CITY OF FRESNO

FRESNO CITY EMPLOYEES

HEALTH AND WELFARE TRUST

PLAN BOOKLET

JULY 1, 2024

This is your Plan Booklet

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IMPORTANT INFORMATION AND CONTACT NUMBERS

Binding Information: As a courtesy to you, the Trust's Administration Office (HealthComp Administrators) may respond informally to oral questions. However, oral information and answers are not binding upon the Fresno City Employees Health and Welfare Trust and cannot be relied on in any dispute concerning your benefits. Binding information may be obtained only through written request to HealthComp Administrators. HealthComp Administrators is the only entity authorized to provide information about the Plan. Any statements by any other individual, whether a trustee, union officer, employer, or representative of same, are unauthorized and may not be relied upon.

TRUST ADMINISTRATION OFFICE:	
HealthComp Administrators	(559) 499-2450 or (800) 442-7247
MANAGED CARE VENDORS:	
Blue Shield of California	Hospital and Physician Provider Network and Medical Management To locate a provider: (800) 219-0030 ext. 1 Website: www.blueshieldca.com Medical Management Blue Shield of CA: (800) 541-6652 For an out of state provider, BlueCard Eligibility: (800) 676-BLUE (2583)
SimpleMSK	Chiropractic Network, Physical Therapy, Occupational Therapy, and Speech-Language Therapy Network To locate a provider: (844) 854-4861 or (559) 400-6230 Website: www.simpletherapy.com/go/cityoffresno
OptumRx	Prescription Drug Card: (800) 777-0074 Website: www.optumrx.com OptumRx Mail Home Delivery: (800) 777-0074 OptumRx BriovaRx Specialty Pharmacy: (855) 427-4682
SimpleBehavioral	Mental Health and Substance Abuse Care Network (888) 425-4800 Call SimpleBehavioral for approval of all in or outpatient mental health and/or substance abuse treatment. Website: www.fresnocitymhsa.com
UnitedHealthcare Dental Company Dental HMO Plan	(877) 816-3596 Website: www.myuhcdental.com
Delta Dental of California Dental PPO Plan	(800) 765-6003 Website: www.WeKeepYouSmiling.com
EyeMed	(866) 939-3633 Website: www.EyeMed.com
Teladoc	(800) 835-2362
Body Scan International	(877) 274-5577 Website: www.bodyscanintl.com/fcehwt/
EPIC Hearing Healthcare	(866) 956-5400 Website: www.epichearing.com

Failure to pre-certify certain medical services outlined on pages 2-11 may result in a reduction of your benefits. Failure to use the Plan's PPO network may result in a reduction in your benefits because your claim will be processed as Non-Network Provider.

WHAT TO DO IF YOU NEED MEDICAL CARE

Please read your Plan Book and familiarize yourself with the benefits provided through the Fresno City Employees Health and Welfare Trust. The Table of Contents is designed to help you find information quickly and assist you in understanding the Plan's benefits, provisions, and eligibility. Becoming familiar with your Plan prior to accessing health care services will assist you in receiving maximum benefits payable under the Plan.

As a quick reference, should you require medical care, follow the procedures outlined below:

EMERGENCY – Inpatient or Outpatient
The Plan pays at Network Provider benefits for Hospital and Medical Services.

1. Call the Patient's Primary Care Physician or 911 as appropriate, OR
2. Go directly to the emergency room, outpatient clinic, or similar provider for needed service.

If you are admitted to the Hospital as an Inpatient **-** On the next business day, someone **MUST CALL** either of the following numbers to obtain certification.

Blue Shield (800) 541-6652 OR SimpleBehavioral (888) 425-4800

If ongoing care (follow-up visit) is required, you may be required to obtain certification for certain Non-Emergency services (see page 2). Failure to pre-certify medically necessary services that require pre-certification may result in a reduction of your benefits by up to 50%.

NON-EMERGENCY
The Plan pays Hospital and Medical services, as outlined on pages 22 through 24, based upon whether a Network or Non-Network Provider is used. Plan Benefits will be greater if a Network Provider is used.

1. Preventive Outpatient Medical Services should be obtained from your Primary Care Physician. You may use Blue Shield Specialists for some outpatient services without obtaining pre-certification. Specialist pre-certification is still required for certain medical services.

While emergency responses are available if needed, normally you should allow 72 hours for certification.

2. **Inpatient and certain Outpatient Hospital Services require pre-certification (laboratory and radiology services do not require Pre-Certification, except as noted above)**.

3. In order to receive benefits for the following services, please refer to the applicable page numbers noted below:

a. Physical Therapy, Occupational Therapy and Speech-Language Therapy – please refer to page 25

b. Chiropractic – please refer to pages 27 - 28

c. Mental Health – call SimpleBehavioral for non-emergency Mental Health Care – **(888) 425-4800 –** please refer to page 26

d. Dental – please refer to pages 44 - 46

e. Benefits paid for routine Obstetric/Gynecological exams, and Pap smears apply toward the routine Annual Physical Exam.

Out-of-Area Services

Overview
The Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Plans Licensees. Generally these relationships are called Inter-Plan Arrangements and they work based on rules and procedures issued by the Blue Cross Blue Shield Association. Whenever you receive Services outside of California, the claims for these services may be processed through one of these Inter-Plan Arrangements described below.

When you access Covered Services outside of California, but within the United States, the Commonwealth of Puerto Rico, or the U. S. Virgin Islands (BlueCard® Service Area), you will receive the care from one of two kinds of providers. Participating providers contract with the local Blue Cross and/or Blue Shield. Licensee in that other geographic area (Host Blue). Non-participating providers don't contract with the Host Blue. The Administrator's payment practices for both kinds of providers are described below.

Inter-Plan Arrangements

Emergency Services
Members who experience an Emergency Medical Condition while traveling outside of California should seek immediate care from the nearest Hospital. The Benefits of this plan will be provided anywhere in the world for treatment of an Emergency Medical Condition.

BlueCard Program
Under the BlueCard® Program, benefits will be provided for Covered Services received outside of California, but within the BlueCard Service Area (the United States, Puerto Rico, and U.S. Virgin Islands). When you receive Covered Services within the geographic area served by a Host Blue, the Administrator will remain responsible paying benefits. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers, including direct payment to the provider.

The BlueCard Program enables you to obtain Covered Services outside of California, as defined, from a healthcare provider participating with a Host Blue, where available. The participating healthcare provider will automatically file a claim for the Covered Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the member Copayment, Coinsurance and Deductible amounts, if any, as stated in this Plan Booklet.

The Administrator calculates the Member's share of cost either as a percentage of the Allowable Amount or a dollar Copayment, as defined in this booklet. Whenever you receive Covered Services outside of California, within the BlueCard Service Area, and the claim is processed through the BlueCard Program, the amount you pay for Covered Services, if not a flat dollar copayment, is calculated based on the lower of:

1. The billed charges for Covered Services; or
2. The negotiated price that the Host Blue makes available to the Administrator.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing of claims as noted above. However, such adjustments will not affect the price the Administrator used for your claim because these adjustments will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any Covered Services according to applicable law.

To find participating BlueCard providers, you can call BlueCard Access® at 1-800-810-BLUE (2583) or go online at www.bcbs.com and select "Find a Doctor".

Prior authorization may be required for non-emergency services. To receive prior authorization from the Fresno City Employees Health and Welfare Trust, the out-of-area provider should call the customer service number noted on the back of your identification card.

Non-participating Providers Outside of California
When Covered Services are provided outside of California and within the BlueCard Service Area by non-participating providers, the amount you pay for such services will normally be based on either the Host Blue's non-participating provider local payment, the Allowable Amount the Administrator pays a Non-Participating Provider in California if the Host Blue has no non-participating provider allowance, or the pricing arrangements required by applicable state law. In these situations, you will be responsible for any difference between the amount that the non-participating provider bills and the payment the Administrator will make for Covered Services as set forth in this paragraph.

If you do not see a participating provider through the BlueCard Program, you will have to pay the entire bill for your medical care and submit a claim to the local Blue Cross and/or Blue Shield plan, or to the Fresno City Employees Health and Welfare Trust for reimbursement. The Administrator will review your claim and notify you of its coverage determination within 30 days after receipt of the claim; you will be reimbursed as described in the preceding paragraph. Remember, your share of the cost is higher when you see a non-participating provider.

Federal or state law, as applicable, will govern payments for out-of-network Emergency Services. The Administrator pays claims for covered Emergency Services based on the Allowable Amount as defined in this Plan Booklet.

Prior authorization is not required for Emergency Services. In an emergency, go directly to the nearest hospital. Please notify the Administrator of your emergency admission within 24 hours or as soon as it is reasonably possible following medical stabilization.

Blue Shield Global® Core

Care for Covered Urgent and Emergency Services Outside the BlueCard Service Area
If you are outside of the BlueCard® Service Area, you may be able to take advantage of Blue Shield Global Core when accessing Out-of-Area Covered Health Care Services. Blue Shield Global Core is unlike the BlueCard Program available within the BlueCard Service Area in certain ways. For instance, although Blue Shield Global Core assists you with accessing a network of inpatient, outpatient, and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard Service Area, you will typically have to pay the provider and submit the claim yourself to obtain reimbursement for these services.

If you need assistance locating a doctor or hospital outside the BlueCard Service Area you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. Provider information is also available online at www.bcbs.com: select "Find a Doctor" and then "Blue Shield Global Core".

Submitting a Blue Shield Global Core Claim
When you pay directly for services outside the BlueCard Service Area, you must submit a claim to obtain reimbursement. You should complete a Blue Shield Global Core claim form and send the claim form along with the provider's itemized bill to the service center at the address provided on the form to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from the Administrator, the service center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

Special Cases: Value-Based Programs

Claims Administrator Value-Based Programs
You may have access to Covered Services from providers that participate in a Value-Based Program. Claims Administrator Value-Based Programs include but are not limited to, Accountable Care Organizations, Episode Based Payments, Patient-Centered Medical Homes, and Shared Savings arrangements.

BlueCard® Program
If you receive covered services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Blue Shield through average pricing or fee schedule adjustments.

Balance Billing

The No Surprises Act, part of Title I of the Consolidated Appropriations Act of 2021, prohibits Physicians, Providers, health care facilities and air ambulance companies from balancing billing you or otherwise holding you liable for any more than the applicable cost sharing amounts that you would have owed for Network care. Specifically, these balance billing protections apply when you receive Emergency Services from a Non-Network provider or facility, when you receive certain non-Emergency Services from Non-Network provider at Network hospital or ambulatory surgical center, and when you receive Emergency Services from a Non-Network air ambulance service.

However, these protections against balance billing do not apply if you consent to treatment by a Non-Network provider (this consent exception generally does not apply in emergency situations).

In addition, this Plan generally will cover Emergency Services without precertification; cover Emergency Services by Non-Network providers; base cost sharing amounts on Network benefits; and count any cost sharing amounts for services subject to balance billing protections toward your Network deductible and out-of-pocket limit.

If you believe you have received a balance bill that is protected under the No Surprises Act, please contact HealthComp Administrators, Inc. at (559) 499-2450 or (800) 442-7247 for additional information.

Please visit www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act for additional information regarding the No Surprises Act.

PROCEDURES TO SAVE YOU MONEY

The information contained on pages 2 through 11, and the Questions and Answers outlined on pages 13 and 14, is provided to help you understand and receive maximum benefits payable under the Plan. It is important that you take a moment to review.

EMPLOYEE CONTRIBUTIONS

EFFECTIVE July 1, 2024

Effective July 1, 2024, the rate required for full medical, prescription drug, dental, and vision coverage will be $1,500 per month for all Active employees. Retired participants may have a different rate. The Trust Fund receives a contribution from the City of Fresno for each eligible employee. In order to receive full benefits, Active employees will be required to make a contribution by payroll deduction equal to the difference between the City of Fresno contribution and the Trust Fund rate. **Once you elect to contribute and receive full benefits, your selection will be binding and remain in force until you submit a Payroll Deduction Authorization Form declining to make the contribution. However, election changes may only be made once per year during open enrollment except in the case of a qualifying event.**

Only those Active employees who have a Payroll Deduction Sheet on file indicating their election to contribute the necessary monthly employee contribution will receive full benefits. If the Trust Fund receives only the City's contribution, a reduction will be applied to Fund payments for benefits. The reduction will be equal to the percentage of the Trust Fund rate not received, plus an additional 5%. The percentage reduction will be made in addition to and AFTER all other Trust Fund benefit calculations are made.

PLEASE NOTE THAT IF AN EMPLOYEE DOES NOT ELECT TO MAKE THE NECESSARY MONTHLY EMPLOYEE CONTRIBUTION, OR FAILS TO COMPLETE THE PAYROLL DEDUCTION AUTHORIZATION FORM, THIS MAY RESULT IN A SUBSTANTIAL PATIENT LIABILITY FOR MEDICAL SERVICES. Please refer to examples of Plan benefit reductions and patient liability starting on page 76 of this Plan Booklet.

PREFERRED PROVIDER ORGANIZATION

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

Your Plan has established a network of participating Hospitals and Physicians called Network Providers. **Please review the Schedule of Benefits contained herein in order to understand the benefits paid to Network and Non-Network Providers**. Network Providers are located throughout the area. Use of this network will result in lowered health care cost for Participants and lower costs for the Plan, which results in lower costs or improved benefits for all. There are savings in several ways:

1. Control of charges for Hospital care;
2. Predetermined maximum allowable charges.

HOW TO USE THE PLAN

To take full advantage of the cost-saving features of the Plan, you'll need to carefully read and fully understand this explanation of how the Plan works. The Summary of Benefits will show you how your claims are paid according to the Hospital and Physician you use.

SPECIAL TERMS

Network Providers have a Participation Agreement in effect with Blue Shield of California, SimpleMSK, SimpleBehavioral at the time services are rendered. They agree to a payment rate which has been negotiated on behalf of the Plan. The Covered Individual will have no additional charges from the Network Provider for covered benefits other than the co-payment and deductible specified in the Summary of Benefits.

You can find a current listing of Blue Shield Network Providers at www.blueshieldca.com. If there is any question regarding the status of any Hospital or Physician or their participation with Blue Shield of California, Blue Shield should be contacted at (800) 219-0030 ext. 1 prior to obtaining services.

To locate a SimpleMSK network provider for physical therapy, occupational therapy, or speech-language therapy, please visit the SimpleMSK website at www.simpletherapy.com/go/cityoffresnoor call SimpleMSK at
(844) 854-4861 or (559) 400-6230.

SimpleBehavioral will monitor the need and appropriateness of Mental Health and Substance Abuse care rendered for both inpatient and outpatient services on an ongoing basis. All Inpatient and Hospitalization, except for admissions required for Emergency Services or involuntary holds, must be pre-certified by SimpleBehavioral at (888) 425-4800.

Some Chiropractic Care services require Precertification by Calling SimpleMSK at 844-854-4861. The amount of the allowable charge differs according to the type of provider and circumstances:

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

2. When referring to Non-Network Providers or types of providers not classified as Network or Non-Network, the allowable charge is the fee, which is the Usual and Customary Charge.

MANDATORY COST CONTAINMENT REQUIREMENTS

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

The programs do not restrict choice of Physician, Hospital or other medical provider nor are they applicable when a medical emergency exists.

Benefits will be reduced if Blue Shield determines the patient or the patient's Physician failed to follow the required procedure or the patient entered the Hospital earlier than required for medical necessity (none of the cost of that day's hospitalization will be covered).

FAILURE TO PRE-CERTIFY MEDICALLY NECESSARY SERVICES THAT REQUIRE PRE-CERTIFICATION MAY RESULT IN A REDUCTION OF YOUR BENEFITS BY UP TO 50%.

BLUE SHIELD OF CALIFORNIA PREFERRED PROVIDERS

This Plan encourages you to use Blue Shield of California Preferred Providers. Preferred Providers include certain Physicians, Hospitals, Alternate Care Services Providers, and Other Providers. Preferred Providers are listed in the Preferred Provider directories. All Blue Shield of California Physician Members are Blue Shield of California Preferred Providers. So are selected Hospitals in your community.

To determine whether a provider is a Preferred Provider, verify this information by accessing Blue Shield's Internet site located at http://www.blueshieldca.com. Please note that a Preferred Provider's status may change. It is your obligation to verify whether the Physician, Hospital or Alternate Care Services provider you choose is a Preferred Provider.

Blue Shield of California Preferred Providers agrees to accept Blue Shield of California's payment, plus your payment of any applicable deductibles, Copayments, or amounts in excess of Benefit maximums, as payment-in-full for covered Services. You are not responsible to Participating and Preferred Providers for payment for covered Services, except for the deductibles, Copayments, and amounts in excess of specified Benefit maximum.

If you go to a Non-Preferred Provider, the Plan's payment for a Service by that Non-Preferred Provider may be substantially less than the amount billed. You are responsible for the difference between the amount the Plan pays and the amount billed by Non-Preferred Providers. It is therefore to your advantage to obtain medical and Hospital Services from Preferred Providers. Terms of agreements that allow Plan access to Network Providers and other discounts may differ from provisions of the Plan and will be honored by the Plan as required. NOTE: Not applicable for Emergency Services, air ambulance and certain Non-Preferred Provider services provided at a Preferred hospital or ambulatory surgical center. See *What To Do If You Need Medical Care, Balance Billing*, for more information.

Blue Shield of California, an independent member of the Blue Shield Association, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

THE BLUECARD PROGRAM

When you access a provider outside of California or the United States, you simply show your ID with Blue Shield logo. The card includes the members ID number and the account's three digit alpha prefix. This prefix and number combination helps route and process the claim. The ID card also includes 800 #'s for the member to locate BlueCard providers and for providers to verify member eligibility and benefits.

To locate a BlueCard provider, you can call the BlueCard 800# on the back of their ID card, or access the Doctor Hospital Finder online at www.blueshieldca.com. However, you are not obligated to access covered services through a BlueCard provider, but are encouraged to do so as it will lower your share of cost.

Covered Services received from a provider who has contracted with the local Blue Cross Blue Shield plan are paid at the network benefit level. Covered Services received from providers who have not contracted with the local Blue Cross Blue Shield plan are paid at the out of network benefit levels. To receive the maximum benefits of your plan, please follow the procedure below.

When you require covered Services while traveling outside of California:

1. Call BlueCard Access® at 1-800-810-BLUE (2583) to locate Physicians and Hospitals that participate with the local Blue Cross Blue Shield plan;

2. Visit the Participating Physician or Hospital and present your membership card. The Participating Physician or Hospital will verify your eligibility and coverage information by calling BlueCard Eligibility at 1-800-676-BLUE (2583).

3. Prior authorization is required for all Inpatient Hospital Services and notification is required for Inpatient Emergency Services. Prior authorization is required for selected Inpatient and Outpatient Services, supplies and Durable Medical equipment. To receive Prior authorization review from Blue Shield of California, the out-of-area provider should call 1-800-541-6652.

If you need Emergency Services, you should seek immediate care from the nearest medical facility.

BLUE SHIELD PRE-CERTIFICATION REQUIREMENTS

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

FAILURE TO PRE-CERTIFY MEDICALLY NECESSARY SERVICES THAT REQUIRE PRE-CERTIFICATION MAY RESULT IN A REDUCTION OF YOUR BENEFITS BY UP TO 50%.

Should you need assistance or information regarding available services, call the Blue Shield Medical Management at (800) 541-6652.

REMINDER: Mental Health services require authorization by SimpleBehavioral.

BENEFITS MANAGEMENT PROGRAM

The Plan has contracted with Blue Shield and the Benefits Management Program to assist you, your Dependents or provider in identifying the most appropriate and cost-effective course of treatment for which Benefits will be provided under this Health Plan and for determining whether the services are Medically Necessary. However, you, your Dependents and provider make the final decision concerning treatment. The Benefits Management Program includes pre-certification review for certain services; preadmission review (except for emergency admissions), emergency admission notification, Hospital Inpatient review; discharge planning; and case management if determined to be applicable and appropriate by Blue Shield.

Your benefits may be reduced for either not contacting Blue Shield or not following Blue Shield's recommendations or may result in non-payment if Blue Shield determines the service was not medically necessary. Please read the following sections thoroughly so you understand your responsibilities in reference to the Benefits Management Program. Remember that all provisions of the Benefits Management Program also apply to your Dependents. Blue Shield requires pre-certification for selected Inpatient and Outpatient services, supplies and Durable Medical Equipment; all home health care, home infusion/home injectable services, and Phenylketonuria (PKU) related formulas and Special Food Products; admission into an approved Hospice Program; and certain radiology procedures. Preadmission review is required for all Inpatient Hospital and Skilled Nursing Facility services.

By obtaining pre-certification for certain services or preadmission review prior to receiving services, you and your provider can verify if Blue Shield considers the proposed treatment Medically Necessary and if the proposed setting is the most appropriate as determined by Blue Shield. You and your provider may be informed about Services that could be performed on an Outpatient basis in a Hospital or Outpatient Facility.

PRE-CERTIFICATION

Before services are provided, you or your provider can determine whether a procedure or treatment program is covered and may also receive a recommendation for an alternative Service. Failure to contact Blue Shield as described below or failure to follow the recommendations of Blue Shield for these services will result in a reduced benefit or may result in non-payment if Blue Shield determines that the service is not a covered Service.

The plan requires pre-certification from Blue Shield for the following services:

1. **Select injectable drugs administered in the physician office setting**. Prior certification is based on Medical Necessity, appropriateness of therapy, or when effective alternatives are available. NOTE: Your Preferred or Non-Preferred Physician must obtain prior authorization for select injectable drugs administered in the physician's office. Failure to obtain prior authorization or to follow the recommendations of Blue Shield for select injectable drugs may result in non-payment by the Plan if the service is determined not to be a covered Service; in that event you may be financially responsible for services rendered by a Non-Preferred Physician.

2. Home Health Care, Home Infusion/Injectable Care, PKU related formulas and Special Food Products.

3. Admission into an approved Hospice Program as specified under Hospice Program Services in the Covered Services section.

4. **Clinical Trial for Cancer.** Persons who have been accepted into an approved clinical trial for cancer as defined under the Covered Services section must obtain prior authorization from Blue Shield in order for the routine patient care delivered in a clinical trial to be covered.

5. **Durable Medical Equipment,** including but not limited to motorized wheelchairs, insulin, infusion pumps, and CPAP (Continuous Positive Air Pressure) machines.

6. **Surgery which may be considered to be Cosmetic in nature rather than Reconstructive (e.g., eyelid surgery, rhinoplasty, abdominoplasty, or breast reduction) and those Reconstructive Surgeries which may result in only minimal improvement in function or appearance.** The Reconstructive Surgery Benefit is limited to Medically Necessary surgeries and procedures.

7. Arthroscopic surgery of the temporomandibular joint (TMJ).

8. Dialysis Services.

9. **Hospital and Skilled Nursing Facility admissions** (see the subsequent Hospital and Skilled Nursing Facility Admissions section for more information).

10. Gene Therapy

11. **Other services and procedures as determined by BlueShield.** A list of services and procedures requiring prior authorization can be obtained by your provider by going to www.blueshieldca.com or by calling 1-800-541-6652.

HOSPITAL AND SKILLED NURSING FACILITY ADMISSIONS

Pre-Certification must be obtained from Blue Shield for all Hospital and Skilled Nursing Facility admissions (except for admissions required for Emergency Services). Included are Hospitalizations for continuing Inpatient Rehabilitation and skilled nursing care, transplants, bariatric surgery, and Inpatient Mental Health or substance abuse Services described later in this section for which Pre-Certification must be obtained from SimpleBehavioral as to Hospitalizations for all Inpatient Mental Health or substance abuse Services, except for admissions required for Emergency Services or involuntary holds.

Pre-Certification for Other than Mental Health or Substance Abuse Admissions
Whenever a Hospital or Skilled Nursing Facility admission is recommended by your Physician, you or your Physician must contact Blue Shield at 1-800-541-6652 at least 5 business days prior to the admission. However, in case of an admission for Emergency Services, Blue Shield should receive Emergency Admission Notification within 24 hours or by the end of the first business day following the admission, or as soon as it is reasonably possible to do so. Blue Shield will review the medical information provided and may recommend that to obtain the full Benefits of this health Plan that the Services be performed on an Outpatient basis. *Examples* of procedures that may be recommended to be performed on an Outpatient basis if medical conditions do not indicate Inpatient care include:

1. Biopsy of lymph node, deep axillary;
2. Hernia repair, inguinal;
3. Esophagogastroduodenoscopy with biopsy;
4. Excision of ganglion;
5. Repair of tendon;
6. Heart catheterization;
7. Diagnostic bronchoscopy;
8. Creation of arterial venous shunts (for hemodialysis).

Failure to contact Blue Shield as described or failure to follow the recommendations of Blue Shield will result in reduction or non-payment if Blue Shield determines that the admission is not a covered Service.

HOSPITAL INPATIENT REVIEW
Blue Shield monitors Inpatient stays. The stay may be extended or reduced as warranted by your condition, except in situations of maternity admissions for which the length is 48 hours or less for a normal, vaginal delivery or 96 hours or less for a Cesarean section unless the attending Physician, in consultation with the mother, determines a shorter Hospital length of stay is adequate. Also, for mastectomies or mastectomies with lymph node dissections, the length of Hospital stays will be determined solely by your Physician in consultation with you. When a determination is made that the Person no longer requires the level of care available only in an Acute Care Hospital, written notification is given to you and your Doctor of Medicine. You will be responsible for any Hospital charges Incurred beyond 24 hours of receipt of notification.

DISCHARGE PLANNING
Further care at home or in another facility is appropriate following discharge from the Hospital; Blue Shield will work with the Physician and Hospital discharge planners to determine whether benefits are available under this Plan to cover such care.

CASE MANAGEMENT
The Benefits Management Program may also include case management, which provides assistance in making the most efficient use of Plan Benefits. Individual case management may also arrange for alternative care benefits in place of prolonged or repeated hospitalizations, when it is determined to be appropriate through a Blue Shield review. Such alternative care benefits will be available only by mutual consent of all parties and, if approved, will not exceed the Benefit to which you would otherwise have been entitled under this Plan. The Plan is not obligated to provide the same or similar alternative care benefits to any other person in any other instance. The approval of alternative benefits will be for a specific period of time and will not be construed as a waiver of the Plan's right to thereafter administer this health Plan in strict accordance with its express terms.

CONTINUITY OF CARE

In the event a Covered Person is a continuing care patient receiving a course of treatment from a Provider which is In-Network or otherwise has a contractual relationship with the Plan governing such care and that contractual relationship is terminated, not renewed, or otherwise ends for any reason other than the Provider's failure to meet applicable quality standards or for fraud, the Participant shall have the following rights to continuation of care.

The Plan shall notify the Covered Person that the Provider's contractual relationship with the Plan has terminated, and that the Covered Person has rights to elect continued transitional care from the Provider. If the Covered Person elects in writing to receive continued transitional care, Plan benefits will apply under the same terms and conditions as would be applicable had the termination not occurred, beginning on the date the Plan's notice of termination is provided and ending 90 days later or when the Covered Person ceases to be a continuing care patient, whichever is sooner.

For purposes of this provision, "continuing care patient" means an individual who:

1. is undergoing a course of treatment for a serious and complex condition from a specific Provider,

2. is undergoing a course of institutional or Inpatient care from a specific Provider,

3. is scheduled to undergo non-elective surgery from a specific Provider, including receipt of postoperative care with respect to the surgery,

4. is pregnant and undergoing a course of treatment for the Pregnancy from a specific Provider, or

5. is or was determined to be terminally ill and is receiving treatment for such illness from a specific Provider.

Note that during continuation, Plan benefits will be processed as if the termination had not occurred, however, the Provider may be free to pursue the Covered Person for any amounts above the Plan's benefit amount.

PRE-CERTIFICATION AND NETWORK PROVIDER QUESTIONS AND ANSWERS

Q What Is Pre-Certification?

Pre-certification is a requirement in which specified services, in order to have maximum coverage under the Plan, must be approved in advance. Nurses and Physicians conduct medical review. A pre-certification review is initiated by contacting Blue Shield Medical Management at (800) 541-6652. As stated on page 2 of this Plan Booklet, pre-certification review does not determine eligibility for Plan Benefits – for example, obtaining pre-certification approval does not assure coverage, and failure to obtain pre-certification approval does not necessarily mean the Plan will deny coverage for the services. Plan benefits are determined by following the claim procedures set forth on page 66 of this Plan Booklet. Plan benefits are payable in accordance with the Schedule of Benefits and the terms of this Plan Booklet. All treatment decisions remain between the patient and the patients' health care provider.

PLEASE READ THE MEDICAL PRE-CERTIFICATION PROCEDURES ON PAGES 2 THROUGH 11.

Q What is a Primary Care Physician?

A Physician who practices in one of the following areas: family practice, general practice, internal medicine, obstetrics/gynecology, and pediatrics.

Q What if I need help in locating or choosing a Primary Care Physician?

You may call Blue Shield for assistance at (800) 219-0030 ext. 1. **You can also find a current listing of Blue Shield of California Network Providers at www.blueshieldca.com.**

Q Do I need to select a Blue Shield Shared of California Network Provider Primary Care Physician?

No, but to ensure a coordinated approach to your healthcare, selection of a Blue Shield of California Network Provider Primary Care Physician is recommended.

Q What if my gynecologist is not my Primary Care Physician?

Up to two routine gynecological visits per year are covered without pre-certification even though the provider is not the patient's Primary Care Physician. For maximum benefit coverage, the gynecologist should be a Network Provider.

Q What is a "Network Provider"?

A Network Provider in the Plan is a Physician, Hospital or other health care provider, which has entered into a participation agreement with Blue Shield of California.

Q What is the "Blue Shield Contract Rate"?

The Blue Shield Contract Rate is the rate at which a Network Provider has contracted to accept payment in full for covered services.

Q Do I need to visit my Primary Care Physician prior to seeing a specialist?

Not necessarily. Please refer to pages 2 through 11 to determine what services require pre-certification.

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

If necessary, you should remind your Doctor of the contracting labs and radiology services. If your Doctor feels that Non-Network Providers are needed for your care, Blue Shield may pre-certify if medically indicated based on the particular situation.

Q **What if I am temporarily out of state or not within distance of Network Providers?**
If emergency care is needed, see emergency services provisions in this Plan. If not an emergency, you must obtain prior authorization.

Q **What if I have questions about specific coverage provisions, deductibles, claims payment, eligibility, or other such matters?**
Contact HealthComp Administrators at either (559) 499-2450 or (800) 442-7247 for answers to these questions.

DEFINITIONS

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

"Approved Clinical Trials" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following:

1. Federally-Funded Trials - The study or investigation is approved or funded (which include funding through in-kind contributions) by one or more of the following:

    a. The National Institutes of Health;

    b. The Centers for Disease Control and Prevention;

    c. The Agency for Health Care Research and Quality;

    d. The Centers for Medicare & Medicaid Services;

    e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or Department of Veterans Affairs; or

    f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

2. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

3. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

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

"Certified IDR Entity" is an entity responsible for conducting determinations under the No Surprises Act and that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

"Chiropractic Care" means services for correction by normal or mechanical means of structure unbalance or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation in the vertebral column.

"Co-Payment" is the amount you pay toward the cost of your care (your out-of-pocket expenses) in addition to your deductible.

"Covered Charges" are the lesser of the Usual and Customary Charges or the negotiated rates payable to preferred providers incurred by an eligible person for the Medically Necessary treatment of conditions covered under the Plan.

"Covered Person" means a covered employee, a covered retiree or a covered dependent.

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

"Deductible" is the amount you pay before the Plan pays benefits. Charges not considered Covered Charges may not be used to satisfy the deductible.

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

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

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

"Emergency Medical Condition" means a medical screening examination and associated services to treat a condition that requires immediate medical attention that would reasonably expect to result in (a) serious jeopardy to the health of an individual (or in the case of a pregnant person, the health of the unborn child); (b) serious impairment to bodily function; or (c) serious dysfunction of any bodily organ or part. Emergency Services include pre-stabilization services that are provided after a patient is moved out of the emergency department and admitted to a Hospital, as well as any additional services rendered after a patient is stabilized as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which other Emergency Services are furnished. These services include those provided at an Independent Freestanding Emergency Department as well as a Hospital emergency department. A decision of what constitutes Emergency Services will not be defined solely on the basis of the diagnosis but rather will be a determination that takes into account the reasonableness of each situation as defined by a prudent layperson.

"Emergency Services" means, with respect to an Emergency Medical Condition, the following:

1. An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

2. Within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

When furnished with respect to an Emergency Medical Condition, Emergency Services shall also include an item or service provided by a Non-Network Provider or Non-Participating Health Care Facility (regardless of the department of the Hospital in which items or services are furnished) after the Participant is stabilized and as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which the Emergency Services are furnished, until such time as the Provider determines that the Participant is able to travel using non-medical transportation or non-emergency medical transportation, and the Participant is in a condition to, and in fact does, give informed consent to the Provider to be treated as a Non-Network Provider.

"Experimental Procedures (Experimental)" are those services that are mainly limited to laboratory and/or animal research, but which are not generally accepted as proven and effective procedures within the organized medical community. The Utilization Manager has discretion to make this determination. However, if a Member has a seriously debilitating condition and the Utilization Manager determines that requested treatment is not a Covered Service because it is Experimental, the Member may request an Independent Medical Review.

"Hospice" means a facility that provides a Hospice Care Program and operates in accordance with the laws of the jurisdiction where it is located. It operates as a unit or program that only admits terminally ill patients. It is separate from any other facility but may be affiliated with a Hospital, nursing home or home health care agency.

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

The definition of "Hospital" shall also include a facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

"Independent Freestanding Emergency Department" is a health care facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable state law, and which provides any Emergency Services.

"Investigational Procedures (Investigational)" are those services:

1. That have progressed to limited use on humans, but which are not generally accepted as proven and effective procedures within the organized medical community; or

2. That do not have final approval from the appropriate governmental regulatory body; or

3. That are not supported by scientific evidence which permits conclusions concerning the effect of the service, drug or device on health outcomes; or

4. That do not improve the health outcome of the patient treated; or

5. That are not beneficial as any established alternative; or

6. Whose results outside the Investigational setting cannot be demonstrated or duplicated; or

7. That are not generally approved or used by Physicians in the medical community.

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

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

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

3. which are not educational or experimental in nature,

4. which are not provided primarily for medical or other research,

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

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

"Network Provider" means a Doctor, Hospital, urgent care center, laboratory or x-ray facility rendering services at reduced rates in accordance with the agreement between Blue Shield and Fresno City Employees Health and Welfare Trust.

"No Surprises Act (NSA)" is the Title I of the Consolidated Appropriations Act of 2021 or any provision or section thereof and which may be amended from time to time.

"Participant" means an employee or retiree of the City of Fresno who meets the eligibility requirements of the Plan and elects to participate in the Plan.

"Participating Health Care Facility" is a Hospital, Ambulatory Surgical Center, or other Provider as required by law, which has a direct or indirect contractual relationship with the Plan with respect to the furnishing of a healthcare item or service. A single direct contract or case agreement between a health care facility and a plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

"Plan" means the Fresno City Employees Health and Welfare Trust group employee benefit program, as amended from time to time.

"Plan Year (or fiscal year)" means the period of time, which starts on July 1st each year and ends June 30th the following year.

"Qualifying Payment Amount" is the median of the contracted rates recognized by the Plan for the same or a similar item or service provided by a Provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning at least three) contracted rates available to determine a Qualifying Payment Amount, said amount will be determined by referencing a state all-payer claims database or, if unavailable, any eligible third-party database in accordance with applicable law.

"Registered Nurse" means a graduated and licensed Registered Nurse who is not related to the Covered Person by blood, marriage or law as well as any person who resides in the same house.

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

1. it is legally operated;

2. it mainly provides short-term nursing and rehabilitation services for persons recovering from sickness or injury;

3. it provides services for a fee, which include both room and board and 24-hour-per-day skilled nursing service;

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

5. it keeps adequate medical records;

6. but "Skilled Nursing Facility" does not include an institution or part of one that is primarily a place for treatment of alcoholism, drug addiction or chemical dependency, or a home for the aged.

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

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

"Trust" means the Fresno City Employees Health and Welfare Trust.

"Usual and Customary Charge" means the charges and prices regularly charged for the medical services and supplies generally furnished for cases of comparable nature and severity in the particular geographical area concerned. For Non-Network Emergency Services, Air Ambulance and certain Non-Network Providers services provided at a Network Facility, the usual and customary charge will be the Qualified Payment Amount or the amount deemed payable by a Certified IDR Entity, whichever is higher.

MEDICAL PLAN SCHEDULE OF BENEFITS

FOR ACTIVE EMPLOYEES AND THEIR DEPENDENTS AND RETIRED EMPLOYEES AND DEPENDENTS UNDER AGE 65

PENALTY MESSAGE

The Plan requires pre-certification for certain Specialists and services. For services and procedures requiring pre-certification: Call (800) 541-6652 for pre-certification. Should services not be pre-certified, and/or if you do not utilize Network Providers, benefits will be substantially reduced as set forth in the Plan's Schedule of Benefits below.

Note: Two routine OB/GYN visits per female employee or dependent per year do not require pre-certification. Plan benefits for these services are payable under the Annual Physical Exam benefit. See page 22 for services which require pre-certification.

MAXIMUM REIMBURSEMENT GUIDELINE

Deductible per Fiscal Year (for all medical/surgical, and mental health or substance use disorder benefits)

Employees electing to make the monthly contribution or employees where Trust is receiving two City contributions (employee and spouse both work for the City):

Per Individual	$200 (plus emergency room co-payment)
Maximum per Family	$600 (plus emergency room co-payment)

Employees electing not to make the monthly contribution and Trust is receiving a single City contribution:

Per Individual	$1,300 (plus emergency room co-payment)
Maximum per Family	$2,600 (plus emergency room co-payment)

Co-Insurance Percentage

The Plan pays covered charges at the following percentages (for medical/surgical benefits and mental health or substance use disorder benefits) after the satisfaction of your deductible each Plan Year unless otherwise stated.

NETWORK PROVIDERS		
Plan Pays	**You Pay**	**Description of Service**
***80%** of the Blue Shield Contract Rate, or the SimpleBehavioral contract rate, as applicable	***20%** of the Blue Shield Contract Rate	Contract Rate for other services pre-certified by Blue Shield or SimpleBehavioral, as applicable.
NON-NETWORK PROVIDERS		
***50%** of the Usual and Customary Charges	**The Balance**	For services by a Non-Network Provider.

"Out-of-Pocket" (OOP) Protection
If an active employee has a current Payroll Deduction Sheet on file indicating their election to make the employee monthly contribution, the maximum out-of-pocket for medical/surgical/mental health/substance use disorder expense shall be **$3,200** per individual **($6,400** per family) per fiscal year for any incurred, allowable and covered medical services from In-Network Providers. **Prescription Drug Plan benefits have a separate maximum out-of-pocket limit of $3,400 per individual ($6,800 per family)** per fiscal year for any incurred, allowable and covered services from In-Network Providers. **The maximum total limit is $6,600 per individual ($13,200 per family) per fiscal year.** Thereafter, the Plan pays 100% of the contract rate for services provided by Network Providers.

If an Active employee does not have a current Payroll Deduction Sheet on file indicating their election to make the employee monthly contribution, the maximum out-of-pocket for medical/surgical/mental health/substance use disorder expense shall be **$4,600** per individual **($9,200** per family) per fiscal year for any incurred, allowable and covered services from In-Network Providers. **Prescription Drug Plan benefits have a separate maximum out-of-pocket limit of $2,000 per individual ($4,000 per family)** per fiscal year for any incurred, allowable and covered services from In-Network Providers. **The maximum total limit is $6,600 per individual ($13,200 per family) per fiscal year.** Thereafter, the Plan pays 100% of the contract rate for services provided by Network Providers.

Services provided by a Non-Network Provider do not accumulate toward the out-of-pocket maximum and the benefits paid for Non-Network services are not affected by reaching the out-of-pocket maximum.

MEDICAL PLAN SCHEDULE OF BENEFITS

MEDICAL BENEFITS

SUMMARY OF SERVICE	Network Provider Benefits	Non-Network Provider Benefits
Physician Office Visit including all other Services while in Office or via Telehealth	*80% after the Deductible	*50% after the Deductible
Physician's Hospital Visits	*80% after the Deductible	*50% after the Deductible
Surgeon, Assistant Surgeon and Anesthesiologists Services	*80% after the Deductible	*50% after the Deductible
Laboratory and X-Ray Procedures **(All Outpatient Lab tests done at a hospital-based laboratory will include an additional $25 co-pay)**	*80% after the Deductible	*50% after the Deductible
CONDITIONS OF PREGNANCY (For covered employee and/or spouse only.)		
Prenatal and Postnatal Office Visits	*80% after the Deductible	*50% after the Deductible
Physician's Hospital Visits	*80% after the Deductible	*50% after the Deductible
Normal Delivery and Cesarean Section	*80% after the Deductible	*50% after the Deductible
Complication of Pregnancy, Including Therapeutic Abortion	*80% after the Deductible	*50% after the Deductible
Newborns' and Mothers' Health Protection Act Compliant No pre-certification is required for minimum length of stay of a 48-hour Hospital stay following an uncomplicated normal delivery and a 96-hour length of Hospital stay following a Cesarean section delivery. 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. Pre-certification is required for a longer stay than described above.		
OTHER SERVICES		
Voluntary Sterilization For employee and spouse only.	*80% after the Deductible	*50% after the Deductible
Blood, Blood Plasma, Blood Derivatives and Blood Factors	*80% after the Deductible	*50% after the Deductible
Ambulance	*80% after the Deductible	
Chemotherapy and Radiation Therapy	*80% after the Deductible	*50% after the Deductible
Hospice Care The Plan covers Charges by Hospices that are licensed as certified home health agencies.	*80% after the Deductible	*50% after the Deductible
Durable Medical Equipment Purchase or rental in excess of $1,000 must be pre- certified by Blue Shield.	*80% after the Deductible	*50% after the Deductible
Annual Physical Exam (Plan Deductible Waived) (Ages 15 years and above) Plan allows for Employees and eligible Dependents to receive an Annual Physical Examination, including routine annual Gynecological exams and Pap smears, under Major Medical benefits.	*100%	*50%

SUMMARY OF SERVICE	Network Provider Benefits	Non-Network Provider Benefits
Adult Immunizations (Includes Exams, and Immunizations)	*100% (Plan Deductible Waived)	*50% after the Deductible
Well Child Care **(Ages 2 through 14)** (Includes Exams, and Immunizations as recommended by the American Academy of Pediatrics at website: www.aap.org)	*100% (Plan Deductible Waived)	*50% after the Deductible
Well Baby Care During the first year after birth (after leaving the Hospital).	*100% (Plan Deductible Waived)	*50% after the Deductible
Hearing Exam	*100% (Plan Deductible Waived)	*50% after the Deductible
Routine Mammograms (Plan Deductible Waived)	*100%	*50%
COVID-19		
Screening and Testing	*80% after the Deductible	*50% after the Deductible
Treatment	*80% after the Deductible	*50% after the Deductible
HOSPITAL AND CONVALESCENT CARE FACILITY SERVICES		
NOTE: Pre-certification for admission is required except in emergencies. The Plan will pay pre-certified services rendered by a Non-Network Hospital-based Physician (such as a radiologist, pathologist or anesthesiologist) in a Network Hospital at the Network benefit level when the Covered Person has no choice of providers.		
Inpatient Hospital Room and Board and Ancillary Services	$250 co-pay then *80% after the Deductible	$250 co-pay then *50% after the Deductible
Skilled Nursing Facility Room and Board and Ancillary Services	$250 co-pay then *80% after the Deductible	*$250 co-pay then *50% after the Deductible
Ambulatory Surgical Center	*80% after the Deductible	*50% after the Deductible
Birthing Center (For covered employee and/or spouse only)	*80% after the Deductible	*50% after the Deductible
Outpatient Services **(All Outpatient surgery has a $250 co-pay, waived if performed at a non-Hospital based Ambulatory Surgery Center.)**	*80% after the Deductible	*50% after the Deductible
EMERGENCY SERVICES		
Emergency Inpatient Services If your Inpatient Hospital claim is deemed "Medically Necessary" and are "Emergency Services," you will be reimbursed at the Network Provider Benefit; otherwise the claim will be paid at the Non-Network Provider Benefit. Please refer to the Definition section of this booklet, beginning on page 15, for an explanation of these terms.		
Emergency Outpatient Services $200 co-payment per visit; waived if admitted as an inpatient directly from the Emergency Department.	$200 co-pay then *80% after the Deductible	$200 co-pay then *80% after the Deductible

* Based on the contracted network rate for network provider benefits and Usual and Customary Charges for non-network provider benefits. Emergency Services, air ambulance and certain non-network services provided at a network hospital or ambulatory surgical center will be subject to the network share of cost.

SUMMARY OF SERVICE	
Hearing Aid The Plan has contracted with EPIC Hearing to provide hearing aid devices and exams. Members must visit www.EPICHearing.com or call 1-866-956-5400 to utilize contracted network benefits. An allowance of $1,500 is provided per device per ear every 36 months (reduction for non-contributory members applies). Non-network services will be paid at 100% of Usual and Customary charges.	
Foot Orthotics Foot orthotics including orthopedic or corrective shoes and other supportive appliances for the feet.	*100% after the Deductible
Flu Shots The Plan sponsors an annual flu shot program during October and November. As a Participant in the Fresno City Employees Health and Welfare Trust, you and your dependents are permitted to participate in this program. The flu shot program is coordinated through a local health care organization and the shots are given at various City locations. In order to know when the program starts and ends, please watch your mail around the middle of August of each year for a detailed description of the dates, times and locations. Should you be unable to participate in the Plan's annual flu shot program, you will be allowed to receive a flu shot from your Physician at the 100% reimbursement level. Pneumonia vaccinations are covered at 100% of the Contract Rate for certified Network services and 50% of Usual and Customary Charges for Non-Network services.	
Preventive Body Scans The Plan has contracted with Body Scan International (BSI) to provide body scans to active employees. Retirees, spouses, and dependents are not eligible for this benefit. Body scans not provided through BSI will continue to be covered in accordance with the medical benefits terms and conditions as set forth in the SPD. There is a frequency limit of one scan every three fiscal years (the fiscal year runs July 1 – June 30). There is a $230 copay per scan and the Plan deductible does not apply. The $230 copay does not accumulate to the Plan out-of-pocket maximum. BSI's mobile unit will visit Fresno periodically in order for members to obtain scans at a convenient location. Information on these events will be mailed to eligible active employees as they are scheduled. The BSI mobile unit has a limited number of spaces available. Examinations are by appointment only.	

* Based on the contracted network rate for network provider benefits and Usual and Customary Charges for non-network provider benefits. Emergency Services, air ambulance and certain non-network services provided at a network hospital or ambulatory surgical center will be subject to the network share of cost.

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH-LANGUAGE THERAPY

SCHEDULE OF BENEFITS
SimpleMSK Network of Providers

SUMMARY OF SERVICE (Physical Therapy, Occupational Therapy, and Speech-Language Therapy)	SimpleMSK Network Provider Benefits	Non-Network Provider Benefits
Outpatient Physical Therapy, Occupational Therapy, and Speech-Language Therapy	*80% of Network Contract Rate after the Deductible	*50% of Network Contract Rate after the Deductible

1. **To locate a SimpleMSK network provider for physical therapy, occupational therapy, or speech-language therapy, please visit the SimpleMSK website at** www.simpletherapy.com/go/cityoffresno **or call SimpleMSK at (844) 854-4861 or (559) 400-6230.**
2. **The following protocol will apply for Physical Therapy, Occupational Therapy, and Speech- Language Therapy treatment services:**
   a. Benefits are provided for Medically Necessary Outpatient Therapy services when ordered by the Member's Personal Physician and provided by a licensed health care provider.
   b. Any treatment involving more than ten (10) visits must have any and all additional visits pre-certified by the treating provider submitting a treatment plan to SimpleMSK for approval.
   c. **Continued outpatient Benefits will be provided as long as treatment is Medically Necessary, pursuant to the provider's treatment plan, and likely to result in clinically significant progress as measured by objective and standardized tests.**

* Based on the contracted network rate for network provider benefits and Usual and Customary Charges for non-network provider benefits. Emergency Services, air ambulance, certain non-network services provided at a network hospital or ambulatory surgical center will be subject to the network share of cost.

EXCLUSIONS AND LIMITATIONS

The following are specifically excluded from this agreement or have specific limitations:

- Services not documented as necessary and appropriate or classified as experimental or investigational
- Treatment or services for pre or post-employment physicals or vocational rehabilitation
- Any treatment or service caused by or arising out of the course of employment or covered under any public liability insurance
- Non-medical self-care or self-help, or any other self-help physical exercise training, or any other related diagnostic testing
- Air conditioners, humidifiers, air purifiers, therapeutic mattress supplies, or any other similar devices and appliances
- Vitamins, minerals, nutritional supplements or other similar products
- Services identified by SimpleMSK as covered by entities or third parties other than the Plan must be coordinated appropriately and will be reimbursed based on Plan responsibility

Subject to all General Provisions, Exclusions and Limitations found in Plan Booklet.

MENTAL HEALTH AND SUBSTANCE ABUSE CARE

SCHEDULE OF BENEFITS

All **Inpatient Services** must be pre-certified, except emergencies, by SimpleBehavioral at (888) 425-4800.

FAILURE TO PRE-CERTIFY MEDICALLY NECESSARY SERVICES THAT REQUIRE PRE-CERTIFICATION MAY RESULT IN A REDUCTION OF YOUR BENEFITS BY UP TO 50%.

For maximum coverage, all outpatient care must be performed by a SimpleBehavioral Network provider.

Outpatient Care
First Outpatient treatment visit, one per family, is provided at no cost to you or your family through SimpleBehavioral.

SUMMARY OF SERVICE (Mental Health Treatment)	SimpleBehavioral Network Provider Benefits	Non-Network Provider Benefits
Inpatient Mental Health Care All inpatient services must be pre-authorized by SimpleBehavioral.	$250 co-pay then *80% of SimpleBehavioral's contract rate after the Deductible	$250 co-pay then *50% after the Deductible.
Outpatient Mental Health Care	*80% of SimpleBehavioral's contract rate after the Deductible	*50% after the Deductible
SUMMARY OF SERVICE (Substance Abuse Treatment)	**SimpleBehavioral Network Provider Benefits**	**Non-Network Provider Benefits**
Inpatient Substance Abuse Care All inpatient services must be pre-authorized by SimpleBehavioral.	$250 co-pay then *80% of SimpleBehavioral's contract rate after the Deductible	$250 co-pay then *50% after the Deductible
Outpatient Substance Abuse Care	*80% of SimpleBehavioral's contract rate after the Deductible	*50% after the Deductible
EMERGENCY SERVICES		
Emergency Inpatient Services If your Inpatient Hospital claim is deemed "Medically Necessary" and are "Emergency Services," you will be reimbursed at the Network Provider Benefit; otherwise the claim will be paid at the Non-Network Provider Benefit. Please refer to the Definition section of this booklet, beginning on page 15, for an explanation of these terms.		
Emergency Outpatient Services $200 co-payment per visit; waived if admitted as an inpatient directly from the Emergency Department.	$200 co-pay then *80% after the Deductible	$200 co-pay then *80% after the Deductible
Aftercare support groups are provided at no cost to employee. **Utilization Management** SimpleBehavioral will monitor the need and appropriateness of care rendered for both inpatient and outpatient services on an ongoing basis. **All Inpatient and Hospitalization - <u>must be pre-certified by SimpleBehavioral.</u>**		

* Based on the contracted network rate for network provider benefits and Usual and Customary Charges for non-network provider benefits. Emergency Services, air ambulance and certain non-network services provided at a network hospital or ambulatory surgical center will be subject to the network share of cost.

CHIROPRACTIC CARE

SCHEDULE OF BENEFITS
Network Provided by SimpleMSK

SUMMARY OF CHIROPRACTIC SERVICES	
Chiropractic services by SimpleMSK	$5 co-payment then *100% of contract rate after the Deductible
Chiropractic services by Non-SimpleMSK Provider Inside Fresno and Madera Counties	*50% of Usual and Customary Charges to a maximum payment of $15 per visit after the Deductible
Chiropractic services by Non-SimpleMSK Provider Outside Fresno and Madera Counties	*50% of Usual and Customary Charges to a maximum payment of $30 per visit after the Deductible.
NOTE: Diagnostic X-Ray Benefit - $100 per year maximum paid at *100% of Usual and Customary Charges or the SimpleMSK contract rate after the Deductible. 24 visits maximum per Plan Year; 10 visits allowed per month and 1 visit allowed per day. **The following protocol will apply for chiropractic treatment requiring precertification:** **Chiropractic Care** - The following services require Precertification by Calling SimpleMSK at 559-400-6230. 1. All children fifteen (15) years of age and under must have either written or verbal authorization for treatment before any claims will be paid. In the case of an emergency or where authorization was unable to be obtained on the first visit, then ONLY the first visit will be covered. 2. Any treatment involving more than twelve (12) visits must have any and all additional visits pre-certified by the treating chiropractor submitting a treatment plan to SimpleMSK for approval. 3. All massage therapy must be pre-certified for medical necessity by the treating chiropractor submitting a treatment plan to SimpleMSK for approval.	

***** Co-payment is in addition to any deductible or "out-of-pocket" limitations.

CHIROPRACTIC PLAN EXCLUSIONS AND LIMITATIONS

The following are specifically excluded from this agreement or have specific limitations:

- Services not documented as necessary and appropriate or classified as experimental or investigational chiropractic care
- Diagnostic scanning, including Magnetic Resonance Imaging (MRI), CAT scan and/or other types of diagnostic scanning, except for the diagnostic x-ray benefit as described on page 22
- Thermography
- Treatment or services for pre or post-employment physicals or vocational rehabilitation
- Any treatment or service caused by or arising out of the course of employment or covered under any public liability insurance
- Hypnotherapy, behavioral training, sleep therapy, weight programs, education programs, non-medical self-care or self-help, or any other self-help physical exercise training, or any other related diagnostic testing
- Air conditioners, humidifiers, air purifiers, therapeutic mattress supplies, or any other similar devices and appliances
- Vitamins, minerals, nutritional supplements or other similar products
- Anesthesia, manipulation under anesthesia, hospitalization, or any related service
- Juveniles under age 15 require a referral from SimpleMSK prior to treatment
- All Massage Therapy must be medically necessary and requires precertification by SimpleMSK prior to treatment.

MEDICARE SUPPLEMENT PLAN

FOR RETIRED EMPLOYEES AND THEIR DEPENDENTS OVER THE AGE OF 65

SCHEDULE OF BENEFITS

Medicare Changes Medicare Part A (Hospital) and Part B (Medical) Deductibles each January 1

BENEFIT	PLAN PAYS
HOSPITAL	
01 - 60 days	Medicare Part A Deductible
61 - 90 days	Medicare Daily Copayment
91 -150 days	Medicare Daily Copayment (Medicare allows up to 60 days total lifetime days)
MENTAL ILLNESS / SUBSTANCE USE DISORDER	
Hospitalization	Medicare deductible and co-payment (Medicare allows up to 190 day lifetime maximum)
SKILLED NURSING FACILITY	Medicare Pays 100% for days 1 – 20, then Plan pays Medicare Daily Copayment
MEDICAL	20% of Medicare Part B Usual, Customary and Reasonable expenses
X-RAY AND LABORATORY	20% of Medicare Usual, Customary and Reasonable expenses
PHYSICAL THERAPY	20% of Medicare Usual, Customary and Reasonable expenses
BLOOD TRANSFUSION	20% of Medicare Usual, Customary and Reasonable expenses after 3 pints per year
OUTPATIENT MENTAL ILLNESS / SUBSTANCE USE DISORDER	20% of Medicare Usual, Customary and Reasonable expenses
AMBULANCE	20% of Medicare Usual, Customary and Reasonable expenses
PRESCRIPTION DRUG	Please refer to pages 31 through 32 for a complete description of walk-in and mail order benefits.
VISION CARE	Subject to a copayment, coverage for Exam/Frames/Prescription Lenses are provided every 12 months
HEARING AID BENEFITS	100% up to $2,000 every 36 months; hearing test once every three years paid at 80% of Usual and Customary Charges
FOOT ORTHOTICS	Foot orthotics including orthopedic or corrective shoes and other supportive appliances for the feet are covered when certified as Medically Necessary by Blue Shield in lieu of surgery. Orthotics are limited to coverage once per lifetime for adults and once every 12 months for children under age 19 or to age 25 if dependent is primarily dependent upon you for support and maintenance and is a full-time student at an institution of learning when replacement is required due to growth. The maximum lifetime Plan benefit per Participant for foot orthotics is $300.
APPLIANCES	20% of Medicare Usual, Customary and Reasonable expenses
WORLDWIDE COVERAGE	100% of Medicare Parts A and B Usual, Customary and Reasonable expenses

All of the exclusions and limitations appearing in this Plan Booklet are applicable to the Medicare Supplement Plan, including Coordination of Benefits provisions starting on page 72. **Note: The Plan will pay the benefits outlined based on Medicare Usual, Customary & Reasonable Expenses (Allowable Charges). If Medicare denies an expense incurred for Medicare Part A and Part B services, the denied expenses will not be considered an eligible expense under this Plan and will not be paid under the Medicare Supplement Plan benefits shown on page 29. Expenses for Prescription Drugs, Vision Care, Hearing Aids, and Foot Orthotics are separate benefits provided by this Plan to Medicare-eligible Retired employees which are generally excluded by Medicare.**

This Plan is a supplement to Medicare's Part A and Part B coverage. If you elect Medicare Part C (Medicare+Choice) at any time, or enroll in an individual Medicare Part D (Prescription Drug) program, you will not be allowed to participate in this Medicare Supplement Plan and/or this Plan's Prescription Drug program.

It is the current policy of the Board of Trustees to adjust the benefits as Medicare provisions change and to increase or decrease the charge accordingly.

Election of such coverage must be made within 90 days after becoming eligible to participate in the program. Please be aware that if you do not elect coverage under the Medicare Supplement Plan, you cannot opt back in at a later date.

The cost of such coverage is intended to fully support the benefits paid.

To Save Money

This Plan's benefit is based on Medicare's usual and customary allowance. To save money, use providers who accept Medicare Assignment. Providers to suppliers are given an option to accept or not accept assignments under the Medicare plan. If the providers/suppliers accept assignment, they agree to reduce their total charge to the charge determined to be usual and customary by Medicare. If you use providers/suppliers who have not accepted Medicare assignment, you will be responsible for all amounts over Medicare's usual and customary allowance.

PRESCRIPTION DRUG PLAN

SCHEDULE OF BENEFITS

Your cost for a Prescription Drug under the Walk-in and Mail Order Programs will depend on whether the prescribed drug is a Generic, a Preferred Brand Drug, or a Non-Preferred Brand Drug (defined below). Your out-of-pocket costs will be less if Generic and Preferred Brand Drugs are dispensed.

The Prescription Drug Program will cover medically-necessary drugs prescribed for the treatment of an illness, medical condition, or injury. In addition, the Prescription Drug Program covers birth control prescribed drugs but does not cover birth control devices; however some birth control devices are covered under the medical benefits. A description of the Walk-in and Mail Order Programs, and how to use them, is outlined on the following pages.

If a Generic Drug is available and you specifically request a Brand Name Drug, you will be responsible to pay the difference in cost between the Brand Name and Generic Drug.

In addition, it is the Plan Administrator's intent to comply with federal law regarding preventive care benefits under the Patient Protection and Affordable Care Act. All prescriptions which qualify for the preventive care benefit, as defined by the appropriate federal regulatory agencies, and which are provided by a network-participating pharmacy, will be covered at 100% with no deductible or co-insurance required.

OPTUMRX - PRESCRIPTION CARD SERVICE (Walk In Program) (34-Day Supply)	
Generic Drugs (Tier 1)	Plan Pays 90% of OptumRx Contract Rate
Preferred Brand Drugs (Tier 2)	Plan Pays 80% of OptumRx Contract Rate
Non-Preferred Brand Drugs (Tier 3)	Plan Pays 60% of OptumRx Contract Rate
MAIL ORDER SERVICE (90-Day Supply) Thru OptumRx Mail	
Generic Drugs (Tier 1)	$5 Member copayment for each prescribed drug
Preferred Brand Drugs (Tier 2)	$20 Member copayment for each prescribed drug
Non-Preferred Brand Drugs (Tier 3)	$50 Member copayment for each prescribed drug

All Specialty Drugs (Tier 4) have a $100 Member copayment for each prescribed drug.

Walk-in Program

After you become eligible for benefits under this Plan, present your HealthComp ID Card at a participating pharmacy and you will pay a percentage of the discounted prescription drug cost of allowable charges for covered prescriptions (equal to *10%, *20% or *40%, depending on whether it is a Generic, a Preferred Brand Drug, or a Non-Preferred Brand Drug). These charges are not applied to the "per person" deductible or the cumulative family deductible.

If the Covered Person does not present an ID card at the time of purchase, or chooses to have the prescription filled at a non-participating pharmacy, the Covered Person must:

1. Pay the full charge for the prescription;

2. Obtain a paid receipt which includes prescription information, not a cash receipt; and

3. Complete in its entirety a Reimbursement Claims Form (available from OptumRx), with the pharmacist's help, if necessary. The receipt should be attached to the claim form and both should be sent directly to the address indicated on the claim form.

Mail Order Program

The OptumRx Mail Service Pharmacy Benefit allows a Covered Person to receive up to a 90-day supply of a maintenance drug. A maintenance drug is a prescription medication taken on a continuous long-term basis for conditions such as diabetes, high blood pressure or heart conditions, and prescribed by a Physician.

Mail Order Co-Pay Amounts

Under the OptumRx Mail Order Pharmacy programs, a single co-payment will be charged per prescription filled or refilled. Your co-payment will be $5 for each prescribed maintenance Generic drug dispensed, a $20 copayment for each Preferred Brand and a $50 copayment for each Non-Preferred Brand drug dispensed. Under the mail order program, a 90-day supply is allowable, provided your Doctor prescribed that amount and refills are permitted.

How to Use the Mail Order Program

1. Simply ask your Doctor to write a prescription for a 90-day supply, plus two or three refills.

2. Request an OptumRx mail order form and envelope from HealthComp Administrators. Complete the form and enclose your prescription(s) in the postage paid envelope.

3. Use the postage paid, self-addressed envelope to mail the form and your prescription(s) to OptumRx.

Your prescription will be filled by a licensed pharmacist exactly as written by your Doctor and will be delivered to your home either by UPS or by first class mail.

You should contact OptumRx's Help Desk for questions regarding your order, or to speak with a pharmacist, or for information concerning paying Mail Order co-payments by check or credit card by calling (800) 777-0074.

Important Information and Questions Concerning the Walk-In and Mail Order Programs

Preferred Brand Drugs are drugs that have been identified by OptumRx to provide the same medical efficacy often at a lower cost than other Brand Drugs.

Non-Preferred Brand Drugs are drugs that are not Generic or on the OptumRx listing of Preferred Brand Drugs.

Over-the-counter (OTC) drugs are drugs that can be obtained without a prescription. Over-the-counter (OTC) drugs are not a covered benefit, even if they are prescribed by a doctor.

Need Help Determining Whether a Brand-Name Drug is a Preferred Brand Drug or a Non-Preferred Brand Drug under the Walk-In or Mail Order Program? Please contact OptumRx's Help Desk at (800) 777-0074, or through OptumRx's website at www.optumrx.com.

If a generic drug is available and I specifically request a brand-name drug, what will happen? You will be responsible to pay the difference in cost between the brand-name and the generic drug.

OPTUMRX MEDICARE PART D PRESCRIPTION DRUG PROGRAM

The Medicare Part D program provides Medicare beneficiaries with a prescription drug benefit. Unlike coverage in Medicare Parts A and B, Part D is not provided within the traditional Medicare program. To take advantage of the Medicare Part D benefits, OptumRx has been selected to offer a Medicare Prescription Drug Plan to retired participants who have Medicare. When you enroll in the OptumRx Medicare Prescription Drug Plan your monthly premium for your health benefits will be reduced by $50.

Under the OptumRx Medicare Prescription Drug Plan, your prescription drug plan will have few changes. A brief summary of these benefits are listed below.

- Your standard copay amounts for a 34 day (Retail/Walk-in) supply are: Generic – Plan pays 90% of contract rate. Preferred Brand – Plan pays 80% of contracted rate and Non Preferred Brand – Plan pays 60% of contracted rate.

- Your standard copay amounts for 90 day supply through MAIL are: $5.00 for Generic, $20.00 for Preferred and $50 for Non-Preferred Brands.

- At (Retail/Walk-in) you will be allowed to fill up to a 90 day supply at select pharmacies.

- At OptumRx Mail you will be allowed to fill up to a 90 day supply.

- Your Mail Service Pharmacy is OptumRx Mail (1-800-777-0074).

- HealthComp produces your ID cards.

Enrollment in the Trust's Medicare Part D pharmacy plan is no longer optional after July 1, 2009 for those that are eligible. You must enroll in the Trust's Medicare Part D pharmacy plan or have other Medicare Part D coverage outside of the Trust. If you chose to opt-out of the Trust's Medicare Part D plan, you will not receive any prescription drug coverage from the Trust fund.

To enroll in the OptumRx Medicare Prescription Drug Plan, you must complete the application form and return it with a copy of your Medicare ID card. When it is received, your enrollment information will be transmitted to OptumRx, who will submit it to Medicare for approval. You will remain enrolled in the current OptumRx benefit plan until you are approved by Medicare. Once approval is received from Medicare, you will be enrolled in the OptumRx Medicare Prescription Drug Plan and you will receive the following information:

1. Evidence of Coverage
2. Pharmacy Listing
3. Formulary Listing
4. Grievance Appeals and Procedures
5. A new Medical/Rx ID card

Once you enroll in the OptumRx Medicare Prescription Drug Plan under the Trust, Medicare will disenroll you from any other Medicare Part D plan.

You will receive a $50 reduction in your health premium beginning the first of the month following your approval from Medicare.

For additional information on the OptumRx Prescription Drug Plan, you may also call OptumRx at (866) 443-1095.

Important Notice from Fresno City Employees Health and Welfare Trust About Your Prescription Drug Coverage and Medicare

This notice is to inform you that your current prescription drug benefit program through the Fresno City Employees Health and Welfare Trust provides "creditable coverage," as defined below. It also includes answers to questions you may have regarding your current prescription drug program and how it relates to Medicare Part D coverage.

2024 CERTIFICATE OF CREDITABLE PRESCRIPTION DRUG COVERAGE

The Fresno City Employees Health and Welfare Trust hereby certifies that the prescription drug coverage it provides to Medicare-eligibles is expected to pay out, on average for all such participants, at least as much as the standard Part D coverage would pay in calendar year 2024. It is therefore designated as providing 2024 "creditable coverage," meaning that any participant who later enrolls in a Part D plan will not be charged a late enrollment penalty for 2024.

This is your notice of creditable coverage. Be sure to read it carefully and keep it in a safe place where you can find it. If you lose this notice and need another copy, please call the Trust's Administrator at (559) 499-2450 or request a copy in writing from HealthComp, 621 Santa Fe Street, Fresno, CA 93721. Updated versions of this notice will be included annually in the Plan Document and you will be informed if the Trust ever loses its creditable coverage status.

Prescription drug coverage for Medicare-eligible participants under the Fresno City Employees Health and Welfare Trust is outlined below.

RETAIL	
Generic Drugs (Tier 1)	Plan pays 90% of contract rate
Preferred Brand Drugs (Tier 2)	Plan pays 80% of contract rate
Non-Preferred Brand Drugs (Tier 3)	Plan pays 60% of contract rate

MAIL-ORDER	
Generic Drugs (Tier 1)	Plan pays 100% after $5 copayment per prescription
Preferred Brand Drugs (Tier 2)	Plan pays 100% after $20 copayment per prescription
Non-Preferred Brand Drugs (Tier 3)	Plan pays 100% after $50 copayment per prescription
Specialty Drugs (Tier 4)	Plan pays 100% after $100 copayment per prescription
Limits	90 days' supply per prescription

FREQUENTLY ASKED QUESTIONS REGARDING THE CERTIFICATE OF CREDITABLE COVERAGE

1. Do I need to do anything now?

No, you can keep using the Trust's prescription drug program the same as you always have. Your copayments will not change, nor will any pharmacy network.

When you first become eligible for Medicare[1], you will have the option to independently enroll in an individual Medicare Part D prescription drug plan. **However, *by enrolling in an individual Part D plan you may permanently lose your current prescription drug coverage under the Fresno City Employees Health and Welfare Trust and you will not be reimbursed for your Part D premiums***. As mentioned above, the standard individual Part D benefit is not as good as the Trust's own prescription drug program (as described in this Trust plan booklet).

You should compare your current prescription drug program, including which drugs are covered, with the benefits and costs of the Medicare Part D plans available in your area. To view the official summary of approved Medicare Part D plans in any U.S. state, visit http://www.medicare.gov. Note that a Part D plan might not include your regular prescription drugs on its formulary. The Trust cannot provide you with a complete comparison of available Part D plans, but we urge you to carefully review any descriptions you may obtain.

2. So why do I need to keep my notice of creditable coverage?

In case you ever drop or lose your Trust coverage, or in the unlikely event that Trust coverage becomes non-creditable, having this notice will allow you to immediately enroll in a Part D plan without having to pay a late enrollment penalty. Specifically, if you try to enroll after your initial eligibility period, you will be charged a permanent Part D premium surcharge of 1% for every month since your initial Medicare eligibility for which you cannot show that you had creditable coverage (if such non-creditable period exceeds 62 days). Also note that you may have to wait for the next regular annual Part D enrollment period, which will be October 15th through December 7th for coverage in the following calendar year.

3. How can I get more information on individual Medicare Part D?

More detail will be in the handbook "Medicare & You" that will be mailed to you by Medicare in October of each year. You may also be contacted directly by Medicare-approved Part D providers. At any time you can visit http://www.medicare.gov/ or call 1-800-MEDICAR (1-800-633-4227). TTY users should call 1-877-486-2048.

Every state has a Health Insurance Assistance Program to help Medicare beneficiaries and their families with their health insurance choices and with problems that might arise. In California it is called the "Health Insurance Counseling and Advocacy Program" (HICAP) and can be reached (by non-cell phones only) at 1-800-434-0222. Further assistance is available from the California Senior Information line (also by non-cell phones only) at 1-800-510-2020. To see the Part D information collected by the California program, visit http://www.aging.ca.gov/ and click the button "Medicare Rx for consumers". Contact information for similar programs in other states will be listed in your "Medicare & You" handbook.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration website at http://www.socialsecurity.gov/ or call them at 1-800-772-1213. TTY users should call 1- 800-325-0778.

Be sure to keep this notice. If you enroll in one of the plans approved by Medicare which offer prescription drug coverage, you may need to give a copy of this notice when you join to show that you are not required to pay a higher premium.

[1] Your Medicare Initial Enrollment Period will be the month in which you become age 65, plus the preceding three months and the succeeding three months.

VISION PLAN

EyeMed

EyeMed is a Preferred Provider Organization that provides access to a large and comprehensive network of providers nationwide. PPO providers agree to accept reduced fees for covered procedures when treating PPO patients. This means your out-of-pocket costs are usually lower when you visit a PPO provider than when you visit a non-PPO provider.

EyeMed PLAN SCHEDULE OF BENEFITS

	In-Network Amount Covered by the Plan[1]	Out-of-PPO Network Amount Reimbursed by the Plan[1]
Benefits		
Vision Examinations	Covered in Full	$40
Standard Lenses (up to 61 mm)	Covered in Full	$30 Single $50 Bifocal $70 Trifocal $70 Lenticular
Standard Progressive Lenses	Covered in Full	$50
Premium Progressive Lenses	Covered in Full	$50
Polycarbonate Lenses[2]	Covered in Full	$50
Frames[3]	Up to $200 Retail	$140
Contact Lenses – Elective[4]	Up to $200	$140
Contact Lenses – Non Elective[4]	Covered in Full with Authorization	$300

1 Less any applicable copay.

2 For Dependent Children through age 18.

3 Retail frame benefits will be converted to wholesale or warehouse equivalent prices at category 5 or 6 provider locations, (please refer to the Plan's website at www.EyeMed.com). The wholesale or warehouse equivalent may be approximately 30% less than the retail frame allowance; please confirm this benefit before ordering your eyewear. $250 allowance provided at PLUS Providers.

4 This benefit is in addition to the comprehensive vision examination, but in lieu of lenses and frame. If contact lenses are for cosmetic or convenience purposes, the Policy will pay up to $200.00 toward the contact lens evaluation, fitting costs and materials. Any balance is your responsibility. If contact lenses are medically necessary, they are a fully covered benefit. Approval from EyeMed is required. Please refer to your Policy if you require additional information.

LIMITATIONS
Vision Benefits are subject to the following limitations:

1. Contact lenses, except as specifically provided.

2. Contact lens fitting, except as specifically provided;

3. Eyewear when there is no prescription change, except when benefits are otherwise available;

4. Lenses or frames which are lost, stolen or broken will not be replaced, except when benefits are otherwise available;

5. Non-standard (“custom”) lenses such as polycarbonate, progressive/no-line blended, occupational, beveled, faceted, coated (anti-reflective, scratch, UV), or oversize exceeding the allowance for covered lenses; and

6. Tints, other than pink or rose #1 or #2, except as specifically provided;

EXCLUSIONS
Vision benefits are subject to the following exclusions:

1. Any eye examination required by an employer as a condition of employment;

2. Care or treatment of a condition for which you are entitled to or eligible for benefits under any Worker’s Compensation Act or similar law.

3. Contact lens insurance or care kits or frame cases;

4. Covered services which began prior to the insured's effective date, or after the benefit has terminated;

5. Covered services for which the Insured is not legally obligated to pay;

6. Covered services required by any government agency or program, (federal, state or subdivision thereof);

7. Covered services performed by a close relative or by an individual who ordinarily resides in the Insured's home;

8. Non-prescription (plano) eyewear;

9. Orthoptics, vision training or subnormal vision aids;

10. Services that are experimental or investigational in nature;

11. Services for treatment directly related to any totally disabling condition, illness or injury.

12. In connection with war or any act of war, whether declared or undeclared, or condition contracted or accident occurring while on full-time active duty in the armed forces of any country or combination of countries.

13. For procedures that are not included in the Schedule of Benefits.

COMPREHENSIVE MEDICAL BENEFITS

COVERED MEDICAL EXPENSES

Covered/Eligible medical expense means the usual, customary and reasonable (UCR) expenses incurred by or on behalf of a Covered Person for the Hospital or other medical services listed below which are:

1. Administered or ordered by a Physician;

2. Medically necessary for the treatment of an injury or illness;

3. Not of a luxury or personal nature; and

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

DEDUCTIBLE AMOUNT

The deductible will be applied to covered expenses only once each Plan Year regardless of the number of accidents or sicknesses the Covered Person may have.

FAMILY LIMIT ON DEDUCTIBLE

If an amount equal to 3 (2 for those employees electing not to make a contribution) deductibles is met by any total of family members during the same 12 month period beginning July 1 of each year, all eligible medical expenses incurred during that 12 month period by covered members of such family shall be considered as being in excess of their deductible amount.

DEDUCTIBLE CARRY OVER PROVISION

Any expenses incurred in April, May and June, which are used to satisfy the deductible for that year, will also be used to reduce the deductible for the following year.

COMMON DEDUCTIBLE

If an employee and one or more of his/her dependents, or if two or more of his/her dependents are injured in the same accident, benefits will be paid separately for each individual and only one deductible will apply.

If a multiple birth occurs and covered expenses are incurred by children born in connection with (a) premature birth, or (b) an abnormal congenital condition, or (c) an injury or sickness which occurs within 30 days after the birth, benefits will be paid separately for each child and only one deductible will apply to the total expenses incurred by the children.

COVERED MEDICAL EXPENSES

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

1. HOSPITAL BENEFITS

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

b. Other Hospital Expenses: The actual charges made by the Hospital for necessary services and supplies used in the Hospital, such as drugs, dressings, blood plasma, anesthetic fees, operating room, etc.. This does not include special nursing fees.

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

Pre-certified services rendered by a Non-Network Hospital based Physician (such as a radiologist, pathologist or anesthesiologist) in a Network Hospital are covered at the Network benefit level unless you give written consent to the Non-Network Physician to bill you at the Non-Network benefit.

2. AMBULANCE EXPENSE BENEFITS

Ambulance expense for transportation to or from the Hospital, except that ambulance service from the Hospital to a Skilled Nursing Facility is limited to $25.00.

3. PROFESSIONAL ANESTHESIOLOGIST BENEFITS

Professional anesthesiologist benefits are provided when a Covered Person is entitled to surgical care and when anesthesia is administered by a licensed Physician.

Pre-certified services rendered by a Non-Network Hospital-based Physician (such as a radiologist, pathologist or anesthesiologist) in a Network Hospital are covered at the Network benefit level unless you give written consent to the Non-Network Physician to bill you at the Non-Network benefit level.

4. SKILLED NURSING FACILITY BENEFITS

The room and board (at the semi-private rate), medical services, physical therapy (if ordered by a Physician) and supplies furnished by or in a Skilled Nursing Facility after an inpatient hospitalization involving surgery, or if not involving surgery, an inpatient hospitalization of at least three days, and the care is ordered by a Physician as Medically Necessary; *provided, however, that no benefits for convalescent care shall be payable for Custodial Care or for services primarily for the convenience of the patient or provider, or because the Covered person has nowhere else to go.*

5. HOSPICE BENEFITS

The Plan covers a wide range of services provided by Hospices to control physical symptoms and to provide emotional and spiritual support during the last six months of life. Covered services include home visits by nurses and other health care professionals in addition to Hospital inpatient and outpatient care when needed. The Plan covers Charges by Hospices that are licensed as certified home health agencies.

6. SURGICAL BENEFITS

The surgical fee incurred when a Covered Person has undergone a surgical operation by a legally qualified Physician or Surgeon because of bodily injury or sickness.

7. IN-HOSPITAL PHYSICIANS' VISITS

When the Covered Person is confined to a Hospital, an additional benefit is provided to help defray the cost of the doctor's daily call other than the operating Surgeon. The benefit provides payment for charges for doctors' visits as often as needed, including charges for extra time and consultants Schedule of Benefits.

8. DIAGNOSTIC X-RAY AND LABORATORY

The Plan covers charges for laboratory tests and x-ray examinations for diagnosis of an injury or sickness with the recommendation and approval of a legally qualified Physician or Surgeon.

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

9. MASTECTOMY BENEFITS

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

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

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

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

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

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

10. MATERNITY BENEFITS

Expense incurred by a female employee or dependent spouse as a result of pregnancy will be considered on the same basis as illness-related expense. All Plan provisions and limitations will apply to pregnancy claims in the same manner as claims incurred as a result of illness. Expense incurred by a female employee or dependent spouse as a result of pre-natal screening will be considered on the same basis as illness related expense.

11. OTHER SERVICES AND SUPPLIES

a. The charges of a Physician for his/her professional medical or surgical services.

b. The charges of a registered graduate nurse or a licensed physiotherapist or licensed midwife other than one who resides in your home or who is a close relative, for professional services and the charges of any other practitioner of the healing arts who renders care or treatment within the limits set forth in the license issued to the practitioner by the applicable agency of the state.

c. The charges of a Hospital or free-standing outpatient surgical facility, made in its own behalf, for services and supplies rendered during confinement as inpatient or outpatient except that, for each day in which the Covered Person occupies a room, the amount, if any, by which the Hospital's charges for room and board exceed the semi-private room rate shall be excluded from Covered Expenses; or the charges of a Hospital, made in its own behalf, for confinement in an intensive care unit, contagion ward, isolation or private accommodations, when such confinement is certified by the attending Physician as being Medically Necessary by reason of the severity of the Covered Person's condition.

d. Well baby care including routine examinations and related expenses during the child's first year after birth. In addition, the Trust will reimburse for immunizations in accordance with the schedule recommended by Patient Protection and Affordable Care Act.

e. The charges for a Hospital stay in connection with childbirth for the mother or newborn child of at least 48 hours following normal vaginal delivery or 96 hours following a cesarean section.

f. The charges for any of the following services and supplies to the extent they do not duplicate charges included under items a, b, c, d and e above:

i. drugs and medicines lawfully obtainable only upon the prescription of a Physician or dentist when prescribed for the treatment of an illness;

ii. anesthesia, and the administration thereof;

iii. x-ray, radium, and radioactive isotope therapy;

iv. x-ray and laboratory examinations made for diagnostic purposes;

v. fair rental value of a wheelchair, Hospital bed, iron lung and other durable equipment, or other apparatus substantially similar to comparable durable equipment prescribed by a Physician, except that rental charges in excess of the purchase cost thereof shall be excluded from Covered Expenses; durable medical equipment is defined as equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, and (c) generally is not useful to a person in the absence of an illness or injury;

vi. initial prostheses (e.g., artificial limbs, artificial eyes and breast implant following mastectomy);

vii. professional ambulance service when used to transport the Covered Person directly from the place where he/she is injured or becomes ill to the nearest Hospital qualified to give treatment;

viii. oxygen and the administration thereof.

g. **Limited Benefits**. Charges incurred with respect to the following areas of limited benefits shall be considered Covered Expenses only to the extent that they satisfy the conditions applicable thereto.

i. Charges incurred in connection with cosmetic surgery, unless required for:

1. accidental injuries occurring while covered, and only if performed while still covered and incurred within a period of 90 days subsequent to the date the injury was sustained; or

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

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

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

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

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

ii. Dental and/or oral surgical procedures are covered under the Hospital outpatient and Anesthesia services of the medical benefits of the Plan when determined as Medically Necessary and pre-certified by Blue Shield.

iii. Foot orthotics including orthopedic or corrective shoes and other supportive appliances for the feet are covered when certified as Medically Necessary by Blue Shield in lieu of surgery.

iv. Eligible expenses for contraceptive devices are limited to physician fees for fitting, insertion and/or removal of a Diaphragm, Intrauterine Device (IUD), Norplant or similar implants including charges for the device itself, supplies, necessary x-rays, ultrasound and laboratory services related to such contraceptive method. Contraceptives which can be obtained over the counter, without a Physician's written prescription (e.g., condoms, foams, jellies, sponges, etc.), or contraceptives which do not require the services of a Physician are not covered. Also, any contraceptives which can be obtained through the prescription drug program (e.g., Depo Provera serum) must be obtained through that program.

v. Diabetic Counseling must be prescribed in writing by the attending Physician, provided by a registered dietician, performed for treatment of a condition of disease origin.

vi. Failure to pre-certify medically necessary services that require pre-certification may result in a reduction of benefits by up to 50%.

12. GENDER AFFIRMING CARE

a. Medically necessary services for treatment of gender dysphoria, including but not limited to, diagnosis, psychotherapy, continuous hormone therapy, laboratory testing, and gender affirming surgery. Preauthorization is required and certain criteria must be met for gender affirming surgery and other services.

13. GENE THERAPY TREATMENT

a. Medically necessary, FDA approved gene therapy treatment. The Plan will pay 80% after the deductible at PPO providers. There is no coverage for gene therapy treatment provided by a non-PPO Provider. Preauthorization is required. Covered under the Medical Plan only.

EXTENSION OF MEDICAL BENEFITS DUE TO TOTAL DISABILITY

If any person is totally disabled at the time his/her coverage terminates under the Plan, the Trust will provide these Medical Benefits for covered expenses incurred in connection with the treatment of the illness or injury responsible for such Total Disability until the first of the following occurs:

1. the end of a period equal to the length of the time the person was continuously covered under the Plan immediately prior to his/her termination;

2. last day of the 12th complete month following date of disability;

3. the day the person acquires coverage under any other group plan that provides benefits for Hospital and professional medical expenses;

4. the end of the period of Total Disability.

DENTAL PLAN SCHEDULE OF BENEFITS (PPO PLAN)

THESE RULES APPLY SOLELY TO PARTICIPANTS WHO ARE ENROLLED THE DENTAL PPO PLAN.

If You Are Enrolled in the DENTAL HMO PLAN, please contact UnitedHealthcare Dental Company at (877) 816-3596 for a complete Summary of your Benefits.

The Delta Dental PPO

Delta Dental PPO, the preferred provider organization (PPO) program, provides access to more than 95,000 PPO dentist locations nationwide. PPO dentists agree to accept reduced fees for covered procedures when treating PPO patients. This means your out-of-pocket costs are usually lower when you visit a PPO dentist than when you visit a non-Delta Dental dentist.

When you are covered under the PPO plan, you and your family members:

- Can visit any licensed dentist, including the dental specialist of your choice.
- May change dentists at any time without notifying Delta Dental.
- Can receive dental care anywhere in the world.
- Will never have to pay more than the patient's share[1] at the time of treatment or file claims forms if you visit a Delta Dental dentist. Delta Dental dentists file claim forms for you and accept payment directly from Delta Dental.

What to Know Before Your Dental Visit

Find a PPO Dentist

A current listing of dental offices that are part of Delta Dental's networks can be found using the online dentist directory. Visit Delta Dental's website and:

- Click on "Find a Dentist"
- Click on the "National Online Directory" link
- Select "Delta Dental PPO" and your state, then click "Continue"
- Enter the criteria for your search

Each dentist listed in Delta Dental's directory has been credentialed by Delta Dental, which includes license and insurance coverage verification, specialty certification and compliance with the dental profession's health, hygiene and safety standards.

Is your Current Dentist a Delta Dental PPO Dentist?

Delta Dental recommends that you verify your current dentist's participation in the Delta Dental PPO network. Simply asking if a dentist "accepts Delta Dental" does not guarantee he or she is a PPO dentist. Make sure you specifically ask if he or she is a Delta Dental PPO dentist. Delta Dental recommends that you verify your dentist's participation before each dental appointment.

[1] Patient's share is the copayment/coinsurance amount, any amounts over plan maximums and any non-covered services.

When You Cannot Find a PPO Dentist
The Delta Dental Premier® network – Delta Dental's larger network – provides cost savings features and is the next best option when you cannot find a PPO dentist. If you must visit a non-PPO dentist, a Delta Dental Premium dentist will usually save you more money than if you visit a non-Delta Dental dentist. While Premier dentists' contracted fees are often slightly higher than PPO dentists' fees, Premier dentists will not balance bill you above Delta Dental's approved amount; non-Delta Dental dentists may balance bill you up to their full fees. You may find a Premium dentist using Delta Dental's dentist directory.

Recommend your Dentist
Delta Dental recognizes that many people have a long-standing relationship with their dentist and may not want to change dental providers. Delta Dental invites you to recommend your dentist for inclusion in the Delta Dental PPO network. Please visit Delta Dental's website and complete the "Recommend Your Dentist" form. Delta Dental will contact your dentist to provide more details. You can help by telling your dentist how important your PPO benefits are to you and that you would like him or her to consider becoming a Delta Dental PPO dentist.

What to Know During Your Dental Visit

Talk to Your Dentist about Your Health and Treatment Options
When you visit the dentist, be sure to share your dental and medical history and any prior complications. Dentists can identify signs of more serious health conditions and should be made aware of health information that may be critical to your dental care. Your hygienist is a great resource for dental health information to help you guard against tooth decay and gum disease. Ask your dentist to explain the pros and cons of each dental treatment option, including the future costs or consequences of postponing or avoiding treatment.

Predeterminations/Pre-Treatment Estimates
Determine costs ahead of time by asking your dentist to submit the treatment plan to Delta Dental for a predetermination of benefits before any treatment is provided. Delta Dental will verify your specific plan coverage and the cost of treatment and provide an estimate of your copayment/coinsurance and what Delta Dental will pay. Predeterminations are free and provide you with an estimate of the cost of your treatment. You and your dentist should make decisions about your treatment plan based on your dental needs and not necessarily on the reimbursement by your dental plan.

Claim Submission
Delta Dental dentists will submit claims for you. If you visit a non-Delta Dental dentist, you may need to submit your own claim. You can download a form from Delta Dental's website.

Dual Coverage/Coordination of Benefits
If your spouse has coverage with another company and you are covered by both dental plans, the two plans will coordinate benefits to potentially lower your out-of-pocket costs. Ask your dentist to indicate the other plan's information on the claim form submitted to Delta Dental and Delta Dental will take it from there.

Questions about Your Plan?
If you have questions about your PPO plan, visit Delta Dental's website or contact one of the helpful Customer Service representatives. You may also get benefits and eligibility information 24 hours a day, seven days a week from Delta Dental's automated information line. Sign up for the free dental health e- newsletter, *Dental Wire*, for valuable dental health topics and information about maximizing your benefits.

What to Know After Your Dental Visit

Dental Health Questions

After your appointment, contact Customer Service if you have any questions about your benefits. You can also learn more about dental health topics by visiting Delta Dental's website and signing up for the free dental health e-newsletter, *Dental Wire*.

Claim Review

After a claim has been processed, you will receive a Benefit Statement/Notice of Payment from Delta Dental. This form lists the services provided and costs of the dental treatment submitted by your dentist. Review the services and costs listed to ensure that the patient copayment/coinsurance amount charged by your dentist is correct. Contact your dental office if you find any discrepancies. Delta Dental's Customer Service representatives are available to help explain your Notice of Payment.

Questions about Quality of Care

If you are unhappy with the dental care you received from a Delta Dental dentist, we can arrange for you to be examined by one of Delta Dental's consulting dentists in your area. If the dental consultant agrees that the work was faulty, Delta Dental will ensure that the original dentist either corrects the work at no additional cost or grants a refund. You may choose another dentist and have the treatment corrected.

DENTAL PPO PLAN SCHEDULE OF DENTAL BENEFITS

	In-Network PPO	Out-of-PPO Network Non-PPO[1]
Reimbursement Basis (Fee Base)	**PPO Fee Allowance[2]**	**Plan Allowance[3]**
Benefits		
Diagnostic/Preventive (X-rays, Exams, Cleanings)	100%	80%
Basic (Restorative, Sealants, Oral Surgery, Periodontic, Endodontic)	80%	65%
Major (Prosthodontic, Crowns)	50%	50%
Orthodontics – Adult & Child(ren)	50%	
Lifetime Ortho Max	$1,500	
Deductible		
Per Patient/Plan Year	$0	$0
Maximum		
Per Patient/Plan Year	$2,500[4]	$1,500

1 Delta Dental Premier and Non-Delta Dental dentists.

2 PPO Fee allowance is the PPO contracted fee.

3 Plan allowance is the lesser of the submitted fee, the Delta Dental Premier dentist's contracted fee or the out-of-network non-Delta Dental dentist fee based on internal UCR.

4 Diagnostic and Preventive Services do not accumulate to the Annual Maximum Benefit.

DENTAL BENEFITS FOR THE DENTAL PPO PLAN

THESE RULES APPLY SOLELY TO PARTICIPANTS WHO ARE ENROLLED IN THE PPO PLAN.

If You Are Enrolled on THE DENTAL HMO PLAN, please Contact UnitedHealthcare Dental Company at (877) 816-3596 for a complete Summary of your Benefits.

COVERED SERVICES
The Plan's dental benefits cover the following services when a licensed dentist provides them and when necessary and customary as determined by the standards of generally accepted dental practice. The Plan covers only the cost of dentist's services. For those members participating in the DENTAL HMO PLAN, additional limitations and exclusions may apply. In addition, please also refer to "Service Limitations" and "Exclusions."

1. BASIC SERVICES

Diagnostic	Procedures to assist the dentist in determining required dental treatment.
Preventative	Prophylaxis (cleaning), not more often than twice in any 12 month period; fluoride treatment; space maintainers through age 12, once in a 5-year period ; sealants on first molars for children through age 8, and on second molars for children through age 15; permanent non-restored teeth once every 2 years.
Oral Surgery	Extractions and certain other surgical procedures, including pre- and post-operative care.
General Anesthesia	When administered by a dentist for a covered oral surgery procedure.
Restorative	Treatment of tooth decay or fracture by use of silver or plastic restoration. Cast restorations and crowns will be provided only when silver or plastic restorations will not suffice and payable as Major services at 50%.
Endodontic	Treatment of the tooth pulp.
Periodontic	Treatment of gums and bones and supporting teeth.

2. PROSTHODONTIC SERVICES
Procedures for construction or repair of fixed bridges, partial or complete dentures.

3. ORTHODONTIC SERVICES
Procedures for straightening and realigning the teeth.

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

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

EXTENSION OF BENEFITS
If within 60 days after employee or dependent ceases to be covered under the Health and Welfare Plan, a covered expense is incurred for services or supplies furnished in connection with a dental procedure which began prior to the date the coverage ceased, benefits will be payable for such expense provided that dental benefits are still payable under the Plan on the date such expense incurred.

SERVICE LIMITATIONS
Dental Benefits are subject to the following limitations:

1. Complete mouth x-rays (at least 14 films) are provided only once in a 3-year period, unless special need is shown. Supplementary bitewing (individual) x-rays are provided twice in a calendar year for children under age 18, and once in a calendar year for adults.

2. Crowns and cast restorations will be replaced only once in any 5-year period.

3. Prosthodontic appliances (including but not limited to fixed bridges and partial or complete dentures) will be replaced only once in any 5-year period unless it is determined that there is such extensive loss of remaining teeth or change in supporting tissue that the existing appliance cannot be made satisfactory.

4. Partial or complete dentures and related procedures are paid at 50% of the customary charge for a standard prosthodontic appliance regardless of special circumstances.

5. Selection of a more expensive plan of treatment than is customarily provided by the Plan will be reimbursed so as to provide payment of the applicable percentage of the lesser fees and the employee will be responsible for the remainder of the dentist's fees: for example, crowns where a silver or plastic restoration could restore the tooth.

6. Implants or the surgical removal of implants are not covered. Delta may make an allowance for the appliance actually placed on the implant(s) (i.e., crown(s), bridge(s), or partial or full dentures). Single crowns will be benefited at a prosthetic value with the original procedure submission being changed to a pontic. Bridges, partials or full dentures will be processed with regular procedure codes, as they are already a prosthetic.

7. Fluoride treatment is limited to treatment twice per calendar year.

DENTAL PPO PLAN EXCLUSIONS

THESE RULES APPLY SOLELY TO PARTICIPANTS WHO ARE ENROLLED IN THE PPO PLAN.

If You Are Enrolled on DENTAL HMO PLAN, please Contact UnitedHealthcare Dental Company at (877) 816-3596 for a complete Summary of your Benefits.

Dental benefits are subject to the following exclusions:

1. Services for injuries or conditions which are work related; services which are provided to the eligible patient by any Federal or State Government Agency or are provided without cost to the eligible patient by any municipal city, county or other political subdivision except as provided in Section 12532.5 of The California Government Code or Federal legislation or ruling;

2. Services with respect to congenital (hereditary) or developmental (following birth) malformations, or cosmetic surgery or dentistry for purely cosmetic reasons: including but not limited to cleft palate, maxillary and mandibular (upper and lower jaw) malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth);

3. Services for restoring tooth structure lost from wear, for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion or for stabilizing the teeth: such services include but are not limited to equilibration and periodontal splinting;

4. Prosthodontic services or any single procedure started prior to the date employee or dependent became eligible for such services under this Plan, including replacement of teeth missing prior to the Plan effective date.

5. Prescribed drugs, premedication or analgesia;

6. Experimental procedures;

7. All Hospital costs and any additional fees charged by the dentist for Hospital treatment. For Participants who, for medical necessity, require hospitalization; benefits will be paid under the major medical benefits of the Plan.

8. Charges for anesthesia, other than general anesthesia, administered by a licensed dentist in connection with covered oral surgery services. For Participants who, for medical necessity, require general anesthesia; benefits will be paid under the major medical benefits of the Plan.

9. Extra oral grafts (grafting of tissues from outside the mouth to oral tissues);

10. Replacement of lost or stolen prosthodontic appliance unless there is no prior history of a lost or stolen appliance.

DENTAL BENEFITS FOR THE HMO PLAN

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

If You Are Enrolled in the DENTAL HMO PLAN, please Contact UnitedHealthcare Dental Company at (877) 816-3596 for a complete Summary of your Benefits.

Under the DENTAL HMO PLAN, dental services are provided through a network of Participating UnitedHealthcare Dental Company Dental Offices. When you enroll, you select the Participating Dental Office most convenient for you. You and your dependents will receive dental services only at that office, except in the case of emergency.

UnitedHealthcare Dental Company sends your name to the Participating Dental Office you have chosen. For as long as you are enrolled, UnitedHealthcare Dental Company will pay the Participating Dental Office. Once you choose this plan, you will not be allowed to change dental plans until the next open enrollment period.

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

* There is a $25.00 per person lifetime record set up fee.

In addition, the DENTAL HMO PLAN is offering a modest Orthodontic Benefit with a standard 24 month full banded service for a co-payment from you of $2,250, approximately 60% of Usual and Customary Charges. If you are covered under the DENTAL HMO PLAN and are currently undergoing orthodontic treatment (e.g., banding, etc.) you will not be eligible for the orthodontic benefit if you decide to switch to the DENTAL PPO PLAN.

Due to the payment nature of the DENTAL HMO PLAN, there is no coordination of benefits in the case where both husband and wife are City employees. In an effort to afford you the fullest possible coverage, you may submit a bill showing your co-payments, and the Trust shall reimburse you.

MEDICAL AND DENTAL BENEFIT LIMITATIONS

COORDINATION OF BENEFITS (COB) (SUMMARY ONLY)

IN GENERAL
All Medical and Dental benefits are subject to coordination. If you or your dependents are entitled to benefits under any other plan which would pay part or all of the expense incurred for treatment of sickness or injury, the benefits payable under this Plan and any other plans will be coordinated so that the aggregate amount paid will not exceed 100% of the Usual and Customary Charges or contracted amount. In no event will the amount of benefits paid under this Plan exceed the amount, which would have been paid if there were no other plan involved. Please refer the Coordination of Benefit provisions for this Plan.

GENERAL EXCLUSIONS AND LIMITATIONS

Benefits are not payable for:

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

2. Any expenses covered under a Workers Compensation Act or similar legislation, or which is due to injury or illness arising out of or in the course of any occupation or employment for wages or profit. Provided, however, that such exclusion shall be inapplicable to injury or illness arising out of or in the course of an occupation or employment for which Workers Compensation or similar insurance would not customarily be procured.

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

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

5. Charges resulting from voluntary self-inflicted injury or illness, unless such actions are a direct result of an underlying physical and/or mental health condition or as required under the No Surprises Act.

6. Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of the Covered Person's commission of or attempt to commit a Serious Illegal Act, or a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that if prosecuted as a criminal offense a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or that, if filed, a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required for this exclusion to apply. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition or as required under the No Surprises Act.

7. Services, supplies, care or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol or controlled substances, including, but not limited to, operation of a motor vehicle. The responding officer's determination of illegal conduct will be sufficient for this exclusion to apply. Expenses will be covered for an Injured Covered Person other than the person illegally using alcohol or a controlled substance and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition or as required under the No Surprises Act.

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

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

10. Charges in excess of the usual and customary guidelines utilized by the Plan.

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

12. Charges for the completion of claim form, prescriptions, missed or broken appointments, finance charges, shipping, handling and postage charges.

13. Procedures that are considered experimental and investigative.

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

15. Charges incurred in connection with cosmetic surgery, unless required for:

    a. Accidental injuries occurring while covered, and only if performed while still covered; or

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

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

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

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

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

16. Treatment of obesity for any Covered Person, except as Medically Necessary.

17. Charges for surgical treatment of obesity, except as Medically Necessary.

18. Any other treatment of obesity including but not limited to appetite or weight control drugs, dietary supplements, special foods or food supplements primarily for weight loss or control, except as Medically Necessary.

19. Nutritional counseling, unless prescribed in writing by the attending Physician, provided by a registered dietician, performed for treatment of a condition of disease origin.

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

21. Reversal of sterilization procedures.

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

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

24. Treatment for attention deficit/hyperactivity disorder unless authorized by SimpleBehavioral.

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

26. Speech therapy unless prescribed for Medically Necessary Speech Therapy services when ordered by the Member's Personal Physician and provided by a licensed speech therapist/pathologist or other appropriately licensed or certified Health Care Provider, pursuant to a written treatment plan to correct or improve (1) a communication impairment; (2) a swallowing disorder; (3) an expressive or receptive language disorder; or (4) an abnormal delay in speech development.

    Continued benefits will be provided as long as treatment is Medically Necessary, pursuant to the treatment plan, and likely to result in clinically significant progress as measured by objective and standardized tests. The provider's treatment plan and records may be reviewed periodically for Medical Necessity.

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

28. Travel expenses, whether or not recommended by a Physician, except for ambulance service (including air ambulance) as specifically provided.

29. Charges incurred for services or supplies, which constitute personal comfort or convenience and beautification items.

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

31. Charges incurred for the replacement of an initial prosthesis unless medical necessity is proven in writing.

32. Charges incurred for injuries sustained as the result of the misuse of a controlled substance, unless such actions are a direct result of an underlying physical and/or mental health condition or as required under the No Surprises Act.

33. Organ transplant donor expenses would not be considered a covered expense unless the expense is directly related to a Plan participant who is the recipient of the organ.

34. Charges for maternity care for a dependent child, including abortions.

35. Charges for biofeedback, hypnosis, sleep apnea, and services relating to pain management centers unless certified by a Physician as required for the necessary medical treatment of an illness, injury or pregnancy.

36. Complications arising from a service or treatment which are excluded from coverage, except as required under the No Surprises Act.

37. Treatment of mandible for correction of a bite problem or treatment of jaw joint problems, including temporomandibular joint syndrome and craniomandibular disorders, or other conditions of the joint linking the jaw bone and skull and a complex of muscle, nerve and other tissue related to that joint (however, necessary services and supplies to diagnose these conditions are covered), except when any of the following criteria is met:

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

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

    c. The associated respiratory problems would endanger life.

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

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

39. Charges for Custodial Care.

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

41. Care and treatment that is either Experimental/Investigational or not Medically Necessary: This exclusion shall not apply to routine patient costs to the extent that the cost is for a Qualified Individual who is a participant in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition. The Plan shall not deny, limit or impose additional conditions on routine patient costs for items and services furnished in connection with participation in the clinical trial.

    The following are not included as routine patient costs:

    a. The investigational item, device, or service itself;

b. Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

c. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

This provision does not require the Plan to pay charges for services or supplies that are not otherwise Covered Charges (including, without limitation, charges which the Qualified Individual would not be required to pay in the absence of this coverage) or prohibit the Plan from imposing all applicable cost sharing and reasonable cost management provisions. For these purposes, a Qualified Individual is a Covered Person who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition, and either: (1) the referring health care professional is a Network Provider and has concluded that the individual's participation in such trial would be appropriate; or (2) the Covered Person provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.

ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE
FOR ACTIVE EMPLOYEES AND NON-MEDICARE SUPPLEMENT RETIREES

Upon receipt by the City of Fresno of due proof that the covered employee has suffered any of the losses enumerated below as a result of bodily injuries effected directly and independently of all other causes and that such injuries resulted in such losses within 90 days from the date such injuries were sustained, and that such loss did not result directly or indirectly from a risk hereinafter excepted, the Trust will pay the benefit designated for such loss, subject to the provisions and limitations hereinafter set forth.

AMOUNT OF PRINCIPAL SUM
MAXIMUM PAYABLE $1,500 (Active Employees and Non-Medicare Supplement Retirees only)

The Principal Sum
Loss of life, loss of both hands, loss of both feet, loss of sight to both eyes, loss of one hand and one foot, loss of one hand and the sight of one eye or loss of one foot and the sight of one eye.

One-Half the Principal Sum
Loss of one hand, loss of one foot or loss of the sight of one eye.

Loss shall mean, with regard to hands and feet, dismemberment by severance through or above the wrist or ankle joints; with regard to the eyes, the entire and irrecoverable loss of sight beyond remedy by surgical or other means.

Risks Excepted
No amount shall be payable if the employee's loss shall directly or indirectly, wholly or partly, result from:

1. suicide or intentionally self-inflicted injury while sane or insane;

2. bacterial infections (except pyrogenic infections occurring simultaneously with and in consequence of bodily injuries as described on this page);

3. bodily or mental infirmity, disease of any kind or as a result of medical or surgical treatment therefore;

4. participation in a riot or the commission of or the attempt to commit an assault or felony by the individual;

5. insurrection;

6. any act of war, whether declared or undeclared.

GENERAL PROVISIONS

ELIGIBILITY

The following persons are eligible for coverage under the Plan:

1. Each covered employee, as defined by the Trust Agreement, shall become eligible for benefits on the first day of the month following one entire calendar month of full-time or other qualifying employment with the City of Fresno. Employees rehired from the reinstatement list shall become effective the first of the month following their reinstatement date. This requirement shall not operate to exclude an employee whose first day of work is delayed solely by a holiday or weekend, which falls at the beginning of a month.

2. Eligible dependents of active and retired employees, including:

    a. legal spouse;

    b. domestic partner, as defined under the California Family Code 297, and has filed a Declaration of Domestic Partnership with the California Secretary of State, or by validly forming a legal union in a jurisdiction other than California consistent with the requirements of Family Code Section 299.2.

    c. Children from birth to the limiting age of 26 years.

3. Either the City or HealthComp Administrators must be notified **within 30 days** of the date of marriage, the date you establish domestic partnership based on the Declaration of Domestic Partnership filed with the California Secretary of State, the date of birth of a new dependent child, or the date you acquire a dependent child, as described in 2.c. above. Completed enrollment forms, available from the City's Personnel Office, with supporting documentation, must be submitted to the City **within 60 days** of the date of marriage, the date you establish domestic partnership based on the Declaration of Domestic Partnership filed with the California Secretary of State, the date of birth of a new dependent child, or the date you acquire a dependent child, as described in 2.c. above, or the date. If valid enrollment forms and supporting documentation are received within the timeframe noted above, then dependents shall become eligible for benefits on the date of marriage, the date you establish domestic partnership based on the Declaration of Domestic Partnership filed with the California Secretary of State, the date of birth of a new dependent child, or the date you acquire a dependent child, as described in 2.c. above.

Definitions: For the purpose of the Fresno City Employees Health and Welfare Trust's Eligibility, the following definitions and requirements will apply:

1. The term "dependent" does not include any person who is in full-time military service.

2. The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives.

3. The term "children" shall include natural children of the Employee or domestic partner, adopted children, foster children or children placed with a covered Employee (or domestic partner) in anticipation of adoption. Step-children may also be included as long as a natural parent remains married to the Employee.

    a. If a covered Employee or domestic partner is the Legal Guardian of an unmarried child or children, these children may be enrolled in this Plan as covered Dependents.

b. The phrase "child placed with a covered Employee or domestic partner in anticipation of adoption" refers to a child whom the Employee or domestic partner intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee or domestic partner of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

c. Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan.

4. A "foster child" shall be defined as a child residing with and dependent upon a covered Participant while awaiting legal adoption by the employee.

5. The term “unmarried disabled dependent” shall be defined as a covered dependent child who, upon reaching the age of 26 (limiting age), was totally disabled, incapable of self-support due to intellectual disability and/or physical disability primarily dependent upon the covered employee for support and maintenance, and unmarried. Unmarried disabled dependents who meet this definition will be covered under the Plan as follows:

   a. If the intellectual disability and/or physical disability began **prior** to age 26 (limiting age), eligibility for the unmarried disabled dependent will remain in effect until the earliest of: the date the employee is no longer eligible under the Plan, or the date the dependent is no longer disabled,

   b. Submission of a Physician’s certificate of disability within six (6) months of the dependent’s 26^{th} birthday is required as proof of the disabled dependent’s continuing incapacity and dependency.

   c. Under no circumstance will the dependent be eligible for benefits if the cause of the intellectual disability and/or physical disability is the result of alcohol or substance abuse.

6. Full-time, permanent employees of a labor organization representing employees who participate in the Trust shall be eligible for coverage under the Trust. Said employees must be covered within thirty (30) days after employment and remain covered so long as their Full-time permanent employment status continues.

7. Early Retirees are City of Fresno employees that retired from City of Fresno service prior to the age of 65; meet the minimum qualifications for the City of Fresno for retirement benefits; and who were enrolled in coverage with the Fresno City Employees Health and Welfare Trust as an employee or dependent at the time of his/her retirement. Early Retirees and their dependents may remain covered under the Plan until they reach the age of 65 years, at which time the eligible individual must:

   a. have been covered, either as an employee or as a dependent, under the Fresno City Employees Health and Welfare Trust until his/her sixty-fifth birthday; and

   b. have celebrated his/her sixty-fifth birthday on or after July 1, 1985; and

   c. be eligible for and enrolled in Medicare's Part A and Part B coverage; and

   d. have signed up for the Fresno City Employees Health and Welfare Trust Medicare Supplement Plan within ninety (90) days of his/her sixty- fifth birthday; and

   e. pay the monthly contribution per Covered Person, which will be withheld from each City of Fresno Pension check.

If you retired after January 1, 1998 and have dependent coverage under the Plan of your actively working spouse (dual coverage), you may defer your election of Early Retiree health coverage until your spouse ceases to be covered as an active employee of the Fresno City Employees Health and Welfare Trust or you or your spouse experience a COBRA qualifying event. Within 30 days thereafter, you must elect Fresno City Employees Health and Welfare Trust Early Retiree Coverage or Fresno City Employees Health and Welfare Trust Medicare Supplemental coverage based on your age at the time of the election. If the election is not made within 30 days, except for COBRA qualifying events, the right to all coverages are waived to participate in the Fresno City Employee Health and Welfare Trust Plan.

Additionally, if you retire and your spouse continued to be covered under the City Plan as an active employee after July 10, 1996, you may rescind your previous election and enroll as a dependent Participant.

8. Upon the death of a covered employee (active or retired), and if such employee was covering his/her dependent spouse or children under the Plan, such spouse or children may continue their coverage under the Plan provided that:

   a. The election to continue is made within 30 days after the death of the employee.

   b. Payments of the required contributions are submitted to City of Fresno Health and Welfare Trust in advance.

   c. Coverage will terminate when the dependent spouse remarries. This provision shall be replaced by the continuation of coverage (COBRA) rules established by Federal legislation at the time such rules become applicable to City of Fresno employees.

REQUESTING A CERTIFICATE OF CREDITABLE COVERAGE

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), when you or any of your Dependents lose coverage, the City's Personnel Office will provide you with a Certificate of Creditable Coverage ("coverage certificate") verifying the length of your coverage under the Plan. If you elect COBRA continuation coverage, you and your covered Dependents will also receive a "coverage certificate" after COBRA continuation coverage ends.

You and your Dependents may request a "coverage certificate" while you are covered under the Plan or within 24 months after your coverage under the Plan ends. Requests for "coverage certificates" should be made to the City's Personnel Office. Telephone requests will be accepted only if the coverage certificate is to be mailed to the address on file for the individual for whom it is requested. All requests must include all of the following information:

1. The name of the individual for whom the "coverage certificate" s requested;

2. The last date that the individual was covered under the Plan;

3. The name of the Employee that enrolled the covered individual in the Plan; and

4. A telephone number where the individual requesting the "coverage certificate" may be reached.

INDIVIDUAL TERMINATIONS
Coverage under the Plan(s) shall terminate at the earliest time indicated below:

1. Termination of the Plan(s).

2. At the end of the month during which the employee ceases to be employed by the City of Fresno.

3. At the end of the month during which the employee ceases to be in a class eligible for coverage.

4. At the end of the month a covered dependent ceases to be a dependent as defined herein. It is the responsibility of the participant to immediately notify the plan when a covered dependent ceases to be a dependent.

5. The Employer or Plan has the right to rescind any coverage of the Employee and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. The employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Dependent's paid contributions.

INDIVIDUAL EFFECTIVE DATE
Employee and dependent coverage will become effective on the date they are eligible if they have enrolled in the Plan prior to that date provided that:

1. The employee qualifies for eligibility as described above.

2. The dependents who are Hospital confined or disabled when they would have otherwise become covered will become covered on the date the disability ends.

3. A newborn child of a covered Employee is automatically enrolled in this Plan for the first 31 days of life. Charges for covered nursery and routine Physician care will be applied toward the Plan of the parent during this 31 day period. If the newborn child is not enrolled in this Plan within the first 31 days of life coverage will terminate at the end of the 31 day period and there will be no additional payment from the Plan. A newborn child enrolled after the first 31 days will be considered a late enrollee.

CONTINUATION OF BENEFITS
When required by Federal law, continuation coverage for Plan benefits will be available at the Participant's cost under whatever regulations are applicable at the time eligibility for continuation coverage occurs. Please refer to the Continuation of Coverage (COBRA) section on page 64 for more information, and the Uniformed Services Employment and Re-Employment Rights Act (USERRA) below.

UNIFORMED SERVICES EMPLOYMENT AND RE-EMPLOYMENT RIGHTS ACT (USERRA)

Under this Federal Act, you may continue coverage for you and your dependents for up to 24 months while you are on military leave. If you make this election, you must submit any self-payment, which may include administrative costs, to the City of Fresno. If you do not continue your coverage during a military leave, it will be reinstated at the same benefit level (if still available) you received before your leave, if you meet the eligibility criteria established under USERRA. For more information, please contact the City's Personnel Office.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or his dependents (including their spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a written request by the employee for enrollment must be made within 31 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a written request for enrollment must be made by the employee within 31 days after the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact HealthComp Administrators.

SPECIAL ENROLLMENT PERIODS
The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

Coverage will become effective as of the first day of the first calendar month following the date the completed enrollment form is received unless an earlier date is established by the Employer or by regulation.

1. **Individuals losing other coverage creating a Special Enrollment right**. An Employee or Dependent, who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage meets all of the following conditions:

    a. The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

    b. If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

    c. The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated.

The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of conditions described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

2. **Loss of Eligibility** A loss of eligibility happens if one of the following occurs:

   a. The Employee or Dependent has a loss of eligibility on the earliest date a claim is denied that would meet or exceed a lifetime limit on all benefits.

   b. The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e., part-time employees).

   c. The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

   d. The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

   e. The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

   f. If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

3. **Dependent beneficiaries.** The Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan if:

   a. The Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

   b. A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption.

   In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll.

   The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 31-day period.

   The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

   a. in the case of marriage, as of the date of marriage;

   b. in the case of a Dependent's birth, as of the date of birth; or

c. in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

4. **Medicaid and State Child Health Insurance Programs**. An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if:

a. The Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State child health plan (CHIP) under Title XXI of such Act, and coverage of the Employee or Dependent is terminated due to loss of eligibility for such coverage, and the Employee or Dependent requests enrollment in this Plan within 60 days after such Medicaid or CHIP coverage is terminated.

b. The Employee or Dependent becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Employee or Dependent requests enrollment in this Plan within 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

If a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.

SAVINGS CLAUSE

It is the intent of this Plan and the Plan Administrator to comply with all applicable Federal and State laws and regulations. In the event of non-compliance with any such law or regulation, the Plan Document will be deemed amended to comply with said law or regulation as of its effective date, and the remainder of the Plan Document will remain in full force and effect. Similarly, in the event a law or regulation applicable to this Plan becomes effective after the initial effective date of this Plan Document, said law or regulation will be deemed included in this Plan Document as of its effective date and without the necessity of an amendment to this Plan Document.

CONTINUATION OF COVERAGE

When required by Federal law, continuation coverage for Plan benefits will be available at the Participant's cost under whatever regulations are applicable at the time eligibility for continuation coverage occurs. Please refer to the **Uniformed Services Employment and Re-Employment Rights Act (USERRA)** section on page 61 and the **Continuation of Coverage (COBRA)** section on page 64 for more information.

Continuation of Benefits coverage requires employee payment of the Trust contribution in order to continue benefits. In addition, the Medical plan provides for an Extension of Medical Benefits Due to Total Disability at no cost to you, as described on page 43 for the treatment of an illness or injury relating to the Total Disability only, as defined therein. **In no event will the combined continuation of benefits described under the Extension of Medical Benefits Due to Total Disability and COBRA Continuation Coverage, if elected, exceed the total number of months permitted under COBRA.**

CONTINUATION OF COVERAGE (COBRA)

A federal law known as COBRA provides for continuation of health/mental, dental and vision coverage for a period of time after the occurrence of a Qualifying Event at 102% of the cost paid by or on behalf of a covered individual similarly situated. **The electing party (employee, spouse or dependent Qualified Beneficiary) may choose full benefits or medical benefits only.** A description of sample Qualifying Events, Qualified Beneficiaries, and Length of Continuation Coverage follows:

Qualifying Events	Who is Eligible (Qualified Beneficiaries)	Length of Continuation Coverage
Employee Termination (except for gross misconduct) and Employee Reduction of Hours	Employees and Dependents	18 months
Employee Death	Spouse and Dependents	36 months
Employee Eligibility for Medicare	Spouse and Dependents	36 months
Divorce or Legal Separation*	Former Spouse and Dependents	36 months
Child Ceases to Qualify as a Dependent*	Child	36 months
* Employee or spouse **MUST** notify the City's Personnel Office **within 60-days** after the date of the occurrence of these events.		

Please note that the City of Fresno determines initial and continuing eligibility for COBRA coverage under the Plan. All questions relating to initial or continued eligibility should be referred to the City Personnel Office for its consideration. To be a Qualifying Event, the occurrence of any one of the above events must cause a loss of coverage under the Plan. A Qualified Beneficiary has 60 days after receipt of notice of COBRA Rights to elect coverage and 45 days thereafter to make initial payments to the City's Personnel Office. Thereafter, payments are due the first day of each coverage month and will be considered timely if made within 30 days after the date due.

The Qualified Beneficiary may choose full benefits or medical benefits only. Any election of Continuation Coverage by a Qualified Beneficiary will be deemed to include an election of Continuation Coverage on behalf of any other Qualified Beneficiary who would lose coverage under the Plan by reason of the Qualifying Event. Each Qualified Beneficiary is entitled to make a separate election.

Failure to make payments in full and on time results in the loss of your right to coverage for whatever remains of the eighteen (18), twenty-nine (29), or thirty-six (36) month total. **Continuation Coverage, once terminated, cannot be reinstated.**

Extension of COBRA Continuation Coverage
If the loss of coverage was due to Employee Termination (termination of employment) or Reduction of Hours, and a second Qualifying Event occurs during the 18-month Continuation Coverage period, your eligible dependents who elected Continuation Coverage may be able to extend their coverage an additional 18 months (up to 36 months) from the date of Employee Termination or Reduction of Hours. Your dependents must give notice to the City's Personnel Office within 60 days after the date of the second Qualifying Event and within the initial 18-month period in order to be able to extend Continuation Coverage under this provision.

If your loss of coverage was due to Employee Termination or a Reduction of Hours, and you are determined to be disabled within 60 days after the Qualifying Event, **and** you receive a Social Security Disability Award prior to the end of your 18-month period, you may be eligible for coverage until 29 months from the Qualifying Event at a higher premium (150% of normal cost) for months 19 to 29. The Qualified Beneficiary is responsible for notifying the City's Personnel Office of such disability determination within 60 days after the date of the determination and **before** the end of the initial 18-month period. The Qualified Beneficiary is also responsible for notifying the Personnel Office within 30 days after the date of any final determination by Social Security that the Qualified Beneficiary is no longer disabled.

Termination of COBRA Continuation Coverage
COBRA Continuation Coverage will terminate the earliest of:

1. when the 18-month, 29-month, or 36-month limit is reached;

2. the City ceases to provide health benefits;

3. you fail to pay monthly premiums when due;

4. the date you or your dependent becomes covered under Medicare;

5. in the case of a Qualified Beneficiary who is disabled at any time during the first 60 days of Continuation Coverage, the month that begins more than 30-days after the date of final determination by Social Security that the Qualified Beneficiary is no longer disabled.

CLAIMS PROCEDURES

HOW TO FILE A "CLAIM"

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

1. Itemized claims are submitted by the provider directly to the Claims Administrator.
2. HealthComp Administrators must have current (less than 1 year old) "Other Insurance Information" on file.
3. Payment is assigned to the provider of service.

Providers must submit itemized statements showing:

1. Participant's Name
2. Participant's Social Security Number
3. Patient's Name
4. Dates of Services
5. List of Services and charges provided by CPT code
6. Provider's name, address and Tax ID Number

NOTICE OF CLAIM

Written notice of claim must be given to the Claims Administrator within 60 days after the occurrence of any loss covered by the Plan, or as soon thereafter as is reasonably possible. Any claim not submitted within 15 months of the date of loss is ineligible for payment unless approved by the Board of Trustees, which approval must be based on proof of special circumstances which prohibited timely filing of the claim.

HOW TO APPEAL A DENIED CLAIM

Internal Claims and Appeals
A Covered Person may appeal any adverse benefit determination, including the rejection or payment of any claim or portion thereof, by filing a request for appeal to the Board of Trustees within one hundred eighty (180) days of the receipt of the Explanation of Benefits (EOB) or written notice that the claim has been rejected. **The appeal must be in writing and submitted to the Claims Administrator.** Appeals can be sent by either email or by mail to the following:

Email: HCAppeals@healthcomp.com

Mail: Attn: Appeals
PO Box 45018
Fresno, CA 93718-5018

The Covered Person may submit new information (e.g., comments, documents and records) in support of the appeal. The Board of Trustees shall have full discretionary authority to interpret Plan language and to decide all claims or disputes regarding right, type, amount or duration of benefits, or claim to any payment from the Trust, and the Board's decision shall be final and binding on all parties. A Covered Person may not take legal action on a denied claim until he or she has exhausted the Plan's mandatory appeal procedures.

A decision with regard to the appeal will be made within the legally permitted timeframe. In the case of a pre-service urgent care claim, a decision will be made as soon as possible consistent with medical exigencies involved, but in no event later than 72 hours, provided that the Plan defers to the attending provider with respect to the decision as to whether the claim constitutes "urgent care." The Plan will provide decisions within 30 days for non-urgent care not yet received by the Covered Person, and within 60 days for denials of services already received.

The decision on appeal will be in writing. If the decision is to continue to reduce or deny benefits, then the notification will include specific information including but not limited to the following: the specific reason for the decision, reference to the pertinent Plan provision upon which the decision is based, information about the external appeals process, and all other information required by law or regulation. If any new evidence is considered, relied upon or is generated during the appeal process, or a determination is based on a new rationale, then the Covered Person will be furnished with the new evidence or rationale free of charge, and sufficiently in advance of the final determination so that they have reasonable opportunity to respond before the determination is made. Additional resources available to the Covered Person will be described in the Final Internal Adverse Benefit Determination.

The Plan will continue coverage for a Covered Person during the appeal process, pending the outcome of the internal appeal.

External Review
An individual may file a request for an external review if the request is filed within four (4) months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt the request must be filed by the first day of the fifth month following receipt of the notice.

A preliminary review will then be conducted to let the Covered Person know if the claim submission is complete. If the request is not complete, the Covered Person will be notified, and the Plan must let the Covered Person perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

The Covered Person will be notified, in a timely manner, of the acceptance of the claim for review by the external review organization. The Covered Person will also be informed of the deadlines for submissions of additional information, which will be no later than ten business days following receipt of said notice. Within 45 days after receiving the request for review, the external review organization will provide written notice of the Final External Review Determination to both the Plan and the Covered Person.

GRIEVANCE PROCESS

The California Department of Managed Health Care is responsible for regulating health care service plans. The Fresno City Employees Health and Welfare Trust is currently exempt from such regulation. However, that exemption is dependent on compliance with certain requirements imposed by California law on the Trust. If you believe the Trust has failed to meet such requirements, you may contact the California Department of Managed Health Care. The department has a toll-free number (888-HMO-2219) and a TDD line (877-688-9891) for hearing and speech disabilities The department's Internet website http://www.hmohelp.ca.gov has complaint forms. You may also contact the Department by writing to the following address: 980 9th Street, Suite 500, Sacramento, CA 95814, or by e-mail at helpline@dmhc.ca.gov.

EXPLANATION OF BENEFITS (EOB) FORM

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

PAYMENT OF CLAIMS

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

Physical Examination

The Trust at its own expense shall have the right to require an examination of any individual whose injury or sickness is the basis of a claim when and as often as it may reasonably be required during the pendency of a claim hereunder.

Legal Action

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

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

Right of Recovery

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

Recovery of overpayments, whether made directly to a Participant or on the Participant's behalf, may be deducted directly from future benefit payments if, after notice of the overpayment and an opportunity to be heard by the Board of Trustees, the Participant does not make other arrangements for payment acceptable to the Board of Trustees.

Reservation of Rights

The benefits payable under this Plan are not pre-funded. Claims are paid out of current revenues. There is no liability on the part of the Board of Trustees or any other individual or entity for provision of benefits in an amount over and beyond the amount collected by the Trust for this Plan. The ability of the Plan to continue coverage is reviewed by the Trustees at least annually, and the Trustees reserve the right to modify or terminate coverage, or to require or increase premiums for benefits now provided at no cost or a reduced cost.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purposes of enforcing or determining the applicability of the terms of this provision of this Plan or any similar provision of the other plan, the Board of Trustees may with the consent of the person, release to, or obtain from an insurance company, organization or person any information with respect to the person which the Board of Trustees deems to be necessary for such purposes, in accordance with the provisions of Protected Health Insurance (PHI) under federally-mandated HIPAA regulations.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)
In accordance with HIPAA, the Plan will comply with the following:

1. The Plan will use and disclose Protected Health Information (PHI) to the extent permitted by law and in accordance with HIPAA. Specifically, the Plan will use and disclose PHI for purposes related to health care treatment payment for health care, and health care operations.

2. Subject to written certification if required, the Plan may disclose PHI to the Board of Trustees, provided the Trustees do not use or disclose such PHI except:

    a. To perform administrative functions which the Trustees perform for the Plan;

    b. To obtain premium bids from insurance companies, HMOs, or other health plans for providing group insurance coverage under the Plan;

    c. To modify, amend, or terminate the Plan; or

    d. As permitted by the Plan, or as required by law.

3. In no event shall the Trustees be permitted to use or disclose PHI in a manner that is inconsistent with the applicable disclosure requirements. The Plan shall not disclose PHI to the Trustees unless the Trustees agree to:

    a. Not use or further disclose the PHI other than as permitted by the Plan, or as required by law.

    b. Ensure that any agent (including subcontractor) who receives PHI from the Plan, agrees in advance to the same restrictions and conditions that apply to the Trustees with respect to the PHI.

    c. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Trustees.

    d. Report to the Fund any use or disclosure of the information that is inconsistent with the uses or disclosures permitted herein.

    e. Make available to a Participant, his or her PHI, and any amendments to his or her PHI, in accordance with applicable law.

    f. Make available to a Participant who requests an accounting of disclosures of his or her PHI, the information required to provide an accounting of disclosures in accordance with applicable law.

    g. Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with applicable law.

h. If feasible, return or destroy all PHI received from the Plan that the Trustees maintain in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosers to those purposes that make the return or destruction of the information infeasible.

i. Ensure that the adequate separation required by applicable law between the Plan and the Trustees exist.

FACILITY OF PAYMENT

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plans, the Board of Trustees shall have the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and to the extent of such payments, the plan shall be fully discharged from liability under this Plan.

THIRD PARTY RECOVERY PROVISION
(Right of Subrogation and Refund)

When this provision applies - The Covered Person may incur medical or dental charges due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or any insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for such medical or dental expenses. This lien shall remain in effect until the Plan is repaid in full.

The payment for benefits received by a Covered Person under the Plan shall be made in accordance with the assignment of rights by or on behalf of the Covered Person as required by Medicaid.

In any case in which the Plan has a legal liability to make payments for benefits received by a Covered Person, to the extent that payment has been made through Medicaid, the payment for benefits under the Plan shall be made in accordance with any state law that has provided that the state has acquired the rights of the Covered Person to the payments of those benefits.

The Covered Person:

1. automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies.

2. must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount Subject to Subrogation or Refund. The Covered Person agrees to recognize the Plan's right to Subrogation and Refund. These rights provide the Plan with 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party or insurer to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses even if the Covered Person's Recovery is less than the amount claimed and, as a result, the Covered Person is not made whole. The Covered Person further specifically agrees and acknowledges that the "made whole doctrine" and "common fund" doctrine are completely abrogated under this Plan, and will not affect the Administrator's right to 100% Subrogation and Refund for any and all benefits paid. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any responsible third party or insurer. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered Person's Third Party Claims and/or the Covered Person's claims under any other policy of insurance including, but not limited to, underinsured or uninsured motorist coverage regardless of whether Covered Person initiates the filing of any such claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorney's fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on account of Injury or Sickness caused by a responsible Third Party under after the Covered Person or his authorized legal representative obtains valid court recognition and approved of the Plan's 100% first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined Terms:

"*Covered Person*" means anyone covered under the Plan, including minor dependents.

"*Recover*", "*Recovered*", "*Recovery*", or "*Recoveries*" means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorney's fees, costs and expenses,
pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"*Refund*" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"*Subrogation*" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical or dental charges against the other person.

"*Third Party*" means any Third Party including another person or a business entity.

Recovery from another plan under which the Covered Person is covered. This right of Refund also applies when a Covered Person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan, or any liability plan.

Rights of Plan Administrator. The Plan Administrator has a right to request reports on and approve of all settlements.

COORDINATION OF BENEFITS

If another plan covering a Covered Person contains a similar Coordination of Benefits provision which coordinates its benefits with this Plan the following rules establishing the order of payments will apply:

1. The plan that covers the person as other than a dependent, (e.g., as an employee, member, subscriber, retiree) is primary and the plan that covers the person as a dependent is secondary.

2. If the claimant is a dependent child whose parents are not divorced or separated then:

    a. The plan of the parent whose birthday anniversary is earlier in the calendar year will pay first, except:

        i. If both parents' birthdays are on the same day, rule 4 below will apply.

        ii. If another plan does not include this COB rule based on the parents' birthday, but instead has a rule based on the gender of the parent, then that plan's COB rule will determine the order of benefits.

3. If the claimant is a dependent child whose parents are divorced or separated, or have never married then the following rules apply:

    a. A plan, which covers a child as a dependent of a parent who by court decree must provide health coverage, will pay first.

    b. When there is no court decree, which requires a parent to provide health coverage to a dependent child, the following rules will apply:

        i. When the parent who has custody of the child has not remarried, that parent's plan will pay first.

        ii. When the parent who has custody of the child has remarried, then benefits will be determined by that parent's plan first, by the stepparent's plan second, and by the plan of the parent without custody third.

4. If none of the above rules establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time, provided that the Covered Person is actively employed by the City of Fresno. The above shall be inapplicable if the Covered Person is a retired City of Fresno employee, in which case the Fresno City Employees Plan shall be secondary to the plan provided by the person's current employer.

5. In all instances when this plan has secondary plan status as determined by this plan's order of priority, the Participant or dependent may not fail to follow all primary plan requirements or refuse primary plan coverage and be eligible for benefits under this plan. When benefits are reduced under a primary plan because a claimant does not comply with plan provisions, the amount of such reduction will not be allowable. In the case of HMO (Health Maintenance Organization) or other in-network only plans, this plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

   a. The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid off or Retired Employee.

   b. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee.

   c. If the other benefit plan does not have 6 a) or 6 b) above, and if, as a result, the plans do not agree on the order of benefits, 6 a) and 6 b) will not apply.

   d. The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

6. If the person is a Medicare beneficiary and, as a result of federal law, Medicare is:

   a. Secondary to the plan covering the person as a dependent; and

   b. Primary to the Plan covering the person as other than a dependent (e.g., a retired employee)

   Then, the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, policyholder, subscriber, or retiree is the secondary plan, and the other plan is the primary plan.

GENERAL PLAN INFORMATION

PLAN NAME AND AFFILIATION

Fresno City Employees Health and Welfare Trust
c/o HealthComp Administrators
P.O. Box 45018
Fresno, California 93718-5018

or

621 Santa Fe Street
Fresno, California 93721
(559) 499-2450
(800) 442-7247

PLAN ADMINISTRATION

The Plan is administered by a Board of Trustees consisting of eleven (11) Trustees representing Employees and three (3) representing the Employer, whose names are as follows:

EMPLOYER TRUSTEES:*

Georgeanne White
City of Fresno

Jennifer Misner
City of Fresno

TJ Miller
City of Fresno

EMPLOYEE TRUSTEES:*

Shane Archer, Chairperson
FFA
(Fresno Firefighters Local 753)

Keola Park
FFA
(Fresno Firefighters Local 753)

William Dearsan
IBEW Trades and Crafts
(International Brotherhood of Electrical Workers Local 100)

Anna Pine
FPOA
(Fresno Police Officers Assn.)

Jeff LaBlue
FPOA
(Fresno Police Officers Assn.)

Vacant
FAPSOA
(Fresno Airports Public Safety Officer Association)

Terri Hauschel
International Union of Operating Engineers, Stationery Local 39

Jesse Gonzalez
CFPEA
(City of Fresno Professional Employees Association)

Sam Hernandez
ATU
(Amalgamated Transit Union)

Kim Jackson
CFMEA
(City of Fresno Management Employees Association)

Sam Frank
FCEA
(Fresno City Employees Assn.)

* For Trustee addresses, call HealthComp Administrators at (800) 442-7247 or (559) 499-2450.

CLAIMS ADMINISTRATOR:
HealthComp Administrators
P.O. Box 45018 Fresno, CA 93718-5018
or
621 Santa Fe Street Fresno, CA 93721
(559) 499-2450 or (800) 442-7247

FEDERAL TAX IDENTIFICATION NUMBER: 94-6362989

PLAN YEAR: July 1 – June 30

PLAN CONSULTANT:
Rael & Letson
(650) 341-3311

PLAN COUNSEL:
The Law Office of Michael E. Moss
(559) 269-4744

HOSPITAL AND PHYSICIAN NETWORK:
Blue Shield of California (800) 219-0030

PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH-LANGUAGE THERAPY:
SimpleMSK
(844) 854-4861 or (559) 400-6230

CHIROPRACTIC NETWORK:
SimpleMSK
(559) 400-6230

PRESCRIPTION DRUG PROVIDER:
Optum Rx
(800) 777-0074

MENTAL HEALTH/SUBSTANCE ABUSE PROVIDER:
SimpleBehavioral
(888) 425-4800

DENTAL PROVIDER:
UnitedHealthcare Dental Company
(877) 816-3596

DENTAL NETWORK:
Delta Dental of California
(800) 765-6003

VISION PROVIDER:
EyeMed
(866) 939-3633

TELADOC:
(800) 835-2362

BODY SCAN INTERNATIONAL:
(877) 274-5577

EPIC HEARING HEALTHCARE:
(866) 956-5400

EXAMPLES OF BENEFIT PAYMENTS

In order for the Plan to pay FULL benefits outlined in this edition of the Plan Booklet, a monthly contribution of $1,500 per Active Employee must be received by the Trust Fund commencing July 1, 2024. The FULL monthly contribution required for Active Employees is comprised of the City of Fresno's contribution and an Active Employee's payroll deduction.

Employees who do not complete and return a Payroll Deduction Authorization Form indicating an election to make a per month Employee Contribution will not receive FULL Plan Benefits.

Only those Active employees who have a Payroll Deduction Sheet on file indicating their election to contribute the necessary monthly employee contribution will receive full benefits. If the Trust Fund receives only the City's contribution, a reduction will be applied to Fund payments for benefits. The reduction will be equal to the percentage of the Trust Fund rate not received, plus an additional 5%. The percentage reduction will be made in addition to and AFTER all other Trust Fund benefit calculations are made.

IMPORTANT NOTE: ALL BENEFIT REDUCTIONS ARE APPLIED AFTER NORMAL BENEFIT CALCULATIONS ARE MADE. THE FOLLOWING EXAMPLES DEMONSTRATE OUT-OF-POCKET COSTS THAT CAN BE INCURRED BY EMPLOYEES IF THE FULL MONTHLY CONTRIBUTION OF $1,500 IS NOT RECEIVED. **THESE REDUCTIONS CAN RESULT IN SUBSTANTIAL PATIENT LIABILITY FOR HEALTH CARE SERVICES.**

Generally, this means that after satisfying the Plan Deductible, benefits would be paid as follows: (**Note:** additional reductions to normal benefits can apply for non-compliance of a PPO Hospital and Physician, Pre-certification, etc.

Full Benefits	25% Reduction	35% Reduction
Plan / Employee Pays	Plan / Employee Pays	Plan / Employee Pays
100% / 0%	75% / 25%	65% / 35%
90% / 10%	68% / 32%	59% / 41%
80% / 20%	60% / 40%	52% / 48%
70% / 30%	53% / 47%	46% / 54%
60% / 40%	45% / 55%	39% / 61%
50% / 50%	38% / 62%	33% / 67%

Percentage reductions are applicable to benefit payments under the Prescription Drug Program as well.

Percentage reductions will not apply to any services that require no cost sharing under the provisions of the Patient Protection and Affordable Care Act.

BENEFIT EXAMPLES:
Please note that if an employee does not elect to make the necessary Monthly Employee contribution, this may result in a substantial patient liability for medical and walk-in prescription drug services. In the following example, Employee A is paying their monthly employee contribution. Employee B gets an 80% contribution from the City and has elected to not make the payroll deduction. Employee C gets a 70% contribution from the City and has elected to not make the payroll deduction. The following chart shows how their benefits would be calculated for a $5,000 in-network charge, assuming the respective deductibles have not previously been satisfied.

	Employee A[1]	Employee B[2]	Employee C[3]
City Contribution	$1,200.00 / $1,050.00	$1,200.00	$1,050.00
Employee Contribution	$300 / $450	$ 0.00	$ 0.00
Total Monthly Contribution	$1,500.00	$1,200.00	$1,050.00
In-Network Medical Charge	$ 5,000	$ 5,000	$ 5,000
Employee Deductible	$ 200	$ 1,300	$ 1,300
Employee Co-Insurance	$ 960	$ 1,480	$ 1,776
Employee Pays	$ 1,160	$ 2,780	$ 3,076
Fund Pays	$ 3,840	$ 2,220	$ 1,924

1 After the first $200 was applied to the deductible, Employee A pays 20% of the next $4,800 in charges or $960 for a total employee payment of $1,160.

2 After the first $1,300 was applied to the deductible, Employee B pays 40% of the next $3,700 in charges or $1,480 for a total employee payment of $2,780.

3 After the first $1,300 was applied to the deductible, Employee C pays 48% of the next $3,700 in charges or $1,776 for a total employee payment of $3,076.

The following chart shows how their benefits would be calculated for a $10,000 in-network charge, assuming the respective deductibles have not previously been satisfied.

	Employee A[1]	Employee B[2]	Employee C[3]
City Contribution	$1,200.00 / $1,050.00	$1,200.00	$1,050.00
Employee Contribution	$300 / $450	$ 0.00	$ 0.00
Total Monthly Contribution	$1,500.00	$1,200.00	$1,050.00
In-Network Medical Charge	$ 10,000	$ 10,000	$ 10,000
Employee Deductible	$ 200	$ 1,300	$ 1,300
Employee %	$ 1,960	$ 3,480	$ 4,176
OOP Adjustment	$ 0	$ (180)	$ (876)
Employee Pays	$ 2,160	$ 4,600	$ 4,600
Fund Pays	$ 7,840	$ 5,400	$ 5,400

1 After the first $200 was applied to the deductible, Employee A pays 20% of the next $9,800 in charges or $1,960 for a total employee payment of $2,160. Maximum employee Out-of-Pocket limit of $3,200 does not apply.

2 After the first $1,300 was applied to the deductible, Employee B pays 40% of the next $8,700 in charges or $4,480. However, subject to a maximum employee Out-of-Pocket limit of $4,600, Employee B payment responsibility gets reduced by $180.

3 After the first $1,300 was applied to the deductible, Employee C pays 48% of the next $8,700 in charges or $4,176. However, subject to a maximum employee Out-of-Pocket limit of $4,600, Employee C payment responsibility gets reduced by $876.

The following chart shows how their benefits would be calculated for a $15,000 in-network charge, assuming the respective deductibles have not previously been satisfied.

	Employee A[1]	Employee B[2]	Employee C[3]
City Contribution	$1,200.00 / $1,050.00	$1,200.00	$1,050.00
Employee Contribution	$300 / $450	$ 0.00	$ 0.00
Total Monthly Contribution	$1,500.00	$1,200.00	$1,050.00
In-Network Medical Charge	$ 15,000	$ 15,000	$ 15,000
Employee Deductible	$ 200	$ 1,300	$ 1,300
Employee %	$ 2,960	$ 5,480	$ 6,576
OOP Adjustment	$ 0	$ (2,180)	$ (3,276)
Employee Pays	$ 3,160	$ 4,600	$ 4,600
Fund Pays	$ 11,840	$ 10,400	$ 10,400

1 After the first $200 was applied to the deductible, Employee A pays 20% of the next $14,800 in charges or $2,960 for a total employee payment of $3,160. Maximum employee Out-of-Pocket limit of $3,200 does not apply.

2 After the first $1,300 was applied to the deductible, Employee B pays 40% of the next $13,700 in charges or $5,480. However, subject to a maximum employee Out-of-Pocket limit of $4,600, Employee B payment responsibility gets reduced by $2,180.

3 After the first $1,300 was applied to the deductible, Employee C pays 48% of the next $13,700 in charges or $6,576. However, subject to a maximum employee Out-of-Pocket limit of $4,600, Employee C payment responsibility gets reduced by $3,276.

VOLUNTARY EMPLOYEE CLAIM SELF-AUDIT PROGRAM

EFFECTIVE July 1, 2016

Participation

This is a voluntary program available to Active and Retired Employees who are not eligible for Medicare. Employees are encouraged to review bills for expenses incurred by you and/or your eligible dependent children covered under the Plan.

If you wish to participate, follow these simple steps:

1. **Review itemized bills** from eligible providers for services and charges that are covered by the Plan, as shown on the Explanation of Benefits - EOB - form you receive.

2. **If you discover an overcharge on the EOB** (after comparing it with the bill you received from the provider), or

   If you discover charge(s) for services that were not received (for example, if your Hospital stay was for 2 days and the EOB shows the Plan paid for 3 or more days),

   ASK THE PROVIDER OF SERVICE TO CORRECT THE ERROR AND GIVE YOU A CORRECT BILL.

3. Submit the Plan's EOB AND the corrected bill to the Plan.

4. **The Plan will** verify original bill submitted by the provider and the corrected bill. If there was an overcharge or charges for services that were not received, the Plan will share in the overall savings as follows:

   50% of savings to the Employee, to a maximum calendar year payment of $500.
   50% of savings to the Plan.

   Examples of shared savings:

   Example #1: Hospital bill reflects 2 days at $1,000/day per diem paid (total of $2,000) under Blue Shield PPO Contract when Employee only stayed in the hospital 1 day.

   Employee submits revised (corrected) billing from Hospital showing 1 day at $1,000 with Plan EOB shown $2,000. After Plan verification, a check is issued to the Employee reflecting 50% of Plan savings which, in this case, is: 50% x $1,000 savings, or $500.

   In this example, the Employee receives 50%, or $500, and the Plan saved $500.

   Example #2: Laboratory bill reflects that blood testing was performed on one date and a Plan payment of $286 was paid, and additional testing was performed two days later and the Plan paid $340, for total eligible charges of $646. Employee only had one testing totaling $286.

   Employee submits revised (corrected) billing from Laboratory showing $340 charges removed. After Plan verification, a check is issued to the Employee reflecting 50% of Plan savings, which in this case is: 50% x $340, or $170.

   In this example, the Employee receives 50%, or $170, and the Plan saved $170.