



**FOOTHILL-DE ANZA**  
**Community College District**

*EMPLOYEE BENEFIT BOOKLET*  
*Plan Highlights*

**OUT-OF-AREA (OOA) MEDICAL PLAN**  
**Prescription Drugs**

UnitedHealthcare **OUT-OF-AREA** Health Plan

**Effective: July 1, 2010**

**Group Number: 708611**



## PLAN HIGHLIGHTS

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

<b>District Out-of-Area Medical Plan</b>	
<b>Lifetime Maximum Payment Limits</b>	
■ Hospice Care.....	\$10,000
■ All Other Benefits (for any medical plan provided by FHDA).....	\$2,000,000
<b>Copay Amounts</b>	
<b>Physician Office Copay Amount</b>	\$25 per visit
<b>Specialist Office Copay Amount</b>	\$30 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 Maximum and will continue to apply after the Out-of-Pocket Maximum has been reached.	
<b>Emergency Room Copay Amount</b>	\$100 per visit*
*Copay waived if admitted.	
<b>Inpatient Hospital Confinement Copay Amount</b>	\$100 per confinement
<b>Annual Deductible</b>	
Per Person	\$350
Per Family	\$1,050
<b>Out-of-Pocket Maximums</b>	
■ Per Person	\$1,000
■ Per Family	\$3,000
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 and Copays do not apply to the Out-of-Pocket Maximum.	

This table provides an overview of the Plan's coverage levels.

Covered Health Services <sup>1</sup>	Percentage of Eligible Expenses Payable by the Plan:
<p><b>Acupuncture/ Acupressure Services</b>            (Copay is per visit) Limited to a combined 30 visits per calendar year with Chiropractic visits.</p>	100% after you pay a \$25 Copay
<p><b>Allergy Injections/Serum</b></p>	100% after you pay a \$30 Copay
<p><b>Ambulance Services - Emergency Only</b>            Ground            Air</p>	90% after you meet the Deductible 90% after you meet the Deductible
<p><b>Ambulatory Surgical Center</b></p>	90% after you meet the Deductible
<p><b>Birthing Centers</b></p>	90% after you meet the Deductible
<p><b>Chiropractic Services</b>            (Copay is per visit)            Limited to a combined 30 visits per Calendar Year with Acupuncture/ Acupressure</p>	100% after you pay a \$25 Copay
<p><b>Cochlear Implants</b>            Physician's Office/Clinic (Copay is per visit)            Hospital - Inpatient Stay (Copay is per admission)            Physician Inpatient Service            (Cochlear Implant device combined with Hearing Aid benefit not to exceed \$1,000 per calendar year.)</p>	100% after you pay a \$30 Copay \$100 Copay and then 90% after you meet the Deductible 90% after you meet the Deductible

<p><b>Congenital Heart Disease</b></p> <p>Hospital - Inpatient Stay (Copay is per admission)</p> <p>Outpatient Services</p>	<p>\$100 Copay and then 90% after you meet the Deductible</p> <p>90% after you meet the Deductible</p>
<p><b>Dental Services - Accident Only</b></p> <p>(Copay is per visit)</p>	<p>100% after you pay a \$30 Copay</p>
<p><b>Diagnostic X-ray and Lab - Includes mammograms</b></p> <p>Outpatient Hospital</p> <p>Physician's Office/Clinic (Copay is per visit)</p> <p>Stand-alone diagnostic X-ray and lab facility</p>	<p>90% after you meet the Deductible</p> <p>100% after you pay a \$25 Copay</p> <p>90% after you meet the Deductible</p>
<p><b>Durable Medical Equipment (DME)</b></p>	<p>90% after you meet the Deductible</p>
<p><b>Emergency Room</b></p> <p>True Emergency</p> <p>Non-Emergency</p>	<p>90% after you pay a \$100 Copay</p> <p>90% after you pay a \$100 Copay and meet the Deductible</p>
<p><b>Hearing Aids</b></p> <p>Limited to \$1,000 annually. Includes hearing aids and fittings. Batteries not included in annual maximum.</p>	<p>90% after you meet the Deductible</p>
<p><b>Home Health Care</b></p> <p>Limited to 60 visits per calendar year with four hours equaling one visit.</p>	<p>90% after you meet the Deductible</p>
<p><b>Hospice Care</b></p> <p>Limited to \$10,000 maximum lifetime benefit for each Covered Person.</p>	<p>90% after you meet the Deductible</p>

<b>Hospital - Inpatient Stay</b>	\$100 Copay then 90% after you meet the Deductible
<b>Infertility Services – Diagnostic Only</b> Physician's Office Services (Copay is per visit)  Outpatient services received at a Hospital or Alternate Facility	100% after you pay a \$30 Copay  90% after you meet the Deductible
<b>Injections in a Physician's Office</b>  Physician's Office Services (Copay is per visit)  Outpatient services received at a Hospital or Alternate Facility	100% after you pay a \$25 Copay  90% after you meet the Deductible
<b>Maternity Services</b> Prenatal care (No Copay applies for prenatal visits after the first visit) Delivery, post-natal care and any related complications <ul style="list-style-type: none"> <li>- Physician's Office Services (Copay is per visit)</li> <li>- Hospital - Inpatient Stay (Copay is per admission)</li> <li>- Professional Fees for Surgical and Medical Services</li> </ul>	100% after you pay a \$25 Copay  100% after you pay a \$25 Copay \$100 Copay then 90% after you meet the Deductible  90% after you meet the Deductible

<b>Mental Health</b>	
<p><b>United Behavioral Health EAP:</b> 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.</p>	
Hospital - Inpatient Stay (Copay is per admission)	\$100 Copay and then 90% after you meet the Deductible
Physician Inpatient Service	90% after you meet the Deductible
Partial Hospitalization (Copay is per admission)	\$100 Copay then 90% after you meet the Deductible
Outpatient Services	100% after you pay a \$25 Copay
<b>Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders</b>	
Hospital - Inpatient Stay (Copay is per admission)	\$100 Copay and then 90% after you meet the Deductible
Physician Inpatient Service	90% after you meet the Deductible
Partial Hospitalization (Copay is per admission)	\$100 Copay then 90% after you meet the Deductible
Outpatient Services	100% after you pay a \$25 Copay
<b>Substance Use Disorder</b>	
Inpatient Chemical Dependency Counselor, Certified Alcohol Counselor, and Certified Drug and Alcohol Counselor	90% after you meet the Deductible
Hospital - Inpatient Stay (Copay is per admission)	\$100 Copay and then 90% after you meet the Deductible
Physician Inpatient Service	90% after you meet the Deductible
Partial Hospitalization	\$100 Copay then 90% after you meet the Deductible

Outpatient Substance Use Disorder Services	100% after you pay a \$25 Copay
<b>Nutritional Counseling</b> (Copay is per visit) Limited to 10 visits per calendar year in a Hospital based program.	100% after you pay a \$30 Copay
<b>Obesity Surgery</b> 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 \$30 Copay  90% after you meet the Deductible  \$100 Copay and then 90% after you meet the Deductible  90% after you meet the Deductible
<b>Outpatient Hospital Services</b>	90% after you meet the Deductible
<b>Outpatient Surgery, Diagnostic and Therapeutic Services</b>	90% after you meet the Deductible
<b>Physical, Occupational, Cardiac, Pulmonary &amp; Speech Therapy Services (Rehabilitation)</b>  Physician's Office Services (Copay is per visit) Hospital - Inpatient Stay (Copay is per admission)	100% after you pay a \$30 Copay  \$100 Copay and then 90% after you meet the Deductible
<b>Physician Hospital Services</b>	90% after you meet the Deductible
<b>Physician's Office Services</b> (Copay is per visit) Primary Specialist	100% after you pay a \$25 Copay  100% after you pay a \$30 Copay

<b>Preventive Care/Routine Health Screenings, including Well Baby Care</b>	100%
<b>Private Duty Nursing - O Private Duty Nursing – Outpatient</b> Services are limited to \$25,000 per year	90% after you meet the Deductible
<b>Professional Fees for Surgical and Medical Services</b>	90% after you meet the Deductible
<b>Prosthetic Devices</b>	90% after you meet the Deductible
<b>Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</b>	\$100 Copay and then 90% after you meet the Deductible
<b>Temporomandibular Joint Dysfunction (TMJ)</b>  Physician’s Office Services (Copay is per visit)  Hospital - Inpatient Stay (Copay is per admission)  Includes surgery to correct TMJ and non-surgical treatment of TMJ. Non-surgical treatment does not include orthodontia	100% after you pay a \$30 Copay  \$100 Copay and then 90% after you meet the Deductible
<b>Transplantation Services</b>  (If services rendered by a Designated United Resource Networks Facility)  Hospital - Inpatient Stay (Copay is per admission)	\$100 Copay and then 90% after you meet the Deductible
<b>Urgent Care Center Services</b>  (Copay is per visit)	100% after you pay a \$30 Copay
<b>All Other Covered Charges</b>	90% after you meet the Deductible
<p><sup>1</sup>In general, your Network Provider must notify Care Coordination<sup>SM</sup>, as described in Section 4, of the Plan Document before you receive certain Covered Health Services. There are some network Benefits, however, for which you are responsible for notifying Care Coordination<sup>SM</sup>. See your Plan Document, Section 6, <i>Additional Coverage Details</i> for further information.</p>	

# 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 or non-Network Pharmacy.

Covered Health Services <sup>1</sup>	Copays
	Network
<b>Retail</b> - up to a 30-day supply	
Tier 1	\$10 Copay
Tier 2	\$25 Copay
Tier 3	\$50 Copay
<b>Mail Order</b> - up to a 90-day supply	
Tier 1	\$20 Copay
Tier 2	\$50 Copay
Tier 3	\$100 Copay
<p>You must notify UnitedHealthcare to receive full Benefits for certain Prescription Drugs. Otherwise, you may pay more out-of-pocket. See <i>Notification Requirements</i> in the Plan Document for details.</p> <p>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 in addition to any ancillary charges will apply. If there is no generic equivalent available and a Brand Name Drug is dispensed, the Brand Name Drug Copay will apply.</p>	

## 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 \$1,000.

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