



FOOTHILL-DE ANZA
Community College District

Office of Human Resources and Equal Opportunity
12345 El Monte Road, Los Altos Hills, CA 94022

TO: All Active Employees
FROM: Christine Vo, Benefits and Workers' Compensation Analyst
DATE: April 6, 2006
RE: **Annual Benefits Open Enrollment (April 10 – 28, 2006)**

Please read the following information on the annual Benefits Open Enrollment Period and the changes to the District Network Only Plan (PPO), District Combined Coverage Medical Plan (PPO+) and Prescription Drug Plan that will go into effect on July 1, 2006.

1) BENEFITS ELECTION FOR JULY 2006 – JUNE 2007

OPEN ENROLLMENT for Plan Year 2006/2007 is **April 10 to April 28**. During this time you have the opportunity to:

- a. Elect to change from one medical plan to another. The District offers three options: 1) Kaiser Foundation Health Plan (HMO), 2) District Combined Coverage Medical Plan (PPO+), and 3) the District Network Only Medical Plan (PPO).
- b. Enroll in Flexible Spending Accounts (FSA).
- c. Enroll in Voluntary Term Life and Accidental Death & Dismemberment Insurance.

The **changes are effective July 1, 2006** and will be applicable for a **twelve (12) month period ending June 30, 2007**.

2) THIRD PARTY ADMINISTRATOR (TPA) CHANGE

Effective July 1, 2006, the District's Self-Funded Medical Plans' TPA will change from Principal Financial Group to **United Healthcare (UHC), GROUP #708611, Customer Care toll free (800) 510-4846**.

3) NEW PPO NETWORKS

Effective July 1, 2006, PPO Network Only Medical Plan (PPO) participants **MUST** choose providers contracted with the **UnitedHealthcare Choice Health Plan**. NO payment will be made to non-contracted providers. The District Combined Coverage Medical Plan (PPO+) offers access to both providers contracted with the **UnitedHealthcare Choice Plus Health Plan** and non-network providers.

To determine if your physician is in the network go to UHC web site: www.provider.uhc.com or contact the UnitedHealthcare Customer Care toll free number: **(800) 510-4846**.

Please note that it is the employee's responsibility to check with the Network to determine whether a chosen provider is contracted with the PPO Network. Using providers outside of the network will increase your out-of-pocket expense.

4) PRESCRIPTION DRUG PLAN

Effective July 1, 2006, the District will change its Pharmacy Benefits Manager to **MEDCO** in partnership with UHC), **GROUP #708611**. Mail order services are also administered by **MEDCO**.

Most major pharmacy chains are included as well as many independent pharmacies. To verify if your local pharmacy is contracted, please call UHC Customer Care at 1-800-510-4846.

MAIL ORDER PRESCRIPTION is provided by **MEDCO**, located in Cincinnati, Ohio. Enclosed is UnitedHealthcare pharmacy benefit information including a mail order form.

The current mail order program provided by Caremark will end June 30, 2006. Please note that by law, remaining mail order refills available through Caremark are not transferable. You must contact your physician(s) for NEW prescriptions (90-day supply plus refills) and submit those to the new carrier (MEDCO). It will take at least two weeks for new prescriptions to be delivered to your home, so plan accordingly.

Please note the Plan requires that all maintenance medications for conditions such as heart disease, diabetes, asthma, birth control, etc. be ordered via the mail order program. Do not submit any other medication requests such as a one-time use or antibiotics. This program is reserved for maintenance medications only; other requests will automatically be denied.

Once your mail order is in place, you can order online from the web site: www.MyUHC.com or call **1-800-4REFILL (1-800-473-3455)** to use the automated refill system.

Please note you will be charged the mail order co-payment (\$30) regardless of the number of the days written on the prescription. Be sure that your physician writes your prescription for a 90-day supply, not a 30-day supply with 3 refills.

To enroll in the automated payment plan for your mail order prescription drug co-pays, call **1-800-948-8779**. This feature will authorize **MEDCO** to keep your credit card number on file and bill future orders and any outstanding balance directly to your credit card.

Prior history of co-payments (from January – June 2006) will be transferred from Caremark to **MEDCO** to ensure the stop loss of \$500 for the Rx Mail Order program.

5) **MyUHC.com – Online Benefits Information Provided by UnitedHealthcare**

During the Open Enrollment period you can access a pre-enrollment web site: www.myuhc.com/groups/fhda to search for PPO contracted providers, rate and compare medical facilities, assess healthcare costs, review your benefit choices, and learn how your medical/pharmacy benefits work.

After July 1, 2006 you can register online with [MyUHC.com](http://www.MyUHC.com). Through MyUHC.com you can search for PPO contracted providers, manage your claims and benefits online, take online health risk assessments, research health topics and participate in group discussions with medical experts.

6) **MANDATORY Medical Benefit Election for all Employees**

ALL benefited employees must enroll online during open enrollment. If you fail to select your medical benefits before the deadline, your coverage will default to your current medical plan, **except** those who are currently insured under the PPO+ Plan. **EMPLOYEES ENROLLED IN THE PPO+ PLAN AND MEDICAL BENEFITS WAIVER* OPTION IN PLAN YEAR 2005/2006 MUST RE-ENROLL OR COVERAGE WILL DEFAULT TO THE PPO NETWORK ONLY PLAN EFFECTIVE JULY 1, 2006.**

*The Medical Benefits Waiver program will end on June 30, 2006. Employees who participated in Plan Year 2005/2006 **must enroll** in one of the District plans (Kaiser, PPO Network Only or PPO+) during open enrollment. Failure to enroll will automatically default participation to the PPO Network Only plan.

7) **PIN NOTIFICATION LETTER FOR BENEFITS ONLINE ENROLLMENT**

Prior to Open Enrollment, UltraLink, the District's online benefits enrollment carrier, will send a customized Personal Identification Number (PIN) to each active employee. This unique Personal Identification Number (PIN) provides the same authority as your signature; it certifies that all the information is complete and true. It also authorizes your 2006-2007 benefit election and payroll deductions.

IMPORTANT: Keep your PIN in a handy place for future use. This PIN will allow you access to the iElect Home Page to view all of the benefit information, confirm your benefit plan elections and coverage, and have easy access to pertinent web sites.

8) **BENEFITS ONLINE ENROLLMENT INFORMATION**

Follow the instructions printed in Ultralink's PIN Notification Letter.

IMPORTANT: When finishing your elections online, you must CLICK the PLEASE CONFIRM button to activate your benefits for the new plan year (July 1, 2006 - June 30, 2007). Otherwise, your election will continue to be in pending status, and no changes will be registered by the system.

Employees who have no access to a District computer or District email system, can send a letter indicating choice of coverage to Christine Vo at the District office. The District will mail a temporary confirmation statement to your home address upon completion of the election.

Employees who elect the PPO+ Medical Plan are required to contribute for dependent coverage. For employees with one dependent, the monthly contribution is **\$150.00**. For employees with two or more dependents, the monthly contribution is **\$200.00**. Contributions will be deducted from your paycheck on a pre-tax basis beginning July 1, 2006. The premium is based on 12 months of coverage. The above rate is subject to change prior to July 1, 2006, pending final renewal rates from medical vendors.

REMEMBER: IF YOU MAKE NO ELECTION TO CHANGE MEDICAL COVERAGE AT THIS TIME, YOUR COVERAGE WILL DEFAULT AUTOMATICALLY TO EITHER KAISER HMO OR THE PPO NETWORK ONLY MEDICAL PLAN ON JULY 1, 2006.

NOTE: By confirming your election online, you authorize changes to your account, including any required payroll deductions. Also understand that you cannot change your selections until the next annual open enrollment (April 2007) unless you have a qualifying "change in family status." If you add or delete a dependent, you must provide documentation (marriage license, legal divorce decree signed by the judge, birth/death certificate, or legal adoption papers and copies of social security card) for each newly enrolled dependent or change in status to Human Resources before the updates/changes can be completed.

All required documentation must be submitted to the Human Resources Office by **April 28, 2006**. We cannot process benefit requests and your added dependent(s) will not be covered on July 1, 2006 if we do not receive the necessary documents.

If you have any questions concerning the medical health plans or experience difficulty enrolling online, please contact Christine Vo via e-mail VoChristine@fhda.edu. **For information regarding the District Combined Medical Plan (PPO+) and the District Network Only (PPO) Plans, UnitedHealthcare PPO Choice and Choice Plus Networks, verification of contracted medical providers, transition of care, FSA eligible/non-eligible expenses, please contact **United Healthcare Customer Care at: 1-800-510-4846, Group #708611.****

For ALL programs, it is the employee's responsibility to notify the District of any changes regarding eligibility. Failure to act in a timely manner may disqualify you from receiving District paid benefits and/or denial of your benefits claim. You are required to notify the District's Human Resources office in writing within **31 days** whenever there is a change in dependent status and within **10 days** if there is a change in address. Your prompt cooperation in this matter is greatly appreciated.

NOTE: Employees who make a change in Medical Plan or added/deleted dependent(s) will receive an official benefits confirmation statement from UltraLink by May 19th for verification.

9) CHIROPRACTIC CARE – Prior Authorization Required for PPO+ Medical Plan

Effective July 1, 2006, the PPO+ Medical Plan is enforcing the **Prior Authorization** requirement for chiropractic treatment after the initial 12 visits. The maximum annual allowance under the Plan remains at 30 visits. Medical services provided under chiropractic care are subject to medical necessity.

10) TRANSITION OF CARE

Transition of Care is provided to a member who is in a course of treatment with a CCN contracted provider that is not a contracted provider with the UnitedHealthcare Choice or Choice Plus Health Plan. The goal is to provide continuity of care by allowing patients to retain their current provider(s) for a maximum period of 90 days until the care can be transferred to a contracted (UnitedHealthcare Choice or Choice Plus Health Plan) provider. Qualifying clinical decisions include: (1) Pregnancy (2nd Trimester), and (2) Serious Medical Condition (follow-up care for surgery, cancer therapies, end stage renal disease and dialysis, behavioral health/substance abuse, transplants) (CHOICE PLUS enrollees may continue to use their out-of-network providers.)

For information regarding *Transition of Care* or to request a form contact **United Healthcare Customer Care at: 1-800-510-4846**. The form must be submitted directly to UnitedHealthcare for processing and approval no later than June 30, 2006. Transition of care decisions are made on a case by case basis by the UnitedHealthcare Care Coordination team.

11) KAISER'S LIVE-WORK ELIGIBILITY RULE

The current **Kaiser's Live-Work Eligibility Rule** allows active employees who reside within the state of California and work in the Kaiser service area, to enroll in the Kaiser Medical Plan regardless of their residence. Article 19 retirees and full-time retirees are not eligible.

12) DISEASE MANAGEMENT PROGRAM

Effective July 1, 2006, the District Self-Funded Medical Plan (PPO Network Only and PPO+) is replacing the American Healthways with **UnitedHealth FOCUS**.

FOCUS is a comprehensive disease management program for individuals who are living with a chronic condition or dealing with complex health care needs such as: coronary artery disease, diabetes, asthma, etc. The goal of FOCUS is to provide a high level of support and information. With FOCUS, you have telephonic access to a registered nurse assigned to you and your family. FOCUS provides access to resources that will help you make health care decisions. The benefits of having FOCUS nurse include:

- Individualized information to help you find ways to improve your health
- A plan to help you learn about preventive care and treatment options
- Proactive outreach to your doctors and specialists.

Members who are currently participating in the Healthways program will be transferred to the new UnitedHealth FOCUS.

13) HEALTH MANAGEMENT PROGRAM

Effective July 1, 2006, the District Self-Funded Medical Program will implement a Health Management program through **Optum Connect24** (in partnership with United Healthcare).

The program is designed to assist at-risk employees by offering appropriate interventions to manage their overall health care services. By analyzing the results from employees' health assessments and utilizing the Optum lifestyle intervention program with personal health coaching, we hope to achieve measurable health improvements for those at risk. This proactive approach will prevent more individuals from entering the high-risk, high-cost, chronically ill category. Qualified participants are matched with a health behavior specialist for personal coaching by telephone and referrals.

14) DEPENDENT VERIFICATION

The District incurs significant costs to provide group insurance coverage for employees and their dependents. To ensure that only eligible dependents are enrolled and to meet health plan contract obligations, the District must verify family member eligibility. Therefore, the District and the insurance carriers reserve the right to request documentation (tax records) to verify enrolled family members. Please do not submit any documentation unless HR/Benefits or your carrier requests it.

Effective July 1, 2006, the District is contracted with **UltraLink** to perform an ongoing verification of enrolled dependent children who are 19 years or older for all insurance carriers (United Healthcare, Delta Dental and Vision Service Plan). You are no longer required to submit separate tax returns to individual carriers. By June 1, 2006, employees who have enrolled any over-aged dependent via open enrollment will be required to respond to an audit from UltraLink. Employees will have 30 days to respond. You are required to submit a copy of your **2005 Federal Income Return (form 1040)**. **Please do not provide any supplemental tax records, only the first page is required. It is your responsibility to file your taxes on time as there will be no exceptions. Failure to provide the required documentation when requested will disqualify the dependent for coverage.**

Thereafter, dependents age 19 and older will be notified 60 days prior to the birth month to comply with the verification process. **Failure to comply will result in termination of coverage on the last day of the birth month and re-enrollment will not be allowed until the next plan year.** In addition, employees may be responsible for any employer contributions to and benefits paid by the plan for ineligible coverage.

For information regarding group health plans or claim forms, you can now access the information via our web site: <http://hr.fhda.edu/benefits>.

IMPORTANT: This is a summary of the most frequently used benefit provisions. Please refer to the Evidence of Coverage or the Summary Plan Description for complete details of benefit limitations, exclusions and general program parameters.

Attachments:

Voluntary Benefits

Filing Claims

USERRA/WHCRA Notice

Summary of Benefits for PY 2006/2007

Delta Dental Plan of Summary Description (SPD)

<p>THE DEADLINE FOR OPEN ENROLLMENT FOR PLAN YEAR 2006-2007 is Friday, April 28, 2006 – 5:00 P.M.</p>
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