FOOTHILL-DE ANZA
Community College District

EMPLOYEE BENEFIT BOOKLET

Preferred Provider Organization (**PPO**) Medical Plan
Prescription Drugs

UnitedHealthcare ***CHOICE PLUS*** 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 Out-of-Pocket Maximum and Lifetime Maximum Benefit.

Preferred Provider Organization (PPO) Medical Plan		
	Network Provider	Non-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		
These limits apply to both network and non-network Benefits combined. 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.		
Physician Office Copay Amount	$20 per visit	None
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*	None*
*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. This $50 Emergency room Copay applies to both the Network and non-Network Providers.		
Out-of-Pocket Maximums		
■ Per Person	$400	$2,000
■ Per Family	$1,200	$6,000
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		

Preferred Provider Organization (PPO) Medical Plan
remainder of the calendar year (except as described above for Copay amounts). Eligible Expenses used to satisfy the individual and family Out-of-Pocket Maximums per calendar year that apply when care is received from a Network Provider will be used to satisfy the individual and family Out-of-Pocket Maximums that apply when care is received from a non-Network Provider and vice versa. The amounts that **do not** apply toward the Out-of-Pocket Maximum are: ■ the Physician office Copay amount, described above; ■ the Routine Health Screening Copay amount; ■ the Urgent Care Copay amount; ■ the per Emergency room visit 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	**Non-Network Percentage of Eligible Expenses**
Acupuncture/Acupressure Services (Copay is per visit)	100% after you pay a $20 Copay	80%
Additional Accident Benefit		
■ First $500 of Eligible Expenses	100%	100%
■ Thereafter	100%	80%
Allergy Injections/Serum	100%	80%
Ambulance Services - Emergency Only		
■ Ground:		
- First $500 of Eligible Expenses	100%	100%
- Thereafter	80%	80%
■ Air:		
- First $500 of Eligible Expenses	100%	100%
- Thereafter	80%	80%
Ambulatory Surgical Center	100%	80%
Artificial Limbs and Artificial Eyes	80%	80%
Birthing Centers	100%	80%
Blood Transfusions Including un-replaced blood and blood plasma.	80%	80%
Chiropractic Services	100% after you pay a $20 Copay	80%
For the services of a chiropractor only if the services would have been covered if provided by a Physician or Surgeon. Spinal manipulations are covered.		
Cochlear Implants	100%	80%

Covered Health Services[1]	Payable by the Plan:	
	Network Percentage of Eligible Expenses	**Non-Network Percentage of Eligible Expenses**
Congenital Heart Disease (CHD) (These Benefits are for Covered Health Services provided through CHD only)	100%	Not covered
Dental Services - Accidental Only	100%	80%
Diagnostic X-ray and Lab Includes mammograms	100%	80%
Durable Medical Equipment (DME) Includes surgical bandages, casts, splints, braces, and crutches.	100%	100%
Emergency Room ■ If due to an Emergency as defined ■ All other conditions	100% after you pay a $50 Copay 80% after you pay a $50 Copay	100% after you pay a $50 Copay 80% after you pay a $50 Copay
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%	80%
Hearing Aid Expenses Limited to $1,000 annually. Includes hearing aids and fittings. Batteries not included in annual maximum.	80%	80%
Home Health Care Limited to 60 visits per plan year with four hours equaling one visit.	100%	80%
Hospice Care Limited to $10,000 maximum lifetime benefit for each Covered Person.	100%	100%

Covered Health Services[1]	Payable by the Plan:	
	Network Percentage of Eligible Expenses	**Non-Network Percentage of Eligible Expenses**
Hospital - Inpatient Stay	100%	80%
Infertility Services - Diagnostic Only		
■ Physician's Office Services (Copay is per visit)	100% after you pay a $20 Copay	80%
■ Outpatient services received at a Hospital or Alternate Facility	100% after you pay a $20 Copay	80%
Injections in a Physician's Office	100%	80%
Massage Therapy When performed by a Physician or health care extender.	100%	80%
Maternity Services		
■ Prenatal care (No Copay applies for prenatal visits after the first visit)	100% after you pay a $20 Copay	80%
■ Delivery, post-natal care and any related complications		
- Physician's Office Services (Copay is per visit)	100% after you pay a $20 Copay	80%
- Hospital - Inpatient Stay	100%	80%
- Professional Fees for Surgical and Medical Services	100%	80%
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.		
Mental Health and Substance Abuse Treatment - Inpatient and Intermediate Substance abuse treatment is limited to 30 days per calendar year.	100%	80%

Covered Health Services[1]	Payable by the Plan:	
	Network Percentage of Eligible Expenses	**Non-Network Percentage of Eligible Expenses**
Mental Health and Substance Abuse Treatment – Partial Hospitalization	100%	80%
Two days of partial hospitalization equals one day of inpatient services and will reduce any inpatient day limit accordingly.		
Mental Health and Substance Abuse Treatment - Outpatient ■ Mental/Nervous Treatment - Outpatient (Copay is per visit)	100% after you pay a $20 Copay	80%
Limited to 25 visits per calendar year and further limited to one visit per day. These limits apply to any combination of network and non-network Benefits.		
■ Substance Abuse Treatment - Outpatient	50%	50%
Limited to $2,000 per calendar year, one visit per day and $50 maximum per visit. These limits apply to any combination of network and non-network Benefits.		
Nutritional Counseling (Copay is per visit)	100% after you pay a $20 Copay	80%
Obesity Surgery		
■ Physician's Office Services (Copay is per visit)	100% after you pay a $20 Copay	Not Covered
■ Professional Fees for Surgical and Medical Services	100%	Not Covered
■ Hospital - Inpatient Stay	100%	Not Covered
■ Outpatient Surgery, Diagnostic and Therapeutic Services	100%	Not Covered
Outpatient Hospital Services	100%	80%
Outpatient Surgery, Diagnostic and Therapeutic Services	100%	80%
Physical Therapy (Copay is per visit)	100% after you pay a $20 Copay	80%

Covered Health Services[1]	Payable by the Plan:	
	Network Percentage of Eligible Expenses	**Non-Network Percentage of Eligible Expenses**
Physician Hospital Services		
■ With pre-notification	100%	80%
■ Without pre-notification	100%	80%
Physician's Office Services (Copay is per visit)	100% after you pay a $20 Copay	80%
Preventive Care/Routine Health Screenings (Copay is per visit)	100% after you pay a $20 Copay	80%
Private Duty Nursing – Outpatient Services are limited to $25,000 per year	100%	80%
Professional Fees for Surgical and Medical Services	100%	80%
Prosthetic Devices	80%	80%
Reconstructive Procedures		
■ Physician's Office Services (Copay is per visit)	100% after you pay a $20 Copay	80%
■ Hospital - Inpatient Stay	100%	80%
■ Professional Fees for Surgical and Medical Services	100%	80%
■ Outpatient Surgery, Diagnostic and Therapeutic Services	100%	80%
Rehabilitation Services - Outpatient Therapy (Copay is per visit)	100% after you pay a $20 Copay	80%
Second Opinion Consultation Charges	100%	80%
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services	100%	80%

Covered Health Services[1]	Payable by the Plan:	
	Network Percentage of Eligible Expenses	**Non-Network Percentage of Eligible Expenses**
Speech Therapy (Copay is per visit)	100% after you pay a $20 Copay	80%
Spinal Treatment (Copay is per visit)	100% after you pay a $20 Copay	80%
Temporomandibular Joint Dysfunction (TMJ)	100%	80%
Includes surgery to correct TMJ and non-surgical treatment of TMJ. Non-surgical treatment does not include orthodontia.		
Transplantation Services (If services rendered by a Designated United Resource Networks Facility)	100%	Not covered
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	Not covered
Urgent Care Center Services (Copay is per visit)	100% after you pay a $20 Copay	80%
All Other Covered Charges	100%	80%

[1]You must notify Care Coordination℠, as described in Section 4, to receive full Benefits before receiving certain Covered Health Services from a non-Network Provider. In general, if you visit a Network Provider, that Provider is responsible for notifying Care Coordination℠ before you receive certain Covered Health Services. 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 or non-Network Pharmacy. For detailed descriptions of your Benefits, refer to *Retail* and *Mail Order* in this section.

Covered Health Services[1]	**Copays required for:**	
	Network	**Non-Network**
Retail - up to a 30-day supply		
■ Generic	$5 Copay	$5 Copay
■ Brand Name[2]	$15 Copay	$15 Copay
Mail Order - up to a 90-day supply	100% after you pay a:	
■ Generic	$10 Copay	$10 Copay
■ Brand Name[2]	$30 Copay	$30 Copay
Half Tablet Program[3] - up to a 90-day supply	100% after you pay a:	
■ Generic	$5 Copay	$5 Copay
■ Brand Name	$15 Copay	$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.