FOOTHILL-DE ANZA
Community College District

EMPLOYEE BENEFIT BOOKLET

Exclusive Provider Organization (**EPO**) Medical Plan
Prescription Drugs

UnitedHealthcare ***CHOICE*** Health Plan

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SECTION 5 - PLAN HIGHLIGHTS

The table below provides an overview of Copays that apply when you receive certain Covered Health Services, and outlines the Plan's Annual Deductible, Out-of-Pocket Maximum and Lifetime Maximum Benefit.

Exclusive Provider Organization (EPO) Medical Plan	
	Network Provider
Lifetime Maximum Payment Limits ■ Hospice Care……$10,000 ■ All Other Benefits (for any medical plan provided by FHDA)……..$2,000,000	
Annual Maximum Limits ■ Hearing Aids and Services……..…...$1,000 ■ Mental and Nervous Inpatient Days ……...…..…30 days per calendar year ■ Mental and Nervous Outpatient Visits (limited to one visit per day)…25 visits per calendar year ■ Substance Abuse Inpatient Day Limit……...30 days per calendar year ■ Substance Abuse Outpatient Maximum Benefit……...$2,000 and a maximum of $50 per visit	
Your employer also offers an Employee Assistance Program through United Behavioral Health EAP. This program enables you and your Dependents to receive an additional five (5) outpatient visits payable at 100% before you seek treatment elsewhere.	
COPAY AMOUNTS	
Physician Office Copay Amount	$20 per visit
Covered Charges will be payable at 100% after the Copay amount. The Copay amount will not count toward satisfaction of the Out-of-Pocket and will continue to apply after the Out-of-Pocket Maximum has been reached.	
Emergency Room Copay Amount	$50 per visit*
*Copay waived if admitted. There is a $100 maximum Copay per person per calendar year. For a family of three or more, there is a $300 maximum Copay for the calendar year. For a family of three or more, no one individual can contribute more than $100 toward the maximum Copay amount. One person cannot meet the $300 maximum for the family. Once an individual has met his or her $100 maximum, that one individual no longer pays an Emergency room Copay for the remainder of that calendar year. The other individuals in the family will need to continue to meet their $100 maximum each or the family maximum of $300, whichever comes first.	
Inpatient Hospital Confinement Copay Amount	$50 per confinement
Annual Deductible ■ Per Person ■ Per Family	 $150 $400

Exclusive Provider Organization (EPO) Medical Plan	
Out-of-Pocket Maximums	
■ Per Person	$600
■ Per Family	$1,800

If the amount you pay for Eligible Expenses in any one calendar year reaches the Out-of-Pocket Maximum shown above, subsequent covered medical Benefits will be payable at 100% for the remainder of the calendar year (except as described above for Copay amounts). The Annual Deductible does not apply to the Out-of-Pocket Maximum.

The amounts that **do not** apply toward the Out-of-Pocket Maximum are:

- the Physician office Copay amounts, described above;
- the Urgent Care Copay amount;
- the per Emergency room visit Copay amount;
- the inpatient Hospital confinement Copay amount;
- the amount you must pay because of penalty charges for failure to comply with notification requirements described below;
- the benefit percentage for Mental Health and Substance Abuse Treatment; and
- private duty nursing care.

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details*.

Covered Health Services[1]	Payable by the Plan: Network Percentage of Eligible Expenses
Acupuncture/Acupressure Services (Copay is per visit)	100% after you pay a $20 Copay
Limited to 10 visits per calendar year combined with holistic providers such as naturopaths and oriental medicine practitioners.	
Allergy Injections/Serum	100% after you meet the Deductible
Ambulance Services - Emergency Only ■ Ground ■ Air	 100% after you meet the Deductible 100% after you meet the Deductible
Ambulatory Surgical Center	100% after you meet the Deductible
Artificial Limbs and Artificial Eyes	80% after you meet the Deductible
Audiology/Hearing Aid Fitter/Dispenser ■ Services by an Audiologist ■ Hearing Aid Fitter/Dispenser	 100% after you pay a $20 Copay 80% after you meet the Deductible
All services limited to $1,000 per calendar year. Includes hearing aids and fittings. Batteries not included in the maximum.	
Birthing Centers	100% after you meet the Deductible
Blood Transfusions Including un-replaced blood and blood plasma.	80% after you meet the Deductible
Chiropractic Services	100% after you pay a $20 Copay
Limited to 10 visits per calendar year by any Physician.	
Cochlear Implants	100% after you meet the Deductible
Congenital Heart Disease (CHD) (These Benefits are for Covered Health Services provided through CHD only)	100% after you pay a $20 Copay

Covered Health Services[1]	Payable by the Plan: Network Percentage of Eligible Expenses
Dental Services - Accidental Only (Copay is per visit)	100% after you pay a $20 Copay
Diagnostic X-ray and Lab ■ Outpatient Hospital ■ Physician's Office/Clinic (Copay is per visit) ■ Stand-alone diagnostic X-ray and lab facility	100% after you meet the Deductible 100% after you pay a $20 Copay* 100% after you meet the Deductible
*For X-ray and lab necessary during an exam in a Physician's office/clinic, you pay only one Copay.	
Dietician/Nutritionist Services	80% after you meet the Deductible
Limited to 10 visits per calendar year in a Hospital based program.	
Durable Medical Equipment (DME)	100% after you meet the Deductible
Emergency Room ■ If due to an Emergency as defined (Emergency services received at a non-network Hospital are covered at the network level) ■ All other conditions	100% after you pay a $50 Copay and meet the Deductible 80% after you pay a $50 Copay and meet the Deductible
If the $50 Copay described above is not waived or the Out-of-Pocket Maximum has not been satisfied, the Copay amount will be applied prior to the 100% or 80% Coinsurance payment.	
Extended Care Facility	100% after you meet the Deductible
Home Health Care Limited to 60 visits per plan year with four hours equaling one visit.	100% after you meet the Deductible

Covered Health Services[1]	Payable by the Plan: Network Percentage of Eligible Expenses
Hospice Care Limited to $10,000 maximum lifetime benefit for each Covered Person.	80% after you meet the Deductible
Hospital - Inpatient Stay (Copay is per admission)	100% after you pay a $50 Copay and meet the Deductible
Infertility Services - Diagnostic Only	
■ Physician's Office Services (Copay is per visit)	100% after you pay a $20 Copay
■ Outpatient services received at a Hospital or Alternate Facility	100% after you pay a $20 Copay
Injections in a Physician's Office	100%
Massage Therapy When performed by a Physician or health care extender.	80% after you meet the Deductible
Maternity Services	
■ Prenatal care (No Copay applies for prenatal visits after the first visit)	100% after you pay a $20 Copay
■ Delivery, post-natal care and any related complications	
– Physician's Office Services (Copay is per visit)	100% after you pay a $20 Copay
– Hospital - Inpatient Stay (Copay is per admission)	100% after you pay a $50 Copay and meet the Deductible
– Professional Fees for Surgical and Medical Services	100% after you meet the Deductible
Mental and Nervous Disorders	
United Behavioral Health EAP: Your employer offers an Employee Assistance Program through United Behavioral Health EAP. This program enables you and your covered Dependents to receive up to five (5) outpatient visits payable at 100%. It is recommended that, before seeking treatment or service elsewhere, you utilize this program first, then any additional treatment or services will be payable as described below.	

Covered Health Services[1]	Payable by the Plan: Network Percentage of Eligible Expenses
■ Inpatient Hospital Service	100% after you pay a $50 Copay and meet the Deductible
Limited to 30 days per calendar year.	
■ Physician Inpatient Service	100% after you meet the Deductible
■ Partial Hospitalization	100% after you pay a $50 Copay and meet the Deductible
Two days of partial hospitalization equals one day of inpatient services and will reduce any inpatient day limit accordingly.	
■ Outpatient Mental/Nervous Services	100% after you pay a $20 Copay
Limited to 25 visits per calendar year and further limited to one visit per day. Includes certified social workers.	
Substance Abuse	
■ Inpatient Chemical Dependency Counselor, Certified Alcohol Counselor, and Certified Drug and Alcohol Counselor	100% after you meet the Deductible
■ Inpatient Hospital Service	100% after you pay a $50 Copay and meet the Deductible
Limited to 30 days per calendar year.	
■ Physician Inpatient Service	100% after you meet the Deductible
■ Partial Hospitalization	100% after you pay a $50 Copay and meet the Deductible
Two days of partial hospitalization equals one day of inpatient services and will reduce any inpatient day limit accordingly.	
■ Outpatient Substance Abuse Services	50% after you meet the Deductible
Limited to $2,000 per calendar year. Further limited to one visit per day with a maximum payable of $50 per visit. Includes Chemical Dependency Counselors, Certified Alcohol Counselors, and Certified Drug and Alcohol Counselors.	
Naturopaths/Oriental Medicine	80% after you meet the Deductible

Covered Health Services[1]	Payable by the Plan: Network Percentage of Eligible Expenses
Practitioners	
Limited to 10 visits per calendar year combined with acupuncture/acupressurist and other holistic providers.	
Obesity Surgery ■ Physician's Office Services (Copay is per visit) ■ Professional Fees for Surgical and Medical Services ■ Hospital - Inpatient Stay (Copay is per admission) ■ Outpatient Surgery, Diagnostic and Therapeutic Services	100% after you pay a $20 Copay 100% after you meet the Deductible 100% after you pay a $50 Copay and meet the Deductible 100% after you meet the Deductible
Outpatient Hospital Services	100% after you meet the Deductible
Outpatient Surgery, Diagnostic and Therapeutic Services	100% after you meet the Deductible
Physical Therapy (Copay is per visit)	100% after you pay a $20 Copay
Physician Hospital Services	100% after you meet the Deductible
Physician's Office Services (Copay is per visit)	100% after you pay a $20 Copay
Preventive Care/Routine Health Screenings (Copay is per visit)	100% after you pay a $20 Copay
Amounts in excess of **$300**, will be subject to the calendar year Deductible and the applicable coinsurance percentage. Routine health screenings include: Routine physical, pap smear, and mammogram. All services billed by providers under a diagnosis of routine and preventive care will be covered under this benefit. Laboratory services provided during a routine physical will be considered part of this benefit and you will only pay one Copay.	
Private Duty Nursing – Outpatient Services are limited to $25,000 per year	80% after you meet the Deductible

Covered Health Services[1]	Payable by the Plan: Network Percentage of Eligible Expenses
Professional Fees for Surgical and Medical Services	100% after you meet the Deductible
Prosthetic Devices	80% after you meet the Deductible
Reconstructive Procedures ■ Physician's Office Services (Copay is per visit) ■ Hospital - Inpatient Stay (Copay is per admission) ■ Professional Fees for Surgical and Medical Services ■ Outpatient Surgery, Diagnostic and Therapeutic Services	100% after you pay a $20 Copay 100% after you pay a $50 Copay and meet the Deductible 100% after you meet the Deductible 100% after you meet the Deductible
Rehabilitation Services - Outpatient Therapy (Copay is per visit)	100% after you pay a $20 Copay
Second Opinion Consultation Charges	100%
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services	100% after you meet the Deductible
Speech Therapy (Copay is per visit) A Physician's referral is required.	100% after you pay a $20 Copay
Spinal Treatment (Copay is per visit)	100% after you pay a $20 Copay
Temporomandibular Joint Dysfunction (TMJ) (Copay is per visit)	100% after you pay a $20 Copay
Includes surgery to correct TMJ and non-surgical treatment of TMJ. Non-surgical treatment does not include orthodontia.	

Covered Health Services[1]	Payable by the Plan: Network Percentage of Eligible Expenses
Transplantation Services (If services rendered by a Designated United Resource Networks Facility)	100% after you meet the Deductible
Travel and Lodging (If services rendered by a Designated United Resource Networks Facility)	For patient and companion(s) of patient undergoing Congenital Heart Disease treatment or transplant procedures
Urgent Care Center Services (Copay is per visit)	100% after you pay a $20 Copay
Well Baby Care (Copay is per visit)	100% after you pay a $20 Copay up to a $300 calendar year maximum
Amounts in excess of $300, will be subject to the calendar year Deductible and the applicable coinsurance percentage.	
All Other Covered Charges	100% after you meet the Deductible

[1]In general, your Network Provider must notify Care Coordination℠, as described in Section 4, before you receive certain Covered Health Services. There are some network Benefits, however, for which you are responsible for notifying Care Coordination℠. See Section 6, *Additional Coverage Details* for further information.

SECTION 14 - PRESCRIPTION DRUGS

Prescription Drug Coverage Highlights

The table below provides an overview of the Plan's Prescription Drug coverage. It includes Copay amounts that apply when you have a prescription filled at a Network Pharmacy. For detailed descriptions of your Benefits, refer to *Retail* and *Mail Order* in this section.

Covered Health Services[1]	**Percentage of Eligible Expenses Payable by the Plan:**
	Network
Retail - up to a 30-day supply	100% after you pay a:
■ Generic	$5 Copay
■ Brand Name[2]	$15 Copay
Mail Order - up to a 90-day supply	100% after you pay a:
■ Generic	$10 Copay
■ Brand Name[2]	$30 Copay
Half Tablet Program[3] - up to a 90-day supply	100% after you pay a:
■ Generic	$5 Copay
■ Brand Name[2]	$15 Copay

[1]You must notify UnitedHealthcare to receive full Benefits for certain Prescription Drugs. Otherwise, you may pay more out-of-pocket. See *Notification Requirements* in this section for details.

[2] Each prescription and each refill will be filled with a Generic Prescription Drug, if there is a generic equivalent available. Whenever a Brand Name Drug is dispensed but a generic equivalent was available, you must pay the difference between the Generic Drug price and the Brand Name Drug price, in addition to the Generic Drug Copay amount. However, if the Physician specifies that the medication prescribed must be a Brand Name Drug and has indicated "Dispense as written" on the prescription, the Brand Name Drug Copay amount will apply. If there is no generic equivalent available and a Brand Name Drug is dispensed, the Brand Name Drug Copay will apply.

[3]***Half Tab (pill splitting) is not appropriate for every type of medication. Do not make any changes in your medications or the way you take your medications without first consulting your physician.***

Rx Mail Order Out-of-Pocket Maximum: The maximum per calendar year that an individual Covered Person will have to pay for mail order prescription Copayments is $500.