

University of California

Open Enrollment

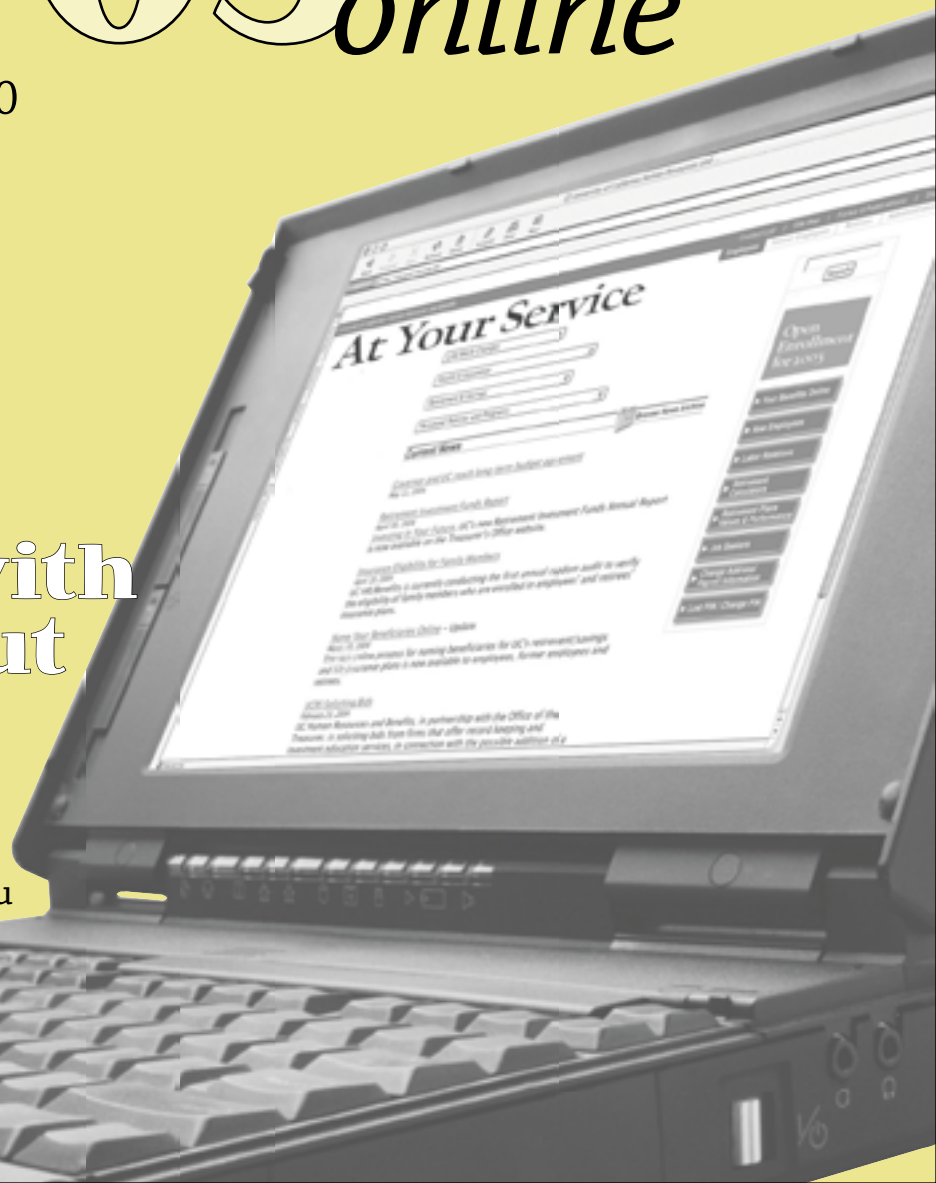
for **2005** *online*

November 1-30

California

**Retirees with
and without
Medicare**

<http://atyourservice.ucop.edu>



Dear UC Retiree,

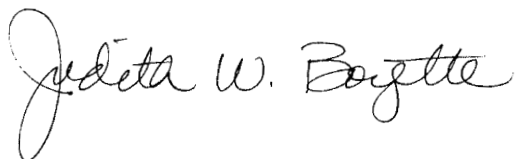
As the annual Open Enrollment period approaches, we are pleased to tell you that the news about health care benefits and costs is better than it has been in recent years. While health care costs nationally and in California continue to rise, this year's increases for UC are less dramatic than they have been over the last several years. We have worked hard to negotiate the best possible rates for our health plans, and changes in the Medicare payment schedules have reduced UC's retiree costs this year. For UC this means that the total premium cost (the UC contribution plus the retiree contribution) for most medical plans will increase by a smaller percentage. We are happy that since the University's contribution to the premiums will be enough to cover most of the increase this year, most retirees will not see an increase in their 2005 medical plan rates; those enrolled in Medicare plans will actually see a decrease. Plan benefits remain the same or, in some cases, are enhanced.

Despite rising costs and reduced state funding for UC, we remain committed to providing access to a wide range of benefits choices to serve our diverse members. We continue to search for ways to soften the impact of rising health care costs.

As a result of last year's successful implementation of online Open Enrollment for employees, we are expanding the online enrollment to retirees. Telephone enrollment is being discontinued. Forms will be available for those who don't have internet access.

You'll find detailed instructions on how to make your Open Enrollment changes online as well as highlights of plan changes in this booklet. The At Your Service website (<http://atyourservice.ucop.edu>) provides additional information about the plans as well as helpful tools regarding your benefits. You also can get information at local Open Enrollment Fairs. A calendar is included in the booklet and posted on the website.

Please know that providing for your health and the health of your family remains a top priority at University of California. We look forward to serving you during Open Enrollment and during the coming year.



Judith W. Boyette
Associate Vice President
Human Resources and Benefits

Open Enrollment for 2005

Open Enrollment begins 8:00 am (PST) Monday, November 1 and ends at midnight Tuesday, November 30

What's New

Open Enrollment is online at <http://atyourservice.ucop.edu>

This year, you can make all your Open Enrollment changes online (by computer) and you won't use the telephone as you have in the past. See the enclosed quick reference guide for instructions. If you don't have a computer, you can use one at your local public library and at many community senior centers or you can ask a family member to help you.

If you do not have computer access or prefer not going online, you can enroll by paper form. You may request a UC paper enrollment form (UBEN 100) by completing the enclosed postcard. Remember that your form must be received by UC HR/Benefits by November 30, 2004, in order to be processed. We cannot guarantee you will receive a new ID card by January 1, 2005, if you submit changes by a paper enrollment.

The Legal Plan is open

If you are not enrolled, you may enroll during Open Enrollment. If you are already enrolled and want to add or de-enroll a family member you may do so during Open Enrollment.

Expanded eligibility for opposite-sex domestic partners and overage disabled children

The eligibility information is on pages 21-23.

Suspend your UC-sponsored medical coverage

If you have other group or individual medical coverage, you may suspend your UC-sponsored medical coverage and re-enroll during a future Open Enrollment or at the time you lose the other coverage. Submit the enclosed postcard to obtain the required UC paper enrollment form (UBEN 100).

Actions You Can Take

- Change to a different medical plan
- Enroll eligible family members
- Change/cancel coverage for currently enrolled family members
- Suspend UC-sponsored medical coverage
- Change to a different dental plan (Retirees living in California only)
- Enroll yourself and/or eligible family members in the Legal Plan

If you wish to continue with the same coverage you have this year, don't do anything.

Table of Contents

Plan Changes for 2005	
Non-Medicare Plans	4
Medicare Plans	5
Review your Coverage and Research your Options	6
Medical Plan Information	
Non-Medicare Plans	7-13
Medicare Plans	14-20
Eligible Family Members	21
Family Member Eligibility Chart	23
For More Information	24
Open Enrollment Fairs	25
Insurance Carrier Toll-Free Phone Numbers	26
Terms and Conditions	27

Non-Medicare Plan Changes for 2005

For more information on Non-Medicare plans go to page 7.

Medical Plans

Changes are summarized here; benefit summaries and links to the plan home pages and evidence of coverage documents are available at the Open Enrollment website.

Blue Cross Plans

Blue Cross PLUS, Blue Cross PPO, Core

Health improvement programs (HIPs) have been added to assist members with cardiovascular disease, musculoskeletal problems and oncology support services.

Blue Cross PLUS & Blue Cross PPO

Generic Select Program: This program helps members taking certain brand-name medications to switch to a lower priced generic alternative. The first generic prescription copayment (certain prescriptions only) is waived when filled at a retail pharmacy or Precision RX (Blue Cross' mail order pharmacy).

Behavioral Health Benefits:

Out-of-network mental health outpatient visits will change. Services will continue to be provided by United Behavioral Health (see page 11).

Blue Cross PLUS only

New web visits with doctors: Certain medical groups will offer "web visits" with your doctor for non-urgent health questions (\$10.00 copayment per visit). Your doctor will let you know if he/she is participating .

Blue Cross PPO only

The lifetime member maximum will increase (see page 12).

Health Net

Behavioral Health: A phone-based clinical consultation service provided by licensed counselors to help focus, direct, and support members with behavioral health problems will be added—limited to up to three times per calendar year. Services will continue to be provided by MHN.

Kaiser Permanente—California

Physician office group visits will be charged at 50% of individual office visits.

The plan will cover only part-time or intermittent alternative home health care covered as follows:

- Up to two hours per visit
- Up to three visits per day
- Up to 100 visits per calendar year

Kaiser Permanente—Mid-Atlantic

Inpatient infertility hospitalization services: Covered at 50% of non-member rate; all other inpatient hospitalization remains at \$250 copayment.

Kaiser Umbrella

The plan is closed to new members; eligible family members can be added for 2005. Benefits vary from plan to plan. Plan members should contact their plan directly for more information and for the paper enrollment form.

PacifiCare of California

Morbid obesity drugs will be covered.

Madera County will be added as a service area.

PacifiCare of Nevada, Western Health Advantage

No plan changes

Dental Plans

Anesthesia benefits for the developmentally disabled will be added. For details, visit the Open Enrollment website (<http://atyourservice.ucop.edu>) or request a copy of the 2005 *Dental Plan Summary*.

Delta Dental

See the Open Enrollment website for the anesthesia benefit details.

PMI Dental Plan

Coverage will be increased for teeth cleanings (beyond two in a 12-month period), certain x-rays and diagnostic tests. The teeth whitening copayment will be reduced from \$175 to \$125 per arch. For other enhancements, see the Open Enrollment website.

ARAG Legal Plan

No plan or rate changes in 2005. This plan is open for enrollment this year. If you are already enrolled and want to add or de-enroll a family member, you may do so during Open Enrollment.

Medicare Plan Changes for 2005

For more information on Medicare plans go to page 14.

Medical Plans

Changes are summarized here; benefit summaries and links to the plan home pages and evidence of coverage documents are available at the Open Enrollment website.

Blue Cross Plans

Blue Cross PLUS, Blue Cross PPO, High Option, Core

Organ transplants: For organ transplants not approved by Medicare but approved by Blue Cross, the member must use a Blue Cross approved transplant center.

Health improvement programs:

See Blue Cross Plans on page 4.

Blue Cross PLUS & Blue Cross PPO

Generic Select Program:

See page 4.

Behavioral Health Benefits:

Out-of-network mental health outpatient visits will change (see the Open Enrollment website). Services will continue to be provided by United Behavioral Health.

Blue Cross PLUS only

New Web visits with doctors: See “Blue Cross PLUS” only on page 4.

Blue Cross PPO only

The lifetime member maximum will increase (see page 20).

Health Net/Seniority Plus

Behavioral Health Benefits: A phone-based clinical consultation service provided by licensed counselors to help focus, direct, and support members with behavioral health problems will be added—limited to up to three times per cal-

endar year. Services will continue to be provided by MHN in 2005.

High Option Supplement to Medicare

The lifetime member maximum will increase (see page 20).

Health improvement programs:

See Blue Cross Plans on page 4.

Kaiser Permanente California/Senior Advantage

Physician office group visits will be charged at 50% of individual office visits.

Kaiser Permanente Mid-Atlantic/Medicare Plus

Inpatient infertility hospitalization services will be covered at 50% of non-member rate; all other inpatient hospitalization remains at \$250 copayment.

Kaiser Umbrella

The plan is closed to new members; eligible family members can be added for 2005. Benefits vary from plan to plan. Plan members should contact their plan directly for more information and for the paper enrollment form.

PacifiCare of California/ Secure Horizons

The Secure Horizons service area is expanding in 2005 to include (full counties) Alameda, Contra Costa, San Francisco, and Yolo Counties; and (partial counties) Nevada, Sonoma, and San Mateo Counties.

PacifiCare of Nevada/ Secure Horizons

No plan changes

Western Health Advantage/ WHA Care+

No plan changes

Dental Plans

Anesthesia benefits for the developmentally disabled will be added. For details, visit the Open Enrollment website (<http://atyourservice.ucop.edu>) or request a copy of the 2005 *Dental Plan Summary*.

Delta Dental

See the Open Enrollment website for the anesthesia benefit details.

PMI Dental Plan

Coverage will be increased for teeth cleanings (beyond two in a 12-month period), certain x-rays and diagnostic tests. The teeth whitening copayment will be reduced from \$175 to \$125 per arch. For other enhancements see the Open Enrollment website.

ARAG Legal Plan

No plan or rate changes in 2005. This plan is open for enrollment this year. If you are already enrolled and want to add or de-enroll a family member you may do so during Open Enrollment.

Review your Coverage & Research your Options

If you don't have any plan changes to make, you don't need to do anything. Your enrollments will remain as printed on the "Options and Costs" section of your Open Enrollment statement.

Review your Current Coverage

Review the "Options and Costs for 2005" section on your Open Enrollment statement. Even if you do not make changes during Open Enrollment, your monthly cost may be different next year and will be reflected in your January 1st monthly benefit check or on your Direct Deposit statement.

If your permanent residence ZIP code is different from what is printed on your statement, the medical plan options listed may not be correct or available to you. Call the UC Customer Service Center (1-800-888-8267, Monday through Friday, 8:30 am–4:30 pm, PST) for your plan options.

Research your Options

Consider if your life and health circumstances have changed and how they may affect your plan enrollments; you may find a better fit for your needs by changing to a different plan.

Review the Medical Benefits Summaries (beginning on pages 10 and 17) to compare benefits. More information is available on the Open Enrollment 2005 website to help you compare medical plans including links to plan websites.

If you need to know the service area of a medical plan, call the plan directly or visit their website (see page 26). Remember: service areas for Medicare plans may differ from non-Medicare plan service areas.

Plan carriers can answer any additional questions you may have.

Attend an Open Enrollment Fair in your area (see page 25) if you wish to speak with a medical plan carrier or a UC benefits representative.

If you have had family member changes, you may need to make changes during Open Enrollment. But remember that marriage, separation, divorce and other life changes allow you a Period of Initial Eligibility of 31 days at any time to change your covered family members—not just during Open Enrollment. Before enrolling a new family member, verify their eligibility (see pages 21–23).

Primary Care Physicians

Before you log on to the Open Enrollment 2005 website, be sure to complete all your research, such as obtaining a Primary Care Physician (PCP) number, if necessary, for the medical plan.

To obtain a PCP number, use the "Find a Doctor" link on the Open Enrollment website or call the medical plan (see page 26).

Confirm that your doctor is a member of the plan you choose, and that he/she is accepting new patients.

Don't Live in California?

You have the following medical plan options for 2005. For details, see the Open Enrollment website on At Your Service.

If you live in the District of Columbia, Maryland or Virginia:

- Blue Cross PPO
- Core
- High Option (Medicare only)
- Kaiser Permanente—Mid-Atlantic
- UHC Select EPO

If you live in Nevada:

- Blue Cross PPO
- Core
- High Option (Medicare only)
- PacifiCare of Nevada
- UHC Select EPO

If you live in New Mexico:

- Blue Cross PPO
- Core
- High Option (Medicare only)
- UHC Select EPO

If you live in any other state or outside the United States:

- Blue Cross PPO
- Core
- High Option (Medicare only)

The Four Types of Medical Plans

Non-Medicare Plans

You and your covered family members must be enrolled in the same medical plan, but you can have different Primary Care Physicians (if applicable). Medicare family members must be enrolled in the Medicare counterpart of the plan you select.

For Medicare information, see page 14

TYPE OF PLAN	HEALTH MAINTENANCE ORGANIZATION (HMO)	POINT-OF-SERVICE PLAN (POS)	PREFERRED PROVIDER ORGANIZATION (PPO)	FEE-FOR-SERVICE
	Health Net, Kaiser, PacifiCare, WHA	Blue Cross PLUS	Blue Cross PPO	Core
Reasons People Choose This Type of Plan	Least costly overall. Focus on preventive care; no deductible or coinsurance balance	Greater choice of medical providers than an HMO; ability to go outside the network for care (at a higher cost).	Broader network of providers than HMO or POS; worldwide coverage available.	No limits on access to providers; desire to self-insure a larger part of front-end costs (high deductible).
Choice of Providers	You choose a Primary Care Physician (PCP) or a primary care group from the network. Both your primary and specialty care are through your chosen PCP/medical group.	Two benefits levels: in-network (IN) and out-of-network (OON). IN works like an HMO. OON—you may choose any provider, but you pay more of the costs.	You do not choose a PCP; you pay less if you use a network provider.	Unrestricted access to any provider.
Provider Relationships	Providers and medical groups are contracted through the HMO network.	Providers and medical groups contracted through the POS network for IN; OON has PPO and non-PPO network.	Providers contracted through the PPO network. Offers services at less cost than non-PPO.	No network.
Primary Care	All care is coordinated by a PCP.	IN—care is coordinated by a PCP; OON—does not require a PCP.	No PCP required.	No PCP required.
Specialty Care	Your PCP authorizes referrals to specialists.	IN—your PCP authorizes referrals. OON—you may self-refer.	You may self-refer to providers in or out of network.	You self-refer to any provider.
Networks	Plan networks are limited, especially in rural areas.	IN is similar to an HMO network. OON has PPO and non-PPO nationwide network.	Networks tend to be wider than HMO networks. Plans often have nationwide networks.	No network.

IN = In-network

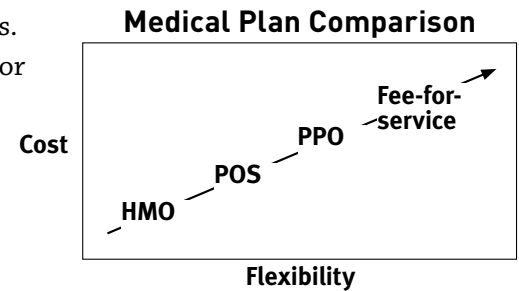
OON = Out-of-network

Copayment = flat dollar cost; coinsurance = % of total cost

Plan Comparison and Flexibility

Non-Medicare Plans

The information on this chart is arranged so that as you move to the right, the plan choices allow you more flexibility for your coverage needs. At the same time, however, you usually pay higher monthly premiums for these plans.



TYPE OF PLAN	HEALTH MAINTENANCE ORGANIZATION (HMO)	POINT-OF-SERVICE PLAN (POS)	PREFERRED PROVIDER ORGANIZATION (PPO)	FEE-FOR-SERVICE
	Health Net, Kaiser, PacifiCare, WHA	Blue Cross PLUS	Blue Cross PPO	Core
UC Premiums	Lowest premiums (except for Core).	More expensive than an HMO; less expensive than PPO.	Most expensive.	Lowest premiums due to plan design (high deductible, catastrophic coverage).
Cost Sharing for Services	Copayments for services; no deductibles or coinsurance.	IN—higher copayments for services than HMO; OON—deductibles and coinsurance.	Annual deductibles; coinsurance payments lower for network providers; higher for non-network providers.	Coinsurance coverage after high annual deductible is satisfied.
Out-of-Pocket Maximum	Yes	Yes	Yes	Yes
Claims	No claims, but preauthorization required for some services (see plan details).	IN—like an HMO. OON—you file claims for partial payment of costs after deductible is satisfied.	For PPO providers, no claims to file. You file claims for non-PPO providers.	You file claims for partial payment of costs after deductible is satisfied.
Prescriptions	Typically, a card program with a formulary and different copayments for generic and brand name drugs. Mail-order refills can be arranged.	Typically, a card program with a formulary and different copayments for generic, brand name, and non-formulary drugs. Usually has a mail-order program for maintenance drugs.	Typically, a card program with a formulary and different copayments for generic, brand name, and non-formulary drugs. Usually has a mail-order program for maintenance drugs.	No formulary; retail prescriptions covered on straight percentage reimbursement with no discounts. No mail order program.

IN = In-network
 OON = Out-of-network

Copayment = flat dollar cost; coinsurance = % of total cost

Some things to consider..

1. Do you want a specific doctor or care provider?

Call the medical plan directly to find out if your doctor is a listed provider with a specific plan and if he or she is currently accepting new patients.

2. Do you visit the doctor frequently?

If the total costs of your copayments are a concern to you, it may be worthwhile to consider a medical plan with lower copayments for office visits or other services you regularly use. You should also consider the maximum payable under each plan.

3. Do you have a chronic medical condition?

Some medical plans have special programs for management of conditions such as heart disease, asthma, or diabetes. Again, contact the individual plans for more information.

4. Are your prescription costs a key concern?

If so, compare the out-of-pocket costs under the various plans. The categories “generic formulary,” “brand formulary,” and “non-formulary” are important because the costs for a specific medication may vary considerably under different medical plans, depending on its formulary category. Call the medical plan for information on coverage for specific medications.

5. Are you or an enrolled family member scheduled for surgery or any other medical procedure or continuing treatment in late 2004?

If so, and you want to change your medical plan during Open Enrollment, call the new plan and ask how they will oversee the transition of your care. You should receive your new medical plan ID card by the first week in January.

6. Are you or a family member currently enrolled in Medicare or do you expect to be enrolled in 2005?

If so, carefully review the Medicare Plans section beginning on page 14. For additional help, visit the insurance carrier websites, available on the At Your Service website (<http://atyourservice.ucop.edu>).

Becoming eligible for Medicare does not provide you with an opportunity to change plans—you will simply transfer to the Medicare version of your current plan.

7. Are you thinking about suspending your medical coverage because you are enrolled under another medical plan?

If you “suspend” your UC medical plan coverage, you and your eligible family members may re-enroll if you lose your other group or individual medical coverage involuntarily (e.g., layoff or termination of employment). You will have 31 days to re-enroll.

Or you and your family members may re-enroll during a future Open Enrollment even if you are covered under the other group or individual plan. UC coverage in this instance would not become effective until the following January 1.

Medical Benefits Summary: 2005

(Non-Medicare)

PLAN	COSTS			HOSPITAL SERVICES		
	Calendar Year Deductible	Annual Out-of-Pocket Maximum	Lifetime Maximum	Inpatient	Surgeon/Assistant Surgeon	Emergency Room
Health Net (HMO) 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)
Kaiser—CA (HMO) 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)
PacificCare—CA (HMO) 1-800-982-9993	\$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)
Western Health Advantage (HMO) 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)
Blue Cross PLUS In-Network (POS) 1-888-209-7975	\$0	Individual: \$1,500 Family: \$4,500	Unlimited	\$250 copayment	No charge	\$75 per visit (waived if admitted)
Blue Cross PLUS Out-of-Network 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)
Blue Cross PPO In-Network (PPO) 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%
Blue Cross PPO Out-of-Network 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%
Core (Fee-for-service) 1-888-209-7975	Individual: \$3,000	Individual: \$7,600	\$2,000,000	20% (preauthorization required) ¹	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.

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.

Non-Medicare Plans

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)

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>).

Medical Benefits Summary: 2005

(Non-Medicare)

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

Non-Medicare Plans

	PRESCRIPTION DRUGS		BEHAVIORAL HEALTH			
Acupuncture	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) ⁴	20% (preauthorization required)
Not covered	At participating pharmacies ⁶ (30-day supply): \$15 generic formulary/ \$25 brand formulary/ \$40 non-formulary.	(90-day supply) \$30 generic formulary/\$50 brand formulary/ \$80 non-formulary. ⁷	30% (\$200 non-notification penalty per admission) ⁵	30% with notification (50% without). Limited to 20 visits per year. ⁵	30% (\$200 non-notification penalty per admission) ^{4,5}	30% (\$200 non-notification penalty per course of treatment) ⁵
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) ⁴	20% (preauthorization required)
40%	At participating pharmacies ⁶ (30-day supply): \$15 generic formulary/ \$25 brand formulary/ \$40 non-formulary.	(90-day supply) \$30 generic formulary/\$50 brand formulary/ \$80 non-formulary. ⁷	40% (\$200 non-notification penalty per admission) ⁵	40% with notification (60% without). Limited to 20 visits per year. ⁵	40% (\$200 non-notification penalty per admission) ^{4,5}	40% (\$200 non-notification penalty per course of treatment) ⁵
20% (\$500 maximum/calendar year)	20%	No mail order benefit	Not covered	Not covered	Not covered	Not covered

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.

Medicare

UC Medical Plans for Medicare Enrollees

In order to keep your UC coverage, you must enroll and stay enrolled in Medicare Part B

This section includes information about UC's medical plans for those enrolled in Medicare Parts A and B, including how Medicare coordinates with the UC plans. This information should help you decide which plan is right for you and your family. You may also want to consider the monthly plan costs listed on your Open Enrollment statement, as well as the out-of-pocket maximums, when making your decision.

If you do not understand how your doctor will bill you or have other questions after reading the information in this section, ask your doctor or call your plan directly at the number listed on page 26.

If you or a family member is in Medicare and your other family members are not, those in Medicare are enrolled in the Medicare version of the plan while the others remain in the non-Medicare version of the plan.

Medicare Requirements

UC requires all retirees and their enrolled family members to enroll in both parts of Medicare (Parts A and B) as soon as they become eligible, usually when they turn 65.

If you become eligible for Medicare Part A (free of charge), and you do not enroll in Part B, you will permanently lose your UC-sponsored medical coverage.

Enrolling in 2005?

If you (or any eligible family member) expect to enroll in Medicare during 2005, you may want to consider now whether the Medicare version of your current medical plan will offer the coverage you want. If not, Open Enrollment is the time to change plans.

For more information on Medicare, read the *UC Medicare Factsheet* available on the At Your Service website or from the UC Customer Service Center (see page 24).

Medicare Offset Penalty

Those who are currently paying UC's monthly offset penalty for not enrolling in Medicare Part B will continue to do so. The penalty for 2005 is \$265 per person per month. Your monthly offset penalty will stop when you notify UC of your eligibility for and enrollment in Medicare Parts A and B. You are able to enroll in Part B every January through March with Part B coverage effective July 1 of that year.

Non-Medicare Providers and Private Contracts

If your doctor does not accept Medicare or has opted out of Medicare and will only render services if you sign a "private contract," those services will not be covered by Medicare or your UC-sponsored medical plan.

Working After Age 65

If you continue to work for UC after age 65 or return to UC as a rehired retiree and are eligible for medical benefits through your UC employment, the Federal Medicare Secondary Payer law states that Medicare cannot be your Primary Insurance.

If you return to UC employment as a rehired retiree, you must maintain your enrollment in Medicare Part B. If you cancel your Medicare Part B, you risk permanent disenrollment from your UC-sponsored medical plan.

Medicare Advantage HMO Plans

Health Net, Kaiser, PacifiCare, and WHA

Note: UC's HMO Plans (except Kaiser Mid-Atlantic) are "Medicare Advantage" plans (previously called "Medicare+Choice" plans) and require special enrollment and disenrollment forms.

Service Areas

To enroll in a Medicare HMO, you must live in that plan's service area. The Medicare version of your HMO may have a different service area than the service area for the

non-Medicare HMO plan. Call your medical plan to confirm that the Medicare plan is available in your service area. If the Medicare version of your HMO is not available where you live, you and your family may transfer to any UC plan available in your area.

Blue Cross PLUS, Blue Cross PPO, High Option and Core Service Areas

In order to enroll in Blue Cross PLUS you must live within the California service area. You may enroll in Blue Cross PPO, High Option, or Core no matter where you live.

Unless you experience a status change that results in a new PIE (Period of Initial Eligibility), you can change medical plans only during Open Enrollment.

Required Forms

The following are Medicare Advantage HMO Plans: Health Net/Seniority Plus, Kaiser Permanente/Senior Advantage, PacifiCare/Secure Horizons, Western Health Advantage/WHA Care+.

If you transfer into a Medicare Advantage plan:

You need to submit a *Medicare Advantage Universal Enrollment Form* to your new medical plan (in addition to completing your Open Enrollment transaction).

If this form is necessary, UC will send one along with a confirmation of your Open Enrollment change. You must submit the form to your new medical plan by December 10, 2004.

To Be Filled out by Employer

Account # _____
Effective Date _____

Medicare+Choice Universal Enrollment Form
Medicare+Choice plan you are requesting enrollment in

Enrolled Contracting Medical Group _____ Enrolled Contracting Physician No. _____ Medical Group/Physician No. _____
Last Name _____ First Name _____ MI _____ Social Security No. _____
Permanent Residence Address _____ City _____ State _____ Zip _____
Mailing Address (if different) _____ City _____ State _____ Zip _____
Telephone Number (including area code) _____ Birth Date _____ Sex _____ Male Female
Part A Effective Date _____ Part B Effective Date _____ Health Insurance Claim No. (HICN) _____
Do you currently have a member's Medicare+Choice plan? Yes No (If "Yes," which one?) _____
Spouse Name (Last, First, MI) _____ Birth Date _____ Sex _____ Male Female
Health Insurance Claim No. _____ Part A Effective Date _____ Social Security No. _____
Dependent Name (Last, First, MI) _____ Birth Date _____ Sex _____ Male Female
Health Insurance Claim No. _____ Part A Effective Date _____ Social Security No. _____
Subsidiary _____ Spouse _____ Independent _____
For all family members enrolling in the Medicare+Choice product, please answer the following:
1. Do you have end-stage renal disease (ESRD) listed in permanent kidney failure and require you to have regular dialysis or a transplant to stay alive? If yes, date of diagnosis: _____
2. Do you or your spouse currently work or plan to work for an employer who provides group health coverage? _____
3. Do you or your spouse or dependents have any health insurance other than Medicare, such as private insurance, workers' compensation or Veterans Administration benefits? _____
If yes, what is the name of your insurance? _____
4. Do you currently reside in an institution? Your answer to this question will not affect your eligibility to enroll. Facility Name _____ Date of Admission _____ Facility Phone Number _____
5. Do you have Medicaid/Medicaid coverage? Your answer to this question will not affect your eligibility to enroll. _____
I understand that my signature on this application certifies that I have read and understood the contents of this application and the terms of understanding on the reverse side of this form. Please refer to the Medicare+Choice plan Evidence of Coverage document for a written copy of the rules you must follow in order to receive coverage under this Medicare+Choice plan. Please keep the pink copy of this form for your records.
Subscriber Signature _____ Date _____
Spouse Signature _____ Date _____
If anyone helped the beneficiary fill out any portion of this form, with the exception of the effective date, please sign the following:
Representative Signature _____ Date _____
Relationship to Beneficiary _____ Date _____
If this is being submitted by a guardian, conservator or person with power of attorney, please attach the legal documents establishing guardianship, conservatorship or power of attorney.
UC-0404-04-1004 White (2) - MHC, Organization

If you transfer out of a Medicare Advantage plan and into Blue Cross PLUS, Blue Cross PPO, Core or High Option,

you need to submit a *Medicare Advantage Disenrollment Form* to the plan you are transferring out of.

If this form is necessary, UC will send one along with a confirmation of your Open Enrollment change. You must submit the form to the plan you are transferring out of by December 10, 2004.

MEDICARE ADVANTAGE PLAN DISENROLLMENT FORM
UCSD 101 (03/04) University of California Human Resources and Benefits

Return completed form to the HMO medical plan you are leaving and keep the duplicate copy for your records. See page 2 for address.

If you are not enrolling in another Medicare Advantage plan (previously called Medicare+Choice), complete this form to disenroll from your current Medicare Advantage plan for yourself and/or your enrolled family members.
If you are enrolling in another Medicare Advantage plan, your current plan membership will terminate automatically; you do not need to complete this form.

Disenrollment for yourself and/or your enrolled family members will be effective the last day of the month in which your medical plan receives your completed and signed form, or the date you request below, whichever is later.

PERSONAL INFORMATION
Name (Last, First, Middle Initial) _____ Social Security Number _____
Address (Last, First, Middle Initial) _____ City _____ State _____ Zip _____
Telephone (Area, City, Home, Office) _____
Mailing Address (Last, First, Middle Initial) _____ City _____ State _____ Zip _____
Date of Birth _____
Request Disenrollment in _____
Reason for Disenrollment: Open Enrollment Change Effective date will be: _____
 I am requesting disenrollment in _____
I understand that my signature on this application certifies that I have read and understood the contents of this application and the terms of understanding on the reverse side of this form. Please refer to the Medicare+Choice plan Evidence of Coverage document for a written copy of the rules you must follow in order to receive coverage under this Medicare+Choice plan. Please keep the pink copy of this form for your records.
Subscriber Signature _____ Date _____
Spouse Signature _____ Date _____
If anyone helped the beneficiary fill out any portion of this form, with the exception of the effective date, please sign the following:
Representative Signature _____ Date _____
Relationship to Beneficiary _____ Date _____
If this is being submitted by a guardian, conservator or person with power of attorney, please attach the legal documents establishing guardianship, conservatorship or power of attorney.
UC-0404-04-1004 White (2) - MHC, Organization

Failure to return these forms may result in eligibility issues that could affect your medical plan coverage.

How Medicare Works with UC Medical Plans

What Will You Pay for Services?

The Medical Benefits Summary beginning on page 17 gives you some examples of what you might expect to pay for certain services. You can use this information to help you decide which plan is right for you.

Medicare Advantage HMO Plans

When you enroll in a UC HMO medical plan, you must assign your Medicare benefits to the HMO. Medicare pays a flat fee to the plan each month, and the HMO agrees to assume full responsibility for your care. Your Primary Care Physician (PCP) manages your care and you must receive all services through your Primary Care Physician's medical group.

UC HMO plans also provide additional benefits that are not covered by Medicare (for example, prescription drug benefits). When you receive services, you pay a predetermined copayment. You have no annual deductible or claim forms.

Blue Cross PLUS

This plan offers two levels of coverage. The "in-network" level works like an HMO; you must coordinate all services through your PCP, and you pay a copayment each time you receive services.

There is no annual deductible for the Blue Cross PLUS in-network level. Unlike the HMO plans, Blue Cross PLUS allows you to see Medicare providers that are not within your medical group. In this case, the service is covered at the "out-of-network" benefit level as long as you go to a Medicare provider.

Blue Cross PPO, Core and High Option Providers

You may see any Medicare provider (a doctor who has a contract with Medicare). If your Medicare provider "accepts assignment," that means he/she will accept the Medicare-approved rate for services. This is the rate that Medicare uses to figure their payments. However, if your doctor does not accept Medicare assignment, he/she can bill you for an additional amount (up to 15 percent) over the Medicare allowable rate. This is called "balance billing."

With these plans, you do not assign your Medicare benefits to the plan. When you receive services, Medicare is the primary payer, and your UC-sponsored medical plan is secondary.

For more information:

- *Medicare & You*, the national Medicare handbook, is available from your local Social Security Administration office or on Medicare's website (www.medicare.gov).
- UC's *Medicare Factsheet* is available from the At Your Service website (<http://atyourservice.ucop.edu>) or from the UC Customer Service Center.
- Call the medical carrier or the UC Customer Service Center (1-800-888-8267) if you have any questions.

Medical Benefits Summary: 2005

(for members with Medicare)

Medicare Plans

PLAN	Doctor Visit	Hospitalization
Health Net/Seniority Plus PacifiCare of CA/ Secure Horizons Western Health Advan- tage/WHA Care+	You pay \$10 copay; Medicare and plan pay the rest.	You pay \$250 copay per occurrence or admittance. Medicare and plan pay the rest.
Kaiser/Senior Advantage	You pay \$10 copay; Medicare and plan pay the rest.	You pay \$250 copay per admittance. Medicare and plan pay the rest.
Blue Cross PLUS In-Network¹	You pay \$20 copay; Medicare and plan pay the rest.	You pay \$250 copay per occurrence or admittance. Medicare and plan pay the rest.
Blue Cross PLUS Out-of-Network¹	Medicare pays 80% of Medicare allowable; plan pays benefits at 70%. If that benefit is greater than Medicare, plan pays the difference. In most cases the plan pays nothing. <i>Example¹:</i> Medicare allowable: \$150 Medicare pays 80%: \$120 Plan pays: \$0 You pay: \$30	You pay 30%, plan pays 70% of the Medicare Hospitalization Deductible (\$912 in 2005). After that, Medicare pays 100% for the first 60 days and a fixed amount for days 61–150. Then you pay 30%; plan pays 70%.
Blue Cross PPO¹	Medicare pays 80% of Medicare allowable; plan pays 80% of the balance; you pay any remaining balance. <i>Example¹:</i> Medicare allowable: \$150 Medicare pays 80%: \$120 Plan pays 80% of balance: \$24 You pay: \$6	You pay 20%, plan pays 80% of the Medicare Hospitalization Deductible (\$912 in 2005). After that, Medicare pays 100% for the first 60 days and a fixed amount for days 61–150. Then you pay 20%; plan pays 80%.
Core¹	Medicare pays 80% of Medicare allowable; plan pays benefits at 80%. If that benefit is greater than Medicare, plan pays the difference. In most cases the plan pays nothing. You pay the 20% balance. <i>Example¹:</i> Medicare allowable: \$150 Medicare pays 80%: \$120 Plan pays: \$0 You pay: \$30	You pay 20%, plan pays 80% of the Medicare Hospitalization Deductible (\$912 in 2005). After that, Medicare pays 100% for the first 60 days and a fixed amount for days 61–150. Then you pay 20%; plan pays 80%.
High Option Supplement¹	You pay nothing. Medicare pays 80% of allowable; plan pays balance. <i>Example¹:</i> Medicare allowable: \$150 Medicare pays 80%: \$120 Plan pays 100% of balance: \$30 You pay: \$0	You pay nothing. Plan and Medicare pays 100%.

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 plan provides service where you live, call the plan directly or see their website. WHA Care+ is only offered in Sacramento and Yolo counties and parts of Solano and Placer counties.

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

¹ The Blue Cross, Core and High Option examples assume that you have met your annual deductible, and that your doctor accepts Medicare assignment. After you meet your annual out-of-pocket maximum, your plan will pay 100% of your covered expenses. Actual charges for office visits are usually higher than the Medicare allowable. If your doctor does not accept Medicare assignment, you are also responsible for balance billing. Call the plan for details.

Medical Benefits Summary: 2005

(for members with Medicare)

Medicare Plans

PLAN	Emergency	Lab Work	Prescription Drug Copay (Generic/Brand/Non-Formulary)	Medical Services when Traveling Outside of U.S. ²
Health Net/Seniority Plus 1-800-596-6565	You pay \$50 copay (waived if admitted); Medicare and plan pay the rest	You pay nothing for Medicare-approved services; Medicare pays 100%	Retail (Up to 30-day supply): \$10/\$20/\$35 Mail Order: \$20/\$40/\$70 ³	Emergencies/urgent care covered at 100%. (PCP/HMO must be notified, you pay copay.) For other services you pay full costs: plan and Medicare do not pay.
Kaiser/Senior Advantage 1-800-443-0815	You pay \$50 copay (waived if admitted); Medicare and plan pay the rest	You pay nothing for Medicare-approved services; Medicare pays 100%	Retail (Up to 100-day supply): \$10/\$20 Mail Order: Refills can be arranged	Emergencies/urgent care covered at 100%. (PCP/HMO must be notified, you pay copay.) For other services you pay full costs: plan and Medicare do not pay.
PacifiCare of CA/Secure Horizons 1-800-610-2660	You pay \$50 copay (waived if admitted); Medicare and plan pay the rest	You pay nothing for Medicare-approved services; Medicare pays 100%	Retail (Up to 30-day supply): \$10/\$20/\$35 Mail Order: \$20/\$40/\$70	Emergencies/urgent care covered at 100%. (PCP/HMO must be notified, you pay copay.) For other services you pay full costs: plan and Medicare do not pay.
Western Health Advantage/WHA Care+ 1-888-563-2251	You pay \$50 copay (waived if admitted); Medicare and plan pay the rest	You pay nothing for Medicare-approved services; Medicare pays 100%	Retail (30-day supply): \$10/\$20/\$35 Mail Order (90-day supply): \$20/\$40/\$70	Emergencies/urgent care covered at 100%. (PCP/HMO must be notified, you pay copay.) For other services you pay full costs: plan and Medicare do not pay.
Blue Cross PLUS In-Network¹ 1-888-209-7975	You pay \$75 copay (waived if admitted); Medicare and plan pay the rest	You pay nothing for Medicare-approved services; Medicare pays 100%	Retail (30-day supply): \$15/\$25/\$40 Mail Order (90-day supply): \$30/\$50/\$80	Emergencies/urgent care covered at 100%. (PCP must be notified, you pay copay.) Other services covered as out-of-network.
Blue Cross PLUS Out-of-Network¹ 1-888-209-7975	You pay \$75 copay (waived if admitted); Medicare and plan pay the rest	You pay nothing for Medicare-approved services; Medicare pays 100%	At participating pharmacies ⁴ : Retail (30-day supply): \$15/\$25/\$40 Mail Order (90-day supply): \$30/\$50/\$80 (Must use plan mail order facility)	After \$500 deductible, you pay 30%, plan pays 70%
Blue Cross PPO¹ 1-888-209-7975	Medicare pays 80%, then plan pays 80% of the balance; you pay amount remaining	You pay nothing for Medicare-approved services; Medicare pays 100%	Retail (30-day supply): \$15/\$25/\$40 Mail Order (90-day supply): \$30/\$50/\$80	After \$100 deductible: PPO providers: you pay 20% and plan pays 80%. Non-PPO: you pay 40% and plan pays 60%.
Core¹ 1-888-209-7975	You pay 20%; Medicare pays 80%	You pay nothing for Medicare-approved services; Medicare pays 100%	You pay 20% of retail cost, plan pays 80%. After you reach out-of-pocket maximum, plan pays 100%.	After \$150 deductible, you pay 20%, plan pays 80%
High Option Supplement¹ 1-888-209-7975	You pay nothing; Medicare and plan pay 100%	You pay nothing for Medicare-approved services; Medicare pays 100%	Retail (30-day supply): \$15/\$25/\$40 Mail Order (90-day supply): \$30/\$50/\$80; Annual prescription out-of-pocket maximum: \$1,000/member	After \$50 deductible, you pay 10%, plan pays 90%

1 The Blue Cross, Core and High Option examples assume that you have met your annual deductible, and that your doctor accepts Medicare assignment. After you meet your annual out-of-pocket maximum, your plan will pay 100% of your covered expenses. Actual charges for office visits are usually higher than the Medicare allowable. If your doctor does not accept Medicare assignment, you are also responsible for balance billing. Call the plan for details.

2 Does not apply if your permanent address is outside the U.S.

Medicare Plans

Preventive Physical Exam	Durable Medical Equipment	Eye Exams	Hearing Exams/ Hearing Aids	Chiropractor	Acupuncture
\$10	No charge	\$10	Exam: \$10, 2 standard hearing aids every 36 months at no charge	\$10/20 visits/ calendar year	Not covered
\$10	No charge	\$10	Exam: \$10, hearing aids every 36 months, \$2500 maximum per ear (medically necessary)	\$10 (manual manipulation as covered by Medicare only)	Not covered
\$10	No charge	\$10	Exam: \$10, hearing aids covered in full every 36 months	\$10, subject to Medicare guidelines	Not covered
\$10	No charge	\$10	Exam: \$10, hearing aids every 36 months (maximum \$2000)	\$10 (as required by Medicare only)	Not covered
\$20	No copay	\$20 (medically necessary)	Exam \$20, aids 50% (Max. \$2000, and 2 aids/36 months analog or digital)	\$20 (Network Panel only). Must be a licensed ASHP provider.	\$20 (Network Panel only). Must be a licensed ASHP provider.
Medicare covers specific preventive services only. Plan does not pay in addition	30%	Routine exams not covered. Medicare pays 80% of approved services, plan does not pay in addition	Exam 30%, aids 50% (Max. \$2000 and 2 aids/36 months analog or digital)	Medicare pays 80% of approved services, plan does not pay in addition	Not covered
Medicare and plan cover 80%, you pay 20%	20%	Routine exams not covered. Medicare pays 80% of approved services, plan does not pay in addition	Exam 20%, aids 20% (Max. \$2000 and 2 aids/36 month analog or digital)	Medicare pays 80% of approved services, plan does not pay in addition	You pay 20%
Medicare and plan cover 80%, you pay 20%	20%	Routine exams not covered. Medicare pays 80% of approved services, plan does not pay in addition	Not covered	Medicare pays 80% of approved services, plan does not pay in addition	You pay 20% (\$500 maximum/calendar year)
Medicare covers specific preventive services only. Plan does not pay in addition	No copay, if covered by Medicare; 20% if not covered by Medicare (deductible applies)	Not covered	Not covered	No copay, network providers only; when Medicare is exhausted, 20% copay after deductible	For treatment of disease, illness, or injury. Network providers only. You pay 20% (deductible applies) \$500 maximum/calendar year limit

3 Annual prescription out-of-pocket maximum is \$2,000/member/calendar year.

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

For details on your behavioral health benefits, call your plan. Coordination of these benefits with Medicare varies depending on the type of Medicare coordination and what is covered by Medicare. Inpatient services are covered by Medicare the same as hospitalization.

Note: For more information on how UC-sponsored medical plans coordinate with Medicare and on “balance billing,” see UC’s *Medicare Factsheet*.

Medical Plan Deductibles and Out-of-Pocket Maximums

PLAN	COSTS		
	Calendar Year Deductible	Annual Out-of-Pocket Maximum	Lifetime Maximum
Health Net/ Seniority Plus (HMO)	\$0	Three inpatient copayments per person per calendar year	No overall maximum lifetime benefit. Some HMOs may have lifetime maximums for specific benefits; see plan booklets.
Kaiser—CA/ Senior Advantage (HMO)	\$0	Individual: \$1,500 Family (3 members or more): \$3,000	No overall maximum lifetime benefit. Some HMOs may have lifetime maximums for specific benefits; see plan booklets.
PacifiCare of CA/ Secure Horizons (HMO)	\$0	Three inpatient copayments per person per calendar year	No overall maximum lifetime benefit. Some HMOs may have lifetime maximums for specific benefits; see plan booklets.
Western Health Advantage/WHA Care+ (HMO)	\$0	Individual: \$1,000 Family (3 members or more): \$3,000	No overall maximum lifetime benefit. Some HMOs may have lifetime maximums for specific benefits; see plan booklets.
Blue Cross PLUS In-Network (POS)	\$0	Individual: \$1,500 Family: \$4,500	Unlimited
Blue Cross PLUS Out-of-Network (POS)	Individual: \$500 Family: \$1,500	Individual: \$5,000 Family: \$15,000	\$2,000,000/member
Blue Cross PPO (PPO)	\$100/member	\$1,500/member	\$5,000,000/member
Core (Fee-for-service)	\$150/member	\$2,260/member	\$2,000,000/member
High Option Supplement (Fee-for-service)	\$50/member	Medical: \$1,050/member. Prescription drugs: \$1,000/member	\$2,000,000/member

Calendar Year Deductible

The calendar year deductible is the amount you must pay before the medical plan begins to pay a percentage of the total cost of benefits. Until the deductible is met, you pay the total cost not covered by Medicare. Review each plan's annual deductible and monthly premium to decide which plan is the most affordable.

Out-of-Pocket Maximum

The out-of-pocket maximum is the annual ceiling for your copayments or coinsurance during the calendar year. After this amount is reached, the plan will pay benefits at 100 percent after Medicare. Some expenses do not apply toward the maximum (see plan booklets).

Lifetime Maximum

The most that will be payable for any person in his/her lifetime.

No Duplicate Coverage

You may be covered in only one of the following categories:

- Employee
- Retiree
- Eligible Family Member

If both you and your spouse or domestic partner are UC employees or retirees, only one of you may cover your children.

If a duplicate enrollment occurs, UC will cancel the later enrollment. UC reserves the right to collect repayment for any duplicate coverage.

Who You May Enroll

You may enroll your family members in your UC-sponsored plans as long as they meet UC's eligibility requirements. See the chart on page 23.

Eligible Adult

Besides yourself, you may have only one eligible adult family member enrolled:

- a legal spouse,
- a domestic partner, or
- an adult dependent relative (must be enrolled by 12/31/03)

NEW FOR 2005: Expanded Eligibility

Plan coverage eligibility is expanding in 2005 for two categories of family members.

NEW—Opposite-Sex Domestic Partners

Eligible opposite-sex domestic partners and their children or grandchildren **who meet the qualifications listed below** may be covered by the retiree's medical, dental and/or legal plan.

One partner must be 62 or older and eligible to receive Social Security based on age, and the other partner must be at least 18.

The opposite-sex domestic partnership must be registered with the State of California, or the following qualifications must be met by both partners:

- must be capable of consenting to the domestic partnership;
- must be each other's sole domestic partner in a long-term, committed relationship and intend to remain so indefinitely;
- must share a common residence;
- must not be related by blood in a way that would prevent them from being married to each other in California;
- must be financially interdependent;
- must not be legally married to someone else or be a member of another domestic partnership.

Children of Domestic Partners

A domestic partner's child(ren) or grandchild(ren) who meet the following qualifications may be enrolled to age 23:

- must be unmarried;
- must live with the UC retiree and receive at least 50% financial support from the domestic partner or retiree;
- must be claimed as a tax dependent by the UC retiree or their domestic partner.

NEW—Disabled Children Over Age 23: Tax Dependency No Longer Required

Qualified disabled children may remain eligible for continued coverage past age 23. This applies to the following children: natural or legally adopted child(ren), and if living with you: stepchild(ren) and grandchild(ren), child(ren) and grandchild(ren) of the eligible domestic partner.

The disabled child must meet these qualifications:

- must be incapable of self-support due to a mental or physical handicap;
- the incapacity began before age 23, the child was enrolled in a group medical plan (including Medicare and Medicaid), and the coverage has been continuous; and
- the child meets any one of these qualifications:

is dependent on you for at least

50% of his or her support and is your dependent for income tax purposes, **or**

is eligible for Social Security Income or Supplemental Security Income (SSI) as a disabled person, **or**

is working in supported employment which may offset the Social Security or SSI benefits.

Contact the UC Customer Service Center since a paper form as well as medical plan certification of incapacity is required to enroll these children. Confirmed coverage is subject to carrier approval. There may be imputed income for non-tax dependent family members.

IMPUTED INCOME

If you enroll the following eligible family members, the UC/employer contribution for the additional coverage may be taxable income to you:

- eligible domestic partner (same-sex and opposite sex)
- domestic partner's child/grandchild(ren)
- overage disabled child who meets all the UC requirements.

This imputed income is subject to federal and California state income taxes, Social Security and Medicare taxes and any other required payroll tax. You may not be subject to tax on imputed income if these family members are your tax dependents, or, for California state income tax purposes only, if you have registered your domestic partnership with the state of California. You may recover any excess federal or California state income tax withheld when you file your tax returns.

Please call the UC Customer Service Center for more information.

Ineligible Family Members

Important Note: If an enrolled family member loses eligibility during the year, call the UC Customer Service Center to have them de-enrolled. Don't wait until Open Enrollment. You are responsible for costs incurred in connection with the enrollment of ineligible family members and you could be subject to penalties associated with the misuse of the plan if you continue coverage for family members who no longer meet UC's rules.

If you de-enroll a family member during Open Enrollment, that individual's coverage will end December 31, 2004.

Your legally separated spouse, former spouse, or former domestic partner is not eligible to participate in UC-sponsored health and welfare plans.

If a divorce or legal separation settlement requires you to provide such coverage, you must do so on your own.

For details on eligibility, see the *Group Insurance Eligibility Factsheet* (for retirees), available on the At Your Service website (<http://atyourservice.ucop.edu>) or from the UC Customer Service Center (1-800-888-8267, Monday–Friday, 8:30 am–4:30 pm).

COBRA and Conversion

Family members who lose eligibility may be able to continue coverage under COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) or other UC continuation options. In some cases, they may be able to convert UC-sponsored coverage to individual policies. For more information, see the *Continuation of Group Insurance Coverage* notice, available on the At Your Service website or from the UC Customer Service Center.

Family Member Eligibility Chart

Medical
Dental
AD&D
Legal

Reminder: As a retiree, you and your eligible family members may continue your medical, dental and legal plans. AD&D coverage is available only to you and your spouse/domestic partner (payment must be made directly to American Home Assurance).

FAMILY MEMBER	ELIGIBILITY	MUST BE	Medical	Dental	AD&D	Legal
Legal spouse¹	Eligible		●	●	●	●
Adult dependent relative (enrolled by 12/31/03)	Age 18 or older	<ul style="list-style-type: none"> related to you (see below)² living with you claimed as your tax dependent not eligible for Medicare Part A 	●	●		
Domestic partner¹ of retiree (same-sex/ opposite-sex)	Age 18 or older	<ul style="list-style-type: none"> if opposite sex either the retiree or the domestic partner must be age 62 or older and eligible to receive Social Security benefits based on age domestic partnership registered with the State of California or established a partnership in jurisdictions other than California (same-sex domestic partners only); otherwise, the following requirements must be met by both partners; <ul style="list-style-type: none"> – must be capable of consenting to the domestic partnership – must be each other’s sole domestic partner in a long-term, committed relationship and intend to remain so indefinitely; – must share a common residence; – must not be related by blood in a way that would prevent them from being married to each other in California; – must be financially interdependent; – must not be legally married to someone else or be a member of another domestic partnership 	●	●	●	●
Natural or adopted child	To age 23	<ul style="list-style-type: none"> unmarried 	●	●		●
Stepchild, grandchild or step-grandchild	To age 23	<ul style="list-style-type: none"> unmarried living with you supported by you or your spouse (50%+) claimed as a tax dependent by you or your spouse 	●	●		●
Domestic partner’s child or grandchild³	To age 23	<ul style="list-style-type: none"> unmarried living with you supported by you or your domestic partner (50%+) claimed as a tax dependent by you or your domestic partner 	●	●		●
Legal ward enrolled 1/1/95 or after	To age 18	<ul style="list-style-type: none"> unmarried living with you supported by you (50%+) claimed as your tax dependent 	●	●		●
Overage disabled child (except a legal ward) of retiree	Age 23 or older	<ul style="list-style-type: none"> enrolled in a group medical plan before age 23 with continuous coverage and the incapacity must have begun before age 23; claimed as your dependent for income tax purposes or eligible for Social Security Income or Supplemental Security Income as a disabled person (the overage disabled child may be working in supported employment which may offset the Social Security or Supplemental Security Income); living with you if he or she is not your or your spouse’s natural or adopted child; unmarried 	●	●		●
A child age 23 and above and incapable of self-support due to a mental or physical disability						

1 If you are the surviving family member of a deceased retiree, you may not enroll a spouse or domestic partner.

2 “Related to you” refers to a family relationship legally acknowledged in the State of California. These relationships include: parents and children; ancestors and descendants of every degree (this means grandparents and grandchildren, great-grandparents and great-grandchildren, etc.); brothers and sisters; half-brothers and half-sisters; uncles and aunts; and nieces and nephews.

3 Domestic partner must be eligible for UC-sponsored health coverage.

For More Information

During Open Enrollment, you may want to compare your current coverage with other options available to you, or to learn more about the plans UC offers. Sources of information include:

The Internet

The UC HR/Benefits website—<http://atyourservice.ucop.edu>—provides information related to Open Enrollment, including:

- The latest news on UC's plans, a step-by-step guide to Open Enrollment, publications, and links to useful sites
- **Medical Plan Wizard**—a ZIP code based tool to help you find medical plans in your area
- Links to insurance carrier websites

Insurance Carriers

You may ask insurance carriers to mail plan materials to you. Be sure to call early to allow sufficient mailing time. If you order too late, you may not receive the materials in time to help you with your Open Enrollment decisions.

UC Customer Service Center

If you need additional benefits assistance, please call the UC Customer Service Center at 1-800-888-8267, Monday–Friday, 8:30 am–4:30 pm (PST).

Service for Hearing Impaired

If you are hearing impaired or speech disabled, call the California Relay Service. Both TT (text telephone) and voice users may initiate calls through California Relay Service. The toll-free access numbers are below:

Inside California:

1-800-735-2929 (TT)
1-800-735-2922 (Voice)

Outside California:

1-800-688-4889 (TT)
1-800-947-8642 (Voice)

Publications

You can find the following publications on the UC HR/Benefits website:

- *Group Insurance Eligibility Factsheet* (for retirees)
- *Dental Plan Summary (2005)*
- *UC's Medicare Factsheet*
- Evidence of Coverage (EOC) and plan booklets for most UC-sponsored plans

Copies of the EOC and plan booklets are also available directly from the carriers—see the phone numbers on page 26.

For some of these publications, only the 2004 version is currently available. The 2005 versions will be available on our website early next year.

Open Enrollment Fairs

CAMPUS/LAB/ MED CENTER	DATES	LOCATIONS	TIMES
UCSF	November 1 Monday	The UCSF Faculty Alumni House 745 Parnassus San Francisco, CA 94143	12:00–2:30
LLNL	November 2 Tuesday	Four Points Hotel 5115 Hopyard Road Livermore Rooms A,B,C &D Presentation: San Ramon Rooms A &B Pleasanton, CA 94588	9:00–12:00
Santa Barbara	November 3 Wednesday	Holiday Inn 5650 Calle Real Fiesta Room 1 Presentation: Fiesta Room 2 Goleta, CA 93117	9:00–12:00
UCLA	November 4 Thursday	UC Los Angeles Faculty Center, California Room Presentation: Sierra Room 480 Charles E. Young Drive Los Angeles, CA 90095	8:30–11:00
Davis	November 8 Monday	Freeborn Hall University of California Presentation: Mee Room Davis, CA 95616	9:00–11:00
Santa Cruz	November 10 Wednesday	UCSC Inn & Conference Center Sierra Room 611 Ocean Street Santa Cruz, CA 95060	9:00–11:30
Irvine	November 12 Friday	UCI University Club Library Presentation: Room C 801 East Peltason Irvine, CA 92697	9:00–11:00
East Bay	November 16 Tuesday	Holiday Inn, Convention Center 1800 Powell Street Emeryville, CA 94608	8:00–11:00
Riverside	November 17 Wednesday	University Extension 1200 University Avenue Conference rooms D&E Riverside, CA 92507	8:30–11:00
San Diego	November 22 Monday	UCSD Price Center Gallery B Presentation: Gallery A UC San Diego La Jolla, CA 92093	8:00–10:00

Open Enrollment Fairs

Open Enrollment is from November 1 through 30, 2004.

Attending an Open Enrollment Fair provides an excellent opportunity to talk to plan representatives and ask your benefits questions. Reference copies of plan materials will be on hand. Be sure to bring with you any Open Enrollment materials you have received in the mail.

Plan to attend a fair that is convenient to you. Reservations are not required, and parking is available although not necessarily free.

Insurance Carrier Toll-Free Numbers

If you need information about plan coverage for a specific condition or prescription medication, a plan's service area, or plan providers, please call the plan directly. During Open Enrollment, you may reach plan representatives at the toll-free numbers below.

Medical Plans

Blue Cross PLUS and PPO	1-888-209-7975
Core	1-888-209-7975
Health Net	1-800-522-0088
Health Net/Seniority Plus	1-800-596-6565
High Option Supplement	1-888-209-7975
Kaiser Permanente—California	1-800-464-4000
Kaiser Permanente/Senior Advantage	1-800-443-0815
Kaiser Permanente—Mid-Atlantic	
Inside Washington D.C. metro area	1-301-468-6000
Outside metro area	1-800-777-7902
PacifiCare of California	1-800-982-9993
PacifiCare of California/Secure Horizons	1-800-610-2660
PacifiCare of Nevada	1-800-347-8600
PacifiCare of Nevada/Secure Horizons	1-800-610-2660
UnitedHealthcare (UHC) EPO and PPO	1-800-603-3816
Western Health Advantage/WHA Care +	1-888-563-2252

Dental Plans

Delta Dental	1-800-777-5854
PMI	1-800-422-4234

Legal Plan (ARAG Legal)	1-800-828-1395
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Terms and Conditions

Enrollment Information

Participation Terms and Conditions

Your Social Security number will be requested only as needed by benefit plan administration for financial reporting and to verify your identity, in compliance with state and federal law.

If you participate in UC-sponsored plans, you agree to the following terms and conditions:

1. Binding Arbitration

Most of the medical plans that UC offers (including the Blue Cross of California plans, Health Net, Kaiser Permanente, PacifiCare, Western Health Advantage, Definity Health, UnitedHealthcare plans, and PacifiCare Behavioral Health), as well as the PMI dental plan, require resolution of medical malpractice and other disputes through binding arbitration. When you enroll in these plans, you agree that any dispute between you (and/or your enrolled family members) and the medical or dental plan must be submitted to binding arbitration. You agree to waive your right to a jury or court trial to resolve these disputes. For more information about each plan's arbitration provision, please see the appropriate plan booklet or call the plan.

2. You acknowledge and accept all terms and conditions of the UC-sponsored plans in which you are enrolled as stated in the plan booklets and UC's Group Insurance regulations.

3. If you enroll family members, the University and/or carrier may require proof of eligibility. Marriage or birth certificates, adoption papers, tax records, and the like may be requested. You agree to provide such documentation upon request.
4. If you enroll your eligible domestic partner and/or your partner's eligible child(ren) or grandchild(ren), you acknowledge that the UC/employer contribution for their medical and/or dental coverage may be considered your taxable income, subject to FICA (Social Security and Medicare) and federal and California state income tax withholding.
5. If you specifically ask UC representatives to intercede on your behalf with your insurance plan, you authorize the plan to release to the UC representatives pertinent health and personal information concerning you and/or your family member(s). University representatives will request and utilize only the minimum necessary health information required to assist you with your problem. In compliance with state privacy laws and federal laws, including HIPAA (Health Insurance and Portability and Accountability Act of 1996), in some instances you may be required to sign an authorization allowing UC to provide the insurance plan with relevant personal health information or authorizing the

insurance plan to release such information to the University representative.

6. You authorize deductions from your earnings to cover your monthly costs, if any, for the plans you have chosen for yourself and your eligible family members.
7. Actions you take during Open Enrollment will be effective the following January 1, unless otherwise stated.
8. You certify that all enrolled family members are eligible for coverage based on the definitions and rules specified in the *UC Group Insurance Eligibility Factsheet*. You agree that you will de-enroll them within 31 days if they lose eligibility. You further certify that all the information you provide is true to the best of your knowledge, under penalty of perjury.
9. Making false statements about satisfying eligibility criteria, failing to notify the University of loss of eligibility within 31 days, or failing to provide documentation when requested will lead to de-enrollment of the family members and possible legal action. In addition, employees/retirees will be subject to disciplinary action (e.g., loss of health benefits for up to 18 months) and will be responsible for any employer contributions to and benefits paid by the plan for the ineligible coverage.

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.

Website address: <http://atyourservice.ucop.edu>



University of California
Human Resources and Benefits
P.O. Box 24570
Oakland, CA 94623-1570

