BOARD COMMUNICATIONS – May 07, 2021

TO: Members of the Board of Education
FROM: Superintendent, Robert G. Nelson, Ed.D.

SUPERINTENDENT – Robert G. Nelson, Ed.D.

S-1	Robert G. Nelson	Superintendent Calendar Highlights

ADMINISTRATIVE SERVICES – Santino Danisi, Chief Financial Officer

AS-1	Kim Kelstrom	School Services Weekly Update Report for April 30, 2021
AS-2	Santino Danisi	Benefit Plan Options and Modeling

OPERATIONAL SERVICES – Karin Temple, Chief Operations Officer

OS-1	Karin Temple	Number of Board of Education Trustees

SCHOOL LEADERSHIP – Kim Mecum, Chief Academic Officer

SL-1	Jeremy Ward	2021 Extended Learning Summer Program

TECHNOLOGY SERVICES – Tami Lundberg, Chief Technology Officer

T-1	Philip Neufeld	Private LTE NetWork and Internet Connectivity

Fresno Unified School District
Board Communication

BC Number S-1

From the Office of the Superintendent
To the Members of the Board of Education
Prepared by: Robert G. Nelson, Superintendent
Cabinet Approval:

Date: May 07, 2021

Phone Number: 457-3884

Regarding: Superintendent Calendar Highlights

The purpose of this communication is to inform the Board of notable calendar items:

- Participated in the Arbinger virtual workshop titled “Developing and Implementing an Outward Mindset”
- Held interviews for Executive Director, College and Career Readiness
- Participated in weekly call with County Superintendents
- Met with small groups of Trustees, District Management Group and district staff to discuss the A-ROI process
- Gave interview with District Management Group as part of their work with a national non-profit to better understand how school districts make decisions related to spending their resources and maintain strong academic programs
- Met with labor partners

Approved by Superintendent
Robert G. Nelson Ed.D. 

Date: 05/07/21

Fresno Unified School District
Board Communication

BC Number AS-1

From the Office of the Superintendent
To the Members of the Board of Education
Prepared by: Kim Kelstrom, Executive Officer
Cabinet Approval:

Date: May 07, 2021

Phone Number: 457-3907

Regarding: School Services Weekly Update Report for April 30, 2021

The purpose of this communication is to provide the Board a copy of School Services of California's (SSC) Weekly Update. Each week SSC provides an update and commentary on different educational fiscal issues. In addition, they include different articles related to education issues.

The SSC Weekly Update for April 30, 2021 is attached and includes the following articles:

- 2021–22 Statutory COLA is 1.70% – April 29, 2021
- Mental Health, Equity Should Be Schools' Focus as Students Return, Report Says – April 29, 2021
- Is This the Year the California Legislature Closes the Digital Divide? – April 29, 2021

If you have any questions or require further information, please contact Kim Kelstrom at 457-3907.

Approved by Superintendent
Robert G. Nelson Ed.D. _____ Date: 05/07/21

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DATE: April 30, 2021

TO: Robert G. Nelson
Superintendent

AT: Fresno Unified School District

FROM: Your SSC Governmental Relations Team

RE: ***SSC's Sacramento Weekly Update***

Assembly Democrats Release Budget Priorities Blueprint

On Wednesday, April 28, 2021, the Assembly Democrats released their blueprint detailing their State Budget priorities for the 2021–22 fiscal year and beyond. For education, Assembly Democrats highlight the following as priorities:

- Budget for fully in-person, safe school instruction, transportation, and student supports
- One million more child care slots by 2025, universal transitional kindergarten, and expand after school access
- Accelerate workforce and college readiness as well as school construction
- Broadband: Eliminate gaps in service and make affordable
- Continue to build reserves and reduce liabilities
- Provide multiyear funding packages with one-time federal and state funds

This document comes out just weeks before Governor Gavin Newsom is set to release his revised 2021–22 State Budget proposal. Releasing this document now tells the Newsom Administration what the Assembly will be advocating for during the upcoming 2021–22 State Budget negotiations and allows the Administration to see how their priorities align with the Assembly's as they look to finalize the May Revision over the next several weeks.

Recall Proponents Reach Valid Signature Threshold

On Monday, April 26, 2021, the California Secretary of State's office announced that more than 1.6 million valid signatures had been received by county registrars—130,000 more than the roughly 1.5 million signatures needed to initiate an election that asks voters whether they would like to recall Governor Newsom. The next step of the recall process is the 30-business-day period in which voters who have signed the recall petition can request to remove their signature from the petition. County election officials are required to report any

withdrawn signatures to the Secretary of State within ten business days after the end of the signature withdrawal period.

Current polling shows Governor Newsom would likely survive the recall if the election were held today. March polling from the Public Policy Institute of California (PPIC) shows that Governor Newsom currently holds a 52% approval rating among likely voters and that 56% of likely voters would not recall the Governor if the election were held today. Additionally, PPIC's April Statewide Survey found that 58% of likely voters approve of the way that the Governor is handling the state's K–12 education system, which is likely to be one of the more significant issues during the recall campaign.

However, the election—should it be officially certified—will not be held until the fall, so there are still several months before voters will start casting their ballots. With the recall election hanging over the Governor's head, it will undoubtedly impact several key decisions that the Governor will have to make over the next several months including 2021–22 State Budget negotiations with the Legislature and the actions he takes on bills sent to him during the 2021 legislative year.

Leilani Aguinaldo

2021–22 Statutory COLA is 1.70%

By Dave Heckler
School Services of California Inc.'s *Fiscal Report*
April 29, 2021

Today, April 29, 2021, the U.S. Department of Commerce released the 2021 first quarter value of the Implicit Price Deflator for state and local government goods and services, which provides the last piece of information needed to establish the 2021–22 statutory cost-of-living adjustment (COLA) for K–14 education apportionments. Based on this data, we calculate the statutory COLA for 2021–22 to be 1.70%, a slight increase from Governor Gavin Newsom's State Budget estimate that projected the statutory COLA to be 1.50%.

Recall that the current enacted State Budget for 2020–21 provided zero COLA for the Local Control Funding Formula (LCFF) and other programs that would normally receive a COLA.

In January, to remedy the zero COLA for 2020–21, the Governor also proposed a compounded COLA to bring LCFF target rates up to where the rates would be had 2020–21's statutory 2.31% had been funded. Applying the 2021–22 statutory COLA to last year's unfunded COLA would provide a compounded COLA of 4.05%, assuming that Governor Newsom continues the policy he proposed in January.

The Governor is scheduled to release the May Revision no later than May 14 and will do so without the full knowledge of the full impact of the COVID-19 pandemic on 2020 tax receipts. This is due to the fact that personal income tax filings, and related payments, were extended from April 15 to May 17.

Note: A new report co-published by the Policy Analysis for California Education and others says schools should use their COVID-relief funding on mental health, equity, and relationships.

Mental Health, Equity Should Be Schools' Focus as Students Return, Report Says

By Carolyn Jones
EdSource
April 29, 2021

To help students readjust to life after the pandemic, schools should use their Covid-relief funding windfall to imbue mental health, equity and relationships into every aspect of the school day, according to a sweeping new report released Thursday.

"This is the biggest infusion of money into schools that many of us will see in our lifetimes. We're hoping educators take advantage of this moment to *not* go back to the way we were," said Christopher J. Nellum, interim executive director of the Education Trust-West, an Oakland nonprofit that advocates for equity in schools and one of more than a dozen groups that contributed to the report. "We should take a moment to explore what we can do that's exciting and innovative."

The report, "Reimagine and Rebuild: Restarting school with equity at the center," was co-published by Policy Analysis for California Education and an array of other groups, including the California PTA, the California Teachers Association, Association for California School Administrators and numerous social justice and youth advocacy groups.

California schools will receive more than $35.7 billion in state and federal pandemic funding over the next few months, which they can use to can pay for services like mental health counseling and tutoring for students. Although most of the funding is not permanent, schools can invest the money in some one-time ventures that could have lasting impacts, such as partnerships with mental health and community groups, said Heather Hough, executive director of PACE.

The report was based on interviews with teachers, administrators and researchers, as well as students of all backgrounds.

"In education, we talk a lot *about* students, but rarely do we talk *with* them. The brief was developed by working with Black, brown, Asian Pacific Islander and low-income students to lay out their blueprint for an education system that is built to support every student to thrive," said Taryn Ishida, executive director of Californians for Justice, which advocates for young people of color.

The report focuses on summer and the first six weeks of school but also calls for longer-term improvements in K-12 education.

"We acknowledge that people are exhausted. We can't do everything we need to do right away," Hough said. "But we also know that schools have not met the needs of a large group of students for a long time, and we need to start looking at long-term changes."

Noting that the pandemic disproportionately affected low-income students and students of color, the report urges schools to give extra help to those students — both academically and to meet their social and emotional needs.

The report also says that schools should focus on locating and re-engaging the estimated 130,000 students statewide who stopped attending school when classes shifted online and the thousands more who were chronically absent or otherwise disengaged.

The report suggests dozens of ideas, including:

- Home visits for teachers to meet families, outdoor activities, games and art projects, small group discussions and other activities to help students and teachers get to know each other;
- Regular mental health screenings and referrals to counselors for students who need extra support;
- Restorative practices — such as group discussions about student behavior — instead of traditional discipline. Schools should also eliminate police and security;
- A review of each student's academic and attendance record during the pandemic to see what specific help they need to catch up. An "individual learning plan" could include goals and progress benchmarks for every student;
- Tutoring for every student who needs it;

- Partnerships with community groups such as the Boys and Girls Club to provide fun activities over the summer and after school so that students can relax, reconnect with their friends and regain their social and communications skills;

- Curriculum "that allows students of all racial, ethnic and linguistic backgrounds to feel safe, acknowledged and respected." In addition, teachers should undergo training on how bias and privilege affects the classroom;

- New technology, books, art supplies, play equipment and other supplies to improve learning opportunities;

- Close attention to teachers' mental well-being. That includes ample time for planning, breaks throughout the day and opportunities to express their own needs;

- Partnerships with mental health organizations to provide extra assistance for students who need it;

- Streamlined curriculum. If teachers don't have time to cover all the content in a lesson, they should prioritize the main points instead of overwhelming students with tests and assignments.

Student well-being should be an urgent priority for every school reopening for in-person learning, Hough said.

"What we don't want to see is kids coming back to school and being hammered with instructional content," Hough said. "Kids cannot learn unless they have opportunities to connect with one another and feel seen and acknowledged as a whole person."

Note: The Legislature has introduced 20 bills related to broadband access and expansion, which has become a key issue due to parents working from home and students doing distance learning.

Is This the Year the California Legislature Closes the Digital Divide?

By Ben Christopher
CalMatters
April 29, 2021

It only took a global pandemic, a year spent working and studying at home and a once-in-a-generation spending blitz from the federal government, but 2021 might be the year that California finally goes big on broadband.

Expanding internet access has long been a cause that lawmakers of all stripes — Democrat and Republican, rural and urban — have been happy to get behind. Few, however, have been willing to actually prioritize it.

That might change this year, just so long as politics and industry resistance don't get in the way.

This time, there's plenty of money to throw at the problem, there's an undeniable sense of urgency to act and there's commitment to the cause coming from both the governor's office and legislative leadership.

"We've been talking about universal broadband since I've been in diapers," Gov. Gavin Newsom said at a recent press conference — maybe a slight overstatement from the 53-year-old chief executive. "I think we're just resolved to solve this once and for all."

Many state lawmakers seem to be thinking along the same lines. There are now 20 pending broadband-related bills — to boost state investments in unconnected areas, to make it easier for providers to lay fiber and hang wireless transmitters, to subsidize internet subscriptions for low-income Californians.

But even easy-to-fund, broadly popular measures can get chewed up in the California legislative process. Large internet providers, which have helped thwart earlier efforts, don't welcome new regulations or new sources of publicly-subsidized competition. Local governments are also pushing back on proposals to speed up the approval of infrastructure. Both groups are formidable lobbying forces in Sacramento.

"There are people who benefit from the existing system," said Geoff Neill, an analyst with the California State Association of Counties, which has made broadband a top priority. "I'm worried that we won't go big enough on this…(that) it won't be the kind of transformative change that we have a once-in-a-generation opportunity to effect here."

Greasing the skids

Lobbyists are used to making their case before lawmakers, but they rarely get to do so by example. Tracy Rhine got that opportunity, inadvertently, at the beginning of this year's legislative session.

Democratic state Sen. Lena Gonzalez of Long Beach was holding a virtual press conference to announce her "Broadband for All" bill, one of the higher profile digital divide proposals. Last year, version 1.0 of the proposal fizzled out, the victim of industry opposition, legislative infighting and a lawmaking schedule constrained by the coronavirus.

Rhine, who represents the Rural County Representatives of California, was invited to sing the new bill's praises. Calling from rural El Dorado County, she was audio-only. Her DSL was down, she explained. And her expensive but patchy backup satellite connection wasn't strong enough to carry the feed. Instead, her voice was coming in over her phone's data plan. And even then, only sometimes.

At the end of the event, she applauded the "really great information from all the speakers today on why…this….is…so…impor—," her voice breaking off with impeccable timing.

Rhine and her organization have been pushing for serious action on internet access for years. Now, for the first time, the rest of the state seems to be receptive to the message.

"Now with COVID, everyone is seeing it," she said in an interview. And with the influx of both state and federal money, "everyone sees the opportunity there too."

The federal COVID relief bill passed last month will be putting an extra $26 billion into the state budget — some of it available to broadband. The Biden administration and Congress are now hammering out a possible $2 trillion infrastructure package that includes $100 billion for broadband. A $568 billion Republican counter-proposal also includes a sizable chunk of change, $65 billion, for network deployment. Either way, more money could be on the way.

Even without the generosity of Uncle Sam, California is sitting on an unexpectedly comfy cushion of cash. Next month, Newsom will unveil his updated budget proposal, which he says will include "a substantial amount of money to adequately advance…the cause of universal broadband."

A study commissioned by the California Public Utility Commission put the price tag on building out high-speed internet infrastructure to every under-connected Californian at $6.8 billion.

Outside of state budget negotiations, lawmakers are pushing through what Ernesto Falcon, a lobbyist with the Electronic Frontier Foundation, calls a "blitzkrieg of legislative activity."

Broadband legislation "usually tinkers around the edges," said Falcon, whose organization is pushing for more public investment and management of internet infrastructure. Not so this year. "This many statewide rethinks at this scale? There's been nothing close to this before."

It's no wonder why. For many Californians weathering the pandemic, a stable, high-speed internet connection has meant the difference between getting an education, applying for a job, staying connected to family and friends, participating in local government meetings, seeing a doctor or snagging a vaccine appointment — or not.

Throughout the legislative session this year, one example has been cited by lawmakers more than any other: two children sitting in a Salinas parking lot doing their homework with Taco Bell WiFi.

It was a viral depiction of a divide that has been there for years. But as with so many of the state's inequalities, COVID has only made things worse — and harder to ignore.

As a CalMatters analysis found, the California public schools where many students don't have access to basic broadband service were also much more likely to have more students living in poverty. That was true before the pandemic.

Assemblymember Cecilia Aguiar-Curry, a Democrat from Winters in rural Yolo County who is working with Gonzalez on a broadband proposal, said she's been pounding the table on this issue for years.

"You might see those pictures of kids sitting outside a Taco Bell. Well, my kids have been sitting for 10 to 15 years in front of the library trying to connect."

One problem, many solutions

Dollar-for-dollar, the biggest broadband proposal is a bill by Torrance Democratic Assemblymember Al Muratsuchi that would put a $10 billion bond on the November 2022 ballot to fund new broadband infrastructure in underserved communities.

That price tag alone could make for some political difficulty when the state is already flush with cash. But there's another challenging wrinkle: The money would be reserved for cities, counties, tribal governments, school districts and other public entities that want to build out internet networks. Private corporations need not apply.

"Wouldn't it be wonderful," Muratsuchi explained at a recent press conference, "if we had the public broadband infrastructure where the state, the school districts, the communities — they would own this

broadband infrastructure? And then we can have the private internet service providers come in and pay, basically, a rent to gain access to that public broadband infrastructure?"

Naturally, the private internet service providers do not agree. Even some universal broadband advocates are skeptical.

Sunne Wright McPeak, president of the nonprofit California Emerging Technology Fund, called the proposal "mind boggling" and questioned whether it was wise to have public sector agencies that "have never been in the business…take a lot of billions of our dollars and go figure out how" to be internet service providers.

Another major funding proposal comes in two bills by Gonzalez and Aguiar-Curry that would put as much as $150 million per year into a state grant program that funds the construction of new broadband networks in unserved and underserved areas.

But the bills would also change the rules, effectively opening up grants to areas that are already served by some private companies, requiring state-funded networks to maintain higher speeds than most cable and DSL lines can provide and making it harder for current providers to stall new subsidized projects.

Carolyn McIntyre, president of the California Cable & Telecommunications Association, which represents industry giants including Comcast, Cox and Charter, said she has mixed feelings about the two bills.

"Competition is great. We support competition," she said in an interview. "What we don't support is government-subsidized competition."

Cable and wireless industry trade groups throw plenty of money around the Capitol. During the last legislative session, they collectively spent more than $1.6 million lobbying legislators and regulators. Since 2015, the two groups and the largest internet service providers have contributed more than $5.6 million to California campaigns.

McIntyre stressed that public investment should stay out of areas where there's already a "robust network…that has been built with private investment."

Distinguishing a "robust network" from one in which the private sector has failed and government needs to intervene is where the most contentious political battle is now taking place.

"We're not fighting the providers," said Sara Bachez, a lobbyist with the California Association of School Business Officials, which supports all three funding bills. "We're just saying, if you're not going to take it on, then help us do it."

Other advocates are a little more direct in their criticism.

"The internet service providers are so short-sighted as to almost have screwed this up royally once again," said McPeak.

McPeak, who served as Business, Consumer Services and Housing Agency secretary under Gov. Arnold Schwartzenegger and who describes herself as a "fierce capitalist," points the finger specifically at the corporate suites of five major providers for failing to invest in rural areas and then resisting change: AT&T, Charter, Comcast, Verizon and Frontier.

"It's basically five men who stand in the way of getting to digital equity and they are headquartered in Dallas, New York, Philadelphia, New Jersey and Connecticut," she said.

Less carrot, more stick

Underlying much of the debate around broadband during the pandemic is a fundamental disagreement about what role internet access plays in society.

In a hearing earlier this month, Democratic state Sen. Anna Caballero from Salinas likened the push for broadband to the New Deal crusade to build out the electrical grid across America in the 1930s.

Then, as now, political leaders realized a lack of access to a highly capital intensive service was miring swaths of the country in poverty. And it took a cataclysmic national crisis — then the Great Depression, now the pandemic — to spur the federal government to fill in gaps left by the private sector.

"What we did as a country is we made an investment in the infrastructure in order to be able to connect people everywhere," said Caballero. "We have to do the same thing in the broadband sector as well."

She was speaking in favor of her bill that would require internet providers to give state regulators detailed information about who is covered and where.

While the bond and subsidy bills provide carrots for more investment, Caballero's proposal packs a stick. All cable companies hold franchise agreements with the state allowing them to operate in certain areas. If they are found to be selectively offering internet service to some people and not others — what Caballero and other advocates liken to discriminatory "redlining" — the bill would give regulators the right to revoke their licenses.

The cable industry is adamantly opposed. McIntyre said that state regulators don't have the legal authority. And even if it was legal, she said, it could be counterproductive, leading cable companies to pull out of some markets.

The cable industry is supporting its own legislation this year that would authorize the state government to buy broadband service from current providers on behalf of school districts and public housing.

Millions of Californians live in areas with high-speed networks, but don't have the money or know-how to log on, McIntyre said. Making it cheaper and easier for potential subscribers to connect could be done "within a couple of months."

Neill, the analyst with the California State Association of Counties, which supports Caballero's bill, said getting the state to pay for existing services isn't good enough.

If the only policy the current providers support "is for the government to give them money" without introducing more competition or regulation, "that's not a very good option," he said.


A "blitzkrieg" of broadband bills
There are 20 "digital divide" bills moving through the Capitol. These are the biggies.
Investment
SB 4 & AB 14
Sen. Lena Gonzalez & Assemblymember Cecilia Aguiar-Curry
AB 34
Assemblymember Al Muratsuchi
Streamlining
SB 378
Sen. Lena Gonzalez
SB 556
Sen. Bill Dodd
AB 537
Assemblymember Gil Cuin
Regulation
SB 28
Sen. Anna Caballero
Affordability
AB 1176
Assemblymembers Eduardo Garcia & Miguel Santiago
AB 1560
Assemblymember Tom Daly
SB 743
Sen. Steven Bradford
CAL MATTERS

Not on my telephone pole

Another political roadblock this year should be familiar to anyone who has followed California's housing crisis: Expanding broadband requires digging trenches, erecting towers and hooking up transmitters. And not everyone wants to make it easy to build.

A raft of bills sponsored by fiber builders and wireless internet providers would force local governments to speed up their permitting for new broadband infrastructure.

Those are all welcome changes for industry groups, who argue that the state's patchwork of local regulations and processes slows deployment and raises costs. They're also supported by a coalition of labor organizations, school districts and economic development groups.

But many local governments argue that these measures could jeopardize their ability to ensure new infrastructure is done safely and efficiently. The League of California Cities has taken particular issue with a bill by Democratic Sen. Bill Dodd of Napa that would make it easier for companies to hang wireless internet transmitters on street lights and traffic poles.

In a letter to its members, the league called it "an attempt by the telecommunications industry to undermine local authority while making no meaningful progress towards closing the digital divide."

But between the demands of industry and local governments, some advocates see potential for compromise.

McPeak of the California Emerging Technology Fund said making it easier for telecommunication companies to build out their infrastructure is worthwhile. "Provided they're going to build where we need the service — as well as where they can make a lot of money."

Fresno Unified School District
Board Communication

BC Number AS-2

From the Office of the Superintendent
To the Members of the Board of Education
Prepared by: Santino Danisi, Chief Financial Officer
Cabinet Approval:

Date: May 07, 2021

Phone Number: 457-6225

Regarding: Benefit Plan Options and Modeling

The purpose of this communication is to provide the Board information related to the Joint Health Management Board (JHMB) meeting on April 22, 2021. In anticipation of a one-time $8.0 million contribution from the Unrestricted General Fund, the agenda included an item for collaborative discussion on how funding might be used to benefit employees during the pandemic and recovery.

Despite having seventeen separate benefit plan change options and financial modeling prepared for consideration, labor voted immediately to approve changes to Plan A and C to have 95/5 coinsurance coverage without any opportunity for discussion. Management voted no and therefore the item was not approved. The seventeen items had previously been agreed upon as potential items for consideration for plan enhancement by both labor and management.

Included with the attached backup is a summary of the seventeen different options. The next regularly scheduled JHMB meeting is on May 20, 2021.

If you have any questions or require further information, please contact Santino Danisi at 457-6225.

Approved by Superintendent
Robert G. Nelson Ed.D. _____ Date: 05/07/21

MARSH & McLENNAN AGENCY

Joint Health Management Board
Fresno Unified School District

AGENDA ITEM
SUMMARY

JHMB MEETING DATE:	April 22, 2021
SUBJECT:	Plan Benefit Options and Modeling
PREPARED BY:	Giovanni Pacheco
STATUS:	☒ Information ☐ Action

The following provides a series of plan benefit options for the JHMB's consideration. It encompasses plan improvements across multiple coverages including *medical, dental, and vision.* Within each of the categories you'll find options in an "a-la-carte" format but also options where pairings have already been made with the corresponding aggregate cost impact. Plan pairings **outside of what's exhibited** may change the percent increment(s) and aggregate claim cost. Also, please keep in mind that the annualized estimates are based on current enrollment counts, therefore, should the population change, the annual estimates will change as well. The assumed enrollment count is provided below.

The plan options you'll find in the following pages is summarized below:

MEDICAL	DENTAL	VISION
Plan A and C to 95/5	Improve Annual Maximum	Improve Vision Exam Copay
Plan A and C to 100/0	Cover Dental Implants	Improve Frame and Elective Contact Lense Allowance
Plan B to 75/25	Include Orthodontia	Choice of Progressive Lense Allowance/Anti-Reflective
Plan B to 80/20	Change to Delta Incentive Plan	
Office Visit Copay Improvement	Evaluate Both Delta Dental and UHC	
OOP Maximum Improvement		
Deductible Decrease		
Include Hearing Aid Coverage		
Improve Dual Spouse Coverage (PENDING)		
Report OOP and Deductible Utilization (PENDING)		

As noted above, enrollment assumptions were used in calculating the following cost estimates. The enrollment counts for the medical plans A and B are noted below. Kaiser, Dental and Vision enrollment is displayed on their respective exhibits.

It's worth noting that as far as your PPO medical plans are concerned, the JHMB has a total of 12,378 active employees and retirees covered. 91% of those enrollees are in PPO Plan A.

Here is the current PPO enrollment breakdown:

	EMP	ESP	ECH	FAM	Grand Total
2021/01	**4847**	**3541**	**1218**	**2772**	**12378**
Active	**2309**	**987**	**1140**	**2583**	**7019**
880 Plan A	1775	888	1027	2370	6060
880 Plan B	534	99	113	213	959
COBRA	**29**	**2**	**1**	**3**	**35**
880 Plan A	27	1	1	3	32
880 Plan B	2	1			3
O65	**2301**	**2250**	**34**	**91**	**4676**
880 Plan A	2286	2216	33	84	4619
880 Plan B	15	34	1	7	57
U65	**208**	**302**	**43**	**95**	**648**
880 Plan A	199	277	42	87	605
880 Plan B	9	25	1	8	43

Finally, at the end of the plan options overview, you'll find your Benefits Information Guide (BIG) which summarizes your medical, dental and vision plans. There are a number of options for consideration and reviewing the current coverage in the BIG will be helpful in your evaluation of the options presented.

We look forward to reviewing the following options and addressing your questions.

NOTE: WellPath and Pharmacy plan options are being presented separately by Delta Team Care and Claremont Partners respectively and are not exhibited in the following pages.

PPO MEDICAL PLAN OPTIONS (90%/70%)

Fresno Unified School District

2022 Plan Option Estimated Costs

Plan A	Plan Design Factor	Estimated Medical Claim Impact 2022	2023	2024
Option 1: Leave In Network Coinsurance at 90%	0.00%	$0	$0	$0
Option 2: Coinsurance at 90% AND Decrease In Network OOP Max to $1,250/$2,500	1.85%	$1,746,641	$1,816,507	$1,889,167
Option 3: Coinsurance at 90%, Decrease In Network Deductible to $200/$400	0.45%	$420,558	$437,381	$454,876
Option 4: Coinsurance at 90% AND Decrease OV Copay to $10	0.16%	$152,946	$159,064	$165,426
Option 5: Coinsurance at 90% AND Decrease ER Copay to $75	0.05%	$45,597	$47,421	$49,318
Option 6: Coinsurance at 90% AND Decrease UC Copay to $25	0.02%	$16,199	$16,847	$17,520
Option 7: Coinsurance at 90% AND Decrease Outpatient Surgery Copay to $75	0.02%	$18,854	$19,609	$20,393
Option 8: Coinsurance at 90% AND Add Hearing Aid Benefit	0.04%	$41,239	$42,888	$44,604

Plan B	Plan Design Factor	Estimated Medical Claim Impact 2022	2023	2024
Option 1: Leave In Network Coinsurance at 70%	0.00%	$0	$0	$0
Option 2: Coinsurance at 70% AND Add Hearing Aid Benefit	0.04%	$2,102	$2,186	$2,273

PPO MEDICAL PLAN OPTIONS (95%/75%)

Fresno Unified School District

2022 Plan Option Estimated Costs

Plan A	Plan Design Factor	Estimated Medical Claim Impact 2022	2023	2024
Option 1: Increase In Network Coinsurance from 90% to 95%	1.53%	$1,441,783	$1,499,455	$1,559,433
Option 2: Coinsurance at 95% AND Decrease In Network OOP Max to $1,250/$2,500	2.59%	$2,442,979	$2,540,698	$2,642,326
Option 3: Coinsurance at 95%, Decrease In Network Deductible to $200/$400	2.03%	$1,913,135	$1,989,660	$2,069,247
Option 4: Coinsurance at 95% AND Decrease OV Copay to $10	1.71%	$1,618,099	$1,682,823	$1,750,136
Option 5: Coinsurance at 95% AND Decrease ER Copay to $75	1.58%	$1,496,333	$1,556,186	$1,618,434
Option 6: Coinsurance at 95% AND Decrease UC Copay to $25	1.55%	$1,459,866	$1,518,261	$1,578,991
Option 7: Coinsurance at 95% AND Decrease Outpatient Surgery Copay to $75	1.55%	$1,467,981	$1,526,700	$1,587,768
Option 8: Coinsurance at 95% AND Add Hearing Aid Benefit	1.57%	$1,484,263	$1,543,634	$1,605,379

Plan B	Plan Design Factor	Estimated Medical Claim Impact 2022	2023	2024
Option 1: Increase In Network Coinsurance from 70% to 75%	1.20%	$59,637	$62,023	$64,503
Option 2: Coinsurance at 75% AND Add Hearing Aid Benefit	1.24%	$61,823	$64,295	$66,867

PPO MEDICAL PLAN OPTIONS (100%/80%)

Fresno Unified School District

2022 Plan Option Estimated Costs

Plan A	Plan Design Factor	Estimated Medical Claim Impact 2022	2023	2024
Option 1: Increase In Network Coinsurance from 90% to 100%	4.37%	$4,126,952	$4,292,030	$4,463,711
Option 2: Coinsurance at 100% AND Decrease In Network OOP Max to $1,250/$2,500	4.37%	$4,130,635	$4,295,861	$4,467,695
Option 3: Coinsurance at 100%, Decrease In Network Deductible to $200/$400	4.92%	$4,649,465	$4,835,443	$5,028,861
Option 4: Coinsurance at 100% AND Decrease OV Copay to $10	4.59%	$4,334,423	$4,507,799	$4,688,111
Option 5: Coinsurance at 100% AND Decrease ER Copay to $75	4.44%	$4,193,445	$4,361,183	$4,535,630
Option 6: Coinsurance at 100% AND Decrease UC Copay to $25	4.39%	$4,147,034	$4,312,915	$4,485,432
Option 7: Coinsurance at 100% AND Decrease Outpatient Surgery Copay to $75	4.41%	$4,164,179	$4,330,747	$4,503,976
Option 8: Coinsurance at 100% AND Add Hearing Aid Benefit	4.42%	$4,171,053	$4,337,895	$4,511,411

Plan B	Plan Design Factor	Estimated Medical Claim Impact 2022	2023	2024
Option 1: Increase In Network Coinsurance from 70% to 80%	2.53%	$125,550	$130,572	$135,795
Option 2: Coinsurance at 80% AND Add Hearing Aid Benefit	2.57%	$127,800	$132,912	$138,228

KAISER MEDICAL PLAN OPTIONS

Kaiser Permanente HMO — 1,074 Subscribers
Current Estimated Annual Premium — $14,266,000

	2021 Current Benefit	2022 Proposed Benefit	Estimated Cost of Benefit % of Premium	Estimated Cost of Benefit Annual
Deductible	$250 per person $500 per family	$200 per person $400 per family	0.45%	$64,197
Out-of-Pocket Max	$2,500 per person $5,000 per family	$1,250 per person $2,500 per family	1.31%	$186,885
Office Visit/Urgent Care	$15 copay	$10 copay	0.78%	$111,275
Generic Rx	$5 copay	$0 copay	1.71%	$243,949
Coinsurance	90%	95%	1.36%	$194,018
Inpatient & ER Coinsurance	90%	Inpatient: 100% ER: $50	2.26%	$322,412
Hearing Aid Benefit	Not covered	$1,000	0.18%	$25,679
		$2,000	0.35%	$49,931
		$2,500	0.43%	$61,344
		$3,000	0.51%	$72,757

Please note:
Costs are estimates. Actual rate increments may vary based on 2022 renewal from Kaiser.
Excludes Senior Advantage plan
Adding options together will require recalculation of rate increments.

MES VISION PLAN OPTIONS

MES Vision Plan — 9,407 Subscribers
Current Estimated Annual Premium — $1,250,755

	2021 Current Benefit	2022 Proposed Benefit	Estimated Cost of Benefit % of Premium	Estimated Cost of Benefit Annual
Vision Exam	$5 copay	$0 copay	1.81%	$22,577
Frame and Elective Contact Lens Allowance	$130	$175	12.36%	$154,651
Choice of: Progressive Lens Allowance Anti-Reflective Lenses	$90 max copay Not covered	$130 max copay Covered	9.03%	$112,884

Adding options together will require recalculation of rate increments.

DELTA DENTAL PLAN OPTIONS

Delta Dental PPO 10,046 Subscribers
Expected 2021 Claims $7,811,000

	2021 Current		2022 Proposed		Estimated Cost of Benefit	
	PPO Providers	Other Providers	PPO Providers	Other Providers	%	Annual $
Dental Implants	Not Covered		50% *Included in regular plan max*	50%	3.75%	$292,913
Annual Maximum Benefit			$2,000	$1,000		
Dental Implants	Not Covered		50% *Separate implant max*	50%	4.50%	$351,495
Annual Maximum Benefit			$2,000	$1,000		
Annual Maximum Benefit	$2,000	$1,000	$2,500	$1,000	3.40%	$265,574
			$3,000	$1,000	5.50%	$429,605
Orthodonia - Adults & Children	Not Covered		50% *Separate ortho max*	50%	8.40%	$656,124
Lifetime Maximum Benefit			$2,000	$1,000		
Orthodonia - Children Only	Not Covered		50% *Separate ortho max*	50%	5.50%	$429,605
Lifetime Maximum Benefit			$2,000	$1,000		
Change to Incentive Plan			70% - 100%	70% - 100%		
based on year in dental plan	100% PPO	50% Non-PPO	$1,500	$1,500	7%	$546,770
	$2,000	$1,000	$2,000	$2,000	17%	$1,327,870
			$2,000	$1,500	11.0%	$859,210

Adding options together will require recalculation of rate increments.

UHC DENTAL PLAN OPTIONS (summary attached)

UHC Dental 995 Subscribers
Current Estimated Annual Premium $607,985

	2021 Current Benefit	2022 Proposed Benefit	Estimated Cost of Benefit % of Premium	Annual
Dental HMO	Custom Plan	Plan 1065	19.32%	$117,490

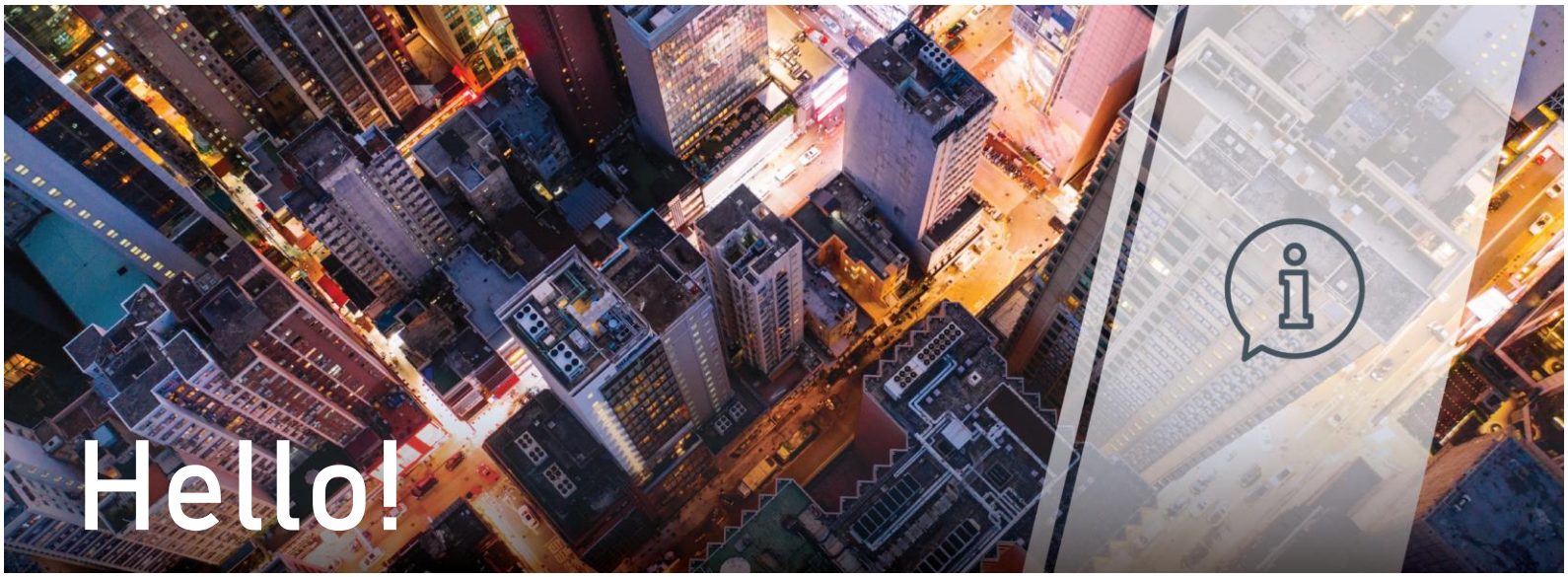
Plan 1065 eliminates copays, except those for implants (copays up to $1,950 per tooth), orthodontia ($1,250 copay for standard treatment), upgrades on materials for crowns.

Joint Health Management Board

Fresno Unified School District

2021 Benefits Information Guide

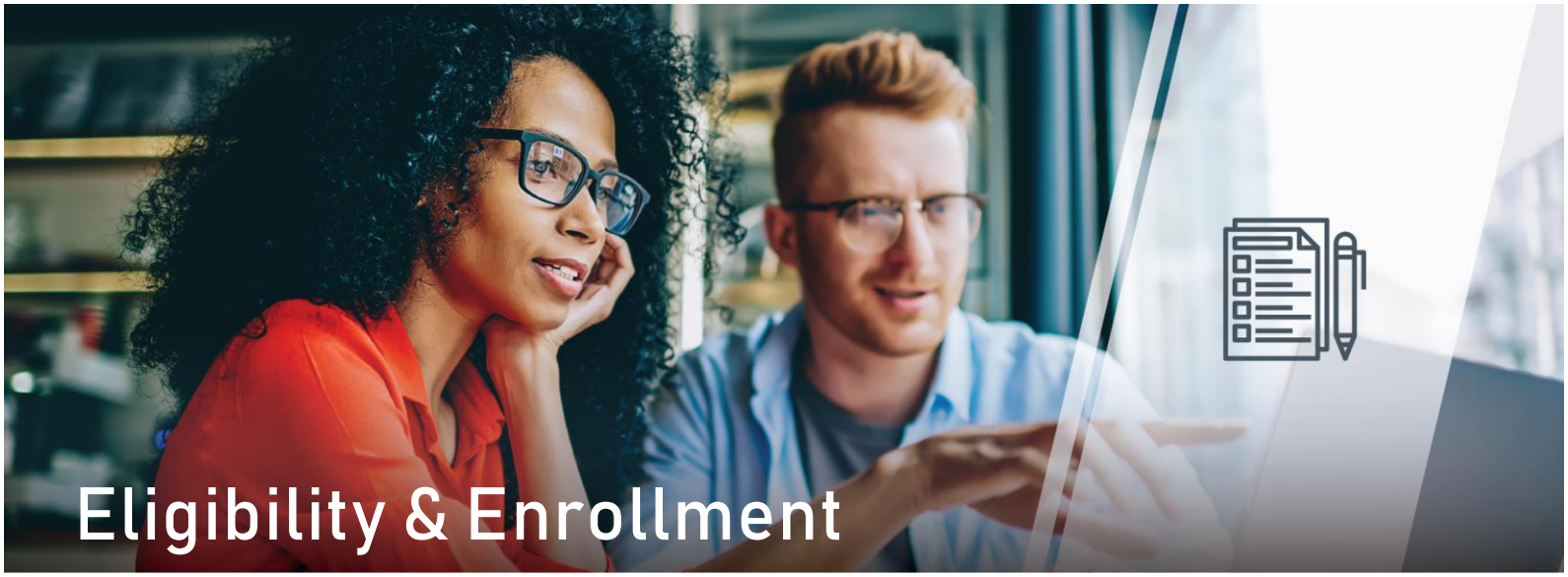
Understanding your Options



Welcome to your 2021 Benefits Information Guide! Since 2006, Fresno Unified School District's Joint Health Management Board has worked tirelessly to manage and maintain the highest quality health and wellness benefits on behalf of the District's employees. Comprised of members from several District groups, including management and union representatives, the Board promotes informed and proactive health and wellness decisions to ensure that our plan participants are responsible healthcare consumers.

This Benefits Information Guide is your initial resource to understanding and selecting the best benefit options for you and your family. We encourage you to review this booklet in its entirety to learn more about eligibility, how to enroll or make changes when applicable, each benefit available to you as an eligible employee, summaries of covered benefits and how to contact each insurance carrier if you need assistance.

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



Eligibility & Enrollment

If you are a new employee or you are re-evaluating your choices as a continuing participant, the benefits program offers a variety of coverage options that are available to you.

Who Can Enroll?

Permanent employees working a minimum of 4 hours a day or 20 hours a week are eligible to participate in the benefits program. Eligible employees may also choose to enroll family members, including a legal spouse/state registered domestic partner and/or children.

Children are considered eligible if they are your or your spouse's/state registered domestic partner's:

- Biological child, stepchild or adopted child
- Child subject to a Qualified Medical Child Support Order (QMCSO)
- Child under permanent legal guardianship up until it ceases due to child's legal age attainment, death, marriage, military enlistment, adoption or any other reason declared by a court
- Child of any age if they are incapable of self-support due to a physical or mental disability that existed prior to such child reaching the age of 26

When Does Coverage Begin?

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

New full-time employees who do not actively make benefit elections during their initial eligibility period will be automatically enrolled with "Employee Only" coverage in Medical Plan A, Delta Dental PPO, MES Vision and Standard Basic Life Insurance plans. Employees must complete enrollment forms to add coverage for dependents, or select alternate plans.

New part-time employees that work less than 20 hours a week may enroll in the UnitedHealthcare Dental HMO and/or MES Vision Plan at their own expense.

Your enrollment choices remain in effect through the end of the benefits plan year, January 1, 2021 – December 31, 2021.

How do I Enroll?

Joint Health Management Board
Fresno Unified School District

Paper Enrollment/Contact Benefits Department

- After reviewing your options, complete the paper enrollment forms and return to the Benefits Department. Forms are located inside your Benefits' Packet.
- If you have questions when completing your enrollment forms, contact the Benefits Department at 559.457.3520.

TIP

If you miss the enrollment deadline, you may not enroll in a benefit plan unless you have a change in status during the plan year. Please review details on HIPAA Special Enrollment Rights qualified change in status events for more information.

Changes During the Year

If you are declining enrollment for your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll your dependents in this Plan if your dependents lose eligibility for that other coverage (because of separation/divorce, termination of employment or reduction in hours, death or cessation of employer contribution), or if your dependents were receiving COBRA coverage and their eligibility for COBRA has expired. However, you must request enrollment within 31 days after your dependents' other coverage ends.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll your new dependents. If you are enrolling a new dependent as a result of birth, adoption or placement for adoption, you can also enroll your Spouse or State Registered Domestic Partner if he or she was not previously enrolled in the Plan, but only if he or she is otherwise eligible to participate in the Plan.

Special enrollment rights may also exist in the following circumstances:

- If your dependents experience a loss of eligibility of Medicaid or a State Children's Health Insurance Program ("SCHIP") coverage and you request enrollment within 60 days after that coverage ends; or
- If your dependents become eligible for a state premium assistance subsidy through Medicaid or a SCHIP program with respect to coverage under this Plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

To request Special Enrollment or to obtain more information, contact the District's Benefits Department at **559.457.3520**.

Paying for Coverage

Fresno Unified School District and the Joint Health Management Board strive to provide you with a valuable benefits package at a reasonable cost. Based on your benefit selections and coverage level, you may be required to pay for a portion of the cost. The Cost of Coverage section in this guide outlines the rate and frequency of the payroll deduction for each benefit.

No Opting Out

All eligible active District employees shall be required to participate in the Health Care Plan and pay the monthly contributions and assessments, at least at the Employee Only level, for the Plan(s) or coverage. You will automatically be enrolled in Medical Plan Option A, Delta Dental, MES Vision and Basic Life Insurance. Coverage for your dependent(s) and/or choosing an alternate plan is available at your expense.

It is important to note that if coverage is waived for your dependents, the next opportunity to enroll in our group benefit plans would be the next open enrollment or when a special enrollment event occurs.

What Are My Options?

Fresno Unified School District and the Joint Health Management Board offer two PPO plan options, Medical Plan A and Medical Plan B, administered by Delta Health Systems and utilizing the Anthem Blue Cross provider network, and one Deductible HMO plan, administered by Kaiser Permanente.

To help guide your plan selection, the following pages include details concerning how the plans operate, as well as plan highlights. Please note, if there is a discrepancy between the information in this Benefits Information Guide, and the Plan Booklet/Evidence of Coverage (EOC) document, the Plan Booklet and EOC will prevail. For your reference, an illustration of employee contibutions is listed in the Cost of Coverage section of this guide.

Using a PPO plan

With a Preferred Provider Organization (PPO) plan, you have greater flexibility and choice to use both in-network and out-of-network providers. However, you are encouraged to receive services from the Anthem Blue Cross network doctors, specialists and facilities. By doing so, you obtain a higher level of benefit than if services were rendered from an out-of-network provider. Also, claim forms are submitted to the plan on your behalf when services are received from within the network. Additional information regarding use of a PPO plan includes:

- You and any enrolled dependent(s) are permitted to visit any doctor or facility without a referral from a Primary Care Physician (PCP)
- Certain services, such as doctor's visits, may require fixed-dollar payment up front, referred to as a copayment
- Before the plan will pay certain medical expenses, you may be required to pay a plan specific amount, referred to as a deductible
- Once the deductible has been fulfilled, the plan will pay a large percentage of the cost of your care, known as coinsurance. You are then financially responsible for the remaining cost up to the out-of-pocket maximum.

You can find an Anthem provider by going online to www.anthem.com/ca. Click on **Individual & Family**, then select **Find Care** under the **Care** menu. Click on **Search as Guest** and select the type of care, **California** for your state, **Medical (Employer-Sponsored)** for your type of plan and **Blue Cross PPO (Prudent Buyer) - Large Group** as your plan/network. Then click continue, and enter the type of provider, specialty or provider's name and location, and click **Search**. From the search results screen, you can find provider contact information, and email or print the results.

Using a Deductible HMO Plan

As a member of the Kaiser Permanente Health Maintenance Organization (HMO), you will receive your medical care from an integrated network of physicians and specialists at a medical office, medical center, or affiliated hospital near you. Additional information regarding use of the Kaiser Permanente HMO Deductible plan includes:

- You may choose a primary care physician for you or your family members at kp.org/chooseyourdoctor or receive assistance in selecting a doctor or scheduling your first appointment by calling **800.278.3296**
- Initial referrals for most specialty care services will be coordinated by a Kaiser Permanente physician. However, many departments such as OB/GYN, Optometry, Psychiatry and Additional Medicine are self-referred
- There is a deductible with the Kaiser Permanente HMO plan; however, there are no claim forms to submit unless you receive emergency services outside of a plan facility
- Preventive care services are covered at 100%

A summary of covered services under the Kaiser Permanente HMO Deductible plan is listed on the following pages. For a complete listing of covered services for each plan, please refer to your Evidence of Coverage (EOC) or Plan Booklet.

Medical (Continued)

Kaiser Permanente – On the Go!

The KP mobile app gives you a suite of tools to use on the go! Use this application with your Kaiser Permanente user ID and password to:

- See your health history at your fingertips
- Refill prescriptions for yourself or another member
- Check the status of your prescription order
- Schedule, view, and cancel appointments
- Access your message center to email your doctor or another KP department
- Find KP locations and facilities near you

Search for Kaiser's mobile app in the App Store or Google Play to get started!

Free Preventive Health Care

The Federal Health Care Reform law requires insurance companies to cover in-network preventive care services in full, saving you money and helping you maintain your health. Such preventive services include:

- Preventive care doctor's visits
- Annual checkups
- Well-baby and child visits
- Several types of immunizations and screenings

To confirm your preventive care services are covered, refer to your Plan Booklet or associated Evidence of Coverage.

Informing You of Health Care Reform

California residents are required to have minimum essential health coverage. You can obtain health insurance through our benefits program or purchase coverage elsewhere, such as a State or Federal Health Insurance Exchange.

For information regarding Health Care Reform, please visit www.cciio.cms.gov. For information regarding the Individual Mandate in the state of California, please refer to the State of California Franchise Tax Board or visit their website at https://www.ftb.ca.gov/. You can also visit www.coveredca.com to review information specific to the Covered California State Health Insurance Exchange.

Prescription Drug Coverage

Many FDA-approved prescription medications are covered through the benefits program. Important information regarding your prescription drug coverage is outlined below:

PPO Medical Plans A and B:

- Prescription drugs are administered through Elixir using the "Select Formulary"
- The Elixir plan includes a four-tier prescription benefit. Tiered prescription drug plans require varying levels of payment depending on the drug's tier and your copayment or coinsurance will be higher with a higher tier number.
    - **Tier 1** includes generic drugs for high blood pressure, high cholesterol, depression and diabetes
    - **Tier 2** includes generic drugs. Generic drugs are required by the FDA to contain the same active ingredients as their brand-name counterparts
    - **Tier 3** includes preferred brand name drugs
    - **Tier 4** includes non-preferred brand name drugs
- If you purchase a brand name prescription when there is a generic equivalent available, you will pay the brand copay plus the difference in cost between the brand name and the generic. Exceptions are available if the brand name medication is authorized as medically necessary by Elixir.
- Up to a 90-day supply available at retail or through mail order.
- Maintenance medication refills are required to be dispensed in a 90-day supply by a pharmacy in the Rx90 network (Elixir Pharmacy, Rite Aid, Walgreens or Costco retail pharmacy). If you are currently taking a maintenance medication, you will need to have your prescription transferred to an Rx90 network pharmacy. For a list of maintenance medications, please visit www.ElixirSolutions.com.

Deductible HMO Plan C:

- The Kaiser Rx plan includes a two-tier prescription benefit.
    - **Tier 1** includes generic drugs. Generic drugs are required by the FDA to contain the same active ingredients as their brand-name counterparts.
    - **Tier 2** includes preferred brand name drugs. Non-preferred brand name and specialty drugs are covered under Tier 2 if approved through an exception process.
- Up to a 30-day supply available at retail, and up to a 100-day supply through mail order.
- For a Kaiser formulary prescription drug list(s) or more information on the mail order service, go to www.kp.org/formulary

WHY PAY MORE?

There are a few ways you can save money when using the Prescription Drug Plan:

Mail Order

Save time and money by utilizing a mail order service for maintenance medications. A 90 or 100-day supply of your medication will be shipped to you, instead of a typical 30-day supply at a walk-in pharmacy.

Shop Around

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

Explore Over-the-Counter Options

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

Plan Highlights	Anthem Blue Cross Plan A		Anthem Blue Cross Plan B	
	In-network	**Out-of-network(1)**	**In-network**	**Out-of-network(1)**
Annual Calendar Year Deductible				
Individual	$250	$750	$1,000	$3,000
Family	$500	$1,500	$2,000	$6,000
Maximum Calendar Year Out-of-pocket	Medical/Mental Health	Medical Only	Medical/Mental Health	Medical Only
Individual	$2,100	$10,000	$5,700	$12,000
Family	$4,200	$20,000	$11,400	$24,000
Lifetime Maximum	Unlimited		Unlimited	
Professional Services				
Primary Care Physician (PCP)	$15 Copay + 10%	40%	$25 Copay + 30%	50%
Specialist	$15 Copay + 10%	40%	$25 Copay + 30%	50%
Preventive Care Exam	No Charge(2)	Not Available(4)	No Charge(2)	Not Available(4)
Well-baby Care (first 5 years)	No Charge(2)	Not Available(4)	No Charge(2)	Not Available(4)
Diagnostic X-ray and Lab	10%	40%	30%	50%
Complex Diagnostics (MRI/CT Scan)	10%	40%	30%	50%
Therapy(3), including Physical, Occupational and Speech	10%	40%	30%	50%
Hospital Services				
Inpatient(3)	10%	40%	30%	50%
Outpatient Surgery(3)	$100 Copay + 10%	Not Available(4)	$100 Copay + 30%	Not Available(4)
Emergency Room	$100 Copay + 10% (copay waived if admitted)		$100 Copay + 30% (copay waived if admitted)	
Urgent Care	$35 Copay + 10%	$35 Copay + 40%	$35 Copay + 30%	$35 Copay + 50%
Maternity Care	Dependent children are only covered for preventive care services			
Physician Services (prenatal or postnatal)	$15 Copay	40%	$25 Copay	50%
Hospital Services	10%	40%	30%	50%
	Mental Health & Substance Abuse services administered through Halcyon Behavioral Health			
Mental Health & Substance Abuse	Pre-Authorization required by Halcyon Behavioral Health for all mental health and substance abuse services. See page 10 for more details.			
	Chiropractic & Acupuncture services administered through PhysMetrics			
Chiropractic & Acupuncture	See page 10 for more details.			
	Prescription Drug Coverage administered through Elixir			
Prescription Drug Maximum Calendar Year Out-of-pocket	$400/individual $800/family	N/A	$900/individual $1,800/family	N/A
Retail and Mail Order Prescription Drugs (30-day supply)				
Tier 1 Generic Drugs	$0 Copay	Not Covered	$0 Copay	Not Covered
Tier 2 Generic Drugs	$10 Copay		$10 Copay	
Tier 3 Preferred Brand Name	$35 Copay		$35 Copay	
Tier 4 Non-Preferred Brand Name	$50 Copay		$50 Copay	
Retail and Mail Order Prescription Drugs (90-day supply)				
Tier 1 Generic Drugs	$0 Copay	Not Covered	$0 Copay	Not Covered
Tier 2 Generic Drugs	$20 Copay		$20 Copay	
Tier 3 Preferred Brand Name	$70 Copay		$70 Copay	
Tier 4 Non-Preferred Brand Name	$100 Copay		$100 Copay	

(1) Member pays coinsurance applicable to Usual, Customary and Reasonable (UCR) rate.
(2) Plan deductible waived.
(3) Requires pre-authorization. For physical therapy services, pre-authorization required exceeding 6 visits.
(4) Plans Not Available for California residents only. Plan A: Non-California residents – 60% UCR. Plan B: Non-California residents – 50% UCR.

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

Plan Highlights

Kaiser Deductible HMO Plan C

	In-Network Only
Annual Calendar Year Deductible	
Individual	$250
Family	$500
Maximum Calendar Year Out-of-pocket	
Individual	$2,500
Family	$5,000
Lifetime Maximum	
Individual	Unlimited
Professional Services	
Primary Care Physician (PCP)	$15 Copay(1)
Specialist	$15 Copay(1)
Preventive Care Exam	No Charge(1)
Well-baby Care (First 23 months)	No Charge(1)
Diagnostic X-ray and Lab	$10 Copay
Complex Diagnostics (MRI/CT Scan)	10% up to $50 Copay per procedure
Therapy, including Physical, Occupational and Speech	$15 Copay
Hospital Services	
Inpatient	10%
Outpatient Surgery	10%
Emergency Room	10%
Urgent Care	$15 Copay(1)
Maternity Care	
Physician Services (prenatal or postnatal)	No Charge(1)
Hospital Services	10%
Mental Health & Substance Abuse	
Inpatient	10%
Outpatient	Individual visit: $15 Copay(1) Group visit: $7 Copay (Mental Health)(1) / $5 Copay (Substance Abuse)(1)
Vision Care	
Routine Eye Exams with a Plan Optometrist	No Charge(1)
Eyeglasses or contact lenses every 24 months	Allowance up to $175(1)
Retail Prescription Drugs (Up to a 30-day supply)	
Generic Drugs	$10 Copay
Preferred Brand Name Drugs	$35 Copay
Mail Order Prescription Drugs (Up to a 100-day supply)	
Generic Drugs	$20 Copay
Preferred Brand Name Drugs	$70 Copay

(1) Deductible Waived

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

Supplemental Services

Mental Health & Substance Abuse

If you are enrolled in Medical Plan Option A or B, your mental health & substance abuse coverage is through Halcyon Behavioral Health. Pre-authorization is required for all mental health and substance abuse services. If you are enrolled in Medical Plan Option C, your coverage is through Kaiser.

Halcyon Behavioral Health Plan Highlights	Medical Plan Options A or B
Mental Health Services	
Inpatient[1]	Covered at 100% as certified medically necessary Inpatient, partial and day treatment 45 units/calendar year/ member
Outpatient	$10 Copay per visit 60 visits/calendar year/ member
Substance Abuse Services	
All levels of substance abuse	Covered at 100% as certified medically necessary

[1] Deductible Waived

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

Chiropractic & Acupuncture

When you're seeking relief from pain caused by an accident, injury, or muscle strain, or just looking for a natural healthcare approach, our Chiropractic and/or Acupuncture Benefits may be able to assist you. These benefits offered by PhysMetrics provide you access to licensed professionals at a discounted rate.

Chiropractic Plan Highlights	Medical Plan Options A, B & C
Chiropractic Services by PhysMetrics Provider (deductible waived)	$5 Copay then 100% of the PhysMetrics contract rate
Chiropractic Services by Non-PhysMetrics Provider (after deductible) Outside 100 miles of Fresno ONLY Referral must be given by a Physician & Pre-Certified by PhysMetrics	Plan A & C: 60% UCR after $100 deductible Plan B: 50% UCR
Chiropractic Diagnostic X-Ray Benefit (after deductible)	100% UCR Limited to $100 per Benefit Calendar Year
Visits	Up to 28 visits per Calendar Year **Note:** For treatment exceeding 12 visits per calendar year, chiropractor must submit a "twelve visit review" and PhysMetrics must pre-certify additional visits for the remainder of the calendar year.

Acupuncture Plan Highlights	Medical Plan Options A & B	
	PhysMetrics Provider	**Non-PhysMetrics Provider**
Acupuncture Visit (20 visits per Calendar Year)	$20 Copay Deductible waived	Up to $20 reimbursement Deductible waived

The above are brief benefit summaries only. Please refer to the Plan Booklet (Plans A and B) and the Kaiser Permanente Evidence of Coverage for additional information.

Note: Acupuncture benefits for Plan Option Care covered through Kaiser facilities at a $15 Copay (deductible waived).

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

Telehealth Services

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

Plushcare (Medical Plan Options A & B)

With Telehealth services provided by Plushcare, you can connect with leading board certified physicians in your state through the internet or telephone, helping you avoid emergency rooms and urgent care centers. Plushcare can assist with prescription medications and with many non-emergency illnesses including:

- Allergies
- Arthritic pain
- Asthma
- Bronchitis
- Colds and flu
- Conjunctivitis (pink eye)
- Diarrhea
- Insect bites
- Pharyngitis
- Rash
- Respiratory infection
- Sinusitis
- Skin inflammation
- Sore throat
- Sports injuries
- Sprains & strains
- Urinary tract infection
- Vomiting

Telehealth services are just $5* per appointment. No deductible applies when using Plushcare.

To access PlushCare, you can:

- Call **866.692.1986**
- Download the Plushcare App (from the Apple App Store or Google Play Store)
- Go online to www.plushcare.com

First time users will need to create a profile by providing your name, date of birth, gender, email address and a password.

To access PlushCare telehealth services, simply:

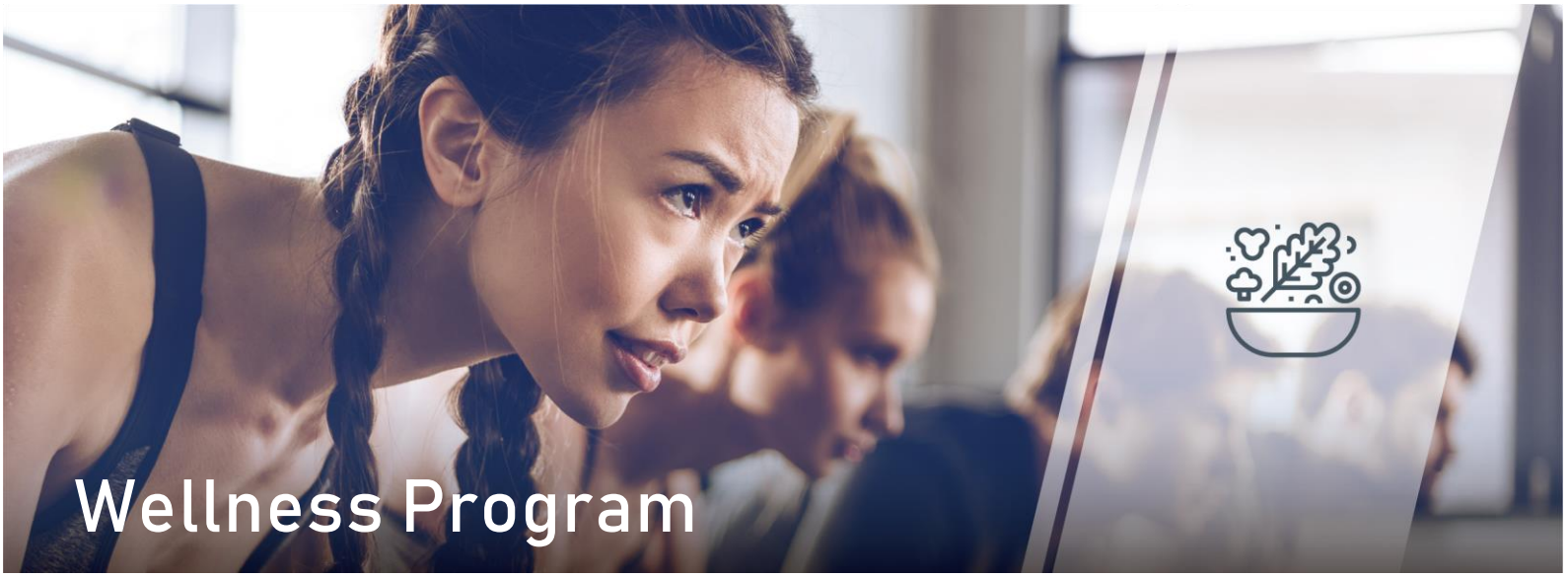
1. Select **Book Appointment** to choose an available physician and time that is convenient to you.
    a. For **Cost/Payment Option**, select **use my insurance**
    b. For **Insurance Provider**, type in **Delta Health Systems**
    c. For **Member ID**, enter your **HealthCare ID** (include all letters and numbers). Your HealthCare ID is on your Medical Identification Card.
2. Once you confirm your appointment, you will receive an email/text confirmation of your appointment. The doctor will call or video chat with you at the scheduled appointment time.
3. If necessary, prescriptions will be sent to the pharmacy you indicate.

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

Kaiser Permanente (Medical Plan Option C)

As a Plan Option C participant, Kaiser Permanente provides you with a myriad of ways to meet with your physician or schedule an appointment. If you are pressed for time and/or prefer to meet with your physician via video, you can schedule an appointment in minutes by phone or using your mobile phone or computer.

Kaiser recommends that participants download the KP Preventive Care app for the most convenient experience in scheduling appointment and conducting video visits. However, you can also visit their website at kp.org/mydoctor/videovisits for more details on how to use their telehealth services.



Wellness Program

Healthy, active lifestyles can help reduce the risk of chronic disease and may lower your annual health care costs. Because we care about your total well-being, we're encouraging all employees to engage in our Wellness Program at no-cost to you.

The JHMB's WellPATH Employee Wellness Program is designed for, and by, Fresno Unified School District employees. WellPATH offers a variety of wellness-related educational opportunities and activities throughout the year to help employees along their path to better healing, including:

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

WellPATH
Your Path to Better Health
Joint Health Management Board

Employees and their dependents who voluntarily participate and successfully complete certain wellness related activities become eligible to win great prizes. These include gift cards for completing monthly quizzes and annual wellness screenings, as well as raffles for participating in wellness challenges. Visit www.JHMBHealthConnect.com/wellpath for more details about the wellness offerings available to you and your family.

Please note: Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact WellPATH at **833.WELLPATH (935.5728)** or email WellPATH@delapro.com and we will work with you (and, if you wish, your doctor) to find a wellness program with the same reward that is right for you in light of your health status. Some prizes may be taxable to the recipient (e.g., gift cards). Contact WellPATH with any questions.

Dental Plan

Your Dental Plan Options

You and your eligible dependents have the opportunity to enroll in a Dental Preferred Provider Organization (PPO) plan offered by Delta Dental or a Dental Health Maintenance Organization (HMO) plan offered by UnitedHealthcare. We encourage you to review the coverage details and select the option that best suits your needs.

Using the Plan

The Delta Dental Dental PPO plan is designed to give you the freedom to receive dental care from any licensed dentist of your choice. Keep in mind, you'll receive the highest level of benefit from the plan if you select an in-network PPO dentist versus an out-of-network dentist who has not agreed to provide services at the negotiated rate. Additionally, no claim forms are required when using in-network PPO dentists.

To find an in-network Delta Dental PPO dentist, go to www.deltadentalins.com and search the Provider Network, or call **866.499.3001**.

UnitedHealthcare Dental HMO (Dental Direct) is unique for a DHMO dental plan. You are not required to select a provider as long as you and your dependents go in-network. If you receive services from a provider outside of the approved network, you would be responsible for paying the entire dental bill yourself.

To find a UnitedHealthcare Dental HMO dentist, go to www.myuhc.com and select **Find a Dentist**, or call **800.999.3367**.

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

Plan highlights for both the Dental PPO and Dental HMO are included on the next page for your review and consideration.

Plan Highlights	Delta Dental Dental PPO		UnitedHealthcare Dental HMO
	In-network	Out-of-network	In-network Only
Annual Calendar Year Deductible			
Per Person	N/A	N/A	N/A
Family Maximum	N/A	N/A	N/A
Calendar Year Maximum	$2,000	$1,000	N/A
Preventive Services			
Office Visit	100%	50%	No Charge
X-rays	100%	50%	No Charge
Cleanings	100%	50%	No Charge
Sealants (per tooth)	100%	50%	$5 Copay
Restorative Services			
Amalgam Fillings	100%	50%	No Charge
Composite Fillings	100%	50%	$0 -$10 Copay
Periodontics (gum treatment)			
Scaling & Root Planning	100%	50%	No Charge
Gingivectomy (4+ teeth)	100%	50%	No Charge
Endodontics (root canal therapy)			
Pulpotomy	100%	50%	No Charge
Root Canal	100%	50%	$0 -$60 Copay
Oral Surgery			
General Anesthesia	100%	50%	$10 Copay
Simple Extraction	100%	50%	No Charge
Soft Tissue Impaction	100%	50%	$17 Copay
Complete or Partial Bony Impaction	100%	50%	$23 -$30 Copay
Crowns & Inlays			
Inlay / Onlay (2 surfaces)	100%	50%	Copay varies on treatment
Crowns	100%	50%	$7 -$73 Copay[1]
Prosthetics & Bridges			
Bridges	50%	50%	$0 - $80 Copay
Denture Adjustment	50%	50%	$0 - $10 Copay
Complete or Partial Denture	50%	50%	$63 - $93 Copay
Other Services			
Implants	Not Covered		$1,950 Copay
Orthodontia Services			
Child / Adult Orthodontia Phase 1 & 2	Not Covered		$2,000 maximum out-of-pocket expense for 24-month treatment plan

[1] Resin, porcelain and any resin to metal or porcelain to metal crowns and pontics are excluded on molar teeth. If titanium, noble or high noble metals are requested for filings, crowns, pontics, bridges or prosthetic devices, there will be an additional charge, based on the amount of the metal used. Flexible base partial dentures are subject to an additional charge based on additional laboratory cost.

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

Vision Plan

Your Vision Plan

Vision coverage for members enrolled in Medical Plan A or B is offered by MES Vision as a Preferred Provider Organization (PPO) plan. If you are enrolled in Medical Plan C, your vision coverage is offered by Kaiser Permanente.

Using the Plan

As with a traditional PPO, you may take advantage of the highest level of benefit by receiving services from in-network vision providers and doctors. You would be responsible for a copayment at the time of your service. However, if you receive services from an out-of-network doctor, you pay all expenses at the time of service and submit a claim for reimbursement up to the allowed amount.

Any questions pertaining to your vision coverage can be directed to MES Vision by calling **800.877.6372**, or by visiting their website at www.mesvision.com.

To locate an in-network MES Vision provider, go to www.mesvision.com, click on the Member tab, enter username/password and click on **Login**. Then click on your Group (Company) Name, enter zip code and click **Search**. You can also call MES Vision at **800.877.6372**.

Plan Highlights	MES Vision PPO	
	In-Network	**Out-of-Network**
Exam – Every 12 months	$5 Copay	Up to $45 Reimbursement
Lenses – Every 12 months		
Single	Covered in Full	Up to $30 Reimbursement
Bifocal	Covered in Full	Up to $50 Reimbursement
Trifocal	Covered in Full	Up to $65 Reimbursement
Frames – Every 24 months	Up to $130 Allowance	Up to $75 Reimbursement
Contacts – Every 12 months, in lieu of lenses & frames		
Medically Necessary	Covered in Full with Authorization	Up to $250 Reimbursement
Cosmetic	Up to $130 Allowance	Up to $130 Reimbursement

The above information is a summary only. Please refer to the Plan Booklet (Plans A and B) and the MES Vision Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

TIP

Five Tips for Superior Vision

Don't take your eyes for granted! The following pointers can help you keep your vision strong:

- **Eat lots of leafy greens and dark berries.**
- **Get regular eye exams.**
- **Give your eyes a rest from staring into the computer screen.**
- **Wear sunglasses to protect your eyes from bright light.**
- **Wear safety eyewear whenever necessary.**

Flexible Spending Accounts (FSA)

A flexible spending account lets you use pre-tax dollars to cover eligible health care and dependent care expenses. There are different types of FSAs that help to reduce your taxable income when paying for eligible expenses for yourself, your spouse, and any eligible dependents, as outlined below:

FSA Type	Detail
 Health Care FSA	• Can reimburse for eligible health care expenses not covered by your medical, dental and vision insurance. • Maximum contribution for 2021 is $2,750.
 Dependent Care FSA	• Can be used to pay for a child's (up to the age of 13) child care expenses and/or care for a disabled family member in the household, who is unable to care for themselves. • Maximum contribution for 2021 is $5,000, if you are single or married and filing a joint tax return. If you are married and filing separately, your maximum contribution is $2,500.

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

Enrolling and Using an FSA

An annual contribution amount within the maximum limit must be determined at the time of enrollment. Once enrolled, you will have online access to view your FSA balance, check on a reimbursement status, and more. Visit www.americanfidelity.com to access American Fidelity's online portal.

For more information regarding how a Section 125 Plan works, please watch the following video:
https://americanfidelity.com/support/videos/section-125/

Examples of eligible expenses, as determined by the Internal Revenue Service (IRS), and additional information are below:

Account Type	Examples of Eligible Expenses
Health Care FSA	• Deductibles, copays and coinsurance, as well as out-of-pocket costs for medical, dental and vision services, including chiropractic and acupuncture services • Prescription drugs and over-the-counter medications with a prescription are considered eligible • Explicit guidelines for determining eligible expenses have yet to be provided by the Internal Revenue Service (IRS); for a list of potential eligible expenses that may be covered by a Flexible Spending Account (FSA), review Internal Revenue Code (IRC) section 213(d). IRS Publication 502 (Medical and Dental Expenses) may be used as a guide for what expenses may be considered by the IRS to be for medical care; however, the guidelines should be used with caution when trying to determine what expenses are reimbursable under an FSA[1]
Dependent Care FSA	• Eligible child care, nanny services or residential disabled adult daycare for your dependents • Dependents claimed on your federal income tax return, including those under age 13 and those of any age who are unable to care for themselves, who live with you for more than half of the taxable year and do not provide more than half of his/her own support, would be considered eligible dependents for this FSA • To determine potential eligible employment-related expenses, view IRC sections 129 and 21. IRS Publication 502 (Child and Dependent Care Expenses) may also be used as a guide for what expenses may be considered employment-related; however, Publication 502 should be used with caution when trying to determine what expenses are reimbursement under a Dependent Care FSA[1]

[1] **Please note:** This is informational only and not intended to serve as legal, tax or financial advice. Participants in a Health Care FSA or a Dependent Care FSA should consult their tax advisor before making any changed to their plan.

Flexible Spending Accounts (FSA) (Continued)

Receiving Reimbursements

Keep itemized receipts in a safe place. The IRS or American Fidelity may request a copy to substantiate a claim. If you are required to submit a receipt or some form of claim documentation, and fail to comply, reimbursement may be denied.

You will have until March 31, 2022 to submit a reimbursement request for eligible expenses incurred between January 1 and December 31, 2021. You can submit a manual reimbursement request by:

- **Fax:** 844.319.3668
- **Mail:** American Fidelity Assurance Company, Attn: Flex Account Administration, P.O. Box 161968, Altamonte Springs, FL 32716
- **Online:** www.americanfidelity.com (you must be registered online to process claim)
- **Mobile Device Using AFmobile:** Create an AFmobile account by downloading the app from the Apple App Store or the Google Play Store. Please note, if you already have an OSC account, your username and password will be the same.

You may receive your manual reimbursement either by a mailed check or by direct deposit into your personal Checking or Savings Account.

For more details about using an FSA, be sure to contact American Fidelity's Customer Service at 800.662.1113.

The FSA Health Plan and Termination

If you are a participant in your Health FSA plan and you are terminated, your funds may be preserved and you may have other options available to you. It is important that you check the Plan Booklet or contact the Benefits Department at 559.457.3520 if you have any further questions regarding your FSA health plan fund at the time of termination. Your failure to act in conjunction with your Health FSA plan may cause your fund to be permanently forfeited after your termination.

Life and AD&D

Basic Life and AD&D

In the event of your death, Life Insurance will provide your family members or other beneficiaries with financial protection and security. Additionally, if your death is a result of an accident or if you become dismembered, your Accidental Death & Dismemberment (AD&D) coverage may apply.

Your Coverage

Paid for in full by Fresno Unified School District and the Joint Health Management Board, the benefits outlined below are provided by The Standard:

Basic Life and AD&D Benefit

Age of Insured	Benefit Amount
Less than 25	$30,000 Regardless of Age
25-29	
30-34	
35-39	
40-44	
45-49	
50-54	
55-59	
60-64	
65-69	
70+	

IRS Regulation: Employees can receive employer paid life insurance up to $50,000 on a tax-free basis and do not have to report the payment as income. However, an amount in excess of $50,000 will trigger taxable income for the “economic value” of the coverage provided to you.

TIP

Required! Are Your Beneficiaries Up to Date?

Beneficiaries are individuals or entities that you select to receive benefits from your policy.

- **You can change your beneficiary designation at any time (Community property rules may apply. Please refer to plan summary or forms for information.)**
- **You may designate a sole beneficiary or multiple beneficiaries to receive payment in the percent allocated.**
- **To select or change your beneficiary, contact the Benefits Department at 559.457.3520.**

Voluntary Dependent Life Insurance

Voluntary Dependent Life Insurance is available for dependent(s) of employees who qualify for the Employer Paid Basic Life and AD&D. Dependent coverage may be purchased by the employee at a cost of $6.00 per year.

Schedule for Voluntary Dependent Life Insurance

Dependent	Benefit Amount
Spouse Dependent	$1,500
Unmarried Children to age 26	$1,500

Voluntary Employee Paid Additional life Insurance

If you are insured under the Basic Life plan and would like to supplement your employer paid insurance, additional Life coverage for you and/or your dependents is available for purchase through The Standard.

- **For employees:** Increments of $10,000 up to a $300,000 maximum (amount may not exceed 5x annual earnings)
- **For your spouse/state registered domestic partner:** Increments of $5,000 up to a $150,000 maximum
- **For your child(ren):** 14 days old up to 6 months of age, $100; 6 months old up to age 26, $5,000 or $10,000
- **Guarantee Issue Amount:** There are no requirements for a medical questionnaire if you apply for the Guarantee Issue Amount within 31 days after you first become eligible. If you apply within 31 days after you first become eligible for coverage: The Guarantee Issue Amount for you is $50,000, $25,000 for your spouse/state registered domestic partner. The insurance for your child(ren) is all guarantee issue.

Any amounts of insurance over the guarantee issue benefit are subject to review of good health by the insurance company. Insurance amounts subject to review will not be effective until the insurance company approves.

If you do not elect Voluntary Additional Life insurance when you are first eligible, you will be required to submit a health questionnaire, also known as Evidence of Insurability (EOI) to The Standard. An EOI will also be required if you wish to become insured for an amount greater than $50,000 or if you wish to insure a spouse for an amount greater than $25,000. The Benefits Office will supply employees with the proper forms if they are interested.

Please consider the following if you are purchasing Voluntary Additional Life for a dependent:

- You must purchase coverage for yourself in order to purchase coverage for your spouse or child(ren)
- Spouse or Child amount cannot exceed 100% of the employee's additional life benefit
- All children will be insured for the same amount
- For child(ren) coverage, one rate is charged regardless of the number of children in the family

Cost of Voluntary Life Coverage

Age of Insured	Tenthly Rate per $1,000
Less than 30	$0.072
30–34	$0.084
35–39	$0.108
40–44	$0.204
45–49	$0.312
50–54	$0.468
55–59	$0.732
60–64	$0.972
65+	$1.608

Dependent Child Coverage

Benefit Amount	Tenthly Premium
$5,000	$1.80
$10,000	$3.60

Please note: Benefits coverage may reduce when you reach age 65. Restrictions may apply if you and/or your dependent(s) are confined in the hospital or terminally ill. Please refer to your Plan Booklet for exclusions and further detail.

Employee Assistance Program (EAP)

Fresno Unified School District and the Joint Health Management Board understand that you and your family members might experience a variety of personal or work-related challenges. Through the Claremont EAP, you have access to resources, information, and counseling that are fully confidential and no cost to you.

Program Component	Coverage Details
Who Can Utilize	All employees/retirees, dependents of employees/retirees, and members of your household
Consultations Available for Subjects Such As:	• Childcare and eldercare assistance • Emotional issues like stress, anxiety and depression • Marital, relationship or family problems • Bereavement or grief counseling • Substance abuse • Identity theft • Financial services to support issues including budgeting, debt management, financial planning and more • Legal services provides one consultation per issue (25% discount) to guide you through a divorce, child custody, real estate issues and other topics • Work/Life services to offer referrals for important matters such as Adoption Assistance or School/College Assistance, among other subjects
Number of Sessions	5 face-to-face sessions per family member per incident

TIP

How to Access:

By Phone: 800.834.3773
Online: www.claremonteap.com

Cost Breakdown

The rates below are effective January 1, 2021 – December 31, 2021.

Coverage Level	Payroll Deduction	
	Employee Monthly	**Employee Tenthly**
Medical Plan Option A (Anthem Blue Cross PPO)		
Employee Only	$160	$192
Employee and Spouse/State Registered Domestic Partner	$220	$264
Employee and Child(ren)	$175	$210
Employee and Family	$230	$276
Medical Plan Option B (Anthem Blue Cross PPO)		
Employee Only	$60	$72
Employee and Spouse/State Registered Domestic Partner	$90	$108
Employee and Child(ren)	$70	$84
Employee and Family	$100	$120
Medical Plan Option C (Kaiser Permanente Deductible HMO)		
Employee Only	$160	$192
Employee and Spouse/State Registered Domestic Partner	$220	$264
Employee and Child(ren)	$175	$210
Employee and Family	$230	$276
UnitedHealthcare Dental HMO		
Employee and Family	No Cost	No Cost
Delta Dental PPO		
Employee Only	No Cost	No Cost
Employee + One Dependent	$33.05	$39.66
Employee + Two or more Dependent	$51.57	$61.88
MES Vision		
Employee and Family	No Cost	No Cost

Health Assessment Premiums – All employees enrolled in the District's medical plans will pay, through payroll deduction, an additional $10 or $12 Health Assessment Fee depending on whether you are paid on a monthly or tenthly basis. The funds generated from this assessment shall be placed in a Health Plan Reserve to offset current and future health care cost increases as needed. If the Joint Health Management Board determines such funds are not needed for this purpose, the Board may determine to reduce, rebate or refund such assessment.

Available to Part-Time Employees Only	Payroll Deduction	
	Employee Monthly	**Employee Tenthly**
UnitedHealthcare Dental HMO		
Employee and Family	$43.75	$52.49
MES Vision		
Employee and Family	$12.15	$14.58
Employee and Family CSEA Only (Employees with 3 years of service)	$7.59	$9.11

Dual-covered coordination of benefits only applies when both employees elect and pay for cross coverage(s).

Guidelines/Evidence of Coverage

The benefit summaries listed on the previous pages are brief summaries only. They do not fully describe the benefits coverage for your health and welfare plans. For details on the benefits coverage, please refer to the Plan Booklet and/or Evidence of Coverage. The Evidence of Coverage or Plan Booklet is the binding document between the elected health plan and the member.

A health plan physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat the members' medical condition. These services and supplies must be provided, prescribed, authorized, or directed by the health plan's network physician unless the member enrolls in the PPO plan where the member can use a non-network physician.

The HMO member must receive the services and supplies at a health plan facility or skilled nursing facility inside the service area except where specifically noted to the contrary in the Evidence of Coverage.

For details on the benefit and claims review and adjudication procedures for each plan, please refer to the Plan Booklet and/or Evidence of Coverage. If there are any discrepancies between benefits included in this summary and the Evidence of Coverage or Plan Booklet, the Evidence of Coverage or Plan Booklet will prevail.

Medicare Part D notice

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

2021 CERTIFICATE OF CREDITABLE PRESCRIPTION DRUG COVERAGE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Fresno Unified School District and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare prescription drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Fresno Unified School District has determined that the prescription drug coverage offered by the Fresno Unified School District Health Care Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare prescription drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Prescription Drug Plan?

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

If you decide to join a Medicare drug plan, your current Fresno Unified School District medical coverage will not be affected. You may keep this coverage if you elect Part D; however, this plan will not coordinate with Part D coverage; will not reimburse you for Part D premiums; nor will it be responsible for any "income-related" monthly adjustment amount (IRMAA) imposed by Medicare. If you do decide to join a Medicare drug plan and drop your current Fresno Unified School District prescription coverage, be aware that you and your dependents will not be able to get this prescription coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Fresno Unified School District and don't join a Medicare prescription drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage…

Contact Fresno Unified School District Benefits Office listed on page 31 for further information. NOTE: You will receive this notice annually, before the next period you can join a Medicare prescription drug plan, and if this coverage through Fresno Unified School District changes. You also may request a copy of this notice at any time.

For More Information about Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call **1-800-MEDICARE (1-800-633-4227)**. TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit the Social Security Administration (SSA) online at www.socialsecurity.gov, or call SSA at **1-800-772-1213** (TTY 1-800-325-0778).

Remember: **Keep this Creditable Coverage notice. If you decide to join one of the Medicare prescription drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).**

Legal Information Regarding Your Plan

REQUIRED NOTICES

Women's Health & Cancer Rights Act

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

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

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

Each of the medical plan options available through Fresno Unified School District Health Plan currently covers mastectomies and reconstructive surgery. Coverage is subject to each plan's deductibles, coinsurance and benefit provisions. These provisions are generally described in the Plan Booklet or Explanation of Coverage.

Newborn Mothers Health Protection Act

Under the Newborn and Mothers Health Protection Act, the following language is included in the Health Plan:

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours for the eligible mother and newborn child following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). The time periods outlined above begin at the birth of the child. The law also prohibits a plan from requiring a health care practitioner to obtain authorization from the Plan for prescribing a length of stay not in excess of those periods.

Health Insurance Portability & Accountability Act Non-discrimination Requirements

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

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

HIPAA Special Enrollment Rights

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

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

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

"HIPAA Special Enrollment Opportunities" include:

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

"Change in Status" Permitted Midyear FSA Election Changes

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

Examples of permitted "change in status" events include:

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

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

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

Mental Health Parity and the Public Health Service Act

Group health plan sponsored by the State and local governmental employers must generally comply with Federal law requirements in title XXVII of the Public Health Service Act (the "PHSA"). However, self-funded group health plans sponsored by state and local governments, including school districts are permitted to elect to be exempt from some of the PHSA requirements. The benefits provided by Anthem Blue Cross, Halcyon Behavioral Health, Elixir, Claremont EAP, PhysMetrics, and Delta Dental constitute the self-insured portions of the Fresno Unified School District Employee Health Care Plan (the "Plan").

The Plan is administered by the Joint Health Management Board ("JHMB"). The JHMB has elected to exempt the self-insured portion of the Plan from the PHSA requirement to have the same financial requirements and treatment limitations for mental health or substance abuse benefits as for medical and surgical benefits. This exemption will be effective for the plan year beginning July 1, 2020 and ending June 30, 2021. The election may be renewed for subsequent plan years.

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

The JHMB is not opting out of other applicable HIPAA requirements. It is not opting out of the provisions regarding standards relating to benefits for mothers and newborns, coverage for reconstructive surgery following a mastectomy, and coverage of dependent students on medically necessary leaves of absences.

IMPORTANT INFORMATION ON HOW HEALTH CARE REFORM AFFECTS YOUR PLAN

Primary Care Provider Designations

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

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

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

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

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

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

Prohibition on Excess waiting Periods

Group health plans may not apply a waiting period that exceeds 90 days. A waiting period is defined as the period that must pass before coverage for an eligible employee or his or her dependent becomes effective under the Plan. State law may require shorter waiting periods for insured group health plans. California law requires fully-insured plans to comply with the more restrictive waiting period limitation of no more than 60-days.

Preexisting Condition Exclusion

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

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

CONTINUATION COVERAGE RIGHTS UNDER COBRA

You're getting this notice because you recently gained coverage under the Fresno Unified School District Employee Health Care Plan (the "Plan"). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan Booklet or contact the Fresno Unified School District Plan Administrator at (559) 457-3520.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to [enter name of employer sponsoring the Plan], and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Fresno Unified School District Plan Administrator has been notified that a qualifying event has occurred. The Fresno Unified School District must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 31 days after the qualifying event occurs. You must provide this notice to: Fresno Unified School District, Attn: Benefits Office, 2309 Tulare Street, Fresno, CA 93721. You may be required to provide supporting documentation (e.g. a divorce/legal separation decree).

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. When you call, you may be asked to provide some or all of the following information: (1) Employee's name; (2) Employee's Social Security Number; (3) the name(s) and social security

How is COBRA continuation coverage provided? (Continued)

number(s) of all qualified beneficiaries; (4) relevant mailing addresses; and (5) the date of the Social Security Administration ("SSA") disability determination. In addition, you will be required to provide the District's Benefits Department with a copy of the SSA Determination Letter. The disability extension will terminate early if the SSA determines that the individual is no longer disabled before the end of the 11 month extension. You or your dependent must notify the District's Benefits Department by calling 559.457.3520 within 31 days of any such final determination that the individual is no longer disabled.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Health Flexible Spending Account (FSA) Information

COBRA coverage under the Fresno Unified School District Health Care FSA will be offered only to Qualified Beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected by the covered employee, reduced by reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for the Fresno Unified School District Health Care FSA COBRA coverage that will be charged for the remainder of the plan year. COBRA coverage will consist of the Fresno Unified School District Health Care FSA coverage in force at the time of the qualifying event. The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and the COBRA coverage for the FSA plan will terminate at the end of the plan year. Unless otherwise elected, all qualified beneficiaries who were covered under the Fresno Unified School District Health Care FSA will be covered together for Health Care FSA COBRA coverage. However, each qualified beneficiary could alternatively elect separate COBRA coverage to cover that beneficiary only with a separate Health Care FSA annual limit and a separate premium. If you are interested in this alternative, contact Administrative Solutions, Inc. at 866.777.1320 during business hours for more information.

Alternative Recipients Under QMCSOs

A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by the Fresno Unified School District during the covered employee's period of employment with Fresno Unified School District is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

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

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

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

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

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

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

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

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

EMPLOYEE RIGHTS & RESPONSIBILITIES UNDER THE FAMILY MEDICAL LEAVE ACT

Basic Leave Entitlement

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

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

Military Family Leave Entitlements

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

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

Benefits & Protections

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

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

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months [3], and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition

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

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

Use of Leave

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

Substitution of Paid Leave for Unpaid Leave

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

Employee Responsibilities

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

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

Employer Responsibilities

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

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

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

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

Enforcement

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

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

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

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

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

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

Right to Continue Coverage

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

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

How to Continue Coverage

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

What Happens if You do not Elect to Continue Coverage?

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

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

Premium for Continuing Your Coverage

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

Length of Time Coverage Can Be Continued

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

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

Reporting to Work / Applying for Reemployment

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

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

Definitions

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

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

HIPAA PRIVACY NOTICE

Notice of Health Information Privacy Practices

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

A copy of this Notice can be obtained at any time by writing or calling the Fresno Unified School District Benefit Office and requesting a copy.

This notice is EFFECTIVE: October 1, 2020

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

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

This notice describes the Plan's legal duties and privacy practices including:

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

Permitted Plan use of Your Health Information

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

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

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

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

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

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

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

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

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

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

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

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

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

Your Rights Regarding Your Health Information

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

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

Plan Responsibilities

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

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

The Plan will not use or disclose your health information without your consent or authorization, except as provided by law or described in this notice. The Plan may use or disclose "summary health information" to the plan sponsor for obtaining premium bids or modifying, amending or terminating the Group Health Plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a Group Health Plan; and from which identifying information has been deleted in accordance with HIPAA. The plan is prohibited from using or disclosing PHI that is genetic information of an individual for any purposes, including underwriting.

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

Your Right to File a Complaint

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

Changes to the Terms of This Notice

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

Contact Person

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

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

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 916-440-5676	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**MONTANA – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

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

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

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

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

Directory & Resources

Below, please find important contact information and resources for Fresno Unified School District.

Information Regarding	Group / Policy #	Contact Information	
Enrollment & Eligibility			
Initial Enrollment: • Benefits & Risk Management Department		559.457.3520	http://fusd.fresnounified.org/dept/benefits/pages/default.aspx
Eligibility / PPO: • Claims: Delta Health Systems		800.807.0820	www.deltahealthsystems.com
Plan Booklet / Forms / SBCs / Policies: • JHMBHealthConnect			www.jhmbhealthconnect.com
Medical Coverage			
Anthem Blue Cross • Medical Plan Option A • Medical Plan Option B • Pre-Authorizations/Case Management	 1866FA 1866FA	 800.807.0820 800.807.0820 800.274.7767	 www.anthem.com/ca www.deltahealthsystems.com
Elixir Prescription Benefit Halcyon Behavioral Health	Rx Bin#009893	833.640.2849 888.425.4800	www.ElixirSolutions.com www.fusdmhsa.com
Medical Coverage			
Kaiser Permanente • Medical Plan Option C	 603815	 800.464.4000	 www.kp.org
Chiropractic / Acupuncture Coverage			
PhysMetrics		877.519.8839	www.fusdchiro.com
Dental Coverage			
Delta Dental • Dental PPO	 00697	 888.335.8227	 www.deltadentalins.com
UnitedHealthcare Dental • Dental HMO	 711904	 800.999.3367	 www.myuhc.com
Vision Coverage			
MES Vision • Vision	 28074	 800.877.6372	 www.MESVision.com
Life, AD&D and Disability			
The Standard • Basic Life/AD&D • Voluntary Additional Life • Travel Assistance Service	 600762 C 600762 B	 559.457.3520 559.457.3520 800.527.0218	 www.standard.com
Flexible Spending Accounts			
American Fidelity Assurance Company • Home Office • Fresno Office • Insurance Claims Fax • FSA Claims Fax	 501, 502, 503, 504, 506, 507	 800.662.1113 866.504.0010 ext 0 800.818.3453 800.543.3539	 www.americanfidelity.com
Employee Assistance Plan			
Claremont EAP		800.834.3773	www.claremonteap.com

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

ADA	DESCRIPTION	MEMBER PAYS
DIAGNOSTIC SERVICES		
D0120	PERIODIC ORAL EVALUATION EST PT	$0
D0140	LTD ORAL EVALUATION - PROBLEM FOCUS	$0
D0145	ORAL EVAL PT<3 AND COUNSEL	$0
D0150	COMP ORAL EVALUATION - NEW/EST PT	$0
D0160	DTL & EXT ORAL EVAL - PROBLEM FOCUS REPORT	$0
D0170	RE-EVALUATION - LTD PROBLEM FOCUSED	$0
D0171	RE-EVALUATION - POST-OPERATIVE OFFICE VISIT	$0
D0180	COMP PERIODONTAL EVAL - NEW/EST PT	$0
D0210	INTRAORAL - COMPLETE SERIES RADIOGRAPHIC IMAGES	$0
D0220	INTRAORAL PERIAPICAL FIRST RADIOGRAPHIC IMAGE	$0
D0230	INTRAORL PERIAPICAL EACH ADD RADIOGRAPHIC IMAGE	$0
D0240	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	$0
D0250	EXTRA-ORAL - 2D PROJECTION RADIOGRAPHIC IMAGE	$0
D0251	EXTRA-ORAL POSTERIOR DENTAL RADIOGRAPHIC IMAGE	$0
D0270	BITEWING - SINGLE RADIOGRAPHIC IMAGE	$0
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES	$0
D0273	BITEWINGS - THREE RADIOGRAPHIC IMAGES	$0
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	$0
D0277	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC IMAGES	$0
D0330	PANORAMIC RADIOGRAPHIC IMAGE	$0
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE - ACQUISITION, MEASUREMENT AND ANALYSIS	$0
D0364	CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW-LESS THAN ONE WHOLE JAW	$0
D0365	CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW OF ONE FULL DENTAL ARCH-MANDIBLE	$0
D0366	CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW OF ONE FULL DENTAL ARCH-MAXILLA	$0
D0367	CONE BEAM CT CAPTURE AND INTERPRETATION WITH FIELD OF VIEW OF BOTH JAWS	$0
D0368	CONE BEAM CT CAPTURE AND INTERPRETATION FOR TMJ SERIES INCLUDING TWO OR MORE EXPOSURES	$0
D0391	INTERPRETATION OF DIAGNOSTIC IMAGE	$0
D0393	SIMULATION USING 3D IMAGES	$0
D0394	DIGITAL SUBTRACTION OF IMAGES	$0
D0395	FUSION OF TWO OR MORE 3D IMAGES	$0
D0414	LABORATORY PROCESSING OF MICROBIAL SPECIMEN TO INCLUDE CULTURE AND SENSITIVITY STUDIES, PREPARATION AND TRANSMISSION OF WRITTEN REPORT	$0
D0415	COLLECT MICROORGANISMS CULT & SENS	$0
D0416	VIRAL CULTURE	$0
D0417	COLLECTION & PREP OF SALIVA SAMPLE	$0
D0418	ANALYSIS OF SALIVA SAMPLE	$0
D0425	CARIES SUSCEPTIBILITY TESTS	$0
D0431	ADJUNCT PREDX TST NO CYTOL/BX PROC	$0
D0460	PULP VITALITY TESTS	$0
D0470	DIAGNOSTIC CASTS	$0
D0472	ACCESS TISSUE, GROSS EXAM - PREP & REPORT	$0
D0473	ACCESS TISSUE, GROSS & MICROSCOPIC - PREP/REPORT	$0
D0474	ACCESS TISSUE, GROSS & MICROSCOPIC SURG MARG PREP/REPORT	$0
D0601	CARIES RISK ASSESSMENT AND DOCUMENTATION, LOW	$0
D0602	CARIES RISK ASSESSMENT AND DOCUMENTATION, MODERATE	$0
D0603	CARIES RISK ASSESSMENT AND DOCUMENTATION, HIGH	$0
D0701	PANORAMIC RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY	$0
D0702	2-D CEPHALOMETRIC RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY	$0
D0705	EXTRA-ORAL POSTERIOR DENTAL RADIOGRAPHIC IMAGE–IMAGE CAPTURE ONLY	$0
D0706	INTRAORAL–OCCLUSAL RADIOGRAPHIC IMAGE–IMAGE CAPTURE ONLY	$0
D0707	INTRAORAL–PERIAPICAL RADIOGRAPHIC IMAGE-IMAGE CAPTURE ONLY	$0
D0708	INTRAORAL–BITEWING RADIOGRAPHIC IMAGE–IMAGE CAPTURE ONLY	$0
D0709	INTRAORAL–COMPLETE SERIES OF RADIOGRAPHIC IMAGES–IMAGE CAPTURE ONLY	$0
PREVENTIVE SERVICES		
D1110	PROPHYLAXIS - ADULT	$0
D1120	PROPHYLAXIS - CHILD	$0
D1206	TOPICALFLUORIDE VARNISH	$0
D1208	TOPICAL APPLICATION OF FLUORIDE - EXCLUDING VARNISH	$0
D1310	NUTRIT CNSL CONTROL DENTAL DISEASE	$0
D1320	TOBACCO CNSL CNTRL&PREVION ORL DZ	$0
D1330	ORAL HYGIENE INSTRUCTIONS	$0
D1351	SEALANT - PER TOOTH	$0
D1352	PREV RESIN RESTORATION IN MOD HIGH CARIES RISK PATIENT- PERM TOOTH	$0
D1353	SEALANT REPAIR – PER TOOTH	$0
D1355	CARIES PREVENTIVE MEDICAMENT APPLICATION – PER TOOTH	$0
D1516	SPACE MAINTAINER - FIXED - BILATERAL, MAXILLARY	$0
D1517	SPACE MAINTAINER - FIXED - BILATERAL, MANDIBULAR	$0
D1520	SPACE MAINTAINER - REMOVABLE-UNILATERAL/QUAD	$0
D1526	SPACE MAINTAINER - REMOVABLE - BILATERAL, MAXILLARY	$0
D1527	SPACE MAINTAINER - REMOVABLE - BILATERAL, MANDIBULAR	$0
D1551	RECEM/REBOND BILATERAL SPACE MAINTAINER – MAXIL	$0
D1552	RECEM/REBOND BILATERAL SPACE MAINTAINER – MANDIB	$0
D1553	RECEM/REBOND UNILATERAL SPACE MAINTAINER/QUAD	$0
D1556	REMOVAL OF FIXED UNILATERAL SPACE MAINTAINER/QUAD	$0
D1557	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MAXIL	$0
D1558	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MANDIB	$0
D1575	DISTAL SHOE SPACE MAINTAINER – FIXED, UNILATERAL/QUAD	$0

ADA	DESCRIPTION	MEMBER PAYS
RESTORATIVE SERVICES		
D2140	AMALGAM - ONE SURFACE PRIMARY/PERMANENT	$0
D2150	AMALGAM - TWO SURFACES PRIMARY/PERMANENT	$0
D2160	AMALGAM - 3 SURFACES PRIMARY/PERMAMENT	$0
D2161	AMALGAM - FOUR/MORE SURFACES PRIMARY/PERMANENT	$0
D2330	RESIN COMPOSITE - ONE SURFACE ANTERIOR	$0
D2331	RESIN COMPOSITE - 2 SURFACES ANTERIOR	$0
D2332	RESIN COMPOSITE - 3 SURFACES ANTERIOR	$0
D2335	RESIN COMPOSITE - 4/> SURF/W/INCISAL ANG	$0
D2390	RESIN COMPOSITE CROWN ANTERIOR	$0
D2391	RESIN COMPOSITE - 1 SURFACE POSTERIOR	$0
D2392	RESIN COMPOSITE - 2 SURFACES POSTERIOR	$0
D2393	RESIN COMPOSITE - 3 SURFACES POSTERIOR	$0
D2394	RESIN COMPOSITE - 4/MORE SURFACES POST	$0
D2510	INLAY - METALLIC - ONE SURFACE	$0
D2520	INLAY - METALLIC - TWO SURFACES	$0
D2530	INLAY - METALLIC - 3/MORE SURFACES	$0
D2542	ONLAY - METALLIC - TWO SURFACES	$0
D2543	ONLAY - METALLIC THREE SURFACES	$0
D2544	ONLAY - METALLIC FOUR OR MORE SURFACES	$0
D2610	INLAY - PORCELAIN/CERAMIC - 1 SURFACE	$0
D2620	INLAY - PORCELAIN/CERAMIC - 2 SURFACES	$0
D2630	INLAY - PORCELAIN/CERAMIC - 3/MORE SURFACES	$0
D2642	ONLAY - PORCELAIN/CERAMIC - 2 SURFACES	$0
D2643	ONLAY - PORCELAIN/CERAMIC - 3 SURFACES	$0
D2644	ONLAY - PORCELAIN/CERAMIC - 4/MORE SURFACES	$0
D2650	INLAY - RESIN BASED COMPOSITE - 1 SURFACE	$0
D2651	INLAY - RESIN BASED COMPOSITE - 2 SURFACES	$0
D2652	INLAY - RESIN BASED COMPOSITE - 3 />SURFACES	$0
D2662	ONLAY - RESIN - BASED COMPOSITE - 2 SURFACES	$0
D2663	ONLAY - RESIN - BASED COMPOSITE - 3 SURFACES	$0
D2664	ONLAY - RESIN - BASED COMPOSITE - 4/> SURFACES	$0
D2710	CROWN - RESIN - BASED COMPOSITE INDIRECT	$0
D2712	CROWN - 3/4 RESIN - BASED COMPOSITE INDIRECT	$0
D2720*	CROWN - RESIN WITH HIGH NOBLE METAL	$0*
D2721	CROWN - RESIN W/PREDOM BASE METAL	$0
D2722*	CROWN - RESIN WITH NOBLE METAL	$0*
D2740	CROWN - PORCELAIN/CERAMIC SUBSTRATE	$0
D2750*	CROWN - PORCELAIN FUSED HI NOBLE METAL	$0*
D2751	CROWN - PORCELAIN FUSED PREDOM BASE METAL	$0
D2752*	CROWN - PORCELAIN FUSED NOBLE METAL	$0*
D2753	CROWN PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$0
D2780*	CROWN - 3/4 CAST HIGH NOBLE METAL	$0*
D2781	CROWN - 3/4 CAST PREDOM BASE METAL	$0
D2782*	CROWN - 3/4 CAST NOBLE METAL	$0*
D2783	CROWN - 3/4 PORCELAIN/CERAMIC	$0
D2790*	CROWN - FULL CAST HIGH NOBLE METAL	$0*
D2791	CROWN - FULL CAST PREDOM BASE METAL	$0
D2792*	CROWN - FULL CAST NOBLE METAL	$0*
D2794*	CROWN - TITANIUM AND TITANIUM ALLOYS	$0*
D2910	RECEMENT OR RE-BOND INLAY ONLAY VENEER OR PART COV REST	$0
D2915	RECEMENT OR RE-BOND INDIRECTLY FABRICATED PREFABRICATED POST & CORE	$0
D2920	RECEMENT OR RE-BOND CROWN	$0
D2921	REATTACHMENT OF TOOTH FRAGMENT	$0
D2930	PREFABRICATED STAINLESS STEEL CROWN - PRIMARY	$0
D2931	PREFABRICATED STAINLESS STEEL CROWN - PERMANENT	$0
D2932	PREFABRICATED RESIN CROWN	$0
D2933	PREFABRICATED STAINLESS STEEL CROWN RESIN WINDOW	$0
D2934	PREFABRICATED ESTHTC COATED STNLESS STEEL CROWN - PRIMARY	$0
D2940	SEDATIVE FILLING	$0
D2941	INTERIM THERAPEUTIC RESTORATION – PRIMARY DENTITION	$0
D2950	CORE BUILDUP INCLUDING ANY PINS	$0
D2951	PIN RETENTION - PER TOOTH ADDITION REST	$0
D2952	POST & CORE ADD CROWN INDIRECT FAB	$0
D2953	EACH ADD INDIRECT FABRICATED POST SAME TOOTH	$0
D2954	PREFABRICATED POST & CORE ADDITION CROWN	$0
D2955	POST REMOVAL	$0
D2957	EACH ADD PREFABR POST - SAME TOOTH	$0
D2960	LABIAL VENEER (RESIN LAMINATE) - DIRECT	$0
D2961	LABIAL VENEER (RESIN LAMINATE) - INDIRECT	$0
D2962	LABIAL VENEER (PORCELAIN LAMINATE) - INDIRECT	$0
D2971	ADD PROCEDURE NEW CROWN XST PART DENTURE	$0
D2975	COPING	$0
D2980	CROWN REPAIR	$0
ENDODONTIC SERVICES		
D3110	PULP CAP - DIRECT	$0
D3120	PULP CAP - INDIRECT	$0
D3220	TX PULPOTOMY - CORONAL DENTNOCEMENTL JUNC	$0
D3221	PULPAL DEBRIDEMENT PRIMARY & PERMAMENT TEETH	$0
D3222	PARTIAL PULPOTOMY	$0
D3230	PULPAL THERAPY - ANTERIOR PRIMARY TOOTH	$0
D3240	PULPAL THERAPY - POSTERIOR PRIMARY TOOTH	$0
D3310	ANTERIOR	$0
D3320	BICUSPID	$0
D3330	MOLAR	$0
D3331	TX RC OBSTRUCTION; NON-SURG ACCESS	$0
D3332	INCMPL ENDO TX;INOP UNRSTR/FX TOOTH	$0
D3333	INTRL ROOT REPAIR PERFORATION DEFEC	$0
D3346	RETX PREVIOUS RC THERAPY - ANTERIOR	$0
D3347	RETX PREVIOUS RC THERAPY - BICUSPID	$0
D3348	RETX PREVIOUS RC THERAPY - MOLAR	$0
D3351	APEXIFICATION/RECALCIFICATION - INITIAL VST	$0
D3352	APEXIFICATION/RECALCIFICATION - INTERIM	$0
D3353	APEXIFICATION/RECALCIFICATION - FINAL VISIT	$0
D3355	PULPAL REGENERATION - INITIAL VISIT	$0
D3356	PULPAL REGENERATION - INTERIM MEDICAMENT REPLACEMENT	$0
D3357	PULPAL REGENERATION - COMPLETION OF TREATMENT	$0
D3410	APICOECTOMY SURG - ANT	$0
D3421	APICOECTOMY SURG-BICUSPID	$0
D3425	APICOECTOMY SURG - MOLAR	$0
D3426	APICOECTOMY SURGERY	$0

ADA	DESCRIPTION	MEMBER PAYS
ENDODONTIC SERVICES		
D3430	RETROGRADE FILLING - PER ROOT	$0
D3450	ROOT AMPUTATION - PER ROOT	$0
D3471	SURGICAL REPAIR OF ROOT RESORPTION - ANTERIOR	$0
D3472	SURGICAL REPAIR OF ROOT RESORPTION – PREMOLAR	$0
D3473	SURGICAL REPAIR OF ROOT RESORPTION – MOLAR	$0
D3501	SURGICAL EXPOSURE ROOT SURFACE W/OUT APICOECTOMY OR REPAIR ROOT RESORPT-ANTERIOR	$0
D3502	SURGICAL EXPOSURE ROOT SURFACE W/OUT APICOECTOMY OR REPAIR OF ROOT RESORPT–PREMOLAR	$0
D3503	SURGICAL EXPOSURE ROOT SURFACE W/OUT APICOECTOMY OR REPAIR OF ROOT RESORPT–MOLAR	$0
D3910	SURG PROC ISOLAT TOOTH W/RUBBER DAM	$0
D3920	HEMISECTION NOT INCL RC THERAPY	$0
D3950	CANAL PREP & FIT PREFORMED DOWEL/POST	$0
PERIODONTIC SERVICES		
D4210	GINGIVECTOMY/GINGIVOPLASTY 4/>CNTIG TEETH QUAD	$0
D4211	GINGIVECTOMY/GINGIVOPLASTY 1-3 CNTIG TEETH QUAD	$0
D4240	GINGL FLP 4/>CNTIG/BOUND TEETH QUAD	$0
D4241	GINGL FLP 1-3 CNTIG/BND TEETH QUAD	$0
D4245	APICALLY POSITIONED FLAP	$0
D4249	CLIN CROWN LEN - HARD TISSUE	$0
D4260	OSSEOUS SURG 4/> CNTIG TEETH QUAD	$0
D4261	OSSEOUS SURG 1-3 CNTIG TEETH QUAD	$0
D4263	BONE REPLACEMENT GRAFT – RETAINED NATURAL TOOTH – FIRST SITE IN QUADRANT	$0
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	$0
D4274	MESIAL/DISTAL WEDGE PROCEDURE, SINGLE TOOTH (WHEN NOT PERFORMED IN CONJUNCTION WITH SURGICAL PROCEDURES IN THE SAME ANATOMICAL AREA)	$0
D4277	FREE SOFT TISSUE GRAFT PROCEDURE -1ST TOOTH	$0
D4320	PROVISIONAL SPLINTING - INTRACORONAL	$0
D4321	PROVISIONAL SPLINTING - EXTRACORONAL	$0
D4341	PERIODONTAL SCAL & ROOT PLAN 4/>TEETH-QUAD	$0
D4342	PERIODONTAL SCAL & ROOT PLAN 1-3 TEETH	$0
D4346	SCALING IN PRESENCE OF GENERALIZED MODERATE OR SEVERE GINGIVAL INFLAMMATION – FULL MOUTH, AFTER ORAL EVALUATION	$0
D4355	FULL MOUTH DEBRID COMP ORAL EVAL & DX ON A SUBSEQUENT VISIT	$0
D4381	LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS VIA A CONTROLLED RELEASE VEHICLE INTO DISEASED CREVICULAR TISSUE, PER TOOTH	$0
D4910	PERIODONTAL MAINTENANCE	$0
D4920	UNSCHEDULED DRESSING CHANGE	$0
D4921	GINGIVAL IRRIGATION PER QUADRANT	$0
REMOVABLE PROSTHODONTIC SERVICES		
D5110	COMPLETE DENTURE - MAXILLARY	$0
D5120	COMPLETE DENTURE - MANDIBULAR	$0
D5130	IMMEDIATE DENTURE - MAXILLARY	$0
D5140	IMMEDIATE DENTURE - MANDIBULAR	$0
D5211	MAXILLARY PARTIAL DENTURE - RESIN BASE	$0
D5212	MANDIBULAR PARTIAL DENTURE - RESIN BASE	$0
D5213	MAX PART DENTUR-CAST METL W/RSN	$0
D5214	MAND PART DENTUR- CAST METL W/RSN	$0
D5221	IMMEDIATE MAXILLARY PARTIAL DENTURE – RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	$0
D5222	IMMEDIATE MANDIBULAR PARTIAL DENTURE – RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	$0
D5223	IMMEDIATE MAXILLARY PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	$0
D5224	IMMEDIATE MANDIBULAR PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	$0
D5225	MAXILLARY PARTIAL DENTURE FLEX BASE	$0
D5226	MANDIBULAR PARTIAL DENTURE FLEX BASE	$0
D5282	REMOVABLE UNILATERAL PARTIAL DENTURE - MAXILLARY	$0
D5283	REMOVABLE UNILATERAL PARTIAL DENTURE - MANDIBULAR	$0
D5284	REMOVABLE UNILATERAL PARTIAL DENTURE – FLEX BASE/QUAD	$0
D5286	REMOVABLE UNILATERAL PARTIAL DENTURE-RESIN/QUAD	$0
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	$0
D5411	ADJUST COMPLETE DENTURE - MANDIBULAR	$0
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	$0
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	$0
D5511	REPAIR BROKEN COMPLETE DENTURE BASE	$0
D5512	REPAIR BROKEN COMPLETE DENTURE BASE - MAXILLARY	$0
D5520	REPLACE MISSING/BROKEN TEETH - COMPLETE DENTURE	$0
D5611	REPAIR RESIN PARTIAL DENTURE BASE - MANDIBULAR	$0
D5612	REPAIR RESIN PARTIAL DENTURE BASE - MAXILLARY	$0
D5621	REPAIR CAST PARTIAL FRAMEWORK - MANDIBULAR	$0
D5622	REPAIR CAST PARTIAL FRAMEWORK - MAXILLARY	$0
D5630	REPAIR OR REPLACE BROKEN CLASP - PER TOOTH	$0
D5640	REPLACE BROKEN TEETH - PER TOOTH	$0
D5650	ADD TOOTH EXISTING PARTIAL DENTURE	$0
D5660	ADD CLASP EXISTING PARTIAL DENTURE - PER TOOTH	$0
D5670	REPLACE ALL TEETH & ACRYLC FRMEWRK MAXILLARY	$0
D5671	REPLACE ALL TEETH & ACRYLC FRMEWRK MANDIBULAR	$0
D5710	REBASE COMPLETE MAXILLARY DENTURE	$0
D5711	REBASE COMPLETE MANDIBULAR DENTURE	$0
D5720	REBASE MAXILLARY PARTIAL DENTURE	$0
D5721	REBASE MANDIBULAR PARTIAL DENTURE	$0
D5730	RELINE CMPL MAXIL DENTURE (DIRECT)	$0
D5731	RELINE CMPL MAND DENTURE (DIRECT)	$0
D5740	RELINE MAXIL PART DENTURE (DIRECT)	$0
D5741	RELINE MAND PART DENTURE (DIRECT)	$0
D5750	RELINE CMPL MAXIL DENTURE (INDIRECT)	$0
D5751	RELINE CMPL MAND DENTURE (INDIRECT)	$0
D5760	RELINE MAXIL PART DENTURE (INDIRECT)	$0
D5761	RELINE MAND PART DENTURE (INDIRECT)	$0
D5810	INTERIM COMPLETE DENTURE (MAXILLARY)	$0
D5811	INTERIM COMPLETE DENTURE (MANDIBULAR)	$0

ADA	DESCRIPTION	MEMBER PAYS
REMOVABLE PROSTHODONTIC SERVICES		
D5820	INTERIM PARTIAL DENTURE MAXILLARY	$0
D5821	INTERIM PARTIAL DENTURE MANDIBULAR	$0
D5850	TISSUE CONDITIONING MAXILLARY	$0
D5851	TISSUE CONDITIONING MANDIBULAR	$0
D5863	OVERDENTURE - COMPLETE MAXILLARY	$0
D5864	OVERDENTURE - COMPLETE MANDIBULAR	$0
D5865	OVERDENTURE - PARTIAL MAXILLARY	$0
D5866	OVERDENTURE - PARTIAL MANDIBULAR	$0
D5876	ADD METAL SUBSTRUCTURE TO ACRYLIC FULL DENTURE (PER ARCH)	$0
IMPLANT SERVICES		
D6010	SURGICAL PLACEMENT OF IMPLANT BODY: ENDOSTEAL IMPLANT	$1,950
D6013	SURGICAL PLACEMENT OF A MINI-IMPLANT	$1,950
D6055	DENTAL IMPLANT SUPPORTED CONNECTING BAR	$540
D6056	PREFABRICATED ABUTMENT - INCLUDES MOD AND PLACEMENT	$368
D6057	CUSTOM FAB ABUTMENT - INCLUDES PLACEMENT	$610
D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN	$1,050
D6059*	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (HIGH NOBLE METAL)	$915*
D6060	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINATELY BASE METAL)	$1,050
D6061*	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (NOBLE METAL)	$946*
D6062*	ABUTMENT SUPPORTED CAST METAL CROWN (HIGH NOBLE METAL)	$981*
D6063	ABUTMENT SUPPORTED CAST METAL CROWN (PREDOMINATELY BASE METAL)	$854
D6064*	ABUTMENT SUPPORTED CAST METAL CROWN (NOBLE METAL)	$1,168*
D6065	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN	$1,144
D6066*	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	$1,083*
D6067*	IMPLANT SUPPORTED CROWN - HIGH NOBLE ALLOYS	$962*
D6068	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD	$1,026
D6069	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)	$1,050
D6070	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (PREDOMINATELY BASE METAL)	$965
D6071*	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (NOBLE METAL)	$984*
D6072*	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (HIGH NOBLE METAL)	$997*
D6073	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINATELY BASE METAL)	$910
D6074*	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (NOBLE METAL)	$967*
D6075	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	$1,018
D6076*	IMPLANT SUPPORTED RETAINER FOR FPD - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	$992*
D6077*	IMPLANT SUPPORTED RETAINER FOR METAL FPD - HIGH NOBLE ALLOYS	$962*
D6080	IMPLANT MAINTENANCE PROCEDURES WHEN PROSTHESIS ARE REMOVED AND REINSERTED, INCLUDING CLEANSING OF PROSTHESIES AND ABUTMENTS	$55
D6081	SCALING AND DEBRIDEMENT IN THE PRESENCE OF INFLAMMATION OR MUCOSITIS OF A SINGLE IMPLANT, INCLUDING CLEANING OF THE IMPLANT SURFACES, WITHOUT FLAP ENTRY AND CLOSURE	$0
D6082	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO PREDOM. BASE ALLOYS	$1,083
D6083	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO NOBLE ALLOYS	$1,083
D6084	IMPLANT SUPPT CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$1,083
D6086	IMPLANT SUPPT CROWN-PREDOM. BASE ALLOYS	$962
D6087	IMPLANT SUPPT CROWN-NOBLE ALLOYS	$962
D6088	IMPLANT SUPPT CROWN-TITANIUM/TITANIUM ALLOYS	$962
D6090	REPAIR IMPLANT SUPPORTED PROSTHESIS, BY REPORT	$135
D6091	REPLACEMT OF REPLACEABLE PT OF SEMI-PRECISION/PRECISION ATTACHMT OF IMPLANT/ABUTMENT SUPPORT PROSTHESIS	$410
D6092	RECEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED CROWN	$79
D6093	RECEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED FIXED PARTIAL DENTURE	$124
D6094*	ABUTMENT SUPPORTED CROWN - TITANIUM AND TITANIUM ALLOYS	$810*
D6095	REPAIR IMPLANT ABUTMENT, BY REPORT	$55
D6096	REMOVE BROKEN IMPLANT RETAINING SCREW	$0
D6097	ABUTMENT SUPPT CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$915
D6098	IMPLANT SUPPT RETAINER-PORCELAIN FUSED TO PREDOM. BASE ALLOYS	$992
D6099	IMPLANT SUPPT RETAINER FOR FPD-PORCELAIN FUSED TO NOBLE ALLOYS	$992
D6100	IMPLANT REMOVAL, BY REPORT	$600
D6101	DEBRIDEMENT PERI IMPLANT DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT	$0
D6102	DEBRIDEMENT & OSSEOUS PERI IMPLANT DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT	$0
D6103	BONE GRAFT FOR REPAIR OF PERI IMPLANT DEFECT	$350
D6104	BONE GRAFT IMPLANT REPLACEMENT	$0
D6110	IMPLANT /ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH – MAXILLARY	$1,840
D6111	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH – MANDIBULAR	$1,840
D6112	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH – MAXILLARY	$1,840
D6113	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH – MANDIBULAR	$1,840
D6118	IMPLANT/ABUTMENT SUPPORTED INTERIM FIXED DENTURE FOR EDENTULOUS ARCH - MANDIBULAR	$0
D6119	IMPLANT/ABUTMENT SUPPORTED INTERIM FIXED DENTURE FOR EDENTULOUS ARCH - MAXILLARY	$0
D6120	IMPLANT SUPPT RETAINER-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$992
D6121	IMPLANT SUPPT RETAINER FOR METAL FPD-PREDOM. BASE ALLOYS	$962
D6122	IMPLANT SUPPT RETAINER FOR METAL FPD-NOBLE ALLOYS	$962
D6123	IMPLANT SUPPT RETAINER FOR METAL FPD-TITANIUM/TITANIUM ALLOYS	$962
D6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY REPORT	$265
D6191	SEMI-PRECISION ABUTMENT – PLACEMENT	$368
D6192	SEMI-PRECISION ATTACHMENT – PLACEMENT	$368
D6194	ABUTMENT SUPPORTED RETAINER CROWN FOR FPD - TITANIUM AND TITANIUM ALLOYS	$835

ADA	DESCRIPTION	MEMBER PAYS
IMPLANT SERVICES		
D6195	ABUTMENT SUPPT RETAINER-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$1,050
FIXED PROSTHODONTIC SERVICES		
D6205	PONTIC- INDIRECT RESIN BASED COMPOSITE	$0
D6210*	PONTIC - CAST HIGH NOBLE METAL	$0*
D6211	PONTIC - CAST PREDOM BASE METAL	$0
D6212*	PONTIC - CAST NOBLE METAL	$0*
D6214*	PONTIC - TITANIUM AND TITANIUM ALLOYS	$0*
D6240*	PONTIC - PORCELAIN FUSED HI NOBLE METAL	$0*
D6241	PONTIC - PORCELAIN FUSED PREDOM BASE METAL	$0
D6242*	PONTIC - PORCELAIN FUSED NOBLE METAL	$0*
D6243	PONTIC-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$0
D6245	PONTIC - PORCELAIN/CERAMIC	$0
D6250*	PONTIC - RESIN W/HIGH NOBLE METAL	$0*
D6251	PONTIC RESIN W/PREDOM BASE METAL	$0
D6252*	PONTIC RESIN W/NOBLE METAL	$0*
D6253	PROVISIONAL PONTIC - FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS NECESSARY PRIOR TO FINAL IMPRESSION	$0
D6545	RETAINER - CASE METAL FOR RESIN FIXED PROSTHESIS	$0
D6548	RETAINER - PORCELAIN CERAMIC FOR RESIN BONDED FIXED PROSTHESIS	$0
D6549	RESIN RETAINER – FOR RESIN BONDED FIXED PROSTHESIS	$0
D6600	RETAINER INLAY - PORCELAIN/CERAMIC 2 SURFACES	$0
D6601	RETAINER INLAY - PORCELAIN/CERAMIC 3/MORE SURFACES	$0
D6602*	RETAINER INLAY - CAST HI NOBLE METAL 2 SURFACES	$0*
D6603*	RETAINER INLAY - CAST HI NOBLE METAL 3/> SURFACES	$0*
D6604	RETAINER INLAY - CAST PREDOM BASE METAL 2 SURFACES	$0
D6605	RETAINER INLAY - CAST PREDOM BASE METAL 3/>SURFACES	$0
D6606*	RETAINER INLAY - CAST NOBLE METAL 2 SURFACES	$0*
D6607*	RETAINER INLAY - CAST NOBLE METAL 3/MORE SURFACES	$0*
D6608	RETAINER ONLAY - PORCELAIN/CERAMIC 2 SURFACES	$0
D6609	RETAINER ONLAY - PORCELAIN/CERAMIC 3/MORE SURFACES	$0
D6610*	RETAINER ONLAY - CAST HI NOBLE METAL 2 SURFACES	$0*
D6611*	RETAINER ONLAY - CAST HI NOBLE METAL 3/> SURFACES	$0*
D6612	RETAINER ONLAY - CAST PREDOM BASE METAL 2 SURFACES	$0
D6613	RETAINER ONLAY - CAST PREDOM BASE METAL 3/>SURFACES	$0
D6614*	RETAINER ONLAY - CAST NOBLE METAL 2 SURFACES	$0*
D6615*	RETAINER ONLAY - CAST NOBLE METAL 3/MORE SURFACES	$0*
D6624*	RETAINER INLAY - TITANIUM	$0*
D6634*	RETAINER ONLAY - TITANIUM	$0*
D6710	RETAINER CROWN - INDIRECT RESIN BASED COMPOSITE	$0
D6720*	RETAINER CROWN - RESIN WITH HIGH NOBLE METAL	$0*
D6721	RETAINER CROWN - RESIN PREDOMINANTLY BASE METAL	$0
D6722*	RETAINER CROWN - RESIN WITH NOBLE METAL	$0*
D6740	RETAINER CROWN - PORCELAIN/CERAMIC	$0
D6750*	RETAINER CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	$0*
D6751	RETAINER CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	$0
D6752*	RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL	$0*
D6753	RETAINER CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS	$0
D6780*	RETAINER CROWN - 3/4 CAST HIGH NOBLE METAL	$0*
D6781	RETAINER CROWN - 3/4 CAST PREDOMINANTLY BASE METAL	$0
D6782*	RETAINER CROWN - 3/4 CAST NOBLE METAL	$0*
D6783	RETAINER CROWN - 3/4 PORCELAIN/CERAMIC	$0
D6784	RETAINER CROWN - 3/4 TITANIUM/TITANIUM ALLOYS	$0
D6790*	RETAINER CROWN - FULL CAST HIGH NOBLE METAL	$0*
D6791	RETAINER CROWN - FULL CAST PREDOMINANTLY BASE METAL	$0
D6792*	RETAINER CROWN - FULL CAST NOBLE METAL	$0*
D6794*	RETAINER CROWN - TITANIUM AND TITANIUM ALLOYS	$0*
D6930	RECEMENT OR RE-BOND FIXED PARTIAL DENTURE	$0
D6940	STRESS BREAKER	$0
D6980	FIXED PARTIAL DENTURE REPAIR, BY REPORT	$0
ORAL SURGERY SERVICES		
D7111	XTRCT CORONAL REMNANTS PRIMARY TOOTH	$0
D7140	EXTRAC ERUPTED TOOTH/EXPOSED ROOT	$0
D7210	EXTRACTION, ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF MUCOPERIOSTEAL FLAP IF INDICATED	$0
D7220	REMOVAL IMPACT TOOTH - SOFT TISSUE	$0
D7230	REMOVAL IMPACT TOOTH - PARTLY BONY	$0
D7240	REMOVAL IMPACTED TOOTH - COMPLETELY BONY	$0
D7241	REMOVAL IMPACTED TOOTH - COMPLETELY BONY W/SURG COMP	$0
D7250	REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)	$0
D7261	PRIMARY CLOSURE OF A SINUS PERFORATION	$0
D7270	TOOTH REIMPLANTATION AND/OR STABILIZATION ACCIDENTLY DISPLACED	$0
D7280	EXPOSURE OF AN UNERUPTED TOOTH	$0
D7282	MOBILIZATION OF ERUPTED OR MALPOSITIONED TOOTH TO AID ERUPTION	$0
D7285	INCISIONAL BIOPSY OF ORAL TISSUE HARD	$0
D7286	INCISIONAL BIOPSY OF ORAL TISSUE SOFT	$0
D7287	EXTOLIATIVE CYTOLOGICAL SAMPLE COLLECTION	$0
D7288	BRUSH BIOPSY	$0
D7290	SURGICAL REPOSITIONING OF TEETH	$0
D7310	ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE	$0
D7311	ALVEOLOPLASTY CONJNC XTRCT 1-3 TEETH	$0
D7320	ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC	$0
D7321	ALVEOLOPLASTY NOT W/XTRCT 1-3 TEETH	$0
D7340	VESTIBULOPLASTY - RIDGE EXTENSION (SECONDARY EPITHELIALIZATION)	$0
D7350	VESTIBULOPLASTY - RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT	$0

ADA	DESCRIPTION	MEMBER PAYS
ORAL SURGERY SERVICES		
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM	$0
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR - LESION DIAMETER GREATER THAN 1.25 CM	$0
D7460	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM	$0
D7461	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER GREATER THAN 1.25 CM	$0
D7471	REMOVAL OF LATERAL EXOSTOSIS	$0
D7472	REMOVAL OF TORUS PALATINUS	$0
D7473	REMOVAL OF TORUS MANDIBULARIS	$0
D7485	REDUCTION OF OSSEOUS TUBEROSITY	$0
D7510	I & D ABSCESS - INTRAORAL SOFT TISSUE	$0
D7511	I & D ABSCESS - INTRAORAL SOFT TISS COMPLICATED	$0
D7520	I & D OF ABSCESS EXTRAORAL SOFT TISSUE	$0
D7521	I & D OF ABSCESS EXTRAORAL COMPLICATED	$0
D7530	REMOVAL OF FOREIGN BODY - SKIN SUBCUTANEOUS	$0
D7961	BUCCAL / LABIAL FRENECTOMY (FRENULECTOMY)	$0
D7962	LINGUAL FRENECTOMY (FRENULECTOMY)	$0
D7963	FRENULOPLASTY	$0
D7970	EXC HYPERPLASTIC TISSUE-PER ARCH	$0
D7971	EXCISION OF PERICORONAL GINGIVA	$0
D7972	SURGICAL RDUC FIBROUS TUBEROSITY	$0
ADJUNCTIVE GENERAL SERVICES		
D9110	PALLIATVE TX DENTAL PAIN-MINOR PROC	$0
D9120	FIXED PARTIAL DENTURE SECTIONING	$0
D9210	LOCAL ANESTHESIA NOT IN CONJUNCTION WITH OPERATIVE OR SURGICAL PROCEDURES	$0
D9211	REGIONAL BLOCK ANESTHESIA	$0
D9212	TRIGEMINAL DIVISION BLOCK ANES	$0
D9215	LOCAL ANESTHESIA	$0
D9219	EVALUATION FOR DEEP SEDATION OR GENERAL ANESTHESIA	$0
D9222	DEEP SEDATION/GENERAL ANESTHESIA - FIRST 15 MINUTES	$0
D9223	DEEP SEDATION/GENERAL ANESTHESIA - EACH 15 MINUTE INCREMENT	$0
D9230	ANALGESIA ANXIOLYSIS, INHALATION OF NITROUS OXIDE	$0
D9239	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANESTHESIA - FIRST 15 MINUTES	$0
D9243	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - EACH 15 MINUTE INCREMENT	$0
D9248	NON-INTRAVENOUS (CONSCIOUS) SEDATION, THIS INCLUDES NON-IV MINIMAL AND MODERATE SEDATION	$0
D9310	CNSLT DX DENT/PHY NOT REQ DENT/PHY	$0
D9430	OV OBS - NO OTH SERVICES PERFORMED	$0
D9440	OV-AFTER REGULARLY SCHEDULED HRS	$0
D9930	TREATMENT OF COMPLICATIONS - POST SURG.	$0
D9943	OCCLUSAL GUARD ADJUSTMENT	$0
D9944	OCCLUSAL GUARD - HARD APPLIANCE, FULL ARCH	$0
D9945	OCCLUSAL GUARD - SOFT APPLIANCE, FULL ARCH	$0
D9946	OCCLUSAL GUARD - HARD APPLIANCE, PARTIAL ARCH	$0
D9951	OCCLUSAL ADJUSTMENT - LIMITED	$0
D9952	OCCLUSAL ADJUSTMENT - COMPLETE	$0
D9972	EXTERNAL BLEACHING - PER ARCH PERFORMED IN OFFICE	$125
D9995	TELEDENTISTRY - SYNCHRONOUS; REAL TIME ENCOUNTER	$0
D9996	TELEDENTISTRY - ASYNCHRONOUS; INFORMATION STORED AND FORWARDED TO DENTIST FOR SUBSEQUENT REVIEW	$0
ORTHODONTIC SERVICES		
D8070	COMPREHENSIVE ORTHODONTIC TREATMENT TRANSITIONAL DENTITION)	$750
D8080	COMPREHENSIVE ORTHODONTIC TREATMENT ADOLESCENT DENTITION	$750
D8090	COMPREHENSIVE ORTHODONTIC TREATMENT ADULT DENTITION	$750
D8670	PERIODIC ORTHODONTIC TREATMENT VISIT	$0
D8680	ORTHODONTIC RETENTION (REMOVAL OF APPLIANCES, CONSTRUCTION AND PLACEMENT OF RETAINERS)	$150
D8695	REMOVAL OF FIXED ORTHODONTIC APPLIANCES FOR REASONS OTHER THAN COMPLETION OF TREATMENT	$75
D8999	a START-UP FEE (INCLUDING EXAM, BEGINNING RECORDS, X-RAYS,TRACING, PHOTOS, AND MODELS)	$350

ADA	DESCRIPTION	MEMBER PAYS

ADA	DESCRIPTION	MEMBER PAYS

For additional coverage details and to locate a dentist please visit myuhc.com® or contact Customer Service.

*If a noble, high noble or titanium metal is used, there will be an additional charge not to exceed $150 per unit. If a base metal is used, there are no additional charges from the provider.

UnitedHealthcare/Select Managed Care dental exclusions and limitations

LIMITATIONS OF BENEFITS

The following are the limitation of benefits, unless otherwise specifically listed as a covered benefit on this Plan's Schedule of Benefits:

1.	DENTAL PROPHYLAXIS	Limited to 1 time per 6 months
2.	FLUORIDE TREATMENTS	Limited to 1 time per 6 months
3.	INLAYS, ONLAYS, AND VENEERS	Restorations - Limited to 1 time per tooth per 5 years. Covered only when a filing cannot restore the tooth.
4.	CROWNS	Restorations - Limited to 1 time per tooth per 5 years. Covered only when a filing cannot restore the tooth.
5.	POST AND CORES	Covered only for teeth that have had root canal therapy.
6.	SCALING AND ROOT PLANING	Limited to 4 quadrants per calendar year.
7.	REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS OR ONLAYS AND IMPLANTS, IMPLANT CROWNS, IMPLANT PROTHESIS	Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays, onlays, and implants, implant crowns, implant prosthesis previously submitted for payment under the plan is limited to 1 time per tooth per consecutive 60 months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances. If damage or breakage was directly related to provider error, this type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
8.	INTRAORAL BITEWING RADIOGRAPHS	Limited to 1 series of 4 films in any 6 month period
9.	STAINLESS STEEL CROWNS	Limited to 1 time per tooth per 60 Months. Covered only when a filing cannot restore the tooth. Prefabricated esthetic coated stainless steel crown - primary tooth, are limited to primary anterior teeth.
10.	ADJUSTMENTS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES OR CROWNS	Limited to repairs or adjustments performed more than 6 months after the initial insertion.
11.	INTRAVENOUS SEDATION OR GENERAL ANESTHESIA	Administration of I.V. sedation or general anesthesia is limited to covered oral surgical procedures involving 1 or more impacted teeth (soft tissue, partial bony or complete bony impactions).
12.	ALL SPECIALTY REFERRAL SERVICES MUST BE	(A) Pre-Authorized by us; and (B) Coordinated by a Covered Person's Participating Dentist. Any Covered Person who elects specialist care without prior referral by his or her Participating Dentist and approval by us is responsible for all charges incurred. • In order for specialty services to be Covered by this plan, the following referral process must be followed: • A Covered Person's Participating Dentist must coordinate all Dental Services. • When the care of a Network Specialist Dentist is required, the Covered Person's Participating Dentist must contact us and request authorization. • If the Participating Dentist request for specialist referral is denied, the Participating Dentist and the Covered Person will be notified of the reason for the denial. If the service in question is a Covered service, and no limitations or exclusions apply, the Participating Dentist may be asked to perform the service. • Covered Person who receives authorized specialty services must pay all applicable Copayments associated with the services provided. When we authorize specialty dental care, a Covered Person will be referred to a Network Specialist Dentist for treatment. The Network includes Network Specialist Dentists in: (a) endodontics; (b) oral surgery; (c) pediatric dentistry; and (d) orthodontics; and (e) periodontics, located in the Covered Person's Service Area. If there is no Network Specialist Dentist in the Covered Person's Service Area, we will refer the Covered Person to a Non-Participating Specialist of our choice. Except for Emergency Dental Services, in no event will we cover dental care provided to a Covered Person by a specialist not preauthorized by us to provide such services. • Covered Person's fi nancial responsibility is limited to applicable Copayments. Copayments are listed in the Covered Person's Schedule of Covered Dental Services.
13.	PERIODONTAL MAINTENANCE PROCEDURES	Limited to once every 6 months, following active therapy, exclusive of gross debridement
14.	REMOVABLE PROSTHETICS/FIXED PROSTHETICS/CROWNS, INLAYS AND ONLAYS (MINOR RESTORATIVE SERVICES)	Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per 5 years from initial or supplemental placement
15.	CROWNS, FIXED BRIDGES, AND IMPLANTS	The maximum benefit within a 12-month period is any combination of 7 crowns or pontics (artificial teeth that are part of a fixed bridge). If more than 7 crowns and/or pontics are done for a Member within a 12-month period, the dentist's fee for any additional crowns within that period would not be limited to the listed Copayment, but instead can reflect the Dentist's Billed Changes.
16.	ADJUNCTIVE	Pre-Diagnostic Test that aids in detection of mucosal abnormalities including premalignant and malignant lesion, not to include cytology or biopsy procedures - Limited to 1 time per year, to Covered Persons over the age of 30.
17.	INTRAORAL	Complete Series (including bitewings) - Limited to 1 time in any 2-year period
18.	TEMPORARY CROWNS	Restorations - Limited to 1 time per tooth per 5 years. Covered only when a filing cannot restore the tooth.
19.	CONE BEAM	Limited to 1 time per consecutive 60 months.

EXCLUSIONS OF BENEFITS

The following procedures and services are excluded and not Covered Services, unless otherwise specifically listed as a covered benefit on this Plan's Schedule of Benefits:

1.	Dental Services that are not Necessary.
2.	Any service done for cosmetic purposes that is not listed as a Covered cosmetic service in the Schedule of Covered Dental Services.
3.	Any Dental Procedure not directly associated with dental disease.

EXCLUSIONS OF BENEFITS

The following procedures and services are excluded and not Covered Services, unless otherwise specifically listed as a covered benefit on this Plan's Schedule of Benefits:

4.	Any implant procedures performed which are not listed as Covered implant procedures in the Schedule of Covered Dental Services.
5.	Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
6.	Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
7.	Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
8.	Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
9.	Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
10.	Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
11.	Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
12.	Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
13.	Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.
14.	Costs for non-dental services related to the provision of dental services in hospitals, extended care facilities, or Member's home are not covered. When deemed necessary by the Primary Care Dentist, the Member's physician, and authorized by the Plan, covered dental services that are delivered in an inpatient or outpatient hospital setting are covered as indicated in the Schedule of Benefits.
15.	Any endodontic, periodontal, crown or bridge abutment procedure or appliance requested, recommended or performed for a tooth or teeth with a guarded, questionable or poor prognosis.
16.	Replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.
17.	Any Covered Person request for: (a) specialist services or treatment which can be routinely provided by a Participating Dentist; or (b) treatment by a specialist without referral from a Participating Dentist and our approval.
18.	Any Dental Procedure not performed in a dental setting. This will not apply to Covered Emergency Dental Services.
19.	Fixed or removable prosthodontic restoration procedures or implant services for complete oral rehabilitation or reconstruction.
20.	Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare
21.	Treatment which requires the services of a pediatric specialist, after the Covered Person's 6th birthday.
22.	Orthodontic Exclusions & Limitations If you require the services of an orthodontist, a referral must first be obtained. If a referral is not obtained prior to the commencement of orthodontic treatment, the Covered Person will be responsible for all costs associated with any orthodontic treatment. Orthodontic services Copayments are valid for authorized services rendered. If you terminate Coverage after the start of orthodontic treatment, you will be responsible for any additional charges incurred for the remaining orthodontic treatment. Orthodontic Exclusions: a) Replacement or repair of lost, stolen or broken appliances or appliances damaged due to the neglect of the Covered Person b) Treatment in progress prior to the effective date of this coverage c) Extractions required for orthodontic purposes d) Surgical orthodontics or jaw repositioning e) Myofunctional therapy f) Cleft palate g) Micrognathia h) Macroglossia i) Hormonal imbalances j) Orthodontic retreatment when initial treatment was rendered under this plan or for changes in orthodontic treatment necessitated by any kind of treatment of accident k) Palatal expansion appliances l) Services performed by outside laboratories Orthodontic Limitations: 1. If a treatment plan is for less than 24 months, then a prorated portion of the full copayment shall apply. 2. If Covered Person's dental eligibility ends, for whatever reason, and the Covered Person is receiving orthodontic treatment under the plan, the remaining cost for that treatment will be prorated at the orthodontist's usual fees over the number of months of treatment remaining. The Covered Person will be responsible for the payment of this balance under the terms and conditions pre-arranged with the orthodontist. 3. If the Covered Person has the orthodontist perform a "diagnostic work-up" (a consultation and diagnosis) and then decides to forgo the treatment program, the Covered Person will be charged a $50 consultation fee, plus any lab costs incurred by the orthodontist. 4. One orthodontic benefit under this plan is available per lifetime, per Covered Person. A Covered Person may access this Comprehensive Orthodontic Treatment. If comprehensive treatment is necessary, and is completed within a 24 month period, the Copayments listed will apply. If necessary and active treatment extends beyond 24 months, the provider is obligated to accept the plan Copayment only for the first 24 months of active therapy. The provider may charge usual and customary fees for active treatment extending beyond the 24 month benefit period.

Joint Health Management Board

Fresno Unified School District

JHMB Meeting Date:	April 22, 2021
Subject:	Rx Options Preliminary Summary
Prepared by:	Brittany King, Claremont Partners
Status:	☑ Information
	☐ Action

Rx Options Preliminary Summary

- All options modeled using 2020 claims data for member impact and estimated costs

Rx Options Preliminary Summary

Add Start Supplies

- 5 day supplies of medications with rejections for prior authorization, non-formulary, and step therapy (note: packages that cannot be broken will be dispensed in it's entirety; excludes specialty drugs)
- 3,044 members would have been eligible in 2020
- Assuming 80% participation, additional plan spend estimated at $252,000 annually; $756,000 for three years

Valley Air Initiative

- Add inhalers to Tier 1 ($0 copay) and exclude from Rx90 (mandatory 90-day fills of maintenance medications) program
- 3,425 members with inhalers in 2020
- Plan spend would increase by $284,151 for 2020; $940,000 for three years (base + 11% trend applied)

Rx Options Preliminary Summary

Tier 1 Expansion: All Generics

- Tier 1 medications, currently defined as low-cost generics treating diabetes, depression, high blood pressure, and high cholesterol and covered with $0 member copay, would be expanded to include ***all generic drugs****
- 16,947 generic utilizers
- Plan spend would increase by $1,683,570 for 2020; $5,091,223 for three years (base + .08% trend applied)

Tier 1 Expansion: Brands in Chronic Conditions

- Tier 1 medications, currently defined as low-cost generics treating diabetes, depression, high blood pressure, and high cholesterol and covered with $0 member copay, would be expanded to cover ***all drugs for chronic conditions, adding diabetes, changing "depression" to "mental health"***
- 21,279 chronic condition utilizers
- Plan spend would increase by $1,296,175 for 2020; $4,122,911 for three years (base + 5% trend applied)

*The PBM Committee may consider removing items such as lifestyle drugs from this expansion

Fresno Unified School District
Board Communication

BC Number OS-1

From the Office of the Superintendent
To the Members of the Board of Education
Prepared by: Karin Temple, Chief Operating Officer
Cabinet Approval: KSTemple

Date: May 07, 2021

Phone Number: 457-3134

Regarding: Number of Board of Education Trustees

The purpose of this communication is to provide the Board a response to an inquiry at the April 21, 2021 Board meeting regarding the potential to expand the number of Board trustees in the future.

California Education Code allows a school district to have either five or seven trustees, per section 5019(a)(1), which states: "Except in a school district governed by a board of education provided for in the charter of a city or city and county, in any school district or community college district, the county committee on school district organization may establish trustee areas, rearrange the boundaries of trustee areas, abolish trustee areas, and increase to seven from five, or decrease from seven to five, the number of members of the governing board, or adopt one of the alternative methods of electing governing board members specified in Section 5030."

Therefore, the Board currently has the maximum allowable number of trustees.

If you have questions or need further information, please contact Karin Temple at 457-3134.

Approved by Superintendent
Robert G. Nelson Ed.D. Robert G. Nelson

Date: 05/07/21

Fresno Unified School District
Board Communication

BC Number SL-1

From the Office of the Superintendent
To the Members of the Board of Education
Prepared by: Jeremy Ward, Executive Officer
Cabinet Approval:

Date: May 07, 2021

Phone Number: 248-7465

Regarding: 2021 Extended Learning Summer Program

The purpose of this communication is to provide the Board information regarding the 2021 Extended Learning Summer Program (ELSP) which will begin on Monday, June 14, 2021 at 44 school sites across Fresno Unified School District. The Extended Learning Summer Program will offer intervention, enrichment, and acceleration opportunities through Summer Academies and Camps.

Summer Academies are designed to support academic growth in literacy and/or math for elementary and middle school students. For high school students, acceleration, or credit recovery for graduation and/or A-G requirements will be offered. Academy students are automatically enrolled in their identified program and families will have the opportunity to choose in-person or distance learning. Learning will be led by teachers through simultaneous instruction in content focused on literacy, math, dual immersion, high school credit recovery, and individualized special education and English Learner instruction. To further address unfinished student learning, the Extended Learning Office in the College and Career Readiness Department worked with other departments to expand summer academy opportunities as follows:

- Elementary programs include a Kinder through third grade Literacy Academy and a fourth through fifth grade Literacy & Math Academy with embedded enrichment experiences.
- Middle school programs include exiting sixth graders as part of their focus on math readiness, math intervention, Career Technical Education and Social Emotional Learning.
- High school includes exiting eighth graders as part of Algebra Readiness to prepare students for success in Algebra One.
- An additional third session (from July 13-26) at comprehensive high schools and alternative education sites expands opportunities to recover credits for graduation and/or A-G.
- A fourth session (from July 27-August 6) will be available at alternative education sites to provide additional credit recovery options.

Summer Camps are designed to provide enriching and fun learning experiences for students of all grade levels. Camps are an opt-in opportunity and week-long in length. Interested students can engage in activities at the Fresno Chaffee Zoo Camp and in various Science, Technology, Engineering and Mathematics themed camps in partnership with Growthpoint Technologies. In an effort to provide equitable access for students at all grade levels and across our district, regional summer camps will be hosted at each of the seven comprehensive high schools during specific weeks so that students may attend camp nearest to their home or residence. All regions will offer the same camp options during their designated weeks. The table below shows the rotation schedule for each high school region.

Dates	**Location 1**	**Location 2**	**Location 3**
June 14-18, 2021	Bullard High	McLane High	
June 21-25, 2021	Hoover High	Edison High	
June 28-July 2, 2021	Sunnyside High		
July 06-09, 2021	Fresno High	Roosevelt High	

July 12-16, 2021	Bullard High	Edison High	
July 19-23, 2021	Hoover High	Roosevelt High	
July 26-30, 2021	Fresno High	McLane High	Sunnyside High

Future ELSP communication strategies include school messenger to district families, District Update and Employee Zone submissions, principal updates to their students, letters mailed to all Summer Academy students, numerous social media infographic messages, and personal phone calls made to students and families from summer program teachers.

Please refer to the attached materials for additional information on Summer Academy and Summer Camp opportunities.

If you have any questions or require additional information, please contact Jeremy Ward at 248-7465.

Approved by Superintendent
Robert G. Nelson Ed.D. _____ Date: 05/07/21

Extended Learning Summer Program 2021
K-12 Overview

Summer School Academies at Elementary and Middle School include 20 days of instruction from June 14 to July 12, 2021.
Extended School Year (Special Education) includes 25 days of instruction from June 14 – July 19, 2021.
High School Summer Academies include 30 days of instruction from June 14 – July 26, 2021.
Alternative Education Summer Academies include 40 days of instruction from June 14 – August 9, 2021.
The Independence Day holiday is observed on July 5, 2021 – summer school is not in session.
Summer graduation date is TBD.
Students identified for Summer Academy programs are automatically enrolled. Parents may choose to opt-out.

Elementary Summer Academy Program Description

K-3 Literacy	An intervention program to support exiting K – 3rd grade students who need additional instruction in foundational skills to help support reading fluency.
4-5 Literacy and Math	An extended and enrichment learning program designed to support exiting 4th and 5th grade students in further engagement with mathematics and science. This program provides hands-on instruction merging both math and science concepts, connecting students to real-world application.
ESY	Extended School Year (ESY) program designated for Special Education (SPED) students Pre K through sixth grade as determined by students' individual IEPs.
EL Redesignation	An intervention program designed to support exiting 3rd - 5th grade English Learner (EL) students in acquiring the necessary proficiency in language and literacy to attain re-designation.
A4's Springboard Collaborative Literacy and Math	African American Academic Acceleration (A4) department's intervention program designed to support K - 5th grade students who are performing below grade level in literacy and/or math. Special target of African American students. *Program dates may vary.*
Dual Language Immersion	An intervention program to support Spanish Dual Immersion exiting K – 3rd grade students in need of additional instruction in foundational skills and reading fluency. This program fosters bilingualism, biliteracy, enhanced awareness of linguistic and cultural diversity, and develops a strong cognitive, social, and emotional identity. Students must be in Spanish/English Dual Language Immersion Program during the school year.
SEL and Literacy	For 3rd and 4th grade students with a focus on improving foundational literacy skills and developing social emotional learning (SEL) skills.
Early Learning	For Pre-School students with a focus on early foundational literacy skills.
A4's Early Learning	African American Academic Acceleration (A4) department's program for pre-school students with a focus on early foundational literacy skills. Special target of African American students. *Program dates may vary.*

Extended Learning Summer Program 2021 | K-12 Overview

Elementary Summer Academy Sites & Programs

	Summer School sites	Feeder sites 	K-3 Literacy	4-5 Literacy and Math	3-5 EL Redesignation	3-6 Newcomers	A4 Springboard Literacy & Math	Dual Immersion	Hmong Heritage	SPED MM	SPED ALPS	SPED Autism	SPED ED	SPED DHH	SEL & Literacy	Early Learning
Bullard	**Figarden 8:30 – 12:30**	Forkner, Lawless, and Malloch, and Starr	X	X	X							X			X	X
	Powers 8:00 – 12:00	Gibson, Kratt, and Slater	X	X	X					X	X				X	
Edison	**King 8:00 – 12:00**	Kirk	X	X	X		X								X	
	Lincoln 8:00 – 12:00	Addams and Columbia	X	X	X					X	X				X	X
Fresno	**Del Mar 8:30 – 12:30**	Fremont, Hamilton, Heaton, and Muir	X	X	X	X				X	X				X	X
	Williams 8:00 – 12:00	Homan, Roeding, Sunset, Wawona DI, and Wilson	X	X	X		X	X		X			X		X	
Hoover	**McCardle 8:00 – 12:00**	Eaton, Robinson, Viking, and Wolters	X	X	X										X	X
	Pyle 8:30 – 12:30	Centennial, Holland, Thomas, and Vinland	X	X	X			X		X	X				X	
	Thomas 8:00 – 12:00	A4 Springboard only					X								X	
Mclane	**Ericson 8:30 – 12:30**	Birney, Norseman, Turner, and Wishon	X	X	X				X	X				X	X	
	Mayfair 8:30 – 12:30	Ewing, Hidalgo, Leavenworth, and Rowell	X	X	X			X		X	X				X	X
Roosevelt	**Anthony 8:00 – 12:00**	Jefferson, Lowell, Webster, and Yokomi	X	X	X					X	X				X	
	Vang Pao 8:00 – 12:00	Balderas, Calwa, Jackson, Lane, and Winchell	X	X	X	X		X	X						X	X
Sunnyside	**Ayer 8:00 – 12:00**	Aynesworth, Greenberg, and Storey	X	X	X		X		X			X			X	
	Bakman 8:30 – 12:30	Burroughs, Easterby, and Olmos	X	X	X	X		X	X	X	X				X	X

Middle School Summer Academy Program Description

Middle School Math, CTE, and SEL	Site and regional based strategic program integrating middle school math instruction, Career Technical Education (CTE), and Social Emotional Learning (SEL) activities. For students who are current 6th graders (incoming 7th) and current 7th graders.

Middle School Summer Academy Sites & Programs

9:00am-1:00pm

Summer School Sites	Feeder Sites	Middle School Math, CTE, and SEL
Ahwahnee		X
Computech		X
Cooper (@ Wilson)		X
Fort Miller	Hamilton	X
Gaston		X
Kings Canyon		X
Scandinavian (@ Norseman)		X
Sequoia		X
Tehipite		X
Tenaya	Wawona	X
Terronez		X
Tioga		X
Yosemite (@ Hidalgo)		X

All Middle School Extended School Year (ESY) Programs for students receiving Special Education services will be held at the high school campus and will run from June 14 – July 19, 2021

Hoover High Campus – Ahwahnee, Fort Miller, Hamilton, Tenaya, Tioga, Wawona

McLane High Campus – Gaston, Kings Canyon, Scandinavian, Sequoia, Tehipite, Terronez, Yosemite

High School Summer Academy Programs

Credit Recovery	A credit recovery program to support students in grades 9th -12th who are deficient in credits for graduation or are A-G deficient for college admissions. Edgenuity program will be used as the curriculum platform.
Special Education	Summer program designated for special education students as determined by students' Individual Education Plan (IEP).

High School Summer Academy Sites

8:00am-2:00pm

Summer School Sites	Session One 6/14-6/25	Session Two 6/28-7/12	Session Three 7/13-7/26	Session Four 7/27-8/9	Special Education 6/14-7/19
Adult Transition Program	X	X			X
Bullard	X	X	X		X
Cambridge	X	X	X	X	
Dewolf	X	X	X	X	
Duncan	X	X			
Edison	X	X	X		X
Fresno	X	X	X		X
Fulton	X	X			X
Hoover	X	X	X		
JE Young	X	X	X	X	
McLane	X	X	X		X
Phoenix Secondary	X				
Rata	X	X			X
Roosevelt	X	X	X		X
Sunnyside	X	X	X		X

Summer Camps

Summer Camp opportunities are available for FUSD students.
Total student opportunities: at least 2580. The following Summer Camp opportunities are available to students by region as specified below. **Registration is required and is opt-in.**

Dates	Location	Location	Location
June 14 – 18, 2021	Bullard High	McLane High	
June 21 – 25, 2021	Hoover High	Edison High	
June 28 – July 2, 2021	Sunnyside High		
July 6 – 9, 2021	Fresno High	Roosevelt High	
July 12 – 16, 2021	Bullard High	Edison High	
July 19 – 23, 2021	Hoover High	Roosevelt High	
July 26 – 30, 2021	Fresno High	McLane High	Sunnyside High

Intro to Robotics Building and programming robots in a team-based environment Grade 3 – 5 20 students per cohort, 2 cohorts per week	**Virtual Campus on Roblox** Recruitment, youth voice, leadership, and educationally driven experiences Grade 3 - 8 20 students per cohort, 2 cohorts per week
Minecraft University Learn fundamental concepts in science, technology, engineering, art, and math through Minecraft Grade 3 – 5 20 students per cohort, 2 cohorts per week	**Drone Certification** Hands-on flight training with licensed UAS (Unmanned Aerial Systems) pilots. Students learn about the FAA regulations required to pass the FAA Part 107 exam for a commercial drone pilot license. Grade 10 - 12 10 students per cohort per week
Game Development Learn how to build 3D models, code game logics, design gameplay and launch your first game for public use Grade 9 - 12 20 students per cohort, 2 cohorts per week	**Young Engineers** Hands-on learning focused on the engineering design process and career-themed literacy strategies Grade K – 2 20 students per cohort, 4 cohorts per week
Lego Robotics Building and programming robots in a team-based environment Grade 6 - 8 20 students per cohort, 2 cohorts per week	

Extended Learning Summer Program 2021 | K-12 Overview

A Summer Camp opportunity is available through the Fresno Chaffee Zoo. Transportation available for students who participate in the Fresno Chaffee Zoo Camp. **Registration is required and is opt-in.**

Dates	**Fresno Chaffee Zoo**
June 14 – 18, 2021	Half-day camp. Students will explore the animal kingdom through crafts, artifacts, games, and other hands-on activities. Experience includes behind-the-scenes adventures, art projects, and visits from ambassador animals. Grade K – 6 20 students per cohort, 4 cohorts per week
June 21 - 25, 2021	
June 28 – July 2, 2021	
July 6 – 9, 2021	
July 12 – 16, 2021	
July 19 – 23, 2021	

A Summer Camp opportunity is available for select students who meet criteria for Gifted And Talented Education (GATE) potential. **Students identified are invited to opt-in.**

Dates	**Young Scholars**
June 14 – 25, 2021	An acceleration program focusing on Science, Technology, Engineering, and Math (STEM) education and verbal explanation for exiting 2nd grade students identified as having GATE potential. Grade 2 25 students per cohort, 10 cohorts
June 28 – July 12, 2021	

Summer Internships

Career Technical Education (CTE) is offering the following Summer Internship-based opportunities available for select student groups. **Total student opportunities: at least 400**. **Students identified are invited to opt-in.**

June 14 – July 23, 2021 June 14-18: Internship Preparation / Aviation June 21-25: Start-Ups June 28-July 2: Cybersecurity July 12-16: Video Game Development July 19-23: Tech Fundamentals	**K16 Collaborative Summer Internships** Paid internship opportunities Cohort Size: 150 (Aviation = 20 students) Grade 8 - 11 Number of Cohorts: 6
June 14 – July 9, 2021	**Teacher Academy** Paid internship opportunities working in Summer Academy classrooms and Summer Camps Cohort Size: 250 Grade 10 – 12 Number of Cohorts: 1
Cohort 1: TBD Cohort 2: July 12 – 30, 2021	**Future Ready Lab** Paid internship with NAF for health pathway students Cohort Size: N/A Grade 11 Number of Cohorts: 2

FRESNO UNIFIED SUMMER CAMPS 2021

Registration begins May 17th for free in-person opportunities

Young Engineers (grades K-2)
Chaffee Zoo (grades K-6)
Intro to Robotics (grades 3-5)
Minecraft University (grades 3-8)
Virtual Campus on Roblox (grades 3-8)
Lego Robotics (grades 6-8)
Game Development (grades 9-12)
Drone Certification (grades 10-12)

Regional Enrichment Camps are Offered Between June 14th-July 30th

Learn when week-long camps will be offered in your high school region by visiting your student's school website
#FUSDregionalsummercamps

Fresno Unified School District
Board Communication

BC Number T-1

From the Office of the Superintendent
To the Members of the Board of Education
Prepared by: Philip Neufeld
Cabinet Approval:

Date: May 07, 2021

Phone Number: 457-3164

Regarding: Private LTE Network and Internet Connectivity

The purpose of this communication is to update the Board on the deployment of Private LTE and how this will improve student internet connectivity.

COVID exposed systemic, inequitable internet access for students and families. Fast *broadband* internet was not universally affordable. Hotspots did not consistently work well where cell tower signals were weak, and hotspots were not fiscally sustainable. Students need affordable, safe, sufficient bandwidth and data to engage in learning and to use the District's standard digital curricula and apps.

The District strives to improve equitable access for all students with a multi-layered approach that prioritizes internet services as follows: 1) broadband wireline service such as Comcast Internet Essentials, 2) the District's private LTE network and hotspots, and/or 3) hotspots from third party carriers, such as T-Mobile's Project 10Million program.

RFP #21-13 for $1,400,000 was awarded to NetSync who uses Nokia's LTE equipment. This initial investment will deliver Internet access within a fixed geographic area. It uses *schools-as-towers* to deliver private LTE service to students. The LTE service provides access where cable broadband is not available or affordable. See diagram of LTE coverage on next page.

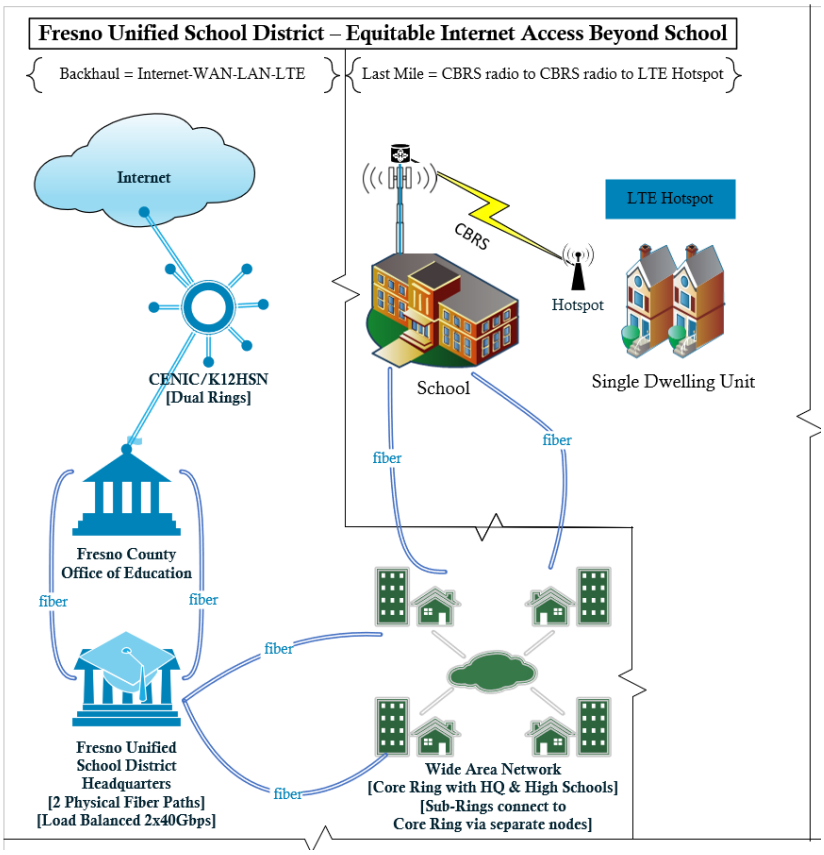
The first four sites will be deployed in May and the remaining 11 sites in June. The service will be available by July with hotspots available prior to August return-to-school.

List of Schools-as-Tower Sites		
Addams	Edison	Sunnyside
Anthony	Gaston	Terronez
Bakman	Lowell	Vang Pao
Calwa	Roosevelt	Yokomi
Columbia	Rowell	Yosemite

If you have any questions or require additional information, please contact Philip Neufeld, 457-3164.

Approved by Superintendent.
Robert G. Nelson Ed.D. _____ Date: 05/07/21

New towers at school sites will broadcast internet to hotspots for student connectivity.



Coverage of the LTE network surrounding the 15 school towers