



Your Group Insurance Plans

2003

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Getting the Most From Your Health and Welfare Plans

Employee benefits are an important part of your University of California compensation package. To cover your needs, the University offers you and your family a wide range of health and welfare plans. This booklet provides a summary of the UC-sponsored benefit plans available and covers eligibility requirements, plan options, plan coverage, and enrollment.

Take the time to read this booklet and other benefits materials carefully, since there are many plan options and coverage levels to consider. The University provides additional materials and resources, which are useful in making decisions about the coverage you elect. For specific information about the UC-sponsored plans, visit the At Your Service website (<http://atyourservice.ucop.edu>) and select "Health and Insurance" or contact your department or Benefits Office for:

- The *UC Group Insurance Eligibility Factsheet*, which provides general rules for enrolling eligible family members in UC's health and welfare plans.
- Evidence of Coverage and plan booklets for detailed summaries about the UC-sponsored medical, vision, life insurance, disability, and accident insurance plans.
- Telephone numbers, addresses, group numbers, and website links for UC-sponsored health plans.

- The *Dental Plan Summary* and summary plan descriptions for the Health Care Reimbursement Account, Dependent Care Reimbursement Account (DepCare), and Tax Savings on Insurance Premiums (TIP) programs.

The At Your Service website provides online options to help you decide on your medical plan coverage. The following features are available:

- "Health Pages" (select "Health & Insurance" and "Medical Plans") compares medical plans and providers, and reviews the quality of physician care and services at affiliated hospitals. "Health Pages" allows you to search for details about a particular provider or specialist and find out what others have said about them.
- "Medical Plan Chooser" (select "Health & Insurance" and "Medical Plans") is an interactive tool to help you compare medical plan costs, quality, services and participating doctors.

For additional descriptions about the At Your Service website, see page 5.

Be sure to complete your enrollment or benefit change transactions by the specified deadline. Some transactions must be completed within a specified time—your 31-day period of initial eligibility (PIE), for example—or your benefits may be canceled or reduced. (See page 16.) See pages 2 and 3 for information about when to enroll.

Make sure UC always has your current address, phone number, and direct deposit number for your monthly or bi-weekly pay, if applicable. You may change your home address and telephone number online through "UC For Yourself" (<https://ucfy.ucop.edu>). So that UC can administer your benefits correctly and send you benefit information, it is important that your records are correct. You may also report any errors in your records or changes in your family to the person in your department who handles benefits.

Subject to plan amendments, the benefits information in this edition of *Your Group Insurance Plans* is effective January 1 through December 31, 2003.

Benefits Overview

As one of the largest employers in California and New Mexico, UC employs a diverse group of people

working in a variety of jobs and careers. To meet the varied needs of its employees and their families,

UC offers a comprehensive and competitive benefits program.

Health and Welfare Plan Summary

	Premiums Paid By	When to Enroll (see page 16)	For More Information
Health Care			
Medical—Full & Mid-level Your choice of health maintenance organization (HMO), point-of-service (POS), preferred provider organization (PPO, available to employees from California locations only), or fee-for-service plan.	You and UC or UC	<ul style="list-style-type: none"> • During PIE • During OE • Anytime with 90-day waiting period 	See section beginning on page 25.
Medical—Core Plan pays 80% of covered charges after a \$3,000 annual per-person deductible. Pays 100% after your out-of-pocket costs reach \$7,600 for an individual.	UC	<ul style="list-style-type: none"> • During PIE • During OE • Anytime with 90-day waiting period 	See section beginning on page 25.
Dental Choice of two dental plans: Delta Dental, a fee-for-service plan, or PMI, a prepaid plan (network available in California only). Both cover preventive, basic, and prosthetic dentistry, as well as orthodontics.	UC	<ul style="list-style-type: none"> • During PIE • During OE 	See section beginning on page 37.
Vision Plan covers a variety of vision care services including eye exams, corrective lenses, and frames.	UC	<ul style="list-style-type: none"> • During PIE • During OE 	See section beginning on page 41.
Disability Insurance			
Short-Term Disability Provides basic coverage for inability to work due to pregnancy/childbirth, disabling injury, or illness. Pays 55% of your eligible earnings for up to six months (\$800 monthly maximum), after a waiting period. Injuries and illness must not be work-related.	UC	<ul style="list-style-type: none"> • Automatic 	See section beginning on page 43.
Supplemental Disability Provides extended coverage for work-related and nonwork-related disabilities due to pregnancy/childbirth, disabling injury, or illness. Supplements your Short-Term Disability/other income to pay up to 70% of your eligible earnings. You choose a waiting period.	You	<ul style="list-style-type: none"> • During PIE • With SOH 	See section beginning on page 43.
Workers' Compensation Provides state-mandated coverage for work-related injuries.	UC	<ul style="list-style-type: none"> • Automatic 	See page 48.
Key: PIE—Period of Initial Eligibility OE—Open Enrollment SOH—Statement of Health			(Chart continued on next page)

Health and Welfare Plan Summary

	Premiums Paid By	When to Enroll (see page 16)	For More Information
Life and Accident Insurance			
Basic Life Provides employees eligible for Full Benefits with life insurance equal to your annual base salary, up to \$50,000. Coverage is adjusted if your appointment is less than 100% time.	UC	• Automatic	See section beginning on page 49.
Core Life Provides employees eligible for Core or Mid-level Benefits with \$5,000 of life insurance.	UC	• Automatic	See section beginning on page 49.
Supplemental Life Provides additional life insurance at group rates. You may insure yourself for up to four times your annual salary (to \$1,000,000 maximum).	You	• During PIE • With SOH	See section beginning on page 50.
Basic Dependent Life Provides \$5,000 of coverage for your spouse or same-sex domestic partner and each child.	You	• During PIE • With SOH	See section beginning on page 53.
Expanded Dependent Life Covers your spouse or same-sex domestic partner for 50% (up to \$200,000) of your Supplemental Life amount and covers each child for \$10,000.	You	• During PIE • With SOH	See section beginning on page 53.
Accidental Death & Dismemberment (AD&D) Provides up to \$500,000 protection for you and your family for accidental death, loss of limb, sight, speech, or hearing, or for complete and irreversible paralysis.	You	• At any time	See section beginning on page 56.
Business Travel Accident Provides \$100,000 of coverage when you travel on official UC business.	UC	• Automatic	See page 58.
Other Insurance			
Legal Expense Provides basic legal assistance for preventive, domestic, consumer, and limited defensive legal services.	You	• During PIE	See section beginning on page 59.
Automobile and Homeowner/Renter Individually underwritten plan provides coverage for cars, boats, motorcycles, homes, and apartments.	You	• At any time	See page 62.
Tax-Savings Programs			
Health Care Reimbursement Account (HCRA) Lowers your taxable income by allowing you to pay for up to \$5,000 of eligible out-of-pocket health care expenses on a pretax basis.	Pretax reductions of your pay	• During PIE • During OE	See section beginning on page 63.
Dependent Care Reimbursement Account (DepCare) Lowers your taxable income by allowing you to pay for up to \$5,000 (\$2,500 if you are married and filing a separate income tax return) of eligible dependent care expenses on a pretax basis.	Pretax reductions of your pay	• During PIE • During OE	See section beginning on page 65.
Tax Savings on Insurance Premiums (TIP) Lowers your taxable income by allowing you to pay health plan premiums (if any) on a pretax basis.	Pretax reductions of your pay	• Automatic • During OE • During PIE	See section beginning on page 67.

Participation Terms and Conditions

Use of your Social Security number for benefit plan administration purposes complies with state and federal law.

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

1. Most of the medical plans that UC offers (including Blue Cross PLUS, Blue Cross PPO, Health Net, Kaiser Permanente, PacifiCare of California, Western Health Advantage, and BluePremier HMO New Mexico), 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 give up 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 understand 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 or carrier may require proof of eligibility—marriage or birth certificates, adoption papers, tax records, and the like. You agree to provide such documentation upon request.
4. If you enroll your same-sex domestic partner and/or your partner's 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. When you specifically ask UC representatives to intercede on your behalf with your insurance plan, you authorize the plan to release to the UC representatives the appropriate records pertaining to you and/or your family member(s). You also authorize UC to provide the insurance plan with any relevant personal health information.
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.
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 disenroll 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 may lead to disenrollment of the family members and to legal action. In addition,

employees will be subject to disciplinary action (e.g., loss of health benefits for 18 months) and will be responsible for any employer contributions to and benefits paid by the plan.

HIPAA (Health Insurance Portability and Accountability Act of 1996) Notification of Medical Program Eligibility

You may decline enrollment in medical plans for yourself and/or your eligible family members because you have other medical insurance coverage. If you lose that coverage involuntarily in the future, you may be able to enroll yourself and/or your eligible family members in a UC-sponsored medical plan. You must request enrollment within 31 days after the other coverage ends.

If you are not enrolled in a UC-sponsored medical plan, and you have a newly eligible family member as a result of marriage, birth, adoption, or placement for adoption, you may be eligible to enroll yourself and your eligible family member(s). You must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

If you do not enroll within the 31 days when you are first eligible, you may enroll at a later date. However, you will need to complete a waiting period of 90 consecutive calendar days before your medical coverage is effective, or you must wait until the next Open Enrollment to enroll.

Benefits Assistance

Whenever you need benefits assistance, you have several resources to help you. The chart below summarizes the options available through the At Your Service website

(<http://atyourservice.ucop.edu>) and bencom.fone (1-800-888-8267), an interactive telephone system available from your touch-tone phone, any time, day or night.

For a brochure covering bencom.fone instructions and features, select "Forms & Publications" on the At Your Service website, or request it through your Benefits Office.

	At Your Service (http://atyourservice.ucop.edu)	bencom.fone (1-800-888-8267)
Health and Welfare		
Compare the medical care services, doctors and specialists available	✓ (under "Health & Insurance—Medical Plans," select "Health Pages" and "Medical Plan Chooser" on right)	n/a
Obtain Summary Plan Descriptions, plan coverage booklets and other plan information	✓ (under "Forms & Publications")	n/a
Change your UC Personal Identification Number (UC PIN)	✓ (select "Lost PIN/Change PIN")	✓
Enroll in health and welfare plans (for new hires or employees eligible for new benefits package)	✓ (under "Your Benefits Online;" not available to LANL employees)	n/a
Obtain benefit forms to complete transactions and to elect/change certain benefits	✓ (select "Forms & Publications")	n/a
Obtain medical plan provider directories	✓ (under "Contact List," select "Medical Plan Carrier Phone Numbers and Links")	n/a
Obtain telephone numbers and Internet links for health and welfare, retirement and savings programs, and state and federal agencies	✓ (select "Contact List")	✓ (telephone numbers only)
Update your personal information, such as name, home address, telephone number, and income tax withholding	✓ (select "Change Address/Payroll Information")	n/a
Obtain a summary of your health and welfare plan enrollments	✓ (under "Your Benefits Online" select "Your Benefits Summary**")	✓
Retirement Plans		
Select, change, or review your contributions to UC retirement and savings programs**	✓ (select "Your Benefits Online")	n/a
Transfer balances in UC retirement and savings plans	✓ (select "Your Benefits Online")	✓
Obtain UCRP service credit balances	✓ (under "Your Benefits Online" select "Your Benefits Summary**")	n/a
Obtain UC-managed fund performance updates	✓ (select "Retirement Plans Values & Performance")	✓
Obtain your UC retirement and savings plans balances	✓ (select "Your Benefits Online")	✓
Estimate future values of your UC retirement and savings plans	✓ (select "Retirement Calculators")	n/a
Elect distributions from your UC retirement and savings plans (certain limitations apply)	✓ (under "Your Benefits Online")	✓
Apply for a 403(b) Plan loan	✓ (under "Your Benefits Online")	✓
Access your 403(b) Plan loan balance	✓ (under "Your Benefits Online" select "UCRS Account Balances")	✓ (not available to LBNL or LLNL employees)
* Not available to all employees		
** Including Fidelity Investments and Calvert Socially Responsible Investments		

“UC For Yourself”

(<https://ucfy.ucop.edu>)

“UC For Yourself” allows UC employees to update personal information, such as name, home address, home telephone number, income tax withholding, and UC PIN. You may also establish security settings for “UC For Yourself” access and obtain UC employment verification to provide to banks and other agencies requesting such information.

Your UC PIN

The key to “Your Benefits Online” and bencom.fone is your UC Personal Identification Number—your PIN. When you become a UC employee, you sign a *Personal Identification Number (PIN) Authorization* form (UPAY 874) and receive a temporary PIN. Before you can access benefits information, you must follow the instructions to customize your PIN. Please see page 18 for additional information.

If you forget or lose your UC PIN, you have the following options to arrange for a new one:

- Use the “UC for Yourself” online option (<https://ucfy.ucop.edu>, or select “Lost PIN/Change PIN” on the home page of At Your Service);
- Call bencom.fone (1-800-888-8267); or
- Contact your local Benefits Office (see phone numbers at right).

Local Benefits Offices

The person in your department who handles benefits and the staff in your Benefits Office are also available to help you.

They can tell you if any special presentations are scheduled for your location. They can also provide forms that you might need or give you additional information about all of UC’s plans.

Location	Phone Number
Berkeley	510-642-7053
San Francisco	415-476-1400
UCSF Medical Center	415-353-4545
Davis	530-752-1774
UCD Medical Center	916-734-8099
UCLA	310-794-0830
UCLA Medical Center	310-794-0500
Riverside	909-787-4766
San Diego	858-534-2816
UCSD Medical Center	619-543-8244
Santa Cruz	831-459-2013
Santa Barbara	805-893-2489
Irvine	949-824-5210
UCI Medical Center	714-456-5736
Office of the President	510-987-0123
Lawrence Berkeley Laboratory	510-486-6403
Lawrence Livermore National Laboratory	925-422-9955
Los Alamos National Laboratory	505-667-1806
Associated Students UCLA (ASUCLA)	310-825-7055
Hastings College of the Law	415-565-4703

Employee Eligibility

The benefits for which you are eligible depend on your appointment level and your membership in UCRP or another defined benefit plan to which UC contributes. Most employees eligible for benefits are covered under one of three benefits packages—Full, Mid-level, or Core.

Initial Requirements

Full Benefits (BELI 1*)

You are eligible to enroll in Full Benefits if:

You are a member of a UC-sponsored retirement plan¹.

There are two ways to qualify for UCRP membership:

- 1) You are appointed to work in an eligible position at least 50% time for a year or more²—or
- 2) After you work 1,000 hours in a 12-month period in an eligible position.

Mid-level Benefits (BELI 2 & 3*)

You are eligible for Mid-level Benefits if:

- You are not a member of a UC-sponsored defined benefit retirement plan, **and**
- You are appointed to work 100% time for at least three months, **or**
- You are appointed to work at least 50% time for a year or more².

Core Benefits (BELI 4*)

You are eligible for Core Benefits if:

- You are appointed to work at least 43.75% time.

Continuing Requirements

UC bases your ongoing eligibility for benefits on the number of regular hours you are paid by UC to work each week. (Paid time excludes stipends, bonuses, and overtime.)

To remain eligible for your benefit level, you must maintain an average regular paid time of at least 17.5 hours per week. Refer to page 21, "Reduced Average Regular Time," for additional details.

* Benefits Eligibility Level Indicator (BELI)

¹ A UC-sponsored retirement plan means UCRP or another defined benefit plan to which UC contributes, such as CalPERS.

² Or your appointment form shows that your ending date is for funding purposes only and that your employment is intended to continue for more than a year.

Health and Welfare Benefit Packages

This chart shows UC's three benefit packages and the benefit plans included in each.

	Full (BELI 1)	Mid-level (BELI 2&3)	Core (BELI 4)
Health Insurance			
Medical	•	•	
	or	or	
Medical–Core	•	•	•
Dental	•		
Vision	•		
Life and Accident Insurance			
Basic Life	•		
Core Life		•	•
Supplemental Life	•	•	
Basic Dependent Life	•	•	
Expanded Dependent Life	•	•	
AD&D	•	•	•
Business Travel Accident	•	•	•
Disability Insurance			
Short-Term Disability	•		
Supplemental Disability	•		
Workers' Compensation	•	•	•
Other Insurance			
Legal Expense	•		
Automobile and Homeowner/Renter	•	•	
Tax-Savings Programs			
Health Care Reimbursement Account	•	•	•
Dependent Care Reimbursement Account (Depcare)	•	•	•
Tax Savings on Insurance Premiums (TIP)	•	•	•

Exclusions for Preexisting Conditions

When you enroll in any UC-sponsored medical, dental, or vision plans, you will not be excluded from enrollment based on your health; nor will your premium or level of benefits be based on any health conditions. In fact, you are not asked for a statement of your health. The same applies to your eligible family members.

As for other UC insurance plans, the following applies:

- Basic and Core Life insurance: there are no exclusions for preexisting conditions.
- Supplemental and Dependent Life insurance: a statement of health is required to enroll for benefits outside of your PIE.
- Short-Term Disability insurance: there are no exclusions for preexisting conditions.
- Supplemental Disability insurance: a statement of health is required to enroll for benefits outside of your PIE. A statement of health is also required to reduce a previously selected waiting period. If you have a preexisting condition which causes you to be disabled in your first year of coverage, benefits will be limited to a total of 12 months of coverage. For more information, see the insurance carrier's summary plan description.
- AD&D: there are no exclusions for preexisting conditions.

Eligible Family Members

If you are eligible, you may enroll eligible family members in UC-sponsored plans as shown on pages 10 and 11.

Eligible Adult

In addition to yourself, you may have only one eligible adult family member enrolled in your UC-sponsored plans:

- a legal spouse **or**
- an adult dependent relative **or**
- a same-sex domestic partner.

For example, if you cover an adult dependent relative on your medical, dental and vision plans, you may not cover your spouse under any medical, dental, vision, AD&D, Dependent Life, or legal expense plan.

Eligible Child

You may enroll eligible children in the allowable family member enrollment groups shown in the chart at right.

Note that your disabled child aged 23 or older is still considered to be your eligible child, and not an adult.

You may enroll your same-sex domestic partner's child or grandchild even if you do not enroll your partner; however, your partner must be eligible for UC-sponsored coverage.

UC and/or the insurance carrier reserves the right to request documentation to verify eligibility

Family Member Groups	
If you enroll	You may enroll your
Legal spouse	<ul style="list-style-type: none"> • natural child • adopted child • stepchild • legal ward • disabled child (before age 23) • grandchild or step-grandchild
Adult dependent relative¹	<ul style="list-style-type: none"> • natural child • adopted child • stepchild or same-sex domestic partner's child/grandchild • legal ward • disabled child (before age 23) • grandchild or step-grandchild
Same-sex domestic partner	<ul style="list-style-type: none"> • natural child • adopted child • same-sex domestic partner's child/grandchild • legal ward • disabled child (before age 23) • grandchild or step-grandchild
No adult	<ul style="list-style-type: none"> • natural child • adopted child • stepchild or same-sex domestic partner's child/grandchild • legal ward • disabled child (before age 23) • grandchild or step-grandchild

¹ Adult dependent relatives may not be covered under Dependent Life, legal or AD&D plans.

(marriage certificate, birth certificates, adoption records, tax records, etc.). Failure to submit these records upon request may result in your family members being disenrolled from the UC-sponsored benefit plans. Eligibility information is also

available in the *UC Group Insurance Eligibility Factsheet*, available from your Benefits Office or on the UC HR/Benefits website (<http://atyourservice.ucop.edu>, and select "Forms & Publications").

Eligible Family Members

Family Member	Eligibility	Must be	May enroll in					
			Medical	Dental	Vision	Dependent Life ²	AD&D	Legal Expense
Legal spouse¹	Eligible	–	•	•	•	•	•	•
Adult dependent relative¹	Age 18 or older	<ul style="list-style-type: none"> • related to you³ • living with you • claimed as your tax dependent • not eligible for Medicare Part A 	•	•	•			
Same-sex domestic partner¹	Age 18 or older	<ul style="list-style-type: none"> • person of same sex as you • not related to you³ • able to enter into a contract • registered with the State of California, otherwise, the following requirements apply: <ul style="list-style-type: none"> – unmarried (neither one of you is legally married) – living with you for the past six months with intent to continue indefinitely – your sole same-sex domestic partner in a relationship of mutual support, caring, and commitment – sharing joint responsibility with you for common welfare – financially interdependent with you 	•	•	•	•	•	•
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 	•	•	•	•	•	•
Same-sex domestic partner's child or grandchild	To age 23	<ul style="list-style-type: none"> • unmarried • living with you • supported by you or your same-sex domestic partner (50%+) • claimed as a tax dependent by you or your same-sex domestic partner 	•	•	•	•	•	•
Legal ward enrolled before 1/1/95	To age 18	<ul style="list-style-type: none"> • unmarried • continuously covered 	•	•	•	•	•	•
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 	•	•	•	•	•	•
Other child enrolled before 9/1/94	To age 23	<ul style="list-style-type: none"> • unmarried • living with you • supported by you (50%+) • claimed as your tax dependent • continuously covered 	•	•	•			

Eligible Family Members

Family Member	Eligibility	Must be	May enroll in					
			Medical	Dental	Vision	Dependent Life ²	AD&D	Legal Expense
Disabled child (does not apply to legal ward)	Age 23 or older	<ul style="list-style-type: none"> • unmarried • living with you (not required if child is your natural or adopted child) • supported by you (50%+) • claimed as your tax dependent • disability approved by carrier before age 23 and periodically thereafter • continuously covered 	•	•	•	•	•	•

¹ The surviving family member of a deceased member cannot enroll a spouse, adult dependent relative, or same-sex domestic partner (or their children/grandchildren).

² Child must be 24 hours old before coverage begins.

³ "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.

No Duplicate Coverage

UC's rules do not allow duplicate coverage. You may not be covered in UC-sponsored plans as an employee or annuitant and at the same time be covered as an eligible family member of a UC employee or annuitant. You may not be covered in more than one category. If you have coverage as an eligible family member and then become eligible for UC coverage yourself, you have two options. You can either opt out of the automatic employee coverage or make sure the UC employee or annuitant who has been covering you deenrolls you from his or her UC-sponsored plans.

Dependents of UC employees may not be covered by more than one UC employee's plan coverage. For example, if two family members work for UC, their children cannot be covered by both family members.

If duplicate enrollment occurs, UC will cancel the later enrollment. UC and the plans reserve the right to collect repayment for any duplicate premium payments and for any plan benefits provided due to the duplicate enrollment.

Ineligible Family Members

Certain family members are not eligible to participate in UC-sponsored plans.

Family members ineligible for coverage in medical, dental, and vision plans include but are not limited to: in-laws, cousins, legally separated spouses, opposite sex domestic partners, former spouses, and your children's and grandchildren's spouses.

Family members ineligible for coverage in all other UC-sponsored plans include in-laws, cousins, legally separated spouses, opposite sex domestic partners, former spouses, your children's and grandchildren's spouses, adult dependent relatives, parents, and grandparents.

Deenrollment

It is your responsibility to deenroll any family member who loses eligibility (see pages 21 through 23). UC and the plans reserve the right to collect repayment for any expenses incurred due to the ineligible enrollment.

Frequently Asked Questions About Eligibility

Eligibility for a Spouse

I am getting married. Can I add my new spouse to my UC-sponsored plans?

Yes. Your spouse becomes eligible for coverage in your UC-sponsored plans on the date you marry. This is the first day of your spouse's 31 day period of initial eligibility (PIE). (See page 16.)

If your new spouse also works for UC, he/she cannot be added to your plans if he/she wishes to also sign up for UC coverage. Since duplicate coverage is not allowed, he/she must choose whether to enroll as your dependent or enroll independently.

My husband and I do not live together. Is he still an eligible family member?

Yes. As your legal spouse, he is eligible. If you divorce, become legally separated, or if the marriage is annulled, he will no longer be eligible and you must disenroll him from your UC-sponsored plans. Eligibility stops at the end of the month in which the divorce/legal separation/annulment is final.

I am a UC employee with self-only UC-sponsored health coverage. My spouse has lost his job and is losing his group benefit coverage. Can I enroll him in my UC-sponsored plans?

Yes. If your eligible family member loses group coverage involuntarily, for a reason such as termination of employment, you may add him/her to your UC-sponsored plans within 31 days of the loss of coverage, or—for your medical plan only—after a 90-day waiting period. (See page 16 for additional information.) Proof

of loss of non-UC group coverage will be required.

My spouse is covered under my UC medical plan. We were recently notified that we are eligible for Medicare. Are we still eligible for UC-sponsored medical coverage? Should we enroll in Medicare?

Yes. Your coverage through UC will continue under the basic (non-Medicare) medical plan, and you should enroll in Medicare Part A. As long as you continue to work at UC, UC-sponsored medical coverage will be primary and Medicare Part A coverage will be secondary. The same applies to your spouse as long as he/she remains covered on your plan.

Once you retire from UC, you will need to contact Medicare to sign up for Medicare Part B. You will also need to complete UC's *Medicare Declaration* form (UBEN 126). Your local Benefits Office or HR/Benefits Customer Service can help you at the time of your retirement.

Eligibility for a Former Spouse

Can my former spouse continue coverage on my UC-sponsored plans?

No. A former spouse is not eligible. Eligibility stops on the last day of the month in which a divorce, legal separation, or annulment is final. If your settlement requires you to continue coverage for your former spouse, you must do so outside the UC-sponsored plans. Your former spouse may be able to continue medical, dental, or vision coverage under COBRA, however. Contact your Benefits Office for information.

My deceased spouse was a UC annuitant, and I am eligible to continue my UC-sponsored group insurance. If I remarry, can I cover my new spouse?

No. The surviving spouse of a deceased member cannot enroll another spouse, adult dependent relative, or same-sex domestic partner in any UC-sponsored group insurance plans.

Eligibility for a Same-Sex Domestic Partner

I am enrolling a family member who I claim as a federal tax dependent. Do I need to submit my tax records at the time of enrollment?

No, not at the time of enrollment. You may be asked to submit tax verification documents each year. Please do not submit tax records until they are requested. If you do not submit the required documentation when requested, your dependent will be deemed ineligible and will be disenrolled retroactively to the beginning of the year or coverage effective date, whichever is later.

Can I enroll my same-sex domestic partner's child and/or grandchild in UC-sponsored health plans if I do not enroll my same-sex domestic partner?

Yes. However, please note that both your same-sex domestic partner and his or her child/grandchild must meet all of the eligibility requirements. You will need to submit a *Declaration—Same-sex Domestic Partnership* form (UBEN 251).

Eligibility for an Adult Dependent Relative

I have enrolled my mother as my adult dependent relative. Although she now lives with me, she will soon move to a nursing home. Will this make her ineligible for coverage?

No. As long as your adult dependent relative is your tax dependent, he/she can be covered while living in a convalescent hospital or nursing home, as long as all other eligibility requirements are met.

If my adult dependent relative is no longer eligible for UC-sponsored group insurance coverage, or my same-sex domestic partnership ends, is there a waiting period or other requirement(s) before I can enroll a new adult dependent relative or same-sex domestic partner?

Yes. At least six months must elapse after eligibility ends before you can enroll an adult dependent relative or a newly eligible partner. If you cancel coverage for your adult dependent relative or same-sex domestic partner due to their death, you may enroll a new adult dependent relative or same-sex domestic partner within their PIE if they meet the eligibility requirements before the six-month waiting period ends.

You must disenroll any family member who loses eligibility at the end of any month in which the loss of eligibility occurred. Note that an adult dependent relative is no longer eligible when he/she becomes entitled to Medicare Part A.

I have an adult dependent relative enrolled under my UC-sponsored plans. Upon my death, will my adult dependent relative (or my spouse) be eligible to continue UC-sponsored coverage?

No. When you die, your adult dependent relative will not be eligible to continue UC-sponsored coverage

since he/she would no longer be dependent upon you for support. Note also that, in this situation, your spouse would not be eligible for any UC-sponsored coverage since he/she was not enrolled in your UC-sponsored coverage at the time of your death. In this scenario, your adult dependent relative would be eligible to continue coverage for a limited time under COBRA only.

Contact your Benefits Office about continuation of group insurance coverage.

Eligibility for Child(ren)

Is there a limit to the number of children I can enroll in my plans?

No. You may enroll all of your children as long as each child is eligible for coverage under the UC-sponsored plan rules.

Eligibility for a Legal Ward

Why does eligibility for a legal ward end at age 18 when it continues to age 23 for other children?

California law stipulates that legal guardianship ends when a child reaches age 18. Consistent with the law, group insurance for legal wards will stop at the end of the month in which the child turns 18.

My legal ward will soon turn 18 and will no longer be eligible for coverage on my UC-sponsored plans. Is she eligible for medical coverage under COBRA?

Yes. COBRA allows insured individuals to continue coverage for a limited time after they lose eligibility for UC-sponsored group coverage. (Note: COBRA does not apply to those who have never met UC's eligibility requirements.) For information about continuing coverage under COBRA and/or converting to an individual policy, refer to the *Continuation of Group Insurance Coverage* notice. To

obtain a copy of this notice, go to "Forms & Publications" on the At Your Service website or contact your local Benefits Office.

Eligibility for Disabled Child(ren)

My child is 22 years old and disabled. How can I continue to cover her on my UC-sponsored plans?

Assuming that all eligibility requirements are met (see page 10), you must obtain approval from your medical plan before your child's 23rd birthday and provide documentation to UC HR/Benefits to confirm your child's disability. Contact your medical plan for information. If the medical plan carrier approves continued coverage, your child may also remain enrolled in UC-sponsored dental, vision, and legal coverage. Contact your local Benefits Office for more details. Note that UC and your medical plan have the right to request proof of continued disability from time to time in order to continue UC-sponsored group coverage.

If you do not have another adult family member enrolled in your coverage and the medical plan did not approve continued coverage as a disabled child, you may want to consider whether the child would be eligible as an adult dependent relative. You would be required to submit proof of tax dependency annually.

I have a disabled child who is over age 23 and has plan approval to continue UC-sponsored coverage. Is my disabled child considered an "adult" so that I cannot enroll another adult in my UC-sponsored plans?

No. Disabled children who are approved by the plan to continue UC-sponsored coverage past age 23 are in the "child" category. Therefore, you may still cover your legal spouse,

adult dependent relative, or same-sex domestic partner.

Eligibility for Stepchildren

I cover my stepson on my UC-sponsored plans. Next year, my husband and I want to file separate tax returns. Will my stepson still be eligible for UC-sponsored coverage?

Yes, as long as he meets all eligibility requirements. UC eligibility requirements specify that a stepchild must be claimed as a tax dependent by either you or your spouse for the tax year corresponding to the coverage.

My stepdaughter lives with my wife and me. The divorce settlement from my wife's previous marriage provides for the child's father to claim my stepdaughter as a dependent for tax purposes. Can I cover her on my UC-sponsored plans?

No. To qualify for coverage, your stepdaughter must be claimed as your (or your wife's) tax dependent.

My stepchildren have lived with me for over ten years, and I think of them as my own. Must I submit my tax records every year to verify their eligibility?

Yes, if UC requests copies of the documents.

Eligibility for Other Enrollees

My son lives with his mother in another town. Is he eligible for coverage under my UC-sponsored plans?

Your unmarried natural or adopted children may be eligible for coverage up to age 23 whether or not they live with you and regardless of how much of their support you provide. If you are enrolled in an HMO medical plan or the PMI dental plan, however, your enrolled family members must live in the plan's service area. Contact your plan directly to confirm your options.

My child goes to school in another state and lives there for nine months of the year. Does this make him ineligible for coverage on my plans?

If the child's permanent residence is your address, living away at school will not make him ineligible. However, if you are enrolled in an HMO medical plan or the PMI dental plan, your enrolled family members can receive services only from contracted providers, except in emergencies. Call your plan for more information.

My husband and I claim his children (my stepchildren) on our tax return and we pay for most of their support. They live with us part of the year. Are they eligible for coverage under my UC-sponsored plans?

To satisfy UC eligibility requirements, their permanent residence must be the same address as yours. (UC eligibility requirements include, but are not the same as, those of the IRS.)

I am a legal guardian for a child who does not live with me. Is this child eligible for coverage on my UC-sponsored plans?

If the child was enrolled before January 1, 1995, and coverage has been continuous, living with you is not a requirement for a legal ward. If the child was enrolled on or after January 1, 1995, however, you cannot enroll a legal ward unless he or she is living with you. Refer to the chart on pages 10 and 11 for complete details.

Verification of Family Member Eligibility

UC and/or the insurance carriers reserve the right to request documentation (marriage certificate, birth certificates, adoption records, tax records, etc.) to verify eligibility for your enrolled family members.

Declaration

You must submit a *Declaration—Same-sex Domestic Partnership* form (UBEN 251) when you first enroll a same-sex domestic partner or your partner's child/grandchild. If you enroll an adult dependent relative you must submit a *Declaration—Adult Dependent Relative* form (UBEN 252). Both forms are available from the At Your Service website (<http://atyourservice.ucop.edu>) under "Forms & Publications."

Exception: If you cover a same-sex domestic partner and/or the partner's child/grandchild in the Dependent Life or AD&D plans, the declaration will be required only if a claim for benefits is filed.

Medicare Declaration

You are required to notify UC if you or another family member enrolled in a UC-sponsored medical plan enrolls in Medicare. This may be when you or your family member reaches age 65 or when you retire (whichever comes later). It may be earlier in cases of disability or certain illnesses.

Adult dependent relatives enrolled in or eligible for Medicare Part A are *not* eligible for coverage in UC-sponsored health plans. Adult dependent relatives reaching age 65 will be automatically disenrolled unless you submit form UBEN 126 and the appropriate documentation which proves they are ineligible for Medicare Part A.

To notify UC that you or another family member has enrolled in Medicare or that your adult dependent relative is not eligible for Medicare, contact your local Benefits Office. Telephone numbers are available on the At Your Service website or on page 6 of this booklet.

Same-Sex Domestic Partner Supporting Documentation

If you enroll a same-sex domestic partner and/or your partner's child or grandchild and you are not registered with the State of California, the University reserves the right to request supporting documentation for your same-sex domestic partnership. This includes copies of at least three of the following items attesting to financial interdependency:

- a) joint mortgage or joint tenancy on a residential lease
- b) joint bank account
- c) joint liabilities (for example, credit cards or car loans)
- d) joint ownership of significant property (for example, a car or house)
- e) durable property or health care powers of attorney
- f) wills, life insurance policies, or retirement annuities naming each other as primary beneficiary
- g) written agreements or contracts regarding the relationship (for example, state/municipality registration form of domestic partnership) or other documents showing mutual support obligations or joint ownership of assets acquired during the relationship

Do not submit these documents unless requested.

Annual Tax Verification

To be eligible for UC-sponsored health plan coverage, certain family members must be your income tax dependent(s) according to the Internal Revenue Code.

To verify tax dependency, each year (generally in March or April) UC HR/Benefits may ask you to submit a copy of the appropriate income tax return. The information you send is kept in confidence.

Important: Do not send any documentation with your benefits enrollment or change transactions! Please wait until UC HR/Benefits asks for it because not all employees with a tax dependent will be contacted.

When notified, it is important that you provide the requested information on time. Family members for whom documentation is not received will be disenrolled and you may be liable for any costs incurred in connection with the invalid enrollment.

Family Member Verification

The University reserves the right to request supporting documentation of eligibility when you enroll a family member (e.g., a spouse or child).

When to Enroll

Generally you should enroll in UC-sponsored plans when you first become eligible. Most plans have an enrollment deadline.

Period of Initial Eligibility

A period of initial eligibility (PIE) is a time during which you or your eligible family members may enroll. A PIE starts on the first day of eligibility. For Internet enrollments, it ends 31 days later. For paper form enrollments, it ends 31 days later or on the last *working day* of that 31-day period, whichever comes first. UC defines a working day as a normal business day—Monday through Friday, excluding holidays—for your Benefits or Accounting Office. Proof of good health is not required.

- If you are eligible for the Full Benefits package but don't enroll, UC will automatically enroll you for self only coverage in the Core medical plan, the Delta Dental plan, and the Vision Service Plan.
- If you are eligible for the Core Benefits package or the Mid-level Benefits package but don't enroll, UC will automatically enroll you for self only coverage in the Core medical plan.

Your enrollment is automatic in some UC-sponsored plans.

- If eligible, you will be automatically enrolled in Basic Life (or Core Life, based on your appointment), Short-Term Disability, Workers' Compensation, and Business Travel Accident Insurance (as applicable).
- For other plans, enrollment is optional and you must enroll yourself and your eligible family members. In most cases, there is an enrollment deadline.

Other Periods of Initial Eligibility

- If you are not enrolled in a UC-sponsored medical plan, and you have a newly eligible family member, you may be eligible to enroll yourself and your eligible family member(s).
- A newly eligible family member's PIE starts the day he or she becomes eligible (for example, the day you marry or your child is born). During this PIE, you may also enroll in or increase your Supplemental Life insurance.
- The PIE for an adopted child begins on the earlier of the date the child is placed in your physical custody or the date you or your spouse has the legal right to control the child's health care. If you do not enroll your child during this PIE, a second PIE begins with the date the adoption is final. Coverage begins on the first day of the PIE in which you enroll the child.
- If you are a newly-appointed faculty member and don't enroll when first eligible, a second PIE starts on the first day of classes for the semester or quarter in which your appointment starts.
- If you previously declined enrollment because you have other medical coverage and you subsequently lose that coverage involuntarily, you may be able to enroll yourself and/or your eligible family members in a UC-sponsored medical plan. You must request the enrollment within 31 days after the other coverage ends.
- If you move out of an HMO service area or the Blue Cross PLUS service area, return to an HMO

service area, you and/or your eligible family members have a new PIE to transfer into a medical plan in your new location. If you return to the HMO or Blue Cross PLUS service area, you may transfer back.

Other Enrollment Options

To be sure you get the coverage you want, sign up during your PIE. If you miss your PIE, however, you may still enroll in UC-sponsored benefits as follows:

- You may enroll in medical coverage at any time by submitting an enrollment form to your Benefits Office. However, you will need to complete a waiting period of 90 consecutive calendar days from the day you submit your form before your medical coverage is effective.
- You may enroll in a UC-sponsored medical plan during Open Enrollment (usually held in November).
- You may decline enrollment for yourself and/or your eligible family members because you have other medical insurance coverage.
- You may enroll in or increase disability and life insurance by submitting a statement of health to the insurance company for approval. The insurance company may or may not accept your enrollment based on the statement of health. You may reduce or cancel your coverage at any time.

See your Benefits Office for more information about situations that may result in a new PIE.

In addition, some plans allow you to enroll during Open Enrollment, usually held in November. (Note: the

Legal Expense plan is not open for new members every year.)

HMO Transfers

As one means to help members when providers leave a California HMO during the plan year, members are able to transfer into and out of any UC-sponsored California HMO on a monthly basis, subject to processing deadlines.

If You Are Already Covered

You may cancel (or opt out of) UC's automatic health coverage if:

- You are already enrolled in another group medical, dental, and/or vision plan that provides equal coverage; or
- Your religious beliefs would not permit you to use the UC-sponsored plan's services.

How to Enroll

Newly Hired Employees

UC provides a convenient, secure, and easy way to enroll in UC-sponsored plans. You can enroll through the At Your Service website (<http://atyourservice.ucop.edu>).

Before you enroll, you must first submit your signed *Personal Identification Number (PIN) Authorization* form (UPAY 874), which you should have received with your employment paperwork. You cannot enroll until this authorization has been processed by your local Payroll or Benefits Office. By using your PIN, you acknowledge that you have read and agree to the terms and conditions of UC coverage.

Your UC PIN

Temporary UC PIN: 0000

You must select a new PIN before you enroll.

Whenever you access At Your Service or call bencom.fone for personal information or transactions, you will be asked to provide your UC PIN and your Social Security number.

Your temporary PIN is shown above. You will be prompted to customize this temporary PIN the first time you use it. Once you've customized your PIN, you can exit or continue and access your data. The next time you use either At Your Service or bencom.fone for personal information or transactions, be sure to use your customized UC PIN.

Your use of the UC PIN authorizes the University to provide the information or service you are requesting. All requests are subject to plan rules and regulations.

If you forget or lose your PIN, you have the following options to request a new one:

- Use the "UC for Yourself" online option (<https://ucfy.ucop.edu>);
- Call bencom.fone (1-800-888-8267); or
- Contact your local Benefits Office (see page 6 for phone numbers).

How to Enroll Online

- Go to At Your Service at: <http://atyourservice.ucop.edu>
- Select "Your Benefits Online" and select "New Employees" and follow the instructions.
- **Note: You will need your UC PIN and your Social Security number. See "Your UC PIN," left.** Be sure to complete all enrollments during your 31-day period of initial eligibility (PIE).

Currently Enrolled Employees

You can make certain changes to your UC-sponsored plans during Open Enrollment or when you have an eligible family status change (for example, you marry, divorce, or add a child to your family). You may also transfer between California HMOs due to provider disruptions. For forms and procedures, see the person in your department who handles benefits. Currently, you cannot use At Your Service or bencom.fone to make these type of changes.

Rehired employees who have a status change in their appointment (for example, a change from working part time to full time) can make these changes on the At Your Service website by accessing "Your Benefits Online."

Remember that some changes must be made within the 31-day PIE that begins on the date of your family or employment status change.

Certain features of At Your Service and bencom.fone may not be available to employees at Los Alamos National Laboratory.

For additional assistance, contact the person in your department who handles benefits or your Benefits Office.

When Coverage Begins

Coverage under UC-sponsored plans generally starts on the day you become eligible, provided you enroll during your period of initial eligibility (PIE). You must also enroll eligible family members before the PIE ends.

If you complete your enrollment transactions before you and/or your eligible family members are eligible, coverage starts on the day you and/or they become eligible.

Open Enrollment actions are effective on January 1 of the following year.

Some UC-sponsored plans also have other stipulations:

- For UC-sponsored plans other than medical plans, if you are on a leave without pay (for reasons unrelated to health) when you become eligible, coverage starts on your first day on pay status.
- If you are on leave for health reasons on the day you become eligible for coverage, coverage starts the day after your first full day at work for these plans:
 - Basic Life,
 - Supplemental Life,
 - Basic or Expanded Dependent Life,
 - AD&D,
 - Short-Term and Supplemental Disability, and
 - Legal Expense.

- If you enroll yourself and/or your eligible family members in a UC-sponsored medical plan outside of a PIE and complete a 90-day waiting period, coverage begins on the 91st consecutive day after the enrollment form is received by your local Payroll or Benefits Office.
- If you or a family member is hospitalized on the day Basic or Expanded Dependent Life, AD&D and/or Legal Expense coverage would normally begin, coverage starts the day after release from the hospital. (This does not apply to a newborn or adopted child.)

See the appropriate plan booklet for more details about when coverage begins.

If You Need Services Right Away

Although you're covered immediately when you become eligible, it may take 30 to 60 days after you enroll for the insurance companies to have a record of your membership. Be sure to keep a copy of your enrollment confirmation and/or enrollment form for your records. Contact your local Benefits Office or the person in your department who handles benefits if you need to use one of your health and welfare plans and your insurance carrier does not have record of your enrollment.

California HMO Medical Plan Transfers

If you transfer from one California HMO plan to another outside the annual Open Enrollment period (see page 17), the effective date for your coverage under the new plan will generally be the first of the month after the form is processed at your UC location. Note that processing dates vary by location.

Be Sure to Review Your Benefits Choices

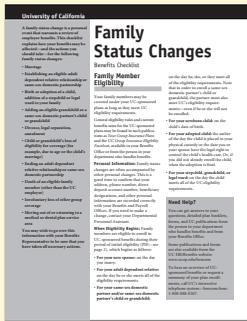
UC makes every effort to ensure the accuracy of your enrollment transactions. However, you should review your payroll check stub or Surepay statement to be sure it reflects your benefits choices. **It is your responsibility to promptly notify your Benefits or Payroll Office of any errors, so that they can be corrected.**

Life Events

Sometimes an event in your personal life may affect your UC employment and employee benefits.

Family Changes

When you have a newly-eligible family member (for example, if you get married or you give birth to or adopt a child), you may enroll him or her in UC-sponsored coverage. You must disenroll any family member who loses eligibility to participate in UC-sponsored plans. See the *Family Status Changes Benefits Checklist* for more information about enrolling and disenrolling family members.



Leaves

If eligible, you may be granted a leave of absence for pregnancy, disability, medical conditions, family illness, military responsibilities, or personal reasons in accordance with the guidelines in UC personnel policies. See your Staff or Academic Human Resources Office for information about taking a leave of absence from UC employment.

Childbirth

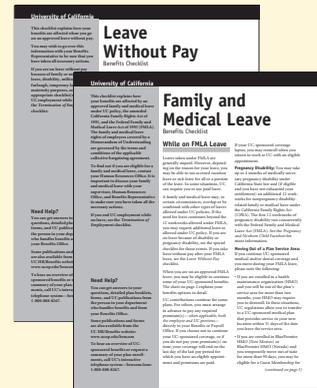
The only benefit income available during childbirth is provided by Short-Term and Supplemental Disability plans. There is no separate maternity benefit. Please see the Disability Insurance section on page 43.

Benefits Checklists

For information about how your benefits are affected by changes in your family's eligibility status or other life events, refer to the appropriate benefits checklist or factsheet:

- *Leave Without Pay*
- *Paid Leave*
- *Sabbatical Leave*

- *Furlough*
- *Family and Medical Leave*
- *Disability (including Pregnancy)*
- *Pregnancy and Newborn Child Factsheet*
- *Military Leave*
- *Temporary Layoff*
- *Indefinite Layoff*
- *Termination of Employment*



These publications are available from your Benefits Office, the person in your department who handles benefits, or from the UC HR/Benefits website (<http://atyourservice.ucop.edu>; select "Forms & Publications" and then "Checklists and Factsheets").

When Coverage Ends

Coverage through UC-sponsored plans can end if certain employment actions occur. For example, if your average regular paid time is reduced below 17.5 hours a week, you leave UC employment, or you retire, your coverage ends. In addition, coverage for your family members ends when they lose eligibility to participate in UC-sponsored plans. See “When Family Members Lose Eligibility” below.

Reduced Average Regular Time

If your average regular paid time drops below 17.5 hours a week, you become ineligible for medical (including Core), dental, vision and Basic Life insurance as well as Short-term and Supplemental Disability coverage. You may still be eligible for Supplemental Life, AD&D, Health Care Reimbursement Account, DepCare, Legal Expense and Auto and Homeowners/Renters coverage.

Separating from UC Employment

When you separate from UC employment, generally your UC-sponsored benefits stop on the last day of the last period for which premiums are paid. If eligible, however, you may be able to continue some benefits for a limited time (see “COBRA/Continuation” on page 22) or convert group coverage to individual policies (see “Conversion Privileges” on page 22).

If you are eligible for MediCal and you have a high-cost medical condition, or if you are unable to work because of disability due to HIV/AIDS, you may be eligible for health

insurance premium assistance through the California Department of Health Services.

For more details about your UC-sponsored benefits when UC employment ends, please see the *Continuation of Group Insurance Coverage* notice and these benefits checklists as appropriate: *Temporary Layoff*, *Indefinite Layoff*, or *Termination of Employment* (see “Benefits Checklists” on page 20).

Retirement and Lump Sum Cashout

If you retire under the UC Retirement Plan, you may be eligible to continue certain benefits. However, if you have elected a lump sum cashout from UCRP, you are not eligible to continue UC-sponsored medical and dental coverage even if you receive an annuity from the University of California 415(m) Restoration Plan or other UC-sponsored retirement plans.

When Family Members Lose Eligibility

Whenever a family member loses eligibility to participate in UC-sponsored plans, it is your responsibility to reenroll that family member. Contact your Benefits Office or the person in your department who handles benefits for assistance. Otherwise, you are liable for any excess UC costs and for any plan expenses incurred by the ineligible family member(s). Family members lose eligibility for the following reasons:

- **For your spouse**, eligibility stops on the last day of the month in which a divorce, legal separation, or annulment is final. You must also

reenroll your spouse if you wish to enroll an eligible adult dependent relative.

- **For your child(ren) or grandchild(ren)**, eligibility stops at the end of the month in which the child reaches age 23 (unless eligible to continue coverage because of disability) or age 18 for legal wards, or when the child marries or no longer meets all eligibility requirements to participate in UC-sponsored benefit plans. (See pages 10–11.)
- **For your adult dependent relative**, eligibility stops at the end of the month in which your family member no longer meets all eligibility requirements to participate in UC-sponsored plans or on the day your adult dependent relative becomes entitled to Medicare (the first day of the month in which he or she becomes age 65, or the first day of the prior month if the birthday is on the first of the month). (See pages 10–11.)
- **For your same-sex domestic partner and/or partner’s child or grandchild**, eligibility stops at the end of the month in which the same-sex domestic partnership ends or your family member no longer meets all eligibility requirements to participate in UC-sponsored plans.

You are also required to reenroll a deceased family member. You should contact your Benefits Office for assistance.

Deenrolling a family member who is no longer eligible to participate in UC-sponsored benefit plans does not in itself create a new period of initial eligibility (PIE). However, if

accompanied by an involuntary loss of other group insurance coverage or by a move out of or a return to a plan service area, you or your family member may be eligible for a new PIE for some benefit plans.

If you reenroll an adult dependent relative or same-sex domestic partner, you must wait six months before you can enroll another eligible adult dependent relative or same-sex domestic partner. If the reenrollment is due to the death of the adult dependent relative or same-sex domestic partner this rule does not apply; however, all other eligibility rules still apply (see *Declaration—Same-sex Domestic Partnership* (UBEN 251) or *Declaration—Adult Dependent Relative* (UBEN 252) available on the At Your Service website or through your Benefits Office.

COBRA/Continuation

If you or any family member(s) lose eligibility for UC-sponsored medical, dental, and/or vision coverage, you may be able to continue group coverage through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended.

If you are enrolled in the Health Care Reimbursement Account (HCRA) and leave UC employment during the plan year, you can continue your participation through the end of the current plan year (December 31) by making after-tax payments to your account. The plan administrator will send you a "Qualifying Event Notice" which explains the procedure for continuing your participation under COBRA.

For more information about COBRA/continuation privileges, see the *Continuation of Group Insurance Coverage* notice, available on At Your Service (select "Forms & Publications") or from your Benefits Office.

Conversion Privileges

Within 31 days after UC-sponsored coverage ends (if your participation has been continuous), you may be able to convert your group insurance coverage to individual policies for these plans:

- Basic Life
- Supplemental Life
- Basic Dependent Life
- Expanded Dependent Life
- AD&D

For medical coverage, you have 31 days after your UC-sponsored or COBRA/continuation coverage ends to apply for conversion (if available).

Note that conversion options are generally more costly and may provide fewer benefits than UC-sponsored plans. See the appropriate plan booklet or call the insurance carrier directly for more information about conversion of a UC-sponsored plan to an individual policy.

Certificate of Creditable Coverage

When you and/or your eligible family member end UC-sponsored medical coverage, you will receive a Certificate of Creditable Coverage from the medical plan as required by the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). Insurance carriers are required to issue the certificate to anyone who leaves their plan. In certain circumstances, an employer requires a certificate during a medical plan enrollment.

This certificate provides evidence of your previous medical plan coverage. It is not needed for enrolling in any UC-sponsored plan. However, if you want to enroll in a non-UC group medical plan or to buy a medical

insurance policy, you may need to show this certificate to the new insurance carrier if the plan/policy would otherwise exclude coverage or impose a waiting period for certain pre-existing medical conditions. Contact your medical plan directly if you do not receive a certificate. If you transfer from one UC-sponsored plan to another and receive a certificate from your former plan, you can disregard it.

When You Retire

When you retire, you may be eligible to continue your UC-sponsored medical and dental coverage as an annuitant. You may also continue some other benefits if you make the arrangements and the applicable payments directly to the plans.

Medical and Dental Plans

If you meet the eligibility requirements, you may continue your UC-sponsored medical and dental coverage when you retire. UC's employer contribution toward the monthly cost of the coverage is determined by UC and may change or stop altogether.

To qualify, you must:

- Be enrolled in UC-sponsored medical and/or dental coverage on the date you separate from UC,
- Have the required retirement plan service credit as listed in the "Annuitant Eligibility Requirements" (see page 23),
- Elect a retirement date within 120 calendar days of the date you separate from UC,
- Have continuous medical and/or dental coverage between the date you separate from UC and your retirement date, and
- Elect to continue medical and/or dental coverage at the time of retirement.

If there is a gap in time between your last day on active pay and your retirement date, you must pay the full amount of your coverage including employer contributions and plan premiums.

Legal

You may continue participation in the Legal Expense plan as long as your monthly retirement benefit covers your monthly cost.

Vision Plan

You may be eligible to continue vision coverage for a limited time though the COBRA/Continuation options (see page 22).

Benefit Plans You May Not Continue

For these benefits, your UC-sponsored coverage stops on your last day actively at work:

- Health Care Reimbursement Account
- Dependent Care Reimbursement Account
- Tax Savings on Insurance Premiums (TIP)
- Short-Term Disability
- Supplemental Disability
- Business Travel Accident Insurance
- Workers' Compensation

You may not continue or convert any of these benefit plans.

Benefit Plans You May Continue with the Carrier

Benefits that you may continue on an individual basis include the following:

- Automobile Homeowner/Renter
You may continue Automobile Homeowner/Renter coverage by arranging to pay premiums directly to the insurance carrier.

Annuitant Eligibility Requirements

If you entered a UC-sponsored retirement plan* before January 1, 1990, and you have not had a break in service of more than 120 days, you will receive 100% of UC's maximum contribution toward the medical and dental plan premium. You are eligible if:

- You retire before age 55, and have at least 10 years of UC service credit (five years for Safety and UC-PERS members);
- You retire at age 55 or later and you have at least five years of UC service credit; or
- You are a UCRP disabled member or survivor.

If you entered a UC-sponsored retirement plan* on or after January 1, 1990, or were rehired after that date following a break in service of more than 120 days, you will receive a percentage of UC's maximum contribution. The percentage corresponds to your years of UC service credit as shown below:

Years of Member's UC Service Credit

Retirees	Survivors	Disabled Members	Percentage of UC Contribution
0-4	N/A	N/A	Not eligible
5-9	N/A	N/A	If age plus years of service credit equal at least 75, then 50%; otherwise not eligible
10	2-10	5-10	50%
11	11	11	55%
12	12	12	60%
13	13	13	65%
14	14	14	70%
15	15	15	75%
16	16	16	80%
17	17	17	85%
18	18	18	90%
19	19	19	95%
20+	20+	20+	100%

Employees who are not eligible to continue UC-sponsored coverage may be able to continue medical and dental coverage for a limited time under COBRA or other continuation option.

The example below illustrates how UC calculates a member's monthly premium. This member retired with 11 years of UCRP service credit and has PacifiCare of California coverage for self + adult (non-Medicare). The amount of UC's maximum contribution varies by coverage level and medical plan.

2003 gross monthly PacifiCare rate	= \$462.04
11 years of UC service credit = 55% of UC's maximum contribution.	
UC's maximum contribution for two adults: \$423.98 x 55%	= \$233.19
Member's monthly premium (\$462.04 - \$233.19)	= \$228.85

* A UC-sponsored retirement plan means UCRP or another defined benefit plan to which UC contributes, such as CalPERS.

- Accidental Death and Dismemberment (AD&D)

You and your spouse may continue coverage after retirement through the UC-sponsored Voluntary Group Accident Insurance Program.

You may convert your eligible children's AD&D coverage to individual policies. Contact the insurance carrier directly for more information.

Benefit Plans You May Convert

- Basic Life
- Supplemental Life
- Basic or Expanded Dependent Life

You and/or your family members may be eligible to convert UC-sponsored life insurance coverage to individual policies (see "Conversion Privileges" on page 22). If not converted, coverage ends on the last day of the last period for which premiums are paid.

For more information about benefits after you retire, see the *Retirement Handbook*, available in your Benefits Office, from the person in your department who handles benefits, or on the UC HR/Benefits website (<http://atyourservice.ucop.edu>).

Medical

Sound medical coverage is one of the most important benefits that UC offers you and your eligible family members. UC offers a wide range of medical plans so you can choose the coverage that best meets your needs.

The following types of plans are available at most locations:

- A health maintenance organization (HMO) plan,
- A point-of-service (POS) plan,
- A preferred provider organization (PPO) plan, not available at Los Alamos National Laboratory
- A fee-for-service plan.

Here’s how these types of plans work.

HMO Plans

UC offers the following HMO plans to any employee who lives (or works, depending on the plan’s rules) in its service area: Health Net of California, Kaiser Permanente of California, Kaiser Mid-Atlantic, PacifiCare of California, PacifiCare of Nevada and Western Health Advantage. In New Mexico, the BluePremier HMO plan is available.

An HMO uses a group of doctors and other health care professionals who emphasize preventive care and early intervention. HMO services are prepaid—there is no annual deductible (except for the BluePremier HMO

plan) and a set premium covers all services, no matter how much you use the plan. You do share costs, however, by paying a fee called a copayment for some products and services.

For BluePremier HMO, some services are also subject to coinsurance. You continue to share benefit expenses with the plan until you reach the annual out-of-pocket maximum. At that point, the plan pays 100 percent for some services for the rest of the calendar year.

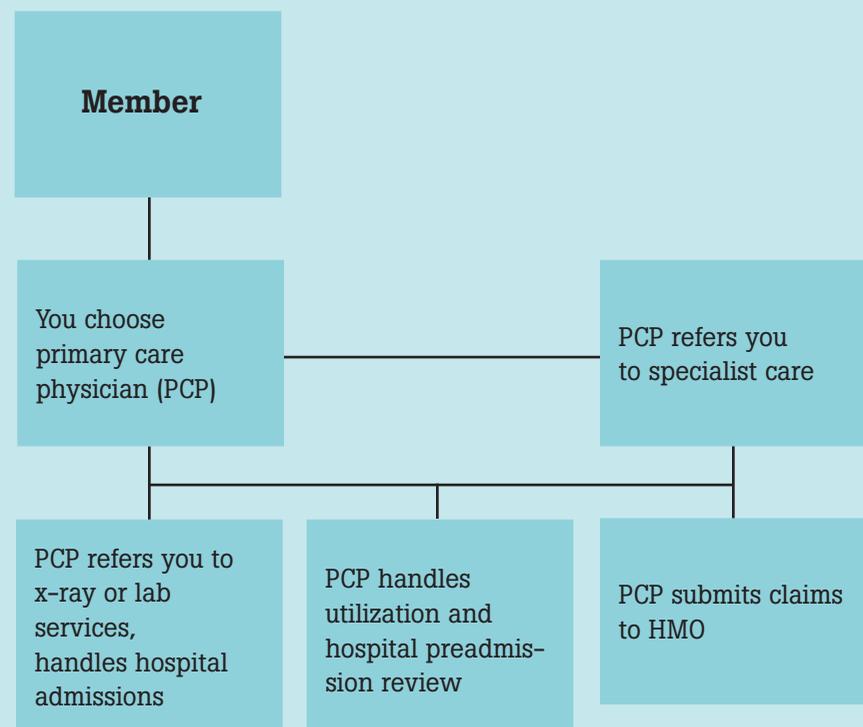
Enrollment in the HMOs requires you to pay part of the monthly premium. Your monthly plan costs are shown on page 30.

To be eligible to enroll in an HMO, you must live (or work, depending upon the plan’s rules) within the HMO’s service area. Services may not be covered unless preauthorized by your primary care physician (PCP), and in some cases they must also be authorized by the medical group and/or the plan. For medical services to be covered, you must follow HMO procedures and (except in emergencies) you must use a network provider.

Primary Care Physician (PCP)

HMO plans (other than Kaiser) and Blue Cross PLUS and BluePremier POS require that all family members select a PCP when enrolling.

HMO Access to Care



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You may select a different PCP for each family member or the same PCP for the entire family. If you are interested in receiving care from a particular doctor, you should find out if that doctor is in the plan’s network. Refer to At Your Service (<http://atyourservice.ucop.edu>) and choose “Health Pages” (select “Health & Insurance” and “Medical Plans”) for information about doctors. You may change your PCP during the year by calling the carrier directly. **Please note that physicians may not be accepting new patients or they may join or leave HMO plan networks throughout the year.**

Fee-for-Service (High Deductible PPO) Plan

UC offers the High Option* and Core fee-for-service plans. Because of the Blue Cross network, the High Option

and Core plans are effectively high deductible PPO plans.

In a **fee-for-service PPO** plan, you choose your own doctors and health care facilities, submit claims for the services you receive, and share the cost of those services with the insurance company.

Your annual cost for medical coverage under a fee-for-service plan depends on your monthly premium, your calendar year deductible, and the covered services of the plan. The deductible varies among the plans. Your monthly plan costs are shown on page 30.

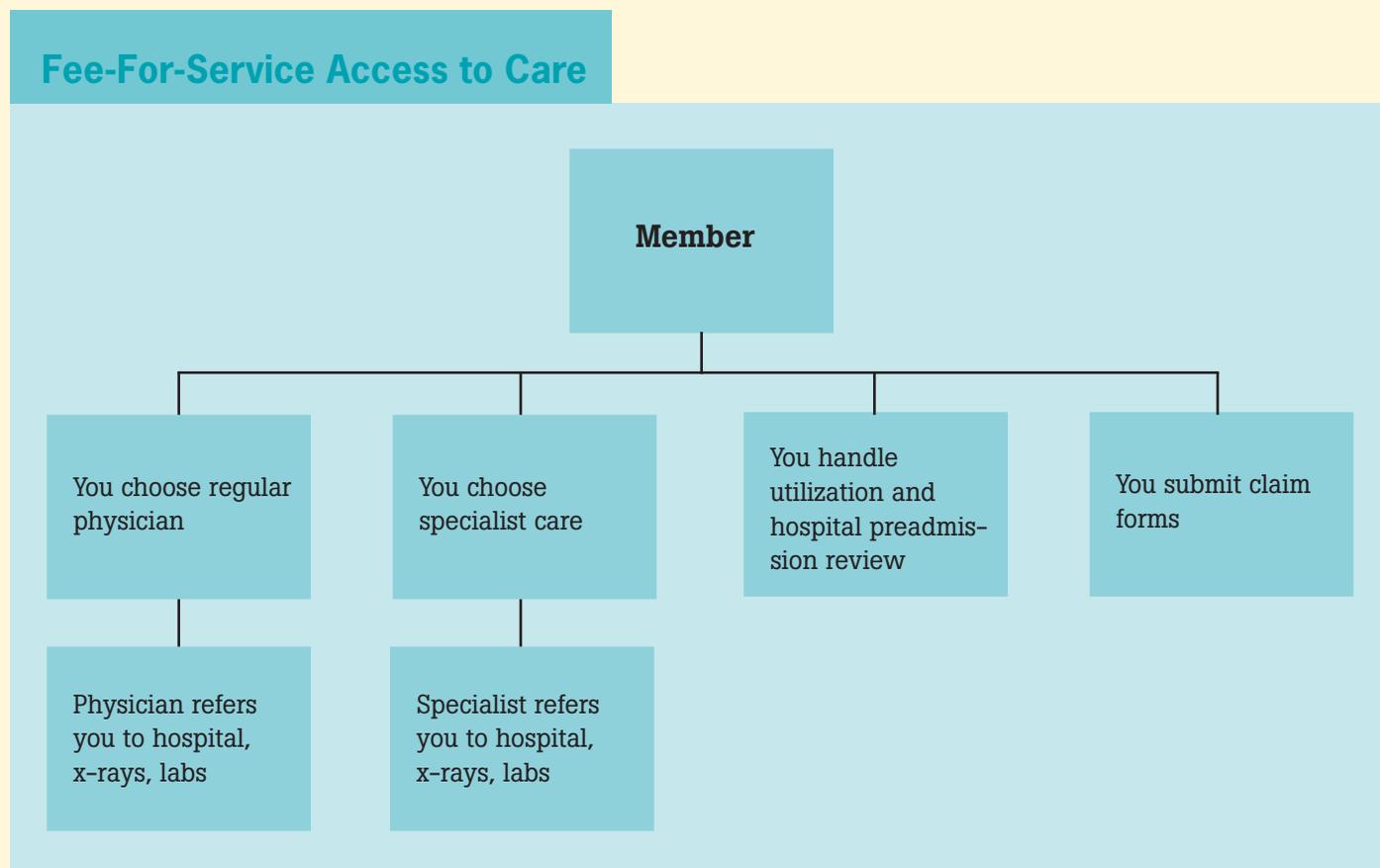
- The Core and High Option plans contract with the Blue Cross PPO network. This is a network of doctors and hospitals who have agreed to provide medical services at contracted rates. Your

out-of-pocket costs will be lower if you use PPO network providers.

Please note that physicians may join or leave the PPO network throughout the year and that such changes are not grounds for you to transfer to another medical plan midyear.

- Once the plan starts paying benefits, you and the insurance company share the cost of the services you receive. Generally, the insurance company pays the larger part of the cost.

Your out-of-pocket costs in a calendar year may be limited. Once your share of the eligible medical expenses reaches a certain amount, called the out-of-pocket maximum, the plan pays 100% of most covered charges for the rest of the calendar year.



* Not open for new enrollments.

Point-of-Service Plans

UC has two **point-of-service** (POS) plans: Blue Cross PLUS for employees from California locations, and the BluePremier POS Plan for Los Alamos National Laboratory (LANL) employees. These plans provide two levels of medical coverage.

Primary Care Physician (PCP)

Everyone enrolled in a UC-sponsored POS medical plan (unless enrolled in BluePremier or worldwide benefits) must select a PCP. You may choose a different PCP for each family member or the same PCP for all family members. If you or your eligible family members do not select a PCP, your medical plan will assign one.

PCPs generally refer patients to specialists or other medical providers within their own medical group. If you are interested in receiving care from a particular doctor, you should find out if that doctor is in the network. Refer to At Your Service (<http://atyourservice.ucop.edu>) and select "Health Pages" (select "Health & Insurance" and "Medical Plans") or call the plan to determine if that doctor is in the network and also in the same medical group as your PCP. **Please note that physicians may join or leave plan networks or medical groups at any time and that such changes are not grounds for you to change medical plans midyear.**

Blue Cross PLUS Benefits

In-Network

Using in-network providers is similar to using an HMO. All of your medical care and specialist referrals are coordinated by your PCP. There is no deductible; you are required to make copayments (\$20 for most covered services) at the time you receive services.

Out-of-Network

You do not use your PCP to coordinate your medical care; you self-refer to out-of-network providers. You are required to pay an annual deductible of \$500/person or \$1,500/family. After you meet the deductible, the plan generally pays 70% of customary and reasonable charges for most covered services and you pay the balance.

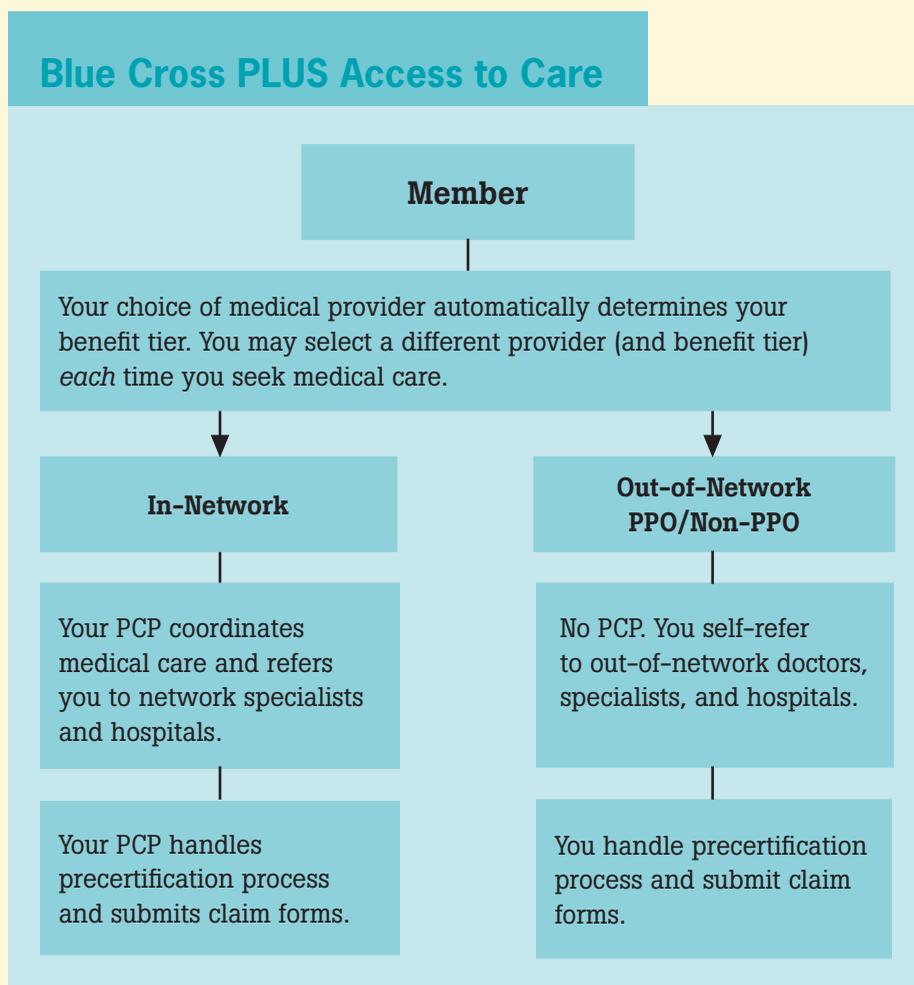
Blue Cross PLUS offers benefits for outpatient prescription drugs, and acupuncture self referral (in-network only) and chiropractic care self referral (in-network only).

Prescription Drugs

You get outpatient prescription drugs at network pharmacies by showing your Blue Cross PLUS ID card and paying a copayment when you pick up your medication. Outpatient prescription drugs are also available through mail order.

Behavioral Health Benefits

Mental and nervous disorders and substance abuse benefits are provided through United Behavioral Health.



BluePremier POS In-Area Benefits (for Los Alamos Employees)

PCP-coordinated care (in-network) is similar to the BluePremier HMO

All of your medical care and specialist referrals are coordinated by your PCP. There is a deductible of \$250 per person/\$750 per family; you are required to make copayments (\$20 for many outpatient services) or pay coinsurance (10% for many inpatient services) at the time you receive services.

Self-coordinated care (in-network or out-of-network) is similar to a PPO plan. You do not use your PCP to coordinate your medical care. You may self-refer to any provider. The

plan generally pays 60% of most covered services. You are required to pay an annual deductible of \$500 per person/\$1,500 per family and the remaining 40% of the cost for services.

Once your share of the eligible medical expenses reaches a certain amount (called the out-of-pocket maximum), the plan pays 100% for some services for the rest of the calendar year.

BluePremier POS Plan Worldwide Benefits (for Los Alamos Employees)

BluePremier POS Plan worldwide benefits eligibility is based on your home ZIP code. If you receive worldwide medical benefits, so will your

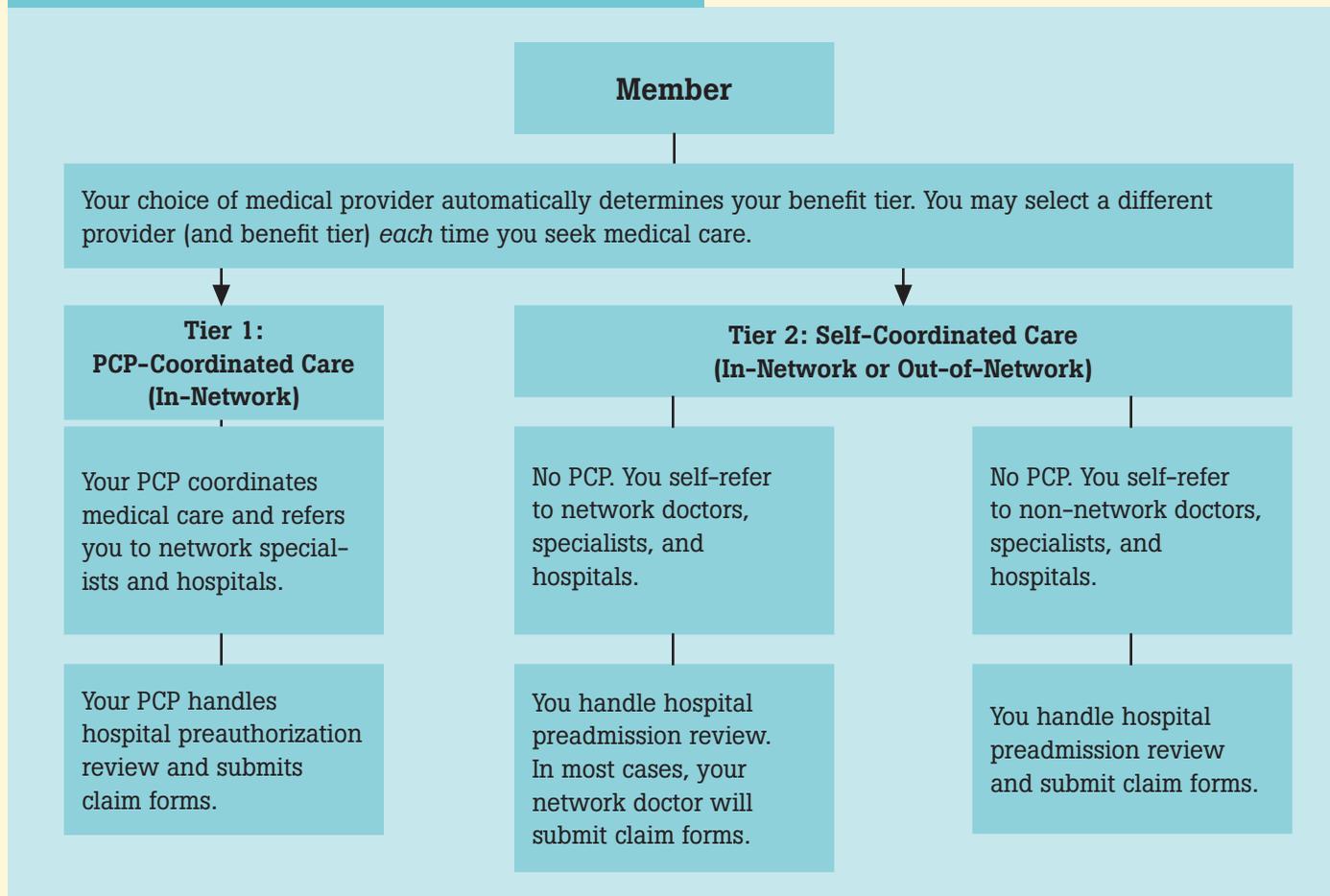
eligible family members, no matter where they live.

If you have a child living outside of the BluePremier POS service area (a full-time student or a natural or adopted child living with a former spouse), you may request worldwide benefits for that child on an individual basis.

Staff participating in the Education Abroad Program, or staff on professional leave outside the BluePremier POS Tier 1 service area, may also be eligible for worldwide benefits.

You may use any medical provider for worldwide benefits; however, you will not receive benefits through BluePremier POS Plan Tiers 1 or 2. After a calendar year deductible of \$250 per person, or \$750 per family, the plan generally pays 80% of

BluePremier POS Plan Access to Care



covered charges for the rest of the calendar year.

Expenses incurred under Tier 2 and worldwide benefits will apply toward both the Tier 2 and worldwide BluePremier POS plan calendar year deductible.

Once your share of the eligible medical expenses reaches a certain amount (called the out-of-pocket maximum), the plan pays 100% for some services for the rest of the calendar year.

Prescription Drugs and Behavioral Health

Outpatient prescription drug benefits are the same under both in-area and worldwide benefits coverage. You get outpatient prescription drugs at network pharmacies by showing your BluePremier POS card and paying a copayment when you pick up your medication. Outpatient prescription drugs are also available through mail order. An insurance carrier specializing in behavioral health provides your mental health and substance abuse benefits. A separate substance abuse deductible applies.

See the BluePremier POS Plan or worldwide booklet for more details.

Preferred Provider Organization

In a Preferred Provider Organization (PPO), you can self-refer to any provider or specialist, and you pay a percentage of the cost for services depending on whether you use a provider in the PPO network.

PPO plan members are not required to select a primary care physician. You may self-refer to any provider or specialist, but your copayment percentage is lower if you access in-network providers. **Please note that physicians may join or leave the PPO network at any time and**

Your Medical Plan Choices

For 2003, UC offers the following medical plans. You may select any medical plan that best meets your needs and for which you are eligible.

Type of Plan	Plans
Health Maintenance Organization (HMO) ¹	BluePremier HMO New Mexico Health Net of California Kaiser Permanente of California Kaiser Permanente Mid-Atlantic PacifiCare of California PacifiCare of Nevada Western Health Advantage
Point-of-Service	BluePremier POS Plan ² Blue Cross PLUS ³
Preferred Provider Organization	Blue Cross PPO ³
Fee-for-Service	High Option ⁴ Core

¹ HMO plans are available to all employees who live or work in the HMO plan service area.

² BluePremier POS is available to all employees from LANL.

³ Available to employees from California locations.

⁴ High Option is closed to new enrollees (only available to employees from California locations)

Please note that plan service areas are established by home (or work, depending on the plan) ZIP codes. If you have questions about whether your ZIP code is included in a plan's service area, please check the HMO or Point-of-Service plan provider directory, call the plan directly (see page 36 for toll-free numbers), or see "Health Pages" on the At Your Service website (<http://atyourservice.ucop.edu>).

For more details about these plans, see the Medical Plan Chooser, the Evidence of Coverage, and the Summary Plan Descriptions on the At Your Service website (see page 1) or contact your Benefits Office.

that such changes do not allow you to transfer to another medical plan midyear.

Your annual cost of coverage under a PPO plan includes your monthly premium, your annual deductible, and your applicable in-network or out-of-network copayments. Each year, you must pay the annual deductible for your coverage level (self/family) before the plan shares your costs. For the Blue Cross PPO, annual deductibles are different and separate for in-network and

out-of-network benefits. After you satisfy your deductible, the plan generally pays 80% (in-network) or 60% (out-of-network) of customary and reasonable charges for most covered services and you pay the balance.

You continue to share benefit expenses with the plan until you reach the annual out-of-pocket maximum. At that point, the plan pays 100 percent of covered charges for the rest of the calendar year. For the Blue Cross PPO, there are separate

out-of-pocket maximums for in-network and out-of-network benefits.

Cost of Coverage

Your medical plan monthly cost depends on the plan and the coverage you choose. The chart below shows the monthly amount that will automatically be deducted from your paycheck in 2003. The UC/employer contribution toward the monthly cost of the coverage is determined by UC and may change or stop altogether.

To help keep costs affordable for 2003, UC has increased contributions

to monthly premiums for employees with an annual full-time salary rate of \$40,000 or less.

Under the Tax Savings on Insurance Premiums (TIP) program, UC automatically deducts from your pay, on a pretax basis, any monthly cost for your health premiums. In other words, TIP reduces your taxable earnings by your share of the premium—you do not pay federal, state, or FICA taxes on this amount. The pretax deductions from your pay are not counted as wages for unemployment insurance and Social Security benefits.

TIP enrollment is automatic. If you wish, you may cancel TIP enrollment either during your period of initial eligibility (PIE; see page 16) or during Open Enrollment. Ask the appropriate person in your department or your Benefits Office for a cancellation form.

If you change or cancel your medical coverage during your PIE, during Open Enrollment, or when your family or employment status changes, the amount of your salary reduction under TIP automatically increases or decreases to reflect the change. If you change or cancel your medical premium deduction at any other time,

Employee Monthly Costs Effective January 1, 2003

Medical Contribution Base: Plan	Full-time annual salary rate of \$40,000 or less				Full-time annual salary rate of over \$40,000			
	Self	Self + Child(ren)	Self + Adult	Self + Family	Self	Self + Child(ren)	Self + Adult	Self + Family
Blue Cross PLUS	\$56.23	\$101.22	\$118.09	\$163.06	\$64.23	\$115.62	\$134.89	\$186.26
Blue Cross PPO	78.78	141.81	165.44	228.46	86.78	156.21	182.24	251.66
BluePremier HMO NM (LANL employees)	35.51	63.92	74.57	102.98	43.51	78.32	91.37	126.18
BluePremier HMO NM (Non-LANL employees)	67.51	120.92	141.57	194.98	75.51	135.32	158.37	218.18
BluePremier POS Plan ¹ (living within the New Mexico HMO service area)	103.89	187.01	218.17	301.29	111.89	201.41	234.97	324.49
BluePremier POS Plan (living outside the New Mexico HMO service area)	25.78	46.41	54.14	74.77	33.78	60.81	70.94	97.97
Core	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Health Net	9.64	17.36	20.25	27.95	17.64	31.76	37.05	51.15
High Option	1,344.00	2,022.60	2,485.20	3,163.80	1,352.00	2,037.00	2,502.00	3,187.00
Kaiser Permanente—California	2.00	3.60	4.20	5.80	10.00	18.00	21.00	29.00
Kaiser Permanente—Mid-Atlantic	39.57	70.63	82.91	113.96	47.57	85.03	99.71	137.16
Kaiser Permanente—Mid-Atlantic (for LANL employees)	7.57	13.63	15.91	21.96	15.57	28.03	32.71	45.16
PacifiCare of California	10.12	18.22	21.26	29.35	18.12	32.62	38.06	52.55
PacifiCare of Nevada (LANL)	51.32	92.38	107.77	148.83	59.32	106.78	124.57	172.03
PacifiCare of Nevada (Non-LANL)	83.32	149.38	174.77	240.83	91.32	163.78	191.57	264.03
Western Health Advantage (WHA)	2.50	4.50	5.25	7.25	10.50	18.90	22.05	30.45

¹ Available only to Los Alamos National Laboratory employees.

you must pay your original premium amount under TIP until the plan year ends. If you increase your monthly medical premium at any time (including the California HMO monthly transfer option), you will pay the extra premium on an after-tax basis through the end of the year.

See page 67 and the *TIP Summary Plan Description* for more information.

Imputed Income

If you enroll your same-sex domestic partner—or your partner's child/grandchild—in a UC medical and/or dental plan, the UC/employer contribution for the additional coverage may be taxable income to you. 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 have any 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.

In the fall of the year for which coverage applies, UC HR/Benefits will send you information about how to have the imputed income reversed at year's end. You may also need to verify tax dependency if requested. See "Annual Tax Verification" on page 15.

Frequently Asked Questions

You need to evaluate carefully your family circumstances and the plan costs before electing medical plan coverage. The chart on pages 32 through 35 contains frequently asked questions about access to care and costs for UC-sponsored medical plans. If you have other questions, call the medical plan directly (see page 36) or call your Benefits Office.

The information below answers questions you may have prior to and after enrolling in your plans.

General Information

If I do not enroll in UC-sponsored medical plan coverage, will I receive the UC contribution to use for plan coverage of my choice?

No. The UC contribution can only be applied to UC plan coverage.

My PIE is about to expire, and the medical plan I will enroll in requires a primary care physician (PCP). May I enroll in a medical plan now and choose a PCP later?

Yes, you may. However, before enrolling, you should refer to the "Health Pages" website (see page 1) or contact the plan directly to obtain information about the PCPs in your area. If you do not select a PCP, the medical plan will assign one to you and your family members. You may then change your PCP directly through your plan at any time.

I recently enrolled in a medical plan. I need to schedule an appointment and have a prescription filled, but my enrollment card has not arrived. How do I get help?

Generally, medical plan identification cards are sent to members within 14 days after the carrier receives the enrollment. If you have not received your medical plan card and you require

medical services, see "If You Need Services Right Away" on page 19. Note: If you change plans during the annual Open Enrollment period, the medical plan cards are usually sent at the end of December (for January 1 coverage).

Once I have enrolled in UC-sponsored coverage, how can I confirm coverage for me and my family?

Approximately 10 days after you have completed your enrollments, you may access information about your UC-sponsored coverage through bencom.fone (1-800-888-8267) under the "Personal Information, New Hire Enrollment, and 403(b) Plan Loan" option, or through At Your Service (<http://atyourservice.ucop.edu>) by selecting "Your Benefits Online" and "Health & Welfare at a Glance."

Once I am enrolled in UC-sponsored coverage, whom do I contact if I have questions about my benefits?

For information about medical plan services, benefits, bills, and/or claims, you should contact your medical plan directly using the phone number on your medical plan ID card. Delta Dental, VSP, AD&D and Dependent Life insurance plans do not issue ID cards. Phone numbers for all UC plans are listed on our website (<http://atyourservice.ucop.edu>) under "Contact List."

If I previously worked at UC and I have returned to UC employment, will I have to reenroll in my UC-sponsored plans?

Yes. When you return to UC employment, you will not be reenrolled automatically in your previous UC-sponsored plan(s). The plans that you are eligible for may depend upon the length of your break in service. If you are eligible and do not enroll, you will be defaulted into single-party coverage under Core medical, Delta Dental, and the vision plan.

Frequently Asked Questions

HMO Plans
 (BluePremier HMO New Mexico, Health Net of California, Kaiser Permanente of California, Kaiser Permanente Mid-Atlantic, PacifiCare of California, PacifiCare of Nevada, Western Health Advantage)

Fee-for-Service Plans, PPO Plan
 (Core, High Option, Blue Cross PPO)

Access to Care

How do I get care from a doctor?

Make an appointment with your primary care physician (PCP) or the appropriate Kaiser facility.

Make an appointment with the doctor of your choice. For High Option and Blue Cross PPO, your benefit will be paid at a higher level if you select a network provider.

How do I get care from a specialist?

Your PCP or regular Kaiser physician will refer you to a specialist whenever one is required. In some cases, you may self-refer to some specialists.

Your regular doctor may refer you or you may self-refer to a specialist.

How do I get care from a hospital?

Your PCP, regular Kaiser physician, or specialist will refer you to a network hospital whenever you need care.

Your regular doctor or specialist may refer you to the hospital whenever you need care. Preadmission review by the plan is required.

What do I do in case of an emergency?

Call your PCP or the nearest Kaiser facility and follow their instructions. In an emergency, or if you are outside of the HMO service area, get necessary medical assistance. You must notify your PCP or Kaiser within 24 hours; for BluePremier HMO, notify your plan within 48 hours.

Get necessary medical assistance. For High Option and Blue Cross PPO, your benefit will be paid at a higher level if you select network providers. If you are hospitalized, notify the plan within one working day.

What will happen if I do not use a network physician or facility?

Except for serious medical or life threatening emergencies, you must use a facility in your HMO's network or Kaiser facility in order to receive benefits.

Coverage is worldwide. For High Option and Blue Cross PPO, your benefit will be paid at a higher level if you select network providers.

How do I obtain medication?

Medical prescriptions are available only at network or Kaiser pharmacies, with a copayment. Maintenance medication may be purchased through mail order or local pharmacies, depending on the HMO.

Medical prescriptions are filled at local pharmacies. You must pay for the prescription and submit a claim for reimbursement. For High Option and Blue Cross PPO, maintenance medication may be purchased through mail order.

Point-of-Service Plans BluePremier POS Plan PCP-Coordinated Care (In-Network)	BluePremier POS Plan Self-Coordinated Care (In-Network or Out-of-Network)
Blue Cross PLUS In-Network	Blue Cross PLUS Out-of-Network
You use your PCP for all medical care and specialist referral.	You may choose any provider, but you pay more of the costs.
<p>Make an appointment with your primary care physician (PCP).</p>	<p>BluePremier POS Plan: Make an appointment with the network or out-of-network physician of your choice.</p>
<p>Your PCP will refer you to a specialist whenever one is required.</p>	<p>BluePremier POS Plan: You may self-refer to a network or out-of-network specialist.</p>
<p>Your PCP or specialist will refer you to a network hospital whenever you need care.</p>	<p>BluePremier POS Plan: Your network or out-of-network physician will refer you to a hospital whenever you need care.</p>
<p>Call your PCP and follow instructions. In an emergency, or if you are outside of the plan service area, get necessary medical assistance. You must notify your PCP within 48 hours.</p>	<p>Get necessary medical assistance. If you are hospitalized, notify your plan within one working day.</p>
<p>Except for serious medical or life threatening emergencies, you must use your PCP for medical care and specialist referrals to receive network benefits.</p>	<p>BluePremier POS Plan: You may use network or out-of-network providers at any time to receive benefits.</p>
<p>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.</p>	

Frequently Asked Questions

HMO Plans

(BluePremier HMO New Mexico, Health Net of California, Kaiser Permanente of California, Kaiser Permanente Mid-Atlantic, PacifiCare of California, PacifiCare of Nevada, Western Health Advantage)

Fee-for-Service Plans, PPO Plan (Core, High Option, Blue Cross PPO)

Cost of Care

Do I have an annual deductible?

No, except for the BluePremier HMO New Mexico Plan

Yes. You must satisfy the calendar year deductible before you receive benefits.

Do I pay a copayment (fixed dollar amount) per visit or service, or a coinsurance (percentage of the fee) amount?

Except for the BluePremier HMO plan, a copayment is set for most visits and services (e.g., physician's office, emergency, and hospital visits). The BluePremier HMO plan includes both copayments for most outpatient services and coinsurance for most inpatient services.

After you satisfy a calendar year deductible, this plan pays a percentage of your medical bills. For High Option and BluePremier HMO, the percentage paid is higher if you use network providers. You must pay the coinsurance.

Is there a maximum lifetime benefit?

No

Yes. Plan maximum is \$2,000,000 per person.

Do I need to file a claim?

No, except for out-of-area emergencies or urgent care services.

Yes, in most cases.

Special Conditions

If you are going on sabbatical leave, have questions about coverage for children attending school away from home, have an extended or separated family, or have other special circumstances, contact your Benefits Office to discuss your medical plan alternatives.

Point-of-Service Plans BluePremier POS Plan PCP-Coordinated Care (In-Network)		BluePremier POS Plan Self-Coordinated Care (In-Network or Out-of-Network)	
Blue Cross PLUS In-Network		Blue Cross PLUS Out-of-Network	
You use your PCP for all medical care and specialist referral.		You may choose any provider, but you pay more of the costs.	
BluePremier POS: for 2003, a deductible was introduced. Coinsurance and copayments also apply.		Yes. You pay deductibles and coinsurance and copayments.	
Blue Cross PLUS: there is no annual deductible if you use your PCP and follow the in-network procedures.			
A copayment is set for most visits and services (e.g. physician office visits and emergencies). Coinsurance also applies for most inpatient services.		Deductibles, coinsurance and copayments may apply.	
No.		Yes. The limit is \$2,000,000 (combined maximum out-of-network and worldwide benefits). (Blue Cross PLUS does not have worldwide benefits.)	
No. In-network providers will process medical claims on your behalf.		No. Out-of-network providers will process medical claims on your behalf.	
Special Conditions If you are going on sabbatical leave, have questions about coverage for children attending school away from home, have an extended or separated family, or have other special circumstances, contact your Benefits Office to discuss your medical plan alternatives.			

If you do not enroll your eligible family members during your period of initial eligibility (PIE), you may only enroll them at specific times (see “When to Enroll” on page 16).

Will UC-sponsored health plan coverage be denied for me or my family member because of our preexisting medical condition?

Preexisting conditions are not excluded under UC health insurance plans. Please note: enrolling in Dependent Life insurance outside of a PIE requires a statement of health.

If my spouse and I are enrolled in a UC medical plan and my spouse has both of us covered under her non-UC plan, which coverage is primary?

When a UC employee is covered under a UC-sponsored medical plan and also has medical coverage under another plan, the UC-sponsored coverage is primary. If the employee’s spouse also has dual medical coverage, the non-UC plan would be his/her primary coverage.

For More Information

This is only an overview of your medical benefits. If you need more information about a particular UC-sponsored medical plan, such as coverage for a specific condition, service areas, or provider information, please refer to At Your Service for a link to the plan (see page 1) or call the plan directly using the toll-free numbers below.

Medical Plans

- Blue Cross PLUS
- Blue Cross PPO
 - United Behavioral Health
- BluePremier HMO New Mexico
- BluePremier POS Plan
 - PacifiCare Behavioral Health, Inc.
- Core
- Health Net of California
 - Managed Health Network
- High Option
- Kaiser Permanente of California
- Kaiser Permanente Mid-Atlantic
- PacifiCare of California
 - PacifiCare Behavioral Health, Inc.
- PacifiCare of Nevada
- Western Health Advantage
 - Magellan Behavioral Health

Toll-free Number

- 1-888-209-7975
- 1-888-209-7975
- 1-888-440-8225
- 1-800-711-3795
- 1-800-711-3795
- 1-800-817-8811
- 1-888-209-7975
- 1-800-522-0088
- 1-888-935-5966
- 1-888-209-7975
- 1-800-464-4000
- 1-301-468-6000 (in Washington D.C. Metro area)
- 1-800-777-7902 (outside Washington D.C. Metro area)
- 1-800-624-8822
- 1-800-999-9585
- 1-800-347-8600
- 1-888-563-2250
- 1-800-424-1778

Special Numbers for Hearing Impaired

- Health Net of California 1-800-929-9955
- PacifiCare of California 1-800-735-2922
- PacifiCare of Nevada 1-800-367-8939
- Western Health Advantage 1-888-877-5378

Dental

Proper dental care plays an important role in your overall good health. That's why UC provides dental coverage for you and your eligible family members including a wide range of dental services, from routine preventive care to oral surgery, dentures, bridges, and braces. The dental plans do not have any exclusions for preexisting conditions.

Here is an overview of your dental plan choices.

The **Delta Dental Plan** provides worldwide coverage from any dentist you choose.

Most California and New Mexico dentists belong to Delta. If you choose a Delta provider, the plan pays for services as described on pages 38 and 39. Almost all preventive dentistry is covered in full. For other services, you pay a \$50 annual deductible per person and a coinsurance of 25% to 50% of the charges. Delta dentists file claims for you.

If you prefer to see a non-Delta dentist, you pay the dentist directly, then file claims with Delta. However, you maximize your benefits if you choose a Delta dentist. You can ask your dentist to submit a predetermination request prior to treatment to find out if the procedure is covered and the amount Delta will pay.

Delta will pay a maximum of \$1,500 per person in a calendar year, regardless of the dentist you use. A separate limit applies to benefits for temporomandibular joint (TMJ)

dysfunction (page 38) and orthodontics (page 39). Delta members are reminded the plan covers two teeth cleanings per year, but only one routine exam per member per calendar year. X-ray coverage is limited to one full set every five calendar years. Bitewing x-rays are available more frequently as prescribed by your dentist. **For any claim you anticipate will be over \$400, you should ask for a predetermination of costs to be sure of Delta's coverage level.**

New for 2003: You can now save on out-of-pocket expenses for basic, prosthetic, and orthodontic services by using the DeltaPreferred Option (DPO) provider network. There isn't a special enrollment to use the DPO. The coverage levels listed on the chart (pages 38 and 39) won't change if you use the DPO. Your savings will be due to the reduced total fees charged by the DPO dentist and will vary according to your region and the dental procedure.

You can find a list of Delta DPO dentists by visiting the special UC Delta Dental website (from the At Your Service website, click on "Contact List" and "Dental Plan Carriers Phone Numbers and Links") or by calling Delta Dental directly.

The **PMI Dental Health Plan** is another option for California residents only. Dental services are covered only when you visit a PMI dentist. See pages 38 and 39 for benefits. The plan emphasizes preventive care—many services cost nothing, while copayments apply to others. There are no deductibles or annual maximums, and you don't file claims.

When you enroll, PMI will assign you to a participating dentist near your home. To change this initial assignment, simply call or write to PMI and

explain why you want to change. Please note that your dentist may join or leave the PMI network throughout the year, and that such changes are not grounds for you to transfer to the Delta Dental Plan midyear.

PMI members are reminded that the plan covers up to two teeth cleanings in a 12-month period. Routine exams are fully covered, and x-ray coverage is limited to one full set per 12-month period. A series of four bitewings are covered in a six-month period.

Cost of Coverage

In 2003, UC pays the monthly cost of your coverage. The UC/employer contribution toward the monthly cost of the coverage is determined by UC and may change or stop altogether.

You do pay a certain percentage or copayment for some services. See the chart on pages 38 and 39 for details.

Imputed Income

If you enroll your same-sex domestic partner—or your partner's child/grandchild—in a UC medical and/or dental plan, the UC/employer contribution for the additional coverage may be taxable income to you. This imputed income may be subject to federal and California state income taxes, Social Security and Medicare taxes, and any other required payroll tax.

You may not have any 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.

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January through December 2003	Delta Dental Plan	PMI Dental Plan*
NETWORK/SERVICE AREA	Any dentist/worldwide	PMI dentists/California only
PREVENTIVE DENTISTRY	No deductible	Copayments apply as noted
Cleaning of teeth	100% of UCR (up to 2 times per calendar year; additional cleanings by report)	No charge (up to 2 times in any 12-month period)
Oral examinations	100% of UCR (1 routine and 2 non-routine exams per calendar year)	No charge
Emergency office visit for pain relief	100% of UCR	No charge
Topical fluoride treatment	100% of UCR (includes cleaning; up to 2 times per calendar year through age 13)	No charge (up to 2 times in any 12-month period through age 18)
Space maintainers	100% of UCR (through age 12)	No charge
X-rays	100% of UCR (1 set in 5 years; bitewings when prescribed)	No charge (1 set in any 12-month period; 4 bitewings in any 6-month period)
Pit and fissure sealants (under age 16 only)	75% of UCR for first permanent molars through age 9 and second permanent molars through age 15	No charge for first permanent molars through age 9 and second permanent molars through age 15
BASIC DENTISTRY	Deductible applies	Copayments apply as noted
Fillings	75% of UCR	No charge
Anesthesia	75% of UCR (general anesthesia for covered oral surgery)	Local—no charge. General—no charge if medically necessary for extraction; otherwise not covered
Prosthetic appliance repair	75% of UCR	No charge
Extractions	75% of UCR	No charge if uncomplicated (not covered if done only for orthodontics)
Crowns	50% of UCR	\$50 per unit copayment (extra charge for precious metals)
Oral surgery	75% of UCR	\$15 copayment for impactions; other covered services at no charge
Endodontics	75% of UCR	\$20 copayment for each canal; other covered services at no charge
Periodontics	75% of UCR	\$100 copayment per quadrant for surgery (mucogingival and osseous gingival); \$150 copayment for soft tissue graft procedures; other covered services at no charge
Inlays/Onlays	50% of UCR	Recementation—no charge
Denture relining	75% of UCR	No charge (limited to 1 in any 12-month period)
Temporomandibular joint (TMJ) dysfunction: occlusal devices/occlusal guards (night guards)	50% up to \$500 for all benefits in a lifetime (not applied to calendar year maximum)	No charge

After an annual deductible of \$50 per person (combined for both basic and prosthetic dentistry)

January through December 2003	Delta Dental Plan	PMI Dental Plan*
PROSTHETIC DENTISTRY	Deductible applies	Copayments apply as noted
Standard, full, or partial dentures	50% of UCR	Upper—\$65 copayment per denture Lower—\$65 copayment per denture (extra charge for precious metals)
Bridges	50% of UCR	\$50 per unit copayment (extra charge for precious metals)
Denture rebase	50% of UCR	\$20 copayment
TOTAL BENEFIT FOR PREVENTIVE, BASIC, AND PROSTHETIC DENTISTRY	\$1,500 per calendar year per person	No maximum
ORTHODONTICS	No deductible	Copayments apply as noted
Who is eligible for service	All covered family members	All covered family members
Benefit	50% of UCR up to \$1,500 in a lifetime for those under age 23; up to \$500 in a lifetime for adults age 23 or older (not applied to calendar year maximum)	\$1,000 copayment (plan covers 36 months of usual and customary treatment—an office visit fee of \$75 applies for orthodontics treatment and retention after 36 months)
SPECIAL PROVISIONS, LIMITATIONS, EXCLUSIONS		
Work in progress when you join	Only services that you receive on or after your effective date of coverage are covered.	Only services received from a PMI provider on or after your effective date of coverage are covered.
Predetermination of benefits	If services will be \$400 or more, your dentist files a treatment plan first; Delta reviews it and notifies you and your dentist of the benefits payable.	Before any work is done, ask your PMI dentist what the charges will be. If you have any questions, call PMI.
Alternate treatment provision	If more than one professionally acceptable and appropriate treatment can be used, Delta benefits will be based on the least expensive method.	If you select a treatment plan different from that customarily provided by PMI, you will pay the applicable copayment, plus the additional cost of the alternate treatment.
Replacement of crowns, dentures, partial dentures, and bridges	Not covered if crown or prosthetic appliance is less than 5 years old.	Not covered if crown or prosthetic appliance is less than 3 years old.
Out-of-area emergencies	Coverage applies worldwide.	Plan pays up to \$100 in any 12-month period for pain relief when you are more than 25 miles from your dentist's office.

* Binding arbitration: When you enroll in PMI, you agree to settle any dispute, grievance, or controversy involving the plan by neutral arbitration.

Definitions

Any 12-month period: Represents 12 continuous months of coverage. This is not necessarily a calendar year.

By report: The dentist submits relevant information to the Delta Dental Plan. If Delta determines an additional cleaning is necessary, they will cover it.

Copayment: A fee you pay for a service.

Deductible: An annual amount you must pay for some services before the plan starts paying benefits for those or other services.

Endodontics: Treatment involving tooth pulp (root canals, for example).

Extractions: Removal of teeth.

Non-routine exam: An exam for an emergency (for example, an injury or infection) or an exam for a specific dental problem (for example, a toothache or an exam to evaluate the need for oral surgery).

Orthodontics: Treatment to correct position or alignment of teeth (braces, for example).

Periodontics: Treatment for diseases of mouth and gum tissue.

Prosthetics: Replacements for teeth (dentures or bridges, for example).

Routine exam: An initial exam with a new dentist or a periodic exam with your existing dentist intended to generally assess your dental health.

UCR (usual, customary, and reasonable): Fees filed with Delta by participating dentists that Delta has determined are customary for the practice area of the participating dentist.

Outline of Benefits and Services

The chart of dental benefits on pages 38 and 39 is only a brief outline of your dental benefits. Please remember that if you need major dental work (for example, a crown, dentures, a bridge, or oral surgery), you should read carefully the complete explanation of benefits, limitations, and exclusions in your Delta Dental or PMI booklet. Whenever you have a question about whether a dental procedure will be covered, you and/or your dentist should contact your dental plan *before* you begin treatment.

For More Information

This is only an overview of your dental benefits. For full details, see your Benefits Office or the appropriate person in your department for the Delta Dental and PMI brochures.

For more information about the Delta Dental Plan, call 1-800-777-5854 (California) or 1-800-999-0963 (New Mexico). To find a Delta dentist, you can access Delta's website through the HR/Benefits website (<http://atyourservice.ucop.edu>) by selecting "Contact List" and "Dental Plan Carrier Phone Numbers and Links," and scrolling down to the Delta Dentist Directory link.

For more information about the PMI plan, call 1-800-422-4234 or 1-562-924-8311.

Once you enroll in a plan, the insurance carrier will send you more information.

Vision

Regular eye exams and good vision are important to everyone. To enable you and your family to get the care you need, UC provides a comprehensive vision plan. Vision Service Plan (VSP)—a preferred-provider organization with over 4,000 members in California and over 22,000 nationwide—offers the benefits described here. The vision plan does not have any exclusions for preexisting conditions.

What the Plan Covers

The plan’s benefits include:

- **One vision examination per calendar year**
The plan covers testing and analysis of eye health, as well as any necessary prescriptions for lenses.
- **One set of corrective lenses per calendar year**
The plan covers single vision, bifocal, trifocal, or other complex glass or plastic lenses. Photo-chromatic lenses and tints are also covered. VSP covers the full cost of polycarbonate lenses when the member uses a VSP provider. For those members using a non-VSP provider, a single \$5 reimbursement is available for tints and polycarbonate options, if elected.
- **One set of frames every other calendar year**
Many frames provided by VSP doctors are fully covered.

- **One set of contact lenses per calendar year**
Contact lenses are fully covered if they are considered medically necessary and a VSP provider is used. Generally, they are covered for those who have had cataract surgery, have extreme acuity problems that cannot be corrected with glasses, or have some conditions of anisometropia or keratoconus.

Members may purchase annual supplies of select contact lenses at a reduced cost. For additional details see the VSP website (www.vsp.com) or call VSP or your VSP provider.

Cosmetic contact lenses are provided once per calendar year; however, benefits are limited to \$110. The \$110 allowance applies to costs for the standard eye examination, contact lens evaluation, fitting costs, adjustments, and materials.

Cosmetic or medically necessary contact lenses are provided instead of any other benefits. (In other words, if you get contact lenses, you cannot receive regular lenses until the following calendar year or frames until the second calendar year.)

VSP offers discounted laser corrective vision surgery through VSP-contracted laser centers. Call VSP for more information.

Cost of Coverage

In 2003, UC pays the entire cost of your coverage. This arrangement is subject to the State of California appropriation, which may change or be discontinued in future years.

You do have to pay deductibles—\$10 for a vision exam and, if you need glasses, \$25 for materials. There is no deductible for contact lenses. You also pay for additional care, services, or products not covered by VSP.

Imputed Income

For vision coverage, UC pays the same amount regardless of the number of enrolled family members. Therefore, if you enroll a same-sex domestic partner and/or a same-sex domestic partner’s child or grandchild, you will not have imputed income for vision coverage.

How to Use the Plan

Once you enroll, VSP will send you a brochure explaining how the plan works. In general, you follow these simple procedures:

- Call the VSP doctor and make an appointment,
- Identify yourself as a VSP member covered under the UC vision plan, and
- Give the VSP doctor your (the UC employee) Social Security number.

The VSP doctor will obtain the necessary authorization and information about your eligibility and coverage directly from VSP.

By using a VSP provider, you pay only the required deductibles for covered services and costs for items and services not covered. In addition, the following discounts—for services not covered by the plan—are available within 12 months following the last covered eye examination from the VSP doctor who provided the examination.

- 20% discount for additional pairs of prescription glasses; and

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- 15% discount for contact lens professional services (for example, fittings or adjustments).

You can also use a non-VSP provider. If you do, you should pay the full amount of the provider’s bill and submit a claim to VSP. You do not need to use a claim form (although your provider may give you a generic form). Simply submit a copy of the itemized bill that shows the amount of the eye examination, lens(es), and/or frames.

To ensure prompt reimbursement, be sure to provide the following information:

- Your (the UC employee) name and mailing address;
- Your identification number (usually your Social Security number);
- Your UC location and group number; and
- Patient’s name, date of birth, and relation to you (the plan member).

VSP will reimburse you up to these limits:

• Routine eye exam	\$ 40.00
• Lenses	
Pair of single vision	\$ 40.00
One single vision	\$ 20.00
Pair of bifocals	\$ 60.00
One bifocal	\$ 30.00
Pair of trifocals	\$ 80.00
One trifocal	\$ 40.00
Pair of lenticulars	\$125.00
One lenticular	\$ 62.50
Medically necessary contacts*	\$250.00
Cosmetic contacts*	\$ 110.00

* Provided instead of any other benefits. This is the combined maximum reimbursement for both the contact lenses and related eye exams.

- Tints \$ 5.00
- Frames \$ 45.00

What the Plan Doesn’t Cover

You pay the additional costs required for these lens options:

- Blended
- Oversize
- Progressive multifocal
- Coated
- Laminated
- Cosmetic lenses
- Cosmetic processes

You also pay the additional cost of frames that cost more than the plan allows. There are also certain limitations on low vision care for severe visual problems that are not correctable with regular lenses.

The plan does not pay for:

- Orthoptics or vision training
- Nonprescription lenses
- Two pairs of glasses instead of bifocals
- Replacement of lenses or frames broken, stolen, or lost before normal intervals
- Medical or surgical treatment of the eyes—you may be covered by your medical plan
- Protective eyewear
- Services and/or materials in excess of those provided under VSP because of a job requirement.

Any additional care, service, and/or materials not covered by this plan may be arranged between you and the provider.

For More Information

This is only an overview of your vision benefits. For full details, see your Benefits Office or the appropriate person in your department for VSP’s brochure. You may call Vision Service Plan at 1-800-877-7195.

You can also access VSP’s website through the At Your Service website (<http://atyourservice.ucop.edu>) by selecting “Contact List” and “Other Insurance Plan Carrier Phone Numbers and Links.”

Once you enroll in the plan, VSP will send you more information, including a plan brochure and EOC (Evidence of Coverage) booklet.

Short-Term Disability and Supplemental Disability

An unexpected injury or illness that keeps you out of work can use up savings rapidly. Making sure you have enough disability insurance is an important part of your personal financial planning. UC offers two plans to help protect you against a loss of income due to a pregnancy/childbirth, disabling injury, or illness: Short-Term Disability and Supplemental Disability.

The Short-Term Disability plan automatically provides basic short-term benefits coverage for nonwork-related disabilities. If you want more coverage, you can enroll in Supplemental Disability, which pays a higher level of benefits for longer periods of time. For both plans, benefits start after your chosen waiting period or after you exhaust a minimum amount of your sick leave, whichever occurs later.

To be sure you get the coverage you want, sign up during your PIE and make your selections carefully. It is important that you consider your circumstances and how your selections will affect major events in your life (for example, having a baby or buying a house).

What the Plans Cover

Short-Term Disability

Short-Term Disability is paid for by the University.

This plan pays short-term benefits if you are unable to work due to a pregnancy/childbirth, disabling injury, or illness. You must be under a doctor's direct and continuous care and your illness or injury must not be work-related.

The plan pays:

- 55% of your eligible earnings, up to \$800 a month, for
- up to six months

You must use your accrued sick leave to cover up to the first 30 calendar days of disability (22 working days, not including paid holidays) before benefits begin. If you have not accumulated that much sick leave, you must use what you have.

If you decide to be covered by the Short-Term Disability plan alone, the waiting period before benefits start is automatically a minimum of seven days. If you enroll in the Supplemental Disability plan, you will be asked to choose the length of your waiting period. The waiting period you choose will apply to both the Short-Term and the Supplemental Disability plans.

See "Choosing a Waiting Period" on page 45 for more on how waiting periods and sick leave work.

Supplemental Disability

Supplemental Disability is paid for by you.

This plan pays benefits if you are unable to work due to a pregnancy/childbirth, disabling injury, or illness. You must be under a doctor's direct and continuous care. If your disability is not work-related, benefits from this plan are coordinated with benefits from Short-Term Disability.

Supplemental Disability and Short-Term Disability benefits, combined with all other sources of disability or retirement income you receive (Social Security for example), pay:

- 70% of your eligible earnings, up to \$10,000 a month, for
- up to 12 months of temporary disability

If you are still disabled after 12 months of benefits, the Supplemental plan pays long-term disability benefits to fill in the difference between other sources of disability or retirement income and 70% of your eligible earnings. The Supplemental plan will pay a minimum of \$100 a month, even if you are receiving a full 70% of eligible earnings from other sources. Other sources of income include, but are not limited to, Workers' Compensation, Social Security, and UCRP.

If you have no other source of income, the Supplemental plan alone pays a maximum of 50% of your eligible earnings up to \$10,000 a month.

As long as you remain disabled, Supplemental Disability plan benefits

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are payable until you reach age 65. (If you become disabled after reaching age 60, benefits may continue past age 65. See the insurance plan booklet for more information.)

As with Short-Term Disability, you must use your accrued sick leave to cover up to the first 30 calendar days of disability (22 working days, not including paid holidays) before benefits begin. If you have not accumulated that much sick leave, you must use what you have.

The Supplemental Disability plan offers a choice of minimum waiting periods before benefits begin—7, 30, 90, or 180 days. See “Choosing a Waiting Period” on page 45.

Other Disability Plans

In addition to Short-Term Disability and Supplemental Disability, UC employees may be eligible for other disability benefits:

- Workers’ Compensation, which covers work-related injuries and illnesses;
- UCRP disability income, which is available for UCRP members with permanent or long-term disabilities (12 months or longer); and
- Social Security disability benefits.

You do not need to enroll to be eligible for these disability programs. Eligibility requirements vary from plan to plan, and benefits are coordinated. That is, benefits paid from one plan may reduce the amount you receive from another plan.

What the Plan Doesn’t Cover

- The Short-Term Disability plan does not pay for work-related injuries or illnesses which cause disability—instead, benefits are provided by Workers’ Compensation. The Supplemental Disability plan pays benefits for a work-related disability in coordination with Workers’ Compensation.
- Disabilities related to preexisting conditions and which begin in your first year of coverage under the Supplemental Disability plan are limited to a total of 12 months of benefits.
- Disabilities related to mental illness and/or substance abuse under the Supplemental plan’s long-term benefits are limited to a 24-month lifetime maximum benefit, unless you remain continuously hospitalized.

Other Information You Should Consider

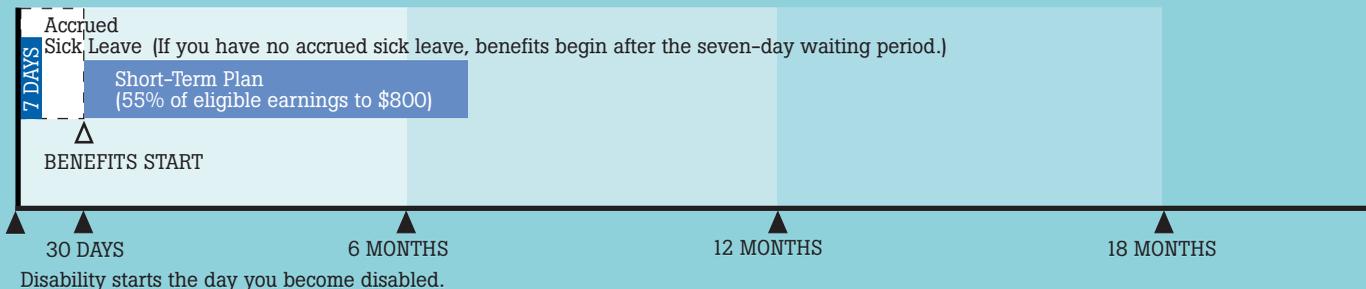
- UC does not participate in the California State Disability Insurance (SDI) program. If you are a new UC employee and become disabled, you may have SDI coverage through a former employer. Any SDI income you are eligible to receive based on past employment will be deducted from your disability benefits payable under the University of California’s disability plan benefits.
- If you do not enroll in the Supplemental Disability plan when you are first hired, you must submit a statement of health and be approved by the insurance company in order to enroll. Previous or currently-existing medical conditions may prevent your approval if you try to enroll without a PIE.

You must also submit a statement of health for approval in order to reduce your waiting period. Generally, disability plans are not “open for enrollment” during the University’s annual Open Enrollment period.

- Under the Supplemental Disability Plan, the definition of disability changes after 12 months of benefits, becoming more difficult to meet. During the first 12 months, disability is defined as being disabled from your “own occupation.” After 12 months of benefits, disability is defined as being disabled from “any occupation” for which you are reasonably suited.
- Benefits payable by the Short-Term and Supplemental Disability plans will be reduced by any other disability benefits for which you are eligible, including California State Disability Insurance, temporary disability benefits from Workers’ Compensation, UCRP disability income, Social Security disability benefits, and any other benefits.

Short-Term Disability Plan Only

This is how benefits work if you have Short-Term Disability only.



Short-Term and Supplemental Disability Plans

If you have Supplemental Disability, this is how both plans work together based on the waiting

period you choose. Remember, the waiting period you choose for the Supplemental Disability plan

automatically becomes your waiting period for the Short-Term Disability plan as well.

7-day Waiting Period

(If you have no accrued sick leave, benefits begin after the seven-day waiting period.)



If you have five days of sick leave or less, you will receive disability benefits up to 70% of your eligible earnings to \$10,000 per month after your seven-day waiting period. If you have more than five days of sick leave, you must use your sick leave to cover up to 30 calendar days of disability (generally 22 working days, not including paid holidays) before benefits begin. After you have received 12 months of Supplemental Disability benefits, the plan will pay 50% of your eligible earnings to \$10,000 per month. This benefit will be reduced if benefits combined with other sources (for example, Social Security and/or UCRP disability) exceed 70% of your eligible earnings.

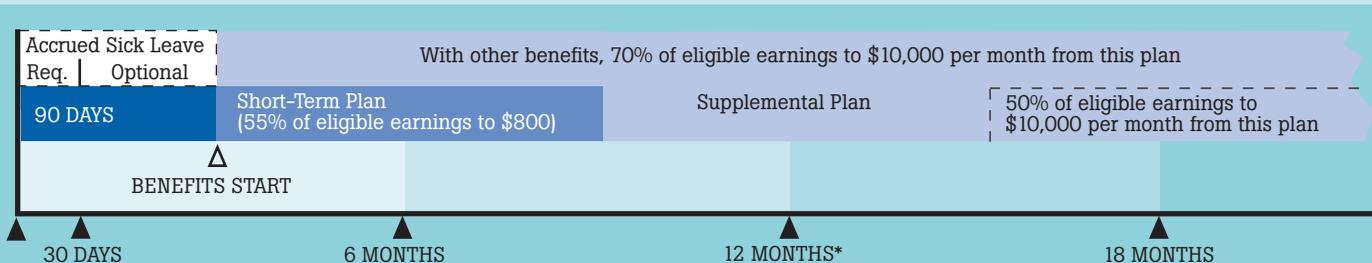
30-day Waiting Period



You must wait 30 calendar days (generally 22 working days, not including paid holidays) before you receive disability benefits up to 70% of your eligible earnings to \$10,000 per month. You may use sick leave to cover your disability waiting period. If you do not have enough sick leave to cover your waiting period, the balance of your waiting period will be unpaid. After you have received 12 months of Supplemental Disability benefits, the plan will pay 50% of your eligible earnings to \$10,000 per month. This benefit will be reduced if benefits combined with other sources (for example, Social Security and/or UCRP disability) exceed 70% of your eligible earnings.

Short-Term and Supplemental Disability Plans

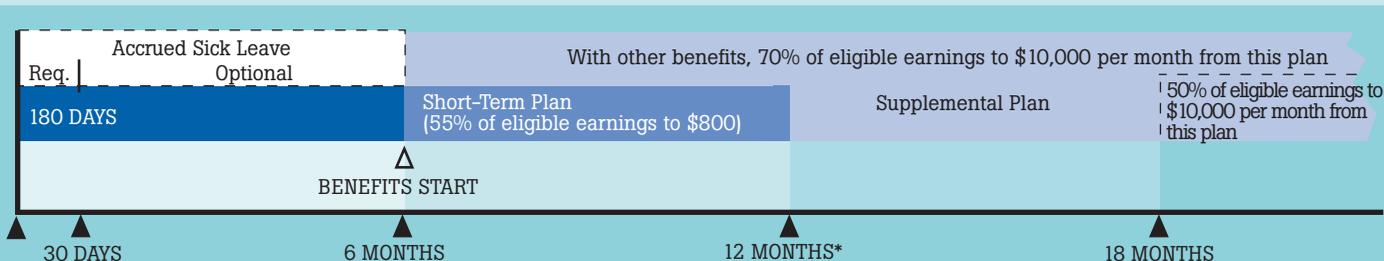
90-day Waiting Period



Disability starts the day you become disabled.

You must wait 90 calendar days before you receive disability benefits up to 70% of your eligible earnings to \$10,000 per month. You must use up to 30 days (generally 22 working days, not including paid holidays) of sick leave—if available—to cover part of your disability waiting period. You may also use additional accrued sick leave, up to the full waiting period. If you do not have enough sick leave to cover your waiting period, the balance of your waiting period will be unpaid. After you have received 12 months of Supplemental Disability benefits, the plan will pay 50% of your eligible earnings to \$10,000 per month. This benefit will be reduced if benefits combined with other sources (for example, Social Security and/or UCRP disability) exceed 70% of your eligible earnings.

180-day Waiting Period



Disability starts the day you become disabled.

You must wait 180 calendar days before you receive disability benefits up to 70% of your eligible earnings to \$10,000 per month. You must use up to 30 days (generally 22 working days, not including paid holidays) of sick leave—if available—to cover part of your disability waiting period. You may also use additional accrued sick leave, up to the full waiting period. If you do not have enough sick leave to cover your waiting period, the balance of your waiting period will be unpaid. After you have received 12 months of Supplemental Disability benefits, the plan will pay 50% of your eligible earnings to \$10,000 per month. This benefit will be reduced if benefits combined with other sources (for example, Social Security and/or UCRP disability) exceed 70% of your eligible earnings.

Waiting Period: During this time you do not receive plan benefits; you receive pay for any sick leave that you use.

Accrued Sick Leave: You are required (Req.) to use accrued sick leave—up to 22 working days. Benefits begin after the concurrent waiting period and used sick leave. For the 90- and 180-day waiting periods, you have the option of using additional accrued sick leave, up to the full waiting period.

* After 12 months, if you continue to be eligible, a \$100 minimum benefit will be paid regardless of other benefits or payments.

Workers' Compensation

California's Workers' Compensation laws guarantee prompt, automatic benefits to workers injured on the job. If you cannot work because of an industrial injury, Workers' Compensation pays your medical bills and provides compensation to help replace your lost income until you can return to work. The benefits guaranteed under Workers' Compensation are:

- Medical care to cure or relieve the effects of the industrial injury,
- Compensation payments to help replace lost wages,
- Permanent disability benefits to compensate for diminished earning capacity, and
- Vocational rehabilitation services to help in returning to work.

The term "industrial injury" is used to describe any injury, illness, or disease which results from work or working conditions, and which occurs during the employee's service to UC.

Under the guidelines of this program, it is your responsibility to:

- Report work-related injuries and illnesses promptly to your supervisor and to cooperate with UC's efforts to provide timely, fair, and equitable benefits pursuant to State laws and UC procedures.
- Comply with all Occupational Safety and Health Standards and rules, regulations, and orders, which are applicable to your own actions and conduct.

- Take every reasonable precaution to work in a safe manner and not put yourself or others at risk.
- Not remove, displace, damage, destroy, or carry off any safety device, notice, or warning furnished for use in any place of employment or interfere in any way with the use thereof by any other person.
- Use personal safety gear provided to you to be able to perform work tasks in a safe manner.
- Learn about potential job hazards and observe potential warning signs.
- Immediately inform your department about your work restrictions and/or capabilities as outlined by your physician when you are ready to return to work.

UC is self-insured and contracts with a third party administrator to manage Workers' Compensation claims.

Each location has a Workers' Compensation Manager who can answer questions about your injury and/or claims and benefits processes as they relate to your injury. You can find a list of UC Workers' Compensation Managers online (www.ucop.edu/riskmgmt/wcmdir.html).

In addition, your location may have a return-to-work program or modified duties to facilitate your recovery. Your location may also direct you to a competent medical provider for your injury.

For More Information

For additional information, see Business and Finance Bulletin BUS 73—*Workers' Compensation Self-Insurance Program*. This bulletin is available online through At Your Service (under "Forms & Publications") or from your local Workers' Compensation Manager.

If the event of your death, financial protection for your dependents can play an important role in their future security. UC automatically provides basic life insurance coverage for all eligible employees. And, if you are eligible, you may buy additional coverage—for both yourself and your family members.

UC’s life insurance plans carry no exclusions based on the cause of death.

UC’s plans are group term life plans that provide coverage at special rates to group members—in this case, UC employees. Term insurance stays in effect only during a set time, or term; in this case, as long as you remain

an eligible employee. Unlike whole life policies, term life policies don’t accumulate a cash value over time. Coverage stops when you are no longer eligible.

Rates and coverage amounts are adjusted each January 1 and usually stay the same for the rest of the year.

University-Paid Life Insurance

The two University-Paid plans—**Basic Life** and **Core Life**—provide a minimum amount of life insurance coverage. The amount varies, depending on your appointment rate and average regular paid time. You are automatically covered by the plan for which you qualify.

What the Plans Cover

Basic Life

This plan provides life insurance equal to your annual base salary, up to \$50,000.* The coverage amount is based on your UC salary and appointment rate as of your date of hire or January 1 of the current year, whichever comes after.

Benefits are paid to your beneficiaries if you die while employed or on paid leave, or during the first four months of approved leave without pay or temporary layoff. Benefits from this plan are payable in addition to any other death benefits for which

you may qualify—for example, from the Supplemental Life insurance plan (see following page) or your retirement plan.

Core Life

This plan provides \$5,000 of life insurance.**

Benefits are paid to your beneficiaries (see page 52) if you die while employed or on paid leave, or during the first four months of approved leave without pay or temporary layoff. Benefits from this plan are payable in addition to any other death benefits for which you may qualify.

Cost of Coverage

In 2003, UC pays the entire cost of your coverage for Basic or Core Life insurance.

Who Is Eligible

Basic Life

You are eligible for coverage if you qualify for Full Benefits (see page 7).

Coverage stops if your UC average regular paid time drops below required levels. However, you may be able to convert your life insurance to an individual policy (see page 22 for conversion privileges). Your Benefits Office has more information.

You may not enroll family members in this plan, nor is it available to retirees or other annuitants. See pages 53–55 for information on Dependent Life insurance.

Core Life

You are eligible for coverage if you qualify for Core or Mid-level Benefits (see page 7).

Coverage stops if your average regular paid time drops below required levels. However, you may be able to convert your life insurance to an individual policy (see page 22). Your Benefits Office has more information.

You may not enroll family members in this plan, nor is it available to retirees or other annuitants.

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* If you are a member of the California Public Employees’ Retirement System (CalPERS), UC provides coverage equal to your annual base salary multiplied by your appointment rate, less \$5,000, up to \$45,000. CalPERS provides \$5,000 of coverage.

** This plan does not cover CalPERS members.

Supplemental Life Insurance

Eligible employees may supplement Basic Life by enrolling in this plan and paying monthly premiums. You must meet the eligibility requirements explained below. If you qualify, you can choose the amount of coverage that meets your needs, up to the limits noted below.

What the Plan Covers

You may choose one of these coverage amounts:

- \$20,000
- One times your annual salary, up to \$250,000
- Two times your annual salary, up to \$500,000
- Three times your annual salary, up to \$750,000
- Four times your annual salary, up to \$1,000,000

Coverage is based on the full-time salary rate for your position as of January 1 of the current year, even if you work part time. Coverage will not be reduced automatically if your full-time salary rate is reduced.

Benefits are paid to your beneficiaries if you die while enrolled. Benefits from this plan are payable in addition to any other death benefits for which you may qualify—for example, from the Basic Life insurance plan or your retirement plan.

Waiver of Premium

If you are covered under Supplemental Life, become totally disabled before age 65, and your disability continues for six consecutive months, you may qualify for continuance of life insurance protection without paying the premiums. You must provide written proof of your disability no later than one year after the disability starts and submit proof of your continuing disability each year. Your life insurance will continue until you reach age 70, as long as you remain totally disabled. You may need to continue your premium payments to your Payroll or Benefits Office while your application is pending. See your insurance booklet or call the insurance carrier for more information.

Living Benefit Option

The plan also provides a “living benefit” option that allows terminally ill employees who have been covered by the plan for at least one year to receive some of their life insurance benefits before death. The cash can be used for any purpose. The money—50% of the total coverage amount, up to \$250,000 (less a discount fee)—is paid directly to the employee in a lump sum or in 12 equal monthly installments. The amount that would otherwise be payable to beneficiaries at death is reduced by the amount paid to the employee. Your life insurance plan booklet has more information.

Who Is Eligible

You are eligible to enroll in Supplemental Life if you qualify for Full or Mid-level Benefits (see page 7). You do not need to be a member of a UC retirement plan.

After the PIE you must submit a statement of health to enroll. The insurance company may or may not accept your enrollment based on the statement of health.

You may not enroll family members in this plan, nor is it available to retirees or other annuitants. See pages 53–55 for information on Dependent Life insurance.

Cost of Coverage

Your cost for Supplemental Life depends on your age and the amount of coverage you buy. Use the table and worksheet at right to figure your monthly premium.

You pay nothing for the first month or partial month of coverage. Likewise, if you increase coverage, you don't pay the extra premium for the first partial month of increased coverage.

Supplemental Life Monthly Rates (Per \$1,000) Effective January 1, 2003

Your Age	Monthly Cost
Under 30	\$.038
30-34	.044
35-39	.055
40-44	.086
45-49	.150
50-54	.230
55-59	.383
60-64	.603
65-69	.920
70 and over	1.661

To calculate your monthly premium, use your age and salary as of January 1 of the current year.

- Round your annual salary up to the next higher thousand (if it is not an exact multiple of \$1,000). Use your full-time salary rate even if you work part time.

$$\text{\$} \underline{\hspace{2cm}}$$
 full-time annual salary
- If you want \$20,000 of coverage, write \$20,000 on Line 3. Otherwise, multiply your full-time annual salary (Line 1, above) by the coverage level you want (1, 2, 3, or 4 times your annual salary).

$$\text{\$} \underline{\hspace{2cm}} \times \underline{\hspace{2cm}}$$
 coverage level
- This is your coverage amount.

$$= \underline{\hspace{2cm}}$$
 coverage amount
- Divide the coverage amount by 1,000.

$$\div 1,000 = \underline{\hspace{2cm}}$$
- Multiply the number on Line 4 by the monthly cost for your age.

$$\times \text{\$} \underline{\hspace{2cm}}$$
 monthly rate
- This is your monthly premium.

$$= \text{\$} \underline{\hspace{2cm}}$$
 monthly premium

Conversion Privileges

You may be eligible to convert your group life insurance to an individual policy if your UC-sponsored coverage ends. See “Conversion Privileges” on page 22 and see your Benefits Office for more information.

Your Beneficiaries

Both Plans

You name beneficiaries by completing the University’s *Designation of Beneficiary—Life and AD&D Insurance* form (UPAY 718). If you don’t name beneficiaries, benefits are paid to the first survivor in this list:

- Your legal spouse,
- Your children—in equal shares,
- Your parents—in equal shares, or
- Your brothers and sisters—in equal shares.

If none of these people survives you, the plan pays benefits to your estate.

You may change your designated beneficiary at any time by submitting a new beneficiary form. Once your Payroll Office accepts a new form, all previous designations are revoked.

Changes in your family situation (e.g., marriage, divorce, birth of a child) do not automatically alter or revoke your previous designations. **Prior designations remain valid until you complete a new designation form.**

Review your beneficiary designations for your insurance plans any time there is a change in your family situation. **A will does not supercede a beneficiary designation.**

You may obtain a designation of beneficiary form through At Your Service (<http://atyourservice.ucop.edu>) under “Forms and Publications” or from your Benefits Office.

Insurance Assignment

Both Plans

Employees, such as those diagnosed with a terminal illness, may make an absolute assignment for the value of Supplemental or Basic/Core Life insurance benefits. Making an absolute assignment *irrevocably* transfers ownership of your life insurance benefits to someone else. For example, a terminally ill person may consider assigning his or her life insurance to a viatical settlement company—a company that pays

a terminally ill person an agreed amount in exchange for future benefits and rights to the person’s life insurance. Once coverage has been assigned, the new “owner” (the viatical settlement company) has the right to designate beneficiaries or convert the insurance. The employee can no longer leave a cash payment to beneficiaries and the employee is not eligible to elect the “living benefit” option described on page 50. Because assigning benefits is permanent and involves complex legal and tax issues, an attorney should be consulted before assigning coverage. Assignment forms can be obtained from your Benefits Office.

For More Information

Both Plans

This is an overview of your University-Paid Life and Supplemental Life insurance benefits. For full details, see your Benefits Office or the appropriate person in your department for a copy of the insurance company’s brochure. Once you are enrolled, the insurance carrier will send you more information.

Dependent Life Insurance

UC offers two plans to employees who are eligible for Full and Mid-level Benefits for insuring your eligible family members. The **basic plan** covers each dependent for a modest amount; the **expanded plan** provides more coverage.

If you currently cover other eligible family members through Basic Dependent Life or have coverage for children under Expanded Dependent Life, newly eligible children are covered automatically after 24 hours of age (or if adopted, the earlier of the date of physical custody or the date you, your spouse, or same-sex domestic partner has the legal right to control the child's health care).

What the Plans Cover

Basic Dependent Life

This plan covers your spouse or same-sex domestic partner (SSDP) and eligible children for \$5,000 each.

Expanded Dependent Life

This plan covers your eligible family members for these amounts:

- Legal spouse or same-sex domestic partner: An amount equal to 50% of your Supplemental Life insurance amount—\$200,000 maximum
- Eligible children: \$10,000 each

Who Is Eligible

The family members you may cover are the same under both plans. See pages 10 and 11 for the eligible family members you may enroll.

You may cover your family members under either the basic or the expanded plan. You may not cover them under both plans.

If both you and a family member are UC employees: You may choose to cover yourself under the Supplemental Life plan or you may be covered (if eligible) by your family members Dependent Life plan. You may not be covered by both plans (see "No Duplicate Coverage" on page 11).

You can cover only one adult in your UC-sponsored plans.

When enrolling family members after the PIE ends, you must submit a statement of health for an adult member; this is not required for children. The insurance company may or may not accept the enrollment based on the statement(s) of health. You may transfer your dependents from the expanded plan to the basic plan at any time. However, to transfer your spouse or same-sex domestic partner from the basic plan to the expanded plan, you must submit a statement of health for that person.

Basic Dependent Life

To cover your eligible family members under this plan, you must be eligible for and enrolled in either:

- The Basic Life plan described on page 49, or
- The Supplemental Life plan described on page 50.

Coverage for your dependents stops if you cancel or lose your life insurance coverage. However, you may be able to convert your Dependent Life insurance to an individual policy. Your Benefits Office has more information.

This plan is not available to retirees or other annuitants.

Expanded Dependent Life

To cover your eligible family members under this plan, you must be eligible for and enrolled in the Supplemental Life plan described on page 50.

If you are interested in covering eligible children only, for \$.36 per month the expanded plan provides \$10,000 of coverage for each covered child (compared to \$5,000 under basic).

Coverage for your dependents stops if you cancel or lose coverage under the Supplemental Life plan. However, you may be able to convert your Dependent Life insurance to an individual policy. Your Benefits Office has more information.

This plan is not available to retirees or other annuitants.

To calculate the monthly premium to cover your spouse or same-sex domestic partner, use your age as of January 1, 2003.

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Basic Dependent Life Monthly Rates Effective January 1, 2003

Your Age	Monthly Cost
Under 35	\$ 0.62
35-39	1.10
40-44	1.22
45-49	1.49
50 and over	1.70

Cost of Coverage

Basic Dependent Life

The table to the left shows your monthly cost, which depends on your age as of January 1, 2003. You pay nothing for the first month of coverage.

Expanded Dependent Life

Your cost depends on your age and on which family members you cover.

You pay nothing for the first month of coverage. Likewise, if you increase coverage, you don't pay the extra premium for the first month of increased coverage.

Use the chart on page 55 to calculate the cost of your Expanded Dependent Life coverage.

Conversion Privileges

You may be eligible to convert Dependent Life insurance to individual policies if your UC-sponsored coverage ends. See "Conversion Privileges" on page 22 and see your Benefits Office for more information.

Also, if you are covered under the Supplemental Life waiver of premium benefit and you become totally disabled, your Dependent Life coverage will end and you may be eligible to convert to an individual policy.

Expanded Dependent Life Monthly Rates (Per \$1,000) Effective January 1, 2003

	Spouse or Same-sex Domestic Partner Only	Children Only	Spouse or Same-sex Domestic Partner and Children
Your Age	Monthly Cost		
Under 30	\$.036	\$.36 covers all eligible children	\$.36 plus the spouse or same-sex domestic partner only premium covers spouse or partner and all eligible children
30-34	.045		
35-39	.054		
40-44	.090		
45-49	.207		
50-54	.288		
55-59	.486		
60-64	.513		
65-69	.792		
70 and over	1.395		

Your Beneficiaries

Basic Dependent Life

You are the beneficiary if a covered dependent dies.

Expanded Dependent Life

You are the beneficiary if a covered dependent dies. (If you prefer, you may designate someone else to receive benefits if a spouse or same-sex domestic partner covered under this plan dies. You cannot designate an alternate beneficiary to receive benefits for covered children. To change your beneficiary use the *Designation of Alternate Beneficiary Expanded Dependent Life and AD&D Insurance* form (UPAY 718A) available on At Your Service website (<http://atyourservice.ucop.edu>) under "Forms & Publications."

For More Information

This is an overview of your Dependent Life insurance benefits. For full details, see your Benefits Office or the appropriate person in your department for a copy of the insurance plan booklet. Once you enroll, the insurance carrier will send you more information.

1. Find your Supplemental Life insurance coverage amount. \$ _____
coverage amount

2. Divide this amount by 2. Round to the next higher \$1,000 if not an exact multiple of 1,000. This is the coverage amount for your spouse or partner. ÷ 2 = \$ _____
coverage amount for spouse or partner (\$200,000 maximum)

3. Divide line 2 by 1,000. ÷ 1,000 = _____

4. Multiply the number on Line 3 by the monthly rate for your age. x \$ _____
monthly rate

5. This is your monthly premium for spouse-only or partner-only coverage. = \$ _____
monthly premium

If you are enrolling in coverage for spouse or partner and children, add \$.36 to the monthly premium on Line 5, above.

Accidental Death and Dismemberment (AD&D)

Accidents happen, and their financial impact can be devastating. To help protect you and your family from the unforeseen financial hardship of an accident, UC offers the Accidental Death and Dismemberment (AD&D) plan. The plan provides worldwide coverage for you and your enrolled family members.

What the Plan Covers

The plan offers three coverage options, including:

- The *self-only* plan—covers you;
- The *family* plan—covers you, your spouse or same-sex domestic partner, and your children; and
- The *modified family* plan—covers you and your children.

The family plan covers your spouse or partner for 60% of your coverage amount. With eligible children, it covers your spouse or partner for 50% of your amount and each child for 20%. The modified family plan covers you, and each eligible child is covered for 20% of your amount. Your spouse or partner is not covered.

You and your enrolled family members are covered worldwide, 24 hours a day.*

The plan provides coverage for accidental death or dismemberment or loss of sight, speech, or hearing caused by an accident.

If you or a covered family member dies in a car accident while using a seatbelt and/or an airbag, the plan pays an additional 10%.

The plan pays a percentage of the coverage amount if an accident causes complete and irreversible paralysis for you or a covered family member. The amount depends on the degree of the paralysis.

It also provides coverage if you are permanently and totally disabled by a covered accident. (Family members are not eligible for this benefit.)

If you or a covered family member dies in a natural disaster, the plan pays an additional 10%. A natural disaster is a storm, earthquake, flood, volcanic eruption, wildfire or other similar event that is due to natural causes and results in the damaged area being officially declared a disaster area by state or federal government. If the event occurs outside of the United States, the disaster declaration must be made by a corresponding government authority.

If you die in a covered accident, the plan provides special educational benefits for your spouse or same-sex domestic partner and/or children. Your spouse or partner may receive up to \$10,000 for the professional or trade training needed to become self-supporting.

If you die in a covered accident, the plan also pays for your covered child’s higher education—either the actual annual tuition or 5% of your coverage amount (up to \$10,000, but not less than \$1,500) per school year,

whichever is less. To be eligible, a child must be enrolled in an institution of higher education on the day of the accident. Or, if a full-time high school student, the child must enroll in an institution of higher education within one year of high school graduation. This benefit is paid annually for up to four consecutive years provided the child continues as a full-time student.

The plan will pay for day care expenses for covered children under age 13 if you die due to a covered accident. This benefit is paid up to four years (\$20,000 maximum) or until the child reaches age 13. The annual amount payable is equal to the lesser of:

- the actual cost of day care expenses incurred after the date of the accident causing your (the employee’s) death,
- 5% of the your coverage amount, or
- \$5,000.

If an insured person suffers a covered accidental dismemberment or paralysis, the plan will pay covered rehabilitative expenses resulting from the covered injury causing the dismemberment or paralysis for two years after the date of the accident, to a maximum of \$10,000.

If an insured person is rendered comatose resulting from a covered accident, the plan will pay a monthly benefit of 1% of the coverage amount beginning after the insured person has been in a coma for 30 consecutive days. This benefit will reduce the coverage amount payable (it is not in addition to the coverage amount).

For more details, see the insurance company’s booklet.

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* If you are in the military, certain wartime exclusions may apply. See the insurance company’s booklet for more information.

Cost of Coverage

Your cost depends on the plan option and the coverage amount you choose, which can range from \$10,000 to \$500,000. You pay nothing for the first month. Likewise, if you increase coverage, you don't pay the extra premium for the first partial month of increased coverage.

Your Beneficiaries

You are the beneficiary if a covered family member dies. (If you prefer, you may designate someone else to receive benefits if a family member dies. To change your beneficiary use the *Designation of Alternate Beneficiary—Expanded Dependent Life and AD&D Insurance* form (UPAY 718A) available on At Your Service website (<http://atyourservice.ucop.edu>) under "Forms & Publications."

You may change your designated beneficiary at any time by submitting a new form. Once your Payroll Office accepts a new form, all previous designations are revoked.

If you don't name beneficiaries, benefits are paid to the first survivor in this list:

- Your legal spouse,
- Your children—in equal shares,
- Your parents—in equal shares, or
- Your brothers and sisters—in equal shares.

If none of these people survives you, the plan pays benefits to your estate.

Changes in your family situation (e.g., marriage, divorce, birth of a child) do not automatically alter or revoke your previous designations. **Prior designations remain valid until you complete a new designation form.** Review your beneficiary designations for your insurance plans any time there is a change in your family situation. **A will does not supercede a beneficiary designation.**

See your Benefits Office for information and forms.

For More Information

This is only an overview of your AD&D benefits. For full details, see your Benefits Office or the appropriate person in your department for a copy of the insurance plan booklet. Once you enroll in the plan, the insurance carrier will send you more information.

AD&D Monthly Rates Effective January 1, 2003

Coverage	Plan Options		
	Self (You)	Family (You, spouse or partner*, and eligible children)	Modified Family (You and eligible children)
\$ 10,000	\$ 0.18	\$ 0.28	\$ 0.22
20,000	0.36	0.56	0.44
30,000	0.54	0.84	0.66
40,000	0.72	1.12	0.88
50,000	0.90	1.40	1.10
60,000	1.08	1.68	1.32
70,000	1.26	1.96	1.54
80,000	1.44	2.24	1.76
90,000	1.62	2.52	1.98
100,000	1.80	2.80	2.20
125,000	2.25	3.50	2.75
150,000	2.70	4.20	3.30
175,000	3.15	4.90	3.85
200,000	3.60	5.60	4.40
300,000	5.40	8.40	6.60
400,000	7.20	11.20	8.80
500,000	9.00	14.00	11.00

* Partner: Same-sex domestic partner

Business Travel Accident Insurance

If eligible, while traveling on official UC business or while engaged in designated hazardous activities on behalf of UC, you will be covered 24 hours a day, worldwide, against accidental death and dismemberment for up to \$100,000 (\$250,000 for Senior Managers).

In addition, the following business travel assistance services are available to you while away from home:

Pre-Travel Assistance

- Advice on required and recommended immunizations,
- Health information and precautions for medically remote or underserved areas,
- Information for disabled travelers, and
- Help in arranging special medical services needed while traveling.

Medical Emergency Services

- Worldwide, 24-hour help to locate and arrange medical care,
- Medical case monitoring, arranging communication between patient, family, physicians, employer, consulate, etc.,
- Medical transportation arrangements, and
- Emergency message service for medical situations.

Legal Assistance

- Help with arranging contact with a local English-speaking attorney, and
- Worldwide, 24-hour contact for non-criminal legal emergencies.

Travel Assistance

- Worldwide, 24-hour telephone contact for advice on handling losses and delays,
- Help with lost passports, tickets, and documents,
- Advice on filing travel-related claims,
- Help with arranging shipments of forgotten, lost, or stolen items, and
- Help with relaying of emergency messages.

Business Trips

An official UC business trip begins when you leave your residence or work site (whichever occurs last) for the purpose of conducting UC business away from your UC work site. The business trip ends when you return to your residence or your UC work site (whichever occurs first).

If a business trip exceeds 60 days in length, you will be considered to be located at an alternate residence and work site. For coverage to apply, you must be on a trip away from the alternate site.

Procedures and conditions of travel must be in accordance with Business and Finance Bulletin G-28, which describes UC policy and regulations regarding travel. This bulletin can be found online (www.ucop.edu/ucophome/policies/bfb/g28toc.html).

Hazardous Activities

The following designated hazardous activities are covered by this insurance when undertaken on behalf of UC:

- transportation of emergency medical patients or donor organs,
- structural inspection,
- scuba diving,
- seismology and wave studies,
- hazardous spills clean up, and
- authorized activities of the UC Police Bomb Squad.

If You Need Help

If you need assistance, 24-hour assistance is available to you, worldwide.

In the United States or Canada, call 1-800-626-2427.

Outside of the United States or Canada, call 1-713-267-2525 (collect).

To receive assistance, you will need to reference the Business Travel Accident Insurance policy number. The policy number is GTP 805 56 49, which is written for The Regents of the University of California. If you require further information, please contact your local Risk Management office.

For More Information

For additional information about insurance coverage and exclusions, see Business and Finance Bulletin BUS 74—*Business Travel Accident Insurance*. This bulletin can be found online (www.ucop.edu/ucophome/policies/bfb/bus74.html) or from your local Workers' Compensation Manager. You can also find a list of UC Workers' Compensation Managers online (www.ucop.edu/riskmgmt/directories.html).

Legal Expense

Most people need legal advice at one time or another, but high legal fees often prevent them from getting the necessary assistance.

UC offers a prepaid legal expense insurance plan that gives you access to basic, personal legal help. The plan provides unlimited access to a toll-free telephone line and covers specific legal services. These services are provided through the Signature LegalCare Plan at an annual cost roughly equal to one or two hours in an attorney's office.

The legal expense insurance plan helps mainly with routine preventive or defensive matters and should cover most basic legal needs. The chart on page 60 explains what the plan covers.

What the Plan Covers

The legal plan helps you with preventive, domestic, consumer, and defensive legal services.

- *Preventive legal services* include general legal advice, negotiation, document review and preparation, preparation of wills and durable power of attorney. Often, a few minutes of legal advice can prevent a small problem from becoming a major one.
- *Domestic legal services* cover divorces, separations, adoptions,

child support, child visitation, and name changes.

- *Consumer services* include legal representation for the enforcement of warranties or promises in connection with the purchase of goods or services. This does not include actions in Small Claims Court. Nor does it include disputes over real estate construction matters for a new home or room additions to and/or remodeling of an existing home.
- *Limited defensive legal services* include misdemeanor defense and felony charge advice.

See the Signature LegalCare booklet for plan limitations and exclusions.

Cost of Coverage

Your monthly cost for 2003 depends on whether you enroll individually or as a family (yourself and one or more family members).

Single	Family
\$6.88	\$10.63

How to Use the Plan

When you need legal help, your first step is to call—toll free—The Preventive LegalCare Office (PLCO), which is an independent legal firm. PLCO attorneys are available to provide advice and assistance from 8:30 a.m. to 6:00 p.m., Monday through Friday (except legal holidays). For emergencies, an attorney is on call 24 hours a day, seven days a week.

When you call, the Signature LegalCare staff and an attorney will

help determine what kind of legal help you need and will advise you on the services the plan will cover. The PLCO attorney can provide unlimited telephone advice. If you need more assistance than the PLCO attorney can provide, he or she may advise you to consult an attorney in person. A claim form, a description of coverage, and a current list of the plan's Participating Attorneys will be sent to you.

These Participating Attorneys have met Signature LegalCare's requirements and have agreed to provide the services described on page 60. Covered services are fully paid.

If you prefer, you may use a nonparticipating attorney of your choice, anywhere in the world. The plan pays at a rate of \$70 an hour, up to the limits shown on page 60.

You may use whatever source of legal assistance is appropriate in a particular situation. You are not restricted to a specific attorney. For example, you can use a Participating Attorney for one matter, then choose any other attorney for another. The plan does not cover legal work in progress at the time you enroll.

Before consulting any attorney, be sure to call the PLCO. Doing so is the best way to be sure the plan serves you to your best advantage.

The plan provides these types of legal services:

- *Legal telephone services:* For simple matters that can be handled adequately by telephone, you may call the PLCO. The PLCO attorney

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What the Plan Covers

Preventive LegalCare Office (PLCO)

Unlimited toll-free telephone service to seek advice and consultation directly with an attorney, and guidance or direction regarding covered personal legal matters.

The PLCO covers all matters except those specifically excluded from the plan.

For the following services you may use a Signature LegalCare attorney or any other local attorney.	Coverage Per Family Each Calendar Year ¹	
	Participating Attorney	Any Other Attorney
Attorney Office Work		
Advice, negotiation, and services for matters not otherwise covered or excluded. The benefit covers such matters as: sale or purchase of a residence, problems with a landlord, administrative hearings (e.g., Social Security, Medicare, and other public benefits)	Up to 8 hours	\$560
Simple wills and trusts (including Power of Attorney) ^{2, 3}	Fully paid	\$175
Codicils to wills, living wills ³	Fully paid	\$ 70
Durable Power of Attorney ²	Fully paid	\$ 70
Domestic		
Uncontested divorce (for employee's use only)	Fully paid	\$525
Contested divorce (for employee's use only)	Fully paid	\$700
Child support, visitation, and/or alimony in conjunction with a modification of divorce decree or a separation or annulment agreement	Fully paid	\$250
Child custody/child support not in conjunction with a modification of a divorce decree or a separation or annulment agreement		
• Legal services required for the creation of a child custody, child support, or visitation agreement	Fully paid	\$245
• Modification/enforcement of an uncontested child custody, child support, or visitation agreement	Fully paid	\$294
• Modification/enforcement of a contested child custody, child support, or visitation agreement	Fully paid	\$490
Establishment of guardianship/conservatorship	Fully paid	\$420
Adoption proceedings ⁴	Fully paid	\$420
Name change	Fully paid	\$280
Defensive		
Criminal misdemeanor defense (except traffic violations) ⁴	Fully paid	\$700
Habeas Corpus proceedings	Fully paid	\$420
Juvenile court hearings—if juvenile is covered dependent	Fully paid	\$490
Defense of a lawsuit for the collection of a debt based on a contract or other written instrument ⁴	Fully paid	\$630
Personal bankruptcy	Fully paid	\$560
Defense of traffic matter that could lead to license suspension ⁴	Fully paid	\$350
Consumer		
Consumer protection (except for disputes over real estate/construction matters) ⁴	Fully paid	\$350

Dollar amounts shown are maximums at \$70 per hour.

¹ Benefits are limited to one claim per item per year, whether you have self-only or family coverage, with the exception of the attorney office work, estate planning, wills, trust benefits and PLCO services.

² Benefits for estate planning, wills, and trusts are limited to four claims per year.

³ In conjunction with this benefit, the eight hours under the Attorney Office Work benefit may be used for more involved trust matters.

⁴ Four-day trial limitation.

For participating attorneys and a claim form, see Signature LegalCare's website at www.legalcareplan.com or call the plan. See the Signature LegalCare booklet for plan limitations and exclusions.

will either work with you over the phone or recommend that you meet with an attorney in person. Unlimited PLCO services help you get the most from the plan. By using the PLCO whenever possible, you can keep other plan benefits available for more serious matters.

- *Attorney Office Work for advice and counseling:* The plan pays for up to eight hours a year when you use a Participating Attorney. If you use a nonparticipating attorney, the plan pays a rate of \$70 an hour, up to \$560 a year. Once the attorney begins working for you, the plan begins to pay benefits.

It is up to you and the attorney to decide how best to use the time available—in personal meetings or by having the attorney review documents or write letters for you. When you exceed the yearly allowance, you must arrange with the attorney to pay for further services yourself.

- *Specific covered services:* The plan also covers services such as wills, legal defense, domestic matters, and consumer protection. See the chart on page 60 for a list of covered services.

For More Information

This is only an overview of your legal expense insurance benefits. For full details, see your Benefits Office or the appropriate person in your department for a copy of the insurance company's summary plan description. You may also visit Signature LegalCare's website through the HR/Benefits website (<http://atyourservice.ucop.edu>) by selecting "Contact List" and "Other Insurance Plan Carrier Phone Numbers and Links."

You may also call Signature LegalCare at 1-800-841-0193. Once you enroll, the insurance carrier will send you more information.

Automobile and Homeowner/Renter

For employees who are eligible for Full or Mid-level Benefits (see page 7), Automobile and Homeowner/Renter insurance is also available. Carrier underwriting requirements must also be met.

These plans are currently offered through A+ Auto & Home Insurance and your premiums are paid conveniently through payroll deduction.

Since coverage is individually underwritten, however, you are encouraged to obtain quotes from other insurers as well. This will help you find the automobile or homeowner/renters policy (and price) that best meets your needs.

You may enroll at any time.

For More Information

For information or to receive an individual premium quotation, contact A+ Auto & Home Insurance directly at 1-800-800-9410.

Health Care Reimbursement Account (HCRA)

The Health Care Reimbursement Account (HCRA) allows you to pay on a pretax, salary reduction basis for eligible out-of-pocket health care expenses not covered by your medical, dental, or vision plan. The program is established under Internal Revenue Code (IRC) §105.

How the Plan Works

You determine the annual amount of your contributions from \$180 to \$5,000. Each month, an equal portion of that amount is deducted from your paycheck on a pretax basis and is deposited in your Health Care Reimbursement Account before federal, state, and Social Security (FICA) taxes are taken out.

You pay your health care expenses as usual. After you incur eligible expenses, you submit a claim form and an Explanation of Benefits (EOB) or proof of services rendered to SHPS, Inc., the company UC has hired to administer the program. SHPS, Inc., reimburses you for your expenses through an automatic deposit to your bank or by check.

Your savings are strictly on taxes and depend on your particular tax situation. See Internal Revenue Service (IRS) Publication 502 Medical and Dental Expenses (www.irs.gov) or consult your tax advisor for additional details. **Please note that UC cannot provide tax advice.**

Eligible Expenses

Eligible expenses include copayments and deductibles (**but not premiums**), prescription drugs, orthodontia, eyeglasses, laser eye surgery, and other expenses incurred for health care that are not reimbursed by your medical, dental, or vision plan. Health care expenses must meet the requirements of IRC §213(d) in order to be eligible for reimbursement.

Expenses must be incurred during the HCRA plan year (January 1 through December 31), in order to be eligible for reimbursement. Expenses incurred after your HCRA participation ends are not eligible for reimbursement. If you enroll mid-year, expenses incurred before your effective date are not eligible for reimbursement.

For more details about eligible and ineligible expenses, see the *Health Care Reimbursement Account Summary Plan Description* or the SHPS website (www.shps.net/myshps).

Note: Expenses reimbursed under the Health Care Reimbursement Account may not be deducted on your income tax form.

Contribution Limits and Forfeiture Rules

You may contribute up to \$5,000 (minimum of \$180) annually to your HCRA. If you and your spouse are UC employees, you may each contribute up to \$5,000.

Be sure to estimate your expenses carefully before enrolling. **The IRC requires that you forfeit any unclaimed funds in your account after the closing date for the plan year.** SHPS, Inc., must receive claims for 2003 eligible expenses by April 15, 2004, in order to reimburse the expenses. Forfeited funds are used to pay the cost of administering the HCRA program.

Who is Eligible

You may participate in HCRA if:

- You are eligible for the Full, Mid-level, or Core benefits package.

Eligible Dependents

You can pay for expenses from the HCRA for yourself or anyone else you claim as a dependent on your federal income tax return.

Enrollment and Change in Participation

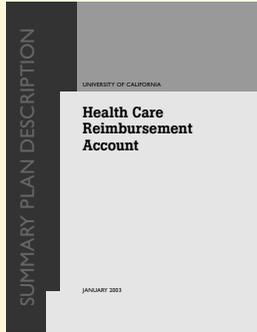
You may enroll when you first become eligible, during your period of initial eligibility (PIE), during Open Enrollment, or when you have a change in family or employment status. Your enrollment is for one year at a time and ends on December 31 of each year. To participate the following year, you must reenroll during the preceding Open Enrollment.

Changes to HCRA participation and/or contribution amounts can be made only during Open Enrollment,

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or during a new 31-day PIE caused by an eligible change in employment or family status. At all other times, IRC rules require that your contributions stay the same. See the *Health Care Reimbursement Account Summary Plan Description* for additional details.

If you leave UC, cancel HCRA, or do not reenroll during Open Enrollment, your participation ends at the end of the pay period in which your last contribution is deducted from your



paycheck. You may submit claims for eligible expenses incurred through the last day of the pay period for which a contribution was made. See the *Health Care Reimbursement Account Summary Plan Description* for additional details.

Plan Administration

Claims processing and reimbursement will be handled exclusively by SHPS, not UC. For more information on HCRA administration, contact SHPS, Inc. (1-877-270-3915 or www.shps.net/myshps). The Flexible Spending Account (FSA) Calculator on the SHPS website will help you estimate your tax savings (www.shps.net/myshps/fsa.htm).

For More Information

This is only an overview of the HCRA program. Be sure to review the *Health Care Reimbursement Account Summary Plan Description* (available on the At Your Service website and from your Benefits Office) for plan details.

Dependent Care Reimbursement Account (DepCare)

DepCare allows you to pay for certain dependent care expenses on a pretax, salary reduction basis. Dependents can be either children or adults (see “Who is Eligible”).

How the Plan Works

The amount you specify is taken from your paycheck each month and deposited in your DepCare account.

After you incur eligible dependent care expenses, you submit a claim form and receipts for these expenses to SHPS, Inc., the company UC has hired to administer the program. SHPS, Inc. reimburses you from the funds in your DepCare account.

Your savings are strictly on taxes. DepCare contributions are deducted from your paycheck on a tax-free basis—before federal, state, and Social Security (FICA) taxes are taken out. This reduces your taxable earnings and, therefore, the amount of taxes you pay. Your savings will depend on your particular tax situation.

Your enrollment is for one year at a time and ends on December 31 of each year. To participate the following year, you must reenroll during the preceding Open Enrollment.

Eligible Expenses

Dependent care expenses must meet the requirements of Internal Revenue Code (IRC) §21 and §129 to be eligible for DepCare reimbursement.

Dependent care must be necessary so that you, or you and your spouse, can work or look for work (you must have work income during the year).

If care is provided in a day care center, the center must charge a fee. If the center cares for six or more children who are not residents, it must comply with all state and local licensing laws and applicable regulations.

Expenses must be incurred during the DepCare plan year (January 1 through December 31) in order to be eligible for reimbursement. If you enroll midyear, expenses incurred before your effective date are not eligible. Expenses incurred after your DepCare participation ends are also not eligible for reimbursement.

Please be aware that expenses submitted for reimbursement will be carefully evaluated against the IRC requirements for eligible and ineligible expenses. If your dependent care expenses are not clearly eligible according to the IRC, you will not be reimbursed for these expenses and you will be asked to submit additional information. In some cases, you may need a statement from your tax advisor that the expense in question is eligible for reimbursement.

For more details about eligible and ineligible expenses, see the *DepCare Summary Plan Description* and IRS Publication 503, *Child and Dependent Care Expenses* (available on the IRS website at www.irs.gov).

Contribution Limits and Forfeiture Rules

You determine how much you want taken from your monthly paycheck(s), from a minimum of \$180 per year up to the lesser of:

- \$5,000 per plan year (\$2,500 if you are married and filing a separate income tax return).
- Your total earned income (**Exception: If your spouse is incapable of self-care or is a full-time student, see below**); or
- Your spouse’s total earned income (**You may not contribute to DepCare if your spouse’s earned income is \$0 and your spouse is capable of self-care or is not a full-time student**); or

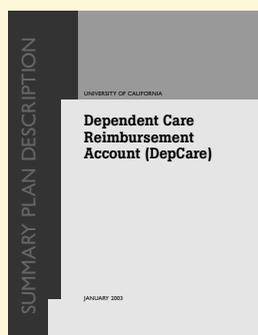
If your spouse is incapable of self-care or is a full-time student, his or her earned income is considered to be at least \$250 per month (\$3,000 per year) if you claim one dependent, or at least \$500 per month (\$6,000 per year) if you claim two or more.

If your spouse is also eligible to participate in UC’s or another employer’s dependent care assistance plan, your combined contributions should not exceed the above maximums.

Be sure to estimate your DepCare expenses carefully. **The IRS requires that you forfeit any unclaimed funds in your DepCare account after the closing date for the plan year.** SHPS, Inc. must receive claims for 2003 eligible expenses by April 15, 2004, in order to reimburse the expenses. Forfeited funds are used to pay the cost of administering the DepCare program.

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Any payment from DepCare reduces, dollar for dollar, the expenses eligible for the dependent care tax credit.



Please note that your savings will depend on your particular tax situation. You may save more money using the dependent care tax credit. See the *DepCare Summary Plan Description* for a general comparison of DepCare versus the federal tax credit.

You should carefully consider your participation in this program in relation to your tax savings and the possible effect on your other benefits. DepCare contributions may also reduce your earnings for Social Security and unemployment benefits. **If you need specific advice about how DepCare applies to your tax situation, please consult a tax advisor.**

Who is Eligible

You are eligible to participate in DepCare if:

- You are eligible for the Full, Mid-level, or Core benefits package.
- If married, both you and your spouse must have earned income during the year unless your spouse is incapable of self-care or is a full-time student.

Eligible Dependents

You may use your DepCare account to pay for eligible expenses for the following eligible family members:

- A child under age 13 in your custody whom you claim as a dependent on your tax return;
- A spouse who is physically or mentally incapable of self-care; and
- A dependent who lives with you—such as a child over age 13, parent, sibling, or in-law—who is physically or mentally incapable of self-care, and whom you claim as a dependent on your tax return.

If care is provided outside the home for a spouse or a family member age 13 or older, either of whom is incapable of self-care, the spouse or family member must live in your home at least eight hours each day.

Enrollment and Change in Participation

You may enroll when you first become eligible, during your period of initial eligibility (PIE), Open Enrollment, or when you have a change in family or employment status. Your enrollment is for one year at a time and ends on December 31 of each year. To participate the following year, you must re enroll during the preceding Open Enrollment.

Changes to DepCare participation and/or contribution amounts can be made only during Open Enrollment, or during a new 31-day PIE caused by an eligible change in employment or family status. At all other

times, IRC rules require that your contributions stay the same. See the Dependent Care Reimbursement Account Summary Plan Description for additional details.

If you leave UC, cancel DepCare or do not reenroll during Open Enrollment, your participation ends at the end of the pay period in which your last contribution is deducted from your paycheck. You may submit claims for eligible expenses incurred through the last day of the pay period for which a contribution was made.

Plan Administration

2003 claims processing and reimbursement will be handled exclusively by SHPS, not UC. For more information on DepCare administration, contact SHPS, Inc. (1-877-270-3915).

For More Information

This is only an overview of the DepCare program. Be sure to review the *DepCare Summary Plan Description* (available on the At Your Service website under “Forms & Publications” and from your Benefits Office) for plan details and penalties. DepCare information is also available on the At Your Service website (see page 5).

Tax Savings on Insurance Premiums (TIP)

The Tax Savings on Insurance Premiums (TIP) program allows you to pay your health plan employee monthly cost—if any—on a pretax, salary reduction basis.

How the Plan Works

If you enroll in a health plan that requires you to pay an employee monthly cost, you are automatically enrolled in TIP. Each month your taxable earnings are reduced by the amount of your premium.

Your savings are strictly on taxes. TIP funds are deducted from your paycheck on a tax-free basis—before federal, state, and Social Security (FICA) taxes are taken out. This reduces your taxable earnings and, therefore, the amount of taxes you pay. Your savings will depend on your particular tax situation.

Cost of Participation

You should carefully consider your participation in this program in relation to your tax savings and the possible effect on your other benefits. TIP contributions may also reduce your earnings for Social Security and unemployment benefits. **Please consult a tax advisor about how TIP applies to your particular tax situation.**

Who Is Eligible

You are eligible to participate if you are an active employee appointed to work at least 43.75% time and are enrolled in a UC-sponsored health plan requiring an employee contribution.

In addition to any cost for yourself, you may pay the health plan monthly costs through TIP for these eligible family members:

- Legal spouse
- Adult dependent relative
- Natural or adopted child
- Stepchild
- Legal ward
- Other child
- Disabled child
- Grandchild

In general, you may not use TIP to pay the out-of-pocket premium cost for medical coverage for your same-sex domestic partner and/or your partner's child/grandchild who is not your tax dependent. Monthly costs for these individuals must be paid on an after-tax basis.

Exception: If you have registered your same-sex domestic partnership with the State of California and have submitted form UPAY 850 indicating such registration and the filing date, any out-of-pocket premium cost for medical coverage for your partner and/or your partner's child/grandchild is deducted from pay on a pretax basis for California income tax purposes only. For federal tax purposes, the out-of-pocket premium cost must still be paid on an after-tax basis.

If these family members are your tax dependents, any necessary adjustments will be made at the end of the year when you respond to the annual tax dependency mailing. You may recover any excess federal or California State income tax withheld when filing tax returns.

Change in Participation

TIP salary reductions can be changed only during your PIE, during Open Enrollment, or during an additional PIE caused by an eligible change in employment or family status as set forth in the Internal Revenue Code. If you are participating in TIP and make a change to your health plan due to an eligible change in employment or family status, your TIP amount will adjust automatically. At all other times, IRC rules require that your TIP salary reduction amount stay the same despite increases or decreases in your net premiums.

Participation Can End

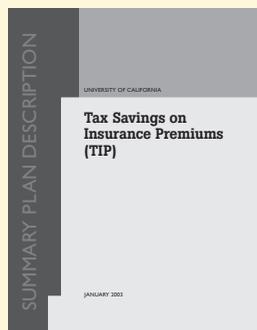
If you want to cancel your TIP participation, IRC rules require you to do so during your PIE, during Open Enrollment, or during an additional PIE caused by an eligible change in employment or family status. If you cancel at any other time, penalties may apply.

TIP participation ends if certain employment actions occur. For example, if you go on leave without pay or reduce your appointment rate, your participation in TIP automatically ends.

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For More Information

This is only an overview of the TIP program. Be sure to review the *Tax Savings on Insurance Premiums (TIP) Summary Plan Description* (available on the At Your Service website under "Forms & Publications" and from your Benefits Office) for plan details.



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, annuitants, 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 Mattie Williams, University of California Office of the President, 300 Lakeside Drive, Oakland, CA 94612 and for faculty to Executive Director Sheila O'Rourke, 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
300 Lakeside Drive, 5th Floor
Oakland, CA 94612-3557



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