

University of California



Medicare Factsheet

for Employees and Retirees

Medicare is the federal health insurance program administered by the Centers for Medicare and Medicaid Services (CMS). This factsheet explains when and how the UC-sponsored medical plans coordinate with Medicare.

Medicare has four parts:

1. **Medicare Part A (hospital insurance)** helps pay for care in a hospital and skilled nursing facility, home health care and hospice care. Usually you do not pay a monthly premium for Part A coverage if you or your spouse paid Medicare taxes while working. For additional information about how you may qualify through a spouse, former spouse, or deceased spouse, contact the Social Security Administration (1-800-772-1213) or visit their website (SSA.gov).
2. **Medicare Part B (medical insurance)** helps pay for medically necessary doctor's services, outpatient hospital care and other medical services. Most people pay a monthly premium for Part B which is deducted from your Social Security benefit. If you are not receiving a Social Security pension, the Social Security Administration will bill you directly.
3. **Medicare Part C (Medicare Advantage)** is the term used to describe the coordination between Medicare and UC's HMO plans. Under this arrangement, you are required to assign your Medicare Part A, B and D benefit to your HMO and to maintain that assignment. In return, your HMO will provide your benefits and will handle the coordination with Medicare. If you are enrolled in an HMO and would like more information on Medicare Advantage, please see pages 4–7 or visit Medicare's website (www.medicare.gov).
4. **Medicare Part D (prescription drug insurance)** helps cover the cost of prescription drugs. UC medical plans coordinate the Part D portion of your Medicare plan with the medical plan. See page 2 for information and enrollment details.

In some cases, the UC/employer contribution for a Medicare medical plan is more than the total premium cost. In that case all or part of your Medicare Part B monthly premium may be reimbursed by the University.

UC Enrollment Requirements for Retirees

If you are a University retiree enrolled in a UC-sponsored medical plan, UC requires you and your family members to maintain Medicare Part B enrollment as soon as you or your family members become eligible for premium-free Medicare Part A, usually at age 65. **Failure to comply with this policy can result in penalties and the permanent loss of your UC-sponsored medical coverage.**

Medicare Eligibility and Part B Enrollment

Medicare eligibility is determined by the Social Security Administration (SSA), not the University. Most people become eligible for Medicare

- At age 65, through their own work history or the work history of a current or former spouse, or
- Before age 65, after receiving Social Security disability benefits for 24 months.

Medicare generally does not cover health services outside the U.S. Therefore, UC waives its requirement that you enroll in Medicare Part B while you live outside the U.S. If/when you return to the U.S. and if you are eligible for Medicare Part A, you will be required to enroll in Part B. Medicare may charge a higher premium if you enroll/re-enroll past age 65.

UC will send you a packet of information regarding Medicare three months before your 65th birthday. This packet will include a *Medicare Declaration* form (UBEN 126), which you must complete and return to UC with a copy of your Medicare card or your Social Security denial letter. The packet will also include all necessary forms and instructions.

For more information, see *Medicare & You*, the national Medicare handbook, available online at www.medicare.gov or from your local Social Security Administration office.

Employees Age 65 or Older

If you do not retire and continue working at the University past age 65, you are not required to sign up for Medicare Part B when you become eligible for premium-free Medicare Part A. Federal law stipulates that your UC group employer plan will be your primary coverage while you are working. When you retire, you must immediately enroll in Medicare Part A and Part B.

UC-Sponsored Medical Plans and Medicare Part D

HMOs

UC has integrated Medicare prescription drug plans into each of the Medicare coordinated HMO medical plans. If you are a retiree and are enrolled in Medicare, UC will automatically enroll you in the Part D portion of your plan and you will not be charged any additional premium. You do not need to purchase Part D from any other source.

Anthem Blue Cross Plans

If you are enrolled in Anthem Blue Cross PLUS, PPO, Core or High Option, you are required to assign your Part D benefit to the medical plan. In return, Anthem will coordinate with Medicare. To assign your Part D benefit to the plan, complete the *Anthem Blue Cross Part D Enrollment* form (UC will provide this) and return it to UC.

The Anthem Blue Cross PPO Medicare without Prescription Drugs plan allows UC retirees who are eligible to participate in another non-Medicare Advantage group medical insurance program with Part D benefits offered

If You Return to Work at the University

University policy stipulates that employees who are rehired after retirement be limited to an average of 43.75 percent time during a 12-month period. In most cases, if your appointment is within this policy, your retiree benefits continue and Medicare remains the primary payer. Your retiree benefits also continue if you are appointed by agreement or are in a per diem appointment.

If you become eligible for UC employee medical coverage because of your rehired appointment, federal law requires that Medicare no longer be your primary payer. To comply with this federal regulation, you are required to suspend your retiree plan and enroll in the non-Medicare version of your plan with Medicare as the secondary payer, or opt-out of UC-sponsored employee medical coverage and have Medicare coverage only.

by another employer to do so while maintaining enrollment in UC's retiree medical insurance program. This plan provides coverage for medical and hospitalization, but **no prescription drug coverage**. It is **not** considered "creditable coverage" under Medicare Part D.

Other Employer or Retiree Plans

If you have health insurance with another employer or retiree plan, you may wish to contact them and inquire about their rules regarding enrollment in Medicare Part D plans. **Under Medicare rules, you may be enrolled in only one Medicare Part D plan.**

Medicare Part D Creditable Coverage

The University of California has determined that the prescription drug coverage offered by most of the UC-sponsored Medicare plans (Anthem Blue Cross PLUS, Anthem Blue Cross PPO, Core, Health Net/Seniority Plus, Health Net Medicare COB, High Option Supplement to Medicare, Kaiser Permanente CA/Senior Advantage, Kaiser Permanente Mid-Atlantic Medicare Plus, Kaiser Umbrella, and WHA Care+ is considered creditable coverage.

This means the prescription drug coverage, on average, is expected to pay out at least as much as the standard Medicare Part D benefit.

Under Medicare rules, Medicare enrollees must maintain continuous Part D coverage or may risk paying more for Part D in the future. If you cancel or lose UC-sponsored medical coverage and do not enroll in another Medicare Part D plan, in the future you may face a late enrollment penalty when you do enroll in Medicare Part D coverage.

For additional details, visit: www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227).

If eligible for UC employee medical coverage, your local Benefits Office or the person in your department who handles benefits will advise you on the impact of your appointment on your Medicare enrollment. Your premium for employee medical coverage will be deducted from your employee earnings and, in most cases, your premium will increase. If you are receiving any Medicare Part B reimbursement, it will stop.

While you are covered as an employee, be sure to show your employee medical plan ID card (not your Medicare card) to your doctor for correct claims payment.

Note: If you are eligible for employee medical coverage as a result of returning to work at UC, you cannot cancel your Medicare Part B enrollment even though Medicare is a secondary payer.

UC Medical Plans for Medicare Enrollees

The UC-sponsored medical program offers separate plans for Medicare enrollees. The Medicare version of your medical plan may have different benefits, services areas, behavioral health providers and doctors than the non-Medicare version of the plan. The Medicare versions of the UC-sponsored plans are listed below:

Non-Medicare	Medicare
Anthem Blue Cross PLUS	Anthem Blue Cross PLUS w/ Medicare
Anthem Blue Cross PPO	Anthem Blue Cross PPO w/ Medicare Anthem Blue Cross PPO Medicare without Rx
CIGNA Choice Fund	Not available
Core	Core w/ Medicare
Health Net HMO	Health Net/Seniority Plus Health Net Medicare Coordination of Benefits
Health Net Primary EPO	Not available
Kaiser CA	Kaiser CA Senior Advantage
Kaiser Mid-Atlantic	Kaiser Mid-Atlantic Medicare Plus
Kaiser Umbrella	Kaiser Umbrella Medicare Cost
WHA	WHA Care+
Not available	High Option Supplement to Medicare

Medicare Providers Required

To receive plan benefits under any UC-sponsored Medicare plan, you must use a provider who participates in Medicare. If your doctor does not take Medicare patients or will only render services under a “private contract” directly with you, neither Medicare nor your UC-sponsored medical plan will cover the services. If your doctor takes non-Medicare patients but not Medicare patients, you may need to select a new doctor when you become eligible for Medicare.

Service Areas May Differ

Some Medicare plans have a different service area than the non-Medicare version of the plan. If your plan requires that you live within the service area of the plan, and the Medicare version of the plan is not available where you live, then you and your family will be allowed to transfer to any UC-sponsored plan available in your area.

Medicare and Behavioral Health Benefits

When you enroll in Medicare and transfer to the Medicare portion of your UC-sponsored medical plan, your behavioral health benefits may change because they are based upon Medicare and the plan in which you are enrolled. Your behavioral health provider network may be different and you may need to obtain new authorizations/referrals to behavioral health providers. **If you are receiving behavioral health benefits when your Medicare coverage becomes active, immediately call your medical plan for assistance.** You are responsible for all charges if you continue with a non-Medicare doctor.

Medicare Eligibility Does Not Create a PIE

Generally, becoming eligible for Medicare will not create a period of initial eligibility (PIE) to change plans. If you live within the Medicare service area, you will be automatically transferred to the Medicare version of your current plan. You can change plans only during Open Enrollment (or if you have another qualifying event) except if you are enrolled in the CIGNA Choice Fund. The CIGNA Choice Fund does not have a Medicare version; therefore, you will be able to select a new plan when you become eligible for Medicare.

How Medicare Works with UC Medical Plans

Health Net, Kaiser–CA, WHA

The Health Net, Kaiser, and WHA plans require you to complete the *Medicare Advantage Universal Enrollment/Election* form before your Medicare coverage (and reduced monthly cost) will be effective. Mail the form directly to the plan; the address is on the form. Medicare pays a flat fee to the plan each month, and the HMO agrees to assume full responsibility for your care.

Anthem Blue Cross PLUS, Anthem Blue Cross PPO, High Option Supplement to Medicare, Core, and Anthem Blue Cross PPO Medicare Without Prescription Drugs

You do not assign your Medicare Part A and B benefits to these plans, but you do assign your Part D prescription drug coverage. When you receive services, Medicare is the primary payer, and the plan is secondary.

The **Anthem Blue Cross PLUS** plan offers two levels of coverage. The “in-network” level works like an HMO; you must coordinate all services through your primary care provider (PCP), and you pay a copayment each time you receive services. Unlike the HMO plans, however, this plan also allows you to see Medicare providers that are not within your medical group and the service is covered at the lower “out-of-network” benefit level. In most cases, Medicare’s benefit will exceed Anthem Blue Cross’ benefit. As a result, the out-of-network benefits will rarely pay benefits in addition to Medicare.

With **Anthem Blue Cross PPO, Core, Anthem Blue Cross PPO Medicare Without Prescription Drugs, and High Option Supplement to Medicare**, you may see any Medicare provider. If your Medicare provider “accepts assignment,” he/she will accept the Medicare-approved rate for services. However, if your provider does not accept Medicare assignment, he/she can bill you for up to 15 percent over the Medicare allowable rate. This is called “balance billing.” (Note: **Anthem Blue Cross PPO Medicare Without Prescription Drugs** is available only to retirees with Medicare who have Medicare Part D prescription drug coverage through another group plan. Retirees enrolled in a Medicare Advantage plan cannot enroll in this plan.)

What You Pay for Services

The following charts give some examples of what you might expect to pay for certain medical services. These are examples; your actual costs, coverage and payments may be different. For more information, see your medical plan’s Evidence of Coverage booklet.

Plan	Hospitalization
Health Net/Seniority Plus Health Net Medicare COB Western Health Advantage/ WHA Care+ Kaiser/Senior Advantage	You pay \$250 copay per occurrence or admittance. Medicare and plan pay the rest.
Anthem Blue Cross PLUS In-Network¹	You pay \$250 copay per admittance. Medicare and plan pay the rest for covered services.
Out-of-Network¹	For the first 60 days, you pay 30% and the plan pays 70% of the Medicare Hospitalization Deductible (\$1,068 in 2009); Medicare pays the remaining balance. For days 61–90, you pay 30% and the plan pays 70% of the daily Medicare coinsurance; Medicare pays the remaining balance. For days beyond 90, you pay 30%, plan pays 70%. \$200 penalty if services are not preauthorized.
Anthem Blue Cross PPO¹	The first 60 days you pay 20% and the plan pays 80% of the Medicare Hospitalization Deductible (\$1,068 in 2009); Medicare pays the remaining balance. Days 61–90: you pay 20% and the plan pays 80% of the daily Medicare coinsurance; Medicare pays the remaining balance. Beyond 90 days: you pay 20%, plan pays 80%. \$200 penalty if services are not preauthorized.
Core¹	The first 60 days you pay 20% and the plan pays 80% of the Medicare Hospitalization Deductible (\$1,068 in 2009); Medicare pays the remaining balance. Days 61–90: you pay 20% and the plan pays 80% of the daily Medicare coinsurance; Medicare pays the remaining balance. Beyond 90 days: you pay 20%, plan pays 80%. \$200 penalty if services are not preauthorized.
High Option Supplement to Medicare¹	You pay nothing. Plan and Medicare pay 100%. For non-emergency admissions: \$200 penalty if services are not preauthorized.
Anthem Blue Cross PPO Medicare without Prescription Drugs³	The first 60 days you pay 20% and the plan pays 80% of the Medicare Hospitalization Deductible (\$1,068 in 2009); Medicare pays the remaining balance. Days 61–90: you pay 20% and the plan pays 80% of the daily Medicare coinsurance; Medicare pays the remaining balance. Beyond 90 days: you pay 20%, plan pays 80%. \$200 penalty if services are not preauthorized.

¹ Core, Anthem Blue Cross PLUS, Anthem Blue Cross PPO and High Option Supplement to Medicare: For non-emergency admissions, your plan will pay 100% of your covered expenses. Actual charges for balance billing. Call the plan for details.

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

³ Retirees may enroll in this plan only if: all family members have Medicare, and all family members are 65 or older.

Doctor Visit	Emergency	Prescription Drug Copay Generic/Brand/Nonformulary	Medical Services when Traveling outside of U.S. ²
You pay \$15 copay; Medicare and plan pay the rest	You pay \$50 copay (waived if admitted); Medicare and plan pay the balance	Retail (30-day supply): \$5/\$20/ \$35. Mail order (up to 90-day supply): \$10/\$40/\$70. Kaiser: Retail (up to 100-day supply): \$10/\$20; mail order: refills can be arranged. Health Net: (Self-injectables and specialty): 25%–50% coinsurance up to \$2,000 out-of-pocket max. WHA: (Self-injectables): 20% up to \$100/month.	Emergencies/urgent care covered. (PCP/HMO must be notified, you may need to file for reimbursement.) For other services you pay full costs: plan and Medicare do not pay.
You pay \$20 copay; Medicare and plan pay the rest for covered services.	You pay \$75 copay (waived if admitted); Medicare and plan pay the balance	Retail (30-day supply): \$10/\$25/\$40. Mail order (90-day supply): \$20/\$50/\$80.	Emergencies/urgent care covered at 100%. (PCP must be notified, you pay copay.) Other services covered as out-of-network.
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.	You pay \$75 copay (waived if admitted); Medicare and plan pay the balance	At participating pharmacies: Retail (30-day supply): \$10/\$25/\$40. Mail order (90-day supply): \$20/\$50/\$80. (Must use plan mail order facility.)	You pay 30% of billed charges after deductible.
Example: ¹ Medicare allowable: \$150 Medicare pays 80%: \$120 Plan pays: \$0 You pay: \$30			
Medicare pays 80% of Medicare allowable; plan pays 80% of the balance; you pay any remaining balance.	Medicare pays 80%, then plan pays 80% of the balance; you pay the amount remaining	Retail (30-day supply): \$10/\$25/\$40. Mail order (90-day supply): \$20/\$50/\$80.	You pay 20% of billed charges after deductible.
Example: ¹ Medicare allowable: \$150 Medicare pays 80%: \$120 Plan pays 80% of balance: \$24 You pay: \$6			
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.	You pay 20%; Medicare pays 80%	At participating pharmacies: Retail (30-day supply): \$10/\$25/\$40. Mail order (90-day supply): \$20/\$50/\$80.	You pay 20% of billed charges after deductible.
Example: ¹ Medicare allowable: \$150 Medicare pays 80%: \$120 Plan pays: \$0 You pay: \$30			
You pay nothing. Medicare pays 80% of allowable; plan pays balance.	You pay nothing, Medicare and plan pay 100%	Retail (30-day supply): \$10/\$25/\$40. Mail order (90-day supply): \$20/\$50/\$80.	After deductible, most benefits will be reimbursed at 100%.
Example: ¹ Medicare allowable: \$150 Medicare pays 80%: \$120 Plan pays 100% of balance: \$30 You pay: \$0			
Medicare pays 80% of Medicare allowable; plan pays 80% of the balance; you pay any remaining balance.	Medicare pays 80%, then plan pays 80% of the balance; you pay the amount remaining	Not covered	You pay 20% of billed charges after deductible.
Example: ¹ Medicare allowable: \$150 Medicare pays 80%: \$120 Plan pays 80% of balance: \$24 You pay: \$6			

Medicare examples assume that you have met your annual deductible, and that your doctor accepts Medicare assignment. After you meet your annual deductible, copay amounts for office visits are usually higher than the Medicare allowable amount. If your doctor does not accept Medicare assignment, you are also responsible for the cost.

Members have outpatient prescription drug coverage (as verified by CMS) through another non-Medicare Advantage group Medicare Part D prescription drug plan.

How Medicare Works with UC Medical Plans

Plan	Preventive Physical Exam	Durable Medical Equipment	Routine Vision Exams	Hearing Exams/ Hearing Aids	Chiropractor	Acupuncture
Health Net/ Seniority Plus Medicare COB	No charge	No charge	\$15 routine exam	Exam: \$15, 2 standard hearing aids (analog or digital) every 36 months at no charge (maximum \$2,000)	\$15/20 visits/ calendar year	Not covered
Kaiser/Senior Advantage	\$15	No charge	\$15 routine exam	Exam: \$15, hearing aids every 36 months, \$2,500 maximum per ear (medically necessary)	\$15 (manual manipulation as covered by Medicare only)	Not covered
Western Health Advantage/WHA Care+	No charge	No charge	No charge for routine exam	Exam: \$15, hearing aids every 36 months, \$15 copay (maximum \$2,000)	\$15 (as required by Medicare only)	Not covered
Anthem Blue Cross PLUS In-Network	No charge	No copay	Routine exams not covered, \$20 (medically necessary)	Exam \$20, aids 50% (Max. \$2,000, 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.
Anthem Blue Cross PLUS Out-of- Network	You pay 30%	You pay 30%	Routine exams not covered. Medicare pays 80% of approved services, plan does not pay in addition.	Exam 30%, aids 50% (Max. \$2,000 and 2 aids/36 months analog or digital)	Medicare pays 80% of approved services, plan does not pay in addition	Not covered
Anthem Blue Cross PPO	No copay (deductible waived)	You pay 20%	Medicare pays 80% of approved services, plan does not pay in addition.	Exam 20%, aids 20% (Max. \$2,000 and 2 aids/36 month analog or digital)	Medicare pays 80% of approved services, plan does not pay in addition	You pay 20%
Core	Plan pays 80%, you pay 20%	You pay 20%	Routine exams not covered. You pay 20% (when medically necessary).	Not covered	You pay 20%	You pay 20% (\$500 maximum/calendar year)
High Option Supplement to Medicare	No copay (deductible applies)	No copay, if covered by Medicare; 20% if not covered by Medicare (deductible applies)	Routine exams not covered	Not covered	No copay; when Medicare is exhausted, 20% copay after deductible	You pay 20% (deductible applies) \$500 maximum/calendar year limit
Anthem Blue Cross PPO Medicare without Prescription Drugs	No copay (deductible waived)	You pay 20%	Medicare pays 80% of approved services, plan does not pay in addition.	Exam 20%, aids 20% (Max. \$2,000 and 2 aids/36 month analog or digital)	Medicare pays 80% of approved services, plan does not pay in addition	You pay 20%

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.

Medical Plan Deductibles and Out-of-Pocket Maximums

Plan	Calendar Year Deductible	Annual Out-of-Pocket Maximum Medical Benefits	Lifetime Maximum
Health Net/ Seniority Plus Health Net Medicare COB Health Net Medicare	\$0	3 inpatient copays per person per year	No overall maximum lifetime benefit. Some HMOs may have lifetime maximums for specific benefits; see plan booklets.
Kaiser/Senior Advantage	\$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.
Western Health Advantage/ WHA Care+	\$0	Individual: \$1,000 Family (2 members or more): \$3,000	No overall maximum lifetime benefit. Some HMOs may have lifetime maximums for specific benefits; see plan booklets.
Anthem Blue Cross PLUS In-Network	\$0	Individual: \$1,500 Family: \$4,500	Unlimited
Anthem Blue Cross PLUS Out-of-Network	Individual: \$500 Family: \$1,500	Individual: \$5,000 Family: \$15,000	\$2,000,000/member
Anthem Blue Cross PPO	\$100/member	\$1,500/member	\$5,000,000/member
Core	\$100/member	\$1,260/member	\$2,000,000/member
High Option Supplement to Medicare	\$50/member	\$1,050/member	\$2,000,000/member
Anthem Blue Cross PPO Medicare without Prescription Drugs	\$100/member	\$1,500/member	\$5,000,000/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 best for you.

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 may pay benefits at 100 percent after Medicare. Some expenses do not apply toward the maximum (see plan booklets).

Lifetime Maximum

The most that a plan will pay for any person in his/her lifetime.

Medicare Part D Prescription Drugs: Calendar Year Out-of-Pocket Maximums

(Benefits after reaching maximum vary by plan. See plan booklet for details.)

Health Net/Seniority Plus:	\$2,000 per member; out-of-pocket maximum is \$4,550/member.
Health Net Medicare COB:	\$2,000 per member; out-of-pocket maximum is \$4,550/member.
Kaiser/Senior Advantage:	\$4,550 per member
Western Health Advantage/WHA Care+:	\$4,550 per member
Anthem Blue Cross PLUS In-Network:	\$4,550 per member (applies to retail and mail order)
Anthem Blue Cross PLUS Out-of-Network:	\$4,550 per member (applies to retail and mail order)
Anthem Blue Cross PPO:	\$4,550 per member (applies to retail and mail order)
Core:	\$1,000 per member
High Option Supplement to Medicare:	\$1,000 per member
Anthem Blue Cross PPO Medicare without Prescription Drugs:	Prescription drugs are not a covered benefit in this plan.

By authority of the Regents, University of California Human Resources, 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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