

PLAN	ALTERNATIVE CARE			OTHER BENEFITS		
	Hospice (Inpatient)	Home Health Care	Skilled Nursing Facility	Outpatient X-Ray and Lab	Eye Exams	Chiropractor
<b>SELECT EPO</b>	10%; no deductible (maximum \$7,400 per lifetime). Notification required by physician.	10%; no deductible. Notification required.	10% (100 day maximum per calendar year); no deductible. Notification required by physician.	10%	Medically necessary: \$20. Routine exams not covered.	\$20 (20 visits per calendar year)
<b>OPTIONS PPO New Mexico In-Network</b>	10%; no deductible (maximum \$7,400 per lifetime) <sup>5</sup>	10%; no deductible. Notification required.	10% (100 days per calendar year); no deductible. <sup>5</sup>	10%	Medically necessary: \$20. Routine exams not covered.	\$20 (20 visits per calendar year)
	<b>Out-of-Network<sup>4</sup></b>	40%; no deductible (maximum \$7,400 per lifetime) <sup>5</sup>	40% (100 visits per calendar year; no deductible)	40% (70 days per calendar year); no deductible. <sup>5</sup>	40%	Medically necessary: 40%. Routine exams not covered.
<b>National In-Network</b>	10%; no deductible (maximum \$7,400 per lifetime) <sup>5</sup>	10%; no deductible. Notification required.	10% (100 days per calendar year); no deductible. <sup>5</sup>	10%	Medically necessary: \$20. Routine exams not covered.	\$20 (20 visits per calendar year)
	<b>Out-of-Network<sup>4</sup></b>	40%; no deductible (maximum \$7,400 per lifetime) <sup>5</sup>	40% (100 visits per calendar year; no deductible)	40% (70 days per calendar year); no deductible. <sup>5</sup>	40%	Medically necessary: 40%. Routine exams not covered.
<b>Out-of-Area</b>	10%; no deductible (maximum \$7,400 per lifetime) <sup>5</sup>	10% (100 visits per calendar year; no deductible) <sup>5</sup>	10% (70 days per calendar year); no deductible <sup>5</sup>	10%	Medically necessary: 10%. Routine exams not covered.	10% (20 visits per calendar year)
<b>iPLAN In-Network</b>	10% <sup>5</sup>	10% <sup>5</sup>	10% (100 days per calendar year) <sup>5</sup>	10%	Medically necessary: 10%. Routine exams not covered.	10%
	Combined in- and out-of-network benefit maximum of \$7,400.					20 visit maximum per calendar year, combined in-network and out-of-network
<b>Out-of-Network</b>	40% <sup>5</sup>	40% (100 visits per calendar year) <sup>5</sup>	40% (70 days per calendar year) <sup>5</sup>	40%	Medically necessary: 40%. Routine exams not covered.	40%
<b>CORE NEW MEXICO</b>	20% (Lifetime Maximums: Inpatient 30 days/Outpatient \$5,000)	20% (up to 100 visits per calendar year)	20% (up to 120 days per calendar year)	20%	20% (medically necessary)	20%

4 Using a non-UHC provider, member will pay 40% of reasonable and customary charges plus the difference between billed charges and reasonable and customary charges.

5 Member must provide UHC with notification for these services or a \$300 penalty per instance will apply.

6 If member or doctor requests brand name drug when generic equivalent is available, member pays generic copayment plus cost difference between brand and generic. Member pays cost difference when selecting brand name over available generic.

7 Retail pharmacy/supply maximum per copayment: During each one-month period, a 31-day supply.

8 Member is responsible for paying the difference between plan's contracted rate and the amount billed by a non-participating pharmacy.

# Medical Benefits Summary: 2005

## (Non-Medicare) New Mexico

Acupuncture	PRESCRIPTION DRUGS		BEHAVIORAL HEALTH <sup>11</sup>			
	Retail	Mail Order	Mental Health Inpatient	Mental Health Outpatient	Substance Abuse Inpatient <sup>13</sup>	Substance Abuse Outpatient <sup>13</sup>
\$20 (20 visits per calendar year). In New Mexico, must use UHC contracted acupuncturists.	One copayment for up to a 31-day supply. <sup>6,7</sup> Generic: \$15 Preferred Brand: \$30 Non-Pref. Brand: \$45	One copayment for up to a 31-day supply. Two copayments for a 32 to 90-day supply. <sup>9</sup> Generic: two copayments or \$30; Preferred Brand: two copayments or \$60; Non-Pref. Brand: two copayments or \$90	No copayment	\$15 per visit copayment	Detox: 20% of auth. charges; no deductible. Rehab: 20% of auth. charges (50% for non-compliance); \$250 calendar year deductible <sup>10</sup>	Rehab: 20% of authorized charges; no deductible
\$20 (20 visits per calendar year, combined in- and out-of-network)  40% (20 visits per calendar year, combined in- and out-of-network)	One copayment for up to a 31-day supply. <sup>6,7</sup> Generic: \$15 Preferred Brand: \$30 Non-Pref. Brand: \$45	One copayment for up to a 31-day supply. Two copayments for a 32 to 90-day supply. <sup>9</sup> Generic: two copayments or \$30; Preferred Brand: two copayments or \$60; Non-Pref. Brand: two copayments or \$90	No copayment	\$15 per visit copayment	Detox: 20% of auth. charges; no deductible. Rehab: 20% of auth. charges (50% for non-compliance); \$250 calendar year deductible <sup>10</sup>	Rehab: 20% of authorized charges; no deductible
\$20 (20 visits per calendar year, combined in- and out-of-network)  40% (20 visits per calendar year, combined in- and out-of-network)	One copayment for up to a 31-day supply. <sup>6,7</sup> Generic: \$15 Preferred Brand: \$30 Non-Pref. Brand: \$45	One copayment for up to a 31-day supply. Two copayments for a 32 to 90-day supply. <sup>9</sup> Generic: two copayments or \$30; Preferred Brand: two copayments or \$60; Non-Pref. Brand: two copayments or \$90	10% \$250 calendar year deductible for all inpatient and outpatient services. <sup>12</sup>	10% \$250 calendar year deductible for all inpatient and outpatient services. <sup>12</sup>	Detox: 20% coinsurance. Rehab: 20% coinsurance (50% for non-compliance) <sup>10</sup>	Rehab: 20% coinsurance. Calendar year benefit maximum per person: \$3,500
10% (20 visits per calendar year)	One copayment for up to a 31-day supply. <sup>6,7</sup> Generic: \$15 Preferred Brand: \$30 Non-Pref. Brand: \$45	One copayment for up to a 31-day supply. Two copayments for a 32 to 90-day supply. <sup>9</sup> Generic: two copayments or \$30; Preferred Brand: two copayments or \$60; Non-Pref. Brand: two copayments or \$90	10% \$250 calendar year deductible for all inpatient and outpatient services. <sup>12</sup>	10% \$250 calendar year deductible for all inpatient and outpatient services. <sup>12</sup>	Detox: 20% coinsurance. Rehab: 20% coinsurance (50% for non-compliance) <sup>10</sup>	Rehab: 20% coinsurance. Calendar year benefit maximum per person: \$3,500
10%  20 visit maximum per calendar year, combined in-network and out-of-network 40%	20%  20% <sup>8</sup>	20%  20% <sup>8</sup>	No copayment	\$15 per visit copayment	Detox: 20% of auth. charges; no deductible. Rehab: 20% of auth. charges (50% for non-compliance); \$250 calendar year deductible <sup>10</sup>	Rehab: 20% of authorized charges; no deductible
20% (\$500 maximum/calendar year) <sup>14</sup>	20%	No mail order	Not covered	Not covered	Not covered	Not covered

(continued on reverse)

9 Mail order/supply maximum per two copayments: During each three-month period, a 90-day supply. If less than a 90-day supply is ordered but at least a 32 day supply, two copayments will apply. If less than a 32-day supply, one copayment will apply.

10 Lifetime maximum per person for all inpatient services: 130 days.

11 UHC plans: All services must be approved in advance by PacifiCare Behavioral Health, Inc.; 1-800-817-8811. The calendar year deductible, benefits, level, and lifetime maximums are combined for a member who transfers between the UHC plans.

12 A separate \$3,000 individual/\$9,000 family out-of-pocket maximum applies to all mental health PPO benefits.

13 For UHC plans, limited to one treatment episode per person, per calendar year, for inpatient and outpatient treatment (up to \$10,000).

14 For treatment of disease, illness, or injury.

# Medical Benefits Summary: 2005

## (Non-Medicare) New Mexico

PLAN	Available to LANL employees...	COSTS			HOSPITAL SERVICES	
		Calendar Year Deductible	Annual Out-of-Pocket Maximum	Lifetime Maximum	Inpatient	Surgeon/Assistant Surgeon
<b>SELECT EPO</b>	Living in UHC service areas in New Mexico, Nevada, or Washington D.C. (tri-state area)	Individual: \$150 <sup>1</sup> Family: \$450 <sup>1</sup>	Individual: \$2,000 Family: \$6,000	None	10% (includes maternity admissions). Notification required by physician.	10%
<b>OPTIONS PPO New Mexico In-Network</b>	Living in UHC New Mexico PPO service area	Individual: \$250 <sup>1</sup> Family: \$750 <sup>1</sup>	Individual: \$3,000 <sup>2</sup> Family: \$9,000 <sup>2</sup>	None	10% <sup>3</sup>	10%
		<b>Out-of-Network</b>	Individual: \$500 <sup>1</sup> Family: \$1,500 <sup>1</sup>	Individual: \$6,000 <sup>2</sup> Family: \$18,000 <sup>2</sup>	\$2,000,000	\$250 copayment plus 40% <sup>3</sup>
<b>National In-Network</b>	Living in UHC PPO service area outside of New Mexico	Individual: \$250 <sup>1</sup> Family: \$750 <sup>1</sup>	Individual: \$3,000 <sup>2</sup> Family: \$9,000 <sup>2</sup>	None	10% <sup>3</sup>	10%
		<b>Out-of-Network</b>	Individual: \$500 <sup>1</sup> Family: \$1,500 <sup>1</sup>	Individual: \$6,000 <sup>2</sup> Family: \$18,000 <sup>2</sup>	\$2,000,000	\$250 copayment plus 40% <sup>3</sup>
<b>Out-of-Area</b>	Living outside the UHC PPO service area, or living abroad	Individual: \$250 <sup>1</sup> Family: \$750 <sup>1</sup>	Individual: \$3,000 Family: \$9,000	\$2,000,000	10% <sup>3</sup> \$250 copayment	10%
<b>iPLAN In-Network</b>	Living anywhere in New Mexico  <b>This plan is not available to retirees</b>	Amounts include PBA dollars: Employee: \$1,500 Employee & Adult: \$2,250 Employee & Child(ren): \$2,250 Family: \$3,000	Employee: \$2,750 Employee & Adult: \$4,125 Employee & Child(ren): \$4,125 Family: \$5,500	None	10% <sup>3</sup>	10%
		<b>Out-of-Network</b>	Deductible is combined for in- and out-of-network	Employee: \$8,500 Employee & Adult: \$12,750 Employee & Child(ren): \$12,750 Family: \$17,000	\$2,000,000	40% <sup>3</sup>
<b>CORE NEW MEXICO</b>	Provides worldwide coverage.	Individual: \$3,000	Individual: \$7,600	\$2,000,000	20% (preauthorization required) <sup>1</sup>	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.

**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.

**PBA (Personal Benefits Account):** Under the iPlan, benefit dollars allocated to help pay out-of-pocket costs under the plan, including annual deductibles and coinsurance.

**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.

**Select EPO** = Exclusive provider organization  
**Options PPO** = Preferred provider organization  
**iPlan** = Consumer-driven health plan  
**Core** = Fee-for-service plan

		PHYSICIAN VISITS					
Emergency Room	Ambulance	Office Visit	Hospital Visit	Preventive Physical Exam	Maternity Outpatient Care	Maternity Inpatient Care	Well Baby Care
10% (+\$75 copayment, waived if admitted to the hospital). Non-emergency not covered.	10% Non-emergency ambulance not covered.	\$20	No charge	\$20 (no charge up to age 2)	No charge (\$20 for first visit to diagnose pregnancy)	No charge	No charge to age 2
10% (emergency) 40% (non-emergency) (+\$75 copayment, waived if admitted to the hospital)	10% (emergency) 40% (non-emergency)	\$20 (no charge up to age 2)	No charge	\$20 (no charge ages 2 through 5)	No charge (\$20 for first visit to diagnose pregnancy)	No charge (\$20 for first visit to diagnose pregnancy)	No charge to age 2
	10% (emergency) 40% (non-emergency)	40%	40%	40% ages 2 through 18; no deductible; not covered age 19 and over	40%	40%	40% to age 2; no deductible
10% (emergency) 40% (non-emergency) (+\$75 copayment, waived if admitted to the hospital)	10% (emergency) 40% (non-emergency)	\$20 (no charge up to age 2)	No charge	\$20 (no charge ages 2 through 5)	No charge (\$20 for first visit to diagnose pregnancy)	No charge (\$20 for first visit to diagnose pregnancy)	No charge to age 2
	10% (emergency) 40% (non-emergency)	40%	40%	40% ages 2 through 18; no deductible; not covered age 19 and over	40%	40%	40% to age 2; no deductible
10% (+\$75 copayment, waived if admitted to the hospital) Non-emergency not covered.	10% Non-emergency ambulance not covered.	10%	10%	10%; no deductible ages 2 through 18	10%	10%	10% to age 2; no deductible
10%	10% (emergency) 40% (non-emergency)	10% (no charge up to age 2) (PBA & deductible waived for In-Network)	No charge. (PBA & deductible waived for In-Network)	No charge; no annual dollar maximum (PBA & deductible waived for In-Network)	10% for first visit, then no charge. (PBA & deductible waived for In-Network)	10% for first visit, then no charge. (PBA & deductible waived for In-Network)	No charge (PBA & deductible waived for In-Network)
		40%	40%	40% coverage from age 2 through age 18; not covered age 19 and over	40%	40%	40% up to age 2
20%	20%	20%	20%	20%	20%	20%	20%

(continued on reverse)

**Note: Benefits show what you pay.** 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 which UHC plan provides service where you live, call UHC directly or see their website.

Except for Core, all plans listed are UnitedHealthcare (UHC) plans. The Core plan is administered by Blue Cross of California.

**UnitedHealthcare:** 1-800-603-3816 ([www.provider.uhc.com/losalamos](http://www.provider.uhc.com/losalamos))

**Core (Blue Cross of California):** 1-888-209-7975 ([www.bluecrossca.com/clients/uc.htm](http://www.bluecrossca.com/clients/uc.htm))

- 1 Visit copayments, emergency room and inpatient hospital copayments are not subject to and do not apply to the calendar year deductible.
- 2 Under the Medical portion of the PPO plan, the PPO In-Network calendar year deductible, visit copayments, the emergency room copayment and coinsurance do apply to the Annual Out-of-Pocket Limit amount.
- 3 Member must provide UHC with notification for services, or a \$300 penalty per instance will apply.

## 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)
Core—New Mexico	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00
Kaiser Permanente—Mid-Atlantic	51.98	93.56	109.16	150.74
Kaiser Umbrella	222.50	400.50	467.25	645.25
PacifiCare of Nevada	164.61	296.30	345.68	477.37
UnitedHealthcare				
Select EPO	43.04	77.48	90.39	124.82
Options PPO (New Mexico)	128.70	231.66	270.27	373.23
Options PPO (National)	31.34	56.41	65.81	90.89
Options PPO (Out-of-Area)	31.34	56.41	65.81	90.89
iPlan	47.04	84.68	98.79	136.42

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

Plan	Self	Self + Child(ren)	Self + Adult	Self + Adult + Child(ren)
Core—New Mexico	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00
Kaiser Permanente—Mid-Atlantic	59.98	107.96	125.96	173.94
Kaiser Umbrella	230.50	414.90	484.05	668.45
PacifiCare of Nevada	172.61	310.70	362.48	500.57
UnitedHealthcare				
Select EPO	51.04	91.88	107.19	148.02
Options PPO (New Mexico)	136.70	246.06	287.07	396.43
Options PPO (National)	39.34	70.81	82.61	114.09
Options PPO (Out-of-Area)	39.34	70.81	82.61	114.09
iPlan	55.04	99.08	115.59	159.62

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## 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)
Core—New Mexico	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00
Kaiser Permanente—Mid-Atlantic	68.98	124.16	144.86	200.04
Kaiser Umbrella	239.50	431.10	502.95	694.55
PacifiCare of Nevada	181.61	326.90	381.38	526.67
UnitedHealthcare				
Select EPO	60.04	108.08	126.09	174.12
Options PPO (New Mexico)	145.70	262.26	305.97	422.53
Options PPO (National)	48.34	87.01	101.51	140.19
Options PPO (Out-of-Area)	48.34	87.01	101.51	140.19
iPlan	64.04	115.28	134.49	185.72

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

Plan	Self	Self + Child(ren)	Self + Adult	Self + Adult + Child(ren)
Core—New Mexico	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00
Kaiser Permanente—Mid-Atlantic	78.98	142.16	165.86	229.04
Kaiser Umbrella	249.50	449.10	523.95	723.55
PacifiCare of Nevada	191.61	344.90	402.38	555.67
UnitedHealthcare				
Select EPO	70.04	126.08	147.09	203.12
Options PPO (New Mexico)	155.70	280.26	326.97	451.53
Options PPO (National)	58.34	105.01	122.51	169.19
Options PPO (Out-of-Area)	58.34	105.01	122.51	169.19
iPlan	74.04	133.28	155.49	214.72

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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