arbitration to the JHMB. The demand must be received by the JHMB within ninety (90) days after the date on the JHMB's notice of decision. If the demand is not received within this time period, the Participant shall be deemed to have withdrawn his or her appeal.

4. The arbitration will be conducted according to the commercial arbitration rules of the American Arbitration Association. The jurisdiction of the arbitrator is limited to interpreting the Plan Booklet. The decision of the arbitrator shall be final and binding upon all parties, including the applicant and any person claiming through the applicant.

5. If a Participant does not obtain a monetary award greater than the decision of the JHMB, the Participant will then be personally responsible to reimburse the JHMB for fifty percent (50%) of the arbitrator's total fee and for fifty percent (50%) of the other costs of arbitration, including court reporter's fee, cost of transcript, hearing room fees, etc.

6. Any time period set forth in this procedure may be extended or reduced by written agreement of the Participant and the Joint Health Management Board (JHMB).

7. A Participant shall not have any right or claim for benefits from the Plan except as specifically set forth in this Plan Booklet.

APPEALS PROCEDURE FOR INSURED PACIFIC UNION DENTAL (PUD) PLAN

A. Insured Plan

If you participate in Pacific Union Dental and a claim for benefits is denied, you must follow the appeals procedure of that plan. Only that plan is able to extend or modify any time limits set forth in that plan's appeals procedure.

B. Joint Health Management Board (JHMB)

If a Participant does not agree with the result obtained under the Insured plan's appeal procedure, the Participant may make a written request to the JHMB to intervene. If the JHMB determines that the position of the Participant is correct, the JHMB shall contact the Insured plan and request that the plan change its decision. The JHMB's role, however, is confined to this limited role; the insurer is the ultimate decision-maker.

EXPLANATION OF BENEFITS (EOB) FORM

You will receive an Explanation of Benefits (EOB) form from the Benefit Administrator after you have gone to a medical facility or healthcare provider for treatment. The EOB explains how your bill was processed and should be saved for tax purposes and future reference.

PAYMENT OF CLAIMS

The benefits will be paid to the provider furnishing the service upon any assignment furnished by the Participant.

Physical Examination
The Plan, at its own expense, shall have the right to require an examination of any individual whose Injury or Sickness is the basis of a claim when and as often as it may be reasonably required during the pendency of a claim hereunder.

Legal Action
No action at law or in equity shall be brought to recover benefits under this Plan prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Plan. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

The Plan is not in lieu of and does not affect any requirement for coverage by Workers' Compensation Insurance.

Right of Recovery

Whenever payments have been made by the Plan in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of these provisions, the Plan shall have the right to recover such payments, to the extent of such excess, from any person, corporation or other entity, to or for or with respect to whom such payments were made.

COORDINATION OF BENEFITS (COB)

ORDER OF BENEFIT DETERMINATION

The benefits of another plan will be ignored for the purpose of determining the benefits under this Plan if the rules set forth in the paragraphs below would require the Plan to determine its benefits before such other plan.

The rules establishing the order of benefit determination are as follows:

1. The plan that covers the person as other than a Dependent is the plan that pays first. This plan is called the "primary" plan. The plan that covers the person as a Dependent is the plan that pays second. This plan is called the "secondary" plan.

2. If the person is a Dependent child, the primary plan is the plan of the parent whose birthdate (month and day), excluding year of birth, occurs earlier in a Calendar Year.

3. When the parents are separated or divorced: If there is a court decree that establishes financial responsibility for the medical, dental or other health care expense with respect to a Dependent child, the benefits are determined in agreement with the court decree. Otherwise, if the parent with custody has not remarried, the plan of the parent with custody is primary; if the parent with custody has remarried, the plan of the parent with custody is primary, the stepparent's plan pays second, and the plan of the parent without custody pays third.

4. If the above rules do not establish an order of benefit determination, the plan that has covered the person for the longer period of time shall be primary except that the benefits of a plan covering the person as laid-off or retired Employee or as a Dependent of such person, shall be determined after the benefits of any plan covering the person as an Employee.

5. Any plan, other than a health maintenance organization (HMO), that does not contain a coordination of benefits provision is automatically primary. Primary coverage by an HMO is determined by numbers 2 and 3 above. When part of a Plan coordinates benefits and a part does not, each part shall be treated like a separate plan.

COORDINATION WITH OTHER MEDICAL PLANS

Effect of Coverage Under Another Plan
If an individual covered under this Plan is also covered under one or more other group health benefit plans, the benefits payable under this Plan may be reduced by the benefits payable under all other plans so that the total payment under this Plan and under all other plans does not exceed 100% of the Allowable Expenses. In no event will the payment under this Plan be larger than it would have been in the absence of this coordination with other plans' provisions. Benefits payable under all other plans include the benefits that would have been payable had a claim been properly made for them.

Definition of "Plan"
Any plan providing benefits or services for or by reason of medical care which services or supplies are provided by:

1. group, blanket or franchise insurance coverage;

2. service plan contracts, group practice, individual practice or other prepayment coverage other than health maintenance organizations;

3. any coverage under labor-management trusteed plans, union welfare plans, employer organization plans or Employee benefit organization plans;

4. any coverage under governmental programs, and any coverage required or provided by any statute.

In no event shall the term "plan" mean a plan which provides benefits or services for or by reason of dental, vision or prescription drug care.

Participants Covered as a Dependent under a Spouse's or Domestic Partner's HMO
The Plan will pay as primary without respect to any HMO contracting by the provider.

Spouse or Domestic Partner who is Covered Under his or her Own HMO
The Plan will not cover the charges of an HMO provider.

Effect on Benefits
Benefits under this Plan will be paid as follows if:

1. this Plan is the primary plan, it shall pay its benefits as if there were no other coverage;

2. an Employee and/or Retiree is covered under this Plan as an Eligible Employee and/or Eligible Retiree and as an Eligible Dependent spouse or Domestic Partner, this Plan shall pay up to 100% of the total Allowable Expenses including annual Deductibles and copays for each of the above parties and their other Eligible Dependents;

3. this Plan is the secondary plan, it shall limit the benefit it pays so that the sum of its benefits and all other benefits payable by the primary plan will not exceed the total Allowable Expenses payable under this Plan;

4. this Plan is the secondary plan, it shall limit the benefits it pays so that the amount of benefits this Plan pays as the secondary plan will not exceed the amount of benefits this Plan would have paid had it been the primary plan; and

5. the above provisions operate to reduce the total amount of benefits otherwise payable as to a Covered Person under this Plan during any Claim Determination Period, each benefit that would be payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit maximum of this Plan.

Right to Receive and Release Information
For the purposes of determining the applicability of and implementing the terms of the above provisions of this Plan or any similar provision of another plan, the Benefit Administrator may release to, or obtain from, any other insurance company, organization or individual any information, concerning any individual, that the Benefit Administrator considers to be necessary for those purposes. Any individual claiming benefits under this Plan shall furnish to the Benefit Administrator the information that may be necessary to implement the above provisions.

THIRD PARTY LIABILITY AND SUBROGATION

Subrogation and Right of Recover
This provision shall apply to all benefits provided under any section of this Plan.

When This Provision Applies
A Covered Person may incur medical or other charges related to Injuries or Illness caused by the act or omission of another person; or Another Party may be liable or legally responsible for payment of charges incurred in connection with the Injuries or Illness. If so, the Covered Person may have a claim against that other person or Another Party for payment of the medical or other charges. In that event, the Plan will be secondary, not primary, and the Plan will be Subrogated to all rights the Covered Person may have against that other person or Another Party and will be entitled to Reimbursement. In addition, the Plan shall have the first lien against any Recovery to the extent of benefits paid or to be paid and expenses incurred by the Plan in enforcing this provision. The Plan's first lien supersedes any right that the Covered Person may have to be "made whole." In other words, the Plan is entitled to the right of first Reimbursement out of any Recovery the Covered Person procures or may be entitled to procure regardless of whether the Covered Person has received compensation for any of his or her damages or expenses, including any of his or her attorneys' fees or costs. Additionally, the Plan's right of first Reimbursement may be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. As a condition to receiving benefits under the Plan, the Covered Person agrees that acceptance of benefits is constructive notice of this provision.

The Covered Person must:

1. Execute and deliver a Subrogation and Reimbursement Agreement;

2. Authorize the Plan to sue, compromise and settle in the Covered Person's name to the extent of the amount of medical or other benefits paid for the Injuries or Illness under the Plan and the expenses incurred by the Plan in collecting this amount, and assign to the Plan the Covered Person's rights to Recovery when this provision applies;

3. Within 10 business days, reimburse the Plan, out of any Recovery made from Another Party, 100% of the amount of medical or other benefits paid for the Injuries or Illness under the Plan and expenses (including attorneys' fees and costs of suit, regardless of an action's outcome) incurred by the Plan in collecting this amount (without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise);

4. Notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and

5. Cooperate fully with the Plan in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan.

When a right of recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for other Illnesses or Injuries), the Covered Person will execute and deliver all required instruments and papers, including a Subrogation and Reimbursement Agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other benefits will be paid by the Plan for the Injuries or Illness. However, failure or refusal on the Covered Person's part to execute such agreements or furnish information does not preclude the Plan from exercising its right to Subrogation or obtaining full reimbursement. In addition, the Covered Person will do nothing to prejudice the Plan's right to Subrogation and Reimbursement and acknowledges that the Plan precludes operation of the made-whole and common-fund doctrines.

The Benefit Administrator has maximum discretion to interpret the terms of this provision and to make changes, as it deems necessary.

Amount Subject to Subrogation or Reimbursement

Any amounts recovered will be subject to Subrogation or Reimbursement. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or other benefits paid for the Injuries or Illness under the Plan and the expenses incurred by the Plan in collecting this amount. The Plan has a right to recover in full, without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise, even if the Covered Person does not receive full compensation for all of his or her charges and expenses.

"Covered Person"
Anyone covered under the Plan, including minor Dependents.

"Another Party"
"Another Party" shall mean any individual or organization, other than the Plan, who is liable or legally responsible to pay expenses, compensation or damages in connection with a Covered Person's Injuries or Illness.

"Another Party" shall include the party or parties who caused the Injuries or Illness; the insurer, guarantor or other indemnifier of the party or parties who caused the Injuries or Illness; a Covered Person's own insurer, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; and any other individual or organization that is liable or legally responsible for payment in connection with the Injuries or Illness.

"Recovery"
"Recovery" shall mean any and all monies paid to the Covered Person by way of judgment, settlement or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the Injuries or Illness. Any Recovery shall be deemed to apply, first, for Reimbursement.

"Reimbursement"
"Reimbursement" shall mean repayment to the Plan for medical or other benefits that it has paid toward care and treatment of the Injury or Illness and for the expenses incurred by the Plan in collecting this benefit amount.

"Subrogation"
Subrogation" shall mean the Plan's right to pursue the Covered Person's claims for medical or other charges paid by the Plan against Another Party.

When a Covered Person Retains an Attorney
If the Covered Person retains an attorney, that attorney must sign the Subrogation and Reimbursement Agreement as a condition to any payment of benefits and as a condition to any payment of future benefits for other Illnesses or Injuries. Additionally, the Covered Person's attorney must recognize and consent to the fact that the Plan precludes the operation of the "made-whole" and "common fund" doctrines, and the attorney must agree not to assert either doctrine in his or her pursuit of Recovery. The Plan will neither pay the Covered Person's attorneys' fees and costs associated with the recovery of funds, nor reduce its reimbursement pro rata for the payment of the Covered Person's attorneys' fees and costs. Attorneys' fees will be payable from the Recovery only after the Plan has received full Reimbursement.

A Covered Person or his or her attorney who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the Recovery to the Plan under the terms of this provision. Furthermore, a Covered Person agrees to direct his or her attorney who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) that he or she has an absolute obligation to immediately tender the Recovery to the Plan under the terms of this provision. A Covered Person or his or her attorney who receives any such Recovery and does not immediately tender the Recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan, because the Covered Person or his or her attorney is not the rightful owner of the Recovery and should not be in possession of the Recovery until the Plan has been fully reimbursed.

When the Covered Person is a Minor or is Deceased
These provisions apply to the parents, trustee, guardian or other representative of a minor Covered Person and to the heir or personal representative of the estate of a deceased Covered Person, regardless of applicable law and whether or not the minor's representative has access or control of the Recovery.

When a Covered Person Does Not Comply
When a Covered Person does not comply with the provisions of this section, the Benefit Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) under the Plan by the amount due as Reimbursement to the Plan. The reductions will equal the amount of the required Reimbursement. If the Plan must bring an action against a Covered Person to enforce this provision, then that Covered Person agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

When Recovery includes the Cost of Past or Future Expenses
In certain circumstances, a Covered Person may receive a Recovery that includes amounts intended to be compensation for past and future expenses for treatment of the Illness or Injury, which is the cause of the Recovery. This Plan will not cover any expenses for which compensation was provided through a previous Recovery. This exclusion will apply to the full extent of such Recovery or the amount of the expenses submitted to the Plan for payment, whichever is less. The Plan also precludes operation of the made-whole and common-fund doctrines in applying this provision.

It is the responsibility of the Covered Person to inform the Benefit Administrator when expenses are incurred related to an Illness or Injury for which a Recovery has been made. Acceptance of benefits under this Plan for which the Covered Person has received a Recovery will be considered fraud, and the Covered Person will be subject to any sanctions determined by the Plan Administrator, in its sole discretion, to be appropriate. The Covered Person is required to submit full and complete documentation of any such Recovery in order for the Plan to consider eligible expenses that exceed the Recovery

EFFECT OF PLAN BENEFITS FOR PARTICIPANTS ELIGIBLE FOR MEDICARE

EFFECT OF MEDICARE FOR ACTIVE EMPLOYEES
Federal law requires that the District offer to active Employees and the Covered Dependents who are age 65 or more the same health benefits as are available to active Employees and Covered Dependents less than age 65. Further, if such Covered Person chooses to be covered under the District's group medical Plan, Medicare will become the secondary provider of benefits. The Plan will determine what benefits are covered under this Plan; the remainder of the expenses may then be submitted to Medicare by the Covered Person for reimbursement.

If the active Employee chooses to be covered under Medicare, then the benefits described in this Plan will be paid separately to Medicare.

EFFECT OF MEDICARE FOR RETIREES
A retired Employee and covered Dependents must enroll in Medicare Part B (Medical) upon becoming eligible for Part A (Hospital) coverage under Social Security. If you are a Retired member or an eligible Dependent of a Retired member and are eligible for Medicare, the benefits of this Plan will be paid secondary and Medicare will be the primary. This means that if you are eligible for Medicare, your benefits under this Plan (as secondary payor) will be reduced by what Medicare pays.

If you are a Retired member or an eligible Dependent of a Retired member and are not eligible for Medicare, the benefits of this Plan will be paid the same as for active Employees and their Dependents.

Medicare Part A (Hospital) benefits are covered at no cost provided you enroll for such coverage when you first qualify under Social Security. Medicare Part B (Medical) benefits require a contribution from Participants. The District will not reimburse Retirees for the Medicare Part B premium(s).

Part D (Prescription Drug)
The Plan offers at least as much as the Standard Medicare Part D coverage so Employees, Retirees and Dependents are urged **NOT** to enroll in an individual Part D plan. The federal Medicare Part D prescription drug program does not allow enrollment in more than one prescription drug plan. Therefore, enrollment in an individual Part D prescription drug plan may risk permanent lose of your current prescription drug coverage. The Plan will not be reimburse for Part D premiums.

GENERAL PLAN INFORMATION

Binding the Plan: As a courtesy to you, the Benefit's Administration Office (Delta Health Systems) and the Fresno Unified School District's Benefit Department may respond informally to oral questions. However, oral information and answers are not binding upon the Fresno Unified School District Health Care Plan and cannot be relied on in any dispute concerning your benefits. Binding information may be obtained only through written request to Delta Health Systems.

PLAN NAME AND AFFILIATION

Fresno Unified School District Employee Health Care Plan

BENEFIT ADMINISTRATOR

Delta Health Systems
P.O. Box 692230
Stockton, California 95269-2230

Or

770 E. Shaw, Suite 320
Fresno, California 93710
Phone: (800) 807-0820
Claim Fax: (559) 228-4198
Eligibility Fax: (209) 474-5402

PLAN ADMINISTRATION

The Plan is administered by the JHMB Board consisting of three Directors from each Union representing Employees and six Directors representing the District, whose names are as follows:

JOINT HEALTH MANAGEMENT BOARD OF DIRECTORS

Fresno Unified School District
Mike Darling
Paul A. Garcia
Steve Gonzalez
Ruth Quinto (Co-Chair)
Caran Resciniti
Vincent Harris
Andrew De La Torre (Alternate)

Fresno Teachers Association
Brenda Emerson
Viola Melella
Joe Tobin
Bill Swanson

California Schools Employees Association
Chapter 125 – White Collar Unit
Kathyleen Gizerian
Margaret Reynoso
Mattie Thomas
Genevieve Reynoso (Alternate)

California Schools Employees Association
Chapter 143 – Food Services Unit
Fonda Kilgore
John Stallsmith (Co-Chair)
Sue Swanbeck
Roseanne Villalvaro (Alternate)

Services Employees International Union
Local No. 521
Gwen Harshaw
Pat Riley
Kathy Seward
Richard Marquez (Alternate)

Building Trades Council of Fresno, Madera, Kings, & Tulare Counties
AFL/CIO Unions
Dan Boyd
Tom Rotella
Bill Yelkin

CONSULTANT
Rael & Letson

LEGAL COUNSEL
Saltzman & Johnson Law Corporation

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It is for quick reference only and is not intended to be all-inclusive.

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