University of California

Your Group Insurance Plans

2009

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Introduction

The University of California is one of the top academic institutions in the world and takes pride in the caliber of its faculty and staff who carry out its mission of education, research and public service.

Accordingly, the University offers to its employees a top-notch total compensation package, which includes not only salary and a generous retirement plan, but also comprehensive health and welfare benefits.

As one of the largest employers in California with employees in a wide range of job and careers, UC strives to provide a high-quality, affordable and flexible benefits program to its diverse and unique workforce.

Please take some time to read this booklet, which provides information about the UC-sponsored health and welfare plans, to help you make important choices for you and your family. Then, keep this booklet as a handy resource for future reference when you have questions about your benefits or want to make changes.

Please also visit the At Your Service website (atyourservice.ucop.edu) for UC benefits news and detailed benefits information. For questions, you may also contact the Benefits Office at your location. (See page 12.)

Subject to plan amendments, the benefits information in this edition of *Your Group Insurance Plans* is effective January 1, 2009 through December 31, 2009.

General Information

Eligibility

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

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

You must be appointed to a position eligible for health and welfare benefits.

Initial Requirements

Full Benefits

You are eligible for Full Benefits if you are a member of a UC-sponsored retirement plan[1].

There are two ways to qualify for UCRP membership:

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

Mid-level Benefits

You are eligible for Mid-level Benefits if:

- You are not a member of a UC-sponsored defined benefit retirement plan, **and**
- You are appointed to work at least 50 percent time for a year or more[2], **or**
- You are appointed to work 100 percent time for at least three months.

Core Benefits

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

Eligible Family Members

Eligible Adult

You may enroll an eligible adult in the health and welfare plans shown in the chart on page 6. Eligibility is based upon your benefit package. The eligible adult must be enrolled in the same plans as you.

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

- A legal spouse, or
- A domestic partner.

Note: an adult dependent relative enrolled by 12/31/03 may continue their coverage until ineligible.

Eligible Child

You may enroll your eligible children in the health and welfare plans shown in the chart on page 6. Your eligible children must be enrolled in the same plans as you.

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

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

For additional eligibility information, refer to the *UC Group Insurance Eligibility Factsheet for Employees and Eligible Family Members*, available on the At Your Service website (atyourservice.ucop.edu). Refer to the *Benefits for Domestic Partners* booklet, if applicable to you. Your local Benefits Office can also provide you with information on your benefits plans.

No Duplicate Coverage

UC's rules do not allow duplicate coverage. That is, you may not be covered in UC-sponsored plans as an employee and as an eligible family member of a UC employee or retiree at the same time. If you are covered as an eligible family member and then become eligible for UC coverage yourself, you have two options:

- You can either opt out of the automatic employee coverage, or
- Make sure the UC employee or retiree who has been covering you de-enrolls you from his or her UC-sponsored plans before you enroll yourself.

Family members of UC employees may not be covered by more than one UC employee's plan coverage. 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. UC and the plans reserve the right to collect repayment for any duplicate premium payments and you may be liable for services under the duplicate plan.

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

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

3 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.

Benefits Overview

This overview lists all the benefit plans included in the three benefits packages that UC offers. You may enroll in the plans that are included in the benefits package for which you are eligible (see "Initial Requirements" on page 3).

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

Health and Welfare Benefits Packages

See pages 7 and 8 for more enrollment information.

Benefits Packages					When You May Enroll				
Full	Mid-level	Core		Premiuns Paid By	During PIE	During OE	90-day Wait[1]	Automatic	With SOH
			Health Care						
•	•		**Medical[2]** 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. See page 15.	You and UC	•	•	•		
•	•	•	**Medical—Core** Fee-for-service plan with a high deductible. See page 16.	UC	•	•	•		
•			**Dental[2]** 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 19.	UC	•	•			
•			**Vision[2]** Plan covers a variety of vision care services including eye exams, corrective lenses, and frames. See page 22.	UC	•	•			
			Disability Insurance						
•			**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 23.	UC				•	
•			**Supplemental Disability[3]** 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 23.	You	•				•
•	•	•	**Workers' Compensation** Provides state-mandated coverage for work-related injuries.	UC				•	

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

(Chart continued on next page)

[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 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.

Health and Welfare Benefits Packages

See pages 7 and 8 for more enrollment information.

Benefits Packages: Full	Mid-level	Core	Benefit	Premiums Paid By	When You May Enroll: During PIE	During OE	90-day Wait[1]	Automatic	With SOH
			Life and Accident Insurance						
•			**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 29.	UC				•	
	•	•	**Core Life** Provides employees eligible for Core or Mid-level Benefits with $5,000 of life insurance. See page 29.	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 31.	You	•				•
•	•		**Basic Dependent Life** Provides $5,000 of coverage for employee's spouse or domestic partner and each child. See page 33.	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 33.	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 35.	You	•				
•	•	•	**Business Travel Accident** Provides $100,000 of coverage when an employee travels on official UC business. See page 36 for enrollment instructions.	UC					
			Other Insurance						
•	•	•	**Legal** Provides basic legal assistance for preventive, domestic, consumer, and limited defensive legal services. See page 37.	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. These plans are offered through A+ Auto & Home Insurance. Your premiums are paid through payroll deduction. You are encouraged to obtain quotes from other insurers to help find the policy (and price) that best meets your needs. For information or to receive an individual premium quotation, contact A+ Auto & Home Insurance directly at 1-866-680-5142.	You	•				
			Tax-Savings Programs						
•	•	•	**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 41.	Pretax salary reduction	•	•			
•	•	•	**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.	Pretax salary reduction	•	•			
•	•	•	**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.	Pretax salary reduction	•	•		•	

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

Eligible Family Members

Family Member	Eligibility	Must be	Medical	Dental	Vision	Dependent Life	AD&D	Legal
Legal spouse[1, 2] (same-sex or opposite-sex)	Eligible	• legally married	•	•	•	•	•	•
Domestic partner[1] (same-sex/ opposite-sex)	Age 18 or older	• if opposite sex, either the employee or the domestic partner must be age 62 or older and eligible to receive Social Security benefits based on age; • a domestic partnership registered with the State of California or a substantially equivalent partnership established in another jurisdiction (same-sex domestic partnership only) is a domestic partnership for UC HR/Benefits purposes. 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 HR/Benefits purposes: – 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	•	•	•	•	•	•
Natural or adopted child	To age 23	• unmarried	•	•	•	•	•	•
Stepchild, grandchild, or step-grandchild	To age 23	• unmarried • living with you • supported by you or your spouse (50%+) • claimed as a tax dependent by you or your spouse	•	•	•	•	•	•
Domestic partner's child or grandchild	To age 23	• unmarried • living with you • supported by you or your domestic partner (50%+) • claimed as a tax dependent by you or your domestic partner	•	•	•	•	•	•
Legal ward enrolled 1/1/95 or after	To age 18	• unmarried • living with you • supported by you (50%+) • claimed as your tax dependent	•	•	•	•	•	•
Overage disabled child (except a legal ward) of employee	Age 23 or older	• unmarried • living with you if not your natural or adopted child • enrolled in a group medical plan before age 23 with continuous coverage and the incapacity must have begun before age 23; • supported by you (50%+) and claimed as your 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; • incapable of self-support due to a mental or physical disability incurred prior to age 23 • must be approved before age 23 or by the carrier during the PIE for newly eligible employees	•	•	•	•	•	•

(Columns Medical through Legal appear under the heading "May enroll in".)

[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.

When to Enroll

Enrollment in health and welfare benefits is optional, and in order to be covered you must enroll yourself and your eligible family members in UC-sponsored plans when you first become eligible; most plans have an enrollment deadline. Be sure to complete your enrollment or benefit change transactions within the specified time—your 31-day period of initial eligibility, for example.

Automatic Enrollment

Your enrollment (self-only coverage) is automatic in some UC-sponsored plans.

If eligible, you will be automatically enrolled in:

- Basic Life (or Core Life, based on your appointment),
- Short-Term Disability,
- Workers' Compensation, and
- Tax Savings on Insurance Premiums (TIP).

For other plans, enrollment is optional and you must enroll yourself and your eligible family members. In most cases, there is an enrollment deadline.

Default Plans

If you are eligible for the Full Benefits package but don't enroll, UC will automatically enroll you for self-only coverage in the Core medical plan, the Delta Dental PPO plan, and the vision plan.

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

You do not have to accept the default coverage for yourself and/or your eligible family members if:

- You are already enrolled in another group or individual medical plan; or
- You are already enrolled in another group dental and/or vision plan that provides equal coverage; or
- Your religious beliefs prohibit you from using the UC-sponsored plan's services.

Period of Initial Eligibility

A period of initial eligibility (PIE) is a time during which you or your eligible family members may enroll. Proof of good health is not required. To be sure you get the coverage you want, sign up during your PIE. A PIE starts on the first day of eligibility, generally your date of hire. For online enrollments, it ends the earlier of the date you confirm enrollment online or 31 days later. For paper enrollments, it ends the earlier of the date you submit your enrollment form or the last working day of the PIE 31 days later or on the last **working day** of the 31-day period, whichever comes first. UC defines a working day as a normal business day—Monday through Friday, excluding holidays—for your Benefits or Accounting Office.

Other Periods of Initial Eligibility

If you do not enroll during your initial PIE, you may be eligible to enroll yourself and your eligible family members at other times when you experience a PIE.

Family Changes

When you have a newly eligible family member, you may enroll yourself and him or her in your UC-sponsored plans. If you are already enrolled in a UC-sponsored medical plan, you may also transfer into a different plan. Your PIE to enroll a newly eligible family member starts the day he or she becomes eligible (for example, the day you marry or your child is born). Enrollment is not automatic; you must complete a form to enroll the new family member. During this PIE, you may change medical plans and enroll in or increase your Supplemental Life insurance and Expanded Dependent Life insurance.

See the *Family Changes Benefits Checklist* available on the At Your Service website (atyourservice.ucop.edu) for more information about enrolling and de-enrolling family members.

Involuntary Loss of Other Coverage

If you decline enrollment in a UC-sponsored health plan due to coverage in another plan, and you or your family member lose the other coverage, or the other employer stops contributing to the cost of the coverage, you may be eligible to enroll yourself and your eligible family members in a UC-sponsored plan.

Moving Out of a Medical Plan or DeltaCare USA® Plan Service Area

If you move out of an HMO, Anthem Blue Cross PLUS, or DeltaCare® USA plan service area, you and/or your eligible family members must transfer into a medical and/or dental plan in your new location. If you return to the HMO, Anthem Blue Cross PLUS, or DeltaCare® USA service area, you may transfer back.

If you are returning from another HMO, you may select any plan for which you are eligible.

New Faculty Member

If you are a newly-appointed faculty member and don't enroll when first eligible, a second PIE starts on the first day of classes for the semester or quarter in which your appointment starts or the first day of arrival at the campus, whichever occurs first.

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

Attainment of Lifetime Maximum

If you decline enrollment in a UC medical plan due to coverage in another medical plan, and you or your family member reach the lifetime maximum for all benefits under that plan, you may be eligible to enroll yourself and your eligible family members in a UC medical plan.

Other Enrollment Options

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

Open Enrollment

Open Enrollment (usually held in the fall) is your annual opportunity to transfer to a different medical or dental plan, add eligible family members, enroll in or opt out of UC-sponsored medical, dental, vision plans, and/or opt in or out of TIP, and enroll or re-enroll in the Health FSA and DepCare FSA. Changes made during Open Enrollment are effective January 1 of the following year. If you have opted out of UC-sponsored coverage, you may enroll yourself and your family members in a UC-sponsored medical, dental and/or vision plan during Open Enrollment. Note: the legal plan is not open for new enrollments every year.

90-Day Waiting Period (Medical Coverage Only)

If you miss your PIE, you may enroll yourself or eligible family members in medical coverage at any time by submitting an enrollment form to your Benefits Office. However, you will need to complete a waiting period of 90 consecutive calendar days from the day you submit your form before your medical coverage is effective. Your premiums may need to be paid on an after-tax basis.

Statement of Health

You may enroll in Supplemental and Dependent Life insurance and Supplemental Disability by submitting a statement of health to the insurance company for approval. A statement of health is also required to increase life insurance coverage or to reduce your waiting period for Supplemental Disability.

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

How to Enroll or Make Changes

UC provides a convenient, secure, and easy way to enroll in UC-sponsored plans. When you enroll in your benefit plans using the At Your Service website (atyourservice.ucop.edu), your benefit options will be displayed online. Your local Benefits Office can also provide you with other enrollment options available to you.

How to Enroll Online

To sign up for your benefits, go to At Your Service (atyourservice.ucop.edu) and select "Sign in to My Accounts."

New Employees

When you access At Your Service to enroll in benefit plans, the benefit plans available to you will be automatically displayed.

Currently Enrolled Employees

For forms and procedures, see the person in your department who handles benefits, or the At Your Service website.

Employees who have an appointment status change (for example, a change from Core Benefits to Full Benefits—see page 3) can make certain changes on the At Your Service website (select "Sign in to My Accounts").

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

When Coverage Begins

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

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

Some UC-sponsored plans also have other stipulations:

- **For the Health Flexible Spending Account and Dependent Care Flexible Spending Account,** the effective date is the first day of the month following enrollment, subject to payroll deadlines.
- **For UC-sponsored plans other than health plans,** if you are on a leave without pay (for reasons unrelated to health) when you become eligible, coverage starts on your first day on pay status.
- **If you are on leave for health reasons on the day you become eligible for coverage,** coverage starts the day after your first full day at work for these plans:
  - Basic Life,
  - Supplemental Life,
  - Basic or Expanded Dependent Life,
  - Accidental Death and Dismemberment,
  - Short-Term and Supplemental Disability, and
  - Legal.
- **If you enroll yourself and/or your eligible family members in a UC-sponsored medical plan outside of a PIE and complete a 90-day waiting period,** coverage begins on the 91st consecutive day after the enrollment form is received by your local Payroll or Benefits Office.
- **For Basic/Expanded Dependent Life, AD&D and/or Legal coverage,** if you or a family member is hospitalized on the day coverage would normally begin, coverage starts the day after release from the hospital. (This does not apply to a newborn or adopted child.)

See the appropriate plan booklet for more details about when coverage begins. Plan booklets are available through the At Your Service website (atyourservice.ucop.edu).

If You Need Services Right Away

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

After You Have Enrolled

Confirm Your Choices

After you enroll, check the At Your Service Online website (select "Sign in to My Accounts") to verify your coverage for you and your family members. It is your responsibility to promptly notify your Benefits or Payroll Office of any errors in your enrollment. The month after you enroll, review your payroll checkstub or direct deposit statement to be sure it reflects your benefit choices.

Keep Your Records Updated

Make sure that UC always has your current address, email address, and phone number to correctly administer your benefits and send you benefits information.

At Your Service Online (select "Sign in to My Accounts") allows UC employees to update personal information, such as home address, home telephone number, and income tax withholding.

When a Family Member Loses Eligibility

If an enrolled family member loses eligibility during the year, you are responsible for de-enrolling that family member. Don't wait until Open Enrollment. You are responsible for costs incurred in connection with the enrollment of ineligible family members 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.

Family members lose eligibility for the following reasons:

- **For your spouse/domestic partner,** eligibility stops on the last day of the month in which a divorce, legal separation, termination of domestic partnership, or annulment is final. Your legally separated spouse, former spouse, or former domestic partner is not eligible to participate in UC-sponsored health and welfare plans and may continue under COBRA for some plans, see page 11. If a divorce, legal separation settlement or termination of a domestic partnership requires you to provide such coverage, you must do so on your own.
- **For your child(ren) or grandchild(ren),** eligibility stops at the end of the month in which the child reaches age 23 (unless eligible to continue coverage because of disability) or age 18 for legal wards, or when the child marries or no longer meets all eligibility requirements to participate in UC-sponsored benefit plans.
- **For your domestic partner's child or grandchild,** eligibility stops at the end of the month in which the domestic partnership ends or your family member no longer meets all eligibility requirements to participate in UC-sponsored plans.

You are also required to de-enroll a deceased family member. You should contact your Benefits Office for assistance. Also, remember to change the level of coverage (if needed) for Expanded Dependent Life and/or Accidental Death and Dismemberment when an ineligible dependent is no longer eligible for your health insurance plans.

De-enrolling a family member who is no longer eligible to participate in UC-sponsored benefit plans does not in itself create a new period of initial eligibility (PIE) for you to switch plans.

Verification of Family Member Eligibility

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

The University performs periodic audits of enrolled family members and failure to comply with an audit may result in the de-enrollment of the employee and all family members.

UC and the insurance carriers reserve the right to request documentation (marriage or birth certificates, verification of domestic partnerships, adoption records, tax records, etc.) to verify eligibility for your enrolled family members. Please do not submit any documentation unless UC HR/Benefits or your carrier asks you to do so.

Failing to provide documentation when requested will lead to de-enrollment of you and your family members and possible legal action. In addition, employees may be responsible for any employer contributions to and benefits paid by the plan for the ineligible coverage. If it is determined that the plan has been misused, you and any eligible family members will be de-enrolled for 12 months.

Imputed Income

Under IRS rules, your taxable income may be affected if you have health plan coverage for any person who is not declared as your federal tax dependent except for your legal spouse. Details are online (atyourservice.ucop.edu).

When Coverage Ends

Coverage through UC-sponsored plans can end if you separate from UC employment or if certain employment actions occur. For example, if your annual average regular paid time is reduced below 17.5 hours a week, you leave UC employment, or you retire without UC-sponsored health plan coverage, your coverage ends. In addition, coverage for your family members ends when they lose eligibility to participate in UC-sponsored plans. See "When a Family Member Loses Eligibility" on page 10.

Ineligibility—Less Than 17.5 Hours Per Week

If your annual average regular paid time drops below 17.5 hours a week, you become ineligible for medical (including Core), dental, vision and Basic Life insurance as well as Short-Term and Supplemental Disability coverage. You may still be eligible for Supplemental Life, AD&D, HCRA, DepCare, Legal, and Auto and Homeowner/Renter coverage.

COBRA Continuation

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

If you are enrolled in the Health Flexible Spending Account (Health 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 plan 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.

Converting to an Individual Policy

Within 31 days after UC-sponsored coverage ends, you may be able to convert your group insurance coverage to individual policies for these plans: Medical, Basic Life, Core Life, Supplemental Life,[4] Basic Dependent Life, Expanded Dependent Life, AD&D, and Legal.

For medical coverage, you have 31 days after COBRA continuation coverage ends to apply for conversion.

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

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

Benefit Plans You May *Not* Continue

For these plans, your UC-sponsored coverage stops on your last day actively at work: DepCare, TIP, Short-Term and Supplemental Disability, Business Travel Accident Insurance, and Workers' Compensation.

You may not continue or convert any of these plans.

Benefit Plan You May Continue with the Carrier

You may continue coverage with the Automobile Homeowner/Renter plan on an individual basis after your UC-sponsored coverage ends by arranging to pay premiums directly to the insurance carrier.

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.

4 Those enrolled in Supplemental Life benefits may also have the option of participating in the Prudential Group Term Life Portability benefit. See "Conversion and Portability Privileges" on page 31.

Benefits Assistance

At Your Service (atyourservice.ucop.edu)

At Your Service is UC's systemwide Human Resources and Benefits website. You'll find complete information on all UC-sponsored benefits including:

- links to carriers' websites and phone numbers;
- tools to help you choose benefits, calculate premiums, and estimate retirement benefits;
- links to forms, publications, plan descriptions and evidence of coverage booklets;
- a link to online actions and personalized information through At Your Service Online (select "Sign in to My Accounts");
- current news about your benefits, including an online benefits newsletter (*HR/B Briefing*).

The *Always At Your Service* brochure provides a summary of features and online actions available on the website. You can download it from the "Forms and Publications" section of the At Your Service website or request one from your local Benefits Office.

Local Benefits Offices

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

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

Location	Phone Number
Berkeley	510-642-7053
Davis	530-752-1774
UCD Medical Center	916-734-8099
Irvine	949-824-5210
UCI Medical Center	714-456-5736
UCLA	310-794-0830
UCLA Medical Center	310-794-0500
Merced	209-228-8247
Riverside	951-827-4766
San Diego	858-534-2816
UCSD Medical Center	619-543-8244
San Francisco	415-476-1400
UCSF Medical Center	415-353-4545
Santa Barbara	805-893-2489
Santa Cruz	831-459-2013
Associated Students UCLA (ASUCLA)	310-825-7055
Hastings College of the Law	415-565-4703
Lawrence Berkeley National Laboratory	510-486-6403
Office of the President	510-987-0123

Participation Terms and Conditions

Your Social Security number will be requested only when needed by benefit plan administration for financial reporting or to verify your identity, in compliance with federal and state law.

As a participant in UC-sponsored plans, you agree to the following terms and conditions:

1. Most of the medical plans that UC offers [including the medical portion of Anthem Blue Cross PLUS and Anthem Blue Cross PPO[5], Health Net, Western Health Advantage, and CIGNA Choice Fund], Core and High Option Supplement to Medicare (offered by Anthem Blue Cross Life and Health Insurance Company)[5], and Kaiser Permanente—CA 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.
2. UC and UC health plan vendors comply with the Health Insurance Portability and Accountability Act (HIPAA) and other federal/state regulations related to the privacy of personal 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 authorized restriction on the sharing of specified health information for health care operations, payment and treatment will be honored as required by HIPAA.
3. 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 monthly costs, if any, for the plans you have chosen for yourself and your eligible family members.
4. 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.
5. If you enroll family members, the University and/or carrier may require proof of eligibility. Marriage or birth certificates, adoption papers, tax records, and the like may be requested. You agree to provide such documentation upon request.
6. If you enroll your eligible same-sex spouse or domestic partner and/or your same-sex spouse or domestic partner's eligible child(ren) or grandchild(ren), or if you enroll or have enrolled your natural or adopted child who 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.
7. If you specifically ask UC representatives to intercede on your behalf with your insurance plan, University representatives will request minimum necessary health information required to assist you with your problem. If more protected health information is needed to solve your problem, in compliance with state privacy laws and federal laws, including HIPAA (Health Insurance Portability and Accountability Act of 1996), you may be required to sign an authorization allowing UC to provide the insurance plan with relevant personal health information or authorizing the insurance plan to release such information to the University representative.
8. Actions you take during Open Enrollment will be effective the following January 1, unless otherwise stated.
9. You certify that all enrolled family members are eligible for coverage based on the definitions and

5 Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association.

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.

10. 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 will lead to de-enrollment of the 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) and will be responsible for any employer contributions to and benefits paid by the plan for the ineligible coverage.

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

Health Care Plans

Medical

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

This is only an overview of your medical benefits. You should to evaluate carefully your family circumstances and plan costs before selecting medical plan coverage. If you need more information about a particular UC-sponsored medical plan, such as coverage for specific condition, service areas, or provider information, please refer to the At Your Service website (atyourservice.ucop.edu) for a link to the plan. At Your Service also contains the Medical Plan Chooser (select "Health & Welfare Benefits" and "Medical Plans") which lets you compare UC-sponsored medical plan costs, quality, services and participating doctors.

Behavioral Health Benefits (Mental Health and Substance Abuse)

Behavioral health benefits for employees are provided by United Behavioral Health (UBH) for Health Net, CIGNA Choice Fund, Western Health Advantage, Anthem Blue Cross PLUS and Anthem Blue Cross PPO health plans. An out-of-network benefit provided by UBH will be available only to those enrolled in the Anthem Blue Cross PPO health plan. Kaiser members will continue to have access to Kaiser's integrated behavioral health services and also have the option to access the UBH services (except the out-of-network provision).

The first three in-network outpatient mental health visits will be covered with no copayment.

Your Medical Plan Choices

For 2009, UC offers the following medical plans. You may select any medical plan for which you are eligible.

Plan	Notes
Anthem Blue Cross PLUS*	Must live or work in plan's service area within California
Anthem Blue Cross PPO*	No service area requirement
CIGNA Choice Fund	Not available if you live in Hawaii or outside the U.S.
Core*	No service area requirement
Health Net HMO	Must live or work in plan's service area within California
Health Net Primary EPO	Available if you live in Imperial or San Luis Obispo counties
Kaiser CA North	Must live or work in plan's service area in No. California
Kaiser CA South	Must live or work in plan's service area in So. California
Kaiser Mid-Atlantic	Must live or work in plan's service area in MD, VA, or DC
Western Health Advantage	Must live or work in plan's service area: Sacramento, Yolo, Solano, Placer, El Dorado, and Colusa counties

Please note that plan service areas are established by home (or work, depending on the plan) ZIP codes. If you want to know whether your ZIP code is in a plan's service area, check the plan provider directory or call the plan directly (see page 18 for toll-free numbers). You may also use the At Your Service website (under "Health & Welfare Benefits," select "Medical Plans," then select "Medical Benefits Summary" at top right). You cannot use a P.O. Box to establish your eligibility for a medical plan.

* Blue Cross of California® and BC Life & Health Insurance Company are independent licensees of Blue Cross Association (BCA). The Blue Cross name and symbol are registered service marks of the Blue Cross Association.

UC Wellness Program[6]

The University is committed to investing in the well being of employees, retirees, and their family members. The University offers UC Living Well, a voluntary, health management program for employees, retirees, and their family members age 18 and older enrolled in all medical plans except Kaiser. Kaiser currently provides fully integrated wellness resources to its members.

StayWell Health Management, a leading provider of health promotion programs and services, administers the program. The program includes a health assessment taken online or via paper and a $100 gift certificate for employees who complete

6 The leadership of the following unions at UC have notified the University that they are choosing not to participate in the StayWell Health Management benefits program on behalf of their UC bargaining unit members: AFSCME 3299 on behalf of SX (Service Unit), EX (Patient Care Technical), and K7 (Skilled Crafts at UC Santa Cruz); CNA on behalf of NX (Nurse Unit); CUE on behalf of CX (Clerical Unit); UAW 2863 on behalf of BX (Academic Student Employees Unit); and UPTE-CWA on behalf of RX (Research Support Professionals Unit), TX (Technical Unit) and HX (Health Care Professionals Unit).

Types of Medical Plans

Plan	Highlights
Health Maintenance Organization (HMO) Plans **Health Net, Kaiser, Western Health Advantage** HMOs will give you a list of doctors from which to choose a primary care doctor (PCP). A PCP coordinates your care, which means that generally you must contact him or her to be referred to a specialist within your designated medical group. If you belong to an HMO, the plan only covers the cost of charges for services authorized by your PCP. HMOs only provide coverage for services outside of your medical group in cases of emergency.	• Available to employees who live (or work, depending on the plan's rules) in the plan's service area. • Most services are prepaid; no annual deductible. • You share cost by paying a copayment for some products and services. • Generally, there is no lifetime maximum benefit. • Behavioral health services must be preauthorized by United Behavioral Health. • Kaiser members may use either Kaiser or United Behavioral Health.
Preferred Provider Organization (PPO) **Anthem Blue Cross PPO** A PPO generally offers a broader network than an HMO. This plan model has arrangements with doctors, hospitals, and other providers of care who have agreed to accept lower fees from the Plan for their services and participate in the network of physicians. If you need or want health care from outside the network you have access, but you should expect to pay a higher copayment than if the provider were from within the PPO network.	• Available to employees worldwide. • Separate annual deductibles apply at the in-network and out-of-network level. • After paying an annual deductible, you share a percentage of the cost of services. Physicians may join or leave the PPO network at any time and you may not transfer to another medical plan mid-year. • There is a lifetime maximum benefit limit per member for this plan. • Behavioral health services must be preauthorized by United Behavioral Health.
Point-of-Service (POS) Plan **Anthem Blue Cross PLUS** This plan combines characteristics of the HMO and the PPO. The in-network level of this plan functions like an HMO and you must choose a primary care physician who is responsible for all referrals within the POS network. If you choose to go outside the network for healthcare, the plan functions more like a PPO.	• Available to employees who live or work in the plan's service area. • No annual deductible when you obtain services at the in-network-level. • When you access out-of-network services, you share a percentage of the cost of services, but you pay less if you use PPO providers. • Generally, there is no lifetime maximum limit at the in-network-level. • Behavioral health services must be preauthorized by United Behavioral Health.
Fee-for-Service Plan **Core Plan** This plan allows you choose the doctor, the hospital, the clinic, or the behavioral health provider and the insurance pays for part or all of the cost according to a schedule laid out in the policy after you have met your plan's deductible. Under this plan, you pay for a services up front and submit a claim to the insurance company, and, if the service is covered in the policy, you receive reimbursement.	• Available to employees worldwide. • High annual deductible applies and has to be met before the plan pays for services. • Once the plan starts paying benefits, you and the insurance company share the cost of the services. Generally, the insurance company pays the larger part of the cost. • There is a lifetime maximum benefit limit per member for this plan.

Plan	Highlights
HRA/PPO Plan **CIGNA Choice Fund** CIGNA Choice Fund is a PPO plan with a Health Reimbursement Account (HRA). The HRA—funded by UC—pays first to help satisfy a member's annual deductible. Once the HRA is exhausted and the deductible is met, this plan works like a PPO—the cost of services is shared between the plan and the member. All in-network preventive care, as defined by the plan is covered at 100 percent.	• Available to employees nationwide except residents of Hawaii. • Annual deductible applies and must be met before the plan pays. Amounts paid out-of-pocket to meet the deductible do not count towards the plan's out-of-pocket maximum. • Services can be obtained from any provider; however the cost is less for services obtained from a provider in the CIGNA (Open Access Plus) Network. • Unused HRA funds at the end of the plan year can be rolled over and accumulate in the member's account for the following plan year. • The HRA account is subject to monthly proration for new hired employees. The deductible remains the same. • Behavioral Health Services for CIGNA members are provided under a separate benefit administered by United Behavioral Health.

the assessment. Spouses/domestic partners receive a $50 certificate if they complete the assessment by April 15. Children and other adult family members other than spouses/domestic partners are not eligible for the StayWell program.

Additional program features include access to extensive online health resources and interactive tools, and health improvement programs with a health coach by telephone.

More details are on the At Your Service website.

Choosing a 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. If you are using your work address to qualify for the plan, you must pick PCPs with 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 during the year by calling the plan directly. See page 18 for telephone numbers.

If you are interested in receiving care from a particular doctor, you should find out if that doctor is in the plan's network. On At Your Service, select "Health & Welfare Benefits" and "Medical Plans" for information about doctors, or call the plan to confirm that the doctor is in their network.

Cost of Medical Coverage

Your medical plan monthly cost depends on:

- The plan you choose,
- The level of coverage, and
- Your annual full-time equivalent salary. The monthly amount will be automatically deducted from your paycheck.

Under the Tax Savings on Insurance Premiums (TIP) program, UC automatically deducts from your pay, on a pretax basis, any monthly cost for your health premiums. You do not pay federal, state, or FICA taxes on this amount. The pretax deductions from your pay are not counted as wages for unemployment insurance or Social Security benefits.

TIP enrollment is automatic. If you wish, you may cancel TIP enrollment either during your period of initial eligibility (PIE: see page 7) or during Open Enrollment. Ask the appropriate person in your department or your Benefits Office for a form.

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

General Information

Confirmation

Approximately 10 days after you have enrolled, you may view/verify your enrollments on At Your Service Online by selecting "Sign in to My Accounts." You may also check your paystubs to confirm that your enrollment is correct.

ID Cards

Medical plan identification cards are sent to members. Although you're covered immediately when you become eligible, it may take 30 to 60 days after you enroll for the insurance companies to have a record of your membership. Be sure to keep a copy of your enrollment confirmation and/or enrollment form for your records. Contact your local Benefits Office or the person in your department who handles benefits if you

need to use the services of one of your health and welfare plans and your insurance carrier does not have a record of your enrollment.

Medical Plan Enrollment Options

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

If you are declining enrollment for yourself or your eligible family members because of other medical insurance or group medical plan coverage, you may be able to enroll yourself and your eligible family members[7] in a UC-sponsored medical plan if you or your eligible[7] family members lose eligibility for that other coverage (or if the employer stops contributing toward the other coverage for you or your family members).

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

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 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 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.

For More Information and Assistance

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

If you have other questions, call the medical plan directly using the toll-free numbers shown below or contact your Benefits Office (see page 12).

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

Medical Plan	Toll-free Number	Website
Anthem Blue Cross PLUS	1-888-209-7975	bluecrossca.com/uc
Anthem Blue Cross PPO	1-888-209-7975	bluecrossca.com/uc
CIGNA Choice Fund (for prospective members)	1-800-401-4041	mycignaplans.com (User ID: UofCA; Password: Choice)
CIGNA Choice Fund	1-800-244-6224	mycigna.com
Core	1-888-209-7975	bluecrossca.com/uc
Health Net	1-800-539-4072	healthnet.com/uc
Kaiser Permanente—California	1-800-464-4000	my.kp.org/ca/universityofcalifornia
Kaiser Permanente Mid-Atlantic		
in Washington D.C. metro area	1-301-468-6000	members.kaiserpermanente.org/kpweb
outside Washington D.C. metro area	1-800-777-7902	members.kaiserpermanente.org/kpweb
Western Health Advantage	1-888-563-2250	westernhealth.com/members
United Behavioral Health	1-888-440-8225	liveandworkwell.com

Special Numbers for Hearing Impaired

Plan	Number
CIGNA Choice Fund	1-800-321-9545
Health Net	1-800-995-0852
Kaiser Permanente—California	1-800-777-1370
Kaiser Permanente—Mid-Atlantic	1-301-816-6344
United Behavioral Health	1-800-842-9489
Western Health Advantage	1-888-877-5378

7 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 audit by the University and/or insurance carriers.

Dental

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

Benefits and Services

For an outline of benefits and services, see the UC *Dental Plan Summary* available on the At Your Service website (atyourservice.ucop.edu).

Please remember that if you need major dental work (a crown, dentures, a bridge, or oral surgery), you should read the complete explanation of benefits, limitations, and exclusions in your Delta Dental PPO or DeltaCare® USA Evidence of Coverage (EOC) booklet. You and/or your dentist should contact your plan before you begin treatment to confirm a dental procedure will be covered.

Delta Dental PPO (available worldwide)

The Delta Dental PPO plan provides you and your family with the flexibility to choose any licensed dentist or specialist. Under this plan, you may choose a PPO network provider, or if you choose a Delta dentist outside the PPO network, such as a dentist in Delta Dental's Premier network, you will be eligible for benefits, as outlined on pages 20 and 21. However, when you choose to visit a PPO network provider, your out-of-pocket costs may be lower because PPO dentists have agreed to charge Delta Dental PPO patients reduced fees.

The plan pays enhanced benefits when you visit a PPO network dentist, so you pay only 20 percent of the PPO dentist's contracted fee after your deductible for such services as fillings, oral surgery, root canals and treatment of gum disease.

If you choose to visit a non-PPO Delta Dental Premier dentist, you'll still enjoy user-friendly claims administration, cost protections and other Delta Dental advantages, plus have access to more than 23,000 dentists in the state.

The annual plan maximum is $1,500 for the Premier network and $1,700 when visiting a PPO dentist. If you go to a dentist not affiliated with Delta Dental, Delta cannot assure you what percentage of the charged fees may be covered.

There are over 16,000 PPO dentists in California and 105,000 nationwide. To see a list of Delta and DeltaCare® USA dentists, go to the At Your Service website for a link to the Delta and DeltaCare websites.

DeltaCare® USA

DeltaCare® USA (your dental HMO option) provides you and your family with comprehensive benefits and easy referrals to specialists and even has a benefit for teeth bleaching. You must be a resident of California to enroll. The plan emphasizes preventive care, so many services are provided at no cost (see pages 20 and 21). There is no annual plan maximum for DeltaCare® USA. Other services are provided at modest copayments to you and there are no deductibles, making this plan a very affordable option to members.

When you enroll, you can select a network dentist to provide all of your basic dental services or the plan will assign you a dentist near your home. The DeltaCare® USA network consists of private practice dental facilities that have been screened by Delta Dental for quality. Throughout the year, you can change your dentist at any time by simply calling the DeltaCare Customer Service number and requesting the change.

Cost of Coverage

All plan members pay a certain percentage or copayment for some services. See the Dental Plan Summary.

UC pays 100 percent of your monthly dental plan premium. UC's contribution toward the monthly cost of coverage is determined by UC and may change or stop altogether.

For More Information

For questions or more information, call Delta Dental PPO or DeltaCare® USA. Call your Benefits Office or the person in your department who handles benefits, for questions or publications.

Delta Dental PPO: 1-800-777-5854
DeltaCare® USA: 1-800-422-4234

For UC forms or publications, and links to the dental plan websites, visit the HR/Benefits website (atyourservice.ucop.edu). To see a list of Delta or DeltaCare® USA dentists, visit their websites.

January through December 2009	**Delta Dental PPO Plan**		**DeltaCare® USA Plan** (Services are only covered when you use your DeltaCare® USA provider.)
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)	80% 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
BASIC DENTISTRY	Deductible applies		Copayments apply as noted
Fillings	80% PPO/75% Premier		100% for standard benefit
Anesthesia[2]	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	After an annual deductible of $50 per person[3]	Relining—100% (limited to 1 in any 12-month period). Rebase—$20 copay.
MAJOR DENTISTRY	Deductible applies		Copayments apply as noted
Crowns	50%		$50 per unit copayment ($100 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)

January through December 2009	Delta Dental PPO Plan	DeltaCare® USA Plan
TOTAL BENEFIT (Total benefit for preventive, basic, and major dentistry; and prosthetic dentistry.)	$1,500 per person per calendar year ($1,700 if a Delta Dental PPO dentist is used)	No maximum
ORTHODONTICS	No deductible	Copayments apply as noted
Who is eligible for service	All covered family members	All covered family members
Benefit	50% up to $1,500 in a lifetime for dependent children as defined in eligibility provisions; up to $500 in a lifetime for adults (not applied to calendar year maximum)	$1,000 copayment (plan covers 36 months of usual and customary treatment—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.[4]
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 less than 5 years old	Not covered if crown or prosthetic appliance is less than 3 years old
Out-of-area emergencies	Coverage applies worldwide.	Plan pays up to $100 in 12-month period for pain relief when you are more than 25 miles from your dentist's office.
Teeth Bleaching	Not covered	$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.

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

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

[2] Disabled members may receive anesthesia for any covered dental service if needed to receive treatment. Preauthorization is required.

[3] Combined for basic and major dentistry, TMJ disorder benefits, and prosthetic dentistry.

[4] Exception: DeltaCare® USA may cover orthondontia treatment in progress for new enrollees/family members if treatment meets specific DeltaCare® USA criteria.

Vision

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

What the Plan Covers

The plan's benefits include:

- **One vision examination per calendar year**
  The plan covers testing and analysis of eye health, as well as any necessary prescriptions for lenses.
- **One set of corrective lenses per calendar year**
  The plan covers single vision, bifocal, trifocal, or other complex glass or plastic lenses. Photochromatic lenses and tints are also covered. VSP covers the full cost of polycarbonate lenses when the member uses a VSP provider. For those members using a non-VSP provider, a single $5 reimbursement is available for tints and polycarbonate options, if elected.
- **One set of frames every other calendar year**
  Some frames provided by VSP doctors are fully covered.
- **One set of contact lenses per calendar year**
  Contact lenses are fully covered if they are considered medically necessary and a VSP provider is used. Generally, they are covered for those who have had cataract surgery, have extreme acuity problems that cannot be corrected with glasses, or have some conditions of anisometropia or keratoconus.

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

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

For plan limitations, refer to the plan booklet available on atyourservice.ucop.edu.

Cost of Coverage

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

How to Use the Plan

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

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

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

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

- 20 percent discount for additional pairs of prescription glasses; and
- 15 percent discount for contact lens professional services (for example, fittings or adjustments).

You can also use a non-VSP provider. If you do, you should pay the full amount of the provider's bill and submit a claim to VSP.

For More Information

This is only an overview of your vision benefits. You can access VSP's Evidence of Coverage booklet and the VSP website through the At Your Service website (atyourservice.ucop.edu). Under "Quick Links" select "Health & Welfare Benefits" and the "Vision Plan" link for the VSP website and the Evidence of Coverage booklet. You may also call VSP at 1-800-877-7195 to request a booklet or to ask a question.

Disability Insurance

Short-Term Disability and Supplemental Disability

An unexpected injury or illness that keeps you out of work can use up savings rapidly. Making sure you have enough disability insurance is an important part of your personal financial planning. UC's disability benefits in conjunction with state-mandated Workers' Compensation and Social Security disability benefits create a comprehensive safety net to provide protection from loss of wages whether a few months or a lifetime.

For Workers Compensation claims, UC is self-insured and contracts with a third party administrator to manage its claims. For questions about Workers' Compensation, see Business and Finance Bulletin BUS 73—*Workers' Compensation Self-Insurance Program,* available online through At Your Service (under "Forms & Publications") or from your local Workers' Compensation Manager. You can find a list of UC Workers' Compensation Managers online (ucop.edu/riskmgt/wcmdir.html).

UC does not participate in the California State Disability Insurance (SDI) program. If you are a new UC employee and become disabled, you may have SDI coverage through a former employer. Any SDI income you are eligible to receive based on past employment will be deducted from your disability benefits payable under the University of California's disability plan benefits.

To be sure you get the coverage you want, sign up during your PIE and make your selections carefully. It is important that you consider your circumstances and how your choice of a disability waiting period will affect major events in your life. If you are on leave for health reasons on the day you become eligible for coverage, coverage starts the day after your first full day at work.

What the Plans Cover

Short-Term Disability

The Short-Term Disability plan provides coverage for nonwork-related disabilities and pays short-term benefits if you are unable to work due to a pregnancy/childbirth, disabling injury, or illness. In order to receive benefits, you must be under a doctor's direct and continuous care and your illness or injury must not be work-related.

The plan pays 55 percent of your eligible earnings, up to $800 a month (maximum), for up to six months. Before benefits begin, you must first use up to 22 working days of accrued sick leave excluding paid holidays. If you have not accumulated that much sick leave, you must use what you have.

If you are covered only by the Short-Term Disability plan, you are automatically assigned a seven day waiting period. Benefits start after your chosen waiting period or after you exhaust a minimum amount of your sick leave, whichever occurs later.

See "Choosing a Waiting Period" on page 25 for more on how waiting periods and sick leave work.

Supplemental Disability

Supplemental Disability pays a higher level of benefits for a longer period of time than the Short-Term plan. If you decide to enroll in the Supplemental Disability plan, the premium is paid by you. This plan pays benefits if you are unable to work due to a pregnancy/childbirth, disabling injury, or illness. You must be under a doctor's direct and continuous care. If your disability is not work-related, benefits from this plan are coordinated with benefits from Short-Term Disability.

Supplemental Disability and Short-Term Disability benefits, combined with all other sources of disability or retirement income you receive (Workers' Compensation or Social Security for example), pay 70 percent of your eligible earnings, up to $10,000 a month for up to 12 months of temporary disability.

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

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

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

As with Short-Term Disability, you must use your accrued sick leave (up to 22 working days—176 hours—not including paid holidays) before benefits begin. If you have not accumulated that much sick leave, you must use what you have.

The Supplemental Disability plan offers a choice of minimum waiting periods before benefits begin—7, 30, 90, or 180 days. See "Choosing a Waiting Period" on page 25. If you enroll in the Supplemental Disability plan, you will be asked to choose the length of your waiting period. The waiting period you choose will apply to both the Short-Term and the Supplemental Disability plans.

Cost of Coverage

The Short-Term Disability Plan is currently paid for by the University.

If you decide to enroll in the Supplemental Disability Plan, the premiums are paid for by you. Use the Insurance Premium Calculator on the At Your Service website (atyourservice.ucop.edu) to calculate your monthly premium. Select "Health & Welfare Benefits," "Disability Insurance" and then "Insurance Premium Calculator."

Other Disability Plans

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

- Workers' Compensation, which covers work-related injuries and illnesses;
- UCRP disability income, which is available for UCRP members with five or more years of service credit with permanent or long-term disabilities (12 months or longer);
- Social Security disability benefits; and
- California State Disability Insurance.

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

Accruing Sick Leave

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

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

Plan Limitations

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

Other Information You Should Consider

- If you do not enroll in the Supplemental Disability plan when you are first hired, you must submit a statement of health and be approved by the insurance company in order to enroll. Previous or currently existing medical conditions may prevent your approval if you try to enroll without a PIE. You must also submit a statement of health for approval in order to reduce your waiting period. Generally, disability plans are not "open for enrollment" during UC's annual Open Enrollment.
- Under the Supplemental Disability plan, the definition of disability changes after 12 months of receiving benefits, 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.

Choosing a Waiting Period

When you enroll in the Supplemental Disability plan, you must select a waiting period.

A waiting period is the time from the day you are unable to work due to an injury, illness, or pregnancy until the day disability benefits start. You may elect a 7-, 30-, 90-, or 180-day waiting period. The longer the waiting period, the lower the monthly premiums you'll pay. However, when you choose a longer waiting period and if you become disabled, you should be prepared to cover your expenses yourself—without income from the disability plans—until your waiting period is complete.

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

For example, consider your choices carefully if you plan to become pregnant. Most pregnancy disabilities last only 6–8 weeks, so the waiting period you select will determine if you will receive any disability income following the birth of your child.

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

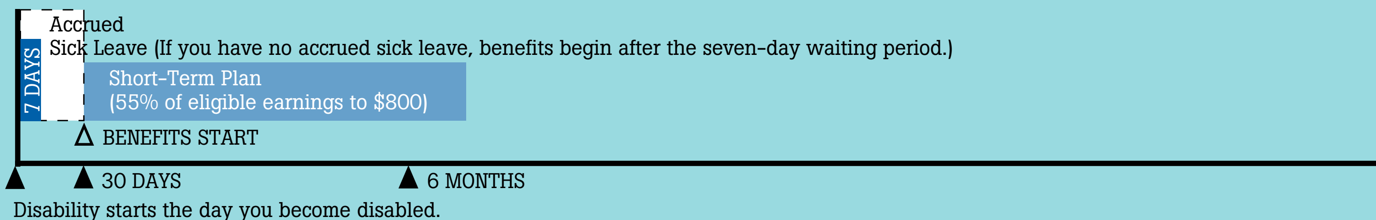
It is also important to consider other sources of income you might have.

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

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

Short-Term Disability Plan Only

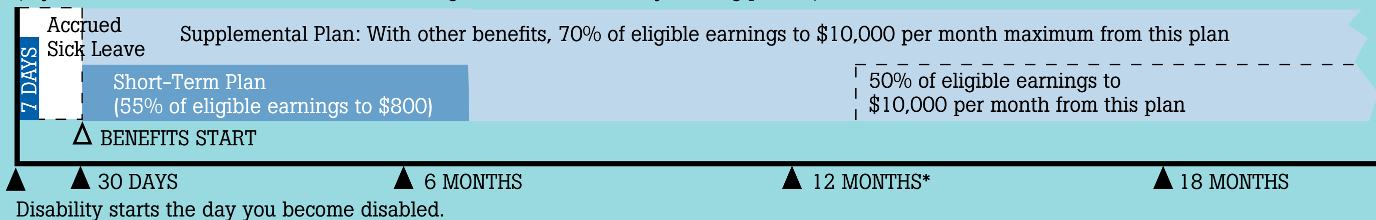
This is how benefits work if you have Short-Term Disability only. Before benefits begin, you must use up to 22 days of sick leave (excluding holidays), if available.



Short-Term and Supplemental Disability Plans

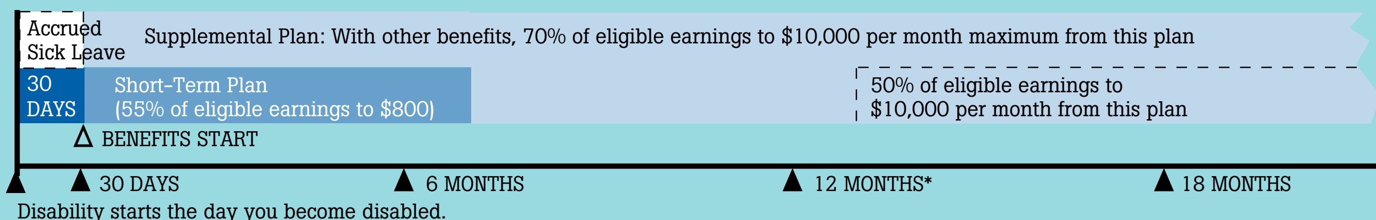
If you have Supplemental Disability, this is how both plans work together based on the waiting period you choose. Remember, the waiting period you choose for the Supplemental Disability plan automatically becomes your waiting period for the Short-Term Disability plan as well. After you have received 12 months of Supplemental Disability benefits, the plan will pay 50% of your eligible earnings to $10,000 per month.

7-day Waiting Period



If you have five days of sick leave or less, you will receive disability benefits up to 70% of your eligible earnings to $10,000 per month maximum after your seven-day waiting period. If you have more than five days of sick leave, before benefits begin you must use up to 22 days of sick leave, excluding paid holidays, if available. This benefit will be reduced if benefits combined with other sources (for example, Social Security and/or UCRP disability) exceed 70% of your eligible earnings.

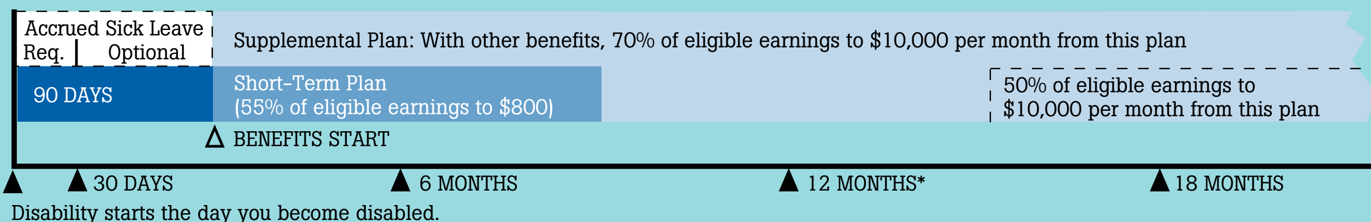
30-day Waiting Period



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

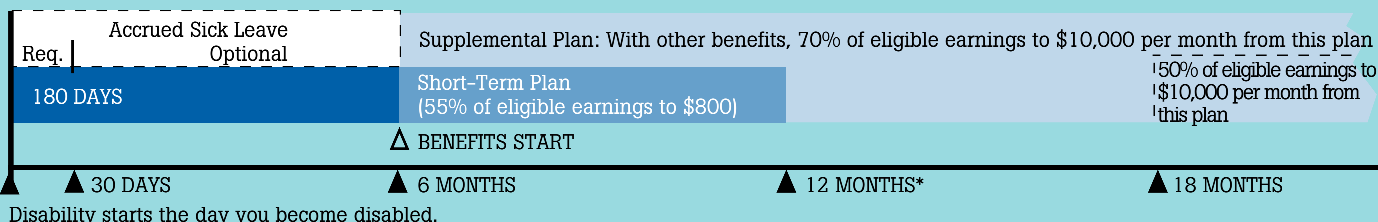
Short-Term and Supplemental Disability Plans

90-day Waiting Period



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

180-day Waiting Period



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

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

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

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

Life and Accident Insurance

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

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

UC's plans are group term life plans that provide coverage at special rates to group members—in this case, UC employees. Term insurance stays in effect only during a set time, or term; in this case, as long as you remain an eligible employee. Unlike whole life policies, term life policies don't accumulate a cash value over time. Coverage stops when you are no longer eligible.

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

University-Paid Life Insurance

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

What the Plans Cover

Basic Life

This plan provides life insurance equal to your annual base salary, up to $50,000.[8] The coverage amount is based on your UC salary and appointment rate as of your date of hire or January 1 of the current year, whichever comes after.

Benefits are paid to your beneficiaries (see page 31) if you die while employed or on paid leave, or during the first four months of approved leave without pay or temporary layoff. Benefits from this plan are payable in addition to any other death benefits for which you may qualify—for example, from the Supplemental Life insurance plan (see page 31) or your retirement plan.

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

Core Life

This plan provides $5,000 of life insurance.[9]

Benefits are paid to your beneficiaries (see page 31) if you die while employed or on paid leave, or during the first four months of approved leave without pay or temporary layoff. Benefits from this plan are payable in addition to any other death benefits for which you may qualify.

Living Benefit Option

The plan also provides a "living benefit" option that allows terminally ill employees who have been covered by the plan for at least one year to receive some of their life insurance benefits before death. The money can be used for any purpose. The money—75 percent of the total coverage amount is paid directly to you in a lump sum or in 12 equal monthly installments. The amount that would otherwise be payable to beneficiaries at death is reduced by the amount paid to the employee. Your life insurance plan booklet has more information.

Insurance Assignment

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

Once coverage has been assigned, the new "owner" (the viatical settlement company) has the right to designate beneficiaries or convert the insurance. The employee can

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

9 This plan does not cover CalPERS members.

no longer leave a cash payment to beneficiaries and the employee is not eligible to elect the "living benefit" option described on page 32. Because assigning benefits is permanent and involves complex legal and tax issues, an attorney should be consulted before assigning coverage. Assignment forms can be obtained from your Benefits Office.

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.

Use the Insurance Premium Calculator on the At Your Service website (atyourservice.ucop.edu) to calculate your monthly premium. Select "Health & Welfare Benefits," "Life Insurance" and then "Insurance Premium Calculator."

Supplemental Life Insurance

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

What the Plan Covers

You may choose one of these coverage amounts:

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

Coverage is based on 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. Coverage will not be reduced automatically if your full-time salary rate is reduced.

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

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

Waiver of Premium

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

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 the At Your Service website to figure your monthly premium. Select "Health & Welfare Benefits," "Life Insurance" and then "Insurance Premium Calculator."

Conversion and Portability Privileges

You may be eligible to convert your group life insurance to an individual policy if your UC-sponsored coverage ends. See "Converting to an Individual Policy" on page 11 and see your Benefits Office for more information.

Or, you may instead participate in Prudential's Portability Group Term-Life Plan by submitting an application to Prudential's Portability unit. The Portability benefit allows you to continue your current UC group term-life Supplemental coverage at Prudential's Portability group term-life rates. The Portability premium rates are lower than the conversion rates. There are separate Portability rates based upon your health status and you will need to submit an additional statement of health for the Portability group's preferred rate. Since this is term-life coverage, the benefits will reduce to 60 percent at age 65; 50 percent at age 70 and terminate at age 80. Similar to your conversion privileges, you will also have 31 days from which your coverage ends to submit your application and the appropriate premiums to Prudential. See your Benefits Office for more information.

Your Beneficiaries

You may designate your beneficiaries online, on the At Your Service website (atyourservice.ucop.edu), by selecting "Sign in to My Accounts."

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

a. Legal spouse or domestic partner of the member;

b. Child or children, including adopted child or children of the member (child or children of a deceased child shall take the share of such child by representation);

c. Parent or parents of the member;

d. Sibling or siblings of the member.

If there is no such survivor, any lump sum death payment shall be paid to the member's estate.

You may change your designated beneficiary at any time by using At Your Service. Once your new designations are processed, all previous designations are invalid. You may complete UC's *Designation of Beneficiary* form (UBEN 116) if you do not have Internet access.

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

Living Benefit Option

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

Insurance Assignment

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

Once coverage has been assigned, the new "owner" (the viatical settlement company) has the right to designate beneficiaries or convert the insurance. The employee can no longer leave a cash payment to beneficiaries and the employee is not eligible to elect the "living benefit" option described at left. Because assigning benefits is permanent and involves complex legal and tax issues, an attorney should be consulted before assigning coverage. Assignment forms can be obtained from your Benefits Office.

For More Information

This is an overview of your University-Paid Life and Supplemental Life insurance benefits. Once you are enrolled, the insurance carrier will send you more information. A copy of the Life Insurance plan booklet is located on the At Your service website (atyourservice.ucop.edu) under "Forms & Publications" "Life Insurance."

Dependent Life Insurance

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

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

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

What the Plans Cover

Basic Dependent Life

This plan covers your spouse or domestic partner and/or eligible children for $5,000 each.

Expanded Dependent Life

This plan covers your eligible family members for these amounts:

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

Living Benefit Option

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

Who Is Eligible

The family members you may cover are the same under both plans. See page 6 for the eligible family members you may enroll.

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

If both you and a family member are UC employees: You may choose to cover yourself under the Supplemental Life plan or you may be covered (if eligible) by your family member's Dependent Life plan. You may not be covered by both plans (see "No Duplicate University Coverage" on page 3).

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

Basic Dependent Life

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

- The Basic Life plan described on page 29, or
- The Supplemental Life plan described on page 31.

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

Expanded Dependent Life

To cover your eligible family members under this plan, you must be eligible for and enrolled in the Supplemental Life plan described on page 31.

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

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

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

Use the At Your Service website (select "Health & Welfare Benefits,"

"Life Insurance" and then "Insurance Premium Calculator") to calculate the cost of your Expanded Dependent Life coverage.

Cost of Coverage

Use the Insurance Premium Calculator on the At Your Service website (atyourservice.ucop.edu) to calculate your monthly premium. Select "Health & Welfare Benefits," "Life Insurance" and then "Insurance Premium Calculator."

Conversion Privileges

You may be eligible to convert your Dependent Life insurance to an individual policy if your UC-sponsored coverage ends. See "Converting to an Individual Policy" on page 11 and see your Benefits Office for more information.

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

Portability Benefit

If you participate in Prudential's group term-life Portability benefit for your Supplemental Life insurance (see page 31), you may also continue dependent life coverage (either the Basic Dependent life or Expanded Dependent life) within the same Portability benefit. See your Benefits Office for more information.

Your Beneficiaries

Basic Dependent Life

You are the beneficiary if a covered dependent dies.

Expanded Dependent Life

You are the beneficiary if a covered dependent dies. If you prefer, you may designate someone else to receive benefits if a spouse or domestic partner covered under this plan dies. You cannot designate an alternate beneficiary to receive benefits for covered children. To change your beneficiary, use the *Designation of Alternate Beneficiary—Expanded Dependent Life and AD&D Insurance* form (UBEN 119), available on the At Your Service website (atyourservice.ucop.edu) under "Forms & Publications."

For More Information

This is an overview of your Dependent Life insurance benefits. Once you enroll, the insurance carrier will send you more information. A copy of the Life Insurance plan booklet is located on the At Your Service website (atyourservice.ucop.edu) under "Forms & Publications" "Life Insurance"

Accidental Death and Dismemberment (AD&D)

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

What the Plan Covers

The plan offers three levels of coverage including:

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

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

You and your enrolled family members are covered worldwide, 24 hours a day.[10]

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

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

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

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

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

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

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

If you die in a covered accident, the plan also pays for your covered child's higher education—either the actual annual tuition or 5 percent of your coverage amount (up to $10,000, but not less than $1,500) per school year, whichever is less. To be eligible, a child must be enrolled in an institution of higher education on the day of the accident. Or, if a full-time high school student, the child must enroll in an institution of higher education within one year of high school graduation. This benefit is paid annually for up to four consecutive years, provided the child continues as a full-time student.

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

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

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

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

Cost of Coverage

Your cost depends on the plan option and the coverage amount you choose, which can range from $10,000 to $500,000. Use the rate chart on the At Your Service website (atyourservice.ucop.edu) to determine your monthly premium. Select "Health & Welfare Benefits," and "Accidental Death and Dismemberment."

For More Information

This is only an overview of your AD&D benefits. Once you enroll in the plan, the insurance carrier will send you more information. A link to the AD&D plan booklet is located on the At Your Service website (atyourservice.ucop.edu) under "Forms & Publications"—Evidence of Coverage and Plan booklets.

Business Travel Accident Insurance

What's Covered

When traveling on official University business, you will be covered worldwide 24 hours a day for a variety of accidents and incidents while away from the workplace. This coverage includes:

- Accidental death,
- Accidental dismemberment,
- Paralysis, and
- Permanent total disability benefits.

Travel Assistance Services (when business traveler is 100+ miles from home or workplace; security extraction not subject to mileage limitation) include:

- Emergency medical evacuation, and repatriation,
- Repatriation of remains,
- Security extraction,
- Out-of-country medical,
- Loss of personal effects, and
- Other travel assistance services

Coverage is also provided to a spouse/domestic partner and dependent child(ren) when accompanying you on a business trip.

How To Register

This insurance coverage is provided at no cost to you, but you must register to ensure coverage for each business trip.

You must register online (www.uctrips-insurance.org) all out-of-state and foreign country business trips to ensure coverage. Coverage is automatic for business travel within the state and registration is not required for those trips.

Upon registration, you will receive confirmation of coverage for your trip and information to use in an emergency while traveling on University business both domestically and abroad. A summary of coverage and claim forms are also available online (www.uctrips-insurance.org).

The registration will ensure coverage for you while traveling on official University business. Your registration information will serve to verify eligibility to the insurance company in the event you submit a claim, use any benefit, or request travel assistance services.

Travel Assistance Services Available

In addition to the insurance protection provided by the insurance plan, ACE USA has arranged with Europ Assistance USA to provide you with access to its travel assistance services around the world which include:

- **Medical Assistance** including referral to a doctor or medical specialist, medical monitoring when you are hospitalized, emergency medical evacuation to an adequate facility, medically necessary repatriation and return of mortal remains.
- **Personal Assistance** including pre-trip referral information (such as immunization requirements, appropriate medical exams and treatments, passport and visa requirements, weather, health warnings and travel hazards) and while you are on a trip: emergency medication, embassy and consular information, lost document assistance, emergency message transmission, emergency cash advance, emergency referral to a lawyer, translator or interpreter access, medical benefits verification and medical claims assistance.
- **Travel Assistance** including security extraction, emergency travel arrangements for the return of your traveling companion or dependents, and vehicle return.

Your Beneficiaries

For purposes of Accidental Death benefits, the designated beneficiaries are the same as those named on the University-provided basic group life insurance, unless you make a separate beneficiary designation.

You can change your beneficiary designation on the At Your Service website (atyourservice.ucop.edu) or complete and submit UC's *Designation of Beneficiary* form (UBEN 116). The beneficiary designation remains in effect until it is either changed or revoked. The beneficiary designation does not automatically end with the return from a business trip.

For More Information

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

Legal Plan

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

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

The legal insurance plan helps mainly with routine preventive or defensive matters and should cover most basic legal needs. The chart on page 38 explains what the plan covers.

What the Plan Covers

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

- *Preventive legal services* includes general legal advice, negotiation, document review and preparation, preparation of wills and durable power of attorney. Often, a few minutes of legal advice can prevent a small problem from becoming a major one.
- *Domestic legal services* cover divorces, separations, adoptions, child support, child visitation, and name changes.
- *Consumer services* include legal representation for the enforcement of warranties or promises in connection with the purchase of goods or services. This does not include actions in Small Claims Court. Nor does it include disputes over real estate construction matters for a new home or room additions to and/or remodeling of an existing home (four-day trial limitation).
- *Limited defensive legal services* include misdemeanor defense and felony charge advice.
- *Major trial representation* includes trial representation beginning on the fourth day of trial in covered proceedings for which indemnity benefits are being provided ($400 per half day of trial time).
- *Online law guide and document library:* The online law guide provides comprehensive overviews of the most common legal issues. The online document library includes Do-It-Yourself Legal Documents™, which allow you to create your own legally valid documents.
- *Identity theft services* gives you toll-free access to an Identity Theft Case Manager, who will explain identity theft and how to prevent it. If you become a victim of identity theft, you'll receive personal guidance, online guides, printed workbooks, risk assessment tools and more.
- *Reduced fees for non-covered matters:* Receive at least 25 percent off an attorney's normal rate for most non-covered personal legal needs when using an attorney from ARAG's Reduced Fee Network. Benefit is subject to plan exclusions.
- *Reduced contingency fees:* Capped at 25 percent for initial trial/settlement and 30 percent for subsequent appeal proceedings.

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

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

Cost of Coverage

Your monthly cost depends on your enrollment. Use the rate chart on the At Your Service website (atyourservice.ucop.edu) to determine your monthly premium. Select "Health & Welfare Benefits," and "Legal Plan."

How to Use the Plan

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

When you call ARAG, a Customer Care Counselor will advise you on the services the plan will cover. A claim form, a description of coverage, and a current list of the plan's Network Attorneys can be sent to you.

These Network Attorneys have met the ARAG's requirements and have agreed to provide the services

(continued on page 39)

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 http://members.araggroup.com/ucop or call an ARAG Customer Care Counselor at 1-800-828-1395.

Worldwide Coverage Per Family Each Calendar Year	Network Attorney	Non-Network Attorney
Attorney Office Work		
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		
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		
• Legal services required for the creation of a child custody, child support, or visitation agreement	Fully paid	$245
• Modification/enforcement of an uncontested child custody, child support, or visitation agreement	Fully paid	$294
• Modification/enforcement of a contested child custody, child support, or visitation agreement	Fully paid	$490
Establishment of guardianship/conservatorship	Fully paid	$420
Adoption proceedings[4]	Fully paid	$420
Name change	Fully paid	$280
Defensive		
Criminal misdemeanor defense (except traffic violations)[4]	Fully paid	$700
Habeas Corpus proceedings	Fully paid	$420
Juvenile court hearings—if juvenile is covered dependent	Fully paid	$490
Defense of a lawsuit for the collection of a debt based on a contract or other written instrument[4]	Fully paid	$630
Personal bankruptcy	Fully paid	$560
Defense of traffic matter that will directly result in license suspension[4]	Fully paid	$350
Defense against civil damage(s) claims: advice, negotiation and office work[5]	Fully paid	$280
Defense against civil damage(s) claims including legal representation[5]	Fully paid	$3,100[6]
Consumer		
Consumer protection (except for disputes over real estate/construction matters)[4]	Fully paid	$350
IRS Coverages		
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 Representation		
Representation at trial beginning on the 4th day of trial ($400 per ½ day of trial time) in covered proceedings for which indemnity benefits are being provided.	Included with Covered Benefits	$100,000[8]

Dollar amounts shown are maximums at $70 per hour.

[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 ½ day of trial time).
[7] This is the annual maximum regardless of whether you are enrolled in self, self plus chid(ren), self plus adult, or self plus adult plus child(ren) coverage
[8] This coverage is paid at a rate of $400 per ½ day of trial time.

Insurance products are underwritten by ARAG Insurance Company of De Moines, Iowa: GuideOne™ Mutual Insurance Company of Wes Des Moines, Iowa, or GuideOne Specialty Mutual Insurance Company of West Des Moines, Iowa. Additional services may be provided by ARAG LLC or Advisory Communication Systems Inc. Some products are only available through membership in the ARAG Association LC.

described on page 38. Attorneys fees for most covered matters are paid in full.

This document is for illustrative purposes only and not a contract. Insurance products are underwritten by ARAG® Insurance Company of Des Moines, Iowa or GuideOne® Mutual Insurance Company of West Des Moines, Iowa or GuideOne Specialty Mutual Insurance of West Des Moines, Iowa. Additional services may be provided by ARAG LLC, ARAG Services LLC, or Advisory Communication Systems Inc. Some products are only available through membership in the ARAG Association LC.

If you prefer, you may use a non-network attorney of your choice, anywhere in the world. The plan pays at a rate of $70 an hour, up to the limits shown on page 38.

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

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

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

The plan provides these types of legal services:

- *Telephone legal services:* For simple matters that can be handled adequately by telephone, you may call a telephone network attorney who will either work with you over the phone or recommend that you meet with an attorney in person. Access to telephone network attorneys can help you get the most from the plan. By using this service whenever possible, you can keep other plan benefits available for more serious matters.
- *Attorney office work for advice and counseling:* The plan pays for up to eight hours a year when you use a Network Attorney. If you use a non-network attorney, the plan pays a rate of $70 an hour, up to $560 a year. Once the attorney begins working for you, the plan begins to pay benefits.

  It is up to you and the attorney to decide how best to use the time available—in personal meetings or by having the attorney review documents or write letters for you. If you exceed the yearly allowance, you must arrange with the attorney to pay for further services yourself.
- *Specific covered services:* The plan also covers services such as wills, legal defense, domestic matters, and consumer protection. See the chart on page 38 for a list of covered services.

For More Information

This is only an overview of your legal insurance benefits. The insurance company's plan booklet is available on the At Your Service website. You may also visit ARAG's website (members.araggroup.com/ucop) or call ARAG at 1-800-828-1395, Monday–Friday, 9 a.m.–5 p.m, PT. Once you enroll, the insurance carrier will send you more information.

Health Flexible Spending Account (Health FSA)

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

How the Plan Works

You determine the annual amount of your contributions from a minimum of $180 to a maximum of $5,000. Each month, an equal portion of that amount is deducted from your paycheck and is credited to your account before federal, state, and Social Security (FICA) taxes are taken out.

When you, your legal spouse, or eligible dependents have eligible expenses, you pay them from your account. Your savings are strictly on taxes and depend on your particular tax situation. See Internal Revenue Service (IRS) Publication 502, *Medical and Dental Expenses* (irs.gov), or consult your tax advisor for additional details. **Please note that UC cannot provide tax advice.**

Participants have a Health FSA Benefit Card that can be used for eligible health care expenses at approved health care merchants. This means that you won't have to pay cash up front for those expenses or file claim forms for reimbursement from your account. Instead, the amounts will be automatically deducted from your account. Use of the card is optional; paper form reimbursement is also an option.

Eligible Expenses

Eligible expenses include copayments and deductibles *(but not premiums)*, prescription drugs, orthodontia, eyeglasses, laser eye surgery, and other expenses incurred for health care that are not reimbursed by your medical, dental, or vision plan.

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

Health care expenses must meet the requirements of IRC §213(d) in order to be eligible for reimbursement. However, note that while an expense listed there may be an eligible tax deduction, it may not be an eligible expense under Health FSA (for example, insurance premiums).

Expenses must be incurred between January 1, 2009 through March 15, 2010 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 your effective date are not eligible for reimbursement. **Note: The effective date is the first of the month following your enrollment, subject to payroll deadlines.**

Please be aware that expenses submitted for reimbursement will be carefully evaluated against the IRC requirements for eligible and ineligible expenses. If your health care expenses are not clearly eligible according to the IRC, you will not be reimbursed for these expenses and you will be asked to submit additional information. For more information about eligible and ineligible expenses, see UC's *Health Flexible Spending Account Summary Plan Description* or the CONEXIS website.

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

Contribution Limits and Forfeiture Rules

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

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

CONEXIS must receive claims for 2009 eligible expenses by June 15, 2010, in order to reimburse the expenses.

Enrollment and Change in Participation

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

Your enrollment is for the current plan year (January 1 through December 31) only, ending on December 31 of each year. To participate the following year, you must re-enroll during Open Enrollment. Unless you have an eligible family or employment status change during the plan year, the IRC rules require that your contributions stay the same and you cannot cancel participation.

If you leave UC, cancel Health FSA, or do not re-enroll during Open Enrollment, you participation terminates at the end of the pay period in which your last contribution is deducted from your pay. You may use the spending account card or submit claims for eligible expenses incurred through the last day of the pay period for which a contribution was made. See the *Health Flexible Spending Account Summary Plan Description* for additional details.

Plan Administration

Claims processing and reimbursement are handled exclusively by CONEXIS. For more information on Health FSA administration, contact CONEXIS (1-877-266-3947). The Flexible Spending Account (FSA) Calculator on the CONEXIS website will help you estimate your tax savings (www.conexis.com/myfsa).

For More Information

This is only an overview of the Health FSA program. Be sure to review the *Health Flexible Spending Account Summary Plan Description* (available on the At Your Service website under "Forms & Publications" and from your Benefits Office) for plan details. Health FSA information is also available on the At Your Service website under "Health & Welfare Benefits."

Dependent Care Flexible Spending Account (DepCare FSA)

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

How the Plan Works

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

After you incur eligible dependent care expenses, you submit a claim form and receipts for these expenses to CONEXIS, the company UC has hired to administer the program. CONEXIS reimburses you for your expenses through an automatic deposit to your bank or by check.

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

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

Eligible Expenses

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

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

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

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

Expenses must be incurred between January 1, 2009 through March 15, 2010 in order to be eligible for reimbursement. Expenses incurred after your DepCare FSA participation ends are also not eligible for reimbursement. If you enroll midyear, expenses incurred before your effective date are not eligible. **Note: The effective date is the first of the month following your enrollment, subject to payroll deadlines.**

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

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

Contribution Limits and Forfeituture Rules

You determine how much you want taken from your monthly pay, from a minimum of $180 per year up to the lesser of:

- $5,000 per plan year ($2,500 if you are married and filing a separate income tax return);
- Your total earned income; or
- Your spouse's total earned income.

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

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

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

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

CONEXIS must receive claims for 2009 eligible expenses by April 15, 2010, in order to reimburse the expenses.

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

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

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

Who is Eligible

You are eligible to participate in the DepCare FSA if:

- You are eligible for the Full, Mid-level, or Core benefits package (see page 3).
- You are married and both you and your spouse have earned income during the year (unless your spouse is incapable of self-care or is a full-time student).

Eligible Dependents

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

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

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

Enrollment and Change in Participation

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

Unless you have an eligible family or employment status change during the plan year, the IRC rules require that your contributions stay the same and you cannot cancel participation. See the *Dependent Care Flexible Spending Account Summary Plan Description* for additional details.

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

Plan Administration

Claims processing and reimbursement are handled exclusively by CONEXIS. For more information on DepCare FSA administration, contact CONEXIS (1-877-266-3947).

For More Information

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

Tax Savings on Insurance Premiums (TIP)

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

How the Plan Works

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

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

Cost of Participation

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

Who Is Eligible

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

In addition to any cost for yourself, you may pay the health plan monthly costs through TIP for your spouse and for the following eligible family members who are your tax dependents: Adult dependent relative, Natural or adopted child, Stepchild, Legal ward, Other child, Disabled child, Grandchild or step-grandchild.

In general, you may not use TIP to pay the out-of-pocket premium cost for medical coverage for your family members who are not your tax dependents; for example, a natural or adopted child, domestic partner, your partner's child/grandchild and/or your disabled child past age 23. Monthly costs for these individuals must be paid on an after-tax basis.

Exception: If you have registered your domestic partnership with the State of California and have submitted UC's form UPAY 850 indicating such registration and the filing date, any out-of-pocket premium cost for medical coverage for your partner and/or your partner's child/grandchild is deducted from pay on a pretax basis for California income tax purposes only. For federal tax purposes, the out-of-pocket premium cost must still be paid on an after-tax basis. If these family members are your tax dependents, any necessary adjustments will be made at the end of the year when you respond to UC's annual tax dependency mailing. You may be able to recover excess federal or California State income tax withheld when filing tax returns.

Change in Participation

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

Participation Can End

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

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

For More Information

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

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

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

In conformance with applicable law and University policy, the University is an affirmative action/equal opportunity employer. Please send inquiries regarding the University's affirmative action and equal opportunity policies for staff to Director of Diversity and Employee Programs, University of California Office of the President, 300 Lakeside Drive, Oakland, CA 94612 and for faculty to Director of Academic Affirmative Action, University of California Office of the President, 1111 Franklin Street, Oakland, CA 94607.

Website address: atyourservice.ucop.edu

University of California
Human Resources and Benefits
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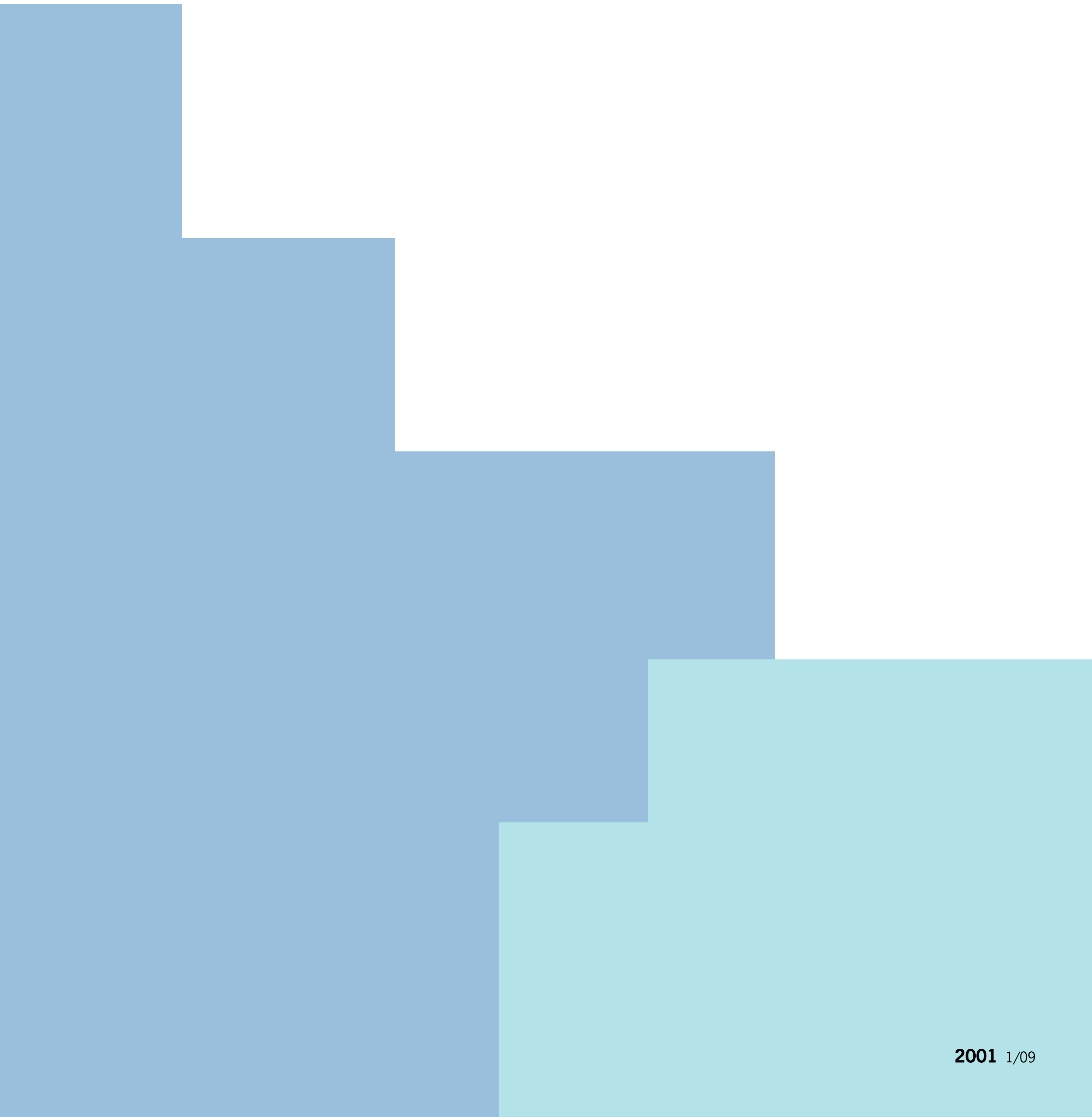
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