FOOTHILL-DE ANZA
Community College District

EMPLOYEE BENEFIT BOOKLET

Preferred Provider Organization (PPO) Medical Plan
Prescription Drugs

UnitedHealthcare **CHOICE PLUS** Health Plan

Effective: July 1, 2010

Group Number: 708611

UnitedHealthcare®
A UnitedHealth Group Company

TABLE OF CONTENTS

SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries and Care Coordination℠: (800) 510-4846;
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 30555, Salt Lake City, UT, 84130-0555;
- Online assistance: **www.myuhc.com**; and
- Mental Health/Substance Use Disorder Administrator: (800) 510-4846.

Foothill-De Anza Community College District (FHDA) is pleased to provide you with this Employee Benefit Booklet (booklet), which describes the health Benefits available to you and your covered family members under Foothill-De Anza Community College District Welfare Benefit Plan. It includes summaries of:

- who is eligible;
- services that are covered, called Covered Health Services;
- services that are not covered, called Exclusions;
- how Benefits are paid; and
- your rights and responsibilities under the Plan.

This booklet is designed to meet your information needs and it supersedes any previous printed or electronic booklet for this Plan.

If you have any questions after reading this material, please call member services at the number on the back of your ID card.

Foothill De-Anza Community College District intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice. This booklet is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this summary and the contents of the Plan, your rights shall be determined under the Plan and not under this summary.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare's goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps your employer to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. Foothill-De Anza Community College District is solely responsible for paying Benefits described in this booklet.

Please read this booklet thoroughly to learn how the Foothill-De Anza Community College District Welfare Benefit Plan works. If you have questions contact the Foothill-De Anza Community College District Human Resources Department or call the UnitedHealthcare telephone number on the back of your ID card.

How To Use This Booklet

- Read the entire booklet, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this booklet are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your booklet and any future amendments at http://hr.fhda.edu/benefits or request printed copies by contacting the Human Resources Department.
- Capitalized words in the booklet have special meanings and are defined in Section 15, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 15, *Glossary*.
- Foothill-De Anza Community College District is also referred to as District.

SECTION 2 - INTRODUCTION

Eligibility

You are eligible to enroll in the Plan if you are a regular full-time Employee who is scheduled to work at least 20 hours per week or a person who retires while covered under the Plan. The following groups of Employees are eligible to enroll on the plan:

- Class I: A permanent or probationary classified Employee (as defined by the Plan) working 20 or more hours per week;
- Class II: A contract or regular Employee (as defined by the Plan) or a leave-replacement temporary faculty Employee who is employed for not less than one complete quarter, or a temporary certificated Employee under categorically-funded projects;
- Class III: A member of the Board of Trustees;
- Class IV: A Retired Employee as defined in Section 15, *Glossary* and retired under the district's Early Retirement Program. This applies to STRS and PERS;
- Class V: A Retired Employee or Board of Trustees member who is eligible for Benefits under the District-Paid Benefits for Retired Employees Program as outlined by policy or negotiated contracts; and
- Class VI: A qualified COBRA participant.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- Your Spouse or Domestic Partner as defined in Section 15, Glossary, under "Dependent".
- Surviving Spouse or Domestic Partner of a Retiree who was a Covered Person at the time of the Retiree's death.
- Your natural or legally adopted children, your spouse's natural or legally adopted children, or your eligible Domestic Partner's natural or legally adopted children who meet the age and eligibility requirements detailed in Section 15, Glossary, under "Dependent". This also includes a child for whom you, your Spouse or Domestic Partner are the legal guardian.

Dependents must meet all eligibility requirements detailed in Section 15, Glossary, under "Dependent" to enroll or continue enrollment in the Plan.

Note: With the exception of a Surviving Spouse or Domestic Partner of a retiree, your dependents may not enroll in the Plan unless you are also enrolled.

No Duplicate FHDA Coverage

FHDA rules do not allow duplicate coverage in FHDA benefit plans. This means you may not be covered in district-sponsored plans as an employee and as an eligible family

member of a FHDA employee or retiree at the same time. If you are covered as an eligible family member and then become eligible for FHDA coverage yourself, you have two options. You may either opt out of the automatic employee coverage and remain covered as another employee's dependent, **or ensure that** the district employee or retiree who has been covering you disenrolls you from his or her district-sponsored plan as a dependent prior to your enrolling as an employee.

The District reserves the right to enjoin the coverage of married Employees or married Retirees, and registered Domestic Partners, who are each eligible for coverage under the Plan, with the employee whose birth month is the earliest in the year enrolled at the Employee rate, and the Employee whose birth month is later in the year enrolled at the Spouse rate. If the married Employees have the same birth month, the Employee with the earliest birthday in the month will be enrolled at the Employee rate, and the Employee with the later birthday in the month will be enrolled at the Spouse rate.

Family members of district employees may not be covered by more than one FHDA employee's plan coverage. For example, if a husband and wife both work for FHDA, their children cannot be covered by both family members. If duplicate enrollment occurs, FHDA will cancel the later enrollment. FHDA and the plans reserve the right to collect reimbursement for any duplicate premium payments and for any plan benefits provided due to the duplicate enrollment. All children in a family unit must be enrolled together under one employee's benefit plan.

Cost of Coverage

Your contributions are deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld - and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Your contributions are subject to review and Foothill-De Anza Community College District reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by calling the Human Resources Department or logging onto http://hr.fhda.edu/benefits.

How to Enroll

1) *Obtain and complete a universal enrollment form* by calling the Human Resources Department or by logging onto http://hr.fhda.edu/benefits.

2) *Return your completed form to the Human Resources Department* within 31 days of the date you first become eligible for medical Plan coverage.

Effective July 1, 2009:

- Each Employee/Retiree may choose his/her plan.
- No Employee/Retiree may be a dependent on his/her Spouse/Domestic Partner's plan (except as administratively joined, as noted below).

- A qualified child may be covered as a dependent on only one plan.
- A qualified child may only be enrolled as a dependent of the employee/retiree who is eligible to claim the child as an IRS qualified child tax dependent on his/her federal income tax returns.
- Where a married couple or Employee/Retiree and Domestic Partner each choose the same plan, the District may administratively join the two individuals, and any qualifying dependents, on one plan, with one Employee/Retiree identified as a dependent of the other. The District reserves the right to determine if and how to administratively join the plans.

Each year during annual Open Enrollment, you have the opportunity to review and change your medical election. Any changes you make during Open Enrollment will become effective the following July 1.

Note
If you wish to change your benefit election following your marriage, birth of a child, adoption of a child, placement for adoption of a child or other family status change, you must contact Human Resources Department within 31 days of the event , or you will be required to wait to change your elections until the next annual open enrollment period.

When Coverage Begins

Coverage for the employee and eligible dependents will be effective on the first day of the month following the date of hire.

Coverage for newly eligible Dependents begins on the date they become eligible (through birth, adoption, etc.), provided you enroll them within 31 days of that date.

Changing Your Coverage

You may make coverage changes during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.). The following are considered family status changes for purposes of the Plan:

- your marriage, divorce, legal separation or annulment;
- registering a Domestic Partner;
- the birth, adoption, placement for adoption or legal guardianship of a child;
- a change in your Spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan;
- loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis;
- the death of a Dependent;
- your Dependent child no longer qualifying as an eligible Dependent;

- a change in your or your Spouse's position or work schedule that impacts eligibility for health coverage; contributions were no longer paid by the employer;
- you or your eligible Dependent no longer live or work in an HMO service area if no other benefit option is available;
- benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent;
- you or your eligible Dependent incurs a claim that would exceed a lifetime limit on all benefits;

- termination of your or your Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact Human Resources Department within 60 days of termination);
  - you or your Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact Human Resources Department within 60 days of determination of subsidy eligibility);
  - a strike or lockout involving you or your Spouse; or
  - a court or administrative order.

Unless otherwise noted above, if you wish to change your elections, you must notify Human Resources Department within 31 days of the change in family status. Otherwise, you will need to wait until the next annual Open Enrollment.

You, or your eligible Dependent, do not need to elect COBRA continuation coverage to preserve the special enrollment rights listed above. These will be available to you or your eligible Dependent even if COBRA is elected.

Note: Any child under age 24 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

Federal Family And Medical Leave Act (FMLA)

Continuation

Federal law requires that Eligible Employees (as defined below) be provided a continuation period in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA).

This is a general summary of the FMLA and how it affects your group plan. See your employer for details on this continuation provision.

FMLA and Other Continuation Provisions

If your employer is an Eligible Employer (as defined below) and if the continuation portion of the FMLA applies to your coverage, these FMLA continuation provisions:

- are in addition to any other continuation provision of this plan, if any; and
- will run concurrently with any other continuation provisions of this plan for sickness, injury, layoff, or approved leave of absence, if any.

If continuation qualifies for both state and FMLA continuation, the continuation period will be counted concurrently toward satisfaction of the continuation period under both the state and FMLA continuation periods.

Eligible Employer

Eligible Employer means any employer who is engaged in commerce or in any industry or activity affecting commerce who employs 50 or more employees for each working day during each of 20 or more calendar workweeks in the current or preceding calendar year.

Eligible Employee

Eligible Employee means an employee who has worked for the Eligible Employer:

- for at least 12 months; and
- for at least 1,250 hours (approximately 24 hours per week) during the year preceding the start of the leave; and
- at a work-site where the Eligible Employer employs at least 50 employees within a 75-mile radius.

For this purpose, "employs" has the meaning provided by the Federal Family and Medical Leave Act (FMLA).

Mandated Unpaid Leave

Eligible Employers are required to allow 12 workweeks of unpaid leave during any 12-month period to Eligible Employees for one or more of the following reasons:

- the birth of a child of an Eligible Employee and in order to care for the child;
- the placement of a child with the Eligible Employee for adoption or foster care;
- to care (physical or psychological care) for the spouse, child, or parent of the Eligible Employee, if they have a "serious health condition"; or
- a "serious health condition" that makes the Eligible Employee unable to perform the functions of his or her job.

Reinstatement

An Eligible Employee's terminated coverage may be reinstated in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA). See your employer for details on this reinstatement provision.

SECTION 3 - HOW THE PLAN WORKS

Network and Non-Network Benefits

As a participant in this plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply.

You are eligible for the network level of Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services. Generally, when you receive Covered Health Services from a Network Provider, you pay less than you would if you receive the same care from a non-Network Provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network Provider.

If you choose to seek care outside the network, the Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Eligible Expense. This amount does not apply to the Out-of-Pocket Maximum. Emergency services received at a non-network Hospital are covered at the network level.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network Provider, you may be eligible to receive network Benefits from a non-Network Provider. In this situation, your network Physician will notify Care Coordination[SM], and they will work with you and your network Physician to coordinate care through a non-Network Provider.

When you receive Covered Health Services through a network Physician, we will pay network Benefits for those Covered Health Services, even if one or more of those Covered Health Services is received from a non-Network Provider.

Network Providers – UnitedHealthcare PPO Health Plan

To verify a Provider's status, you can contact UnitedHealthcare's Customer Care at 1-800-510-4846, or log onto **www.myuhc.com**.

Network Providers are independent practitioners and are not employees of Foothill-De Anza Community College District or UnitedHealthcare.

Possible Limitations on Provider Use

If Care Coordination[SM] determines that you are using health care services in a harmful or abusive manner, Care Coordination[SM] will notify the Plan Administrator. The Plan Administrator may take further measures which may include lowering of Benefits or even denial of claims associated with the harmful or abusive use of Plan Benefits.

Eligible Expenses

Eligible Expenses are charges for Covered Health Services that are provided while the Plan is in effect, determined according to the definition in Section 15, *Glossary*. Foothill-De Anza Community College District has delegated to UnitedHealthcare the discretion and authority

to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Copayment

A Copayment (Copay) is the amount you pay each time you receive certain Covered Health Services. The Copay is a flat dollar amount and is paid at the time of service. Copays do not count toward the Out-of-Pocket-Maximum.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each plan year for Covered Health Services. There are separate network and non-network Out-of-Pocket Maximums for this Plan. If your eligible out-of-pocket expenses in a plan year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the plan year.

The Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 14, *Prescription Drugs*.

Covered Expenses charged by both Network and non-Network Providers apply toward both the network individual and family Out-of-Pocket Maximums and the non-network individual and family Out-of-Pocket Maximums.

The following table identifies what applies toward the network and non-network Out-of-Pocket Maximums:

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Copays, even those for Covered Health Services available in Section 14, *Prescription Drugs*	No	No
Coinsurance Payments	Yes	Yes
Charges for non-Covered Health Services	No	No
The amounts of any reductions in Benefits you incur by not notifying Care Coordination℠	No	No
Any amounts you pay toward private duty nursing care	No	No
Charges that exceed Eligible Expenses	No	No

Lifetime Maximum Benefit

The Lifetime Maximum Benefit is the most the Plan will pay for Benefits during the entire period you are enrolled in this Plan and any other medical plans offered by Foothill-De Anza Community College District. There is a combined network and non-network Lifetime Maximum Benefit for this Plan. The Lifetime Maximum Benefit also includes Prescription Drug Benefits as described in Section 14, *Prescription Drugs*.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services.

SECTION 4 - CARE COORDINATION[SM]

UnitedHealthcare provides a program called Care Coordination[SM] designed to encourage personalized, efficient care for you and your covered Dependents.

Care Coordination[SM] nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available. A Care Coordination[SM] nurse is notified when you or your Provider calls the toll-free number on your ID card regarding an upcoming treatment or service.

If you are living with a chronic condition or dealing with complex health care needs, UnitedHealthcare may assign to you a primary nurse, referred to as a UnitedHealth MyNurse[SM] to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The UnitedHealth MyNurse[SM] will provide you with their telephone number so you can call them with questions about your conditions, or your overall health and well-being.

Care Coordination[SM] nurses or a UnitedHealth MyNurse[SM] will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components and notification requirements are subject to change without notice. As of the publication of this booklet, the Care Coordination[SM] program includes:

- **Admission counseling** – For upcoming inpatient Hospital admissions for certain conditions, a Care Coordination[SM] nurse or a UnitedHealth MyNurse[SM] may call you to help answer your questions and to make sure you have the information and support you need for a successful recovery.
- **Inpatient care advocacy** – If you are hospitalized, a Care Coordination[SM] nurse or a UnitedHealth MyNurse[SM] will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- **Readmission Management** – This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Care Coordination[SM] nurse to confirm that medications, needed equipment, or follow-up services are in place. The nurse or a UnitedHealth MyNurse[SM] will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.
- **Risk Management** – Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Care Coordination[SM] nurse or a UnitedHealth MyNurse[SM] to discuss and share important health care information related to the participant's specific chronic or complex condition.

If you do not receive a call from a Care Coordination[SM] nurse or a UnitedHealth MyNurse[SM] but feel you could benefit from any of these programs, please call the toll-free number on your ID card.

Requirements for Notifying Care Coordination[SM]

There are some services for which you are responsible for notifying Care Coordination[SM] prior to receiving these services. In general, Network Providers are responsible for notifying Care Coordination[SM] before they provide these services to you. There are some network Benefits, however, for which you are responsible for notifying Care Coordination[SM].

When you choose to receive certain Covered Health Services from non-Network Providers, you are responsible for notifying Care Coordination[SM] before you receive these Covered Health Services.

In many cases, your non-network Benefits will be reduced if Care Coordination[SM] is not notified. The services that require Care Coordination[SM] notification are:

- Congenital Heart Disease services;
- Dental services;
- Durable Medical Equipment for items that will cost more than $1,000 to purchase or rent;
- Home health care services;
- Hospice care services;
- Hospital Inpatient Stay, including Emergency admission;
- Maternity care that exceeds the delivery timeframes as described in Section 6, *Additional Coverage Details*;
- Reconstructive Procedures;
- Skilled Nursing Facility/Inpatient Rehabilitation Facility services; and
- Transplantation services.

The following procedures also require that you notify Care Coordination[SM] prior to receiving services in order for Care Coordination[SM] to determine if they are Covered Health Services:

- breast reduction and reconstruction (except following cancer surgery);
- vein stripping, ligation and sclerotherapy (an injection of a chemical to treat varicose veins); and
- blepharoplasty (surgery to correct aging of the eyelids).

These services will not be covered when considered to be Cosmetic Procedures, as defined in Section 15, *Glossary*.

For notification timeframes, and reductions in Benefits that apply if you do not notify Care Coordination, see Section 6, *Additional Coverage Details*. The Care Coordination℠ toll-free telephone number is on the back of your ID card.

Special Note Regarding Mental Health and Substance Use Disorder Treatment

For inpatient or intermediate Mental Health/Substance Use Disorder Treatment, you are responsible for calling the Mental Health/Substance Use Disorder Administrator in advance of any service to get authorization to receive these Benefits. **Without prior authorization**, non-network Benefits will be subject to a **$100 reduction**. The Mental Health/Substance Use Disorder Administrator's phone number appears on your ID card.

Special Note Regarding Medicare

If you are enrolled in Medicare and Medicare pays benefits before the Plan, you are not required to notify Care Coordination℠ before receiving Covered Health Services. Since Medicare pays benefits first, the Plan will pay Benefits second as described in Section 10, *Coordination of Benefits (COB)*.

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.

Medical Plan (Preferred Provider Organization)		
	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		
Physician Office Copay Amount	$25 per visit	None
Specialist Office Copay Amount	$30 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	$100 per visit*	$100 per visit*
*Copay waived if admitted.		
Inpatient Hospital Confinement Copay Amount	$100 per confinement	None
Annual Deductibles		
■ Per Person	$350	$700
■ Per Family	$1,050	$2,100
Out-of-Pocket Maximums		
■ Per Person	$1,000	$3,000
■ Per Family	$3,000	$9,000
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. 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) Limited to a combined 30 visits per calendar year with Chiropractic visits.	100% after you pay a $25 Copay	70% after you meet the Deductible
Allergy Injections/Serum	100% after you pay a $30 Copay	70% after you meet the Deductible
Ambulance Services - Emergency Only		
– Ground:	90% after you meet the Deductible	90% after you meet the Deductible
– Air:	90% after you meet the Deductible	90% after you meet the Deductible
Ambulatory Surgical Center	90% after you meet the Deductible	70% after you meet the Deductible
Birthing Centers	90% after you meet the Deductible	70% after you meet the Deductible
Chiropractic Services (Copay is per visit) Limited to a combined 30 visits per Calendar Year with Acupuncture/Acupressure	100% after you pay a $25 Copay	70% after you meet the Deductible
Cochlear Implants		
– Physician's Office/Clinic (Copay is per visit)	100% after you pay a $30 Copay	70% after you meet the Deductible
– Hospital - Inpatient Stay (Copay is per admission)	$100 Copay and then 90% after you meet the Deductible	70% after you meet the Deductible
– Physician Inpatient Service	90% after you meet the Deductible	70% after you meet the Deductible
(Cochlear Implant device combined with Hearing Aid benefit not to exceed $1,000 per calendar year.)		
Congenital Heart Disease		

Covered Health Services[1]	Payable by the Plan:	
	Network Percentage of Eligible Expenses	**Non-Network Percentage of Eligible Expenses**
Hospital - Inpatient Stay (Copay is per admission)	$100 Copay and then 90% after you meet the Deductible	70% after you meet the Deductible
Physician Inpatient Service	90% after you meet the Deductible	70% after you meet the Deductible
Dental Services - Accidental Only (Copay is per visit)	100% after you pay a $30 Copay	70% after you meet the Deductible
Diagnostic X-ray and Lab - Includes mammograms		
Outpatient Hospital	90% after you meet the Deductible	70% after you meet the Deductible
Physician's Office/Clinic (Copay is per visit)	100% after you pay a $25 Copay	70% after you meet the Deductible
Stand-alone diagnostic X-ray and lab facility	90% after you meet the Deductible	70% after you meet the Deductible
Durable Medical Equipment (DME)	90% after you meet the Deductible	70% after you meet the Deductible
Emergency Room		
– True Emergency	90% after you pay a $100 Copay	90% after you pay a $100 Copay
– Non-Emergency	90% after you pay a $100 Copay plus Deductible	70% after you pay a $100 Copay plus Deductible
Hearing Aids Limited to $1,000 annually. Includes hearing aids and fittings. Batteries not included in annual maximum.	90% after you meet the Deductible	70% after you meet the Deductible
Home Health Care Limited to 60 visits per calendar year with four hours equaling one visit.	90% after you meet the Deductible	70% after you meet the Deductible

Covered Health Services[1]	Payable by the Plan:	
	Network Percentage of Eligible Expenses	**Non-Network Percentage of Eligible Expenses**
Hospice Care Limited to $10,000 maximum lifetime benefit for each Covered Person.	90% after you meet the Deductible	70% after you meet the Deductible
Hospital - Inpatient Stay	$100 Copay then 90% after you meet the Deductible	70% after you meet the Deductible
Infertility Services - Diagnostic Only		
– Physician's Office Services (Copay is per visit)	100% after you pay a $30 Copay	70% after you meet the Deductible
Outpatient services received at a Hospital or Alternate Facility	90% after you meet the Deductible	70% after you meet the Deductible
Injections in a Physician's Office		
Physician's Office Services (Copay is per visit)	100% after you pay a $25 Copay	70% after you meet the Deductible
Outpatient services received at a Hospital or Alternate Facility	90% after you meet the Deductible	70% after you meet the Deductible
Maternity Services		
– Prenatal care (No Copay applies for prenatal visits after the first visit)	100% after you pay a $25 Copay	70% after you meet the Deductible
– Delivery, post-natal care and any related complications		
- Physician's Office Services (Copay is per visit)	100% after you pay a $25 Copay	70% after you meet the Deductible
- Hospital - Inpatient Stay	$100 Copay then 90% after you meet the Deductible	70% after you meet the Deductible
- Professional Fees for Surgical and Medical Services	90% after you meet the Deductible	70% after you meet the Deductible
Mental Health		

Covered Health Services[1]	Payable by the Plan:	
	Network Percentage of Eligible Expenses	**Non-Network Percentage of Eligible Expenses**
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.		
Hospital - Inpatient Stay (Copay is per admission)	$100 Copay and then 90% after you meet the Deductible	70% after you meet the Deductible
Physician Inpatient Service	90% after you meet the Deductible	70% after you meet the Deductible
Partial Hospitalization (Copay is per admission)	$100 Copay then 90% after you meet the Deductible	70% after you meet the Deductible
Outpatient Services	100% after you pay a $25 Copay	70% after you meet the Deductible
Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders		
Hospital - Inpatient Stay (Copay is per admission)	$100 Copay and then 90% after you meet the Deductible	70% after you meet the Deductible
Physician Inpatient Service	90% after you meet the Deductible	70% after you meet the Deductible
Partial Hospitalization (Copay is per admission)	$100 Copay then 90% after you meet the Deductible	70% after you meet the Deductible
Outpatient Services	100% after you pay a $25 Copay	70% after you meet the Deductible
Substance Use Disorders		
Inpatient Chemical Dependency Counselor, Certified Alcohol Counselor, and Certified Drug and Alcohol Counselor	90% after you meet the Deductible	70% after you meet the Deductible

Covered Health Services[1]	Payable by the Plan:	
	Network Percentage of Eligible Expenses	**Non-Network Percentage of Eligible Expenses**
Hospital - Inpatient Stay (Copay is per admission)	$100 Copay and then 90% after you meet the Deductible	70% after you meet the Deductible
Physician Inpatient Service	90% after you meet the Deductible	70% after you meet the Deductible
Partial Hospitalization (Copay is per admission)	$100 Copay then 90% after you meet the Deductible	70% after you meet the Deductible
Outpatient Services	100% after you pay a $25 Copay	70% after you meet the Deductible
Nutritional Counseling (Copay is per visit) Limited to 10 visits per calendar year in a Hospital based program.	100% after you pay a $30 Copay	70% after you meet the Deductible
Obesity Surgery		
– Physician's Office Services (Copay is per visit)	100% after you pay a $30 Copay	70% after you meet the Deductible
– Professional Fees for Surgical and Medical Services	90% after you meet the Deductible	70% after you meet the Deductible
– Hospital - Inpatient Stay	$100 Copay and then 90% after you meet the Deductible	70% after you meet the Deductible
– Outpatient Surgery, Diagnostic and Therapeutic Services	90% after you meet the Deductible	70% after you meet the Deductible
Outpatient Hospital Services	90% after you meet the Deductible	70% after you meet the Deductible
Outpatient Surgery, Diagnostic and Therapeutic Services	90% after you meet the Deductible	70% after you meet the Deductible
Physical, Occupational, Cardiac, Pulmonary & Speech Therapy Services (Rehabilitation) Physician's Office Services (Copay is per	100% after you pay a $30 Copay	70% after you meet the Deductible

Covered Health Services[1]	Payable by the Plan:	
	Network Percentage of Eligible Expenses	**Non-Network Percentage of Eligible Expenses**
visit) Hospital - Inpatient Stay (Copay is per admission)	$100 Copay and then 90% after you meet the Deductible	70% after you meet the Deductible
Physician Hospital Services	90% after you meet the Deductible	70% after you meet the Deductible
Physician's Office Services (Copay is per visit) Primary Specialist	100% after you pay a $25 Copay 100% after you pay a $30 Copay	70% after you meet the Deductible 70% after you meet the Deductible
Preventive Care/Routine Health Screenings, including Well Baby Care	100%	70% after you meet the Deductible
Private Duty Nursing – Outpatient Services are limited to $25,000 per year	90% after you meet the Deductible	70% after you meet the Deductible
Professional Fees for Surgical and Medical Services	90% after you meet the Deductible	70% after you meet the Deductible
Prosthetic Devices Limited to $10,000 per Calendar Year	90% after you meet the Deductible	70% after you meet the Deductible
Second Opinion Consultation Charges – Physician's Office Services (Copay is per visit) Professional Fees (inpatient setting)	100% after you pay a $30 Copay 90% after you meet the Deductible	70% after you meet the Deductible 70% after you meet the Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services	$100 Copay and then 90% after you meet the Deductible	70% after you meet the Deductible

Covered Health Services[1]	Payable by the Plan:	
	Network Percentage of Eligible Expenses	**Non-Network Percentage of Eligible Expenses**
Temporomandibular Joint Dysfunction (TMJ)		
– Physician's Office Services (Copay is per visit)	100% after you pay a $30 Copay	70% after you meet the Deductible
– Hospital - Inpatient Stay (Copay is per admission)	$100 Copay and then 90% after you meet the Deductible	70% after you meet the Deductible
– 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) Hospital - Inpatient Stay (Copay is per admission)	$100 Copay and then 90% after you meet the Deductible	Not covered
Urgent Care Center Services (Copay is per visit)	100% after you pay a $30 Copay	70% after you meet the Deductible
All Other Covered Charges	90% after you meet the Deductible	70% after you meet the Deductible

[1]In general, your Network Provider must notify Care Coordination℠, 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℠. See your Plan Document, Section 6, *Additional Coverage Details* for further information.

SECTION 6 - ADDITIONAL COVERAGE DETAILS

This section supplements the second table in Section 5, *Plan Highlights*.

While the table provides you with Copayment, and coverage level information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any limitations that may apply, as well as Covered Health Services for which you must call Care Coordination[SM]. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 8, *Exclusions*.

Acupuncture/Acupressure Services

The Plan pays for acupuncture services for pain therapy provided that:

- the service is performed by a certified acupuncturist or acupressurist or Physician in the Provider's office.

Covered Health Services include treatment of nausea as a result of:

- chemotherapy;
- early Pregnancy; and
- post-operative procedures.

Ambulance Services - Emergency Only

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency health services. See Section 15, *Glossary* for the definition of Emergency.

Assistant Surgeon

Benefits will be payable for the services of an assistant to a surgeon if such services are determined by the Claims Administrator to be Covered Health Services. An assistant to a surgeon is considered to be a Covered Health Service if the skill level of an M.D. or D.O. would be required to assist the primary surgeon. Eligible Expenses for such services will be paid according to the Claims Administrator's reimbursement policy.

Congenital Heart Disease (CHD)

The Plan pays Benefits for Congenital Heart Disease (CHD) services ordered by a Physician and received at a CHD Resource Services program. Benefits are available for the following CHD services:

- outpatient diagnostic testing;
- evaluation;
- surgical interventions;

- interventional cardiac catheterizations (insertion of a tubular device in the heart);
- fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology); and
- approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by United Resource Networks or Care Coordination℠ to be proven procedures for the involved diagnoses. Contact United Resource Networks at (888) 936-7246 or Care Coordination℠ at the toll-free number on your ID card for information about CHD services.

If you receive Congenital Heart Disease service from a facility that is not a CHD Resource Services facility, the Plan pays Benefits as described under:

- Physician's Office Services;
- Professional Fees for Surgical and Medical Services;
- Hospital-Inpatient stay; and
- Outpatient Surgery, Diagnostics and Therapeutic Service.

United Resource Networks or Care Coordination℠ must be notified as soon as CHD is suspected or diagnosed. If United Resource Networks or Care Coordination℠ is not notified, Benefits for Covered Health Services will be subject to a **$100 reduction**.

Note: The services described under Travel and Lodging are Covered Health Services only in connection with CHD services received at a Congenital Heart Disease Resource Services program.

Dental Services - Accident Only

Dental services are covered by the Plan when all of the following are true:

- treatment is necessary because of accidental damage to a sound, natural tooth;
- dental damage does not occur as a result of normal activities of daily living or extraordinary use of the teeth;
- dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry; and
- the dental damage is severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident.

The following services are also covered by the Plan:

- dental transplant preparation;
- initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system); and

- direct treatment of cancer or cleft palate.

Before the Plan will cover treatment of an injured tooth, the dentist must certify that the tooth is virgin or unrestored, and that it:

- has no decay;
- has no filling on more than two surfaces;
- has no gum disease associated with bone loss;
- has no root canal therapy;
- is not a dental implant; and
- functions normally in chewing and speech.

Dental services for final treatment to repair the damage must be started within three months of the accident and completed within 12 months of the accident.

You must notify Care Coordination[SM] as soon as possible, but at least **five business days before** follow-up (post-Emergency) treatment begins. You do not have to provide notification before the initial Emergency treatment. When you provide notification, Care Coordination[SM] can determine whether the service is a Covered Health Service.

Durable Medical Equipment (DME)

The Plan pays for Durable Medical Equipment (DME) that is:

- ordered or provided by a Physician for outpatient use;
- used for medical purposes;
- not consumable or disposable;
- not of use to a person in the absence of a Sickness, Injury or disability;
- durable enough to withstand repeated use; and
- appropriate for use in the home.

If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Examples of DME include but are not limited to:

- equipment to administer oxygen;
- wheelchairs;
- Hospital beds;
- delivery pumps for tube feedings;
- glucose monitors;

- braces that stabilize an injured body part and braces to treat curvature of the spine, including necessary adjustments to shoes to accommodate braces; and
- equipment for the treatment of chronic or acute respiratory failure or conditions.

The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with DME.

Benefits are provided for the replacement of a type of Durable Medical Equipment once every three plan years.

At UnitedHealthcare's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at anytime and are not subject to the three year timeline for replacement.

No Benefits are paid for the repair, adjustment or replacement of DME if damage results from your negligence or abuse of such equipment.

Note: DME is different from prosthetic devices – see *Prosthetic Devices* in this section.

For non-network Benefits, you must notify Care Coordination℠ if the purchase, rental, repair or replacement of DME will cost more than $1,000. You must purchase or rent the DME from the vendor Care Coordination℠ identifies. If Care Coordination℠ is not notified, Benefits will be subject to a **$100 reduction**.

Emergency Room

The Plan's Emergency services benefit pays for outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment.

If you are admitted as an inpatient to a network Hospital within 24 hours of receiving treatment for an Emergency health service, you will not have to pay the Copay for Emergency health services. The Coinsurance for an Inpatient Stay in a network Hospital will apply instead.

Network Benefits will be paid for an Emergency admission to a non-network Hospital as long as Care Coordination℠ is notified within two business days of the admission or as soon as reasonably possible after you are admitted to a non-network Hospital. If you continue your stay in a non-network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a network Hospital, non-network Benefits will apply.

There is a $100 maximum Copay per Covered 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 3 or

more no one individual can contribute more than $100 toward the maximum Copay amount. Once an individual has met his or her $100 Copay, that one individual no longer pays an Emergency room Copay for the remainder of that calendar year.

For non-network Benefits, you must notify Care Coordination℠ **within two business days or as soon as reasonably possible** if you are admitted to a Hospital as a result of an Emergency. If Care Coordination℠ is not notified, Benefits for the Inpatient Hospital Stay will be subject to a **$100 reduction**.

Home Health Care

Covered Health Services are services that a Home Health Agency provides if you are homebound due to the nature of your condition. Services must be:

- ordered by a Physician;
- provided by or supervised by a registered nurse in your home;
- not considered Custodial Care, as defined in Section 15, *Glossary*; and
- provided on a part-time, intermittent schedule when Skilled Home Health Care is required. Refer to Section 15, *Glossary* for the definition of Skilled Home Health Care.

Care Coordination℠ will decide if Skilled Home Health Care is needed by reviewing both the skilled nature of the service and the need for Physician-directed medical management.

Any combination of network and non-network Benefits is limited to 60 visits per plan year. One visit equals four hours of Skilled Home Health Care services.

Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Benefits are available only when hospice care is received from a licensed hospice agency. The Plan also pays Benefits for bereavement counseling.

Any combination of network and non-network Benefits is limited to $10,000 per Covered person during the entire period you are covered under the Plan.

For **home health care or hospice** non-network Benefits, you must notify Care Coordination℠ **five business days before** receiving services. If Care Coordination℠ is not notified, Benefits will be subject to a **$100 reduction**.

Hospital - Inpatient Stay

Hospital Benefits are available for:

- services and supplies received during an Inpatient Stay; and
- room and board in a semi-private room (a room with two or more beds).

The Plan will pay the difference in cost between a semi-private room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for Hospital-based Physician services are described in this section under *Professional Fees for Surgical and Medical Services*.

Benefits for Emergency admissions and admissions of less than 24 hours are described under *Emergency Health Services* and *Outpatient Surgery, Diagnostic and Therapeutic Services*, respectively.

For non-network Benefits, you must notify Care Coordination[SM] as follows:

- for elective admissions: **five business days before** admission;
- for Emergency admissions (also termed non-elective admissions): within **two business days,** or as soon as is reasonably possible.

If Care Coordination[SM] is not notified, Benefits will be subject to a **$100 reduction**.

Infertility Services - Diagnostic Only

The Plan pays Benefits for infertility services and associated expenses for the diagnosis and treatment of an underlying medical condition that causes infertility, when under the direction of a Physician.

Injections in a Physician's Office

Benefits are paid by the Plan for injections administered in the Physician's office, for example allergy immunotherapy, when no other health service is received.

Maternity Services

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

The Plan will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery; or
- 96 hours for the mother and newborn child following a cesarean section delivery.

These are federally mandated requirements under the Newborns' and Mothers' Health Protection Act of 1996 which apply to this Plan. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

For non-network Benefits, you must notify Care Coordination℠ as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be longer than the timeframes indicated above. If Care Coordination℠ is not notified, Benefits for the extended stay will be subject to a **$100 reduction**.

Newborns' and Mothers' Health Protection Act of 1996

Under Federal law, group health plans generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's Physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, a group health plan may not, under Federal law, require that a provider obtain authorization from the group health plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

You must notify Care Coordination℠ as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be longer than the timeframes indicated above.

Healthy moms and babies

The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 7, *Resources to Help you Stay Healthy*, for details.

Mental Health Services

Mental Health Services include those received on an inpatient or Intermediate Care basis in a Hospital or Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits for Mental Health Services include:

- mental health evaluations and assessment;
- diagnosis;
- treatment planning;
- referral services;
- medication management;
- inpatient services;
- partial hospitalization/day treatment;
- intensive outpatient treatment;

- services at a Residential Treatment Facility;
- individual, family and group therapeutic services; and
- crisis intervention.

The Mental Health/Substance Use Disorder Administrator, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

Referrals to a Mental Health provider are at the sole discretion of the Mental Health/Substance Use Disorder Administrator, who is responsible for coordinating all of your care. Mental Health Services must be authorized and overseen by the Mental Health/Substance Use Disorder Administrator. Contact the Mental Health/Substance Use Disorder Administrator regarding Benefits for Mental Health Services.

Special Mental Health Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Mental Health Services benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under this Plan. You must be referred to such programs through the Mental Health/Substance Use Disorder Administrator, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders

The Plan pays Benefits for psychiatric services for Autism Spectrum Disorders that are both of the following:

- Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider; and
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These Benefits describe only the psychiatric component of treatment for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories as described in this section.

Benefits include:

- diagnostic evaluations and assessment;

- treatment planning;
- referral services;
- medical management;
- inpatient/24-hour supervisory care;
- Partial Hospitalization/Day Treatment;
- Intensive Outpatient Treatment;
- services at a Residential Treatment Facility;
- individual, family, therapeutic group and provider-based case management services;
- psychotherapy, consultation and training session for parents and paraprofessional and resource support to family;
- crisis intervention; and
- transitional care.

Autism Spectrum Disorder services must be authorized and overseen by the Mental Health/Substance Use Disorder Administrator. Contact the Mental Health/Substance Use Disorder Administrator regarding Benefits for *Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders*.

Multiple Surgical Procedures

If you or one of your Depends undergoes two or more procedures during the same anesthesia period, Eligible Expenses for the services of the Physician, facility, or other covered Provider for each procedure that is clearly identified and defined as a separate procedure will be based on:

- 100% of Eligible Expenses for the first or primary procedure; and
- 50% of Eligible Expenses for each of the other procedures.

Nutritional Counseling

The Plan will pay for Covered Health Services provided by a registered dietician in an individual session if you have a medical condition that requires a special diet. Some examples of such medical conditions include:

- diabetes mellitus;
- coronary artery disease;
- congestive heart failure;
- severe obstructive airway disease;
- gout (a form of arthritis);
- renal failure;

- phenylketonuria (a genetic disorder diagnosed at infancy); and
- hyperlipidemia (excess of fatty substances in the blood).

Benefits are limited to three individual sessions during the entire period you are covered under the Plan for each medical condition.

Obesity Surgery

- The Plan covers surgical treatment of obesity provided by or under the direction of a Physician when all of the following are true:
- you have a minimum Body Mass Index (BMI) of 40;
- you have documentation from a Physician of a diagnosis of morbid obesity for a minimum of five years;
- you are over the age of 21; and
- the surgery is performed at a network Hospital by a network surgeon even if there are no network Hospitals near you.

Outpatient Surgery, Diagnostic and Therapeutic Services

Outpatient surgery, diagnostic and therapeutic services received on an outpatient basis at a Hospital or Alternate Facility are paid by the Plan including:

- surgery and related services;
- lab and radiology/X-ray;
- mammography testing, other than as described under *Preventive Care* in this section;
- computerized tomography (CT) scans;
- position emission tomography (PET) scans;
- magnetic resonance imaging (MRIs);
- nuclear medicine; and
- other diagnostic tests and therapeutic treatments (including cancer chemotherapy or intravenous infusion therapy).

Benefits include only the facility charge and the charge for required services, supplies and equipment. Benefits for the professional fees, including a surgeon's fee related to outpatient surgery, diagnostic and therapeutic services are described under *Professional Fees for Surgical and Medical Services* in this section. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* as follows.

Physician's Office Services

Benefits are paid by the Plan for Covered Health Services received in a Physician's office including:

- evaluation and treatment of a Sickness or Injury;
- vision and hearing screenings, which could be performed as part of an annual physical examination in a Provider's office (vision screenings do not include refractive examinations to detect vision impairment); and
- hearing aids and services up to a $1,000 annual maximum.

Benefits for preventive services are described under *Preventive Care* in this section.

Preventive Care

In general, the Plan pays preventive care Benefits based on the recommendations of the U.S. Preventive Services Task Force (USPSTF). The Plan will pay Benefits for the Covered Health Services listed below, as well as preventive care services for which your Physician documents the need based on your family or medical history.

If the USPSTF's recommendations change, your preventive care Benefits may also change.

Covered Preventive Care Services	
Children under age 18	one routine physical per plan year; phenylketonuria (PKU) tests; immunizations for children through age 7*; exams that are more frequent than annual in accordance with the U.S. Preventive Services Task Force guidelines.
Women	one baseline mammogram between ages 35 and 39; one every two plan years from ages 40 to 49; one per plan year after age 50; one routine gynecological exam per plan year including breast and pelvic examination, and PAP test. – HPV for women beginning at age 7.
Men	PSA blood test and digital rectal exam annually, beginning at age 50.
Both Men and Women	one routine physical per plan year for ages 18 and above; colorectal cancer screening beginning at age 50; frequency of screening depends on the test performed.

*Covered childhood immunizations generally include: Diptheria-tetanus-pertussis (DTP), Oral poliovirus (OPV), Measles-mumps-rubella (MMR), Conjugate haemophilus influenzae type B, Hepatitis B, and Varicella (Chicken Pox).

Private Duty Nursing - Outpatient

The Plan covers private duty nursing care given on an outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

Professional Fees for Surgical and Medical Services

The Plan pays professional fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Alternate Facility, outpatient surgery facility, or birthing center.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* in this section.

Prosthetic Devices

Benefits are paid by the Plan for prosthetic devices and appliances that replace a limb or body part, or help an impaired limb or body part work. Examples include, but are not limited to:

- artificial limbs;
- artificial eyes; and
- breast prosthesis following mastectomy as required by the Women's Health and Cancer Rights Act of 1998, including mastectomy bras and lymphedema stockings for the arm.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most Cost-Effective prosthetic device. The device must be ordered or provided either by a Physician, or under a Physician's direction.

Benefits are provided for the replacement of a type of prosthetic device once every five plan years.

At UnitedHealthcare's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement or when a change in the Covered Person's medical condition occurs sooner than the five year timeframe. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.

Note: Prosthetic devices are different from DME - see *Durable Medical Equipment (DME)* in this section.

Women's Health and Cancer Rights Act of 1998

Under federal law, group health plans and health insurance issuers providing benefits for a mastectomy must also provide, in connection with the mastectomy for which the participant or beneficiary is receiving benefits, coverage for:

- reconstruction of the breast on which the mastectomy has been performed; and
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and physical complications of mastectomy, including lymphedemas;

- in a manner determined in consultation between the attending Physician and the patient.

These benefits may be subject to Copay provisions that are appropriate and consistent with other Benefits under the plan or coverage.

Reconstructive Procedures

Reconstructive Procedures are services performed when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function for an organ or body part.

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed mastectomy.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 15, *Glossary*.

You must notify Care Coordination[SM] **five business days before** undergoing a Reconstructive Procedure. When you provide notification, Care Coordination[SM] can determine whether the service is considered reconstructive or cosmetic. Cosmetic Procedures are always excluded from coverage.

Rehabilitation Services - Outpatient Therapy

The Plan provides short-term outpatient rehabilitation services for the following types of therapy:

- physical;
- occupational;
- speech;
- orthoptic (eye exercise therapy);
- pulmonary rehabilitation;
- cardiac rehabilitation; and
- massage (when performed by a Physician or health care extender).

Speech Therapy

- Benefits are paid for services of a licensed speech therapist for treatment given when speech is impaired due to one of the following conditions:
- Injury or sickness;
- autism spectrum disorder;
- a Congenital Anomaly; or following the placement of a cochlear implant;
- development delay or cerebral palsy;
- hearing impairment; or
- major Congenital Anomalies that affect speech, such as, but not limited to, cleft lip and cleft palate.

For all rehabilitation services, a licensed therapy Provider, under the direction of a Physician, must perform the services. The Plan gives UnitedHealthcare the right to exclude from coverage rehabilitation services that are not expected to result in significant physical improvement in your condition within two months of the start of treatment. In addition, UnitedHealthcare has the right to deny Benefits if treatment ceases to be therapeutic and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or recurring.

The Plan will pay Benefits for orthoptic therapy if:

- the treatment is for an Injury or Sickness;
- a Physician prescribes and performs the therapy; and
- treatments are not for correction of vision.

Any combination of network and non-network Benefits for cardiac rehabilitation therapy is limited to 36 visits per plan year.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. Benefits include:

- services and supplies received during the Inpatient Stay; and
- room and board in a semi-private room (a room with two or more beds).

Benefits are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

The intent of skilled nursing is to provide Benefits if, as a result of an Injury or illness, you require:

- an intensity of care less than that provided at a general acute Hospital but greater than that available in a home setting; or
- a combination of skilled nursing, rehabilitation and facility services.

You are expected to improve to a predictable level of recovery.

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 15, *Glossary*.

For non-network Benefits, you must notify Care Coordination℠ as follows:

- for elective admissions: five business days before admission;
- for Emergency admissions (also termed non-elective admissions): within two business days, or as soon as is reasonably possible.

If Care Coordination℠ is not notified, Benefits will be subject to a **$100 reduction**.

Spinal Treatment

The Plan pays Benefits for Spinal Treatment when provided by a network or non-network Spinal Treatment specialist in the specialist's office. Covered Health Services include chiropractic and osteopathic manipulative therapy.

The Plan gives UnitedHealthcare the right to deny Benefits if treatment ceases to be therapeutic and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or recurring.

Benefits include diagnosis and related services. The Plan limits any combination of network and non-network Benefits for Spinal Treatment to one visit per day up to 30 visits per calendar year. However, it is required that there is a review for medical necessity after the 12th visit.

Substance Use Disorder Services

Substance Use Disorder Services include those received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits for Substance Use Disorder Services include:

- Substance Use Disorder or chemical dependency evaluations and assessment;
- diagnosis;
- treatment planning;
- detoxification (sub-acute/non-medical);
- inpatient services;
- Partial Hospitalization/Day Treatment;

- Intensive Outpatient Treatment;
- services at a Residential Treatment Facility;
- referral services;
- medication management;
- individual, family and group therapeutic services; and
- crisis intervention.

The Mental Health/Substance Use Disorder Administrator, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

Referrals to a Substance Use Disorder provider are at the sole discretion of the Mental Health/Substance Use Disorder Administrator, who is responsible for coordinating all of your care. Substance Use Disorder Services must be authorized and overseen by the Mental Health/Substance Use Disorder Administrator. Contact the Mental Health/Substance Use Disorder Administrator regarding Benefits for Substance Use Disorder Services.

Special Substance Use Disorder Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Substance Use Disorder Services benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Substance Use Disorder which may not otherwise be covered under this Plan. You must be referred to such programs through the Mental Health/Substance Use Disorder Administrator, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

Temporomandibular Joint Dysfunction (TMJ)

The Plan covers diagnostic and non-surgical treatment of conditions affecting the temporomandibular joint and craniomandibular when provided by or under the direction of a Physician. Coverage includes necessary treatment required as a result of accident, trauma, a Congenital Anomaly, developmental defect, or pathology.

Please note that Benefits are not available for charges for services that are dental in nature. Treatment will not include orthodontia but will include splinting.

Transplantation Services

Inpatient facility services (including evaluation for transplant, organ procurement and donor searches) for transplantation procedures must be ordered by a Network Provider and received at a Designated United Resource Networks Facility. Benefits are available to the donor and the recipient when the recipient is covered under this Plan. The transplant must

meet the definition of a Covered Health Service and cannot be Experimental or Investigational, or Unproven. Examples of transplants for which Benefits are available include but are not limited to:

- heart;
- heart/lung;
- lung;
- kidney;
- kidney/pancreas;
- liver;
- liver/kidney;
- liver/intestinal;
- pancreas;
- intestinal; and
- bone marrow (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service – please see below.

Benefits are also available for cornea and skin transplants that are provided by a Network Provider at a network Hospital. You are not required to notify United Resource Networks or Care Coordination[SM] of a cornea or skin transplant nor is the cornea or skin transplant required to be performed at a Designated United Resource Networks Facility.

The search for bone marrow/stem cells from a donor who is not biologically related to the patient is a Covered Health Service only for a transplant received at a Designated United Resource Networks Facility. If a separate charge is made for a bone marrow/stem cell search, the Plan will pay up to $25,000 for all charges made in connection with the search.

The Plan has specific guidelines regarding Benefits for transplant services. Contact United Resource Networks at (888) 936-7246 or Care Coordination[SM] at the telephone number on your ID card for information about these guidelines.

Note: The services described under Travel and Lodging are Covered Health Services only in connection with transplant services received at a Designated United Resource Networks Facility.

You or your network Physician must notify United Resource Networks or Care Coordination[SM] as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you do not notify United Resource Networks or Care Coordination[SM], and services are not performed at a Designated United Resource Networks Facility, you will be responsible for paying all charges and **Benefits will not be paid**.

Travel and Lodging

United Resource Networks will assist the patient and family with travel and lodging arrangements related to:

- Congenital Heart Disease (CHD); and
- transplantation services.

For travel and lodging services to be covered, the patient must be receiving services at a Designated United Resource Networks Facility.

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:

- transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the CHD service, or the transplant for the purposes of an evaluation, the procedure or necessary post-discharge follow-up;
- Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion. Benefits are paid at a per diem (per day) rate of up to $50 per day for the patient or up to $100 per day for the patient plus one companion; or
- if the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging and meal expenses will be reimbursed at a per diem rate up to $100 per day.

Travel and lodging expenses are only available if the recipient lives more than 50 miles from the Designated United Resource Networks Facility (for transplantation) or the CHD facility. UnitedHealthcare must receive valid receipts for such charges before you will be reimbursed. Examples of travel expenses may include:

- airfare at coach rate;
- taxi or ground transportation; or
- mileage reimbursement at the IRS rate for the most direct route between the patient's home and the Designated United Resource Networks Facility.

A combined overall maximum Benefit of $10,000 per Covered Person applies for all travel, lodging and meal expenses reimbursed under this Plan in connection with all transplant procedures and CHD treatments during the entire period that person is covered under this Plan.

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 15, *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services* earlier in this section.

SECTION 7 - RESOURCES TO HELP YOU STAY HEALTHY

Foothill-De Anza Community College District believes in giving you the tools you need to be an educated health care consumer. To that end, the District has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- take care of yourself and your family members;
- manage a chronic health condition; and
- navigate the complexities of the health care system.

NOTE:

Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. UnitedHealthcare and Foothill De-Anza Community College District are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text.

www.myuhc.com

UnitedHealthcare's member website, **www.myuhc.com**, provides information at your fingertips anywhere and anytime you have access to the Internet. **myuhc.com** opens the door to a wealth of health information and convenient self-service tools to meet your needs.

Health Information

With **myuhc.com** you can:

- search for Network Providers available in your Plan through the online Provider directory;
- research a health condition and treatment options to get ready for a discussion with your Physician;
- access all of the content and wellness topics from Optum NurseLine/Connect24 including Live Nurse Chat 24 hours a day, seven days a week;
- complete a health risk assessment to identify health habits you can improve, learn about healthy lifestyle techniques and access health improvement resources;
- use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
- use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Self-Service Tools

Visit **myuhc.com** and:

- make real-time inquiries into the status and history of your claims;
- view eligibility and Plan benefit information, including Copays;
- view and print all of your Explanation of Benefits (EOBs) online; and
- order a new or replacement ID card, print a temporary ID card, or check on an ID card request.

Registering on myuhc.com

If you have not already registered as a myuhc.com subscriber, simply go to myuhc.com and click on "Register Now." Have your UnitedHealthcare ID card handy. The enrollment process is quick and easy.

United Healthy Living Programs

This web-based program, which can be accessed through **myuhc.com**, provides you with a lifestyle action plan tailored to your risk, preferences and lifestyle. Action plans are available for:

- physical activity;
- nutrition;
- stress management;
- weight management;
- blood pressure;
- cholesterol;
- smoking cessation,
- diabetes; and
- cancer prevention.

In addition, you will receive a personalized weekly e-mail to help you in your personal health management.

Optum® NurseLine℠/Connect24

Optum NurseLine/Connect24 is a toll-free telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. NurseLine nurses can provide health information for routine or urgent health concerns. When you call, a registered nurse may refer you to any additional resources that Foothill-De Anza Community College District has available to help you improve your health and well-being or manage a chronic condition.

Call any time when you want to learn more about:

- a recent diagnosis;
- a minor Sickness or Injury;
- men's, women's, and children's wellness;
- how to take Prescription Drugs safely;
- self-care tips and treatment options;
- healthy living habits; or
- any other health related topic.

NurseLine/Connect24 gives you another convenient way to access health information. By calling the same toll-free number, you can listen to one of the Health Information Library's over 1,100 recorded messages. There are also 590 messages available in Spanish.

NurseLine/Connect24 is available to you at no cost. To use this convenient service, simply call the toll-free number on the back of your ID card.

Note: If you have a medical emergency, call 911 instead of calling Optum NurseLine/Connect24.

Live Nurse Chat

With NurseLine/Connect24, you also have access to nurses online. To use this service, log onto **myuhc.com** and click "Live Nurse Chat" in the top menu bar. You'll be connected with a registered nurse who can answer your general health questions any time, 24 hours a day, seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

Note: If you have a medical emergency, call 911 instead of logging onto **myuhc.com**.

Live Events on myuhc.com

Periodically, **myuhc.com** hosts live events with leading health care professionals. After viewing a presentation, you can chat online with the experts. Topics include:

- weight control;
- parenting;
- heart disease;
- relationships; and
- depression.

For details, or to participate in a live event, log onto **myuhc.com**.

Healthy Pregnancy Program

You can get valuable educational information and advice by calling the toll-free number on your ID card. This program offers:

- maternity nurses on duty 24 hours a day;
- a free copy of *The Healthy Pregnancy Guide*;
- a phone call from a maternity nurse halfway through your Pregnancy, to see how things are going;
- a phone call from a nurse approximately four weeks postpartum to give you information on infant care, feeding, nutrition, immunizations and more; and
- a copy of an available publication, for example, *Healthy Baby Book*, which focuses on the first two years of life.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first 12 weeks of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the toll-free number on the back of your ID card.

Disease Management Services

These services have been designed to assist individuals who have been diagnosed with, or who are at risk for developing, chronic medical conditions, such as diabetes, heart disease, and asthma.

The program offers:

- educational materials mailed to your home that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications;
- access to educational and self-management resources on consumer website;
- an opportunity for the disease management nurse to work with your Physician to ensure that you are receiving the appropriate care; and
- toll-free access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:

- education about the specific disease and condition,
- medication management and compliance,
- reinforcement of on-line behavior modification program goals,
- preparation and support for upcoming Physician visits,
- review of psychosocial services and community resources,
- caregiver status and in-home safety,
- use of mail-order pharmacy and Network Providers.

Participation is completely voluntary and free of charge. Please contact UnitedHealthcare's Customer Care at 1-800-510-4846.

Reminder Programs

To help you stay healthy, UnitedHealthcare may send you and your covered Dependents reminders to schedule recommended screening exams. Examples of reminders include:

- mammograms for women between the ages of 51 and 68;
- pediatric and adolescent immunizations;
- cervical cancer screenings for women between the ages of 20 and 64;
- comprehensive screenings for individuals with diabetes; and
- influenza/pneumonia immunizations for enrollees age 65 and older.

There is no need to enroll in this program. You will receive a reminder automatically if you have not had a recommended screening exam.

UnitedHealth Premium℠ Program

UnitedHealthcare designates network Physicians and facilities as UnitedHealth Premium Program Physicians or facilities for certain medical conditions. Physicians and facilities are evaluated on two levels - quality and efficiency of care. The UnitedHealth Premium Program was designed to:

- help you make informed decisions on where to receive care;
- provide you with decision support resources; and
- give you access to Physicians and facilities across areas of medicine that have met UnitedHealthcare's quality and efficiency criteria.

For details on the UnitedHealth Premium Program including how to locate a UnitedHealth Premium Physician or facility, log onto **myuhc.com** or call the toll-free number on your ID card.

SECTION 8 - EXCLUSIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

The Plan does not pay Benefits for any of the following services, treatments or supplies even if they are recommended or prescribed by a Provider or are the only available treatment for your condition.

Alternative Treatments

- aromatherapy;
- hypnotism;
- rolfing (holistic tissue massage); and
- other forms of alternative treatment as defined by the National Center for Complimentary and Alternative Medicine of the National Institutes of Health.

Comfort and Convenience

Supplies, equipment and similar incidentals for personal comfort. Examples include:

- television;
- telephone;
- air conditioners;
- beauty/barber service;
- guest service;
- air purifiers and filters;
- batteries and battery chargers;
- dehumidifiers and humidifiers;
- ergonomically correct chairs;
- non-Hospital beds and comfort beds;
- devices and computers to assist in communication and speech; and
- home remodeling to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides).

Dental

- dental care, except as identified under Dental Services - Accident Only in Section 6, Additional Coverage Details;
- services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered dental in nature, including oral appliances;
- preventive dental care;

- diagnosis or treatment of the teeth or gums. Examples include:

- extractions (including wisdom teeth);
- restoration and replacement of teeth;
- medical or surgical treatments of dental conditions; and
- services to improve dental clinical outcomes;

- dental implants and braces;

- dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia; and

- treatment of congenitally missing (missing at birth), malpositioned, or supernumerary (extra) teeth, even if part of a Congenital Anomaly.

Drugs

The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the Prescription Drug portion of the Plan. See Section 14, *Prescription Drugs*, for coverage details and exclusions.

- Prescription Drugs for outpatient use that are filled by a prescription order or refill;

- self-injectable medications (These are covered under the Prescription Drug Plan.);

- non-injectable medications given in a Physician's office except as required in an Emergency; and

- over the counter drugs and treatments.

Experimental and Investigational, or Unproven Services

- Experimental and Investigational Services or Unproven Services, unless the Plan has agreed to cover them as stated in Section 15, *Glossary*.

This exclusion applies even if Experimental and Investigational or Unproven Services are the only available treatment options for your condition.

Foot Care

- routine foot care, except when needed for severe systemic disease. Routine foot care services that are not covered include:

- cutting or removal of corns and calluses;
- nail trimming or cutting; and
- debriding (removal of dead skin or underlying tissue);

- hygienic and preventive maintenance foot care. Examples include:

- cleaning and soaking the feet;
- applying skin creams in order to maintain skin tone; and
- other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot;

- treatment of flat feet;
- treatment of subluxation (joint or bone dislocation) of the foot;
- shoes (standard or custom), lifts and wedges; and
- shoe orthotics (unless surgery is required).

Jawbone Surgery

- diagnosis or treatment of the jawbones, including orthognathic surgery (procedure to correct underbite or overbite), except as treatment of obstructive sleep apnea; and
- upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, tumor or cancer.

Medical Supplies and Appliances

- devices used specifically as safety items or to affect performance in sports-related activities;
- prescribed or non-prescribed medical and disposable supplies, except for ostomy bags and related supplies. Examples of supplies that are not covered include, but are not limited to:

- elastic stockings, ace bandages, diabetic strips, and syringes; and
- tubings, nasal cannulas, connectors and masks that are not used in connection with DME; and
- orthotic appliances and devices, except when all of the following are met:

- prescribed by a Physician for a medical purpose; and
- custom manufactured or custom fitted to an individual Covered Person. Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics, cranial bands, or any braces that can be obtained without a Physician's order.

Mental Health/Substance Use Disorder

- inpatient or intermediate care services that were not pre-authorized by the Mental Health/Substance Use Disorder (MH/SUD) Administrator;
- services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;
- services that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments or crisis intervention to be effective;
- treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements unless pre-authorized by the Mental Health/Substance Use Disorder Administrator;

- services or supplies for the diagnosis or treatment of Mental Illness2, alcoholism or substance use disorders that , in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following:
  - not consistent with generally accepted standards of medical practice for the treatment of such conditions;
  - not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental;
  - typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective;
  - not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time; or
  - not clinically appropriate in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

  The Mental Health/Substance Use Disorder Administrator may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.
- Mental Health Services as treatment for a primary diagnosis of insomnia other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis;
- treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias (sexual behavior that is considered deviant or abnormal) and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as determined by the MH/SUD Administrator;
- educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning;
- tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act;
- learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;
- mental retardation and autism spectrum disorder as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;
- methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction;
- psychosurgery (lobotomy)
- Substance Use Disorder Services for the treatment of nicotine or caffeine use;

- intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorders;
- routine use of psychological testing without specific authorization; and
- pastoral counseling.

Nutrition and Health Education

- megavitamin and nutrition based therapy;
- nutritional counseling for either individuals or groups, except as defined under *Nutritional Counseling* in Section 6, *Additional Coverage Details*;
- food of any kind, even if it is the only source of nutrition and even if it is specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Foods that are not covered include:
  - enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk;
  - foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes;
  - oral vitamins and minerals;
  - meals you can order from a menu, for an additional charge, during an Inpatient Stay; and
  - other dietary and electrolyte supplements;

- health club memberships and programs, and spa treatments; and
- health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Physical Appearance

Cosmetic Procedures, as defined in Section 15, *Glossary*, are excluded from coverage. Examples include:

- liposuction;
- pharmacological regimens;
- nutritional procedures or treatments;
- tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures);
- replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure;
- physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation;
- weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity;
- wigs regardless of the reason for the hair loss;
- treatments for hair loss;
- a procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy;
- varicose vein treatment of the lower extremities, when it is considered cosmetic; and
- treatment of benign gynecomastia (abnormal breast enlargement in males).

Preexisting Conditions

- Benefits for the treatment of a Preexisting Condition are excluded until the earlier of the following:

- the date you have had Continuous Creditable Coverage for 12 months; or
- the date you have had Continuous Creditable Coverage for 18 months if you are a Late Enrollee.

This exclusion does not apply to newborn children, newly adopted children or children placed for adoption. This exception for newborn, adopted children and children placed for adoption no longer applies after the end of the first 63-day period during which the child has not had Continuous Creditable Coverage.

Pregnancy and Infertility

- health services and associated expenses for infertility treatments including, but not limited to:

- in vitro fertilization (IVF);
- gamete intrafallopian transfer (GIFT);
- zygote intrafallopian transfer (ZIFT);
- artificial insemination;
- embryo transport; and
- donor ovum and semen and related costs including collection, preparation and storage of;

- surrogate parenting;
- the reversal of voluntary sterilization;
- artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes;
- elective surgical, non-surgical or drug induced Pregnancy termination;
- oral contraceptive supplies and services;
- services provided by a doula (labor aide); and
- parenting, pre-natal or birthing classes.

Providers

Services:

- performed by a Provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child;
- a Provider may perform on himself or herself;
- performed by a Provider with your same legal residence;
- ordered or delivered by a Christian Science practitioner;
- performed by an unlicensed Provider or a Provider who is operating outside of the scope of his/her license;
- provided at a diagnostic facility (Hospital or otherwise) without a written order from a Provider; and
- ordered by a Provider affiliated with a diagnostic facility (Hospital or otherwise), when that provider is not actively involved in your medical care:

- prior to ordering the service; or
- after the service is received.

This exclusion does not apply to mammography testing.

Services Provided under Another Plan

Services for which coverage is available:

- under another plan, except as described in Section 10, *Coordination of Benefits (COB)*;
- under workers' compensation or similar legislation if you could elect it, or could have it elected for you;
- while on active military duty; and
- for treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably accessible.

Transplants

- Organ and tissue transplants, including multiple transplants:
  - except as identified under *Transplantation Services* in Section 6*, Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines;
  - determined by Care Coordination℠ not to be proven procedures for the involved diagnoses; and
  - not consistent with the diagnosis of the condition;
- mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available);
- transplants that are not performed at a Designated United Resource Networks Facility; and
- donor costs for organ or tissue transplantation to another person (these costs may be payable through the recipient's benefit plan).

Travel

- travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* in Section 6, *Additional Coverage Details*.

Vision and Hearing

- purchase cost of eyeglasses or contact lenses;
- fitting charges for assistive devices, amplifiers, eyeglasses, and contact lenses; and
- surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

- autopsies and other coroner services and transportation services for a corpse;
- charges for:
  - missed appointments;
  - room or facility reservations;
  - completion of claim forms;
  - record processing; or
  - services, supplies or equipment that are advertised by the Provider as free;
- charges by a Provider sanctioned under a federal program for reason of fraud, abuse or medical competency;
- charges prohibited by federal anti-kickback or self-referral statutes;
- chelation therapy, except to treat heavy metal poisoning;
- Custodial Care as defined in Section 15, *Glossary*, or services provided by a personal care assistant;
- diagnostic tests that are:
  - delivered in other than a Physician's office or health care facility; and
  - self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests;
- Domiciliary Care, as defined in Section 15, *Glossary*;
- growth hormone therapy;
- expenses for health services and supplies:
  - that do not meet the definition of a Covered Health Service in Section 15, *Glossary*;
  - that are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country;
  - that are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends;
  - for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this benefit Plan;
  - that exceed Eligible Expenses or any specified limitation in this Booklet; or
  - for which a non-Network Provider waives the Copay or Coinsurance amounts;
- medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer). Appliances for snoring are always excluded;
- physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:
  - required solely for purposes of career, education, sports or camp, employment, insurance, marriage or adoption; or as a result of incarceration;
  - conducted for purposes of medical research;
  - related to judicial or administrative proceedings or orders; or

- required to obtain or maintain a license of any type;
- private duty nursing received on an inpatient basis;
- respite care;
- rest cures;
- sex transformation operations;
- speech therapy to treat stuttering, stammering, or other articulation disorders;
- speech therapy, except when the speech impediment or dysfunction results from Injury, Sickness, stroke, cancer, autism spectrum disorder or a Congenital Anomaly or is needed following the placement of a cochlear implant; as identified under *Rehabilitation Services – Outpatient Therapy* and *Speech Therapy* in Section 6, *Additional Coverage Details*;
- Spinal Treatment to treat a condition unrelated to alignment of the vertebral column, such as asthma or allergies;
- storage of blood, umbilical cord or other material for use in a Covered Health Service, except if needed for an imminent surgery;
- the following treatments for obesity:
- non-surgical treatment, even if for morbid obesity; and
- surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under *Obesity Surgery* in Section 6, *Additional Coverage Details*; and
- treatment of hyperhidrosis (excessive sweating).

SECTION 9 - CLAIMS PROCEDURES

Network Benefits

In general, if you receive Covered Health Services from a Network Provider, UnitedHealthcare will pay the Physician or facility directly. If a Network Provider bills you for any Covered Health Service other than your Copay, please contact the Provider or call UnitedHealthcare at the phone number on your ID card for assistance.

Keep in mind, you are responsible for paying any Copays owed to a Network Provider at the time of service, or when you receive a bill from the Provider.

Non-Network Benefits

Non-Network Providers may require that you pay their fees at the time of service. If you receive a bill for Covered Health Services from a non-Network Provider, you (or the Provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on the back of your ID card.

Prescription Drug Benefit Claims

If you wish to receive reimbursement for a prescription, you may submit a post-service claim as described in this section if:

- you are asked to pay the full cost of the Prescription Drug when you fill it and you believe that the Plan should have paid for it; or
- you pay a Copay and you believe that the amount of the a Copay was incorrect.

If a pharmacy (retail or home delivery) fails to fill a prescription that you have presented and you believe that it is a Covered Health Service, you may submit a pre-service claim as described in this section.

If Your Provider Does Not File Your Claim

To obtain a claim form when a non-Network Provider is used, visit **www.myuhc.com** or the District website at http://fhda.edu/benefits.

It is your responsibility to pay the non-Network Provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

UnitedHealthcare will pay Benefits to you unless:

- the Provider notifies UnitedHealthcare that you have provided signed authorization to assign Benefits directly to that Provider; or
- you make a written request for the non-Network Provider to be paid directly at the time you submit your claim.

UnitedHealthcare will only pay Benefits to you or, with written authorization by you, your Provider, and not to a third party, even if your Provider has assigned Benefits to that third party.

Once a claim has been processed by UnitedHealthcare, you will receive an Explanation of Benefits (EOB) that outlines approved charges, payment amount, any amount that is the patient's responsibility, and the reason if denied or partially paid.

Important

All claim forms must be submitted within 12 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense. This requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your ID card before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied claim, you must submit your appeal in writing within 90 days of receiving the denial. This written communication should include:

- the patient's name and ID number as shown on the ID card;
- the Provider's name;
- the date of medical service;
- the reason you think your claim should be paid; and
- any documentation or other written information to support your request.

You or your eligible Dependent may send your written request for an appeal to:

Claims Administrator
UnitedHealthcare – Appeals
PO Box 30432
Salt Lake City, UT 84130-0432

For claims that have been denied, you or your Provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional who was not consulted during the initial benefit determination process.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

UnitedHealthcare has two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare within 60 days from receipt of the first level appeal. UnitedHealthcare must notify you of the benefit determination within 15 days after receiving the completed appeal for a pre-service claim and 30 days after receiving the completed post-service appeal.

Note: Upon written request any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. UnitedHealthcare will review all claims in accordance with the rules established by the U.S. Department of Labor. UnitedHealthcare's decision will be final.

Timing of Claim Denials and Appeals

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent Care - a claim for Benefits provided in connection with Urgent Care services, as defined in Section 15, *Glossary*;
- Pre-Service - a claim for Benefits which the Plan must approve before non-Urgent Care is provided; and
- Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

Urgent Care Claims*	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**24 hours**
You must then provide completed claim information to UnitedHealthcare within:	**48 hours** after receiving notice

Urgent Care Claims*	
Type of Claim or Appeal	**Timing**
If UnitedHealthcare denies your initial claim, they must notify you of the denial:	
– if the initial claim is complete, within:	**72 hours**
– after receiving the completed claim (if the initial claim is incomplete), within:	**48 hours**
You must appeal the claim denial no later than:	**90 days** after receiving the denial
UnitedHealthcare must notify you of the appeal decision within:	**72 hours** after receiving the appeal

*You do not need to submit Urgent Care claim appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an Urgent Care claim.

Pre-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is filed improperly, UnitedHealthcare must notify you within:	**5 days**
If your claim is incomplete, UnitedHealthcare must notify you within:	**15 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days** after receiving an extension notice*
If UnitedHealthcare denies your initial claim, they must notify you of the denial:	
– if the initial claim is complete, within:	**15 days**
– after receiving the completed claim (if the initial claim is incomplete), within:	**30 days****
You must appeal the claim denial no later than:	**90 days** after receiving the denial
UnitedHealthcare must notify you of the appeal decision within:	**15 days** after receiving the appeal

*UnitedHealthcare may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

[**]This timeframe assumes that UnitedHealthcare gives notice of the need for an extension during the initial 15-day period. Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days** after receiving an extension notice[*]
If UnitedHealthcare denies your initial claim, they must notify you of the denial:	
– if the initial claim is complete, within:	**30 days**
– after receiving the completed claim (if the initial claim is incomplete), within:	**45 days**[**]
You must appeal the claim denial no later than:	**90 days** after receiving the denial
UnitedHealthcare must notify you of the appeal decision within:	**30 days** after receiving the appeal

[*]UnitedHealthcare may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

[**]This timeframe assumes that UnitedHealthcare gives notice of the need for an extension during the initial 30-day period.

SECTION 10 - COORDINATION OF BENEFITS (COB)

Determining Which Plan is Primary

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- this Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy;
- when you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first;
- a plan that covers a person as an Employee pays benefits before a plan that covers the person as a Dependent;
- your Dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:

- the parents are married and not legally separated; or
- a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage;

- if two or more plans cover a Dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:

- the parent with custody of the child; then
- the Spouse of the parent with custody of the child; then
- the parent not having custody of the child; then
- the Spouse of the parent not having custody of the child;

- plans for active Employees pay before plans covering laid-off or retired Employees;
- finally, if none of the above rules determines which plan is primary or secondary, the plan that has covered the individual claimant the longest will pay first. The expenses must be covered in part under at least one of the plans.

When This Plan is Secondary

The Plan will determine the amount it will pay for a Covered Health Service by following the steps below.

- The Plan determines the amount it would have paid had it been the only plan involved.
- The Plan pays the difference between the allowable expense and the amount paid by the primary plan.
- The primary plan may not reduce its benefits due solely to the existence of the secondary District coverage.

The maximum combined payment you may receive from all plans cannot exceed 100% of the total allowable expense. See the textbox below for the definition of allowable expense.

Retirees and Eligible Dependents of Retirees Who are Eligible for Medicare

To the extent permitted by law, this Plan will pay benefits secondary to Medicare when you become eligible for Medicare, even if you do not elect it. When a retiree or retiree's eligible dependent is 65 or over but ineligible for Medicare benefits; the District Self-Funded Plans will pay benefits primary to Medicare.

Determining the Allowable Expense When this Plan is Secondary

When this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the Provider accepts Medicare. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total allowable expense. If the physician is a non-Medicare contracted provider, no benefits will be payable by the Plan unless the services are Emergency in nature or received from a provider outside of the United States. Such non-U.S. services are payable at 80% of Covered Health Services.

Effective July 1, 2006, the District Self-Funded Medical Plans will strictly enforce the SECONDARY PAYOR RULE to such Medicare participants who utilize medical services provided by the Plan. Such Medicare participants and their Medicare-eligible dependents are required to use only Medicare-contracted physicians. All medical claims must be processed first as PRIMARY with Medicare, and the District Self-Funded Plans will coordinate payment for these claims as SECONDARY. Failure to comply will result in non-payment of these claims. Please note your physician must be a Medicare-contracted provider; however, he or she does not have to accept Medicare assignment.

SECTION 11 - SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement, as defined below.

Right to Subrogation

The right to subrogation means the Plan is substituted to any legal claims that you may be entitled to pursue for Benefits that the Plan has paid. Subrogation applies when the Plan has paid Benefits for a Sickness or Injury for which a third party is considered responsible, e.g. an insurance carrier if you are involved in an auto accident.

The Plan shall be subrogated to, and shall succeed to, all rights of recovery from any or all third parties, under any legal theory of any type, for 100 percent of any services and Benefits the Plan has paid on your behalf relating to any Sickness or Injury caused by any third party.

Right to Reimbursement

The right to reimbursement means that if a third party causes a Sickness or Injury for which you receive a settlement, judgment, or other recovery, you must use those proceeds to fully return to the Plan 100% of any Benefits you received for that Sickness or Injury.

Third Parties

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages;
- Foothill-De Anza Community College District; or
- any person or entity who is or may be obligated to provide you with benefits or payments under:
  - underinsured or uninsured motorist insurance;
  - medical provisions of no-fault or traditional insurance (auto, homeowners or otherwise);
  - workers' compensation coverage; or
  - any other insurance carrier or third party administrator.

Subrogation and Reimbursement Provisions

As a Covered Person, you agree to the following:

- the Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party.
- the Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries, or pay any of your associated costs, including attorneys' fees. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

- the Plan may enforce its subrogation and reimbursement rights regardless of whether you have been "made whole" (fully compensated for your injuries and damages).
- you will cooperate with the Plan and its agents in a timely manner to protect its legal and equitable rights to subrogation and reimbursement, including, but not limited to:

- complying with the terms of this section;
- providing any relevant information requested;
- signing and/or delivering documents at its request;
- appearing at medical examinations and legal proceedings, such as depositions or hearings; and
- obtaining the Plan's consent before releasing any party from liability or payment of medical expenses.

- if you receive payment as part of a settlement or judgment from any third party as a result of a Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to it, you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.
- if the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you.
- you may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- you will assign to the Plan all rights of recovery against third parties to the extent of Benefits the Plan has provided for a Sickness or Injury caused by a third party.
- the Plan's rights will not be reduced due to your own negligence.
- the Plan may file suit in your name and take appropriate action to assert its rights under this section. The Plan is not required to pay you part of any recovery it may obtain from a third party, even if it files suit in your name.
- the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party.
- in case of your wrongful death, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs.
- your failure to cooperate with the Plan or its agents is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan.
- if a third party causes you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer a Covered Person.

SECTION 12 - WHEN COVERAGE ENDS

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, Foothill-De Anza Community College District will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits will not be provided for health services that you receive for medical conditions that occurred before your coverage ended, even if the underlying medical condition occurred before your coverage ended.

Your coverage under the Plan will end on the earliest of:

- the last day of the month your employment with the District ends;
- the date the Plan ends;
- the last day of the month you stop making the required contributions;
- the last day of the month you are no longer eligible
- the last day of the month in which UnitedHealthcare receives written notice from Foothill-De Anza Community College District to end your coverage, or the date requested in the notice, if later; or
- at the end of a three-month period following the date coverage would normally end for a union Employee who is laid off and has a minimum of five years of continuous service to the District.

Coverage for your eligible Dependents will end on the earliest of:

- the date your coverage ends, except for a Surviving Spouse of a retiree;
- the last day of the month you stop making the required contributions;
- the last day of the month in which UnitedHealthcare receives written notice from Foothill-De Anza Community College District to end your coverage, or the date requested in the notice, if later; or
- the last day of the month your Dependents no longer qualify as Dependents under this Plan.

The Plan will provide written notice to you that your coverage has ended if any of the following occur:

- you permit an unauthorized person to use your ID card or you use another person's ID card;
- you knowingly give UnitedHealthcare false material information including, but not limited to, false information relating to another person's eligibility or status as a Dependent;

- you commit an act of physical or verbal abuse that imposes a threat to Foothill-De Anza Community College District's staff, UnitedHealthcare's staff, a Provider or another Covered Person; or
- you violate any terms of the Plan.

Note: Foothill-De Anza Community College District has the right to demand that you pay back all Benefits Foothill-De Anza Community College District paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Coverage for a Disabled Child

Benefits for Covered Health Services will be continued beyond the maximum age for a Dependent child who is incapable of self-support because of developmental disability or physical handicap and is dependent on you for primary support. You must apply for this continuation within 31 days after the child reaches the maximum age and furnish the District with the following proof that:

- your child is developmentally or physically disabled and not self-supporting;
- the child became developmentally disabled or physically handicapped prior to reaching 19 years of age for Dependent coverage and is covered under this plan; and
- the child is dependent on you for support.

Proof must be given within 31 days after the date the Dependent child reaches the maximum age for coverage. During the two years after the child reaches the maximum age, the District may request proof of the child's continued disability. After two years, the District cannot request proof more often than once a year.

- Continuation ceases on the earliest of:
- the date the child is no longer considered developmentally or physically disabled according to the Plan; or
- the date you fail to provide required proof of handicap; or
- the date Dependent coverage would otherwise cease as described above.

Extended Coverage for Full-time Students

Coverage for an enrolled Dependent child who is a Full-time Student at a post-secondary school and who needs a medically necessary leave of absence will be extended until the earlier of the following:

- one year after the medically necessary leave of absence begins; or
- the date coverage would otherwise terminate under the Plan.

Coverage will be extended only when the enrolled Dependent is covered under the Plan because of Full-time Student status at a post-secondary school immediately before the medically necessary leave of absence begins.

Coverage will be extended only when the enrolled Dependent's change in Full-time Student status meets all of the following requirements:

- the enrolled Dependent is suffering from a serious Sickness of Injury;
- the leave of absence from the post-secondary school is medically necessary, as determined by the enrolled Dependent's treating Physician; and
- the medically necessary leave of absence causes the enrolled Dependent to lose Full-time Student status for purposes of coverage under the Plan.

A written certification by the treating Physician is required. The certification must state that the enrolled Dependent child is suffering from a serious Sickness or Injury and that the leave of absence is medically necessary.

For purposes of this extended provision, the term "leave of absence" shall include any change in enrollment at the post-secondary school that causes the loss of Full-time Student status.

Continuing Coverage Through COBRA

Federal Required Continuation – Consolidated Omnibus Budget Reconciliation Act (COBRA)

COBRA applies to any employer (except the federal government and religious organizations) that: (a) maintains a group health coverage; and (b) normally employed 20 or more employees on a typical business day during the preceding calendar year. For this purpose, "employee" means full-time employees and full-time equivalent for part-time employees.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that your group plan allow qualified persons (described below) to continue group health coverage after it would normally end. The tem "group health coverage" includes any medical, dental, vision care, and prescription drug coverages that are part of your plan. Please note that this Plan is not subject to Cal-COBRA rules.

A. Qualified Person/Qualifying Events

Continuation of group health coverage must be offered to the following person if they would otherwise lose that coverage as a result of the following events:

1) An Employee (and any covered Dependents) following the Employee's:

   a) Termination of employment for a reason other than gross misconduct: or

   b) A reduction in work hours.

   (Note: Taking a family or medical leave under the Federal family & Medical Leave Act (FMLA) is not a qualifying event under COBRA. A

Member qualifies for COBRA when the Member does not return to work after the end of FMLA leave): and

2) An Employee's former spouse (and any Dependent children) following a divorce or legal separation from the Employee; and

3) An Employee's Surviving Spouse (and any Dependent children) following an Employee's death; and

4) An Employee's Dependent child following loss of status as a Dependent under the terms of the group plan (e.g., attaining the maximum age, marriage, joining the armed forces, etc.); and

5) An Employee's spouse (and any Dependent children) following the Employee's entitlement to Medicare; and

6) An Employee's Dependent child who is born to or placed for adoption with the Employee who is on COBRA continuation due to termination of employment or reduction in work hours; and

7) If the group plan covers retired Employees, a retired Employee and his/her Dependents (or surviving Dependents) when retiree health benefits are "substantially eliminated" or terminated within one year before or after the employer files Chapter 11 (United States Code) bankruptcy proceedings.

B. Maximum Continuation Period

Following a qualifying event, health coverage can continue up to the maximum continuation period. The maximum continuation period for an Employee (and any Dependents) following a termination of employment or reduction in work hours is 18 months. The maximum continuation period for an Employee's Dependent child that is born to or placed for adoption with the Employee while on COBRA continuation will extend to the end of the Employee's maximum continuation period.

Following a termination of employment or reduction in work hours, a qualified person may request an 11-month extension of COBRA continuation. The maximum COBRA continuation will be 29 months (see Disabled Extension, Section D below).

When an Employee becomes entitled to Medicare before employment terminates or work hours are reduced, the maximum continuation period for the Dependent will be the longer of:

1) 36 months dating back to the Employee's entitlement to Medicare; or

2) 18 months from the date of the qualifying event (termination of employment or reduction in work hours).

The maximum continuation period for qualified Dependents following a qualifying event described in A(2) through A(5) is 36 months.

If the group plan covers retired Employees and the qualifying event is the employer's bankruptcy filing, the following rules apply;

1) If the retired Employee is alive on the date of the qualifying event, the retired Employee and his or her spouse and Dependent Children may continue coverage for the life of the retired Employee. In addition, if the retired Employee dies while covered under COBRA, the spouse or Dependent Children may continue coverage for an additional 36 months.; or

2) If the retired Employee is not alive on the date of the qualifying event, his or her spouse may continue coverage to the date of his or her death.

C. Second Qualifying Events

If during an 18-month continuation period (or, 29 months for qualified persons on the disabled extension), a second qualifying event described in A(2) through A(5) occurs, the maximum continuation period may be extended for the qualified Dependents up to 36 months. That is, following a second qualifying event, qualified Dependents may continue for up to a maximum of 36 months dating from the Employee's termination of employment or reduction in work hours. The extension is only available if the second qualifying event described in A(2) through A(5), absent the first qualifying event, results in a loss of coverage for Dependents under the group plan. An Employee's Dependent child who is born to or placed for adoption with the Employee who is on COBRA continuation may also be eligible for a second qualifying event that occurred prior to birth or placement for adoption.

D. Disabled Extension

Following a termination of employment or reduction in work hours, a qualified person (Employee or Dependent) who has been determined disabled by the Social Security Administration either before or within 60 days after the qualifying event may request an extension of the continued coverage from 18 months to 29 months. An Employee's Dependent child who is born to or placed for adoption with the Employee who is on COBRA continuation must be determined disabled by the Social Security Administration within 60 days after the date of birth or placement for adoption. The disabled extension also applies to each qualified person (the disabled person and any family members) who is not disabled and who is on COBRA continuation as a result of termination of employment or reduction in work hours.

The 11-month extension for all qualified persons will end the earlier of (a) 30 days following the date the disabled person is no longer determined by Social Security to be disabled, or (b) the date continuation would normally end as outlined in Section E below.

E. Termination of Continued Coverage

Continued coverage ends the earliest of the following:

1) The date the maximum continuation period ends; or

2) The date the qualified person enrolls in Medicare. However, this does not apply to a person who is already enrolled in Medicare on the date he or she elects COBRA or to a person who is on COBRA due to the employer's bankruptcy filling as described in A(7); or

3) The end of the last coverage period for which payment was made if payment is not made prior to the expiration of the grace period. (See Grace Period, Section I.); or

4) The date the group plan is terminated (and not replaced by another group health plan); or

5) The date the qualified person becomes covered by and has satisfied the preexisting exclusion provision of another group health plan, however, this does not apply to a person who is already covered by the other group health plan on the date he or she elects COBRA.

NOTE: Persons who, after the date of COBRA continuation election, become entitled to Medicare or become covered under another group health plan and have satisfied the preexisting exclusion provision, are not eligible for continuation coverage. However, if the group plan covers retired Employees, continued coverage for retired person and their Dependents (or surviving Dependents) due to qualifying event A(7) above may not be terminated due to Medicare coverage.

F. Employer/Plan Administrator Notification Requirement

When an Employee or Dependent becomes ineligible and loses group health coverage due to termination of employment, reduction in work hours, death of the Employee, the Employee entitlement to Medicare, or if the group plan covers retired Employees, the commencement of the employer's Chapter 11 (United States Code) bankruptcy proceedings, the employer must notify the COBRA Administrator of the qualifying event. The COBRA Administrator must notify the qualified person of the right to COBRA continuation within 14 days after receiving notice of a qualifying event form the employer.

G. Qualified Person Notice and Election Requirements

Qualified persons must notify the COBRA Administrator within 60 days after (a) the date of a qualifying event (i.e., divorce, legal separation, or a child ceases to be a Dependent child under the terms of the group plan); (b) the date the qualified persons would otherwise lose coverage as a result of a qualifying event; or (c) the date the qualified person is first informed of this notice obligation;

otherwise the right to COBRA continuation coverage ends. This 60-day notice period applies to initial and second qualifying events.

Qualified persons who request an extension of COBRA due to disability must submit a written request to the COBRA Administrator before the 18-month COBRA continuation period ends and within 60 days after the latest of the following dates: (a) the date of disability determination by the Social Security Administration; (b) the date of the qualifying event; (c) the date the qualified person would otherwise lose coverage as a result of a qualifying event; or (d) the date the qualified person is first informed of this notice obligation; otherwise the right to the disabled extension ends. Qualified persons must also notify the COBRA Administrator within 30 days after the date the Social Security Administration determines the qualified person is no longer disabled.

Notification of a qualifying event to the COBRA Administrator must include the following information: (a) name and identification number of the Employee and each qualified beneficiary; (b) type and date of initial or second qualifying event; (c) if the notice is for an extension due to disability, a copy of any letters from the Social Security Administration and the Notice of Determination; and (d) the name, address and daytime phone number of the qualified person (or legal representative) that the COBRA Administrator may contact if additional information is needed to determine COBRA rights.

Within 14 days after receiving notice of a qualified event from the qualified person, the COBRA Administrator must provide the qualified person with an election notice.

Qualified person must make written election within 60 days after the later of: (a) the date group health coverage would normally end; or (b) the date of the COBRA Administrator's election notice. The election notice must be returned to the COBRA Administrator within this 60-day period; otherwise the right to elect COBRA continuation on behalf of his/her covered Dependent children.

To protect COBRA rights, the COBRA Administrator must be informed of any address changes for covered Employees and Dependents. Retain copies of any notices sent to the COBRA Administrator.

H. Monthly Cost

Persons electing continued coverage can be required to pay 102% of the cost for the applicable coverage (COBRA permits the inclusion of a 2% billing fee). Persons who qualify for the disabled extension and are not part of the family unit that includes the disabled person can be required to pay 102% for the cost of the applicable coverage during the disability extension. Persons who qualify for the disabled extension and are part of the family unit that includes the disabled person can be required to pay 150% of the cost for the applicable coverage (including a 2% billing fee) for the 19th through the 29th month of coverage (or

through the 36th month if a second qualifying event occurs during the disabled extension).

I. Grace Period

Qualified person have 45 days after the initial election to remit the first contribution. The first contribution must include all contributions due when sent. All contributions (except for the first contribution) will be timely if made within the Grace Period. "Grace Period" means the first 30-day period following a contribution due date. Except for the first contribution, a Grace Period of 30 days will be allowed for payment of contributions. Continued coverage will remain in effect during the Grace Period provided payment is made prior to the expiration of the Grace Period. If payment is not made prior to the expiration of the Grace Period, continued coverage will terminate at the end of the last coverage period for which payment was made.

J. Plan Changes

Continued coverage will be subject to the same benefits and rate changes as the group plan.

K. Newly Acquired Dependents

A qualified person may elect coverage for a Dependent acquired during COBRA continuation. All enrollment and notification requirements that apply to Dependents of active Employees acquired by qualified person during COBRA continuation.

Coverage for a newly acquired Dependent will end on the same dates as described for qualified person in Section B above. Exception: Coverage for newly acquired Dependents, other than the Employee's Dependent child who is born to or placed for adoption with the Employee, will not be extended as a result of a second qualifying event.

L. Contact Information

To notify the COBRA Administrator of an initial or second qualifying event, request a disabled extension, request termination of COBRA, change of address, or request additional information concerning the group plan or COBRA, contact the following:

Foothill-De Anza Community College District
Human Resources Department
12345 El Monte Road
Los Altos Hills, CA 94022
650-949-6225

When COBRA Ends

COBRA coverage will end before the maximum continuation period if:

- you or your covered Dependent becomes covered under another group medical plan, as long as the other plan doesn't limit your coverage due to a preexisting condition; or if the other plan does exclude coverage due to your preexisting condition, your COBRA benefits would end when the exclusion period ends;
- you or your covered Dependent becomes eligible for Medicare after electing COBRA;
- the first required premium is not paid within 45 days;
- any other monthly premium is not paid within 30 days of its due date;
- the entire Plan ends; or
- coverage would otherwise terminate under the Plan as described in the beginning of this section.

Note: If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

Federal law requires that if your coverage would otherwise end because you enter into active military duty, you may elect to continue coverage (including Dependents coverage) in accordance with the provisions of Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Continuation

If active employment ends because you enter active military duty, coverage may be continued until the earliest of:

- For you and your Dependents:
  - the date the group plan is terminated; or
  - the end of the contribution period for which contributions are paid if you fail to make timely payment of a required contribution; or
  - the date 18 months after the date you enter active military duty; or
  - the date after the day on which you fail to return to active employment or apply for reemployment with the Plan Administrator.
- For your Dependents:
  - the date Dependent coverage would otherwise cease as provided in this document; or
  - any date desired, if requested by you before that date.

The continuation provision will be in addition to any other continuation provisions described in this plan for sickness, injury, layoff, or approved leave of absence, if any. If you

qualify for both state and USERRA continuation, the election of one means the rejection of the other.

Reinstatement

The reinstatement time period may be extended for an approved leave of absence taken in accordance with the provisions of the federal law regarding USERRA.

This is a general summary of the USERRA and how it affects your group plan. See your employer for details on this continuation provision.

SECTION 13 - OTHER IMPORTANT INFORMATION

Future of the Plan

Although the District expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination. The District's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code, or any other reason.

Plan Document

This Employee Benefit Booklet (booklet) represents an overview of your Benefits. In the event there is a discrepancy between the booklet and the official plan document, the plan document will govern. You (or your personal representative) may obtain a copy of these documents by written request to the Plan Administrator.

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	
	Network	Non-Network
Retail - up to a 30-day supply		
Tier 1	$10 Copay	$10 Copay
Tier 2	$25 Copay	$25 Copay
Tier 3	$50 Copay	$50 Copay
Mail Order - up to a 90-day supply		
Tier 1	$20 Copay	$20 Copay
Tier 2	$50 Copay	$50 Copay
Tier 3	$100 Copay	$100 Copay
You must notify UnitedHealthcare to receive full Benefits for certain Prescription Drugs. Otherwise, you may pay more out-of-pocket. See *Notification Requirements* in the Plan Document for details. 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.		

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.

Lifetime Maximum Benefit

See page 14 of this Booklet for information on the Lifetime Maximum Benefit.

Benefit Levels

Benefits are available for outpatient Prescription Drugs that are considered Covered Health Services.

The Plan pays Benefits at different levels for Generic and Brand Name Prescription Drugs. All Prescription Drugs covered by the Plan are categorized into these levels on the Prescription Drug List (PDL). Since the PDL may change periodically, you can visit **myuhc.com** or call UnitedHealthcare at the toll-free number on your ID card for the most current information.

Each level is assigned a Copay, which is the amount you pay when you visit the pharmacy or order your medications through mail order. Your Copay will also depend on whether or not you visit the pharmacy or use the mail order service - see the table shown at the beginning of this section for further details. Here's how the level system works:

- Generic is your lowest Copay option. For the lowest out-of-pocket expense, you should consider Generic drugs if you and your Physician decide they are appropriate for your treatment.
- Brand Name is your highest Copay option. Consider a Brand Name drug if no Generic drug is available to treat your condition.

Retail

To obtain your prescription from a retail pharmacy, simply present your ID card and pay the Copay. The Plan pays Benefits for certain covered Prescription Drugs:

- as written by a Physician;
- up to a consecutive 30-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits; and
- a one-cycle supply of an oral contraceptive.

Note: Pharmacy Benefits apply only if your prescription is for a Covered Health Service, and not for Experimental and Investigational, or Unproven Services. Otherwise, you are responsible for paying 100% of the cost.

Rx Mail Order

The mail order prescription service may allow you to purchase up to a 90-day supply of a covered maintenance drug through the mail. Maintenance drugs help in the treatment of chronic illnesses, such as heart conditions, allergies, high blood pressure, and arthritis.

To use the mail order prescription service, all you need to do is complete a patient profile and enclose your prescription order or refill. Your medication, plus instructions for obtaining refills, will arrive by mail about 14 days after your order is received. If you need a

patient profile form, or if you have any questions, you can reach UnitedHealthcare customer service toll-free at the number on your ID card.

The Plan pays mail order Benefits for certain covered Prescription Drugs:

- as written by a Physician; and
- up to a consecutive 90-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.

Note: You will be charged a mail order Copay if you use the mail order prescription service, regardless of the number of days' supply that is written on the order or refill. Be sure your Physician writes your mail order or refill for a 90-day supply, not a 31-day supply with three refills.

Notification Requirements

To determine if a Prescription Drug requires notification, either visit **myuhc.com** or call the toll-free number on your ID card. The Prescription Drugs requiring notification are subject to UnitedHealthcare's periodic review and modification.

Before certain Prescription Drugs are dispensed to you, it is the responsibility of your Physician, your pharmacist or you to notify UnitedHealthcare. UnitedHealthcare will determine if the Prescription Drug is:

- a Covered Health Service as defined by the Plan; and
- not Experimental and Investigational or Unproven, as defined in Section 15, *Glossary*.

If UnitedHealthcare is not notified before the Prescription Drug is dispensed, you may pay more for that Prescription Drug order or refill. You will be required to pay for the Prescription Drug at the time of purchase. If UnitedHealthcare is not notified before you purchase the Prescription Drug, you can request reimbursement after you receive the Prescription Drug - see Section 9, *Claims Procedures*, for information on how to file a claim.

Prescription Drug Benefit Claims

For Prescription Drug claims procedures, please refer to Section 9, *Claims Procedures*.

Supply Limits

Erectile dysfunction drugs are subject to a supply limit of 6 pills per month (18 pills if 90-day prescription through mail order).

Other Prescription Drugs may be subject to supply limits that restrict the amount dispensed per prescription order or refill. To determine if a Prescription Drug has been assigned a maximum quantity level for dispensing, either visit myuhc.com or call the toll-free number on your ID card. Whether or not a Prescription Drug has a supply limit is subject to UnitedHealthcare's periodic review and modification.

Exclusions - What the Prescription Drug Plan Will Not Cover

Medications that are:

- available for payment under workers' compensation law or similar laws;
- available over the counter;
- Compounded and do not contain at least one ingredient that requires a prescription – see Section 15, *Glossary* for the definition of Compounded;
- comprised of components that are available in over the counter form or equivalent;
- dispensed outside of the United States, except in an Emergency;
- for smoking cessation;
- in excess of any supply limits (days' supply or quantity limit);
- new drugs and/or new dosages, until they are reviewed and assigned to a tier by the PDL Management Committee;
- oral non-sedating antihistamines or a combination of antihistamines and decongestants;
- prescribed, dispensed or intended for use while you are an inpatient in a Hospital, Skilled Nursing Facility or Alternate Facility;
- prescribed to treat infertility;
- typically administered by a qualified Provider or licensed health professional in an outpatient setting;
- used for conditions and/or at dosages determined to be Experimental and Investigational, or Unproven, unless UnitedHealthcare and Foothill-De Anza Community College District have agreed to cover an Experimental and Investigational or Unproven treatment, as defined in Section 15, *Glossary*;
- used for cosmetic purposes;
- used to replace a Prescription Drug that was lost, stolen, broken or destroyed;

■ Prescription Drugs that contain (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug;

- Prescription Drugs that contain (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug;
- used to treat toenail Onychomycosis (toenail fungus); and
- vitamins, except for the following which require a prescription:

- prenatal vitamins;
- vitamins with fluoride; and
- single entity vitamins.

SECTION 15 - GLOSSARY – MEDICAL PLAN (PPO)

Addendum - any attached written description of additional or revised provisions to the Plan. The benefits and exclusions of this booklet and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and booklet and/or amendments to the booklet, the Addendum shall be controlling.

Alternate Facility – a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- surgical services;
- Emergency health services; or
- rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health or Substance Use Disorder Treatment on an outpatient or inpatient basis.

Autism Spectrum Disorders - a group of neurobiological disorders that includes *Autistic Disorder*, *Rhett's Syndrome*, *Asperger's Disorder*, *Childhood Disintegrated Disorder*, and *Pervasive Development Disorders Not Otherwise Specified (PDDNOS).*

Benefits – Plan payments for Covered Health Services, subject to the terms and conditions of the Plan.

Body Mass Index (BMI) – a calculation used in obesity risk assessment which uses a person's weight and height to approximate body fat.

BMI – see Body Mass Index (BMI).

Cancer Resource Services (CRS) – a program administered by UnitedHealthcare or its affiliates made available to you by your Employer. The CRS program provides:

- specialized consulting services to Participants and enrolled Dependents with cancer;
- access to cancer centers with expertise in treating specific forms of cancer – even the most rare and complex conditions; and
- guidance for the patient on the prescribed plan of care and the potential side effects of radiation and chemotherapy.

Care Coordination[SM] – programs provided by UnitedHealthcare that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

CHD – see Congenital Heart Disease (CHD).

Claims Administrator – UnitedHealthcare (also known as UnitedHealthcare Insurance Company) and its affiliates, who provide certain claim administration services for the Plan.

Clinical Trial – a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA – see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance – the percentage of Eligible Expenses you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*.

Congenital Anomaly – a physical developmental defect that is present at birth and is identified within the first twelve months of birth.

Congenital Heart Disease (CHD) – any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- be passed from a parent to a child (inherited);
- develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy; or
- have no known cause.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – a federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

Continuous Creditable Coverage – health care coverage under any of the types of plans listed below, during which there was no break in coverage of 63 consecutive days or more:

- a group health plan;
- health insurance coverage;
- Medicare;
- Medicaid;
- medical and dental care for members and certain former members of the uniformed services, and for their dependents;
- a medical care program of the Indian Health Services Program or a tribal organization;
- a state health benefits risk pool;
- The Federal Employees Health Benefits Program;
- The State Children's Health Insurance Program (S-CHIP);
- health plans established and maintained by foreign governments or political subdivisions and by the U.S. government;
- any health coverage provided by a governmental entity;

- any public health benefit program provided by a state, county, or other political subdivision of a state; or
- a health benefit plan under the Peace Corps Act.

If you or your eligible Dependents were covered by any of the above plans before first becoming covered by this Plan, you should have received a Certificate of Creditable Coverage when that plan's coverage ended.

Copayment (or Copay) – the set dollar amount you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*.

Cosmetic Procedures – procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator. Reshaping a nose with a prominent bump is a good example of a Cosmetic Procedure because appearance would be improved, but there would be no improvement in function like breathing.

Cost-Effective – the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Health Services – those health services and supplies that are:

- provided for the purpose of preventing, diagnosing or treating Sickness, Injury, Mental Illness, Substance Use Disorder, or their symptoms;
- included in Sections 5 and 6, Plan Highlights and Additional Coverage Details;
- provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*; and
- not identified in Section 8, *Exclusions*.

Covered Person – either the Employee or an enrolled Dependent only while enrolled or eligible for Benefits under the Plan.

CRS – see Cancer Resource Services (CRS).

Custodial Care – services that do not require special skills or training and that:

- provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating);
- do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing; or
- do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dependent:

- Your spouse who is legally married to you, and
    - Is not in the Armed Forces of any country, and
    - Is not covered under this Plan as an Employee, and
    - Who is claimed as a tax dependent on the Employee's Federal tax return
- A Surviving Spouse or Domestic Partner of a Retiree who was a Covered Person at the time of the Retiree's death.
- Your Domestic Partner when both the Employee and Domestic Partner have filed a Declaration of Domestic Partnership with the California Secretary of State or with a similar jurisdiction in another state, and all of the following requirements are met:
        - Both persons have a common residence;
        - Neither person is married to someone else or is a member of another Domestic Partnership with someone else that has not been terminated, dissolved, or adjudged a nullity;
        - The two persons are not related by blood in a way that would prevent them from being married to each other in the State of California;
        - Both persons are at least 18 years of age;
        - Both persons are members of the same sex, or if opposite sex, one or both of the persons is over the age of 62;
        - Both persons are capable of consenting to the domestic partnership.
        - Both persons are financially interdependent..
- Your unmarried natural or legally adapted child, or your spouse's or Domestic Partner's unmarried natural or legally adopted, child, or a child for whom you, your Spouse or Domestic Partner are the legal guardian; if the child:
    - Is under the age of 19, meets the definition of a "qualifying child" under Section 152 of the Internal Revenue code, and is claimed as a tax dependent on the Employee's Federal tax return, and
        - Is not in the armed forces of any country, and
        - Is not covered under this Plan as an Employee, or
    - Is under the age of 24, a full-time student (12 or more units per semester), is not in the armed services of any country, is not covered under this Plan as an Employee, and who meets the definition of a "qualifying child" under Section 152 of the Internal Revenue Code, and is claimed as a tax dependent on the Employee's Federal tax return.
    - Or, if the above criteria is not applicable, your child must meet one of the following two requirements:
        - Must be a dependent child for whom you have a State Qualified Medical Support Order (SQMSO) or a Divorce Decree issued by a Court or administrative agency (in some cases the order may override the residency and/or dependency requirements; or
        - Must be a dependent child between the ages of 19 and 24 for whom you have a National Qualified Medical Support Order (NQMSO) issued by a court or administrative agency to provide coverage (In some cases the order may override the residency and/or dependency requirements).
- Disabled Dependent Children Prior to Age 19:

Medical Expense Coverage will be continued beyond the maximum age of a dependent child who is incapable of self-support because of Developmental Disability or Physical Handicap and is dependent on you for primary support. You must apply for this continuation within 31 days after the child reaches the maximum age and furnish the plan with the following proof that:

- Your child is developmentally disabled or physically handicapped and not self-supporting; and
- The child became developmentally disabled or physically handicapped prior to reaching 19 years of age for Dependent coverage and is covered under this plan.
- The child is claimed as a tax dependent on the Employee's Federal tax return.

Proof must be provided within 31 days from the date the Dependent Child reaches the maximum age for coverage. During the first two years after the child reaches the maximum age, the Planholder has the right to seek medical proof of disability and a copy of the determination letter from Social Security, if applicable, at its discretion as proof of the child's continued disability or handicap. After two years, the Planholder cannot request proof more often than once a year.

- Continuation ceases on the earliest of:
  - The date the child is no longer considered developmentally disabled or physical handicapped according to the Plan; or
  - The date you fail to provide required proof of handicap; or
  - The date Dependent coverage would otherwise cease as described above.

Designated United Resource Networks Facility – a Hospital that has entered into an agreement with the Claims Administrator or with an organization contracting on behalf of the Plan, to provide Covered Health Services for transplantation.

To be considered a Designated United Resource Networks Facility, a facility must meet certain standards of excellence and have a proven track record of performing transplants. The fact that a Hospital is a network Hospital does not mean that it is a Designated United Resource Networks Facility.

District – Foothill-De Anza Community College District.

DME – see Durable Medical Equipment (DME).

Domestic Partner – Domestic Partners residing in California are two adults of the same sex (or of the opposite sex if one or both is age 62 or older) who have chosen to share one another's lives in an intimate and committed relationship of mutual caring. A domestic partnership shall be established in California when both persons file a Declaration of Domestic Partnership with the Secretary of State, and meet all of the requirements for a Domestic Partnership. FHDA also recognizes same sex Domestic Partners who are registered in a similar jurisdiction in another state if they are unable to marry because of laws prohibiting marriage to persons of the same sex in the state of legal residence.

If you reside in a state that does not recognize a same-sex Domestic Partnership, FHDA will provide the District's Affidavit of Domestic Partnership form to you to be completed as evidence of your non-registered Domestic Partnership. It will be necessary that the Partnership meet all of the guidelines listed on the Affidavit. This provision does not apply to opposite-sex domestic partners.

Both the Employee and Domestic Partner must jointly sign the affidavit of domestic partnership form, and must also attest to the IRS dependency of the Domestic Partner and the Domestic Partner's children, if any, to be enrolled. If the Domestic Partner and/or Domestic Partner's children are not certified as tax dependents of the Employee, enrollment of these individuals in the District's plans will result in imputed income to the Employee.

Domiciliary Care – living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME) – medical equipment that is all of the following:

- ordered or provided by a Physician for outpatient use;
- used for medical purposes;
- not consumable or disposable;
- not of use to a person in the absence of a Sickness, Injury or disability;
- durable enough to withstand repeated use; and
- appropriate for use in the home.

Eligible Expenses – charges for Covered Health Services that are provided while the Plan is in effect, determined as follows:

For:	Eligible Expenses are Based On:
Network Benefits	Contracted rates with the Provider
Non-Network Benefits	– selected data resources which, in the judgment of the Claims Administrator, represent competitive fees in that geographic area; or – negotiated rates agreed to by the non-Network Provider and either the Claims Administrator or one of its vendors, affiliates or subcontractors. These provisions do not apply if you receive Covered Health Services from a non-Network Provider in an Emergency. In that case, Eligible Expenses are the amounts billed by the Provider, unless the Claims Administrator negotiates lower rates.

For certain Covered Health Services, you are required to pay a percentage of Eligible Expenses in the form of a Copay and/or Coinsurance.

Eligible Expenses are subject to the Claims Administrator's reimbursement policy guidelines. You may request a copy of the guidelines related to your claim from the Claims Administrator.

Emergency – a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness, or Substance Use Disorder which:

- arises suddenly; and
- in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Employee – a full-time Employee of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. An Employee must live and/or work in the United States.

Experimental and Investigational Services – medical, surgical, diagnostic, psychiatric, Substance Use Disorder or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time UnitedHealthcare and Foothill-De Anza Community College District make a determination regarding coverage in a particular case, are determined to be any of the following:

- not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;
- subject to review and approval by any institutional review board for the proposed use; or
- the subject of an ongoing Clinical Trial that meets the definition of a Phase 1, 2 or 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

If you have a Sickness or Injury that is likely to cause death within one year of the request for treatment, UnitedHealthcare and Foothill-De Anza Community College District may, at their discretion, determine that an Experimental and Investigational Service is a Covered Health Service for that Sickness or Injury. For this to take place, UnitedHealthcare and Foothill-De Anza Community College District must determine that the procedure or treatment is:

- proved to be safe and promising;
- provided in a clinically controlled research setting; and
- using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

EOB – see Explanation of Benefits (EOB).

Explanation of Benefits (EOB) – a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- the Benefits provided (if any);
- the allowable reimbursement amounts;
- Coinsurance;
- any other reductions taken;
- the net amount paid by the Plan; and
- the reason(s) why the service or supply was not covered by the Plan.

Home Health Agency – a program or organization authorized by law to provide health care services in the home.

Hospital – an institution, operated as required by law, which is:

- primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, Substance Use Disorder, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians; and
- has 24 hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a Skilled Nursing Facility, convalescent home or similar institution.

Injury – bodily damage from trauma other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility – a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides physical therapy, occupational therapy and/or speech therapy on an inpatient basis, as authorized by law.

Inpatient Stay – an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

IRS Dependent Child – a person who meets the IRS rules and definition of a dependent child.

Intensive Outpatient Treatment - a structured outpatient Mental Health or Substance Use Disorder treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermediate Care – Mental Health or Substance Use Disorder treatment that encompasses the following:

- care at a Residential Treatment Facility;
- care at a Partial Hospitalization/Day Treatment program; or
- care through an Intensive Outpatient Treatment Program.

Late Enrollee – an Employee or Dependent who enrolls for coverage under the Plan at a time other than:

- within 31 days of the date you first become eligible for coverage under the Plan;
- during an Open Enrollment; and
- within 31 days of the date you experience a change in family status as described under *Changing Your Coverage* in Section 2, *Introduction*.

Lifetime Maximum Benefit – the most the Plan will pay for Benefits during the entire period you are enrolled in this Plan or any other medical plan offered by Foothill-De Anza Community College District. The Lifetime Maximum Benefit is shown in the first table in Section 5, *Plan Highlights*.

Medicaid – a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medicare – Parts A, B, and C of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health and Substance Use Disorder Treatment – treatment for the following:

- any diagnosis which is identified in the current edition of *The Diagnostic and Statistical Manual of the American Psychiatric Association*, including a psychological and/or physiological dependence on alcohol or psychoactive drugs or medications, regardless of any underlying physical or organic cause; and
- any diagnosis where the treatment is primarily the use of psychotherapy or other psychotherapeutic methods.

Mental Health/Substance Use Disorder Administrator – the organization or individual designated by Foothill-De Anza Community College District who provides or arranges Mental Health and Substance Use Disorder Treatment under the Plan.

Mental Illness – mental health or psychiatric diagnostic categories listed in *The Diagnostic and Statistical Manual of the American Psychiatric Association*, unless they are listed in Section 8, *Exclusions*.

Network Provider – a health care Provider who has:

- entered into an agreement with the Claims Administrator or an affiliate; and
- agreed to accept specified reimbursement rates for Covered Health Services.

Open Enrollment – the period of time, determined by Foothill-De Anza Community College District, during which eligible Employees may enroll themselves and their Dependents under the Plan.

Out-of-Pocket Maximum – the maximum amount you pay out-of-pocket every plan year as shown in the first table in Section 5, *Plan Highlights*.

Two separate Out-of-Pocket Maximums apply for network Benefits and non-network Benefits. Once you reach the network Out-of-Pocket Maximum, the Plan pays network Benefits at 100% of Eligible Expenses during the rest of that plan year. Once you reach the non-network Out-of-Pocket Maximum, the Plan pays non-network Benefits at 100% of Eligible Expenses during the rest of that plan year.

The Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 14, *Prescription Drugs*.

Covered Expenses charged by both Network and non-Network Providers apply toward both the network individual and family Out-of-Pocket Maximums and the non-network individual and family Out-of-Pocket Maximums.

The table on page 13 of this booklet identifies what does and does not apply toward your network and non-network Out-of-Pocket Maximums.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Physician – any individual who is practicing medicine within the scope of his or her license, and who is licensed to prescribe drugs. The individual must also be properly licensed and qualified by law to practice in the state in which the Covered Person receives health services.

Plan – The Foothill-De Anza Community College District Medical Plan.

Plan Administrator – Foothill-De Anza Community College District or its designee.

Plan Sponsor – Foothill-De Anza Community College District.

Preexisting Condition – a Preexisting Condition occurs when you or your eligible Dependent receives medical care or has been diagnosed or treated for any Sickness or Injury within six months before coverage under this Plan begins. A Preexisting Condition does not include Pregnancy. Genetic information is not an indicator of a Preexisting Condition, if there is not a diagnosis of a condition related to the genetic information.

If you have Continuous Creditable Coverage, you or your Dependent will be eligible to receive Plan Benefits for a Preexisting Condition. Continuous Creditable Coverage is defined in this section.

Pregnancy – includes prenatal care, postnatal care, childbirth, and any complications associated with Pregnancy.

Provider – a health care professional or facility operating as required by law.

Reconstructive Procedure – a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Residential Treatment Facility - a facility which provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements:

- it is established and operated in accordance with applicable state law for residential treatment programs;
- it provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Administrator;
- it has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient; and
- it provides at least the following basic services in a 24-hour per day, structured milieu:
  - room and board;
  - evaluation and diagnosis;
  - counseling; and
  - referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

Retired Employee – a person who retires while covered under the Plan and is at least 55 years of age with 10 years of service.

Sickness – physical illness, disease or Pregnancy. The term Sickness as used in this booklet does not include Mental Illness or Substance Use Disorder, regardless of the cause or origin of the Mental Illness or Substance Use Disorder.

Skilled Home Health Care – skilled nursing, teaching, and rehabilitation services when:

- they are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient;
- a Physician orders them;
- they are not delivered for the purpose of assisting with activities of daily living, including, but not limited to, dressing, feeding, bathing or transferring from a bed to a chair;
- they require clinical training in order to be delivered safely and effectively; and
- they are not Custodial Care, as defined in this section.

Skilled Nursing Facility – a nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine. For Mental Health Services and Substance Use Disorder Services, any licensed clinician is considered on the same basis as a Specialist Physician.

Spinal Treatment – detection or correction, by manual or mechanical means, of bone or joint dislocation(s) (subluxation) in the body to remove nerve interference or its effects. The nerve interference must be the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Spouse – an individual to whom you are legally married or a Domestic Partner as defined in this section.

Surviving Spouse – a Spouse or Domestic Partner of a deceased Retiree, who at the time of death, was a Covered Person.

Total Disability – an Employee's inability to perform all substantial job duties because of physical or mental impairment, or a Dependent's or retired person's inability to perform the normal activities of a person of like age and gender.

Transitional Care - Mental Health Services/Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- supervised living arrangement which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

True Emergency – True Emergency is defined as level 1 critical care Emergency as determined by the Emergency room Physician and the medical facility, i.e., life threatening situations such as heart attack, stroke, bleeding, etc.

UnitedHealth MyNurse – the primary nurse that UnitedHealthcare may assign to you if you have a chronic or complex health condition. If a UnitedHealth MyNurse is assigned to

you, this nurse will call you to assess your progress and provide you with information and education.

Unproven Services – health services that, according to prevailing medical research, do not have a beneficial effect on health outcomes, and are not based on:

- well-conducted randomized controlled trials; or
- well-conducted cohort studies.

In a randomized controlled trial, two or more treatments are compared to each other, and the patients are not allowed to choose which treatments they receive. In a cohort study, patients who receive study treatment are compared to a group of patients who receive standard therapy. In both cases, the comparison group must be nearly identical to the study treatment group.

If you have a Sickness or Injury that is likely to cause death within one year of the request for treatment, UnitedHealthcare and Foothill-De Anza Community College District may, at their discretion, determine that an Unproven Service is a Covered Health Service for that Sickness or Injury. For this to take place, UnitedHealthcare and Foothill-De Anza Community College District must determine that the procedure or treatment is:

- proved to be safe and promising;
- provided in a clinically controlled research setting; and
- using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Urgent Care – treatment of an unexpected Sickness or Injury that is not life threatening but requires outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering, such as high fever, a skin rash, or an ear infection.

Urgent Care Center – a facility that provides Urgent Care services, as previously defined in this section. In general, Urgent Care Centers:

- do not require an appointment;
- are open outside of normal business hours, so you can get medical attention for minor illnesses that occur at night or on weekends; and
- provide an alternative if you need immediate medical attention, but your Physician cannot see you right away.
-

Glossary - Prescription Drugs

Ancillary Charge – a charge, in addition to the Copay, that you are required to pay for a Brand-name Drug which at your Provider's request, is dispensed when a Generic Drug is

available. (Generic Substitution availability is identified on that Maximum Allowable cost ("MAC") List.) For Prescription Drugs from Network Pharmacies the Ancillary Charge is calculated as the difference between the contracted reimbursement rate for Network Pharmacies for the Prescription Drug dispensed, and the MAC list price of the Generic Drug substitute.

Brand-name Drug - a Prescription Drug that is either:

- manufactured and marketed under a trademark or name by a specific drug manufacturer; or
- identified by UnitedHealthcare as a Brand-name Drug based on available data resources that classify drugs as either Brand-name or Generic Drugs.

Compounded- those medications containing two or more ingredients that are combined "on-site" by a pharmacist, provided at least one of the ingredients is covered by the Plan.

Generic Drug - a Prescription Drug that is either

- chemically equivalent to a Brand-name Drug; or
- identified by UnitedHealthcare as a Generic Drug based on available data resources that classify drugs as either Brand-name or Generic Drugs.

Network Pharmacy - a retail or mail order pharmacy that has:

- entered into an agreement with the Claims Administrator to dispense Prescription Drugs to Covered Persons;
- agreed to accept specified reimbursement rates for Prescription Drugs; and
- been designated by the Claims Administrator as a Network Pharmacy.

PDL - see Prescription Drug List (PDL).

PDL Management Committee - see Prescription Drug List (PDL) Management Committee.

Prescription Drug - a medication, product or device that has been approved by the Food and Drug Administration and that can only be legally dispensed using a prescription order or refill. A Prescription Drug is appropriate for self-administration or administration by a non-skilled caregiver. For purposes of this Plan, Prescription Drugs include:

- inhalers (with spacers);
- insulin;
- the following diabetic supplies:

- insulin syringes with needles;
- blood testing strips - glucose;
- urine testing strips - glucose;

- ketone testing strips and tablets;
- lancets and lancet devices; and
- insulin pump supplies, including infusion sets, reservoirs, glass cartridges, and insertion sets.

Prescription Drug List (PDL) - a list of Prescription Drugs, as identified by the Claims Administrator, for which the Plan pays benefits. This list is subject to review and modification, no more than six times per year.

Prescription Drug List (PDL) Management Committee - the committee that UnitedHealthcare designates for, among other responsibilities, classifying Prescription Drugs into specific tier

SECTION 16 - IMPORTANT ADMINISTRATIVE INFORMATION

Employer Identification Number:

EIN: 94-1597718

Type of Administration:

Self-Insured

Plan Administrator:

Foothill-De Anza Community College District
Human Resources Department
12345 El Monte Road
Los Altos Hills, CA 94022
(650) 949-6625

Plan Sponsor:

Foothill-De Anza Community College District
Human Resources Department
12345 El Monte Road
Los Altos Hills, CA 94022

Agent for Legal Service:

Foothill-De Anza Community College District
Human Resources Department
12345 El Monte Road
Los Altos Hills, CA 94022

Type of Participants Covered Under the Plan:

All eligible active and retired Employees, Surviving Spouses and COBRA beneficiaries of Foothill-De Anza Community College District

Sources and Methods of Contributions To The Plan:

The District pays 100% of the premium for eligible Active Employees and Retirees. Surviving Spouses and COBRA Beneficiaries pay the total premium amount in its entirety.

Employee pays part of Dependent's contribution (if the Employee elects to enroll Dependents in the plan).

District pays part of the contribution.

Ending Date Of Plan's Fiscal Year:

June 30