

Medical Benefits Summary: 2012
(Non-Medicare)

PLAN	HOSPITAL SERVICES				PHYSICIAN VISITS						OTHER BENEFITS						PRESCRIPTION DRUGS		BEHAVIORAL HEALTH ¹				
	Inpatient	Surgeon/Assistant Surgeon	Emergency Room	Ambulance	Office Visit	Hospital Visit	Preventive Physical Exam	Maternity Outpatient Care	Maternity Inpatient Care	Well Baby Care	Hospice Inpatient and Outpatient	Home Health Care	Skilled Nursing Facility	Outpatient X-Ray and Lab	Eye Exams	Chiropractor	Acupuncture	Retail (Up to 30-day supply)	Mail Order (Up to 90-day supply)	Mental Health Inpatient	Mental Health Outpatient	Substance Abuse Inpatient	Substance Abuse Outpatient
Health Net HMO	\$250 copayment per admittance	No charge	\$50 (waived if admitted)	No charge	\$15	No charge	No charge	No charge	\$250 copayment per admittance	No charge to age 2	No charge	No charge	No charge (up to 100 days/ calendar year)	No charge	\$15	Not covered (discount program available)	Not covered (discount program available)	Generic: \$5 Brand: \$20 Non-Formulary: \$35	Generic: \$10 Brand: \$40 Non-Formulary: \$70	\$250 copayment per admittance or course of treatment (preauthorization required)	Visits 1–3: No copayment. Visits 4+: \$15 (waived for children through age 6)	\$250 copayment per admittance or course of treatment (preauthorization required)	Visits 1–3: No copayment. Visits 4+: \$15 (waived for children through age 6)
Health Net Blue & Gold HMO	\$250 copayment per admittance	No charge	\$50 (waived if admitted)	No charge	\$15	No charge	No charge	No charge	\$250 copayment per admittance	No charge to age 2	No charge	No charge	No charge (up to 100 days/ calendar year)	No charge	\$15	Not covered (discount program available)	Not covered (discount program available)	Generic: \$5 Brand: \$20 Non-Formulary: \$35	Generic: \$10 Brand: \$40 Non-Formulary: \$70	\$250 copayment per admittance or course of treatment (preauthorization required)	Visits 1–3: No copayment. Visits 4+: \$15 (waived for children through age 6)	\$250 copayment per admittance or course of treatment (preauthorization required)	Visits 1–3: No copayment. Visits 4+: \$15 (waived for children through age 6)
Health Net Primary EPO	\$250 copayment per admittance	No charge	\$50 (waived if admitted)	No charge	\$15	No charge	No charge	No charge	\$250 copayment per admittance	No charge to age 2	No charge	No charge	No charge (up to 100 days/ calendar year)	No charge	\$15	Not covered (discount program available)	Not covered (discount program available)	Generic: \$5 Brand: \$20 Non-Formulary: \$35	Generic: \$10 Brand: \$40 Non-Formulary: \$70	\$250 copayment per admittance or course of treatment (preauthorization required)	Visits 1–3: No copayment. Visits 4+: \$15 (waived for children through age 6)	\$250 copayment per admittance or course of treatment (preauthorization required)	Visits 1–3: No copayment. Visits 4+: \$15 (waived for children through age 6)
Kaiser—CA (HMO)	\$250 copayment per admittance	No charge	\$50 (waived if admitted)	No charge	\$15	No charge	No charge	No charge	\$250 copayment per admittance	No charge to age 2	No charge	No charge (up to 100 visits/calendar year) (part time or intermittent care only)	No charge (up to 100 days/ calendar year)	No charge	No charge if part of a routine physical exam	Not covered	\$15 (medically necessary)	30-day supply—Generic: \$5; Brand: \$20; 31–60 day supply—Generic: \$10; Brand: \$40; 61–100 day supply—Generic: \$15; Brand: \$60. Non-Formulary: does not apply	30-day supply—Generic: \$5; Brand: \$20; 31–100 day supply—Generic: \$10; Brand: \$40. Non-Formulary: does not apply	\$250 copayment per occurrence or admittance	\$15 for individual visit; \$7 for group visit	\$250 copayment per occurrence or admittance. \$100 copayment for home transitional residential recovery services	\$15 for individual visit; \$5 for group visit
Western Health Advantage (HMO)	\$250 copayment per admittance	No charge	\$50 (waived if admitted)	No charge	\$15	No charge	No charge	No charge	\$250 copayment per admittance	No charge to age 2	No charge	No charge	No charge (up to 100 days/ calendar year)	No charge	No charge if part of a routine physical exam	Not covered	Not covered	Generic: \$5 Brand: \$20 ⁴ Non-Formulary: \$35	Generic: \$10 Brand: \$40 ⁴ Non-Formulary: \$70	\$250 copayment per admittance (preauthorization required)	Visits 1–3: No copayment. Visits 4+: \$15 (waived for children through age 6)	\$250 copayment per admittance (preauthorization required)	Visits 1–3: No copayment. Visits 4+: \$15 (waived for children through age 6)
Anthem Blue Cross PLUS In-Network	\$250 copayment	No charge	\$75 per visit (waived if admitted)	No charge	\$20	No charge	No copayment	\$20 first visit, no charge thereafter	\$250 copayment	No charge up to age 7	No charge	No charge	No charge	No charge if part of a routine physical exam	\$20 (Network Panel only)	\$20 (ASHP Network Panel only)	Generic: \$10 Brand Formulary: \$25 Non-Formulary: \$40	Generic: \$20 Brand Formulary: \$50 Non-Formulary: \$80	\$250 copayment per admittance	Visits 1–3: No copayment. Visits 4+: \$15 (waived for children through age 6)	\$250 copayment per admittance	Visits 1–3: No copayment. Visits 4+: \$15 (waived for children through age 6)	
Anthem Blue Cross PLUS Out-of-Network	30% (\$200 penalty if services are not preauthorized)	30%	\$75 per visit (waived if admitted)	30% (no copayment if emergency)	30%	30%	30% (age 7 and older)	30%	30%	No charge up to age 7 (deductible waived)	30%	30%; not covered if services are not preauthorized. (up to 100 visits/calendar year)	30%; not covered if services are not preauthorized. (up to 240 days/calendar year)	30%	Not covered	Not covered	Not covered	At non-participating pharmacies: 50%	No mail order benefit	30% (\$200 penalty if treatment is not preauthorized)	30% (no visit limit)	30% (\$200 penalty if treatment is not preauthorized)	30% (no visit limit)
Anthem Blue Cross PPO In-Network	20% (\$200 penalty if services are not preauthorized)	20%	20%	20%	20%	20%	No charge (deductible waived)	20% (deductible waived)	20%	No charge up to age 7 (deductible waived)	20%	20%; preauthorization required. (up to 100 visits/calendar year combined PPO and non-PPO)	20%; preauthorization required. (up to 240 days/ calendar year combined PPO and non-PPO)	20%	No charge if part of a routine physical exam	20%	20%	Generic: \$10 Brand Formulary: \$25 Non-Formulary: \$40	Generic: \$20 Brand Formulary: \$50 Non-Formulary: \$80	20%	Visits 1–3: No copayment. Visits 4+: 20% (waived for children through age 6)	20%	Visits 1–3: No copayment. Visits 4+: 20% (waived for children through age 6)
Anthem Blue Cross PPO Out-of-Network	40% (\$200 penalty if services are not preauthorized)	40%	20%	20%	40%	40%	40% (deductible NOT waived) age 7 and older	40% (deductible NOT waived)	40%	No charge up to age 7	20%	40%; preauthorization required. (up to 100 visits/calendar year combined PPO and non-PPO)	40%; preauthorization required. (up to 240 days/ calendar year combined PPO and non-PPO)	40%	Not covered	40%	40%	At non-participating pharmacies: 50%	No mail order benefit	40% (\$200 penalty if treatment is not preauthorized)	40% (no visit limit)	40% (\$200 penalty if treatment is not preauthorized)	40% (no visit limit)
Anthem Lumenos PPO with HRA In-Network	20%	20%	20%	20%	20%	20%	No charge (HRA & deductible waived)	20%	20%	No charge (HRA & deductible waived)	20%	20% (up to 180 visits/ calendar year)	20% (up to 180 days/ calendar year)	20%	No charge if part of a routine physical exam	20% (20 visit limit/calendar year combined with acupuncture)	20% (20 visit limit/calendar year combined with chiropractor)	20%	20%	20%	Visits 1–3: No copayment. Visits 4+: 20% (waived for children through age 6)	20%	Visits 1–3: No copayment. Visits 4+: 20% (waived for children through age 6)
Anthem Lumenos PPO with HRA Out-of-Network	40% (\$500 penalty if treatment is not preauthorized)	40%	20% (40% if not true emergency)	20%	40%	40%	40%	40%	40%	40%	40%	40% (up to 180 visits/ calendar year)	40% (up to 180 days/ calendar year)	40%	40% (medically necessary)	40% (20 visit limit/calendar year combined with acupuncture)	40% (20 visit limit/calendar year combined with chiropractor)	40%	No mail order benefit	40% (\$500 penalty if treatment is not preauthorized)	40% (no visit limit)	40% (\$500 penalty if treatment is not preauthorized)	40% (no visit limit)
Core (Fee-for-service)	20% (\$500 penalty if services are not preauthorized)	20%	20%	20%	20%	20%	Network: No charge (deductible waived) Non-Network: 20%	20%	20%	No charge (deductible waived)	20%	20% (up to 100 visits/ calendar year)	20% (up to 120 days/ calendar year)	20%	No charge if part of a routine physical exam	20%	20% (\$500 maximum/ calendar year)	20%	No mail order benefit	20%	20%	20%	20%

Note: Benefits show what member pays.

This is a summary only. Important details—such as limitations, exclusions, exceptions, and other qualifiers—may not be included. For detailed information, call the plan or see their website for specific benefits, benefits when traveling overseas, provider information, and plan booklets.

Service areas: To determine if a medical plan provides service where you live, call the plan directly.

For plan website links, visit UC's Human Resources website, At Your Service (atyourservice.ucop.edu).

¹ One family member may satisfy entire deductible. Deductibles cross accumulate between PPO and non-PPO and includes HRA dollars.

² Unlimited annual rollover. Covered eligible expenses include medical, prescription and behavioral health charges. This is the amount if you enroll during Open Enrollment. The HRA is prorated if you enroll during the plan year.

³ United Behavioral Health provides behavioral health benefits for plans except Core. Core members receive behavioral health benefits through their medical plan. Kaiser members have access to the Kaiser benefit shown, in addition to the UBH in-network benefits and network of providers.

⁴ If a brand name medication is dispensed when a generic is available, the member will pay the generic copayment plus the difference in price between the brand and the generic regardless of medical necessity.

By authority of The Regents, University of California Human Resources, located in Oakland, administers all benefit plans in accordance with applicable plan documents and regulations, custodial agreements, University of California Group Insurance Regulations, group insurance contracts, and state and federal laws. No person is authorized to provide benefits information not contained in these source documents, and information not contained in these source documents cannot be relied upon as having been authorized by The Regents. Source documents are available for inspection upon request (1-800-888-8267). What is written here does not constitute a guarantee of plan coverage or benefits—particular rules and eligibility requirements must be met before benefits can be received. The University of California intends to continue the benefits described here indefinitely; however, the benefits of all employees, retirees, and plan beneficiaries are subject to change or termination at the time of contract renewal or at any other time by the University or other governing authorities. The University also reserves the right to determine new premiums, employer contributions and monthly costs at any time. Health and welfare benefits are not accrued or vested benefit entitlements. UC's contribution toward the monthly cost of the coverage is determined by UC and may change or stop altogether, and may be affected by the state of California's annual budget appropriation. If you belong to an exclusively represented bargaining unit, some of your benefits may differ from the ones described here. For more information, employees should contact your Human Resources Office and retirees should call the UC Customer Service Center (1-800-888-8267).

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides for continued coverage for a certain period of time at applicable monthly COBRA rates if you, your spouse, or your dependents lose group medical, dental, or vision coverage because you terminate employment (for reasons other than gross misconduct); your work hours are reduced below the eligible status for these benefits; you die, divorce, or are legally separated; or a child ceases to be an eligible dependent. Note: The continuation period is calculated from the earliest of these qualifying events and runs concurrently with any other UC options for continued coverage. See your Benefits Representative for more information.

In conformance with applicable law and University policy, the University is an affirmative action/equal opportunity employer. Please send inquiries regarding the University's affirmative action and equal opportunity policies for staff to 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.

Which medical plan is right for me?

MEDICAL PLANS COMPARISON

Employee Medical Plan Costs

UC will continue to pay the greater portion of monthly medical plan premiums in 2012, and employees will pay the balance as shown in the tables.

Four Rate Levels Based on Salary

Four rate tables (“pay bands”) are shown here. Your pay band, and thus your premium, is based on your full-time salary rate as of January 1, 2011. This structure allows UC to provide larger monthly employer contributions for those earning less to help alleviate a disproportionate premium burden on them.

FOR THOSE WITH FULL-TIME SALARY RATE OF \$48,000 OR LESS

PLAN	S	+C	+A	+S, C, A
Anthem Blue Cross PLUS	\$75.24	\$135.43	\$204.63	\$264.83
Anthem Blue Cross PPO	\$52.57	\$94.63	\$157.02	\$199.09
Anthem Lumenos PPO with HRA	\$8.07	\$14.53	\$16.95	\$23.40
Core	0.00	0.00	0.00	0.00
Health Net Blue & Gold HMO	\$23.08	\$41.55	\$95.10	\$113.56
Health Net HMO	\$79.27	\$142.69	\$213.10	\$276.52
Kaiser Permanente—California	\$8.07	\$14.53	\$16.95	\$23.40
Kaiser Permanente Umbrella*	\$95.92	\$172.66	\$248.06	\$324.80
Western Health Advantage (WHA)	\$8.07	\$14.53	\$16.95	\$23.40

FOR THOSE WITH FULL-TIME SALARY RATE OF \$48,001–\$96,000

PLAN	S	+C	+A	+S, C, A
Anthem Blue Cross PLUS	\$111.29	\$200.32	\$286.93	\$375.97
Anthem Blue Cross PPO	\$88.62	\$159.52	\$239.32	\$310.23
Anthem Lumenos PPO with HRA	\$44.12	\$79.42	\$99.25	\$134.54
Core	0.00	0.00	0.00	0.00
Health Net Blue & Gold HMO	\$59.13	\$106.44	\$177.40	\$224.70
Health Net HMO	\$115.32	\$207.58	\$295.40	\$387.66
Kaiser Permanente—California	\$44.12	\$79.42	\$99.25	\$134.54
Kaiser Permanente Umbrella*	\$131.97	\$237.55	\$330.36	\$435.94
Western Health Advantage (WHA)	\$44.12	\$79.42	\$99.25	\$134.54

S: Self +C: Self Plus Child(ren) +A: Self Plus Adult +S, C, A: Self Plus Adult and Child(ren)
*Closed to new members

FOR THOSE WITH FULL-TIME SALARY RATE OF \$96,001–\$144,000

PLAN	S	+C	+A	+S, C, A
Anthem Blue Cross PLUS	\$148.29	\$266.92	\$360.69	\$479.33
Anthem Blue Cross PPO	\$125.62	\$226.12	\$313.08	\$413.59
Anthem Lumenos PPO with HRA	\$81.12	\$146.02	\$173.01	\$237.90
Core	\$0.00	\$0.00	\$0.00	\$0.00
Health Net Blue & Gold HMO	\$96.13	\$173.04	\$251.16	\$328.06
Health Net HMO	\$152.32	\$274.18	\$369.16	\$491.02
Kaiser Permanente—California	\$81.12	\$146.02	\$173.01	\$237.90
Kaiser Permanente Umbrella*	\$168.97	\$304.15	\$404.12	\$539.30
Western Health Advantage (WHA)	\$81.12	\$146.02	\$173.01	\$237.90

FOR THOSE WITH FULL-TIME SALARY RATE GREATER THAN \$144,000

PLAN	S	+C	+A	+S, C, A
Anthem Blue Cross PLUS	\$186.60	\$335.88	\$437.11	\$586.40
Anthem Blue Cross PPO	\$163.93	\$295.08	\$389.50	\$520.66
Anthem Lumenos PPO with HRA	\$119.43	\$214.98	\$249.43	\$344.97
Core	\$0.00	\$0.00	\$0.00	\$0.00
Health Net Blue & Gold HMO	\$134.44	\$242.00	\$327.58	\$435.13
Health Net HMO	\$190.63	\$343.14	\$445.58	\$598.09
Kaiser Permanente—California	\$119.43	\$214.98	\$249.43	\$344.97
Kaiser Permanente Umbrella*	\$207.28	\$373.11	\$480.54	\$646.37
Western Health Advantage (WHA)	\$119.43	\$214.98	\$249.43	\$344.97

S: Self +C: Self Plus Child(ren) +A: Self Plus Adult +S, C, A: Self Plus Adult and Child(ren)
*Closed to new members

DEFINITIONS

CALENDAR YEAR DEDUCTIBLE:

The amount you must pay for medical services before the plan will provide benefits.

ANNUAL OUT-OF-POCKET MAXIMUM:

The amount you must pay during the calendar year before the plan will pay 100% of covered charges. Some expenses do not apply toward the maximum; see the plan's evidence of coverage booklet.

COPAYMENTS:

Shown in dollars; represents the amount you pay.

COINSURANCE:

Shown as a percentage; represents the percentage of the usual, customary and reasonable amount you pay.

USUAL, CUSTOMARY AND REASONABLE (UCR):

UCR is the amount established by insurance companies to determine the maximum amount they will consider eligible for reimbursement. Your provider may charge substantially more than the UCR and you will be responsible for the difference.

¹ One family member may satisfy entire deductible. Deductibles cross accumulate between PPO and non-PPO and includes HRA dollars.

² Unlimited annual rollover. Covered eligible expenses include medical, prescription and behavioral health charges. This is the amount if you enroll during Open Enrollment. The HRA is prorated if you enroll during the plan year.

Medical Benefits Summary: 2012

(Non-Medicare)

PLAN	COSTS		
	Calendar Year Deductible	Health Reimbursement Account	Annual Out-of-Pocket Maximum—Medical Benefits
Health Net HMO 1-800-539-4072	\$0	Not applicable	One person: \$1,000 Family (3 persons or more): \$3,000
Health Net Blue & Gold HMO 1-800-539-4072	\$0	Not applicable	Individual: \$1,000 Family (3 persons or more): \$3,000
Health Net Primary EPO 1-800-539-4072	\$0	Not applicable	Individual: \$1,000 Family (3 persons or more): \$3,000
Kaiser—CA (HMO) 1-800-464-4000	\$0	Not applicable	Individual: \$1,500 Family (2 persons or more): \$3,000
Western Health Advantage (HMO) 1-888-563-2250	\$0	Not applicable	Individual: \$1,000 Family (3 persons or more): \$3,000
Anthem Blue Cross PLUS In-Network (POS) 1-888-209-7975	\$0	Not applicable	Individual: \$1,500 Family (3 persons or more): \$4,500
Anthem Blue Cross PLUS Out-of-Network 1-888-209-7975	Individual: \$500 Family: \$1,500	Not applicable	Individual: \$5,000 Family (3 persons or more): \$15,000
Anthem Blue Cross PPO In-Network (PPO) 1-888-209-7975	Individual: \$250 Family: \$750	Not applicable	Individual: \$3,000 Family (3 persons or more): \$9,000
Anthem Blue Cross PPO Out-of-Network 1-888-209-7975	Individual: \$500 Family: \$1,500	Not applicable	Individual: \$6,000 Family (3 persons or more): \$18,000
Anthem Lumenos PPO with HRA In-Network 1-888-209-7975	Combined Deductible ¹ : Employee: \$1,700; Employee & Adult: \$2,550; Employee & Children: \$2,550; Family: \$3,400	Combined HRA ² : Employee: \$1,000; Employee & Adult: \$1,500; Employee & Children: \$1,500; Family: \$2,000	Individual: \$5,000 Family (3 persons or more): \$10,000 (does not cross accumulate)
Anthem Lumenos PPO with HRA Out-of-Network 1-888-209-7975	Combined Deductible ¹ : Employee: \$1,700; Employee & Adult: \$2,550; Employee & Children: \$2,550; Family: \$3,400	Combined HRA ² : Employee: \$1,000; Employee & Adult: \$1,500; Employee & Children: \$1,500; Family: \$2,000	Individual: \$10,000 Family (3 persons or more): \$20,000 (does not cross accumulate)
Core (Fee-for-service) 1-888-209-7975	Individual: \$3,000	Not applicable	Individual: \$7,600