

2012 A Complete Guide to Your UC Health Benefits

Welcome to the University of California!

As a University of California employee, you help shape the quality of life for people throughout California and around the world.

Every faculty and staff member plays an important role in UC's mission of education, research and public service; UC's high-quality, comprehensive benefits are among the rewards you receive in return. These benefits are an important part of your total compensation.

Our health and welfare benefits program provides both choice and value to meet the needs of our diverse workforce.

We know that making benefits choices can be a bit overwhelming. So we have tools and information to help you make the right choices for you and your family.

This booklet gives you the details of our health and welfare plans. Use it with the enrollment guide you received in your welcome kit to help you. Then keep this booklet for future reference when you have questions about your benefits or want to make changes.

You'll find additional tools and information on our employee website, At Your Service (atyourservice.ucop.edu). You can also call your local benefits office or any of the plans. You'll find their contact information on the insert at the front of this booklet.



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Eligibility and Enrollment

UC offers three benefits packages — Full, Mid-level and Core. Your eligibility for a particular benefits package depends on the type of job you have, the percentage of time you work and the length of your appointment. Membership in the UC Retirement Plan (UCRP) also determines your benefits eligibility.

The initial eligibility requirements are listed below. See the chart on pages 8 to 10 for a list of the benefits included in each package and information on when you may enroll in the various plans.

INITIAL REQUIREMENTS

FULL BENEFITS

You are eligible if you are a member of the UC Retirement Plan (UCRP) or another defined benefit plan to which UC contributes. You qualify for UCRP membership if:

- You are appointed to work in an eligible position at least 50 percent time for a year or more¹ or
- You have worked 1,000 hours in a continuous 12-month period in an eligible position.²

MID-LEVEL BENEFITS

You are eligible if:

- You are not a member of a UC-sponsored defined benefit plan, and
- You are appointed to work at least 50 percent time for a year or more¹, or
- You are appointed to work 100 percent time for at least three months, but less than one year.

CORE BENEFITS

You are eligible if you are appointed to work at least 43.75 percent time.

ELIGIBLE FAMILY MEMBERS

ELIGIBLE ADULT

You may enroll a legal spouse or domestic partner. The eligible adult may be enrolled only in the same plans as you. See the chart on page 11 for more information.

ELIGIBLE CHILD

You may enroll your eligible children up to age 26 in the same plans as those in which you enroll. A disabled child may be covered past age 26, if the carrier approves. The chart on pages 11 and 12 gives the eligibility criteria for children, step-children, grandchildren and disabled children. If your same-sex spouse or domestic partner is eligible for UC-sponsored insurance, you may enroll his/her child or grandchild, even if you do not enroll your spouse or partner.

TAX IMPLICATIONS OF ENROLLING A DOMESTIC PARTNER OR SAME-SEX SPOUSE

In most cases, your same-sex spouse or domestic partner and his or her children do not automatically qualify as your dependents under the Internal Revenue Code (IRC). That means any UC contribution toward their medical, dental and vision coverage will be considered “imputed income” or taxable income for federal tax purposes. This income is reflected in your annual W-2 statement.

If your same-sex spouse or domestic partner and his or her children or grandchildren are your dependents as defined by the IRC, you are not subject to imputed income on UC contributions toward health insurance for these family members. In order for your payroll records to accurately reflect this tax dependency, complete form UPAY 886 (Declaration of Tax Dependency) and submit it to your local Payroll Office.

UC’s contribution for medical, dental and vision coverage is not considered imputed income for California state income tax purposes if you and your domestic partner have registered your partnership with the State of California. This also applies if you married your same-sex spouse in California between June 16, 2008 and November 4, 2008, or if your marriage outside the jurisdiction of California is valid under the laws of the state in which you married.

You must notify your local Benefits Office that you have married or that your partnership is registered with the State of California so that imputed income is not reported for state tax purposes. Use form UPAY 850, available on the At Your Service website or from your local Benefits Office.

¹ 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.

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 continuous 12-month period in an eligible position.

Eligibility and Enrollment

OTHER ELIGIBILITY RULES AND INFORMATION

NO DUPLICATE COVERAGE

You can enroll in UC-sponsored plans as a UC employee or as an eligible family member of a UC employee or retiree, but not as both at the same time. If you are covered as an eligible family member and then become eligible as an employee, you have two options:

- You can opt out of employee coverage, or
- You can enroll yourself after the UC employee or retiree who has been covering you de-enrolls you from his or her plans

Family members may not be covered by more than one UC employee's plan. For example, if a husband and wife both work for UC, their children cannot be covered by both parents.

If duplicate enrollment occurs, UC will cancel the later enrollment.

IF A FAMILY MEMBER LOSES ELIGIBILITY

You are responsible for de-enrolling any family member that loses eligibility. To de-enroll a family member, submit form UPAY 850, available on the At Your Service website or from your Benefits Office, within 31 days of such loss. Don't wait until Open Enrollment to remove the family member from your plan. You are responsible for costs incurred in connection with the enrollment of an ineligible family member, and you could be subject to penalties associated with the misuse of the plan if you continue coverage for family members who no longer meet UC's rules.

De-enrolling a family member who is no longer eligible for UC-sponsored benefit plans does not provide an opportunity for you to change plans.

FAMILY MEMBERS MUST BE DE-ENROLLED IN THE EVENT OF:

Divorce, legal separation, termination of domestic partnership, annulment. Eligibility for your spouse or domestic partner and any children for whom you are not the legal parent/guardian ends on the last day of the month in which the event occurs. Your legally separated spouse, former spouse or former domestic partner and the former partner's child or grandchild may continue certain coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985). To be eligible for COBRA, you or the family member losing coverage must contact your Benefits Office within 60 days of the divorce, annulment, legal separation or termination of domestic partnership.

If a settlement agreement between you and your legally separated/former spouse or domestic partner requires you to provide coverage, you must do so on your own.

An eligible child turns age 26. Unless a child is eligible to continue coverage because of disability, coverage ends at the end of the month in which the child reaches age 26. This rule applies to your natural born and adopted children, stepchildren, grandchildren, step-grandchildren and your domestic partner's children or grandchildren. Certain coverage may be continued under COBRA. To be eligible for COBRA, you or the child losing coverage must contact your Benefits Office within 60 days of the child turning age 26.

A legal ward turns age 18. Eligibility ends at the end of the month in which the legal ward turns 18. Your legal ward may continue certain coverage under COBRA. To be eligible for COBRA, you or the former legal ward must contact your Benefits Office within 60 days of the child turning age 18.

Family member no longer meets all eligibility criteria. See the chart on pages 11 and 12 for eligibility criteria. Eligibility ends at the end of the month in which your family member no longer meets all eligibility criteria.

A family member dies. You should contact your Benefits Office for assistance in the event of an enrolled family member's death.

In addition to de-enrolling ineligible family members from your health plans, remember to change the level of coverage for Expanded Dependent Life and/or Accidental Death and Dismemberment insurance when a dependent is no longer eligible.

ELIGIBILITY VERIFICATION

To control health care costs and meet health plan contract obligations, UC performs periodic reviews to verify family members' eligibility for enrollment in UC benefits plans.

UC and the insurance carriers reserve the right to request documentation (marriage or birth certificates, verification of domestic partnerships, etc.) to verify eligibility. Failure to comply with an audit or request for documentation may result in the de-enrollment of you and your family members and possible legal action.

If UC finds that you have enrolled individuals who are not eligible for coverage, those individuals will be permanently de-enrolled and you and any eligible family members may lose coverage for up to 12 months.

ELIGIBILITY FOR STATE PREMIUM ASSISTANCE

If you are eligible for health coverage from UC, but cannot afford the premiums, some states have premium assistance programs that can help pay for coverage from their Medicaid or Children's Health Insurance Program (CHIP) funds.

If you live in California, you can contact the California Medicaid (Medi-Cal) office for further information (dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx). If you live outside of California, see the At Your Service website (atyourservice.ucop.edu/employees/health_welfare/medical/chipra.html) for a list of states that currently provide premium assistance. You can also contact the U.S. Department of Health and Human Services, Centers for Medicare & Medicare Services at cms.hhs.gov; 877-267-2323, ext. 61565.

FOR MORE INFORMATION

- The chart on pages 8 to 12
- UC Group Insurance Eligibility Factsheet for Employees and Eligible Family Members
- Benefits for Domestic Partners
- Your local benefits office

Benefits Overview

HEALTH CARE

	Benefits Packages			When You May Enroll	During PIE	During OE	90-Day Wait	Automatic	With SOH ¹	Premium Paid By
	Full	Mid-Level	Core							
Medical² Choice of various options depending on your address, including health maintenance organization (HMO), point-of-service (POS), preferred provider organization (PPO), exclusive provider organization (EPO) or a Health Reimbursement Account (HRA). See page 16.	•	•			•	•	•			You and UC
Medical — Core Fee-for-service plan with a high deductible. See page 16.	•	•	•		•	•	•			UC
Dental² Choice of two plans: Delta Dental PPO, a fee-for-service plan, or DeltaCare® USA, a Dental HMO (network available in California only). Both cover preventive, basic and prosthetic dentistry, as well as orthodontics. See page 20.	•				•	•				UC
Vision² Plan covers a variety of vision care services including eye exams, corrective lenses and frames. See page 24.	•				•	•				UC

DISABILITY INSURANCE

	Benefits Packages			When You May Enroll	During PIE	During OE	90-Day Wait	Automatic	With SOH ¹	Premium Paid By
	Full	Mid-Level	Core							
Short-Term Disability 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 27.	•							•		UC
Supplemental Disability³ 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 (\$10,000 monthly maximum). Choice of waiting periods. See page 27.	•				•				•	You
Workers' Compensation Provides state-mandated coverage for work-related injuries.	•	•	•					•		UC

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

¹ The 90-day waiting period is available when the PIE is missed. See page 8. You may need to pay part of your premiums on an after-tax basis.

² 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 genetic information or pre-existing health conditions. The same applies to your eligible family members.

³ If you have a pre-existing condition which causes you to be disabled in your first year of coverage, benefits will be limited to a total of 12 months. For more information, see the insurance carrier's summary plan description.

LIFE AND ACCIDENT INSURANCE

	Benefits Packages			When You May Enroll	During PIE	During OE	90-Day Wait	Automatic	With SOH	Premium Paid By
	Full	Mid-Level	Core							
Basic Life 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 32.	•							•		UC
Core Life Provides employees eligible for Core or Mid-level Benefits with \$5,000 of life insurance. See page 32.		•	•					•		UC
Supplemental Life Provides employees with additional life insurance at group rates. Coverage up to four times annual salary (to \$1,000,000 maximum). See page 33.	•	•			•				•	You
Basic Dependent Life Provides \$5,000 of coverage for employee's spouse or domestic partner and each child. See page 35.	•	•			•				•	You
Expanded Dependent Life Covers spouse or domestic partner for 50% (up to \$200,000) of employee's Supplemental Life amount. Covers each child for \$10,000. See page 35.	•	•			•				•	You
Accidental Death & Dismemberment (AD&D) You may enroll at any time. 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 36.	•	•	•		•					You
Business Travel Accident Provide up to \$500,000 of coverage when an employee travels on official UC business. See page 37 for enrollment instructions.	•	•	•							UC

OTHER INSURANCE

	Benefits Packages			When You May Enroll	During PIE	During OE	90-Day Wait	Automatic	With SOH	Premium Paid By
	Full	Mid-Level	Core							
Legal Provides basic legal assistance for preventive, domestic, consumer and limited defensive legal services. See page 39.	•	•	•		•					You
Automobile and Homeowner/Renter You may enroll at any time. Individually underwritten plan provides coverage for cars, boats, motorcycles, homes and apartments. Carrier underwriting requirements must also be met.	•	•			•					You
Sittercity Provides access to prescreened caregivers, petsitters, tutors and other family services. See page 42.	•	•	•							You

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

Benefits Overview

TAX-SAVINGS PROGRAMS

	Benefits Packages			When You May Enroll	During PIE	During OE	90-Day Wait	Automatic	With SOH	Pretax Salary Reduction
	Full	Mid-Level	Core							
Health Flexible Spending Account (Health FSA) Health Flexible Spending Account (Health FSA). 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 42.	•	•	•		•	•				•
Dependent Care Flexible Spending Account (DepCare FSA) 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 43.	•	•	•		•	•				•
Tax Savings on Insurance Premiums (TIP) Lowers taxable income by allowing payment of health plan premiums (if any) on a pretax basis. See page 45.	•	•	•		•	•		•		•

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

ELIGIBLE FAMILY MEMBERS

	Eligibility	May enroll in	Medical	Dental	Vision	Dependent Life	AD&D	Legal
Legal Spouse^{1,2} Domestic Partner¹ (same-sex/opposite sex) For opposite-sex domestic partners, either the employee or the domestic partner must be age 62 or older and eligible to receive Social Security benefits based on age or supplemental security income for aged individuals; Registered with the State of California or a substantially equivalent same-sex partnership established in another jurisdiction. A domestic partnership that has not been registered with the State of California must meet the following criteria to be a domestic partnership for UC Human Resources purposes: <ul style="list-style-type: none"> Parties must be each other's sole domestic partner in a long-term, committed relationship and must intend to remain so indefinitely Neither party may be legally married or be a partner in another domestic partnership Parties must not be related to each other by blood to a degree that would prohibit legal marriage in the State of California Both parties must be at least 18 years old and capable of consenting to the relationship Both parties must be financially interdependent Parties must share a common residence 	Eligible		•	•	•	•	•	•
Natural or adopted child, stepchild, domestic partner's child³	To age 26		•	•	•	•	•	•
Grandchild, step-grandchild, domestic partner's grandchild³ <ul style="list-style-type: none"> Unmarried Living with you Supported by you or your spouse/domestic partner (50% or more) Claimed as a tax dependent by you or your spouse/domestic partner 	To age 26		•	•	•	•	•	•
Legal ward <ul style="list-style-type: none"> Unmarried Living with you (enrolled 1/1/95 or after) Supported by you or your spouse/domestic partner (50% or more) Claimed as your tax dependent (enrolled 1/1/95 or after) 	To age 18		•	•	•	•	•	•

¹ The surviving family member of a deceased member cannot enroll a spouse or domestic partner (or their children/grandchildren).

² A legally separated or divorced spouse is not eligible for UC-sponsored coverage.

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

Benefits Overview

ELIGIBLE FAMILY MEMBERS (CONTINUED)

Overage disabled child (except a legal ward) of employee

- Unmarried
- Incapable of self-support due to a mental or physical disability incurred prior to age 26
- Enrolled in a UC group medical plan before age 26 and coverage is continuous or, if you are a newly eligible employee with, or have newly acquired, a disabled child over age 26, the child must have had continuous group coverage since age 26
- Chiefly dependent upon you, your spouse or eligible domestic partner for support (50% or more)
- Claimed as your, your spouse's or your eligible domestic partner's dependent for income tax purposes or eligible for Social Security income or Supplemental Security Income as a disabled person. The overage disabled child may be working in supported employment which may offset the Social Security or Supplemental Security Income
- Must be approved by the carrier before age 26 or by the carrier during your PIE if you are a newly eligible employee or if you newly acquire a disabled child over age 26

Eligibility	May enroll in	Medical	Dental	Vision	Dependent Life	AD&D	Legal
Age 26 or older		•	•	•	•	•	•

Enrollment

To be certain you get the insurance coverage you want, you should enroll yourself and your eligible family members when you first become eligible. Usually your period of initial eligibility, or PIE, starts on your hire date and ends 31 days later. The easiest way to enroll is online.

For step-by-step instructions on how to enroll, see the Enrollment Guide you received in your Benefits of Belonging Welcome Kit.

OTHER ENROLLMENT OPPORTUNITIES

If you don't enroll in benefits during your initial 31-day period of eligibility, you may be able to enroll yourself and your family members in some plans at other times, including:

WHEN YOU HAVE A FAMILY CHANGE

When you have a new family member, such as a spouse, domestic partner, newborn or newly adopted child, you may enroll yourself, the new family member and any other eligible family members not already enrolled in your UC-sponsored plans.

If you are enrolled in a UC-sponsored medical plan, you may transfer to a different plan. You may also enroll in or increase your Supplemental Life insurance and Dependent Life insurance during this eligibility period; however, there is no opportunity to enroll in or increase your Supplemental Disability insurance.

You have 31 days from the date your new family member becomes eligible to enroll the new member or to make any permitted plan changes (for example, 31 days from the day you marry or your child is born). Enrollment is not automatic; you must complete a form UPAY 850 (available on At Your Service or from your Benefits Office) to enroll the new family member.

WHEN YOU LOSE OTHER COVERAGE

If you decline enrollment in a UC-sponsored plan because you and/or your family member(s) have other coverage and you later lose the other coverage, you may be eligible to enroll yourself and/or your eligible family member(s) in a UC-sponsored plan. You may also be eligible to enroll if you are enrolled in another employer-sponsored plan and the employer stops contributing to the cost of the coverage.

If you declined UC coverage to continue COBRA coverage, you cannot enroll in a UC-sponsored plan until the next Open Enrollment period or the end of your full COBRA coverage period, whichever occurs first.

You have 31 days from the day you or your family member(s) lose coverage to enroll — unless you lose coverage under Medicaid (Medi-Cal in California) or under a state children's health insurance program (CHIP). In those cases, you have a 60-day enrollment period.

IF YOU ARE A NEW FACULTY MEMBER

Newly appointed faculty members who don't enroll within 31 days of their start date have a second period of eligibility that begins on the first day of classes for the semester or quarter in which the appointment starts or the first day the faculty member arrives at the campus, whichever comes first.

OPEN ENROLLMENT

Usually held in the fall, Open Enrollment is your annual opportunity to make changes to your benefits including:

- Transferring to a different medical or dental plan
- Adding eligible family members
- Enrolling in or opting out of UC-sponsored medical, dental and vision plans
- Opting in or out of Tax Savings on Insurance Premiums (TIP) and
- Enrolling or re-enrolling in the Health and Dependent Care Flexible Spending Accounts

Changes made during Open Enrollment are effective January 1 of the following year.

MEDICAL ONLY: WITH A 90-DAY WAITING PERIOD

If you miss your initial enrollment period, and none of the special enrollment periods described above applies, you may enroll yourself and/or your family members in medical coverage at any time by submitting an enrollment form to your Benefits Office. Your medical coverage will become effective 90 calendar days from the date you submit your form. Your premiums may be paid on an after-tax basis until the following January 1.

LIFE & DISABILITY INSURANCE: WITH A STATEMENT OF HEALTH

If you miss your initial enrollment period, you may apply for Supplemental and Dependent Life Insurance and Supplemental Disability by submitting a statement of health to the insurance company for approval. The insurance company may or may not approve your enrollment based on the statement of health.

A statement of health is also required to increase your life insurance coverage or to reduce your waiting period for Supplemental Disability.

IF YOU MOVE OUT OF A PLAN'S SERVICE AREA

If you move out of an HMO, Anthem Blue Cross PLUS or DeltaCare® USA plan service area, you and your eligible family members must transfer into a different plan available in your new location. If you later return to your plan's service area, you must transfer back.



Medical Plans

Benefits packages: Full, Mid-Level, Core (Core medical plan only)

Who's covered: You and your family members

Who pays: You and UC for most plans

Medical coverage is one of the most important benefits that UC offers you and your eligible family members, and UC makes medical coverage as accessible and affordable as possible.

UC offers a range of high-quality medical plans with comprehensive coverage so you can choose the coverage that best meets your needs. You can select from three choice plans and five value plans. In general, the choice plans offer more flexibility and a wider choice of providers while the value plans have lower costs.

You should carefully evaluate your family circumstances and plan costs before selecting medical plan coverage. If you need more information about a specific medical plan, you'll find telephone numbers and links to all the plans' websites on the inside cover or on At Your Service (atyourservice.ucop.edu).

WHAT THE PLANS COVER

UC's medical plans provide comprehensive coverage including doctor visits, hospital services, prescription drugs and behavioral health services. Preventive care such as physical exams and immunizations are free of charge; some restrictions, such as using in-network providers, may apply.

There are no exclusions for pre-existing conditions.

An overview of the plans UC offers is on pages 16 and 17. The chart on pages 18 and 19 provides a comparison of the plans.

COST OF COVERAGE

Your medical plan's monthly cost depends on:

- The plan you choose,
- Whether you choose to cover yourself only or yourself and other family members, and
- Your annual full-time equivalent salary.

Premium costs are available on the At Your Service website, on the Medical Plan Chooser (uc.chooser.pbgh.org/) and on the Medical Benefits Summary included in your Benefits Welcome Kit.

Please note: if you are represented by a union, your premiums are subject to collective bargaining. Your premiums are available when you sign in to At Your Service Online or talk to your Benefits Office.

Medical

HEALTH MAINTENANCE ORGANIZATIONS (HMO)

HMOs require you to choose a primary care physician (PCP) from their network of providers to coordinate your care. To see a specialist, you must have a referral from your PCP. The HMO covers your expenses only if your PCP has authorized the services, unless it's an emergency. You pay a copayment for some products and services, and there is no annual deductible.

You must live (or work, depending on the plan's rules) in the plan's service area to be eligible. Service areas are established by ZIP codes; you cannot use a P.O. Box to establish eligibility. If you want to know whether your ZIP code is in a plan's service area, check the plan's website or call the plan directly. You can also use the Medical Plan Chooser on the At Your Service website to see if your ZIP code is in a plan's service area.

These plans are available to UC employees living and working in California only.

UC'S HMOs

Health Net HMO (Choice Plan)	Provides a wide network of medical groups, doctors and hospitals, including all of UC's medical centers and medical groups.
Health Net Blue & Gold HMO (Value Plan)	Offers a more tailored network of medical groups, doctors and hospitals than Health Net HMO, but it also includes all of UC's medical centers and medical groups.
Kaiser Permanente-CA (Value Plan)	Is a closed network, meaning you must use only Kaiser doctors and hospitals.
Western Health Advantage (Value Plan)	Provides a regional network of medical groups, doctors and hospitals in the Davis/Sacramento area — including UC Davis Health System

UC'S OTHER MEDICAL PLANS

Anthem Blue Cross Preferred Provider Organization (PPO) (Choice Plan)	PPOs offer a broad network of providers, and allow you the flexibility to see non-network providers if you wish; you don't need a referral to see your primary care doctor or specialists. You pay less if you use a provider in the network. If you use a provider outside the network, you should expect to pay more. You pay separate annual deductibles for in-network and out-of-network benefits. Once the deductible is met, you pay a percentage of the cost of services.
Anthem Blue Cross PLUS (Choice Plan)	This plan combines characteristics of the HMO and the PPO. The in-network services function like an HMO: you choose a primary care physician (PCP) who manages your care and refers you to specialists within the plan network; there are no annual deductibles for in-network services, and you pay a co-payment for in-network services. If you choose to go outside the network, the plan functions more like a PPO: you have an annual deductible and you pay a percentage of the cost of services, but you pay less if you use PPO providers.
Anthem Lumenos PPO with Health Reimbursement Account (Value Plan)	This plan is a PPO with a UC-funded health reimbursement account to help pay your annual deductible. You pay nothing for preventive care and other services until you use up the HRA balance, after which you pay 100 percent of the costs until the full deductible is met. Once the deductible is met, the plan works like a PPO: you pay a percentage of the cost of services, with lower costs for in-network services. If you don't use all of the HRA balance, it rolls over to the next year unless you change to a different plan.
Core Fee-for-Service Plan (Value Plan)	This is UC's high-deductible catastrophic plan. You can choose any doctor, hospital, clinic or behavioral health provider, but you pay less if you use a provider in the Anthem Blue Cross PPO network. After you have met the plan's annual deductible, the plan pays for part of the cost of services. If you use non-network providers, you must pay for services up front and submit a claim; you receive reimbursement if the plan covers the service.

MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

United Behavioral Health (UBH) covers mental health and substance abuse services for all UC-sponsored medical plans except Core Medical. The first three in-network outpatient mental health visits are covered at no cost to you.

Kaiser members have access to Kaiser's integrated behavioral health services as well as UBH in-network services. Kaiser and UBH do not coordinate care or costs of behavioral health services. Each plan has specific requirements; therefore, it is important that you select behavioral health services carefully and follow all plan guidelines and authorization requirements for the behavioral health plan you select.

If you enroll in Anthem Lumenos PPO with HRA, Anthem Blue Cross PLUS or Anthem Blue Cross PPO, you have access to both in-network and out-of-network behavioral health services. All other plans have in-network benefits only.

Core Medical's mental health and substance abuse benefits are provided by Anthem Blue Cross.

UC WELLNESS PROGRAM

Because UC is committed to the well being of employees and their family members, it offers wellness programs as part of its health benefits.

Kaiser members have access to the plan's fully integrated wellness resources. Faculty and staff enrolled in any other medical plan have access to StayWell, a voluntary health management program.⁵

The StayWell program features a health assessment, health improvement programs, wellness coaching and extensive online health resources and interactive tools. See the At Your Service website for more details.

GENERAL INFORMATION

CHOOSING A PRIMARY CARE PHYSICIAN (PCP)

Some medical plans require you to select a primary care physician (PCP). You may choose a different PCP for each family member or the same PCP for the entire family. You may choose a pediatrician as the PCP for your child(ren). If you use your work address to qualify for a plan, you must pick PCPs in the service area of your work address.

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 at any time by calling the plan directly.

If you want to receive care from a particular doctor, you should call the plan or check the plan's online doctor directory to confirm that the doctor is in their network and accepting new patients.

ID CARDS

Once you enroll, the medical plan will send identification cards for you and your enrolled family members. Although you're covered as soon as you enroll, it may take 30 to 60 days for the insurance company to have a record of your membership and send your ID card(s). If you need immediate services before you receive your card, first check with your plan to see if it has a record of your enrollment; if not, contact your Benefits Office.

WHEN COVERAGE ENDS

If your annual average regular paid time drops below 17.5 hours per week or you leave UC employment, you are no longer eligible for medical coverage. You can continue coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) for a period of time. You may be able to convert your coverage to an individual policy if you apply within 31 days of the date your UC-sponsored coverage or COBRA continuation coverage ends.

Conversion options are generally more expensive and may provide fewer benefits than UC-sponsored plans. See your medical plan booklet or call your plan for more information.

FOR MORE INFORMATION

Evidence of Coverage booklets for all of UC's medical plans are available on the At Your Service website under "Forms and Publications" or from the carriers (see front of booklet for contact information).

If you have other questions about your medical benefits including services, benefits, billing and claims, call the medical plan directly (see insert at front of booklet for contact information).

⁵ Participation in the StayWell Health Management program is subject to bargaining with individual unions at UC. Contact your local Benefits Office to find out whether your union is participating in StayWell.

Medical: Value Plans

UC MEDICAL PLANS	Your Monthly Paycheck	Your Costs For Services	Your Cost For Prescription Drugs Generic/Brand/ Non-formulary	Best Fit for People Who:
Anthem Lumenos PPO with HRA May use any doctor without referral from primary care physician; in-network providers cost less. Health Reimbursement Account covers part of annual deductible before PPO benefits apply	\$	\$\$\$ You pay nothing until Health Reimbursement Account is used up; then you have high out-of-pocket costs until deductible is met. You pay a coinsurance thereafter	Full cost up to deductible; then 20% at in-network pharmacies, 40% at non-network pharmacies	<ul style="list-style-type: none"> Want lower premium and broad access to providers Are willing to take an active role in managing care and costs Are able to risk incurring greater out-of-pocket costs
Core You may use any doctor	\$0	\$\$\$+ Except for certain preventive services, you pay the full cost until you reach the \$3,000 deductible. Then you pay 20%	Full cost until you reach the \$3,000 deductible then 20%	<ul style="list-style-type: none"> Want to pay no monthly premium Want protection for catastrophic care Are willing to risk incurring high out-of-pocket costs Want direct access to all providers without need for referrals
Health Net Blue & Gold HMO Must use custom network of providers, except in emergencies	\$\$	\$ No deductible; you pay a copay for office visits and hospital stays; most other services have no charge	Retail (30-day supply) \$5/\$20/\$35 Mail order (up to 90 days) \$10/\$40/\$70	<ul style="list-style-type: none"> Want low premiums and cost per service Are comfortable with HMO model: primary care physician manages care; no out-of-network coverage Are content with the selection of community providers
Kaiser Permanente—CA Must use network providers, except in emergencies	\$	\$ No deductible; you pay a copay for office visits and hospital stays; most other services have no charge	Retail (30-day supply) \$5/\$20/NA Mail order (31-100 days) \$10/\$40/NA	<ul style="list-style-type: none"> Want low premiums and cost per service Are comfortable with getting medical care only within the Kaiser system
Western Health Advantage Must use network providers, except in emergencies	\$	\$ No deductible; you pay a copay for office visits and hospital stays; most other services have no charge	Retail (30-day supply) \$5/\$20/\$35 Mail order (up to 90 days) \$10/\$40/\$70	<ul style="list-style-type: none"> Want low premiums and cost per service Are comfortable with HMO model: primary care physician manages care; no out-of-network coverage

\$ Lowest costs in relation to all plans \$\$ mid-range of costs in relation to all plans \$\$\$ highest costs in relation to all plans

Medical: Choice Plans

UC MEDICAL PLANS	Your Monthly Paycheck	Your Costs For Services	Your Cost For Prescription Drugs Generic/Brand/ Non-formulary	Best Fit for People Who:
Anthem Blue Cross PLUS Use a network doctor for highest benefits, however, out-of-network benefits are available	\$\$\$	\$\$ Annual deductible for out-of-network services only and fewer out-of-pocket expenses for in-network services	Retail (30-day supply) \$10/\$25/\$40 Mail order (up to 90 days) \$20/\$50/\$80	<ul style="list-style-type: none"> Want no deductible and fixed copay for in-network services Accept primary care physician model for in-network care Are willing to pay higher premium for access to out-of-network providers
Anthem Blue Cross PPO May use any doctor without referral from primary care physician; in-network providers cost less	\$\$\$	\$\$\$ Annual deductible and higher out-of-pocket expenses	Retail (30-day supply) \$10/\$25/\$40 Mail order (up to 90 days) \$20/\$50/\$80	<ul style="list-style-type: none"> Are willing to pay higher premiums and cost per service for provider choice Want direct access to all providers without need for referrals Want access to in-network and out-of-network providers
Health Net HMO Must use network providers, except in emergencies	\$\$\$	\$ No deductible; you pay a copay for office visits and hospital stays; most other services have no charge	Retail (30-day supply) \$5/\$20/\$35 Mail order (up to 90 days) \$10/\$40/\$70	<ul style="list-style-type: none"> Accept higher premium to get access to wider network of providers Want lower cost per service Are comfortable with HMO model: primary care physician manages care; no out-of-network coverage

\$ Lowest costs in relation to all plans \$\$ mid-range of costs in relation to all plans \$\$\$ highest costs in relation to all plans

Benefits packages: Full

Who's covered: You and your family members

Who pays: UC

Proper dental care plays an important role in your overall health. That's why UC provides dental coverage for you and your family, including routine preventive care and fillings, oral surgery, dentures, bridges and braces. You have a choice of two plans, a PPO and an HMO.

UC'S DENTAL PLANS

DELTA DENTAL PPO

The Delta Dental PPO plan, available worldwide, provides you and your family with the flexibility to choose any licensed dentist or specialist. Your share of the cost of services depends on whether you use a dentist in Delta Dental's PPO network or an out-of-network dentist.

If you choose a PPO dentist, you will usually pay less for services. PPO dentists agree to accept a reduced fee for services, and the dentist will complete and submit all claim forms for you at no charge. Preventive dentistry — exams and cleanings — is free of charge; basic dentistry, such as fillings and extractions, are covered at 80 percent, and most other dental care is covered at 50 percent, up to \$1,700 per year.

Delta has more than 18,000 PPO dentists in California and 119,000 nationwide. To see a list of Delta Dental PPO dentists, visit the Delta Dental website: deltadentalca.org/uc

Delta's Premier dentists are not in the PPO network but have agreed to accept a reduced fee for services and also will complete and submit claim forms for you. Delta Dental covers only 75 percent of basic dentistry costs if you use a Premier dentist, up to \$1,500 per year.

If you go to a dentist not affiliated with Delta Dental, you may have to pay the dentist's total fee and then submit your claim form to Delta Dental for reimbursement. Delta cannot assure you what percentage of the charged fees may be covered.

DELTACARE® USA

DeltaCare® USA is a dental HMO that provides you and your family with comprehensive benefits and easy referrals to specialists. You must live in California to enroll.

The plan stresses preventive care, so many preventive services are provided at no cost. Other services are provided for modest copayments with no deductibles or annual plan maximum.

When you enroll, you select a network dentist to provide all your basic dental services and to refer you to specialists when necessary. The DeltaCare® USA network consists of private practice dental facilities that have been screened by Delta Dental for quality. Some areas of California have more network providers than others, so be sure there are dentists available in your area before choosing this plan.

You may change your dentist at any time by calling the Delta Care Customer Service number to request the change. Visit the DeltaCare website (deltadentalca.org/uc) for a list of participating dentists.

BENEFITS AND SERVICES

For a comparison of benefits and services, see the chart on pages 21 to 23. You can also use the website uc.chooser2.pbgh.org/dental to compare the two plans.

If you need major dental work, such as a crown, dentures or oral surgery, you and/or your dentist should contact your plan before you begin treatment to confirm that the procedure is covered and to determine your portion of the cost for services.

COST OF COVERAGE

UC pays 100 percent of your monthly dental plan premium. UC's contribution toward the monthly cost is determined by UC and may change or stop altogether. You pay a certain percentage or copayment for some services.

WHEN COVERAGE ENDS

If your annual average regular paid time drops below 17.5 hours per week or you leave UC employment, you are no longer eligible for dental coverage. You can continue coverage under COBRA for a period of time. You may be able to convert your coverage to an individual policy if you apply within 31 days of the date your UC-sponsored coverage or COBRA continuation coverage ends.

Conversion options are generally more expensive and may provide fewer benefits than UC-sponsored plans. See your plan booklet or call your plan for more information.

FOR MORE INFORMATION

Evidence of Coverage booklets are available on the At Your Service website under "Forms and Publications."

If you have other questions about your dental benefits including services, benefits, billing and claims, call the plan directly.

Delta Dental PPO
800-777-5854, deltadentalca.org/uc

DeltaCare® USA
800-422-4234, deltadentalca.org/uc

DENTAL SERVICES	Delta Dental PPO Plan	DeltaCare® USA Plan
Service Area	Worldwide ¹	California Only
Preventive Dentistry	No deductible	Copayments apply as noted
Cleaning of teeth — Prophylaxis cleanings	You are covered at 100% (up to 2 times in a calendar year; additional cleanings by report)	100% up to 2 times in any 12-month period. Additional cleanings when necessary: \$45 copayment for adults, \$35 copayment for children.
Oral examinations	100% (1 routine and 2 non-routine exams per calendar year)	100%
Emergency office visit for pain relief	100%	100%
Topical fluoride treatment	100% (includes cleaning; up to 2 times in a calendar year through age 13)	100% (up to 2 times in any 12-month period through age 18)
Space maintainers	100% (through age 12)	100%
X-rays (full mouth, bitewings, other films)	100% (full mouth x-rays limited to 1 set in 5 years unless necessary)	100% (full mouth x-rays limited to 1 set in any 12-month period)
Pit and fissure sealants (under age 16 only)	100% PPO/75% Premier for first permanent molars through age 9 and second permanent molars through age 15	100% for first permanent molars through age 9 and second permanent molars through age 15

¹ Nationwide — Delta Dental PPO, Delta Dental Premier and non-Delta dentists (licensed); Worldwide — Coverage available only from non-Delta dentists (licensed).

DENTAL SERVICES	Delta Dental PPO Plan	DeltaCare® USA Plan
Basic Dentistry	Deductible applies	Copayments apply as noted
Fillings	80% PPO/75% Premier	100% for standard benefit
Anesthesia ¹	80% PPO/75% Premier (general anesthesia for covered oral surgery)	Local — 100%. General and intravenous Sedation — 100%; limited to medically necessary extractions
Prosthetic appliance repair	80% PPO/75% Premier	100%
Extractions	80% PPO/75% Premier	100% if uncomplicated (not covered if done only for orthodontics)
Oral surgery	80% PPO/75% Premier	\$15 copayment for impactions; other covered services at 100%
Endodontics	80% PPO/75% Premier	\$20 copayment for each canal; other covered services at 100%
Periodontics	80% PPO/75% Premier	\$100 copayment per quadrant for surgery (mucogingival and osseous gingival); \$150 copayment for soft tissue graft procedures; periodontal maintenance: 100% for 1 in each 6-month period; additional maintenance when necessary: \$55 copayment
Denture Relining and Rebase	80% PPO/75% Premier	Relining — 100% (limited to 1 in any 12-month period). Rebase — \$20 copay
Major Dentistry	Deductible applies	Copayments applied as noted
Crowns	50%	\$50 per unit copayment (\$150 extra charge for precious metals)
Inlays/onlays	50%	100% for standard benefit
TMJ Disorder Benefits 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). Deductible applies.	100%
Prosthetic Dentistry	Deductible applies	Copayments apply as noted
Standard, full or partial dentures	50%	Upper — \$65 copayment per denture Lower — \$65 copayment per denture (extra charge for precious metals) Removable partial denture with flexible base — \$115
Bridges	50%	\$50 per unit copayment (extra charge for precious metals)
Implants	50%	Not covered
Total Benefit (Total benefit for preventive, basic and major dentistry; and prosthetic dentistry.)	\$1,700 if a Delta Dental PPO dentist is used; otherwise \$1,500 per person per calendar year	No maximum

After an annual deductible of \$50 per person²

TYPES OF DENTAL PLANS	Delta Dental PPO Plan	DeltaCare® USA Plan
Orthodontics	No deductible	Who is eligible for service
Who is eligible for service	All covered family members	All covered family members
Benefit	50% copayment; maximum of \$1,500 for each eligible patient under age 26 and \$500 for each eligible patient age 26 and older	\$1,000 copayment (plan covers 36 months of usual and customary treatment — a monthly office visit fee of \$75 applies after the 36 months)
Special Provisions, Limitations, Exclusions		
Work in progress when you join	Only services that you receive on or after your effective date of coverage are covered	Only services received from a DeltaCare® USA provider on or after your effective date of coverage are covered ³
Predetermination of benefits	If services are expected to 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 DeltaCare® USA dentist what the charges will be. If you have any questions about what will be covered, call DeltaCare® USA
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 DeltaCare® USA, 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 fewer 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	\$125 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
Tobacco counseling for prevention of oral disease	Not covered	100%

NOTE: Other limitations and exclusions may apply. See the Delta Dental or DeltaCare® USA booklet.

¹ Disabled members may receive anesthesia for any covered dental service if needed to receive treatment. Preauthorization is required.
² Combined for basic and major dentistry, TMJ disorder benefits and prosthetic dentistry.
³ Exception: DeltaCare® USA may cover orthodontia treatment in progress for new enrollees/family members if treatment meets specific DeltaCare® USA criteria.

Vision

VISION PLAN

Benefits package: Full

Who's covered: You and your family members

Who pays: UC

UC provides the Vision Service Plan (VSP) to enable you and your family to get the vision care you need. VSP is a preferred-provider organization with more than 4,000 providers in California and 24,000 nationwide. The vision plan has no exclusions for pre-existing conditions.

WHAT THE PLAN COVERS

- One vision examination per calendar year — including testing and analysis of eye health and any necessary prescriptions for lenses or contact lenses. You pay a \$10 copay.
- One set of corrective lenses per calendar year — including single vision, bifocal, trifocal or other complex glass or plastic lenses. Photo-chromatic lenses, tints and polycarbonate lenses are fully covered if you use a provider in the VSP network. You pay a \$25 copay. If you use a non-VSP provider and you elect tints and polycarbonate options, you receive a \$5 reimbursement.
- One set of frames every other calendar year up to \$130.
- Contact lens allowance of \$110. If you choose elective contact lenses, you cannot also have frames and corrective lenses covered in the same calendar year. If contact lenses are medically necessary and you use a VSP provider, the cost is fully covered. Generally, contacts are covered for those who have had cataract surgery, have extreme acuity problems that cannot be correct with glasses or have some conditions of anisometropia or keratoconus.
- You may also purchase annual supplies of select contact lenses at a reduced cost. Talk to your VSP provider or see the VSP website (vsp.com) for additional details.
- Discounts on laser corrective vision surgery through VSP-contracted laser centers. Call VSP for more information.
- Eye care services for Type 1 diabetics through the Diabetic EyeCare Program. Contact a VSP doctor for more information.

If you use a VSP network doctor or provider, you pay only the required copays for covered services and the cost of any services or materials beyond the allowance. Additional discounts are available for services the plan doesn't cover, including:

- 30 percent discount on additional pairs of glasses, including sunglasses, if purchased from the VSP doctor who provides the member's eye exam on the same day as the exam.
- 20 percent discount for additional pairs of prescription glasses purchased within 12 months following the last covered eye exam, if purchased from the VSP doctor who provided the exam.
- 15 percent discount for contact lens professional services; for example, fittings or adjustments.

COST OF COVERAGE

UC pays the full cost of the monthly vision plan premium. UC's contribution toward the monthly cost of coverage is determined by UC and may change or stop altogether.

You pay copays — \$10 for a vision exam and, if you need glasses, \$25 for materials. You also pay for additional care, services or products that VSP does not cover.

WHEN COVERAGE ENDS

If your annual average regular paid time drops below 17.5 hours per week or you leave UC employment, you are no longer eligible for vision coverage. You can continue coverage under COBRA for a period of time. You may be able to convert your coverage to an individual policy if you apply within 31 days of the date your UC-sponsored coverage or COBRA continuation coverage ends.

Conversion options are generally more expensive and may provide fewer benefits than UC-sponsored plans. See your plan booklet or call your plan for more information.

FOR MORE INFORMATION

VSP website: vsp.com
VSP phone: 800-877-7195

VSP Evidence of Coverage Booklet, available on At Your Service or the VSP website.



Short-Term and Supplemental Disability

Benefits package: Full

Who's covered: You

Who pays: You and UC

An unexpected injury or illness that keeps you out of work for a long time can use up your savings rapidly. Disability insurance can help replace lost wages and can be an important part of your personal financial planning. UC does not participate in the California State Disability Insurance (CA SDI) program, so it's important to consider your enrollment options carefully.

UC's disability benefits, along with state-mandated Workers' Compensation and Social Security disability benefits, create a comprehensive safety net, whether for a few months or a lifetime. UC's disability benefits also provide coverage for female employees during pregnancy and the first few weeks after childbirth.

If you are eligible for Full Benefits, you are automatically enrolled in Short-Term Disability at no cost to you. If you choose to enroll in Supplemental Disability, you pay the premium.

WHAT THE PLANS COVER

SHORT TERM DISABILITY

UC provides the Short-Term Disability plan at no cost to you and does not participate in the California State Disability Insurance (SDI) program.

Short Term Disability insurance provides coverage if you are unable to work due to a pregnancy/childbirth, non-work-related disabling injury or illness. It pays 55 percent of your eligible earnings, up to \$800 per month, for up to six months.

SUPPLEMENTAL DISABILITY

This plan works in conjunction with Short-Term Disability and other sources of disability or retirement income (for example, Workers' Compensation or Social Security) you may receive as a result of your pregnancy/childbirth or disabling injury or illness.

Supplemental Disability, combined with these other sources of disability and retirement income, pays 70 percent of your eligible earnings, up to \$10,000 per month for up to 12 months.

If you are still disabled after 12 months of benefits and are receiving other disability income, the Supplemental Disability plan continues to pay long-term benefits to fill in the difference between those other sources of income and 70 percent of your eligible earnings. The plan pays a minimum of \$100 per month, even if you are receiving a full 70 percent of eligible earnings from other sources. If you have no other source of income, the Supplemental Disability plan alone pays a maximum of 50 percent of your eligible earnings up to \$10,000 per month.

Supplemental Disability plan benefits are payable as long as you remain disabled up to age 65. (If you become disabled after reaching age 60, benefits may continue past age 65. See the insurance plan booklet, available on At Your Service, for more information.)

OTHER SOURCES OF DISABILITY BENEFITS

UC employees may be eligible for other disability benefits including:

- Workers' Compensation, which covers work-related injuries and illnesses;
- UC Retirement Plan disability income, which is available to UCRP members with five or more years of service credit in the event of a permanent or long-term disability (12 months or longer);
- Social Security disability benefits; and
- California State Disability Insurance (if you worked outside of UC and paid into the system within the past 18 months).

HOW THE PLANS WORK

If you are pregnant or have a disabling illness or injury, you apply for disability benefits by contacting your Benefits Office. In order to receive disability benefits, you must be under a doctor's direct, continuous care.

Coverage under both plans is subject to a waiting period, which is the time between the day you are unable to work due to an injury, illness or pregnancy and the day disability benefits start. If you have Short-Term Disability only, the waiting period is 7 days; if you enroll in Supplemental Disability, you may elect a waiting period of 7, 30, 90 or 180 days. That single waiting period will apply to both Short-Term and Supplemental coverage; that is, you will not have a second waiting period at the end of the short-term period.

However, if you have accrued sick leave, you must first use up to 22 working days of sick leave before your benefits start under both Short-Term and Supplemental Disability. As a new

Short-Term and Supplemental Disability

employee, you may want to consider a shorter waiting period until you accrue sufficient sick leave — you can increase your waiting period at any time, but shortening it requires a statement of health and approval of the insurance company.

See the charts on pages 30 and 31 for examples of how the waiting period and benefits work.

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

- Most pregnancy disabilities last only six to eight weeks, so if you choose a 90- or 180-day waiting period, you are not likely to receive any disability income following the birth of your child.
- If you have recently 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.
- If you are a new employee without much sick leave, you might consider a shorter waiting period.
- If you have substantial savings and/or a lot of sick leave, you might choose a longer waiting period with a lower premium. The chart below shows the amount of sick leave needed to cover each waiting period.

SICK LEAVE NEEDED TO COVER WAITING PERIOD

Waiting period (calendar days)	Minimum sick leave needed (working days)	Years of UC employment to earn needed sick leave*
7	5 (40 hours)	0.4
30	22 (176 hours)	1.8
90	66 (528 hours)	5.5
180	131 (1,048 hours)	10.9

* Calculations assume that you work 174 hours a month, earn 8 hours of sick leave per month and do not use any earned sick leave.

IMPORTANT CONSIDERATIONS

- 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. Previously or currently existing medical conditions may prevent approval if you try to enroll outside of a period of eligibility. You must also submit a statement of health for approval in order to shorten your waiting period. Generally, you cannot enroll in Supplemental Disability during UC's annual Open Enrollment or due to family changes.
- Under the Supplemental Disability plan, the definition of disability changes after you receive benefits for 12 months, and it becomes more difficult to meet the insurance carrier's requirements. 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.
- Disabilities related to pre-existing conditions and that begin in your first year of coverage under the Supplemental Disability plan are limited to a total of 12 months of benefits.
- If you are a new UC employee and become disabled, you may have California State Disability Insurance (SDI) coverage through a former employer. Any SDI income you are eligible to receive will be deducted from your disability benefits payable under UC's disability plans.
- Supplemental Disability long-term benefits for disabilities related to mental illness and/or substance abuse are generally limited to a 24-month lifetime maximum benefit, unless you remain continuously hospitalized or in an extended treatment plan.

DISABILITY BENEFITS AND WORKERS' COMPENSATION

The Short-Term Disability plan does not pay benefits for work-related injuries or illnesses that cause disabilities. Instead, Workers' Compensation provides benefits. The Supplemental Disability plan pays benefits for work-related disabilities in coordination with Workers' Compensation.

For Workers' Compensation claims, UC is self-insured and contracts with a third-party administrator to manage its claims. More information is available in the *Business and Finance Bulletin BUS 73—Workers' Compensation Self-Insurance Program*, available on At Your Service or from your local Workers' Compensation Manager. A directory of UC Workers' Compensation Managers is available online at ucop.edu/riskmgt/wcmgr.html.

COST OF COVERAGE

The University provides the Short-Term Disability Plan at no cost to you.

You pay a monthly premium if you enroll in the Supplemental Disability plan. The premium depends on your age and the waiting period you choose. The longer the waiting period, the lower the monthly premium. To calculate your premium, use the Insurance Premium Calculator on the At Your Service website (ucal.us/premiumcalculator).

WHEN COVERAGE ENDS

If your annual average regular paid time drops below 17.5 hours per week or you leave UC employment, you are no longer eligible for coverage. Your coverage stops on your last day actively at work. You may not continue to receive benefits or convert these plans.

FOR MORE INFORMATION

The following publications are available on At Your Service under "Forms and Publications":

- *Disability Factsheet*
- *Disability Benefits Information for Faculty*
- *Pregnancy, Newborn Child and Adoption Factsheet*
- *Partial Disability: Stay at Work/Return to Work Factsheet*
- *Short-Term Disability Insurance Plan Booklet*
- *Supplemental Disability Insurance Plan Booklet*
- *UCRP Disability Handbook*

How Disability Benefits Work

The charts on these pages show how UC's Short-term and Supplemental Disability plans work to provide benefits.

SHORT-TERM DISABILITY PLAN ONLY

Before benefits begin, you must use up to 22 days of sick leave (excluding holidays), if available.

SHORT TERM DISABILITY

Week	1	2	3	4	Week 5 to Week 26
	<ul style="list-style-type: none"> Waiting Period: 7 days or up to 22 days of sick leave and/or vacation Full Pay and Benefits 				<ul style="list-style-type: none"> Short-Term Disability 55% of monthly earnings to \$800 per month

Date you become eligible for disability benefits

SHORT-TERM AND SUPPLEMENTAL DISABILITY PLAN

Short-Term and Supplemental Disability work together based on the waiting period you choose. This means the waiting period you choose for the Supplemental Disability plan automatically becomes your waiting period for the Short-Term Disability Plan as well. Regardless of the waiting period you choose, you must use up to 22 days of sick leave, excluding paid holidays, if available. You may also use additional accrued sick leave and vacation days, 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.

If you have benefits from other sources (for example, Social Security and/or UCRP disability), your Short-Term and Supplemental Disability benefits will be reduced; your combined benefits from all sources cannot exceed 70% of your eligible earnings.

After receiving 12 months of Supplemental Disability benefits, the plan will pay 50% of your eligible earnings to \$10,000 per month.

SHORT-TERM AND SUPPLEMENTAL DISABILITY INSURANCE: 7-DAY WAITING PERIOD

Week	1	2	3	4	Week 5 to Week 52	Week 53 and Beyond
	<ul style="list-style-type: none"> Waiting Period: 7 days or up to 22 days of sick leave and/or vacation Full Pay and Benefits 				<ul style="list-style-type: none"> Short-Term and Supplemental Disability 70% of monthly earnings to \$10,000 per month 	<ul style="list-style-type: none"> 50% of eligible earnings to \$10,000 per month

Date you become eligible

If you have five days of sick leave or fewer, you will receive disability benefits after your seven-day waiting period. If you have more than five days of sick leave, before benefits begin you must use up to 22 days of sick leave, excluding paid holidays, before your benefits begin.

SHORT-TERM AND SUPPLEMENTAL DISABILITY INSURANCE: 30-DAY WAITING PERIOD

Week	1	2	3	4	Week 5 to Week 52	Week 53 and Beyond
	<ul style="list-style-type: none"> Waiting Period: Up to 22 days of sick leave and/or vacation Full Pay and Benefits 				<ul style="list-style-type: none"> Short-Term and Supplemental Disability 70% of monthly earnings to \$10,000 per month 	<ul style="list-style-type: none"> 50% of eligible earnings to \$10,000 per month

Date you become eligible

SHORT-TERM AND SUPPLEMENTAL DISABILITY INSURANCE: 90-DAY WAITING PERIOD

Week	Week 1 to Week 13	Week 14 to Week 52	Week 53 and Beyond
	<ul style="list-style-type: none"> Waiting Period: Up to 66 days of sick leave and/or vacation Full Pay and Benefits 	<ul style="list-style-type: none"> Short-Term and Supplemental Disability 70% of monthly earnings to \$10,000 per month 	<ul style="list-style-type: none"> 50% of eligible earnings to \$10,000 per month

Date you become eligible

SHORT-TERM AND SUPPLEMENTAL DISABILITY INSURANCE: 180-DAY WAITING PERIOD

Week	Week 1 to Week 26	Week 27 to Week 52	Week 53 and Beyond
	<ul style="list-style-type: none"> Waiting Period: Up to 131 days of sick leave and/or vacation Full Pay and Benefits 	<ul style="list-style-type: none"> Short-Term and Supplemental Disability 70% of monthly earnings to \$10,000 per month 	<ul style="list-style-type: none"> 50% of eligible earnings to \$10,000 per month

Date you become eligible

Life and Accident Insurance

Benefits package: Full (Basic), Mid-Level (Core) and Core (Core)

Who's covered: You

Who pays: UC

Life insurance provides financial protection for your dependents in the event of your death, and can be important to their future security. UC automatically provides basic life insurance coverage for all eligible employees. And you may be eligible to buy additional coverage for yourself and your family members.

UC's life insurance plans carry no exclusions based on the cause of death. They are group term life plans that provide coverage at special rates to group members — in this case, UC employees. UC's life insurance is in effect only as long as you remain an eligible employee, and do not accumulate a cash value over time.

UC provides a minimum amount of life insurance coverage at no cost to you. The plan and amount of coverage varies, depending on your appointment rate and average regular paid time.

WHAT THE PLANS COVER

BASIC LIFE

This plan provides life insurance equal to your annual base salary, up to \$50,000.⁷ 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 is later.

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. Your beneficiaries receive these benefits in addition to any other death benefits for which you may qualify.

CORE LIFE

This plan provides \$5,000 of life insurance.⁸

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. Your beneficiaries receive these benefits in addition to any other death benefits for which you may qualify.

OTHER FEATURES OF THE PLANS

LIVING BENEFIT OPTION

The "living benefit" option allows terminally ill employees to receive some of their life insurance benefits before death; the money can be used for any purpose. The insurance company pays you 75 percent of the total coverage amount in a lump sum or in 12 equal monthly installments. Benefits paid to your beneficiaries at the time of your death are reduced by the amount previously paid to you. See the life insurance plan booklet for more information.

EXTENDED DEATH BENEFIT

The Basic or Core Life Insurance protection may continue up to one year beyond the date coverage terminates if you become totally disabled while covered under the Plan and are you are under age 65. You must remain continuously unable to engage in any occupation until the date of death. Protection continues for one year, until you reach age 65, or until your disability ends, whichever occurs first.

COST OF COVERAGE

UC pays the entire cost of your coverage for Basic or Core Life insurance. UC's contribution toward the monthly cost of coverage is determined by UC and may change or stop altogether.

WHEN COVERAGE ENDS

If your annual average regular paid time drops below 17.5 hours per week or you leave UC employment, you are no longer eligible for Basic or Core Life insurance. You may be able to convert your coverage to an individual policy if you apply within 31 days of the date your UC-sponsored coverage ends.

Conversion options are generally more expensive and may provide fewer benefits than UC-sponsored plans. See your plan booklet or call your plan for more information.

BENEFICIARIES

You should designate your beneficiaries online by signing in to At Your Service Online. If you don't name beneficiaries, benefits are paid to the first survivor in this list:

- Your legal spouse or domestic partner
- Your child or children, including your adopted children; if your child is deceased, his/her child or children receives your deceased child's share
- Your parent or parents
- Your sibling or siblings

If there is no such survivor, any lump sum death payment will be paid to your estate.

You may change your designated beneficiary at any time using At Your Service Online. Once your new designation is processed, all previous designations are invalid. Changes in your family situation — such as marriage, divorce or birth of a child — do not automatically alter or revoke your previous designations. A will also does not supersede a beneficiary designation. Prior designations remain valid until you change your designations online.

If you do not have access to the Internet, you may complete UC's *Designation of Beneficiary* form (UBEN 116), available from your Benefits Office.

Supplemental Life Insurance

Benefits Package: Full and Mid-level

Who's covered: You

Who pays: You

Eligible employees may supplement their Basic or Core Life insurance coverage by enrolling in this plan and paying monthly premiums. You can choose the amount of coverage that meets your needs.

WHAT THE PLAN COVERS

You may choose one of several 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 million

Coverage is based on your UC salary and appointment rate as of your date of hire or the full-time salary rate for your position as of January 1 of the current year, whichever is later — even if you work part time. If your full-time salary rate is reduced, coverage will not be reduced until the beginning of the next calendar year.

Benefits are paid to your beneficiaries if you die while enrolled. They 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.

PLAN FEATURES

LIVING BENEFIT OPTION

The "living benefit" option allows terminally ill employees covered by the plan to receive a portion of their life insurance benefits before death. The benefit — 75 percent of the total coverage, up to \$250,000 — is paid directly to you in a lump sum or in 12 equal monthly installments. The money can be used for any purpose. The benefit that would otherwise be payable to your beneficiaries at death is reduced by this amount. Your life insurance plan booklet has more information.

⁷ If you are a member of the California Public Employees' Retirement System (CalPERS), CalPERS provides \$5,000 of coverage and UC provides coverage equal to your annual base salary less \$5,000, up to \$45,000.

⁸ This plan does not cover CalPERS members.

Supplemental Life Insurance

WAIVER OF PREMIUM

If you 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.

IMPORTANT CONSIDERATIONS

If you do not enroll in the Supplemental Life plan during a period of eligibility, you must submit a statement of health and be approved by the insurance company in order to enroll. Previous or current medical conditions may prevent your approval if you try to enroll outside of an eligibility period.

If you are on leave for health reasons on the day you become eligible for Supplemental Life coverage, your coverage will start the day after your first full day at work.

For information on beneficiaries, see page 33.

COST OF COVERAGE

Your cost for Supplemental Life depends on your age and the amount of coverage you purchase. Use the Insurance Premium Calculator on At Your Service to determine your monthly premium. (atyourservice.ucop.edu/applications/insurance_premium_est/index.php)

WHEN COVERAGE ENDS

If you leave UC employment, you are no longer eligible for Basic or Core Life insurance. You may be able to port or convert your coverage if you apply within 31 days of the date your UC-sponsored coverage ends.

The Portability Benefit allows you to continue your current UC Supplemental life coverage at Prudential's Portability group term-life rates, which are lower than the conversion premium rates. A statement of health is not required but you must submit proof of good health satisfactory to Prudential to qualify for preferred rates.

You have 31 days from the date your coverage ends to submit your application and the appropriate premiums to Prudential. See your Benefits Office for more information.

Conversion options are generally more expensive and may provide fewer benefits than UC-sponsored plans. See your plan booklet or call your plan for more information.

Dependent Life Insurance

Benefits Package: Full and Mid-Level

Who's covered: Your spouse or domestic partner and/or your eligible children

Who pays: You

UC offers two plans for insuring your eligible family members. You can enroll your dependents in the Basic Dependent Life plan if you are enrolled in Basic Life or in the Expanded Dependent Life plan, which provides more coverage, if you are also enrolled in the Supplemental or Senior Management Life plan. You may cover your family members under either plan, but not under both.

WHAT THE PLANS COVER

BASIC DEPENDENT LIFE

This plan covers your spouse or domestic partner and/or your eligible children; the benefit is \$5,000 for each dependent. See pages 11 and 12 for each family member's requirements for eligibility. You are the beneficiary if a covered dependent dies.

EXPANDED DEPENDENT LIFE

You may choose to cover:

- Your legal spouse or domestic partner with a benefit amount equal to 50 percent of your Supplemental Life insurance amount, up to a maximum benefit of \$200,000, and/or
- Your eligible children with a benefit of \$10,000 each

You are the beneficiary if a covered dependent dies. You may designate someone else to receive benefits if a covered spouse or domestic partner dies. You cannot designate an alternate beneficiary for covered children. Use the *Designation of Alternate Beneficiary — Expanded Dependent Life and AD&D Insurance* form (UBEN 119), which is available on the At Your Service website.

Living Benefit Option: This option allows a terminally ill spouse or domestic partner covered for at least one year to receive some of their life insurance benefits before death. The benefit — 50 percent of the total benefit, up to \$50,000 — is paid directly to the spouse or partner in a lump sum or in 12 equal monthly installments. The money can be used for any purpose. The benefit that would otherwise be payable to beneficiaries at death is reduced by the amount paid to you. Your life insurance plan booklet has more information.

COST OF COVERAGE

Use the Insurance Premium Calculator on the At Your Service website to determine your monthly premium. (atyourservice.ucop.edu/applications/insurance_premium_est/index.php)

IMPORTANT CONSIDERATIONS

If both you and a family member are UC employees, you may choose to cover yourself under the Supplemental Life plan or, if eligible, under your family member's Dependent Life plan. You cannot be covered by both plans.

If you miss your period of initial eligibility, you must submit a statement of health when enrolling a spouse or domestic partner. This is not required for children — children may be enrolled at any time. The insurance company may or may not accept your request for enrollment based on the statement of health.

You may transfer your dependents from the Expanded plan to the Basic plan at any time. However, to transfer your spouse or domestic partner from the Basic plan to the Expanded plan, you must submit a statement of health for that person.

WHEN COVERAGE ENDS

If you leave UC employment, you are no longer eligible for Basic or Expanded Dependent Life insurance. You may be able to port or convert your coverage if you apply within 31 days of the date your UC-sponsored coverage ends.

If you participate in Prudential's group term-life Portability benefit for your Supplemental Life insurance (see page 34), you may also continue dependent life coverage within the same Portability benefit. See your Benefits Office for more information.

You may also be eligible to convert your Dependent Life to an individual policy if:

- Your UC-sponsored coverage ends, or
- You become totally disabled and you are covered under the Supplemental Life waiver of premium benefit.

You must apply for the conversion option within 31 days of the date your UC-sponsored coverage ends.

Conversion options are generally more expensive and may provide fewer benefits than UC-sponsored plans. See your plan booklet or call your plan for more information.

FOR MORE INFORMATION

This is an overview of your life insurance benefits. You'll find more information and tools, such as a life insurance needs estimator, on Prudential's microsite for UC employees (www.prudential.com/media/managed/UC_Index.html). A copy of the life insurance plan booklet is available on the At Your Service website under "Forms & Publications," "Life Insurance."

Accidental Death and Dismemberment Insurance

Benefits Package: Full, Mid-Level, Core

Who's covered: You and your family members

Who pays: You

The financial impact of an accident can be devastating. To help protect you and your family from the financial hardship of an unforeseen accident, UC offers Accidental Death and Dismemberment (AD&D) insurance.

WHAT THE PLAN COVERS

The plan provides \$10,000 to \$500,000 coverage for accidental death, dismemberment or loss of sight, speech or hearing caused by an accident. It offers three levels of coverage:

- Individual coverage for you only
- Family coverage for you, your spouse or eligible domestic partner and your child(ren)
- Modified family coverage for you and your child(ren)

If you are on leave for health reasons on the day you become eligible for coverage, your coverage starts the day after your first full day at work.

THE PLAN OFFERS THESE ADDITIONAL BENEFITS:

Seatbelt Benefit: The plan pays an additional 10 percent if you or a covered family member dies in a car accident while using a seatbelt or airbag.

Indemnity for a Child's Dismemberment or Paralysis: The plan pays a percentage of the covered amount if an accident causes irreversible paralysis of a covered child. The percentage payable depends on the degree of the paralysis.

Rehabilitation Benefit: The plan will pay up to \$10,000 for covered rehabilitative expenses for two years after the date of an accident that causes dismemberment or paralysis. Work-related injuries covered under Workers' Compensation or other similar laws are excluded.

Education Benefit: Under family or modified family coverage, if you die in a covered accident, the plan pays for your child's higher education — either the actual tuition or 5 percent of your coverage amount, up to \$10,000, but not less than \$1,500 per school year, whichever is less.

Day Care Benefit: The plan will pay for up to four years of day-care expenses for covered children under age 13 if you die due to a covered accident.

Repatriation of Remains: If you or a covered dependent suffer an accidental death while at least 100 miles from home, the plan will pay for covered expenses up to \$50,000 to return your body or the body of a covered dependent to your home.

Common Disaster Benefit: If you and your covered spouse both die in the same accident within 90 days of the covered accident, your spouse's principal benefit amount will be increased to equal yours to a maximum of \$500,000.

Coma Benefit: The plan will pay a portion of your benefits when a covered accident renders you or a covered family member comatose within 30 days of the accident.

Natural Disaster: The plan will pay 10 percent if you or a covered family member suffers loss as a result of a natural disaster (i.e., storm, earthquake, flood).

Permanent & Total Disability Benefit: (for employee only.) See plan booklet for details.

COST OF COVERAGE

Your cost depends on the level of coverage and coverage amount you choose. Use the rate chart on the At Your Service website (atyourservice.ucop.edu/employees/health_welfare/accidental_death_dismemberment/costs.html) to determine your monthly premium.

WHEN COVERAGE ENDS

If you leave UC employment, you may be able to convert your coverage to an individual policy if you apply within 31 days of the date your UC-sponsored coverage ends.

Conversion options are generally more expensive and may provide fewer benefits than UC-sponsored plans. See your plan booklet or call your plan for more information.

EXCLUSIONS

There are certain exclusions under the AD&D Insurance. See your Plan Booklet for more information.

FOR MORE INFORMATION

This is only an overview of your AD&D benefits. The AD&D plan booklet, available on the At Your Service website, provides additional details.

Business Travel Accident Insurance

Benefits Packages: Full, Mid-Level, Core

Who's covered: You and your traveling companion(s)

Who pays: UC

UC faculty and staff traveling on official UC business are covered, at no cost to you, worldwide 24 hours a day for a variety of accidents and incidents.

WHAT THE PLAN COVERS

The coverage includes:

- Accidental death
- Accidental dismemberment
- Paralysis
- Permanent total disability benefits
- Evacuation in the event of a security emergency
- Travel assistance services when you are 100+ miles from your home and workplace (see below for more information)

Your spouse/domestic partner, dependent child(ren) or other traveling companion are covered when accompanying you on a business trip.

TRAVEL ASSISTANCE SERVICES

In addition to insurance protection, the plan gives you access to travel services around the world, including:

Medical assistance such as referral to a doctor or medical specialist, medical monitoring if you are hospitalized, emergency medical evacuation to an adequate facility, medically necessary repatriation and return of remains.

Personal assistance such as emergency medication, embassy and consular information, assistance with lost documents, emergency message transmission, emergency cash advance, emergency referral to a lawyer, access to a translator or interpreter, medical benefits verification and assistance with medical claims.

Travel assistance including vehicle return and emergency travel arrangements for the return of your traveling companion or dependents.

HOW THE PLAN WORKS

You are covered automatically for business travel within the state of California and when you make travel arrangements through Connexus, UC's systemwide travel program. For all other out-of-state and international business trips, you must register your travel online at www.uctrips-insurance.org. Once registered, you will receive confirmation of coverage for your trip and information to use in the event of an emergency.

You will also receive current travel alerts for your destination as well as information about changing conditions that may arise during the course of your travel. The plan also gives you access to general information about your destination including information about security, health, communications and technology, transportation, legal, entry and exit, financial, weather and environment, language and culture.

BENEFICIARIES

For purposes of accidental death benefits, the designated beneficiaries are the same as those you name for UC-provided Basic or Core Life insurance, unless you make a separate beneficiary designation.

To change your beneficiary designation, visit the At Your Service website and select "Sign in to My Accounts." After you log in, select "My Beneficiaries" and then "Add Change Delete." Be sure to confirm any changes you make.

You may also designate your beneficiaries by submitting UC's Designation of Beneficiary form (UBEN 116).

Your beneficiary designation remains in effect until it is either changed or revoked. It does not automatically end with the return from a business trip.

FOR MORE INFORMATION

Additional information, including frequently asked questions, a summary of coverage and claim forms is available online at www.uctrips-insurance.org.



Legal Insurance

Benefits Package: Full, Mid-Level, Core

Who's covered: You and your family members

Who pays: You

Most people need legal advice at one time or another, but high legal fees often prevent you from getting the necessary assistance. For a small monthly premium, UC offers the ARAG Legal plan, which gives you access to a range of legal services. The plan provides assistance with routine preventive or defensive matters and covers most basic legal needs.

WHAT THE PLAN COVERS

- Legal consultation including general legal advice, document preparation and review, preparation of wills and durable powers of attorney;
- Matrimonial proceedings including divorce, separation, annulment, child support, visitation and/or alimony;
- Consumer protection including legal representation for enforcement of warranties or promises in connection with lease or purchase of goods or services. Small Claims Court actions and disputes over real estate construction matters are not included;
- Defense of misdemeanor charges except traffic charges;
- Defense in traffic matters that will directly lead to license suspension;
- Major trial representation, up to and including four days;
- Identity theft services, with toll-free access to identity theft case managers;
- Online legal tools and resources such as the Do-It-Yourself Legal Documents™ that enable you to create documents such as powers of attorney;
- Reduced fees for non-covered matters when using an attorney from ARAG's Reduced Fee Network. (Some exclusions apply.)

Benefits are limited to one claim per item per year, whether you have individual or family coverage, except for attorney office work, estate planning, wills, trust benefits and telephone legal services. See the plan booklet for plan limitations and exclusions.

HOW TO USE THE PLAN

Before consulting any attorney, call ARAG to be sure the plan serves you to your best advantage. When you call ARAG, a customer care counselor will advise you on the services the plan will cover and send you a claim form, description of coverage and current list of the plan's network.

All network attorneys have met ARAG's requirements and agreed to provide the services described in the chart on pages 40 and 41. When you use a network attorney, fees for most covered matters are paid in full.

ARAG network attorneys provide services in two ways:

- 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. Using telephone network attorneys can help you get the most from the plan. By using this service whenever possible, you can reserve other plan benefits for more serious matters.
- Office appointments: The plan pays the network attorney's hourly fee for up to eight hours a year. 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.

If you prefer, you may use an attorney outside the ARAG network for general advice. In that case, the plan pays a rate of \$70 per hour, up to \$560 a year.

COST OF COVERAGE

Your monthly cost depends on whether you choose individual or a family coverage option. See the plan costs chart on the At Your Service website.

WHEN COVERAGE ENDS

If you leave UC employment, you may be able to convert your coverage to an individual policy if you apply within 31 days of the date your UC-sponsored coverage ends. See your plan booklet or call ARAG for more information.

FOR MORE INFORMATION

See the plan booklet on At Your Service.

Visit the ARAG website: ARAGLegalCenter.com; enter access code 11700uc.

Call ARAG: 800-828-1395 or TTD: 800-383-4184, M-F, 9am–5pm, PT.

Once you enroll, ARAG will send you additional information.

What the Plan Covers

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. For the following services, you may use an attorney from ARAG's network or any attorney you choose.

For a list of network attorneys, a claim form or a complete list of limitations and exclusions, log on to ARAGLegalCenter.com (enter access code 11700uc) or call an ARAG Customer Care Counselor at 800-828-1395.

This document is for illustrative purposes only and is not a contract.

WORLDWIDE COVERAGE PER FAMILY EACH CALENDAR YEAR

Attorney Office Work	Network Attorney	Non-Network Attorney
Advice, negotiation and service for legal matters that are not listed as a covered benefit or exclusion under the plan. The benefit covers such matters as sale or purchase of a residence, problems with a landlord, administrative hearings (e.g., Social Security, Medicare and other public benefits).	Up to 8 hours ¹	\$560
Simple wills and simple trusts (including Power of Attorney) ^{2,3}	Fully paid	\$175
Codicils to wills, living wills ^{2,3}	Fully paid	\$70
Durable Power of Attorney ²	Fully paid	\$70
Domestic Proceedings	Network Attorney	Non-Network Attorney
Uncontested divorce (for self use only)	Fully paid	\$525
Contested divorce (for self use only)	Fully paid	\$700
Child support, visitation and/or alimony in conjunction with a modification of divorce decree or a separation or annulment agreement	Fully paid	\$280
Child custody/child support not in conjunction with a modification of a divorce decree or a separation or annulment agreement	Fully paid	
• Legal services required for the creation of a child custody, child support or visitation agreement		\$245
• Modification/enforcement of an uncontested child custody, child support or visitation agreement		\$294
• Modification/enforcement of a contested child custody, child support or visitation agreement		\$490
Establishment of guardianship/conservatorship	Fully paid	\$420
Adoption proceedings ⁴	Fully paid	\$420
Name change	Fully paid	\$280

WORLDWIDE COVERAGE PER FAMILY EACH CALENDAR YEAR (CONTINUED)

Defense	Network Attorney	Non-Network Attorney
Criminal misdemeanor defense (except traffic violations) ⁴	Fully paid	\$700
Habeas Corpus proceedings	Fully paid	\$420
Juvenile court hearings — if juvenile is covered dependent	Fully paid	\$490
Defense of a lawsuit for the collection of a debt based on a contract or other written instrument ⁴	Fully paid	\$630
Personal bankruptcy	Fully paid	\$560
Defense of traffic matter that will directly result in license suspension ⁴	Fully paid	\$350
Defense against civil damage(s) claims: advice, negotiation and office work ⁵	Fully paid	\$700
Defense against civil damage(s) claims including legal representation ⁵	Fully paid	\$3,100 ⁶
Consumer Protection Actions	Network Attorney	Non-Network Attorney
Consumer protection (except for disputes over real estate/construction matters) ⁴	Fully paid	\$350
IRS Audit Protection	Network Attorney	Non-Network Attorney
IRS Collection Defense prior to trial	\$1,800 ⁷	\$1,800 ⁷
IRS Collection Defense Court representation at trial as a defendant	\$1,200 ⁷	\$1,200 ⁷
IRS Audit Advice, consultation and negotiation	\$420 ⁷	\$420 ⁷
Representation at IRS Audit	\$900 ⁷	\$900 ⁷
Major Trial	Network Attorney	Non-Network Attorney
Representation at trial beginning on the fourth day of trial (\$400 per one-half day of trial time) in covered proceedings for which indemnity benefits are being provided.	Included with Covered Benefits	\$100,000 ⁸

¹ The eight hours under attorney office work may be used for more involved trust matters and post-dissolution matters as a result of bifurcated dissolution.

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

³ In conjunction with this benefit, the eight hours allowed under the attorney office work may be used for more involved trust matters.

⁴ Four-day trial limitation.

⁵ Except claims involving motorized vehicle or claims which are covered by other insurance.

⁶ Trial Indemnity Benefits of \$2,400 for up to three days of trial time are included in this amount (\$400 per one-half day of trial time).

⁷ 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

⁸ This coverage is paid at a rate of \$400 per one-half day of trial time.

Family Care Benefit

Benefits package: Full, Mid-Level, Core¹

Who's covered: You and your family members

Who pays: UC pays for access; you pay for care

One of the toughest challenges many working families face is finding the right caregivers for their loved one. Whether you need a full-time nanny or an emergency back-up eldercare provider — even a pet sitter — Sittercity can help. If you are traveling to a conference or for business, you can use Sittercity to find a caregiver at most destinations.

Sittercity is the nation's largest website for connecting you with quality local in-home caregivers. Through the Sittercity website, you have access to local caregivers with profiles that include qualifications, background checks, references, parent reviews and more.

HOW THE PLAN WORKS

You register on Sittercity's website specifically for UC faculty and staff (sittercity.com/universityofcalifornia). Then you can review local providers based on criteria you select. You can also post your job on the Sittercity website, and providers can respond. You interview, check references and background checks, select and make all payment arrangements directly with the provider.

COST OF COVERAGE

UC pays the fee for access to the Sittercity website. You make arrangements with the providers you hire, including all payments to them.

WHEN COVERAGE ENDS

Your access to Sittercity ends when you leave UC employment or move to an ineligible position.

FOR MORE INFORMATION

Sittercity.com/universityofcalifornia
888-SIT-CITY Option 1

¹ Participation in Sittercity is subject to bargaining with individual unions at UC. Contact your local Benefits Office to find out whether your union is participating in Sittercity benefit.

Health and Dependent Care Flexible Spending Account Plans

Benefits Package: Full, Mid-Level, Core

Who's covered: You and your family members

Who pays: You

UC's Health and Dependent Care Flexible Spending Account Plans (FSAs) allow you to pay for eligible out-of-pocket expenses on a pretax basis. As a result, your salary is reduced before taxes are assessed, and you pay less in taxes.

HOW THE PLANS WORK

You determine the annual amount of your contributions to a plan. An equal portion of that amount is deducted from your paycheck and credited to your Health FSA and/or DepCare FSA account. When you have eligible expenses, you pay them from your account.

It's important to estimate your annual expenses carefully, because the Internal Revenue Service requires that you forfeit any unclaimed funds in your account after the closing date for the plan year; these are "use it or lose it" plans.

Each plan has its own rules, so be sure to read the details about each plan below.

ENROLLMENT AND CHANGES IN PARTICIPATION

You may enroll when you first become eligible, when you have an eligible change in family or employment status, or during Open Enrollment.

You enroll in the FSAs for the plan year, which ends on December 31 of each year. You must re-enroll during Open Enrollment to participate the following year.

You may also change your contribution or cancel participation during a 31-day period of eligibility resulting from an eligible change in family or employment status. Mid-year changes must be on account of and consistent with the change in status. See the Health or DepCare FSA Summary Plan Description for details regarding what types of changes are allowed.

Enrollment and changes in contributions take effect on the first of the month following the action taken, subject to payroll deadlines.

PLAN ADMINISTRATION

CONEXIS is the plan administrator for the FSA; they handle all claims processing and reimbursement. **CONEXIS must receive claims for a plan year by April 15th of the following year in order to reimburse the expenses; for example, they must receive claims for the 2012 plan year by April 15, 2013.** Claims incurred for a plan year include claims incurred during the January 1 to March 15 "grace period" of the following year.

HEALTH FSA

The Health FSA allows you to pay for eligible out-of-pocket health care expenses on a pre-tax basis. The Health FSA covers expenses for yourself, your legal spouse, your children up to age 26 or anyone else you claim as a dependent on your federal income tax return. Expenses must meet the requirements of Internal Revenue Code (IRC) §213(d) in order to be eligible for reimbursement.

Eligible expenses include:

- Copayments and deductibles, but not premiums
- Prescription drugs
- Orthodontia
- Eyeglasses and contact lenses
- Laser eye surgery
- Other health care expenses that are not reimbursed by your medical, dental or vision plan

Note that while an expense may be an eligible tax deduction, it may not be an eligible expense under the Health FSA (for example, insurance premiums). Expenses reimbursed under the Health FSA may not be deducted on your federal income tax form.

You must incur expenses between January 1 of the plan year and March 15 of the following year in order to be eligible for reimbursement. Expenses incurred after your Health FSA participation ends are not eligible for reimbursement. If you enroll mid-year, expenses incurred before the date your enrollment is effective are not eligible for reimbursement. The effective date generally is the first of the month following your enrollment, but it may be later depending on payroll deadlines.

If you enroll in the Health FSA, you will be issued a Benefit Card that can be used to pay for eligible health care expenses at approved health care merchants such as doctors' offices and pharmacies. Instead of paying first and then filing a claim for reimbursement, the expenses are automatically deducted from your account. In most cases you will need to provide CONEXIS, the plan administrator, with documentation to substantiate the eligibility of your expenses.

Expenses submitted for reimbursement are carefully evaluated against the IRC eligibility requirements. If your expenses are not clearly eligible according to the IRC, you will need to submit additional information to CONEXIS and you may not be reimbursed for these expenses. See the CONEXIS website (conexis.com/employees) or the Health FSA Summary Plan Description for more information.

CONTRIBUTION LIMITS AND FORFEITURE RULES

You may contribute a minimum of \$180 to a maximum of \$5,000 annually to your health FSA. If both 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 if you miscalculate your anticipated expenses or misunderstand what expenses are eligible. The IRS requires that you forfeit any unclaimed funds in your account after the closing date for the plan year.

DEPENDENT CARE FSA

The DepCare FSA allows you to pay for eligible expenses for care of your child or eligible adult dependent on a pretax basis. After you incur eligible dependent care expenses, you submit a claim form and receipts for the expenses to CONEXIS, the plan administrator. CONEXIS reimburses you through an automatic deposit to your bank or by check.

ELIGIBLE EXPENSES

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 in order to participate in the DepCare FSA. If you are married, your spouse must also have earned income during the year, unless your spouse is incapable of self-care or is a full-time student.

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.

Health and Dependent Care Flexible Spending Accounts

Eligible expenses must be 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 legal spouse (as defined under federal law) who is physically or mentally incapable of self-care; and
- A dependent who lives with you — such as a child over age 13, a parent, sibling, in-law or other adult — 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.

You must incur expenses between January 1 of the plan year and March 15 of the following year in order to be eligible for reimbursement. Expenses incurred after your DepCare FSA participation ends are not eligible for reimbursement. If you enroll mid-year, expenses incurred before the date your enrollment is effective are not eligible for reimbursement. The effective date generally is the first of the month following your enrollment, but may be later depending on payroll deadlines.

Expenses submitted for reimbursement are carefully evaluated against the IRC requirements for eligible expenses. If your expenses are not clearly eligible according to the IRC, you will need to submit additional information to CONEXIS and you may not be reimbursed for these expenses. In some cases, you may need a tax advisor's statement certifying the eligibility of the expense.

See the CONEXIS website (uc.conexisfsa.com), IRS Publication 503, Child and Dependent Care Expenses (available on the IRS website at irs.gov) or the DepCare FSA Summary Plan Description for more information.

CONTRIBUTION LIMITS AND FORFEITURE RULES

When you enroll in the DepCare FSA, you determine how much you want deducted from your monthly pay, from a minimum of \$180 per year (\$15 per month) to the least 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. (You may not contribute to the DepCare FSA if your spouse's earned income is \$0 and your spouse is capable of self-care or is not a full-time student.)

The maximum contribution to the DepCare FSA is the same regardless of your marital status or the number of eligible dependents.

If your spouse is also eligible to participate in UC's or another employer's dependent care FSA, your combined contributions cannot exceed the contribution maximum.

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 IRS requires that you forfeit any unclaimed funds in your account after the closing date for the plan year.

DEPCARE FSA AND DEPENDENT CARE TAX CREDIT

Your participation in the DepCare FSA may or may not provide more tax savings than using the federal dependent care tax credit. Any payment from the DepCare FSA reduces, dollar for dollar, the expenses eligible for the dependent care tax credit. Your tax savings from the FSA depend on your particular tax situation. For a general comparison of the DepCare FSA with the tax credit, see the DepCare FSA Summary Plan Description.

If you need specific advice about how the DepCare FSA applies to your tax situation, please consult a tax advisor.

FOR MORE INFORMATION

This is only an overview of the Health and DepCare Flexible Spending Account plans. Be sure to review the Summary Plan Descriptions, available on At Your Service. Additional information about the FSA plans is available on the CONEXIS website (uc.conexisfsa.com) and the At Your Service website (atyourservice.ucop.edu).

Tax Savings on Insurance Premiums

Benefits Package: Full, Mid-level, Core

Who's covered: You, your legal spouse, your children and other tax dependents

Who pays: There are no costs

The Tax Savings on Insurance Premiums (TIP) program allows you to pay your medical plan premiums, if any, on a pretax basis.

HOW THE PLAN WORKS

If you enroll in a medical plan that requires you to pay a premium, you are automatically enrolled in TIP. Each month your taxable earnings are reduced by the amount of your premium 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 are strictly on taxes and will depend on your particular tax situation.

Because TIP reduces your taxable earnings, it may also reduce your earnings for Social Security and unemployment benefits. If you have questions or concerns, you should consult a tax advisor about how TIP applies to your situation.

You may cancel your participation in TIP when you are first eligible to enroll in benefits, during Open Enrollment or during a period of eligibility caused by an eligible change in employment or family status.

PREMIUMS ELIGIBLE FOR TIP

In addition to any premium costs for your coverage, the premiums for family members who meet the plan's eligibility requirements and are enrolled in your medical plan will be paid before taxes are withheld. These family members may include:

- Your legal spouse (as defined under federal law),
- Your natural or adopted child(ren),
- Your step-child(ren) if they are the children of your opposite-sex spouse, and
- The following family members if they are your tax dependents: grandchild(ren), step-grandchild(ren), disabled child(ren) age 26 and older and legal ward(s)

The monthly costs for your same-sex spouse or domestic partner and/or your spouse's/partner's child(ren) or grandchild(ren) must be paid on an after-tax basis unless these family members are your dependents as defined under the Internal Revenue Code.

Exception: The premiums for medical coverage for your same-sex spouse or domestic partner, your spouse's/partner's children (including overage disabled child(ren)), and your spouse's/partner's grandchildren who are your California tax dependents may be deducted from pay on a pretax basis for California income tax purposes if:

- You and your same-sex spouse were married in California between June 16, 2008, and November 4, 2008 or at any time in another jurisdiction where the marriage would be valid, or
- You have registered your domestic partnership with the state of California.

In either case, you must submit a UC form UPAY 850 indicating that you are married to your same-sex spouse or that your domestic partnership is registered with the state of California in order to have the premiums deducted on a pretax basis.

CHANGES IN PARTICIPATION

TIP salary reductions can be canceled or restarted only during Open Enrollment or a period of eligibility, as set forth in the Internal Revenue Code (IRC).

If you go on a leave without pay or lose benefits eligibility due to a reduction in your appointment rate, your participation in TIP automatically ends.

If you make a change to your medical plan due to an eligible change in employment or family status while participating in TIP, your TIP amount will adjust automatically. At most other times, IRC rules require that your TIP salary reduction amount stay the same despite increases or decreases in your net premiums.

FOR MORE INFORMATION

For plan details see the Tax Savings on Insurance Premiums (TIP) Summary Plan Description, available on the At Your Service website, or from your Benefits Office.



Legal Notifications

PARTICIPATION TERMS AND CONDITIONS

Your Social Security number is required for purposes of benefit plan administration, for financial reporting, to verify your identity or for legally required reporting purposes, all in compliance with federal and state laws.

Participants in all UC-sponsored plans are subject to the following terms and conditions:

- With the exception of benefits provided by United Behavioral Health, UC-sponsored medical plans require resolution of disputes through arbitration. With regard to each plan, **it is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under the contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to the contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.** For more information about each plan's arbitration provision, please see the appropriate plan booklet or call the plan.
- UC and UC health plan vendors comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other federal/state laws and regulations related to the privacy of personal health information. To fulfill their contracted responsibilities and services, health plans and associated service vendors may share UC member health information between and among each other within the limits established by HIPAA and federal/state regulations for purposes of health care operations, payment and treatment. A member's requested restriction on the sharing of specified protected health information for health care operations, payment and treatment will be honored as required by HIPAA.
- By making an election with your written or electronic signature, you are authorizing the University to take deductions from your earnings (employees)/monthly Retirement Plan income (retirees) to cover your contributions toward the monthly costs, if any, for the plans you have chosen for yourself and your eligible family members.
- You acknowledge and accept all terms and conditions of the UC-sponsored plans in which you are enrolled as stated in the plan booklets and "UC's Group Insurance Regulations."
- If you enroll family members, the University and/or carrier may require proof of eligibility. Marriage or birth certificates, domestic partner verification, adoption papers, tax records and the like may be requested. You agree to provide such documentation upon request.

- If you enroll your eligible same-sex spouse or domestic partner and/or an eligible child or grandchild of your same-sex spouse or domestic partner and such family member is not claimed as your tax dependent, you acknowledge that the UC/ employer contribution for their medical and/or dental and/or vision coverage may be reported as income to you and (where appropriate) may be subject to FICA (Social Security and Medicare) and/or federal/state income tax withholding.
- If you specifically ask UC representatives to intercede on your behalf with your insurance plan, University representatives will request the minimum necessary protected health information required to assist you with your problem. If more protected health information is needed to solve your problem, in compliance with state laws and federal privacy laws, including HIPAA, you may be required to sign an authorization allowing UC to provide the insurance plan with relevant protected health information or authorizing the insurance plan to release such information to the University representative.
- Actions you take during Open Enrollment will be effective the following January 1, unless otherwise stated — provided all electronic and form transactions have been properly completed.
- You certify that all enrolled family members are eligible for coverage based on the definitions and rules specified in the UC publications, "Group Insurance Eligibility Factsheet for Employees and Eligible Family Members" and "Group Insurance Eligibility Factsheet for Retirees and Eligible Family Members". You agree that you will de-enroll them within 31 days if they lose eligibility. You further certify that all the information you provide is true to the best of your knowledge, under penalty of perjury.
- Making false statements about satisfying eligibility criteria, failing to notify the University of loss of eligibility within 31 days of such loss, or failing to provide documentation when requested may lead to de-enrollment of the affected family members and possible legal action. In addition, employees/retirees may be subject to disciplinary action (e.g., loss of health benefits for up to 12 months).

If a conflict exists between this book and UC's Group Insurance Regulations, the regulations govern.

Legal Notifications

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

HIPAA CERTIFICATE OF CREDITABLE COVERAGE

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

This certificate provides evidence of your previous medical plan coverage. Your new insurance carrier may need this certificate if the plan/policy would otherwise exclude coverage or impose a waiting period for certain pre-existing medical conditions. Contact your medical plan directly if you do not receive a certificate. Enrolled family members who live at a different address from you should contact the plan to send a certificate to their addresses.

HIPAA NOTIFICATION OF MEDICAL PROGRAM ELIGIBILITY

If you decline enrollment for yourself and/or your eligible family members because of other medical insurance or group medical plan coverage, you may be able to enroll yourself and/or your eligible family members¹ in a UC-sponsored medical plan if you and/or your eligible family members lose eligibility for that other coverage (or if the employer stops contributing toward the other coverage for you and/or your family members).

You must request enrollment within 31 days after your and/or your family members' other medical coverage ends (or after the employer stops contributing toward the other coverage).

If you decline enrollment for yourself and/or for an eligible family member because of coverage under Medicaid (in California, Medi-Cal) or a state children's health insurance program (CHIP) and you lose eligibility for that coverage, you may be able to enroll yourself and your eligible family members in a UC-sponsored plan. You must request enrollment within 60 days after your or your family members' coverage ends under Medicaid or CHIP.

Also, if you are eligible for health coverage from UC but cannot afford the premiums, some states have premium assistance programs. See page 7.

In addition, if you have a newly eligible family member as a result of marriage, domestic partnership, birth, adoption, or placement for adoption you may be eligible to enroll yourself and your eligible to enroll yourself and your eligible family members. You must request enrollment within 31 days after the marriage/partnership, birth, adoption or placement for adoption.

If you do not enroll yourself and/or your family member(s) within the 31 days (60 days for Medicaid or CHIP) when first eligible, you may enroll at a later date; however, each member will need to complete a waiting period of 90 consecutive calendar days before medical coverage becomes effective. You/they can also enroll during the next Open Enrollment period.

To request special enrollment or obtain more information, contact your local Benefits Office.

Note: If you are enrolled in a UC medical plan, you may be able to change medical plans if:

- You acquire a newly eligible family member; or
- Your eligible family member loses other coverage.

In either case you must request enrollment within 31 days of the occurrence.

COBRA CONTINUATION

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

If you are enrolled in the Health Flexible Spending Account (FSA) and you leave UC employment during the plan year, you may be able to continue your participation under COBRA through the end of the current plan year (December 31) by making direct, after-tax payments to your account.

The COBRA administrator will send you a "Qualifying Event Notice" which explains the procedure for continuing your participation. For more information about COBRA continuation privileges, see the At Your Service website or contact your Benefits Office.

NOTICE REGARDING ADMINISTRATION OF BENEFITS

By authority of The Regents, University of California Human Resources, located in Oakland, administers all benefit plans in accordance with applicable plan documents and regulations, custodial agreements, University of California Group Insurance Regulations, group insurance contracts and state and federal laws. No person is authorized to provide benefits information not contained in these source documents, and information not contained in these source documents cannot be relied upon as having been authorized by The Regents. Source documents are available for inspection upon request (800-888-8267). What is written here does not constitute a guarantee of plan coverage or benefits — particular rules and eligibility requirements must be met before benefits can be received. The University of California intends to continue the benefits described here indefinitely; however, the benefits of all employees, retirees and plan beneficiaries are subject to change or termination at the time of contract renewal or at any other time by the University or other governing authorities. The University also reserves the right to determine new premiums, employer contributions and monthly costs at any time. Health and welfare benefits are not accrued or vested benefit entitlements. UC's contribution toward the monthly cost of the coverage is determined by UC and may change or stop altogether, and may be affected by the state of California's annual budget appropriation. If you belong to an exclusively represented bargaining unit, some of your benefits may differ from the ones described here. For more information, employees should contact your Human Resources Office and retirees should call the UC Customer Service Center (800-888-8267).

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 Systemwide AA/EEO Policy Coordinator, University of California, Office of the President, 1111 Franklin Street, 5th Floor, CA 94607, and for faculty to Associate Director of Academic Personnel, University of California, Office of the President, 1111 Franklin Street, Oakland, CA 94607.

¹ To be eligible for plan membership, you and your family members must meet all UC eligibility requirements for coverage. All plan members are subject, as a condition of coverage, to eligibility verification by the University and/or insurance carriers.

