

PLAN	ALTERNATIVE CARE				OTHER BENEFITS		
	Hospice (Inpatient)	Hospice (Outpatient)	Home Health Care	Skilled Nursing Facility	Outpatient X-Ray and Lab	Eye Exams	Chiropractor
<b>Health Net (HMO)</b>	No charge	No charge	No charge	No charge	No charge	\$10	Not covered
<b>Kaiser—CA (HMO)</b>	No charge	No charge	No charge (part time or intermittent care only)	No charge	No charge	\$10	Not covered
<b>PacifiCare—CA (HMO)</b>	\$250 copayment per occurrence or admittance	No charge	No charge	No charge	No charge	\$10	Not covered
<b>Western Health Advantage (HMO)</b>	No charge	No charge	No charge	No charge (to 100 days per benefit period)	No charge	\$10	Not covered
<b>Blue Cross PLUS In-Network (POS)</b>	No charge	No charge	No charge	No charge	No charge	\$20 (medically necessary)	\$20 (Network Panel only)
<b>Blue Cross PLUS Out-of-Network</b>	30%	30%	30% <sup>2</sup> Up to 100 visits/ calendar year	30% <sup>2</sup> Up to 240 days/ calendar year	30%	Not covered	Not covered
<b>Blue Cross PPO In-Network (PPO)</b>	20%	20%	20% (preauthorization required) <sup>3</sup> (up to 100 visits/ calendar year combined PPO and non-PPO)	20% (preauthorization required) <sup>3</sup> (up to 240 days/ calendar year combined PPO and non-PPO)	20%	20% (medically necessary)	20%
<b>Blue Cross PPO Out-of-Network</b>	20%	20%	40% (preauthorization required) <sup>3</sup> (up to 100 visits/ calendar year combined PPO and non-PPO)	40% (preauthorization required) <sup>3</sup> (up to 240 days/ calendar year combined PPO and non-PPO)	40%	Not covered	40%
<b>Core (Fee-for-service)</b>	20% (Lifetime Maximums: Inpatient 30 days)	20% (Lifetime Maximums: Outpatient \$5,000)	20% (up to 100 visits/ calendar year)	20% (up to 120 days/ calendar year)	20%	20% (medically necessary)	20%

## Definitions

**Copayments:** Shown in dollars; represents the amount you pay.

**Coinsurance:** Shown as a percentage; represents the percentage of the usual, customary and reasonable amount you pay.

**Usual, Customary and Reasonable (UCR):** UCR is the amount established by insurance companies to determine the maximum amount they will consider eligible for reimbursement. Your provider may charge substantially more than the UCR and you will be responsible for the difference.

# Medical Benefits Summary: 2005

## (Non-Medicare) California

Acupuncture	PRESCRIPTION DRUGS		BEHAVIORAL HEALTH			
	Retail	Mail Order	Mental Health Inpatient	Mental Health Outpatient	Substance Abuse Inpatient	Substance Abuse Outpatient
Not covered	Generic: \$10 Brand: \$20 Non-Formulary: \$35	Generic: \$20 Brand: \$40 Non-Formulary: \$70	\$250 copayment per occurrence or admittance	\$10	\$250 copayment per occurrence or admittance	\$10
Not covered	Generic: \$10 Brand: \$20 Non-Formulary: does not apply	Mail order refills can be arranged	\$250 copayment per occurrence or admittance	\$10 for individual visit; \$5 for group visit	\$250 copayment per occurrence or admittance. \$100 copayment for home transitional residential recovery services up to 60 days per calendar year	\$10 for individual visit; \$5 for group visit
Not covered	Generic: \$10 Brand: \$20 Non-Formulary: \$35	Generic: \$20 Brand: \$40 Non-Formulary: \$70	\$250 copayment per occurrence or admittance	\$10	\$250 copayment per occurrence or admittance	\$10
Not covered	Generic: \$10 Brand: \$20 Non-Formulary: \$35	Generic: \$20 Brand: \$40 Non-Formulary: \$70	\$250 copayment per occurrence or admittance	\$10	\$250 copayment per occurrence or admittance	\$10
\$20 (Network Panel only)	(30-day supply) \$15 generic formulary/\$25 brand formulary/ \$40 non-formulary	(90-day supply) \$30 generic formulary/\$50 brand formulary/ \$80 non-formulary	No copayment (preauthorization required)	Visits 1–5: No copayment. Visits 6+: \$10 (waived for children up to age 6) (preauthorization required)	20% (\$100 calendar year deductible) (preauthorization required) <sup>4</sup>	20% (preauthorization required)
Not covered	At participating pharmacies: <sup>6</sup> (30-day supply) \$15 generic formulary/\$25 brand formulary/ \$40 non-formulary	(90-day supply) \$30 generic formulary/\$50 brand formulary/ \$80 non-formulary <sup>7</sup>	30% (\$200 non-notification penalty per admission) <sup>5</sup>	30% with notification (50% without). Limited to 20 visits per year. <sup>5</sup>	30% (\$200 non-notification penalty per admission) <sup>4, 5</sup>	30% (\$200 non-notification penalty per course of treatment) <sup>5</sup>
20%	(30-day supply) \$15 generic formulary/\$25 brand formulary/ \$40 non-formulary	(90-day supply) \$30 generic formulary/\$50 brand formulary/ \$80 non-formulary	No copayment (preauthorization required)	Visits 1–5: No copayment. Visits 6+: \$10 (waived for children up to age 6) (preauthorization required)	20% (\$100 calendar year deductible) (preauthorization required) <sup>4</sup>	20% (preauthorization required)
40%	At participating pharmacies: <sup>6</sup> (30-day supply) \$15 generic formulary/\$25 brand formulary/ \$40 non-formulary	(90-day supply) \$30 generic formulary/\$50 brand formulary/ \$80 non-formulary <sup>7</sup>	40% (\$200 non-notification penalty per admission) <sup>5</sup>	40% with notification (60% without). Limited to 20 visits per year. <sup>5</sup>	40% (\$200 non-notification penalty per admission) <sup>4, 5</sup>	40% (\$200 non-notification penalty per course of treatment) <sup>5</sup>
20% (\$500 maximum/calendar year)	20%	No mail order benefit	Not covered	Not covered	Not covered	Not covered

(continued on reverse)

**Note: Benefits show what member pays.**

**Benefits for each plan are described generally.** For detailed information, call the plan or see their website for specific benefits, provider information, and plan booklets.

**Service areas:** To determine if a medical plan provides service where you live, call the plan directly or see their website.

**For plan website links,** visit UC's HR/Benefits website, At Your Service (<http://atyourservice.ucop.edu>).

2 Not covered if services are not preauthorized.

3 Preauthorization required for PPO and non-PPO facilities; waived for emergency admissions. Penalty for not obtaining preauthorization where required is \$200 per occurrence or admittance.

4 30% coinsurance penalty for non-compliance with treatment plan.

5 Separate behavioral health deductible applies.

6 At non-participating pharmacy (30-day supply): 50% of average wholesale price schedule plus charges above the schedule.

7 Must use plan mail order facility.

# Medical Benefits Summary: 2005

## (Non-Medicare) California

PLAN	COSTS			HOSPITAL SERVICES		
	Calendar Year Deductible	Annual Out-of-Pocket Maximum	Lifetime Maximum	Inpatient	Surgeon/Assistant Surgeon	Emergency Room
<b>Health Net (HMO)</b> 1-800-522-0088	\$0	One person: \$1,000 Family (3 persons or more): \$3,000	No overall maximum lifetime benefit. May have lifetime maximums for specific benefits; see plan booklet.	\$250 copayment per occurrence or admittance	No charge	\$50 (waived if admitted)
<b>Kaiser—CA (HMO)</b> 1-800-464-4000	\$0	Individual: \$1,500 Family (3 persons or more): \$3,000	No overall maximum lifetime benefit. May have lifetime maximums for specific benefits; see plan booklet.	\$250 copayment per occurrence or admittance	No charge	\$50 (waived if admitted)
<b>PacifiCare—CA (HMO)</b> 1-800-624-8822	\$0	Individual: \$1,000 Family (3 persons or more): \$3,000	No overall maximum lifetime benefit. May have lifetime maximums for specific benefits; see plan booklet.	\$250 copayment per occurrence or admittance	No charge	\$50 (waived if admitted)
<b>Western Health Advantage (HMO)</b> 1-888-563-2252	\$0	Individual: \$1,000 Family (2 persons or more): \$3,000	No overall maximum lifetime benefit. May have lifetime maximums for specific benefits; see plan booklet.	\$250 copayment per occurrence or admittance	No charge	\$50 (waived if admitted)
<b>Blue Cross PLUS In-Network (POS)</b> 1-888-209-7975	\$0	Individual: \$1,500 Family: \$4,500	Unlimited	\$250 copayment	No charge	\$75 per visit (waived if admitted)
<b>Blue Cross PLUS Out-of-Network</b> 1-888-209-7975	Individual: \$500 Family: \$1,500	Individual: \$5,000 Family: \$15,000	\$2,000,000	30%	30%	\$75 per visit (waived if admitted)
<b>Blue Cross PPO In-Network (PPO)</b> 1-888-209-7975	Individual: \$250 Family: \$750	Individual: \$3,000 Family: \$9,000	\$5,000,000 (combined in-network and out-of-network)	20%	20%	20%
<b>Blue Cross PPO Out-of-Network</b> 1-888-209-7975	Individual: \$500 Family: \$1,500	Individual: \$6,000 Family: \$18,000	\$5,000,000 (combined in-network and out-of-network)	40%	40%	20%
<b>Core (Fee-for-service)</b> 1-888-209-7975	Individual: \$3,000	Individual: \$7,600	\$2,000,000	20% (preauthorization required) <sup>1</sup>	20%	20%

## Definitions

**Calendar Year Deductible:** The amount you must pay for medical services before the plan will provide benefits.

**Annual Out-of-Pocket Maximum:** The amount you must pay during the calendar year before the plan will pay 100% of covered charges. Some expenses do not apply toward the maximum; see the plan's evidence of coverage booklet.

**Lifetime Maximum:** The most that will be payable for any person in his/her lifetime.

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**Coinsurance:** Shown as a percentage; represents the percentage of the usual, customary and reasonable amount you pay.

**Usual, Customary and Reasonable (UCR):** UCR is the amount established by insurance companies to determine the maximum amount they will consider eligible for reimbursement. Your provider may charge substantially more than the UCR and you will be responsible for the difference.

PHYSICIAN VISITS						
Ambulance	Office Visit	Hospital Visit	Preventive Physical Exam	Maternity Outpatient Care	Maternity Inpatient Care	Well Baby Care
No charge	\$10	No charge	\$10 for Periodic Health Evaluations	No charge	\$250 copayment per occurrence or admittance	No charge to age 2
No charge	\$10	No charge	\$10	No charge	\$250 copayment per occurrence or admittance	No charge to age 2 (no charge through 23 months)
No charge	\$10	No charge	\$10	No charge	\$250 copayment per occurrence or admittance	No charge to age 2
No charge	\$10	No charge	\$10	No charge	\$250 copayment per occurrence or admittance	No charge to age 2
No charge	\$20	No charge	\$20	\$20 first visit, no charge thereafter	\$250 copayment	No charge up to age 7
30% (no copayment if emergency)	30%	30%	30%	30%	30%	No charge up to age 7 (deductible waived)
20%	20%	20%	20% (deductible waived) age 7 and older	20% (deductible waived)	20%	No charge up to age 7 (deductible waived)
20%	40%	40%	40% (deductible NOT waived) age 7 and older	40% (deductible NOT waived)	40%	No charge up to age 7
20%	20%	20%	20%	20%	20%	20%

(continued on reverse)

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## Medical Plans—Employee Monthly Costs for 2005

### \$40,000 or Less—Medical Contribution Base

Plan	Self	Self + Child(ren)	Self + Adult	Self + Adult + Child(ren)
Blue Cross PLUS	\$59.44	\$107.00	\$124.83	\$172.37
Blue Cross PPO	83.12	149.62	174.55	241.04
Core	0.00	0.00	0.00	0.00
Definity Health (UCSF and UCSB)	29.17	52.51	74.40	97.74
Health Net	12.29	22.12	25.81	35.62
Kaiser Permanente—California	3.50	6.30	7.35	10.15
Kaiser Permanente—Mid-Atlantic	46.71	83.38	97.87	134.53
Kaiser Umbrella	213.60	384.48	482.10	652.98
PacifiCare of California	12.84	23.11	26.97	37.23
PacifiCare of Nevada	155.71	280.28	360.53	485.10
UnitedHealthcare Select EPO	78.84	141.22	165.33	227.71
Western Health Advantage (WHA)	4.08	7.34	8.56	11.82

### \$40,001–\$80,000—Medical Contribution Base

Plan	Self	Self + Child(ren)	Self + Adult	Self + Adult + Child(ren)
Blue Cross PLUS	\$69.49	\$125.10	\$159.09	\$214.68
Blue Cross PPO	99.21	178.59	221.49	300.87
Core	0.00	0.00	0.00	0.00
Definity Health (UCSF and UCSB)	37.17	66.91	91.20	120.94
Health Net	25.27	45.49	66.21	86.43
Kaiser Permanente—California	12.79	23.02	32.43	42.60
Kaiser Permanente—Mid-Atlantic	69.62	125.31	173.52	229.22
Kaiser Umbrella	221.60	398.88	498.90	676.18
PacifiCare of California	26.39	47.51	68.57	89.69
PacifiCare of Nevada	166.68	300.01	377.33	510.67
UnitedHealthcare Select EPO	76.84	138.31	188.67	250.15
Western Health Advantage (WHA)	13.04	23.47	36.80	45.82

(continued on reverse)

## Employee Medical Plan Rates

The University pays the greater portion of monthly medical plan premiums in 2005, and employees pay the balance shown in the tables.

### Four Rate Categories

The four categories of coverage shown (Self, Self+Child(ren), Self+Adult, and Self+Adult+Child(ren)) are designed to align premiums with actual plan utilization and the differences in costs of care for children and adults.

### Four Rate Levels Based on Salary

The four-level rate structure shown in the four tables is based on full-time salary rates. This structure allows UC to provide larger monthly employer contributions for those earning less to help alleviate a disproportionate premium burden for those who are lower paid.

## Medical Plans—Employee Monthly Costs for 2005 (cont.)

### \$80,001–\$120,000—Medical Contribution Base

Plan	Self	Self + Child(ren)	Self + Adult	Self + Adult + Child(ren)
Blue Cross PLUS	\$ 85.30	\$153.53	\$205.63	\$273.86
Blue Cross PPO	118.24	212.82	274.80	369.38
Core	0.00	0.00	0.00	0.00
Definity Health (UCSF and UCSB)	49.17	88.51	116.40	155.74
Health Net	39.41	70.93	109.26	140.78
Kaiser Permanente—California	22.00	39.60	57.45	74.92
Kaiser Permanente—Mid-Atlantic	81.62	146.91	198.72	264.02
Kaiser Umbrella	233.60	420.48	524.10	710.98
PacifiCare of California	41.19	74.13	113.00	145.94
PacifiCare of Nevada	178.68	321.61	402.53	545.47
UnitedHealthcare Select EPO	88.84	159.91	213.87	284.95
Western Health Advantage (WHA)	22.00	39.60	65.20	79.94

### Over \$120,000—Medical Contribution Base

Plan	Self	Self + Child(ren)	Self + Adult	Self + Adult + Child(ren)
Blue Cross PLUS	\$101.30	\$182.33	\$239.23	\$320.26
Blue Cross PPO	134.24	241.62	308.40	415.78
Core	0.00	0.00	0.00	0.00
Definity Health (UCSF and UCSB)	65.17	117.31	150.00	202.14
Health Net	55.41	99.73	142.86	187.18
Kaiser Permanente—California	38.00	68.40	91.05	121.32
Kaiser Permanente—Mid-Atlantic	97.62	175.71	232.32	310.42
Kaiser Umbrella	249.60	449.28	557.70	757.38
PacifiCare of California	57.19	102.93	146.60	192.34
PacifiCare of Nevada	194.68	350.41	436.13	591.87
UnitedHealthcare Select EPO	104.84	188.71	247.47	331.35
Western Health Advantage (WHA)	38.00	68.40	98.80	126.34

By authority of the Regents, University of California Human Resources and Benefits, located in Oakland, administers all benefit plans in accordance with applicable plan documents and regulations, custodial agreements, University of California Group Insurance Regulations, group insurance contracts, and state and federal laws. No person is authorized to provide benefits information not contained in these source documents, and information not contained in these source documents cannot be relied upon as having been authorized by the Regents. Source documents are available for inspection upon request (1-800-888-8267). What is written here does not constitute a guarantee of plan coverage or benefits—particular rules and eligibility requirements must be met before benefits can be received. The University of California intends to continue the benefits described here indefinitely; however, the benefits of all employees, retirees, and plan beneficiaries are subject to change or termination at the time of contract renewal or at any other time by the University or other governing authorities. The University also reserves the right to determine new premiums, employer contributions and monthly costs at any time. Health and welfare benefits are not accrued or vested benefit entitlements. UC's contribution toward the monthly cost of the coverage is determined by UC and may change or stop altogether, and may be affected by the state of California's annual budget appropriation. If you belong to an exclusively represented bargaining unit, some of your benefits may differ from the ones described here. Contact your Human Resources Office for more information.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides for continued coverage for a certain period of time at applicable monthly COBRA rates if you, your spouse, or your dependents lose group medical, dental, or vision coverage because you terminate employment (for reasons other than gross misconduct); your work hours are reduced below the eligible status for these benefits; you die, divorce, or are legally separated; or a child ceases to be an eligible dependent. Note: The continuation period is calculated from the earliest of these qualifying events and runs concurrently with any other UC options for continued coverage. See your Benefits Representative for more information.

In conformance with applicable law and University policy, the University is an affirmative action/equal opportunity employer. Please send inquiries regarding the University's affirmative action and equal opportunity policies for staff to Director of Diversity and Employee Programs, University of California Office of the President, 300 Lakeside Drive, Oakland, CA 94612 and for faculty to Director of Academic Affirmative Action, University of California Office of the President, 1111 Franklin Street, Oakland, CA 94607.



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