



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

TO: All Retirees, Surviving Spouses and COBRA Enrollees  
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 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).

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

**IMPORTANT:** If you make no election to change medical coverage, and/or add/delete dependent(s) your coverage will default automatically to your current coverage on July 2006.

**To insure under the PPO Network Only Medical Plan, you must have access to contracted PPO providers and facilities within the 30 miles radius from your home residence. Otherwise, you must select the PPO+ Plan.**

Members who reside outside of the U.S. territory or in non-PPO service areas will default automatically to the PPO+ Plan and premiums will be billed accordingly.

Pursuant to the agreements with the bargaining units you are required to sign up for Medicare Part B if you are eligible. Each retiree and every eligible dependent shall, upon obtaining eligibility for Medicare, notify the District of his/her eligibility. **It is the sole responsibility of the retired employee and his or her eligible dependents to apply for and satisfy the requirements of Medicare.** The District will reimburse retired employees and eligible dependents for the cost of optional Medicare, Part B on a quarterly basis (March, June, September, and December).

NOTE: The signed Request to Change Benefit Plan form authorizes changes to your account and the monthly billing, if required for your selection. Retirees with one or more dependents who select the PPO+ Plan will be billed by UHCDirectBill accordingly. 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 documents must be submitted to the Human Resources Office by April 28, 2006. We cannot process benefit requests for the new Plan Year 2006/2007 without the required information.

Your added dependent(s) will not be covered effective July 1, 2006 if we do not receive the necessary documents.

For ALL programs, it is the retiree'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: All retirees will receive an official benefits confirmation statement from UltraLink by May 19th for verification.**

## **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](http://www.provider.uhc.com) or contact the UnitedHealthcare Customer Care toll free number: **(800) 510-4846.**

Please note that it is the retiree'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](http://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) 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.

**6) 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](http://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://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.

**7) UHCDirectBill BUSINESS UNIT – Billing Service provided by UnitedHealthcare**

Effective July 1, 2006, the District is replacing Principal with **UHCDirectBill** to handle all billing.

Retirees who elect to continue the PPO+ Medical Plan are required to contribute for dependent coverage. For retirees with one dependent, the monthly contribution is **\$150.00**. For retirees with two or more dependents, the monthly contribution is **\$200.00**. UHCDirectBill will bill you directly for these costs beginning July 1, 2006. The above rate is subject to change prior to July 1, 2006, pending final renewal rates from medical vendors.

For information regarding retirees' billing or Automated Clearing House (ACH), which is a nationwide electronic funds transfer (EFT) system, please contact **UHCDirectBill, P. O. Box 224708, Dallas, TX 75222, Customer Service Phone (866) 747-0048 (service available after June 15, 2006)**. Surviving Spouses and COBRA enrollees will continue to be billed by the District.

**IMPORTANT: For the July 2006 premium, you must pay the bill with a regular check. Thereafter, an ACH service will be available. An ACH form will be provided along with the initial billing for your convenience.**

Please ensure that the check or money order is signed, properly dated, and references your account number on the lower left corner of check. Make the check payable to: **UHCDirectBill**.

Effective July 1, 2006, you may also obtain information, print Premium Statements and communicate with UHCDirectBilling Service Unit by visiting their web site: [www.uhcdirectbill.info](http://www.uhcdirectbill.info). You will need your Social Security Number and birth date for your initial log in. You should receive a password from UHCDirectBill within two days of your initial log in. This password should be retained for future log in purposes.

## 8) 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 (2<sup>nd</sup> 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.

## 9) MANDATORY SECONDARY COVERAGE FOR QUALIFIED MEDICARE PARTICIPANTS

Effective July 1, 2006, the District Self-Funded Medical Plans will strictly enforce the **SECONDARY PAYER RULE** to all Qualified Medicare participants who utilize medical services provided by the Plan. Qualified Medicare retirees and 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. Please note your physician **must be** a Medicare contracted provider, however, he/she does not have to accept Medicare assignment. **Failure to comply will result in non-payment of these claims. (Non-Medicare participants can still use non-Medicare providers).**

## 10) KAISER MEDICAL PLAN

**A. ELIGIBILITY RULE:** Please note: Members who reside outside of the Kaiser service area are not qualified to be insured under the Kaiser Program. You can only select the District Combined Coverage Medical Plan (PPO+) or the District Network Only Plan (PPO). Retirees who reside within the greater Santa Cruz and Monterey counties, or part of the Pope Valley and Bells Station communities, which lie within the zip codes 94567 and 95020 are not in the Kaiser service area.

**B. SENIOR ADVANTAGE PROGRAM:** Retirees who are insured under Kaiser Foundation Health Plan must notify Kaiser Permanente as soon as they become eligible for Medicare and must sign up for the Kaiser Senior Advantage Plan. The Plan is identical to the District Kaiser Plan. This action is necessary to authorize Kaiser to do direct billing for all your medical claims with Medicare as primary. In return, the District receives a reduced premium for your medical coverage. Failure to comply may disqualify you from all District paid benefits.

**C. HOW TO TRANSFER FROM KAISER PLAN TO PPO PLAN:** If you are currently a Medicare recipient enrolled in the Kaiser Senior Advantage Program and wish to transfer your coverage to the District PPO or PPO+ Plan for the Plan Year 2006/2007, you must request a **Senior Advantage Disenrollment Form** from Christine Vo to disallow Kaiser the right to bill Medicare effective July 1, 2006.

## 11) 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.

## 12) 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 retirees by offering appropriate interventions to manage their overall health care services. By analyzing the results from 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.

## 13) 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.**

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