

**University of California**

# **Your Group Insurance Plans**

**2004**

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# What You Need to Know After You've Enrolled

## Confirm Your Choices

It is your responsibility to promptly notify your Benefits or Payroll Office of any errors in your enrollment. Review your payroll checkstub or Surepay statement to be sure it reflects your benefit choices.

## When Coverage Begins

In order to access services and submit claims, it is important to know when your coverage begins. Coverage effective dates vary by plan. See page 13 for additional details.

## Continuing Requirements

UC bases your ongoing eligibility for benefits on the number of regular hours you are paid by UC to work each week. To remain eligible, you must maintain a specified number of hours per week in an eligible appointment (see page 3).

## Documentation

UC and the insurance carriers may request documentation to verify eligibility for your family members (see page 14).

If benefit eligibility rules require your family member to be your income tax dependent, UC may ask you to submit a copy of your income tax return.

## Keep Your Records Updated

### “UC For Yourself” Website (<https://ucfy.ucop.edu>)

Make sure that UC always has your current address, phone number, and direct deposit number for your monthly or bi-weekly pay (if applicable) so that UC can correctly administer your benefits and send you benefits information.

“UC For Yourself” allows UC employees to update personal information, such as name, home address, home telephone number, income tax withholding, and UC personal identification number (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.

## If You Move Out of Service Area

If you move out of an HMO, Select EPO, Blue Cross PLUS, or PMI service area, you and/or your eligible family members have a new PIE to transfer to a health plan and/or a new dental plan in your new location. If you return to the HMO, Select EPO, Blue Cross PLUS, or PMI service area, you may transfer back.

## Life Events

There are events in your personal life (such as marriage, divorce or childbirth) that may affect your UC employee benefits. See page 15 for additional details.

## Separation or Retirement

If you separate or retire from UC employment, generally, your UC-sponsored benefits will stop as an active employee. See pages 16–19 for more details.

## Deenrollment

It is your responsibility to deenroll any family member who loses eligibility (see pages 16 and 17). UC and the plan reserve the right to collect repayment for any expenses incurred due to the ineligible enrollment.

If you or a family member lose eligibility for UC-sponsored medical, dental, and/or vision coverage, you may have the option to continue coverage (see pages 16 and 17).

## Employee Eligibility

### Health and Welfare Benefit Packages

The benefits for which you are eligible depend on your appointment level and your membership in the University of California Retirement Plan (or another defined benefit plan to which UC contributes).

UC offers three benefit packages—Full, Mid-level, and Core. The initial requirements are listed at right. See the chart on pages 4 and 5 for a listing of the various benefits included in each of these packages and information on when to enroll.

### Initial Requirements

#### Full Benefits (BELI\* 1)

You are eligible for Full Benefits if you are a member of a UC-sponsored retirement plan<sup>1</sup>.

There are two ways to qualify for UCRP membership:<sup>2</sup>

- 1) You are appointed to work in an eligible position at least 50 percent time for a year or more<sup>3</sup>—**or**
- 2) You have worked 1,000 hours in a 12-month period in an eligible position.

#### Mid-level Benefits (BELI\* 2 and 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 percent time for at least three months, **or**
- You are appointed to work at least 50 percent time for a year or more<sup>3</sup>.

#### Core Benefits (BELI\* 4)

You are eligible for Core Benefits if you are appointed to work at least 43.75 percent 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 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 in an eligible appointment. See page 16, "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 If you are a member of the Non-Senate Instructional Unit, you qualify for UCRP membership if you are appointed to work in an eligible position for at least 50 percent time for a year or more or after you work 750 hours in a 12-month period in an eligible position.

3 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.

# Benefits Overview

This overview lists all the benefit plans included in the three benefits packages that UC offers. You may enroll in the plans that are included

in the benefits package for which you are eligible (see “Employee Eligibility” on page 3).

## Health and Welfare Benefits Packages

See pages 11 and 12 for more enrollment information.

Benefits Packages			Premiums Paid By	When to Enroll					
Full	Mid-level	Core		During PIE	During OE	90-day Wait <sup>1</sup>	Automatic	With SOH	At Any Time
<b>Health Care</b>									
•	•	<b>Medical</b> Choice of various options depending on your location, including health maintenance organization (HMO), point-of-service (POS), preferred provider organization (PPO), Exclusive Provider Organization (EPO) or a consumer model. See page 21.	You and UC or UC	•	•	•			
•	•	• <b>Medical—Core</b> Fee-for-service plan provides catastrophic coverage only. See page 23.	UC	•	•	•			
•		<b>Dental</b> Choice of two 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. See page 27.	UC	•	•				
•		<b>Vision</b> Plan covers a variety of vision care services including eye exams, corrective lenses, and frames. See page 31.	UC	•	•				
<b>Disability Insurance</b>									
•		<b>Short-Term Disability</b> Provides basic coverage for inability to work due to pregnancy/childbirth, disabling injury, or illness. Pays 55% of eligible earnings for up to six months (\$800 monthly maximum), after a waiting period. Injuries and illness must not be work-related. See page 33.	UC				•		
•		<b>Supplemental Disability</b> Provides extended coverage for work and nonwork-related disabilities due to pregnancy/childbirth, injury, or illness. Supplements Short-Term Disability/other income to pay up to 70% of eligible earnings. Choice of waiting periods. See page 33.	You	•				•	
•	•	• <b>Workers' Compensation</b> Provides state-mandated coverage for work-related injuries. See page 38.	UC				•		

Key: PIE—Period of Initial Eligibility OE—Open Enrollment SOH—Statement of Health

<sup>1</sup> The 90-day waiting period is available when the PIE is missed. See page 12.

(Chart continued on next page)

## Health and Welfare Benefits Packages

See pages 11 and 12 for more enrollment information.

Benefits Packages			Premiums Paid By	When to Enroll					
Full	Mid-level	Core		During PIE	During OE	90-day Wait <sup>1</sup>	Automatic	With SOH	At Any Time
<b>Life and Accident Insurance</b>									
•			<b>Basic Life</b> Provides employees eligible for Full Benefits with life insurance equal to annual base salary, up to \$50,000. Coverage is adjusted if appointment is less than 100% time. See page 39.	UC			•		
	•	•	<b>Core Life</b> Provides employees eligible for Core or Mid-level Benefits with \$5,000 of life insurance. See page 39.	UC			•		
•	•		<b>Supplemental Life</b> Provides employees with additional life insurance at group rates. Coverage up to four times your annual salary (to \$1,000,000 maximum). See page 40.	You	•			•	
•	•		<b>Basic Dependent Life</b> Provides \$5,000 of coverage for employee's spouse or same-sex domestic partner and each child. See page 43.	You	•			•	
•	•		<b>Expanded Dependent Life</b> Covers spouse or same-sex domestic partner for 50% (up to \$200,000) of employee's Supplemental Life amount. Covers each child for \$10,000. See page 43.	You	•			•	
•	•	•	<b>Accidental Death &amp; Dismemberment (AD&amp;D)</b> Provides up to \$500,000 protection for employee and family for accidental death, loss of limb, sight, speech, or hearing, or for complete and irreversible paralysis. See page 46.	You	•				•
•	•	•	<b>Business Travel Accident</b> Provides \$100,000 of coverage when an employee travels on official UC business. See page 48.	UC			•		
<b>Other Insurance</b>									
•	•	•	<b>Legal</b> Provides basic legal assistance for preventive, domestic, consumer, and limited defensive legal services. See page 49.	You	•				
•	•		<b>Automobile and Homeowner/Renter</b> Individually underwritten plan provides coverage for cars, boats, motorcycles, homes, and apartments. See page 52.	You					•
<b>Tax-Savings Programs</b>									
•	•	•	<b>Health Care Reimbursement Account (HCRA)</b> Lowers taxable income by allowing payment for up to \$5,000 of eligible out-of-pocket health care expenses on a pretax basis. See page 53.	Pretax salary reduction	•	•			
•	•	•	<b>Dependent Care Reimbursement Account (DepCare)</b> Lowers taxable income by allowing payment for up to \$5,000 (\$2,500 if married and filing a separate income tax return) of eligible dependent care expenses on a pretax basis. See page 55.	Pretax salary reduction	•	•			
•	•	•	<b>Tax Savings on Insurance Premiums (TIP)</b> Lowers taxable income by allowing payment of health plan premiums (if any) on a pretax basis. See page 57.	Pretax salary reduction	•	•	•		

## Eligible Adult

You may enroll an eligible adult in the health and welfare plans shown in the chart below. Eligibility is based upon your benefit package (see

page 3 to determine the benefits plans for which you are eligible). The eligible adult must be enrolled in the same plans as you.

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

- a legal spouse, **or**
- a same-sex domestic partner.

Eligible Adult Family Member	Eligibility	Must be	May enroll in					
			Medical	Dental	Vision	Dependent Life	AD&D	Legal
<b>Legal spouse<sup>1</sup></b>	Eligible	—	•	•	•	•	•	•
<b>Same-sex domestic partner<sup>1</sup></b>	Age 18 or older	<ul style="list-style-type: none"> <li>• person of same sex as you</li> <li>• not related to you<sup>2</sup></li> <li>• able to enter into a contract</li> <li>• registered with the State of California, otherwise, the following requirements apply:               <ul style="list-style-type: none"> <li>– unmarried (neither one of you is legally married)</li> <li>– living with you with the intent to continue indefinitely</li> <li>– your sole same-sex domestic partner in a relationship of mutual support, caring, and commitment</li> <li>– sharing joint responsibility with you for common welfare</li> <li>– financially interdependent with you</li> </ul> </li> </ul>	•	•	•	•	•	•

<sup>1</sup> The surviving family member of a deceased member cannot enroll a spouse or same-sex domestic partner (or their children/grandchildren).

<sup>2</sup> "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.

## Eligible Child

You may enroll your eligible children in the health and welfare plans shown in the chart below. Your eligible children must be enrolled in the same plans as you.

Note that your disabled child may be covered past age 23, subject to carrier approval.

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.

Eligible child	Eligibility	Must be	May enroll in					
			Medical	Dental	Vision	Dependent Life <sup>1</sup>	AD&D	Legal
<b>Natural or adopted child</b>	To age 23 <sup>2</sup>	<ul style="list-style-type: none"> <li>unmarried</li> </ul>	•	•	•	•	•	•
<b>Stepchild, grandchild, or step-grandchild</b>	To age 23 <sup>2</sup>	<ul style="list-style-type: none"> <li>unmarried</li> <li>living with you</li> <li>supported by you or your spouse (50%+)</li> <li>claimed as a tax dependent by you or your spouse</li> </ul>	•	•	•	•	•	•
<b>Same-sex domestic partner's child or grandchild</b>	To age 23 <sup>2</sup>	<ul style="list-style-type: none"> <li>unmarried</li> <li>living with you</li> <li>supported by you or your same-sex domestic partner (50%+)</li> <li>claimed as a tax dependent by you or your same-sex domestic partner</li> </ul>	•	•	•	•	•	•
<b>Legal ward</b> enrolled 1/1/95 or after	To age 18	<ul style="list-style-type: none"> <li>unmarried</li> <li>living with you</li> <li>supported by you (50%+)</li> <li>claimed as your tax dependent</li> </ul>	•	•	•	•	•	•
<b>Disabled child</b> (does not apply to legal ward)	Age 23 or older	<ul style="list-style-type: none"> <li>unmarried</li> <li>living with you (not required if child is your natural or adopted child)</li> <li>supported by you (50%+)</li> <li>claimed as your tax dependent</li> <li>disability approved by carrier before age 23 and periodically thereafter</li> <li>continuously covered</li> </ul>	•	•	•	•	•	•

<sup>1</sup> Child must be 24 hours old before coverage begins.

<sup>2</sup> If you are a LANL employee or a resident of New Mexico, you may enroll eligible children in your dental or vision plan (active employees only) until age 25. (Note: this does not apply to legal wards; they are covered only to age 18.)

# Important Rules and Regulations

## No Duplicate University 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. 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.

## Exclusions for Preexisting Conditions

When you enroll in any UC-sponsored medical, dental, or vision plan, 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, Short-Term Disability insurance and AD&D: 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.
- 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 your 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.

## Verification of Family Member Eligibility

The University incurs significant costs to provide group insurance coverage for employees and their family members. To ensure that only those who are truly eligible for coverage are enrolled and to meet health plan contract obligations, UC must verify family member eligibility.

UC HR/Benefits will randomly select a number of enrolled family members and request documentation from them to verify eligibility. Examples of documentation include marriage or birth certificates, verification of same-sex domestic partnerships, adoption records, or tax records. Please see page 14 for additional details.

# 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 the Blue Cross of California plans, Health Net, Kaiser Permanente, PacifiCare, Western Health Advantage, Definity Health, UnitedHealthcare plans, and PacifiCare Behavioral Health), as well as the PMI dental plan, require resolution of medical malpractice and other disputes through binding arbitration. When you enroll in these plans you agree that any dispute between you (and/or your enrolled family members) and the medical or dental plan must be submitted to binding arbitration. You agree to 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 and/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). For health plans, you may be required to provide a signed authorization allowing the plan to release personal health information to the University representative. 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.

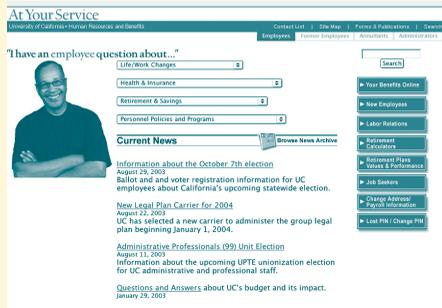
If you do not enroll within the 31 days when you are first eligible, you may enroll at a later date. However, you will need to complete a waiting period of 90 consecutive calendar days before your medical coverage is effective, or you must wait until the next Open Enrollment to enroll.

# Benefits Assistance

## Benefits Information

### At Your Service

The At Your Service website (<http://atyourservice.ucop.edu>) provides answers to employees' most frequently asked questions about their benefits. It also includes links to online actions and personalized information through "Your Benefits Online" and features online research tools to help you compare medical plans (see page 1 for more details).



For a brochure with a summary of instructions and features (the *Always At Your Service* brochure), select "Forms & Publications" on the At Your Service website or request one from your Benefits Office.

## Local Benefits Offices

The person in your department who handles benefits as well as the staff in your Benefits Office are available to help you with benefits questions.

They can tell you if any special presentations are scheduled for your location, provide forms you may need, or give you additional information about all of UC's plans.

### Location

Berkeley  
 San Francisco  
 UCSF Medical Center  
 Davis  
 UCD Medical Center  
 UCLA  
 UCLA Medical Center  
 Riverside  
 San Diego  
 UCSD Medical Center  
 Santa Cruz  
 Santa Barbara  
 Irvine  
 UCI Medical Center  
 Office of the President  
 Lawrence Berkeley Laboratory  
 Lawrence Livermore National Laboratory  
 Los Alamos National Laboratory  
 Associated Students UCLA (ASUCLA)  
 Hastings College of the Law

### Phone Number

510-642-7053  
 415-476-1400  
 415-353-4545  
 530-752-1774  
 916-734-8099  
 310-794-0830  
 310-794-0500  
 909-787-4766  
 858-534-2816  
 619-543-8244  
 831-459-2013  
 805-893-2489  
 949-824-5210  
 714-456-5736  
 510-987-0123  
 510-486-6403  
 925-422-9955  
 505-667-1806  
 310-825-7055  
 415-565-4703

## When to Enroll

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. Proof of good health is not required. To be sure you get the coverage you want, sign up during your PIE. A PIE starts on the first day of eligibility, generally your date of hire. 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.

### Default Plans

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.

You do not have to accept the default coverage—see “Declined Enrollment” at right.

### Automatic Enrollment

Your enrollment (self only coverage) 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, Tax Savings on Insurance Premiums (TIP), 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).

### New Family Member

Your PIE to enroll a newly eligible family member 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 and Expanded Dependent Life insurance.

### Adopted Child

The PIE to enroll an adopted child begins on the earlier of the date the child is placed in your physical custody or the date you, your spouse, or same-sex domestic partner 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 the date the adoption is final. Coverage begins on the first day of the PIE in which you enroll the child.

### Moving Out of a Service Area

If you move out of an HMO, Select EPO, Blue Cross PLUS, or PMI service area, you and/or your eligible family

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

### Declined Enrollment

If you decline enrollment in a UC medical plan for yourself and/or your eligible family members because you have other medical insurance 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 enrollment within 31 days after the other coverage ends.

### New Faculty Member

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 or the first day of arrival at the campus, whichever occurs first.

### Other Enrollment Options

If you miss your PIE, you may enroll in selected UC-sponsored benefits as follows:

#### Open Enrollment

You may enroll in a UC-sponsored health plan during Open Enrollment (usually held in November).

In addition, you may enroll in the Health Care Reimbursement Account (HCRA), Dependent Care Reimbursement Account (DepCare), and TIP plans during Open Enrollment, usually held in November. (Note: the legal plan is not open for new enrollments every year.)

## 90-Day Waiting Period (Medical Coverage only)

You may enroll yourself or eligible family members 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.

## Statement of Health

You may enroll in Supplemental and Dependent life insurance by submitting a statement of health to the insurance company for approval. A statement of health is also required to enroll in Supplemental Disability insurance or to reduce your waiting period (see “Exclusions for Preexisting Conditions” on page 8 for more details).

The insurance company may or may not accept your enrollment based on the statement of health. You may cancel your coverage at any time.

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

## HMO Transfers

To help you when your medical plan providers leave a California HMO during the plan year, you are able to transfer into and out of any UC-sponsored California HMO medical plan on a monthly basis, subject to processing deadlines.

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.

## If You Are Already Covered

You may cancel your coverage in (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 prohibit you from using the UC-sponsored plan’s services.

## How to Enroll or Make Changes

### 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.

### How to Enroll Online

- Go to At Your Service at: <http://atyourservice.ucop.edu>
- Select “New Employees” and follow the instructions.

### 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, when 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.

Employees who have an appointment status change (for example, a change from Core Benefits to Full Benefits—see page 3) can make certain 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 appointment status change.

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 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 the Health Care Reimbursement Account and Dependent Care Reimbursement Account, the effective date is the first day of the month following enrollment, subject to payroll deadlines.
- 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.

- 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 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.

## After You Have Enrolled

### Verification of Family Member Eligibility

Both UC and the insurance carriers reserve the right to request documentation (marriage certificates, verification of same-sex domestic partnerships, birth certificates, adoption records, tax records, etc.) to verify eligibility for your enrolled family members.

**Please keep the appropriate records on hand, but do not send any documentation unless you are asked to do so.**

**If you are asked for documentation, it is important that you provide it by the specified deadline.** If documentation is not received, UC will disenroll the family member(s) in question. You will be liable for any costs incurred in connection with the enrollment of a family member for whom documentation is not received.

If it is determined that the plan has been misused, you and any eligible family members will be disenrolled for 18 months.

### Documentation for Same-sex Domestic Partners

**If requested**, the following documentation will support the enrollment of your same-sex domestic partner and/or your partner's child or grandchild.

If you have **registered** your partnership **with the state of California**, a copy of the state registration form will be the only documentation required.

If you have **not registered with the state of California**, you must submit copies of at least three of the following documents:

- copy of any declaration, affidavit or similar document filed with any other governmental entity
- joint mortgage or joint tenancy on a residential lease
- joint bank account
- joint liabilities (for example, credit cards or car loans)
- joint ownership of significant property (for example, a car)
- power of attorney for durable property or health care
- wills, life insurance policies or retirement annuities naming each other as primary beneficiary
- written agreements or contracts showing mutual support obligations or joint ownership of assets acquired during the relationship

### Tax Dependency and Imputed Income

The UC contribution for medical/dental coverage for a same-sex domestic partner (and/or a partner's child or grandchild) is considered to be taxable income to you (imputed income) unless you qualify for a waiver.

#### Imputed Income Waivers

You qualify for a waiver of federal and California state income tax if your partner and/or your partner's child or grandchild is your dependent for income tax purposes.

You may receive a mailing from UC HR/Benefits to verify tax dependency and have your payroll records adjusted. It is important to respond to the mailing in a timely manner.

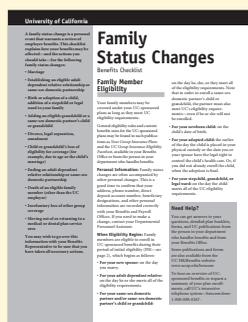
Also, if you have registered your same-sex domestic partnership with the state of California, you are not subject to imputed income for California income tax purposes. This tax exemption applies whether or not your partner/partner's child/grandchild are your tax dependents. See the *Benefits for Domestic Partners for Active Employees* booklet for more details.

# Life Events

Sometimes an event in your personal life may affect your 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 your UC-sponsored plans. 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 UC personnel policies. See your Staff or Academic Human Resources Office for information about taking a leave of absence from UC employment.

## Childbirth

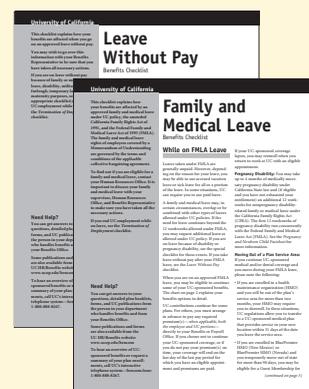
During pregnancy disability leave, the only wage replacement benefit in addition to accrued sick leave is provided by the Short-Term and Supplemental Disability plans. There is no separate maternity benefit. Please see the Disability Insurance section on page 33 and the *Pregnancy and Newborn Child Factsheet*.

## 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:

- *Leave Without Pay*
- *Paid Leave*

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



These publications are available on the UC HR/Benefits website (<http://atyourservice.ucop.edu>); select "Life/Work Changes", from your Benefits Office, or from the person in your department who handles benefits.

## 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, Dependent Care Reimbursement Account, Legal, and Auto and Homeowner/Renter 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 17) or convert group coverage to individual policies (see “Conversion Privileges” on page 17).

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 15).

### When Family Members Lose Eligibility

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

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.
- **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. If you are a LANL employee

or a resident of New Mexico, you may enroll eligible children in your dental or vision plan until age 25.

- **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 deenroll 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.

## Certificate of Creditable Coverage

When you and/or your eligible family member end or change UC-sponsored medical coverage, you will receive a Certificate of Creditable Coverage from your former 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.

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 preexisting medical conditions. Contact your medical plan directly if you do not receive a certificate.

If you transfer from one UC-sponsored plan to another, you will receive a certificate from your former plan.

## 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 HCRA 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:

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

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

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

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.

## Benefit Plans You May Not Continue

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

- Dependent Care Reimbursement Account (DepCare)
- 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.

- 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.

## When You Retire

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

### Retirement and Lump Sum Cashout

If you retire under the UC Retirement Plan and receive monthly retirement income, 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, dental, and legal coverage even if you receive an annuity from the University of California 415(m) Restoration Plan or other UC-sponsored retirement plans.

### 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 happen when you or your family member reaches age 65 or when you retire, if later. It may be earlier in cases of disability or certain illnesses.

### Medical, Dental, and Legal Plans

If you meet the eligibility requirements, you may continue your UC-sponsored medical, dental, and legal 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, dental, or legal coverage on the date you separate from UC,
- Have the required retirement plan service credit as listed in the "Annuitant Eligibility Requirements" (see page 19),
- Elect a retirement date within 120 calendar days of the date you separate from UC,
- Have continuous coverage between the date you separate from UC and your retirement date, and
- Elect to continue medical, dental, or legal 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.

### Reciprocity

UCRP and CalPERS have a reciprocal agreement for members who change employers and transfer between the two retirement systems under certain circumstances. The reciprocal agreement does not apply to eligibility for health and welfare benefits.

### Vision Plan

You may be eligible to continue vision coverage for a limited time though the COBRA/continuation options (see page 17).

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

## 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 percent 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 entered the retirement plan after 1/1/90 and 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.

2004 gross monthly PacifiCare rate for self + adult coverage  
(what UC pays) = \$509.37

11 years of UC service credit = 55% of UC's maximum contribution.

UC's maximum contribution for two adults: \$440.80 x 55% = \$242.44

Member's monthly premium (\$509.37 - \$242.44) = \$266.93

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



## 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.

For more details about what you need to know before you enroll, see page 1.

The At Your Service website provides the following:

- Under “Contact List” you will find website links, telephone numbers (also listed on page 26), and group numbers for the medical plan carriers.
- Under “Forms & Publications” you will find the medical plan Evidence of Coverage booklets.

You may also contact your local Benefits Office for assistance. See page 10 for telephone numbers.

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### Your Medical Plan Choices

For 2004, UC offers the following medical plans. You may select any medical plan for which you are eligible.

Plan	CA-paid active employees	LANL-paid active employees	Notes
Blue Cross PLUS	•		Must live in plan’s service area within California
Blue Cross PPO	•		No service area requirement
Core California	•		No service area requirement
Core New Mexico		•	No service area requirement
Definity Health Plan	•		UCSB and UCSF employees only; must live within the U.S.
Health Net	•	•	Must live in plan’s service area within California
Kaiser CA North	•	•	Must live or work in plan’s service area in No. California
Kaiser CA South	•	•	Must live or work in plan’s service area in So. California
Kaiser Mid-Atlantic	•	•	Must live or work in plan’s service area in MD, VA, or DC
Kaiser Umbrella			Closed to new enrollment. Must live in plan’s service area
PacifiCare of CA	•	•	Must live or work in plan’s service area in California
PacifiCare of Nevada	•	•	Must live or work in plan’s service area in Nevada
UnitedHealthcare iPlan		•	Must live in New Mexico
UnitedHealthcare Options PPO		•	Must live in plan’s service area within New Mexico
UnitedHealthcare Options PPO National		•	Must live in PPO service area outside of New Mexico
UnitedHealthcare Out-of-Area		•	No service area requirement
UnitedHealthcare Select EPO	•	•	Must live in plan’s service areas in NM, NV, MD, VA, or DC
Western Health Advantage	•	•	Must live or work in plan’s service area: Sacramento, Yolo, Solano, Placer, El Dorado, and Colusa counties

Please note that plan service areas are established by home (or work, depending on the plan) ZIP codes. If you want to know whether your ZIP code is in a plan’s service area, please use “Health Pages” on the At Your Service website, check the plan provider directory, or call the plan directly (see page 26 for toll-free numbers).

## Types of Medical Plans

### HMO Plans (Health Net, Kaiser, PacifiCare, Western Health Advantage)

UC offers HMO plans to employees who live (or work, depending on the plan's rules) in the plan's service area. An HMO uses a group of contracting doctors and other health care professionals who emphasize preventive care and early intervention. Most HMO services are prepaid and there is no annual deductible. You do share costs, however, by paying a fee called a copayment for some products and services.

#### HMO Providers

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 you must use a network provider. Medical emergencies are covered anywhere in the world.

#### Prescription Drugs

HMOs offer coverage for prescription drugs with a formulary and different copayments for generic, brand name and non-formulary drugs. You get outpatient prescription drugs at the network pharmacies by showing your medical plan ID card and paying a copayment. A mail order program for maintenance drugs is available.

#### Behavioral Health Benefits

For mental health and substance abuse benefits, you must call the plan's behavioral health carrier before accessing care.

### Exclusive Provider Organization (UnitedHealthcare Select EPO)

UC offers the Select EPO plan to employees who live in the EPO service areas within New Mexico, Nevada, Washington D.C., Maryland, and Virginia. An EPO is similar to an HMO; however, Select EPO offers more flexibility with a nationwide network of providers, specialists, and hospitals.

Enrollment in the Select EPO requires you to choose a Primary Care Physician (see page 24) or primary care group from the network. Your PCP will manage your care and referrals but you may also self-refer to any provider within the EPO network.

For medical services to be covered, you must follow EPO procedures and use a network provider. You share costs by paying a fee called a copayment. Coinsurance and deductibles for services may also apply. Medical emergencies are covered anywhere in the world.

#### Prescription Drugs

The EPO offers coverage for prescription drugs with a formulary and different copayments for generic, preferred brand and non-preferred brand drugs. You get outpatient prescription drugs at the network pharmacies by showing your plan's ID card and paying a copayment. A mail order program for maintenance drugs is available.

#### Behavioral Health Benefits/ Substance Abuse

For mental health and substance abuse benefits, you must call the plan's behavioral health carrier before accessing care.

### Point-of-Service Plan (Blue Cross PLUS)

For employees from California locations, UC offers Blue Cross PLUS as its Point-of-Service (POS) plan. This plan provides a greater choice of medical providers than an HMO. You are required to choose a PCP (see page 24) but you have the option to go outside the network for care (at a higher cost). A POS plan provides different levels of medical coverage depending on what kind of provider you use.

#### 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

Using out-of-network providers gives you more flexibility and responsibility. 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 percent of reasonable and customary charges for most covered services and you pay the balance.

#### Prescription Drugs

The POS offers coverage for prescription drugs with a formulary and different copayments for generic, brand name, and non-formulary drugs.

#### Behavioral Health Benefits

For mental health and substance abuse benefits, you must call the plan's behavioral health carrier before accessing care.

## Preferred Provider Organization (Blue Cross PPO and Options PPO)

UC offers the Blue Cross PPO (for California employees) and United-Healthcare Options PPO (for LANL employees) as its Preferred Provider Organizations. A PPO offers a broad network of providers that have contracted with the plan to provide discounted services. Employees also have access to non-PPO-providers anywhere in the world.

### PPO Providers

In a PPO, you are not required to select a primary care physician and you can self-refer to any provider or specialist. You pay a percentage of the cost for services, but you pay less if you use in-network providers.

**Please note that physicians may join or leave the PPO network at any time and that such changes do not allow you to transfer to another medical plan midway.**

Individuals who use a PPO provider receive in-network benefits. Individuals who use a non-PPO provider receive out-of-network benefits.

### PPO Costs

In a PPO plan, you pay an annual deductible, and applicable in-network or out-of-network copayments and coinsurance. Each year, you must pay the annual deductible for your coverage level (self/family) before the plan shares your costs.

You continue to share the cost of your care 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. There are separate out-of-pocket maximums for in-network and out-of-network benefits.

## Prescription Drugs

Prescriptions are covered with different copayments for generic, brand-name/preferred brand and non-formulary/non-preferred brand drugs.

### Behavioral Health Benefits/ Substance Abuse

For mental health and substance abuse benefits, you must call the plan's behavioral health carrier before accessing care.

## Fee-for-Service Plan (Core Plan)

In a fee-for-service 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. The Core plan has a high deductible which you must meet before the plan pays benefits. You can save money by using the Blue Cross PPO providers.

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 percent of most covered charges for the rest of the calendar year.

## Prescription Drugs

The Core plan covers prescriptions on a straight percentage reimbursement, once your deductible is met. There is no formulary and you can go to any pharmacy.

## Consumer Model Health Plans (Definity Health and UHC iPlan)

**Consumer model or consumer-driven health plans give employees more control in making health care decisions and in managing their health care costs.**

Definity Health is a consumer-driven health plan for employees of UC Santa Barbara and UC San Francisco.

UnitedHealthcare (UHC) iPlan is a consumer-driven health plan for Los Alamos employees in New Mexico only.

There are four components to consumer-driven plans:

### 1) Personal Care Account (PCA): Definity Health Personal Benefit Account (PBA): iPlan

UC/LANL deposits benefit dollars in your account based on your level of coverage, and you decide how to spend these benefit dollars. Your PCA or PBA covers 100 percent of a wide range of health care services such as office visits and prescription drugs. Any funds left over at the end of the year are rolled over to the next year's account.

#### PCA or PBA

Employee:	\$750
Employee & Adult:	\$1,125
Employee & Child:	\$1,125
Employee & Adult & Child(ren):	\$1,500

### 2) Membership Responsibility

If you exhaust your PCA or PBA, you are responsible for expenses up to the amount of your deductible.

### 3) Health Coverage

If you meet your deductible, then a more traditional health coverage component takes effect. You receive a higher level of benefits when

you see in-network providers. You are responsible for the coinsurance percentage up to an out-of-pocket maximum.

#### 4) Preventive Care

Expenses such as physical exams, immunizations and health screenings are covered at 100 percent when you see a network provider. There's no deduction from your PCA or PBA and no out-of-pocket cost to you.

#### Annual Deductible (Includes PCA or PBA Dollars and Member Responsibility)

Employee:	\$1,500
Employee & Adult:	\$2,250
Employee & Child:	\$2,250
Employee & Adult & Child(ren):	\$3,000

#### Prescription Drugs

If you exhaust your PCA or PBA, the prescription drug coinsurance percentage applies after you meet the plan's annual deductible.

#### Behavioral Health Benefits

For mental health and substance abuse benefits, you must call the plan's behavioral health carrier before accessing care.

### Primary Care Physicians (PCP)

Everyone enrolled in the following UC-sponsored medical plans must select a Primary Care Physician (PCP) to coordinate their medical care:

- PacifiCare (California and Nevada)
- Health Net
- Western Health Advantage
- Select EPO (UnitedHealthcare)
- Blue Cross PLUS

#### Choosing a PCP

You may choose a different PCP for each family member or the same PCP for the entire family.

If you or your eligible family members do not select a PCP, your medical plan will assign one to you.

You may change your PCP during the year by calling the plan directly. See page 26 for telephone numbers.

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 plan's network. On At Your Service, choose "Health Pages" (select "Health & Insurance" and "Medical Plans") for information about doctors, or call the plan to confirm if that doctor is in their network.

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

### Cost of Medical Coverage

Your medical plan monthly cost depends on the plan you choose, the level of coverage and your annual full-time equivalent salary. The monthly amount will be automatically deducted from your paycheck. The UC/employer contribution toward the monthly cost of the coverage is determined by UC and may change or stop altogether.

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 or 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 11) 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, 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 when you use the**

California HMO monthly transfer option), you will pay the extra premium on an after-tax basis through the end of the year.

## 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 same-sex domestic partnership with the state of California. For more information, see the *Benefits for Domestic Partners* booklet.

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 "After You Have Enrolled" on page 14.

## General Information

### Confirmation

Approximately 10 days after you have enrolled, you may view/verify your enrollments on At Your Service by selecting "Your Benefits Online" and "View Your Enrollments." You may also do so using [bencom.fone](http://bencom.fone) (1-800-888-8267) under "Personal Accounts and Transactions, Health and Insurance." You may also check your paystubs to confirm that your enrollment is correct.

### ID Cards

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 13. Note: if you change plans during the annual Open Enrollment period, the medical plan ID cards are usually sent at the end of December (for January 1 coverage).

### Questions

You need to evaluate carefully your family circumstances and plan costs before selecting medical plan coverage. The At Your Service website contains additional information about medical plan coverage, including medical plan links and telephone numbers (see "Contact Lists") and the Evidence of Coverage booklets (see "Forms & Publications"). If you have other questions, call the medical plan directly (see page 26) or call your Benefits Office.

Once you are enrolled in UC-sponsored coverage, if you have questions about your benefits (including services, benefits, bills and claims), you should contact your medical plan directly using the phone number on your medical plan ID card.

**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 specific condition, service areas, or provider information, please refer to At Your Service for a link to the plan (see page 10). At Your Service also contains the Medical Plan Chooser (select “Health & Insurance” and “Medical Plans”) to compare UC-sponsored medical plan costs, quality, services and participating doctors. For more plan information, you may also call the plan directly using the toll-free number at the right.

**Medical Plan**

- Blue Cross PLUS
- Blue Cross PPO
  - United Behavioral Health
- Core
- Health Net
  - Managed Health Network
- High Option
- Kaiser Permanente—California
- Kaiser Permanente Mid-Atlantic
- PacifiCare of California
  - PacifiCare Behavioral Health, Inc.
- PacifiCare of Nevada
- Western Health Advantage
  - Magellan Behavioral Health
- UnitedHealthcare

**Toll-free Number**

- 1-888-209-7975
- 1-888-209-7975
- 1-888-440-8225
- 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
- 1-888-563-2252
- 1-800-424-1778
- 1-800-603-3816

**Special Numbers for Hearing Impaired**

- Health Net 1-800-995-0852
- Kaiser Permanente—California 1-800-777-1370
- PacifiCare of California 1-800-442-8833
- PacifiCare of Nevada 1-800-360-1797
- UnitedHealthcare 1-866-249-9172
- United Behavioral Health 1-800-842-9489
- 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 contract with Delta. If you choose a Delta provider, the plan pays for services as described on pages 28 and 29. Almost all preventive dentistry is covered in full. For other services, you pay a \$50 annual deductible per person and a coinsurance of 25 percent to 50 percent 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.

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 28) and orthodontics (page 29). Delta 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. 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. **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.**

If you enroll in the Delta Dental plan, you can save on out-of-pocket expenses for basic, prosthetic, and orthodontic services by using the DeltaPreferred Option (DPO) provider network. The coverage levels listed on the chart (pages 28 and 29) won't change if you use the DPO.

You can find a list of Delta DPO dentists by visiting the 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 Plan** is another option for California residents only. Dental services are covered only when you visit a PMI dentist. See pages 28 and 29 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.

The PMI 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 2004, 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 pay a certain percentage or copayment for some services. See the chart on pages 28 and 29 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 same-sex domestic partnership with the state of California. For more information, see the *Benefits for Domestic Partners* booklet.

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January through December 2004	Delta Dental Plan	PMI Dental Plan*
<b>SERVICE AREA</b>	Any dentist/worldwide	PMI dentists/California only
<b>PREVENTIVE DENTISTRY</b>	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
<b>BASIC DENTISTRY</b>	Deductible applies	Copayments apply as noted
Fillings	75% of UCR	No charge for standard benefit
Anesthesia	75% of UCR (general anesthesia for covered oral surgery)	Local—no charge. General and intravenous sedation—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	No charge for standard benefit
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
<b>PROSTHETIC DENTISTRY</b>	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

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

January through December 2004	Delta Dental Plan	PMI Dental Plan*
<b>TOTAL BENEFIT FOR PREVENTIVE, BASIC, AND PROSTHETIC DENTISTRY</b>	\$1,500 per person per calendar year	No maximum
<b>ORTHODONTICS</b>	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 dependent children as defined in eligibility provisions; up to \$500 in a lifetime for adults (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)
<b>SPECIAL PROVISIONS, LIMITATIONS, EXCLUSIONS</b>		
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 12-month period for pain relief when you are more than 25 miles from your dentist's office.
Teeth bleaching	Not covered	Teeth Bleaching (\$175 copayment per arch): External bleaching is limited to one bleaching tray per arch per 36-month period; bleaching gel for two weeks of patient self treatment. Exclusions: replacement of restorations, crowns, bridges, dentures or prosthetic teeth to enhance cosmetics and/or to better match bleached teeth.

\* 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 28 and 29 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 Evidence of Coverage (EOC) 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

For more information about the Delta Dental Plan, call them at 1-800-777-5854. You can access Delta's website through the HR/Benefits website (<http://atyourservice.ucop.edu>) by selecting "Contact List" and "Dental Plan Carriers." Select the "Delta Dentist Directory" link to find a Delta dentist, or call 1-800-427-3237.

For help in choosing a PMI dentist or more information about the PMI plan, check the At Your Service website or call 1-800-422-4234 or 1-562-924-8311.

To find the Evidence of Coverage booklets for Delta or PMI, go to the At Your Service website, select "Forms & Publications," and scroll down to "Evidence of Coverage (EOC) and Plan Booklets for UC-Sponsored Health and Welfare Plans." You may also ask the carrier to send you a booklet.

# 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 providers 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**  
Some 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](http://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 2004, 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 the 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’s) 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 percent discount for additional pairs of prescription glasses; and

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- 15 percent 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’s) 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 UC employee).

**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. You can access VSP’s Evidence of Coverage booklet and the VSP website through the At Your Service website (<http://atyourservice.ucop.edu>). For the VSP website, select “Contact List” and “Other Insurance Plans.” To find VSP’s Evidence of Coverage booklet on the At Your Service website, select “Forms & Publications” and scroll down to “Evidence of Coverage (EOC) and Plan Booklets for UC-Sponsored Health and Welfare Plans.” You may also call VSP at 1-800-877-7195 to request a booklet or to ask a question.

## 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 of a disability waiting period will affect major events in your life. See page 35—"Choosing a Waiting Period."

### What the Plans Cover

#### Short-Term Disability

Short-Term Disability is paid for by the University.

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.

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 percent of your eligible earnings, up to \$800 a month (maximum), for
- up to six months

**You must first use up to 30 days of your accrued sick leave to cover up to the first 30 calendar days of disability (22 working days—176 hours—not including paid holidays) before benefits begin. If you have not accumulated that much sick leave, you must use what you have.**

If you are covered by the Short-Term Disability plan alone, you are automatically assigned a seven day waiting period. 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 35 for more on how waiting periods and sick leave work.

#### Supplemental Disability

If you decide to be covered by the Supplemental Disability plan, the premium is paid 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 percent 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 has a provision that pays long-term disability benefits to fill in the difference between other sources of disability or retirement income and 70 percent of your eligible earnings. The Supplemental plan will pay a minimum of \$100 a month, even if you are receiving a full 70 percent of

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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 percent of your eligible earnings up to \$10,000 a month.

As long as you remain disabled, Supplemental Disability plan benefits 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 35.

### 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);
- Social Security disability benefits; and
- California State Disability Insurance.

Benefits payable by the Short-Term and Supplemental Disability plans will be reduced by most other disability benefits for which you are eligible, including but not limited to the above.

### 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

- 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.

### Accruing Sick Leave

Waiting period (calendar days)	Minimum sick leave needed (working days)	Years of UC employment needed to earn leave*
7	5 (40 hours)	0.4
30	22 (176 hours)	1.8
90	66 (524 hours)	5.5
180	131 (1,048 hours)	10.9

\* Calculations assume that you work 174 hours a month, earn eight hours of sick leave per month, and do not use any earned sick leave.

## Choosing a Waiting Period

When you enroll in either the Short-Term or Supplemental Disability plan, you must select a waiting period.

A waiting period is the time from the day you are unable to work due to an injury, illness, or pregnancy until the day disability benefits start. You may elect a 7-, 30-, 90-, or 180-day waiting period. The longer the waiting period, the lower the monthly premiums you'll pay. However, when you choose a longer waiting period and if you become disabled, you should be prepared to cover your expenses

yourself—without income from the disability plans—until your waiting period is complete.

No matter which waiting period you choose, you must use up to 30 calendar days (22 working days or 176 hours) of accrued sick leave (if available) before benefits begin. If you have not accumulated that much sick leave, you must use what you have.

If you enroll in the Supplemental Disability plan, your waiting period for the Short-Term Disability plan will be the same as that which you choose for Supplemental Disability.

If you do not enroll in the Supplemental Disability plan, your waiting period for the Short-Term Disability plan is automatically seven days.

No one waiting period is right for everyone. It is important that you consider your circumstances and how your selection will affect major events in your life.

For example, consider your choices carefully if you plan to become pregnant. Most pregnancy disabilities last only 6-8 weeks, so the waiting period you select will determine if you will receive any disability income benefits during childbirth.

Additionally, you should consider your major financial obligations when selecting a waiting period. If you have just purchased a new house, you may not want to risk a long waiting period, during which you might be without income to pay your mortgage.

It is also important to consider other sources of income you might have. For instance, if you have a lot of savings, you might choose a longer waiting period and pay a lower premium. On the other hand, if you are a new employee without much sick leave, you might consider choosing a shorter waiting period.

You can always increase the length of your waiting period later, but a statement of health and approval by the insurance company is required in order to shorten your waiting period.

## Supplemental Disability Monthly Rates Effective January 1, 2004

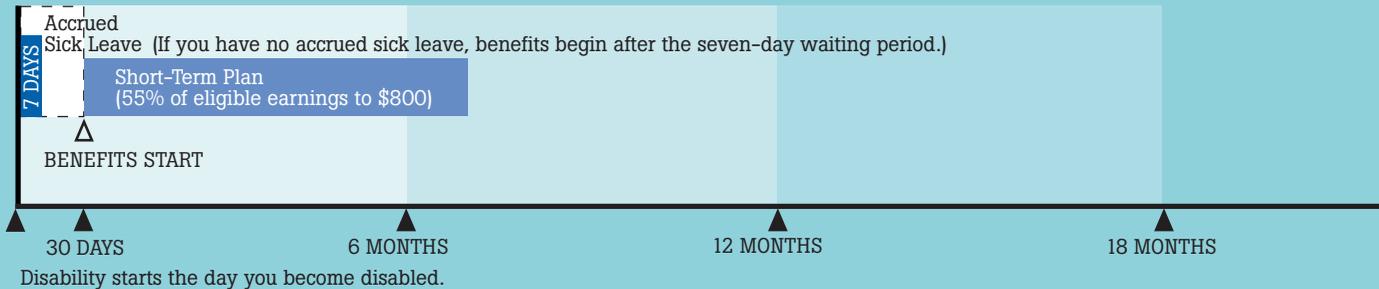
Age	Waiting Period			
	7 Days	30 Days	90 Days	180 Days
Under 35	\$0.0065	\$0.0024	\$0.0021	\$0.0008
35-39	0.0069	0.0027	0.0023	0.0011
40-44	0.0077	0.0033	0.0028	0.0017
45-49	0.0085	0.0039	0.0033	0.0021
50-54	0.0105	0.0049	0.0042	0.0032
55-59	0.0126	0.0070	0.0059	0.0052
60-64	0.0174	0.0114	0.0098	0.0093
65-69	0.0154	0.0090	0.0077	0.0068
70 and over	0.0117	0.0049	0.0042	0.0027

- Find the rate for your age and waiting period.  
\$ \_\_\_\_\_  
monthly rate
- Multiply the rate by your gross monthly covered salary\* up to \$14,286 per month. If your salary is higher, use \$14,286. X \$ \_\_\_\_\_  
gross monthly covered salary rate
- This is your estimated monthly premium. = \$ \_\_\_\_\_  
monthly premium

\* Use the full-time monthly covered salary rate for your position, even if you work part time. Premiums are based on the full-time salary rate for your position; if you normally work less than full time, benefits will be based on your part-time earnings. Do not include special pay, such as overtime.

## Short-Term Disability Plan Only

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



## Short-Term and Supplemental Disability Plans

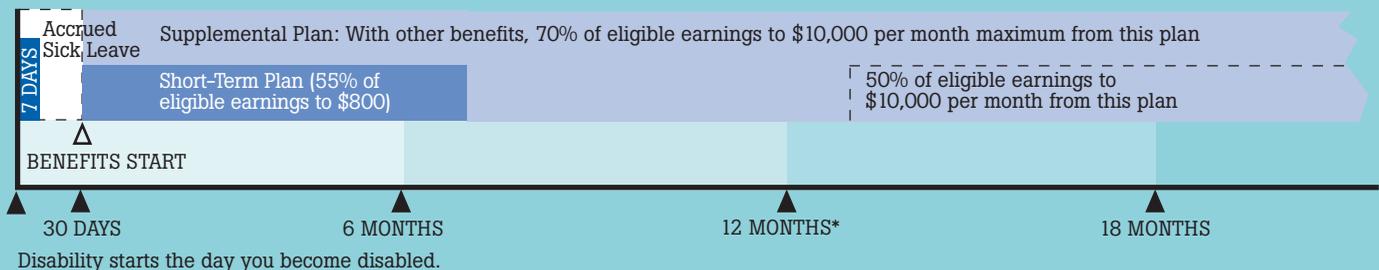
If you have Supplemental Disability, this is how both plans work together based on the waiting

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.

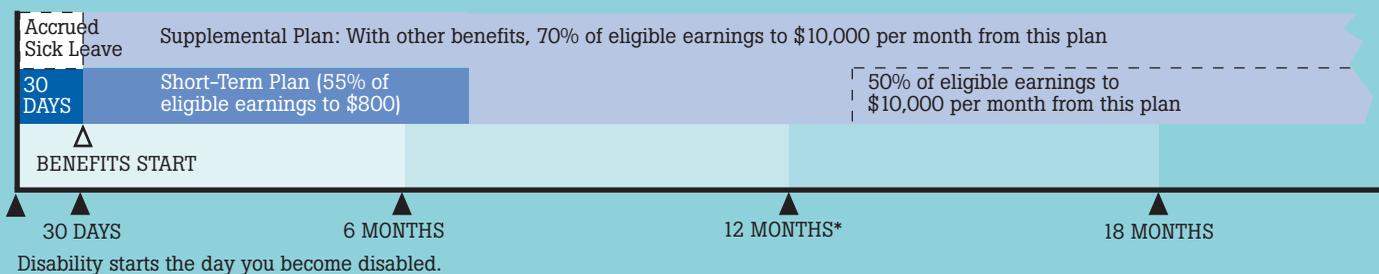
### 7-day Waiting Period

(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 maximum 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.

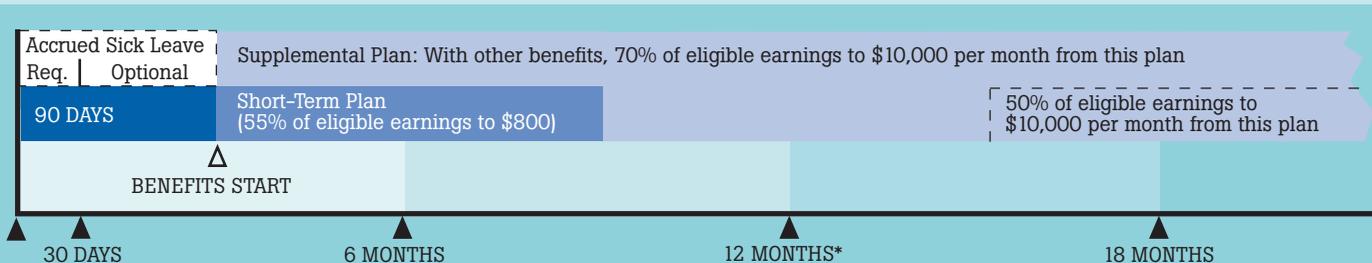
### 30-day Waiting Period



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

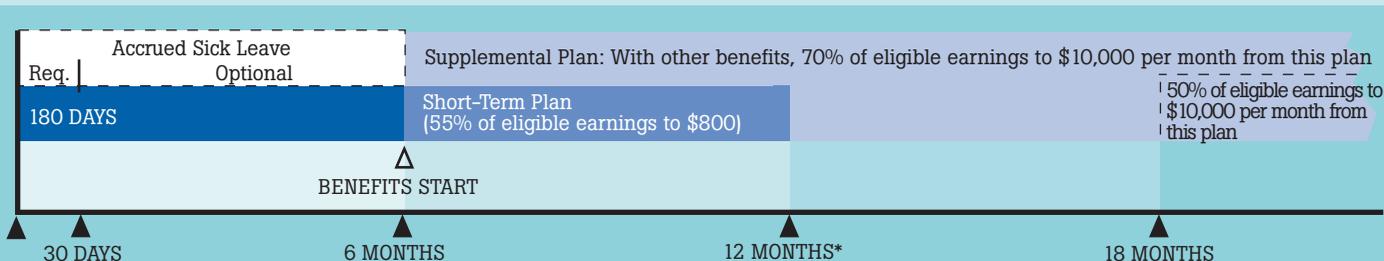
### 90-day Waiting Period



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.

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](http://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 42) 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 2004, 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 3).

Coverage stops if your UC appointment and average regular paid time drops below required levels.

However, you may be able to convert your life insurance to an individual policy (see page 17 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 43–44 for information on Dependent Life insurance.

#### Core Life

You are eligible for coverage if you qualify for Core or Mid-level Benefits (see page 3).

Coverage stops if your UC appointment and average regular paid time drops below required levels. However, you may be able to convert your life insurance to an individual policy (see page 17). 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 their Basic Life coverage 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 money can be used for any purpose. The money—50 percent 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 3).

If you do not enroll during your PIE, you may enroll by submitting a statement of health. The insurance company may or may not accept your request for coverage 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 43–44 for information on Dependent Life insurance.

## Cost of Coverage

Your cost for Supplemental Life depends on your age and the amount of coverage you purchase. 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, 2004

Your Age	Monthly Cost
Under 30	\$.027
30-34	.031
35-39	.038
40-44	.061
45-49	.111
50-54	.161
55-59	.291
60-64	.454
65-69	.696
70 and over	1.250

To estimate 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 estimated 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 17 and see your Benefits Office for more information.

## Your Beneficiaries

You name beneficiaries by completing UC’s online beneficiary form available on At Your Service. If you don’t name beneficiaries, benefits are paid to the first survivor in this list:

- Your legal spouse or eligible domestic partner,
- 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 using At Your Service. Once your new designations are processed, all previous designations are invalid. You may complete UC’s *Designation of Beneficiary* form if you do not have Internet access.

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

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 40. 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

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 specific 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 and/or 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 percent 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 6 and 7 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 member's Dependent Life plan. You may not be covered by both plans (see "No Duplicate University Coverage" on page 8).

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 your request for 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 39, or
- The Supplemental Life plan described on page 40.

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 40.

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.

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To calculate the monthly premium to cover your spouse or same-sex

domestic partner, use your age as of January 1, 2004.

### Basic Dependent Life Monthly Rates Effective January 1, 2004

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, 2004. 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 45 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 17 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, 2004

	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, available on the 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 estimated 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 levels of coverage 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 percent of your coverage amount. With eligible children, it covers your spouse or partner for 50 percent of your amount and each child for 20 percent. The modified family plan covers you, and each eligible child is covered for 20 percent 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 percent.

The plan pays a percentage of the coverage amount if an accident causes irreversible paralysis for you or a covered family member. The percentage payable 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 percent. 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 percent of your coverage amount (up to \$10,000, but not less than \$1,500)

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

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 percent 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 percent 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).

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

## 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.

### AD&D Monthly Rates Effective January 1, 2004

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

## Your Beneficiaries

To name or change your beneficiary use the online beneficiary form on At Your Service website.

You may change your designated beneficiary at any time on At Your Service. Once your designations are processed, all previous designations are revoked. You may complete the University's *Designation of Beneficiary* form if you do not have Internet access.

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

- Your legal spouse or eligible domestic partner,
- 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.**

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

See your Benefits Office (see page 10) 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.

# 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 outside a 100-mile radius of your home or regular place of employment:

## 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](http://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 01-713-267-2525 (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. Note: Any conflict between the policy and this summary will be governed by the terms and conditions of the policy. 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](http://www.ucop.edu/ucophome/policies/bfb/bus74.html)) or from your local Risk Management office. You can also find a list of UC Risk Managers online ([www.ucop.edu/riskmgt/directories.html](http://www.ucop.edu/riskmgt/directories.html)).

## Legal Plan

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 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 ARAG Group at an annual cost roughly equal to one or two hours in an attorney's office.

The legal insurance plan helps mainly with routine preventive or defensive matters and should cover most basic legal needs. The chart on page 50 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* includes 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 (four-day trial limitation).
- *Limited defensive legal services* include misdemeanor defense and felony charge advice.
- *Major trial representation* includes trial representation beginning on the fourth day of trial in covered proceedings for which indemnity benefits are being provided (\$400 per half day of trial time).
- *Online law guide and document library*: The online law guide provides comprehensive overviews of the most common legal issues. The online document library includes Do-It-Yourself Legal Documents™, which allow you to create your own legally valid documents.
- *Identity theft services* gives you unlimited, toll-free access to an Identity Theft Case Manager, who will explain identity theft and how to prevent it. If you become a victim of identity theft, you'll receive personal guidance, online guides, printed workbooks, risk assessment tools and more.
- *Reduced fees for non-covered matters*: Receive at least 25 percent off an attorney's normal rate for most non-covered personal legal needs when using an attorney from ARAG Group's Reduced Fee

Network. Benefit is subject to plan exclusions.

- *Reduced contingency fees*: Capped at 25 percent for initial trial/settlement and 30 percent for subsequent appeal proceedings.

Benefits are limited to one claim per item per year, whether you have individual or family coverage, with the exception of the attorney office work, estate planning, wills, trust benefits and telephone legal services.

See the ARAG Legal plan booklet for plan limitations and exclusions.

### Cost of Coverage

Your monthly cost for 2004 depends on your enrollment.

Self:	\$8.49
Self plus adult:	\$11.67
Self plus child(ren):	\$11.67
Self plus adult plus child(ren):	\$12.73

### How to Use the Plan

When you need legal help, your first step is to call ARAG Group's toll-free number. You can also send them an email or visit an attorney in person. You can visit the ARAG Legal website to access the Law Guide and Document Library for a variety of updated educational legal information.

When you call the ARAG Group, an attorney will help determine what kind of legal help you need and will advise you on the services the plan will cover. A claim form, a description of coverage, and a current list of the plan's Network Attorneys will be sent to you. (continued on page 51)

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## What the Plan Covers

### Telephone Legal Services

Unlimited toll-free telephone services to seek advice and consultation directly with a Telephone Network Attorney, assistance with telephone calls and/or letters to third parties to determine the extent of a problem and/or resolve the

issue, and guidance or direction regarding covered personal legal matters. The Telephone Network Attorney will also review simple documents. The Telephone Legal Services covers all matters except those specifically excluded from the plan.

### Worldwide Coverage Per Family Each Calendar Year

#### 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)

Simple wills and trusts (including Power of Attorney)<sup>1, 2</sup>

Codicils to wills, living wills<sup>1, 2</sup>

Durable Power of Attorney<sup>1</sup>

#### Domestic

Uncontested divorce (for self use only)

Contested divorce (for self use only)

Child support, visitation, and/or alimony in conjunction with a modification of divorce decree or a separation or annulment agreement

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

- Modification/enforcement of an uncontested child custody, child support, or visitation agreement

- Modification/enforcement of a contested child custody, child support, or visitation agreement

Establishment of guardianship/conservatorship

Adoption proceedings<sup>3</sup>

Name change

#### Defensive

Criminal misdemeanor defense (except traffic violations)<sup>3</sup>

Habeas Corpus proceedings

Juvenile court hearings—if juvenile is covered dependent

Defense of a lawsuit for the collection of a debt based on a contract or other written instrument<sup>3</sup>

Personal bankruptcy

Defense of traffic matter that could lead to license suspension<sup>3</sup>

#### Consumer

Consumer protection (except for disputes over real estate/construction matters)<sup>3</sup>

#### IRS Coverages

IRS Collection Defense prior to trial

IRS Collection Defense Court representation at trial as defendant

IRS Audit Advice, consultation and negotiation

Representation at IRS Audit

#### Major Trial Representation

Representation at trial beginning on the 4th day of trial (\$400 per ½ day of trial time) in covered proceedings for which indemnity benefits are being provided.

**Network  
Attorney**

**Non-Network  
Attorney**

Up to 8 hours

\$560

Fully paid

\$175

Fully paid

\$70

Fully paid

\$70

Fully paid

\$525

Fully paid

\$700

Fully paid

\$280

Fully paid

\$245

Fully paid

\$294

Fully paid

\$490

Fully paid

\$420

Fully paid

\$420

Fully paid

\$280

Fully paid

\$700

Fully paid

\$420

Fully paid

\$490

Fully paid

\$630

Fully paid

\$560

Fully paid

\$350

Fully paid

\$350

\$1,800<sup>4</sup>

\$1,800<sup>4</sup>

\$1,200<sup>4</sup>

\$1,200<sup>4</sup>

\$420<sup>4</sup>

\$420<sup>4</sup>

\$900<sup>4</sup>

\$900<sup>4</sup>

Included with  
Covered Benefits

\$100,000<sup>5</sup>

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

<sup>1</sup> Benefits for estate planning, wills, and trusts are limited to four claims per year.

<sup>2</sup> In conjunction with this benefit, the eight hours under the Attorney Office Work benefit may be used for more involved trust matters.

<sup>3</sup> Four-day trial limitation.

<sup>4</sup> This is the annual maximum regardless of whether you are enrolled in self, self plus child(ren), self plus adult, or self plus adult plus child(ren) coverage

<sup>5</sup> This coverage is paid at a rate of \$400 per ½ day of trial time.

These Network Attorneys have met the ARAG Group's requirements and have agreed to provide the services described on page 50. Covered services are fully paid.

If you prefer, you may use a non-network 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 50.

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 Network 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 ARAG Group. Doing so is the best way to be sure the plan serves you to your best advantage.

For the services listed on the previous page, you may use an ARAG Group Network Attorney, or any attorney you choose. For a list of Network Attorneys, a claim form, or a complete list of limitations and exclusions, visit their website (<http://members.araggroup.com/ucop>) or call an ARAG Group Customer Care Counselor at 1-800-828-1395.

The plan provides these types of legal services:

- *Telephone legal services:* For simple matters that can be handled adequately by telephone, you may call a telephone network attorney who will either work with you over the phone or recommend that you meet with an attorney in person. Unlimited access to telephone network attorneys can help you get the most from the plan. By using this service 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 Network Attorney. If you use a non-network 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. If 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 50 for a list of covered services.

## For More Information

This is only an overview of your legal insurance benefits. For full details, see your Benefits Office or the appropriate person in your department for a copy of the insurance company's plan booklet. You may also visit the ARAG Group's website (<http://members.araggroup.com/ucop>) or call the ARAG Group at 1-800-828-1395, Monday–Friday, 5 a.m.–5 p.m. PT. 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 3), 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 1-888-744-9043.

## Health Care Reimbursement Account (HCRA)

The Health Care Reimbursement Account (HCRA) allows you to pay for eligible out-of-pocket health care expenses on a pretax, salary reduction basis. The program is established under Internal Revenue Code (IRC) §105.

### How the Plan Works

You determine the annual amount of your contributions from a minimum of \$180 to a maximum of \$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 either 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](http://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, certain over-the-counter 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. However, note that while an expense listed there may be an eligible tax deduction, it may not be an eligible expense under HCRA (for example, insurance premiums).

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. **Note: The effective date is the first of the month following your enrollment, subject to payroll deadlines.**

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 *Health Care Reimbursement Account Summary Plan Description* or the SHPS website ([www.shps.net/myshps](http://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. Once elected, you cannot change the amount of your contribution due to miscalculating your anticipated expenses, or to misunderstanding what expenses are eligible. **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 2004 eligible expenses by April 15, 2005, in order to reimburse the expenses. Forfeited funds are used to pay the cost of administering the HCRA program.

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## Who is Eligible

You are eligible to participate in HCRA if you are eligible for the Full, Mid-level, or Core benefits package (see page 3).

## Eligible Dependents

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

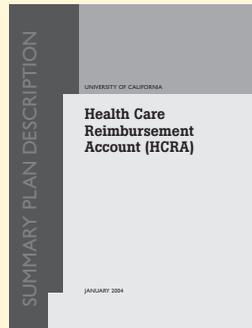
## Enrollment and Change in Participation

You may enroll when you first become eligible, during your period of initial eligibility (PIE), during Open Enrollment, or when you have an eligible change in family or employment status. You may also enroll, change your contribution or cancel participation during a new 31-day PIE caused by an eligible change in family or employment status. Mid-year changes must be on account of and consistent with the change in status. Enrollments and changes in contributions take effect on the first of the month following the action taken, subject to payroll deadlines.

Your enrollment is for the current plan year (January 1 through December 31) only, ending on December 31 of each year. To participate the following year, you must reenroll during the preceding Open Enrollment.

Unless you have an eligible family or employment status change during the plan year, the IRC rules require that your contributions stay the same and you cannot cancel participation.

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](http://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\\_calculator.asp](http://www.shps.net/myshps/fsa_calculator.asp)).

## 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 under "Forms & Publications" and from your Benefits Office) for plan details. HCRA information is also available on the At Your Service website under "Health & Insurance."

# 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 for your expenses through an automatic deposit to your bank or by check.

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 31st 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.

However, note that while an expense listed there may be an eligible tax deduction, it may not be an eligible expense under DepCare.

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. **Note: The effective date is the first of the month following your enrollment, subject to payroll deadlines.** 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](http://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; or
- Your spouse’s total earned income.

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 dependents.

**If your spouse has no earned income, is capable of self-care, and is not a full-time student, you may not contribute to DepCare.**

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.

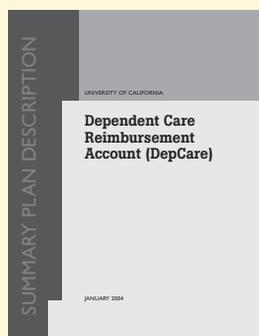
Be sure to estimate your DepCare expenses carefully. Once elected, you cannot change the amount of your contribution due to miscalculating your anticipated expenses, or to misunderstanding what expenses are eligible. **The IRS requires that you forfeit any unclaimed funds in your DepCare account after the closing date for the plan year.** SHPS, Inc. must receive claims for 2004 eligible

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expenses by April 15, 2005, in order to reimburse the expenses. Forfeited funds are used to pay the cost of administering the DepCare program.

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 (see page 3).
- You are married and 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), during Open Enrollment, or when you have an eligible change in family or employment status. You may also enroll, change your contribution or cancel participation during a new 31-day PIE caused by an eligible change in family or employment status. Mid-year changes must be on account of and consistent with the change in status. Enrollments and changes in contributions take effect on the first of the month following the action taken, subject to payroll deadlines.

Your enrollment is for the current plan year (January 1 through December 31) only, ending on December 31 of each year. To participate the following year, you must reenroll during the preceding Open Enrollment. Unless you have an eligible family

or employment status change during the plan year, the IRC rules require that your contributions stay the same and you cannot cancel participation. 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

2004 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 under “Health & Insurance.”

# Tax Savings on Insurance Premiums (TIP)

The Tax Savings on Insurance Premiums (TIP) program allows you to pay your medical, dental, or vision 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 eligible for the Full, Mid-level, or Core benefits package (see page 3).

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 or step 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 UC's 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

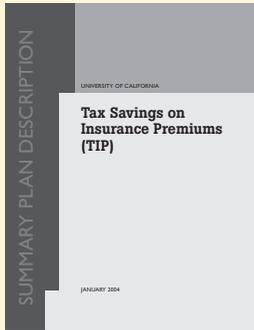
If you want to cancel your TIP participation, IRC rules require you to do so during your PIE, during Open Enrollment, or during an additional PIE caused by an eligible change in employment or family status. If you cancel at any other time, penalties may apply.

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>



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