

2016 A Complete Guide to Your UC Health Benefits

Welcome to the University of California!

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

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

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

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

This booklet gives you the details of our health and welfare plans. Use it with *Your Benefits at a Glance*, which you received in your welcome kit to help you. Then keep this booklet for future reference—check UCnet (ucnet.universityofcalifornia.edu) for updates—when you have questions about your benefits or want to make changes.

You'll find additional tools and information online: ucnet.universityofcalifornia.edu. You can also call your local benefits office or any of the plans. You'll find their contact information on the insert at the front of this booklet.



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Eligibility

UC offers three benefits packages — Full, Mid-Level and Core. Your eligibility for a particular benefits package depends on the type of job you have, the percentage of time you work and the length of your appointment.

The eligibility requirements are listed below. See the chart on pages 9 to 11 for a list of the benefits available to you, based on the level of benefits for which you qualify.

REQUIREMENTS FOR EMPLOYEES IN CAREER, ACADEMIC, LIMITED, PARTIAL-YEAR CAREER, CONTRACT AND FLOATER APPOINTMENTS

CORE BENEFITS

You are eligible if you are a member of the UC Retirement Plan (UCRP) or another defined benefit plan to which UC contributes. You qualify for UCRP membership if your appointment type is among those listed above in this section and:

- You are appointed to work at least 50 percent time for a year or more¹, (unless an exception applies; see footnote 3) or
- You have worked 1,000 hours in a continuous 12-month period.²

MID-LEVEL BENEFITS

You are eligible if your appointment type is among those listed above in this section:

- You are appointed to work 100 percent time for at least three months but for less than one year or
- You are appointed to work at least 50 percent time for a year or more but you are in a position that is not eligible for UCRP³

CORE BENEFITS

You are eligible if your appointment type is among those listed above in this section and you are appointed to work at least 43.75 percent time.

¹ Or your appointment form shows that your ending date is for funding purposes only and that your employment is intended to continue for more than a year.

² If you are a member of the Non-Senate Instructional Unit, you qualify for UCRP membership if you are appointed to work in an eligible position for at least 50 percent time for a year or more or after you work 750 hours in a continuous 12-month period in an eligible position.

³ In a few specifically defined situations, UC employees may be eligible to participate in UC health and welfare benefits while being enrolled in a non-UC retirement plan. Eligible employees may have been covered by entities that were acquired by the University and/or they may have opted to remain in a previous public retirement plan at the time of UC employment.

REQUIREMENTS FOR EMPLOYEES IN PER DIEM, CASUAL/RESTRICTED (STUDENTS), BY AGREEMENT AND SEASONAL APPOINTMENTS

CORE BENEFITS

You are eligible if your appointment type is among those listed above in this section and you are appointed to work at least 75 percent for at least three months.

ELIGIBLE FAMILY MEMBERS

You may enroll one eligible adult family member in addition to yourself. Your children are also eligible for enrollment as outlined below.

ELIGIBLE ADULT

You may enroll your spouse or an eligible domestic partner.

You may enroll your same or opposite-gender domestic partner if your partnership is registered with the State of California or otherwise meets criteria for a domestic partnership as set forth in the University of California Group Insurance Regulations.

You may enroll your opposite-sex domestic partner only if either you or your domestic partner is age 62 or older and eligible to receive Social Security benefits based on age. Same-sex domestic partners from jurisdictions other than California will be covered to the extent required by law.

An adult dependent relative is not eligible for coverage in UC plans unless enrolled prior to Dec. 31, 2003 and continuously eligible and enrolled since that date. Also, remember: If your eligible adult dependent relative is still enrolled in the plan, you cannot enroll your spouse or domestic partner.

The eligible adult may be enrolled only in the same plans as you. See the chart on page 12 for more information on eligible plans.

ELIGIBLE CHILD

You may enroll your eligible children up to age 26 in the same plans as those in which you enroll. A disabled child may be covered past age 26, if the carrier approves. You may also enroll your legal ward up to age 18 in the same plan(s) as those in which you enroll. The Family Member Eligibility chart on pages 12 and 13 gives the eligibility criteria for children, stepchildren, grandchildren, disabled children and legal wards. You may enroll your eligible domestic partner's child or grandchild, even if you do not enroll your partner.

In order to be eligible for UC-sponsored coverage, your grandchild, step-grandchild, legal ward or overage disabled child(ren) (see Family Member Eligibility chart) must be claimed as a tax dependent by you or your spouse. Your eligible domestic partner's grandchild must be claimed as a tax

Eligibility

dependent by you or your domestic partner. Also eligible are children you are legally required by administrative or court order to provide with group health insurance.

Your children (or ward) are eligible for only the plans for which you are eligible and in which you have enrolled (See “Benefits Overview,” pages 12–13).

Except as provided elsewhere in this document, application for coverage beyond age 26 due to disability must be made to the plan 60 days prior to the date coverage is to end due to the child reaching limiting age. If application is received within this timeframe but the plan does not complete determination of the child’s continuing eligibility by the date the child reaches the plan’s upper age limit, the child will remain covered pending the plan’s determination. The plan may periodically request proof of continued disability, but not more than once a year after the initial certification. Disabled children approved for continued coverage under a University-sponsored medical plan are eligible for continued coverage under any other University-sponsored dental, vision or AD&D plan. If enrollment is transferred from one plan to another, a new application for continued coverage is not required; however, the new plan may require proof of continued disability, but not more than once a year.

If you are a newly hired employee with a disabled child over age 26 or if you acquire a disabled child over age 26 (through marriage, adoption or domestic partnership), you may also apply for coverage for that child. The child’s disability must have begun prior to the child turning age 26. Additionally, the child must have had continuous group health coverage since age 26, and you must apply for University coverage during your Period of Initial Eligibility. The plan will ask for proof of continued disability, but not more than once a year after the initial certification.

TAX IMPLICATIONS OF ENROLLING A DOMESTIC PARTNER

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

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

UC’s contribution for medical, dental and vision coverage is not considered imputed income for California state income tax purposes if you and your domestic partner have registered your partnership with the state of California. Also, if your partner’s

child is considered your stepchild under state law, federal imputed income will not apply to UC’s contribution toward the child’s coverage.

You must notify your local Benefits Office that your partnership is registered with the state of California so that imputed income is not reported for state tax purposes. Use form UPAY 850 (*Enrollment, Change, Cancellation or Opt Out—Employees Only*), available online at ucal.us/UPAY850 or from your local Benefits Office. Also, if your domestic partner is covered as your family member, and the two of you marry, be sure to notify your local Benefits Office (use form UBEN 850 available at ucal.us/UBEN850) so that imputed income and state taxes, if your partnership was not registered, no longer apply.

OTHER ELIGIBILITY RULES AND INFORMATION

NO DUPLICATE COVERAGE

UC rules do not allow duplicate coverage. This means 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 your own employee coverage and remain covered as another employee’s or retiree’s family member or make sure the UC employee or retiree who has been covering you de-enrolls you from his or her UC-sponsored plan before you enroll yourself.

Family members of UC employees may not be enrolled in more than one UC employee’s plan. For example, if spouses both work for UC, their children cannot be covered by both parents.

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

ELIGIBILITY VERIFICATION

When you enroll anyone in a plan as a family member, you must provide documentation specified by the University verifying that the individuals you have enrolled meet the eligibility requirements outlined above. The plan may also require documentation verifying eligibility status. In addition, the University and/or the plan reserve the right to periodically request documentation to verify the continued eligibility of enrolled family members.

Secova, Inc., which administers the verification process, will send you a packet of materials to help you complete the verification process. If you fail to provide the required documentation by the

deadline specified in these materials, your family member(s) may be disenrolled. Individuals whose eligibility has not been verified will be disenrolled until verification is provided. Individuals who are not eligible family members will be permanently disenrolled.

You also may be responsible for any UC-paid premiums due to enrollment of ineligible individuals.

WHEN COVERAGE BEGINS

The following effective dates apply provided the appropriate enrollment transaction (electronic or paper form) has been completed within the applicable enrollment period.

- If you enroll during a PIE, coverage for you and your family members is effective the date the PIE starts.
- If you enroll during Open Enrollment, the effective date of coverage is the date announced by the University. In most cases, it is the January 1 following Open Enrollment.
- If you complete a 90-day waiting period, coverage is effective on the 91st consecutive calendar day after the date the enrollment transaction is completed.

FAMILY MEMBERS

When you have a family status change, coverage begins on the first day you have a new family member—such as a spouse, domestic partner, newborn or newly adopted child.

If you are already enrolled in adult plus child(ren) or family coverage, you may add additional children, if eligible, at any time after their PIE.

CONTINUING ELIGIBILITY

UC bases your ongoing eligibility for benefits on your average hours of service⁴ over a 12-month, standard measurement period (SMP). UC's SMP for monthly-paid employees is Nov. 1–Oct. 31; for bi-weekly paid employees, the SMP includes the pay periods inclusive of those same dates (for example, in 2016, it runs Nov. 8, 2015 until Nov. 5, 2016).

If your hours during the SMP meet the threshold to be offered coverage, then that coverage must be offered, and if accepted, will be provided during the subsequent stability period, regardless of your number of hours during the stability period (as long as you remain employed). UC's standard stability period for all employees is Jan. 1–Dec. 31.

If your hours during the SMP do not meet the threshold, then all coverage ends on Dec. 31.

The required average hours of service threshold is:

Appointment Type	Average Hours Threshold
Career, Academic, Limited, Partial-Year Career, Contract, Floater	17.5 hours per week
Per Diem, Casual/Restricted (students), By Agreement or other flat-dollar payments, Seasonal	30 hours per week

WHEN COVERAGE ENDS

The termination of coverage provisions established by the University are summarized below.

DISENROLLMENT DUE TO LOSS OF ELIGIBLE STATUS

If you are an employee and lose eligibility, your coverage and that of any enrolled family members ends at the end of the month in which eligible status is lost.

OTHER DISENROLLMENTS

If you are enrolled in a health and welfare plan that requires premium payments, and you do not continue payment, your coverage will be terminated at the end of the last month for which you paid.

You and/or your family members may be disenrolled if you and/or a family member misuse the plan, as described in the Group Insurance Regulations. Misuse includes, but is not limited to, actions such as falsifying enrollment or claims information; allowing others to use the plan identification card; intentionally enrolling, or failing to disenroll, individuals who are not/no longer eligible family members; threats or abusive behavior toward plan providers or representatives.

LEAVE OF ABSENCE, LAYOFF, CHANGE IN EMPLOYMENT STATUS OR RETIREMENT

Coverage may end when you go on unpaid leave or leave UC employment. For information about continuing your coverage in the event of an authorized leave of absence, layoff, change of employment status or retirement, contact the person who handles benefits for your location.

⁴ Defined as all hours on pay status (including hours on call, hours on paid vacation, paid holiday, paid sick leave, paid sabbatical, paid jury duty, or any other paid leave) as well as hours on unpaid leave protected by the federal Family & Medical Leave Act, unpaid jury duty, and unpaid leave protected by the Uniformed Services Employment & Reemployment Rights Act. May also include up to 501 hours during the SMP due to "employment break periods" of at least 4 consecutive weeks (e.g., academic breaks, etc.).

Eligibility

OTHER FAMILY CHANGES THAT RESULT IN LOSS OF COVERAGE

Divorce, legal separation, termination of domestic partnership, annulment. Eligibility for your spouse or domestic partner and any children for whom you are not the legal parent/guardian ends on the last day of the month in which the event occurs. Your legally separated spouse, former spouse or former domestic partner and the former partner's child or grandchild may continue certain coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) or they may seek individual coverage, including through the healthcare marketplace (coveredca.com). If a settlement agreement between you and your legally separated/former spouse or domestic partner requires you to provide coverage, you must do so on your own.

An eligible child turning age 26. Unless a child is eligible to continue coverage because of disability, coverage ends at the end of the month in which the child reaches age 26. This rule applies to your biological and adopted children, stepchildren, grandchildren, step-grandchildren and your domestic partner's children or grandchildren. Certain coverage may be continued under COBRA or they may seek individual coverage, including through the healthcare marketplace (coveredca.com).

A legal ward turning age 18. Eligibility ends at the end of the month in which the legal ward turns 18. Your legal ward may continue certain coverage under COBRA or they may seek individual coverage, including through the healthcare marketplace (coveredca.com).

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

CONTRACT TERMINATION

Health and welfare benefits coverage is terminated when the group contract between the University and the plan vendor is terminated. Benefits will cease to be provided as specified in the contract and you may have to pay for the cost of those benefits incurred after the contract terminates. You may be entitled to continued benefits under terms described in the plan evidence of coverage booklet. (If you apply for an individual conversion plan, the benefits may not be the same as you had under the original plans.)

OPPORTUNITIES FOR CONTINUATION

If you separate from UC employment, generally, your UC-sponsored benefits will stop. If you retire from UC, see the *Group Insurance Eligibility Factsheet for Retirees and Eligible Family Members* (available on the UCnet website at ucnet.universityofcalifornia.edu/forms/pdf/group-insurance-eligibility-factsheet-for-retirees.pdf) for more details.

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985):

If you or a family member lose eligibility for UC-sponsored medical, dental and/or vision coverage and/or Health Flexible Spending Account (Health FSA), you may be eligible to continue coverage under COBRA. See the UCnet website for more information.

Conversion: Within 31 days after UC-sponsored coverage ends (if your participation has been continuous), you may be able to convert your group insurance coverage to individual policies. See the specific plan sections which follow for details.

Also, you may wish to contact the California Department of Managed Health Care at www.dmhc.ca.gov or 1-888-466-2219 to determine whether you are eligible for HIPAA Guaranteed Issue individual plan coverage or Covered California, California's health insurance marketplace, at www.coveredca.com or 1-800-300-1506 to review options for purchasing individual plan coverage.

ELIGIBILITY FOR STATE PREMIUM ASSISTANCE

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

If you live in California, you can contact the California Medicaid (Medi-Cal) office for further information via email (HIPP@dhcs.ca.gov) or visit their website (dhcs.ca.gov). If you live outside of California, go online to ucal.us/chipra for a list of states that currently provide premium assistance. You can also contact the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services at cms.hhs.gov; 877-267-2323, ext. 61565.

FOR MORE INFORMATION

- Participation Terms and Conditions on page 51
- *Benefits for Domestic Partners*
- Your local benefits office

Benefits Overview

	Benefits Packages			When You May Enroll	During PIE	During OE	90-Day Wait ¹	Automatic	With SOH ²	Premium Paid By
	Full	Mid-Level	Core							
Medical³ Choice of various options depending on your address, including health maintenance organization (HMO), preferred provider organization (PPO) or a high-deductible PPO with a health savings account. See page 17.	•	•			•	•	•			You and UC
Medical — Core Fee-for-service plan with a high deductible. See page 17.	•	•	•		•	•	•			UC
Dental³ 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 22.	•				•	•				UC
Vision³ Plan covers a variety of vision care services including eye exams, corrective lenses and frames. See page 26.	•				•	•				UC

DISABILITY INSURANCE

Short-Term Disability⁴ Provides basic coverage when unable 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 29.	•							•		UC
Supplemental Disability⁵ Provides short-term and long-term coverage for work and nonwork-related disabilities such as pregnancy/childbirth, injury or illness. Supplements employer-paid Short-Term disability and other sources of disability income you may receive (e.g., Worker's Compensation or Social Security), up to 70% of eligible earnings (\$15,000 monthly maximum). Choice of waiting periods.	•				•				•	You
Workers' Compensation Provides state-mandated coverage for work-related injuries.	•	•	•					•		UC

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

¹ The 90-day waiting period is available when the PIE is missed. See page 17. You may need to pay part of your premiums on an after-tax basis.

² If you do not enroll during the PIE, you may apply for coverage by submitting an evidence of insurability/statement of health. The carrier may or may not approve your enrollment.

³ When you enroll in any UC-sponsored medical, dental or vision plan, you will not be excluded from enrollment based on your health, nor will your premium or level of benefits be based on any genetic information or pre-existing health conditions. The same applies to your eligible family members.

⁴ Employees are not covered under California state disability insurance for period of employment at UC.

⁵ 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.

Benefits Overview

	Benefits Packages			When You May Enroll			90-Day Wait	Automatic	With SOH ²	Premium Paid By
	Full	Mid-Level	Core	During PIE	During OE					
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 34.	•							•		UC
Core Life Provides employees eligible for Core or Mid-Level Benefits with \$5,000 of life insurance. See page 34.		•	•					•		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 35.	•	•		•					•	You
Basic Dependent Life Provides \$5,000 of coverage for employee's spouse or domestic partner and each child. See page 37.	•	•		•					•	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 37.	•	•		•					•	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 39.	•	•	•	•						You
Business Travel Accident Provides up to \$500,000 of coverage when an employee travels on official UC business. See page 41 for enrollment instructions.	•	•	•							UC

OTHER BENEFITS

Legal Provides basic legal assistance for consultation/representation, domestic, consumer and limited defensive legal services and identity theft benefits. See page 43.	•	•	•	•						You
Automobile and Homeowner/Renter You may enroll at any time. Individually underwritten plan provides coverage for cars, boats, motorcycles, homes and apartments. Carrier underwriting requirements must also be met.	•	•		•						You
Family Care Resources Provides access to prescreened caregivers, pet sitters, tutors and other family services. See page 44.	•	•	•							You

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

TAX-SAVINGS PROGRAMS

	Benefits Packages			When You May Enroll	During PIE	During OE	90-Day Wait	Automatic	With SOH	Pretax Salary Reduction
	Full	Mid-Level	Core							
<p>General Purpose Health Flexible Spending Account (Health FSA) Lowers taxable income by allowing payment for up to \$2,550 of eligible out-of-pocket health care expenses on a pretax basis. See page 45.</p>	•	•	•		•	•				•
<p>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 46.</p>	•	•	•		•	•				•
<p>Tax Savings on Insurance Premiums (TIP) Lowers taxable income by allowing payment of health plan premiums (if any) on a pretax basis. See page 48.</p>	•	•	•		•	•		•		•

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

Benefits Overview

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

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

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

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

ELIGIBLE FAMILY MEMBERS

Overage disabled child (except a legal ward) of employee

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

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

Enrollment

To be certain you get the insurance coverage you want, you should enroll yourself and your eligible family members when you first become eligible.

For step-by-step instructions on how to enroll, see *Your Benefits at a Glance*, which you received in your Welcome Kit.

WHEN TO ENROLL

DURING A PERIOD OF INITIAL ELIGIBILITY (PIE)

A PIE is a time during which you may enroll yourself and/or your eligible family members in UC-sponsored health and welfare plans. A PIE generally starts on the first day of eligibility—for example, the day you are hired into a position that makes you eligible for benefits. It ends 31 days later.

If you're enrolling electronically, you must complete the transaction online by the last day of the applicable PIE. Paper enrollment forms need to be received at the location noted on the form by the last day of the applicable PIE. (If the last day falls on a weekend or holiday, the PIE is extended to the following work day.)

You may enroll your eligible family members during the 31-day PIE that begins on the first day the family member meets all eligibility requirements. If your enrollment is completed during your PIE, coverage is effective the date the PIE began.

The PIE to enroll family members starts the day your family member becomes eligible:

- For a spouse, on the date of marriage.
- For a domestic partner, on the date the domestic partnership is legally established or the partnership meets UC's criteria (see page 12).
- For a newborn child, on the child's date of birth.
- For an adopted child, the earlier of:
 - the date the child is placed for adoption with you, or
 - the date you or your spouse/domestic partner has the legal right to control the child's health care.

A child is "placed for adoption" as of the date you assume and retain a legal obligation for the child's total or partial support in anticipation of the child's adoption.

If the child is not enrolled during the PIE beginning on that date, there is an additional PIE beginning on the date the adoption becomes final.

- For a legal ward, the effective date of the legal guardianship.

Where there is more than one eligibility requirement, the PIE begins on the date all requirements are satisfied.

During this family member PIE, you may also enroll yourself and/or any other eligible family member who was not already enrolled during an earlier PIE. To enroll a family member, you must also enroll yourself. Remember that family members are only eligible for enrollment in medical, dental, vision and supplemental life coverage and must be enrolled in the same plans in which you are enrolled.

OTHER ENROLLMENT OPPORTUNITIES

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

OPEN ENROLLMENT

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

- Transferring to a different medical or dental plan
- Adding or disenrolling eligible family members
- Enrolling in or opting out of UC-sponsored medical, dental and vision plans and
- Enrolling or re-enrolling in the Health and Dependent Care Flexible Spending Accounts

Changes made during Open Enrollment are effective January 1 of the following year. Not all plans are available during every Open Enrollment.

WHEN YOU HAVE A FAMILY CHANGE

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

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

You have 31 days from the date your new family member becomes eligible to enroll the new member or to make any permitted plan changes (for example, 31 days from the day you marry or your child is born). Enrollment is not automatic; you must complete a UPAY 850 form (available online at ucal.us/UPAY850 or from your Benefits Office) to enroll the new family member.

You will be required to complete the Family Member Eligibility Verification process after enrolling the new family member. If you do not respond by the given deadline, your new family member may be disenrolled from the plans.

WHEN YOU LOSE OTHER COVERAGE

If you decline UC-sponsored coverage because you and/or your family members are covered elsewhere, and you later lose the other coverage, you may be eligible to enroll yourself and/or your eligible family members in a UC-sponsored plan. The same is true if you are enrolled in another employer-sponsored plan and the employer stops contributing to the cost of the coverage.

For medical, dental and vision coverage, you may enroll without waiting for the University's next open enrollment period if you have met all of the following requirements:

- You were covered under another health plan as an individual or dependent, including coverage under COBRA or CalCOBRA (or similar program in another state), the Children's Health Insurance Program or "CHIP" (called the Healthy Families Program in California), or Medicaid (called Medi-Cal in California).
- Coverage under another health plan for you and/or your eligible family members ended because you/they lost eligibility under the other plan or employer contributions toward coverage under the other plan terminated, coverage under COBRA or CalCOBRA continuation was exhausted, or coverage under CHIP or Medicaid was lost because you/they were no longer eligible for those programs.
- You properly file an application with the University during the 31-day PIE which starts on the day after the other coverage ends. **Note that if you lose coverage under CHIP or Medicaid, your PIE is 60 days.** You may need to provide proof of loss of coverage.

OTHER SPECIAL CIRCUMSTANCES

For medical, dental and vision coverage, you may enroll without waiting for the University's next open enrollment period if you are otherwise eligible under any one of the circumstances below:

- You or your eligible family members are not currently enrolled in UC-sponsored medical, dental or vision coverage and you or your eligible family members become eligible for premium assistance under the Medi-Cal Health Insurance Premium Payment (HIPP) Program or a Medicaid or CHIP premium assistance program in another state. Your PIE is 60 days from the date you are determined eligible for premium assistance. If the last day of the PIE falls on a weekend or holiday, the PIE is extended to the following work day if you are enrolling with paper forms.
- A court has ordered coverage be provided for a dependent child under your UC-sponsored medical, dental or vision plan pursuant to applicable law and an application is filed within the PIE which begins the date the court order is issued. The child must also meet UC eligibility requirements.

IF YOU ARE A NEW FACULTY MEMBER

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



Medical Plans

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

Who's covered: You and your eligible family members

Who pays the premium: You and UC for most plans

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

UC offers a range of high-quality medical plans with comprehensive coverage so you can choose the coverage that best meets your needs.

You should carefully evaluate your family circumstances and plan costs before selecting medical plan coverage. If you need more information about a specific medical plan, you'll find telephone numbers and links to all the plans' websites on the inside cover of this guide.

In addition to the general eligibility rules beginning on page 6 and plan eligibility rules found in each plan's evidence of coverage booklet, the following rules and information apply to UC medical plans.

ELIGIBILITY

The medical plans you're eligible for are based on whether your overall benefits package is Full, Mid-level or Core.

If you are eligible for coverage, you must take action to enroll.

BLUE SHIELD HEALTH SAVINGS PLAN

If you or a covered family member is enrolled in Medicare, you are not eligible for this plan due to IRS rules that do not allow Medicare members to make or receive contributions to a Health Savings Account.

WITH A 90-DAY WAITING PERIOD

If you miss your initial enrollment period, you may enroll yourself and/or your family members in medical coverage at any time by submitting an enrollment form to your Benefits Office. Your medical coverage will become effective 90 calendar days from the date you submit your form. Your premiums may be paid on an after-tax basis until the following January 1.

IF YOU MOVE OUT OF A PLAN'S SERVICE AREA

If you move out of an HMO plan service area, you and your eligible family members must transfer into a different plan available in your new location. If you later return to your original location, you may enroll in any UC medical plan unless your current plan also serves that area. Otherwise, you may change plans during the next Open Enrollment period or if you experience another event that permits you to change plans midyear.

WHAT THE PLANS COVER

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

There are no exclusions for pre-existing conditions.

An overview of the plans UC offers is on pages 18 and 19. The chart on page 21 provides a comparison of the plans. You can also view the Medical Plans Comparison video on UCnet at ucal.us/medicalplans.

COST OF COVERAGE

Your medical plan's monthly cost depends on:

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

Premium costs are available online at ucal.us/medicalpremiums, on the Medical Plan Chooser (uc.chooser.pbgh.org) and in *Which Medical Plan is Right for Your?* included in your Welcome Kit.

Please note: if you are represented by a union, your premiums are subject to collective bargaining and may be different from those posted or printed. Your premiums are available when you sign in to At Your Service Online or talk to your Benefits Office.

Medical Plans

HEALTH MAINTENANCE ORGANIZATIONS (HMO)

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

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

UC's HMOs are available to employees living and working in California only.

UC'S HMO

Health Net Blue & Gold HMO	Offers a tailored network of medical groups, doctors and hospitals, and includes all of UC's medical centers and medical groups. For more information, see healthnet.com/uc
Kaiser Permanente—CA	A closed network, meaning you must use only Kaiser doctors and hospitals. For more information, see kp.org/universityofcalifornia
Western Health Advantage	Provides a regional network of medical groups, doctors and hospitals in the following areas: Davis/Sacramento (including UC Davis Health System), Marin, Napa and Sonoma counties. For more information, see westernhealth.com

PREFERRED PROVIDER ORGANIZATIONS (PPO)

PPOs offer a broad network of providers and allow you the flexibility to see non-network providers if you wish. You don't need a referral to see your primary care doctor or specialists. Usually, you must meet the plans deductible and then you pay coinsurance, which is a percentage of the cost of services. You pay a smaller percentage for in-network providers.

UC'S PPO

Blue Shield Health Savings Plan	This is a high-deductible PPO plan with a Health Savings Account (HSA), which you can use to pay your eligible medical expenses. UC contributes to the HSA and you can, too. You pay the cost of medical services until you meet the deductible, then you pay a percentage of the cost of services, with lower costs when you use in-network providers. You own the HSA, so the money goes with you if you leave UC. You can continue to contribute to it as long as you are enrolled in a qualifying high deductible health plan. For more information, see blueshieldca.com/uc and healthequity.com/ed/uc
UC Care	This is a PPO plan with a custom network tier. If you use providers in the UC Select Network, which includes UC medical center doctors, hospitals and other facilities as well as select providers near other UC locations, you pay copayments for services. If you use other providers in the Blue Shield Preferred network, you pay 20 percent coinsurance once you've met the deductible. You pay a higher deductible and a greater percent of the coinsurance if you use a provider outside the network. For more information, see uc-care.org
Core Fee-for-Service Plan	This is UC's high-deductible catastrophic plan. You can choose any doctor, hospital, clinic or behavioral health provider, but you pay less if you use a provider in the Blue Shield PPO network. After you have met the plan's annual deductible, the plan pays for part of the cost of services. If you use non-network providers, you must pay for services up front and submit a claim; you receive reimbursement if the plan covers the service. For more information, see blueshieldca.com/uc

ABOUT THE BLUE SHIELD HEALTH SAVINGS PLAN (HSP) WITH HEALTH SAVINGS ACCOUNT (HSA)

The Health Savings Account (HSA), which is part of the Blue Shield Health Savings Plan, lets you pay for your out-of-pocket health care expenses with tax-free dollars.

With the HSA, administered by Health Equity, you can use the funds at any time for qualified medical expenses or save them for future health care needs. You file claims directly with Health Equity. The HSA has a “use-it-or-keep-it” feature, so your account balance rolls over annually. When you’re ready to use your funds, you can take them out of your HSA without paying any federal taxes. You earn interest on your account, and can invest any funds in excess of \$2,000—the same way you invest funds in retirement savings accounts, except interest accrues federal tax-free. Contributions and earnings are subject to California income tax.

For 2016, the IRS allows HSA contributions up to \$3,350 for single/individual coverage and up to \$6,750 for family coverage (if you are covering at least one family member), inclusive of UC contributions. UC contributes up to \$500 for individual coverage and up to \$1,000 for all other coverage levels, depending on the effective date of your HSP coverage. You can also contribute with pre-tax payroll deductions, subject to payroll deadlines. You are responsible for making sure the combined HSA contributions are within the IRS limits. Individuals age 55 and older can make an additional “catch-up” contribution of \$1,000 using the UPAY 850 form (ucal.us/UPAY850). If you enroll in the Blue Shield Health Savings Plan anytime after January, UC’s contribution to your HSA will be prorated for the calendar year. The proration schedule is available online (ucnet.universityofcalifornia.edu/compensation-and-benefits/health-plans/medical/hsa-proration-schedule.html).

To be eligible for the HSA, you must enroll in the Blue Shield Health Savings Plan. You also must have a valid Social Security number and U.S. address to establish your HSA. In addition, you cannot enroll in UC’s or in any general-purpose Health Flexible Spending Account.

If you or your dependent(s) are enrolled in Medicare, you cannot enroll in this plan, according to the IRS. Due to the UC contribution to your HSA, if you cover a family member and he/she is enrolled in Medicare, you cannot enroll in this plan unless you de-enroll your Medicare-enrolled family member from your coverage. Remember that the entire UC contribution is deposited automatically at the beginning of the year and is based on your coverage level.

Here are a few things to keep in mind if you become an HSP member. As an HSA owner, you must decide:

- Whether you are eligible to make contributions to an HSA
- The amount of the eligible contribution to the HSA for any calendar year
- The withdrawal of any excess contributions

- How funds in your HSA will be spent

You cannot delegate these responsibilities to the University or to HealthEquity. As the HSA owner, you are responsible for reporting all contributions and distributions to the IRS on your Form 1040.

BEHAVIORAL HEALTH AND SUBSTANCE ABUSE BENEFITS

Optum covers behavioral health and substance abuse services for all UC-sponsored medical plans except Core Medical. The first three in-network outpatient mental health visits are covered at no cost to you for all plans except Blue Shield Health Savings Plan.

Kaiser members have access to Kaiser’s integrated behavioral health services as well as Optum in-network services. Kaiser and Optum do not coordinate care or costs of behavioral health services. Each plan has specific requirements. Kaiser members should understand plan and authorization guidelines when they consider their options for behavioral health services.

If you enroll in the Blue Shield Health Savings Plan or UC Care, you have access to both in-network and out-of-network behavioral health services. All other plans have in-network benefits only.

Core Medical’s mental health and substance abuse benefits are provided by Blue Shield.

UC LIVING WELL WELLNESS PROGRAM

UC is committed to the well-being of employees and their family members and supports healthy living through the systemwide UC Living Well program.

UC Living Well offers faculty, staff and retirees access to programs, activities and resources that support healthy lifestyles.

UC Living Well includes:

- Campus and health system wellness activities
- Programs and support from UC’s benefits providers
- Preventive exams and screenings
- Disease management programs such as Health Net Blue & Gold’s Omada Prevent Diabetes and Heart Disease Prevention Program and Kaiser’s online coaching program

Participation in on-site campus and health system wellness programs varies by campus; contact your location’s wellness coordinator for details.

For more information, see the UC Living Well website (uclivingwell.ucop.edu).

Medical Plans

GENERAL INFORMATION

CHOOSING A PRIMARY CARE PHYSICIAN (PCP)

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

If you or your eligible family members do not select a PCP, your medical plan will assign one to you. You may change your PCP at any time by calling the plan directly.

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

ID CARDS

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

WHEN COVERAGE ENDS

If you lose eligibility for medical coverage, you can continue coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) for a period of time. You may be able to convert your coverage to an individual policy if you apply within 31 days of the date your UC-sponsored coverage or COBRA continuation coverage ends. You may also seek individual coverage, including through the healthcare marketplace (coveredca.com)

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

FOR MORE INFORMATION

Evidence of Coverage booklets for all of UC's medical plans are available online at ucal.us/EOCs or from the carriers (see front of booklet for contact information).

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

TIPS:

If you want lower monthly premiums:

- Blue Shield Health Savings Plan with HSA
- Core
- Kaiser Permanente
- Western Health Advantage

If you want more flexibility in choosing doctors:

- Blue Shield Health Savings Plan with HSA
- UC Care
- Core

If you want predictable costs:

- Health Net Blue & Gold HMO
- Kaiser Permanente
- Western Health Advantage

If you reside or have a child in college outside California:

- Blue Shield Health Savings Plan
- UC Care
- Core

If you want one doctor to manage all your care:

- Health Net Blue & Gold HMO
- Kaiser Permanente
- Western Health Advantage

If you want access to UC medical centers and doctors:

- Blue Shield Health Savings Plan
- Health Net Blue & Gold HMO (if you are within service area)
- UC Care
- Western Health Advantage
- Core

Medical Plans

UC MEDICAL PLANS	Your Monthly Premium	Your Costs for Services	Your Cost for Prescription Drugs: Generic/Brand/Non-formulary	Best Fit for People Who:
<p>Blue Shield Health Savings Plan May use any doctor without referral from primary care physician; in-network providers cost less. Health Savings Account (HSA) covers part of annual deductible before PPO benefits apply.</p>	\$	<p>\$\$\$</p> <p>You have higher out-of-pocket costs until the deductible is met; you pay coinsurance thereafter. You may make pretax contributions to the Health Savings Account to help pay your out-of-pocket costs.</p>	Full cost up to deductible; then 20% at in-network pharmacies; 40% at non-network pharmacies	<ul style="list-style-type: none"> Want lower premium and broad access to providers Are able to risk incurring greater out-of-pocket costs Want tax-free savings for current and future health care costs Want direct access to all providers without need for referrals
<p>Core You may use any doctor.</p>	\$0	<p>\$\$\$+</p> <p>Except for certain preventive services, you pay the full cost until you reach the \$3,000 deductible. Then you pay 20%.</p>	20%	<ul style="list-style-type: none"> Want to pay no monthly premium Want protection for catastrophic care Are willing to risk incurring high out-of-pocket costs Want direct access to all providers without need for referrals
<p>Health Net Blue & Gold HMO Must use custom network of providers, except in emergencies</p>	\$\$	<p>\$</p> <p>No deductible; you pay a copay for office visits and hospital stays; most other services have no charge.</p>	<p>Retail (30-day supply) \$5/\$25/\$40</p> <p>Mail order (up to 90 days) \$10/\$50/\$80</p>	<ul style="list-style-type: none"> Want lower premium and cost per service Are comfortable with HMO model: primary care physician manages care; no out-of-network coverage Are content with the selection of community providers
<p>Kaiser Permanente—CA Must use network providers, except in emergencies</p>	\$	<p>\$</p> <p>No deductible; you pay a copay for office visits and hospital stays; most other services have no charge.</p>	<p>Retail (30-day supply) \$5/\$25/NA</p> <p>Mail order (31–100 days) \$10/\$50/NA</p>	<ul style="list-style-type: none"> Want lower premium and cost per service Are comfortable with getting medical care only within the Kaiser system
<p>UC Care May use any doctor without referral from a primary care physician; you pay copayment for UC Select Network providers; in network providers cost less than out-of-network providers.</p>	\$\$\$	<p>\$/\$\$</p> <p>UC Select Network providers: no deductible and copay for office visits and hospital stays; Blue Shield Preferred providers: calendar year deductible and then 20% coinsurance; out-of-network: calendar year deductible and then 50% coinsurance.</p>	<p>Retail (30-day supply) \$5/ \$25/ \$40</p> <p>Mail order (up to 90 days) \$10/\$50/\$80</p>	<ul style="list-style-type: none"> Want direct access to all providers without a referral Want no deductible and fixed copay for using providers in the UC Select network Want coverage when you are traveling or living abroad You and/or your family members live outside California
<p>Western Health Advantage Must use network providers, except in emergencies</p>	\$	<p>\$</p> <p>No deductible; you pay a copay for office visits and hospital stays; most other services have no charge.</p>	<p>Retail (30-day supply) \$5/\$25/\$40</p> <p>Mail order (up to 90 days) \$10/\$50/\$80</p>	<ul style="list-style-type: none"> Want lower premium and cost per service Are comfortable with HMO model: primary care physician manages care; no out-of-network coverage

\$ Lowest costs in relation to all plans \$\$ Mid-range of costs in relation to all plans \$\$\$ Highest costs in relation to all plans

Dental

Benefits packages: Full

Who's covered: You and your eligible family members

Who pays the premium: UC

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

The following rules and information about UC's dental plans are in addition to the general eligibility rules beginning on page 6.

ELIGIBILITY

You are eligible to enroll in dental coverage only if you have Full Benefits.

If you are eligible for dental benefits, you must take action to enroll.

You may enroll in DeltaCare® USA only if you meet the plan's geographic service area criteria.

IF YOU MOVE OUT OF A PLAN'S SERVICE AREA

If you move out of a DeltaCare® USA plan service area, you and your eligible family members must transfer into a different plan available in your new location. If you later return to your original location, you may enroll in either plan unless your current plan also serves that area. Otherwise, you may change plans during the next Open Enrollment period or if you experience another event that permits you to change plans midyear.

UC'S DENTAL PLANS

DELTA DENTAL PPO

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

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

Delta has more than 43,000 PPO dentists in California and 234,000 nationwide. To see a list of Delta Dental PPO dentists, visit the Delta Dental website: www.deltadentalins.com/uc.

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

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

DELTACARE® USA

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

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

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

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

BENEFITS AND SERVICES

For a comparison of benefits and services, see the chart on pages 23 to 25. You can also use the website uc2016.chooser2.pbgh.org/dental/uc2016.htm to compare the two plans.

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

COST OF COVERAGE

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

WHEN COVERAGE ENDS**DISENROLLMENT DUE TO LOSS OF ELIGIBLE STATUS**

If your family member loses eligibility, and you wish to make a permitted change in your dental coverage, you must complete the appropriate transaction to delete him or her within 31 days of the eligibility loss event, although for purposes of COBRA eligibility, notice may be provided to UC within 60 days of the family member's loss of coverage. For information on disenrollment procedures, contact the person who handles benefits for your location.

OPPORTUNITIES FOR CONTINUATION

To learn about how you may continue your coverage through COBRA or individual conversion, please see "Opportunities for Continuation" on page 8 of the Eligibility section.

FOR MORE INFORMATION

Evidence of Coverage booklets are available online at ucal.us/EOCs.

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

Delta Dental PPO

800-777-5854, www.deltadentalins.com/uc

DeltaCare® USA

800-422-4234, www.deltadentalins.com/uc

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

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

Dental

DENTAL SERVICES	Delta Dental PPO Plan	DeltaCare® USA HMO Plan
Basic Dentistry	Deductible applies.	Copayments apply as noted.
Fillings	80% PPO/75% Premier	100% for standard benefit
Anesthesia ¹	80% PPO/75% Premier (general anesthesia for covered oral surgery)	Local—100%. General and intravenous sedation—100%; limited to medically necessary extractions
Prosthetic appliance repair	80% PPO/75% Premier	100%
Extractions	80% PPO/75% Premier	100% if uncomplicated (not covered if done only for orthodontics)
Oral surgery	80% PPO/75% Premier	\$15 copayment for impactions; other covered services at 100%
Endodontics	80% PPO/75% Premier	\$20–\$60 copayment for each canal; other covered services at 100%
Periodontics	80% PPO/75% Premier	\$100 copayment per quadrant for surgery (mucogingival and osseous gingival); \$150 copayment for soft tissue graft procedures; periodontal maintenance: 100% for 1 in each 6-month period; additional maintenance when necessary: \$55 copayment
Denture Relining and Rebase	80% PPO/75% Premier	Relining—100% (limited to 1 in any 12-month period). Rebase—\$20 copay
Major Dentistry	Deductible applies.	Copayments applied as noted.
Crowns	50%	\$50 per unit copayment (\$150 extra charge for precious metals)
Inlays/onlays	50%	100% for standard benefit
TMJ Disorder Benefits Temporomandibular joint (TMJ) dysfunction: occlusal devices/occlusal guards (night guards)	50% up to \$500 for all benefits in a lifetime (not applied to calendar year maximum). Deductible applies.	100%
Prosthetic Dentistry	Deductible applies.	Copayments apply as noted.
Standard, full or partial dentures	50%	Upper—\$65 copayment per denture Lower—\$65 copayment per denture (extra charge for precious metals) Removable partial denture with flexible base—\$115
Bridges	50%	\$50 per unit copayment (extra charge for precious metals)
Implants	50%	Not covered
Total Benefit (Total benefit for preventive, basic and major dentistry, and prosthetic dentistry)	\$1,700 if a Delta Dental PPO dentist is used; otherwise \$1,500 per person per calendar year	No maximum

After an annual deductible of \$50 per person²

DENTAL SERVICES	Delta Dental PPO Plan	DeltaCare® USA HMO Plan
Orthodontics	No deductible	Copayments apply as noted below
Who is eligible for service	All covered family members	All covered family members
Benefit	50% copayment; maximum of \$1,500 for each eligible patient under age 26 and \$500 for each eligible patient age 26 and older	\$1,000 copayment (plan covers 36 months of usual and customary treatment—a monthly office visit fee of \$75 applies after the 36 months)
Special Provisions, Limitations, Exclusions		
Work in progress when you join	Only services that you receive on or after your effective date of coverage are covered.	Only services received from a DeltaCare® USA provider on or after your effective date of coverage are covered ³ .
Predetermination of benefits	If services are expected to be \$400 or more, your dentist files a treatment plan first; Delta reviews it and notifies you and your dentist of the benefits payable.	Before any work is done, ask your DeltaCare® USA dentist what the charges will be. If you have any questions about what will be covered, call DeltaCare® USA.
Alternate treatment provision	If more than one professionally acceptable and appropriate treatment can be used, Delta benefits will be based on the least expensive method.	If you select a treatment plan different from that customarily provided by DeltaCare® USA, you will pay the applicable copayment, plus the additional cost of the alternate treatment.
Replacement of crowns, dentures, partial dentures and bridges	Not covered if crown or prosthetic appliance is fewer than 5 years old	Not covered if crown or prosthetic appliance is less than 3 years old
Out-of-area emergencies	Coverage applies worldwide.	Plan pays up to \$100 in 12-month period for pain relief when you are more than 25 miles from your dentist's office.
Teeth bleaching	Not covered	\$125 copayment per arch. External bleaching is limited to one bleaching tray per arch per 36-month period; bleaching gel for two weeks of patient self treatment.
Tobacco counseling for prevention of oral disease	Not covered	100%

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

¹ Disabled members may receive anesthesia for any covered dental service if needed to receive treatment. Preauthorization is required.

² Combined for basic and major dentistry, TMJ disorder benefits and prosthetic dentistry.

³ Exception: DeltaCare® USA may cover orthodontia treatment in progress for new enrollees/family members if treatment meets specific DeltaCare® USA criteria.

Vision

Benefits package: Full

Who's covered: You and your eligible family members

Who pays the premium: UC

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

ELIGIBILITY

See the general eligibility rules beginning on page 5.

WHAT THE PLAN COVERS

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

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

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

WHEN COVERAGE BEGINS

Please see "When Coverage Begins" on page 7 of the Eligibility section.

COST OF COVERAGE

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

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

WHEN COVERAGE ENDS

DISENROLLMENT DUE TO LOSS OF ELIGIBLE STATUS

If your family member loses eligibility, and you wish to make a permitted change in your vision coverage, you must complete the appropriate transaction to delete him or her within 31 days of the eligibility loss event, although for purposes of COBRA eligibility, notice may be provided to UC within 60 days of the family member's loss of coverage. For information on disenrollment procedures, contact the person who handles benefits for your location.

OPPORTUNITIES FOR CONTINUATION

To learn about how you may continue your coverage through COBRA or individual conversion, please see "Opportunities for Continuation" on page 8 of the Eligibility section.

FOR MORE INFORMATION

VSP website: vsp.com

VSP phone: 866-240-8344

VSP Evidence of Coverage Booklet, available online at ucal.us/EOCs.



Short-Term and Supplemental Disability

Benefits package: Full

Who's covered: You

Who pays the premium: You and UC

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

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

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

WHEN TO ENROLL

You are automatically enrolled in Short-Term Disability, if eligible, on your first day of work.

For general information about enrolling in Supplemental Disability, please see "When Coverage Begins" on page 7 of the Eligibility section.

ENROLLMENT WITH STATEMENT OF HEALTH

If you do not enroll in the Supplemental Disability plan when you are first hired, you must submit an evidence of insurability and be approved by the insurance company in order to enroll.

Previous or existing medical conditions may prevent approval if you try to enroll outside of your initial period of eligibility. You must also submit an evidence of insurability for approval in order to shorten your waiting period. Generally, you cannot enroll in Supplemental Disability during UC's annual Open Enrollment or due to family changes.

LIMITATIONS TO COVERAGE

Under the Supplemental Disability plan, the definition of disability changes after you receive benefits for 12 months, and it becomes more difficult to meet the insurance carrier's requirements. During the first 12 months, disability is defined as being disabled from your "own occupation." After 12 months of benefits, disability is defined as being disabled from "any occupation" for which you are reasonably suited.

WHAT THE PLANS COVER

SHORT-TERM DISABILITY

UC provides the Short-Term Disability plan at no cost to you and does not participate in the California State Disability Insurance (CA SDI) program, although employees who have worked for UC for fewer than 18 months may have some residual CA SDI benefits.

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

SUPPLEMENTAL DISABILITY

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

Supplemental Disability, combined with these other sources of disability income, pays 70 percent of your eligible earnings, up to \$15,000 per month for up to 12 months.

If you are still disabled after 12 months of benefits and are receiving other disability income, the Supplemental Disability plan continues to pay long-term benefits to fill in the difference between those other sources of income and 70 percent of your eligible earnings. The plan pays a minimum of \$100 per month, even if you are receiving a full 70 percent of eligible earnings from other sources. If you have no other source of income, the Supplemental Disability plan alone pays a maximum of 50 percent of your eligible earnings up to \$15,000 per month.

Supplemental Disability plan benefits are payable as long as you remain disabled up to age 65. (If you become disabled after reaching age 60, benefits may continue past age 65. See the insurance plan booklet, available online at ucal.us/EOCs.)

OTHER SOURCES OF DISABILITY BENEFITS

UC employees may be eligible for other disability benefits, including:

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

Short-Term and Supplemental Disability

HOW THE PLANS WORK

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

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

However, if you have accrued sick leave, you must first use up to 22 working days of sick leave before your benefits start under both Short-Term and Supplemental Disability. As a new employee, you may want to consider a shorter waiting period until you accrue sufficient sick leave—you can increase your waiting period at any time, but shortening it requires an evidence of insurability and approval of the insurance company.

See the charts on pages 32 and 33 for examples of how the waiting period and benefits work.

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

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

SICK LEAVE NEEDED TO COVER WAITING PERIOD

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

¹ 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.

IMPORTANT CONSIDERATIONS

- Under the Supplemental Disability plan, the definition of disability changes after you receive benefits for 12 months, and it becomes more difficult to meet the insurance carrier's requirements. During the first 12 months, disability is defined as being disabled from your "own occupation." After 12 months of benefits, disability is defined as being disabled from "any occupation" for which you are reasonably suited.
- Disabilities related to pre-existing conditions and that begin in your first year of coverage under the Supplemental Disability plan are limited to a total of 12 months of benefits.
- If you are a new UC employee and become disabled, you may have California State Disability Insurance (CA SDI) coverage through a former employer. Any CA SDI income you are eligible to receive will be deducted from your disability benefits payable under UC's disability plans.
- Supplemental Disability long-term benefits for disabilities related to mental illness and/or substance abuse are generally limited to a 24-month lifetime maximum benefit, unless you remain continuously hospitalized or in an extended treatment plan.

DISABILITY BENEFITS AND WORKERS' COMPENSATION

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

For Workers' Compensation claims, UC is self-insured and contracts with a third-party administrator to manage its claims. More information is available in the *Business and Finance Bulletin BUS 81—Insurance Programs*, available on At Your Service or from your local Workers' Compensation Manager. A directory of UC Workers' Compensation Managers is available online at ucop.edu/risk-services/staff-contacts/workers-compensation-managers.

COST OF COVERAGE

The university provides the Short-Term Disability plan at no cost to you.

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

WHEN COVERAGE ENDS

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

FOR MORE INFORMATION

The following publications are available online at ucal.us/disabilitypubs:

- *Guide to UC Disability Benefits*
- *Disability Benefits for Faculty*
- *Pregnancy, Newborn Child and Adoption Fact Sheet*
- *Partial Disability: Stay at Work/Return to Work Factsheet*
- *Short-Term Disability Insurance Plan Booklet*
- *Supplemental Disability Insurance Plan Booklet*

How Disability Benefits Work

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

SHORT-TERM DISABILITY PLAN ONLY

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

SHORT TERM DISABILITY

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

Date you become eligible for disability benefits

SHORT-TERM AND SUPPLEMENTAL DISABILITY PLAN

Short-Term and Supplemental Disability work together based on the waiting period you choose. This means the waiting period you choose for the Supplemental Disability plan automatically becomes your waiting period for the Short-Term Disability Plan as well. Even if you choose the 7-day waiting period, you must use 22 days of sick leave, excluding paid holidays, if available. You may also use additional accrued sick leave and vacation days, up to the full waiting period. If you do not have enough sick leave to cover your waiting period, the balance of your waiting period will be unpaid.

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

After receiving 12 months of Supplemental Disability benefits, the plan will pay 50 percent of your eligible earnings up to \$15,000 per month.

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

Week	1	2	3	4	Week 5 through Week 52	Week 53 and Beyond
	<ul style="list-style-type: none"> • Waiting Period: 7 days or up to 22 days of sick leave and/or vacation • Full pay and benefits 				<ul style="list-style-type: none"> • Short-Term and Supplemental Disability • 70% of monthly earnings up to \$15,000 per month 	<ul style="list-style-type: none"> • 50% of eligible earnings up to \$15,000 per month

Date you become eligible

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

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

Week	1	2	3	4	Week 5 through Week 52	Week 53 and Beyond
	<ul style="list-style-type: none"> • Waiting Period: up to 22 days of sick leave and/or vacation • Full pay and benefits 				<ul style="list-style-type: none"> • Short-Term and Supplemental Disability • 70% of monthly earnings up to \$15,000 per month 	<ul style="list-style-type: none"> • 50% of eligible earnings up to \$15,000 per month

Date you become eligible

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

Week	Week 1 to Week 13	Week 14 through Week 52	Week 53 and Beyond
	<ul style="list-style-type: none"> • Waiting Period: up to 66 days of sick leave and/or vacation • Full pay and benefits 	<ul style="list-style-type: none"> • Short-Term and Supplemental Disability • 70% of monthly earnings up to \$15,000 per month 	<ul style="list-style-type: none"> • 50% of eligible earnings up to \$15,000 per month

Date you become eligible

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

Week	Week 1 to Week 26	Week 27 through Week 52	Week 53 and Beyond
	<ul style="list-style-type: none"> • Waiting Period: up to 131 days of sick leave and/or vacation • Full pay and benefits 	<ul style="list-style-type: none"> • Short-Term and Supplemental Disability • 70% of monthly earnings up to \$15,000 per month 	<ul style="list-style-type: none"> • 50% of eligible earnings up to \$15,000 per month

Date you become eligible

Life Insurance

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

Who's covered: You

Who pays the premium: UC

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

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

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

WHAT THE PLANS COVER

BASIC LIFE

This plan provides life insurance equal to your annual base salary, up to \$50,000.¹ The coverage amount is based on your UC salary and appointment rate as of your date of hire or January 1 of the current year, whichever is later.

Benefits are paid to your beneficiaries if you die while employed or on paid leave, or during the first four months of approved leave without pay or temporary layoff. Your beneficiaries receive these benefits in addition to any other death benefits for which you may qualify.

CORE LIFE

This plan provides \$5,000 of life insurance.²

Benefits are paid to your beneficiaries if you die while employed or on paid leave, or during the first four months of approved leave without pay or temporary layoff. Your beneficiaries receive these benefits in addition to any other death benefits for which you may qualify.

OTHER FEATURES OF THE PLANS

LIVING BENEFIT OPTION

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

EXTENDED DEATH BENEFIT

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

COST OF COVERAGE

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

WHEN COVERAGE ENDS

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

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

EXCEPTION TO DUPLICATE UC COVERAGE RULE

You may be enrolled in Basic Life Insurance, Core Life Insurance or Senior Management Life Insurance and be covered as a dependent of another UC employee.

¹ If you are a member of the California Public Employees' Retirement System (CalPERS), CalPERS provides \$5,000 of coverage and UC provides coverage equal to your annual base salary less \$5,000, up to \$45,000.

² This plan does not cover CalPERS members.

Supplemental Life Insurance

BENEFICIARIES

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

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

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

You may change your designated beneficiary at any time using At Your Service Online. Once your new designation is processed, all previous designations are invalid. Changes in your family situation—such as marriage, divorce or birth of a child—do not automatically alter or revoke your previous designations. A will also does not supersede a beneficiary designation. Prior designations remain valid until you change your designations online. However, a beneficiary designation may be subject to challenge if it will result in your spouse receiving less than his or her community property share of the benefit.

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

Benefits package: Full and Mid-Level

Who's covered: You

Who pays the premium: You

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

WHEN TO ENROLL

ENROLLMENT

To obtain coverage without the need for a statement of health, enroll during your first PIE or during a PIE that occurs as the result of the acquisition of a new family member. During a PIE that occurs as the result of the acquisition of a new family member, you can also increase your Supplemental Life Insurance. Otherwise you can enroll at any time, but a statement of health will be required.

ENROLLMENT WITH STATEMENT OF HEALTH

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

WHEN COVERAGE BEGINS

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

COVERAGE AMOUNTS

You may choose one of several coverage amounts:

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

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

Supplemental Life Insurance

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

PLAN FEATURES

LIVING BENEFIT OPTION

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

WAIVER OF PREMIUM

If you become totally disabled before age 65 and your disability continues for six consecutive months, you may qualify for continuance of life insurance protection without paying the premiums.

You must provide written proof of your disability no later than one year after the disability starts and submit proof of your continuing disability each year. Your life insurance will continue until you reach age 70, as long as you remain totally disabled.

You may need to continue your premium payments to your Payroll or Benefits Office while your application is pending. See your insurance booklet or call the insurance carrier for more information.

COST OF COVERAGE

Your cost for Supplemental Life depends on your age and the amount of coverage you purchase. Use the online Insurance Premium Calculator (ucal.us/premiumcalculator) to determine your monthly premium.

WHEN COVERAGE ENDS

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

The portability benefit allows you to continue your current UC Supplemental life coverage at Prudential’s Portability group term-life rates, which are lower than the conversion premium rates. A statement of health is not required, but you must submit proof of good health satisfactory to Prudential to qualify for preferred rates. There are additional requirements for portability. See the Supplemental Life Insurance plan booklet for details.

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

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

Dependent Life Insurance

Benefits package: Full and Mid-Level

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

Who pays the premium: You

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

WHEN TO ENROLL

To obtain coverage for a spouse or domestic partner without the need for a statement of health, enroll them during your own initial PIE, or if the marriage or partnership occurs later, during the 31-day PIE following the marriage or partnership date. Otherwise they can be enrolled at any time, but a statement of health will be required.

Children may be enrolled at any time without a statement of health.

ELIGIBILITY

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

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

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

WHAT THE PLANS COVER

BASIC DEPENDENT LIFE

This plan covers your spouse or domestic partner and/or your eligible children; the benefit is \$5,000 for each dependent. See pages 12 and 13 for each family member's requirements for eligibility. You are the beneficiary if a covered dependent dies.

EXPANDED DEPENDENT LIFE

You may choose to cover:

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

You are the beneficiary if a covered dependent dies. You may designate someone else to receive benefits if a covered spouse or domestic partner dies. You cannot designate an alternate beneficiary for covered children. Use the *Designation of Alternate Beneficiary—Expanded Dependent Life and AD@D Insurance* form (UBEN 119), available online at ucal.us/UBEN119.

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

COST OF COVERAGE

Use the online Insurance Premium Calculator (ucal.us/premiumcalculator) to determine your monthly premium.

Dependent Life Insurance

WHEN COVERAGE ENDS

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

If you participate in Prudential's group term-life Portability benefit for your Supplemental Life insurance (see page 36), you may also continue Dependent Life coverage within the same Portability benefit. See your Benefits Office for more information.

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

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

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

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

FOR MORE INFORMATION

This is an overview of your life insurance benefits. You'll find more information and tools, such as a life insurance needs estimator, on Prudential's microsite for UC employees (www3.prudential.com/cmelinks/UniversityOfCalifornia). A copy of the life insurance plan booklet is available online at ucal.us/EOCs.

Accidental Death and Dismemberment Insurance

Benefits package: Full, Mid-Level, Core

Who's covered: You and your eligible family members

Who pays the premium: You

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

WHEN TO ENROLL

You may enroll at any time.

WHAT THE PLAN COVERS

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

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

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

THE PLAN OFFERS THESE ADDITIONAL BENEFITS:

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

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

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

Education Benefit: Under family or modified family coverage, if you die in a covered accident, the plan pays for your child's higher education — the lesser of the actual tuition, 5 percent of your coverage amount, or \$1,500 annually. The child must be enrolled in an institution of higher learning on the date of the

accident, or be a high school student and enroll in an institution of higher learning within 365 days of high school graduation.

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

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

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

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

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

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

COST OF COVERAGE

Your cost depends on the level of coverage and coverage amount you choose. Use the rate chart online at ucal.us/adanddpremiums to determine your monthly premium.

WHEN COVERAGE ENDS

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

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

Accidental Death and Dismemberment Insurance

EXCLUSIONS

There are certain exclusions under the AD&D insurance. See your plan booklet for more information.

FOR MORE INFORMATION

This is only an overview of your AD&D benefits. The AD&D plan booklet, available online at ucal.us/EOCs, provides additional details.

Business Travel Accident Insurance

Benefits package: Full, Mid-Level, Core

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

Who pays the premium: UC

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

WHAT THE PLAN COVERS

The coverage includes:

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

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

TRAVEL ASSISTANCE SERVICES

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

- Medical assistance such as referral to a doctor or medical specialist, medical monitoring if you are hospitalized, emergency medical evacuation to an adequate facility, medically necessary repatriation and return of remains
- Personal assistance such as emergency medication, embassy and consular information, assistance with lost documents, emergency message transmission, emergency cash advance, emergency referral to a lawyer, access to a translator or interpreter, medical benefits verification and assistance with medical claims
- Travel assistance, including vehicle return and emergency travel arrangements for the return of your traveling companion or dependents

HOW THE PLAN WORKS

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

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

BENEFICIARIES

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

To change your beneficiary designation, sign in to your account on At Your Service Online. After you log in, select "My Beneficiaries" and then "Add Change Delete." Be sure to confirm any changes you make.

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

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

FOR MORE INFORMATION

Additional information, including frequently asked questions, a summary of coverage and claim forms is available online at ucop.edu/risk-services/loss-prevention-control/travel-assistance.



Legal Insurance

Benefits package: Full, Mid-Level, Core

Who's covered: You and your family members

Who pays the premium: You

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

WHAT THE PLAN COVERS

- Legal advice, representation and preparation or review of documents in-office from an ARAG Network Attorney;
- Legal advice via phone from ARAG's nationwide network of telephone attorneys;
- Estate planning documents, including wills, trusts (using the eight hour General In-Office benefit once per certificate year), powers of attorney and healthcare directive;
- Family legal matters, including divorce, separation, annulment, child support, visitation and/or alimony, adoption, guardianship/conservatorship and name change;
- Identity theft protection services, including credit monitoring, internet identity surveillance, child identity monitoring, full-service identity restoration, and identity theft insurance¹;
- Consumer protection issues including personal bankruptcy, debt collection defense and legal representation for enforcement of warranties or promises in connection with lease or purchase of goods or services; Disputes over real estate construction matters are not included.
- Defense of traffic offenses, including traffic tickets;
- Driving privilege protection;
- Defense of misdemeanor charges such as trespassing, public intoxication and vandalism;
- General In-Office—eight hours of attorney time per family per certificate year for advice, negotiation and service for personal legal matters that are not covered or excluded. This includes preparation of a trust, administrative hearings or sale/purchase of a residence.
- Online legal tools and resources, such as DIY Docs® that enable you to create documents like a standard will, power of attorney, child medical authorization, HIPAA authorization, contractor agreement and more.

See the ARAG Legal website or the plan booklet for the full list of covered services, plan limitations and exclusions.

¹ Eligibility, coverage, limitations and exclusions are governed by a separate coverage document. Please see the identity theft plan summary for details.

HOW TO USE THE PLAN

Before consulting any attorney, call ARAG to be sure the plan serves you to your best advantage. When you call ARAG, a customer care specialist will advise you on the services the plan will cover and send you a CaseAssist confirmation package, which includes a description of coverage and referrals to network attorneys.

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

ARAG network attorneys provide services in two ways:

- **Telephone:** You may call a telephone network attorney who will either work with you over the phone or recommend that you meet with an attorney in person. Using telephone network attorneys can help you get the most from the plan. By using this service whenever possible, you can reserve other plan benefits for more serious matters.
- **Office appointments:** The plan covers a wide-range of legal matters, most of which are fully paid when you work with a network attorney. For matters not listed, the plan provides "Attorney Office Work" benefit for up to eight hours per year. See the plan booklet available online at ucal.us/EOCs for details.

If you prefer, you may use an attorney outside the ARAG network for general advice. In that case, the plan pays the non-network attorney amount listed in the plan booklet.

COST OF COVERAGE

Your monthly cost depends on whether you choose individual or a family coverage option. See the plan costs online at ucal.us/legal.

WHEN COVERAGE ENDS

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

FOR MORE INFORMATION

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

See the plan booklet online at ucal.us/EOCs.

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

Family Care Resources

Benefits package: Full, Mid-Level, Core¹

Who's covered: You and your family members

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

Finding the right caregivers for loved ones is one of the toughest challenges many working families face. UC offers Bright Horizons Care Advantage, an online resource to help you find quality caregivers—especially on short notice—so that you can get to the office or classroom with minimal disruption.

Bright Horizons Care Advantage offers two programs:

- Sittercity, which offers individual in-home caregivers, including babysitters, nannies, senior caregivers, pet sitters, tutors and housekeepers
- Years Ahead, which offers a nationwide network of memory and hospice care facilities, independent and assisted living communities, and in-home health care and senior care companions

HOW THE PLAN WORKS

On the UC-specific Bright Horizons Care Advantage website (careadvantage.com/universityofcalifornia), you can register for Sittercity and/or Years Ahead. You must register for each separately. Once you've registered, you can read provider profiles and reviews to help you find the right caregiver for you. Sittercity allows you to post jobs and providers can respond. Years Ahead offers certified senior care advisers to help you and your family through the process of finding the right caregiver.

COST OF COVERAGE

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

WHEN COVERAGE ENDS

Your access to Bright Horizons Care Advantage ends when you leave UC employment or move to an ineligible position.

FOR MORE INFORMATION

careadvantage.com/universityofcalifornia
888-748-2489

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

Health and Dependent Care Flexible Spending Account Plans

Benefits package: Full, Mid-Level, Core

Who's covered: You

Who pays: You

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

ELIGIBILITY

You are eligible to enroll in the Health and Dependent Care Flexible Spending Accounts while you are eligible for Full, Mid-level or Core Benefits, except that if you enroll in the Blue Shield Health Savings Plan for your medical coverage, you cannot enroll in the Health FSA.

ENROLLMENT AND CHANGES IN PARTICIPATION

You may enroll when you first become eligible, when you have an eligible change in family or employment status, or during Open Enrollment. If you enroll in the Blue Shield Health Savings Plan for your medical coverage, you cannot enroll in the Health FSA.

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

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

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

HOW THE PLANS WORK

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

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

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

PLAN ADMINISTRATION

CONEXIS is the plan administrator for the FSAs; they handle all claims processing and reimbursement. **CONEXIS must receive claims for a plan year by April 15 of the following year in order to reimburse the expenses; for example, they must receive claims for the 2016 plan year by April 15, 2017.**

HEALTH FSA

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

Eligible expenses include:

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

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

Health and Dependent Care Flexible Spending Account Plans

The Health FSA includes a feature that lets you carry over up to \$500 of unused funds to the next plan year. With the carryover, if your balance is less than \$500, you do not have to rush to spend all of your Health FSA funds or worry about losing money when the current plan year ends, even if you do not re-enroll for the next plan year.

You have until Dec. 31 of the plan year to incur eligible expenses. After the April 15 filing deadline, unused funds up to \$500 will be credited automatically to the next plan year and will be available for reimbursement in early May. Unused funds greater than \$500 will be forfeited.

If you enroll midyear, expenses incurred before the date your enrollment is effective are not eligible for reimbursement. The effective date generally is the first of the month following your enrollment, but it may be later, depending on payroll deadlines.

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

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

CONTRIBUTION LIMITS AND FORFEITURE RULES

You may contribute a minimum of \$180 to a maximum of \$2,550 annually to your Health FSA. If both you and your spouse are UC employees, you may each contribute up to \$2,550. The carryover does not count against the \$2,550 maximum contribution. You may carry over up to \$500 and still elect to contribute \$2,550.

Be sure to estimate your expenses carefully before enrolling. Unless you experience a permitted status change (see the *Health FSA Summary Plan Description* for details), once elected, you cannot change the amount of your contribution if you miscalculate your anticipated expenses or misunderstand what expenses are eligible. The IRS requires that you forfeit any unclaimed funds in your account after the closing date for the plan year.

OPPORTUNITIES FOR CONTINUATION

If you lose eligibility for the Health FSA, and want to continue your participation through COBRA, please see "Opportunities for Continuation" on page 8 of the Eligibility section.

DEPENDENT CARE FSA

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

ELIGIBLE EXPENSES

Dependent care must be necessary so that you, or you and your spouse, can work or look for work. You must have work income during the year in order to participate in the DepCare FSA. If you are married, your spouse must also have earned income during the year, unless your spouse is incapable of self-care or is a full-time student.

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

Eligible expenses must be for the following eligible family members:

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

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

IRS rules do not allow a DepCare FSA to have a carryover feature, but you can incur eligible expenses for reimbursement during the grace period. You must incur expenses between Jan. 1 of the plan year and March 15 of the following year in order to be eligible for reimbursement. Any claims for expenses incurred during this period must be submitted by the run-out period, which ends on April 15 following the plan year. The period from Jan. 1–April 15 is called the claims "run-out

period,” which provides additional time to submit eligible expenses incurred during the prior plan year.

Expenses incurred after your DepCare FSA participation ends are not eligible for reimbursement. If you enroll midyear, expenses incurred before the date your enrollment is effective are not eligible for reimbursement. The effective date generally is the first of the month following your enrollment, but may be later depending on payroll deadlines.

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

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

CONTRIBUTION LIMITS AND FORFEITURE RULES

When you enroll in the DepCare FSA, you determine how much you want deducted from your monthly pay, from a minimum of \$180 per year (\$15 per month) to the least of:

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

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

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

Be sure to estimate your expenses carefully before enrolling. Unless you experience a permitted status change (see *DepCare FSA Summary Plan Description* for details) once elected, you cannot change the amount of your contribution due to miscalculating your anticipated expenses or to misunderstanding what expenses are eligible. The IRS requires that you forfeit any unclaimed funds in your account after the closing date for the plan year.

DEPCARE FSA AND DEPENDENT CARE TAX CREDIT

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

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

FOR MORE INFORMATION

This is only an overview of the Health and DepCare Flexible Spending Account plans. Be sure to review the Summary Plan Descriptions, available online at ucal.us/EOCs. Additional information about the FSA plans is available on the CONEXIS website (uc.conexisfsa.com).

Tax Savings on Insurance Premiums

Benefits package: Full, Mid-Level, Core

Who's covered: You

Who pays: There are no costs.

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

HOW THE PLAN WORKS

If you enroll in a medical plan that requires you to pay a premium, you are automatically enrolled in TIP. Each month your taxable earnings are reduced by the amount of your premium before federal, state and Social Security (FICA) taxes are taken out. This reduces your taxable earnings and, therefore, the amount of taxes you pay. Your savings are strictly on taxes and will depend on your particular tax situation.

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

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

PREMIUMS ELIGIBLE FOR TIP

Premium costs for your coverage and for family members who meet the plan's eligibility requirements and are enrolled in your medical plan will be paid before taxes are withheld. These family members may include:

- Your legal spouse,
- Your biological or adopted child(ren),
- Your stepchild(ren), and
- The following family members if they are your tax dependents: grandchild(ren), step-grandchild(ren), disabled child(ren) age 26 and older and legal ward(s)

The monthly costs for your domestic partner and/or your partner's child(ren) or grandchild(ren) must generally be paid on an after-tax basis unless these family members are your dependents as defined under the Internal Revenue Code. However, if you are in a registered domestic partnership and your partner's children are considered your stepchildren under federal law, premiums can be paid on a pretax basis.

Exception: The premiums for medical coverage for your domestic partner, your partner's children (including overage disabled child(ren)), and your partner's grandchildren who are your California tax dependents may be deducted from pay on a pretax basis for California income tax purposes if you have registered your domestic partnership with the state of California.

You must submit a UC form UPAY 850 indicating that your domestic partnership is registered with the state of California in order to have the premiums deducted on a pretax basis.

CHANGES IN PARTICIPATION

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

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

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

FOR MORE INFORMATION

For plan details see the *Tax Savings on Insurance Premiums (TIP) Summary Plan Description*, available online at ucal.us/tip or from your Benefits Office.



Legal Notifications

PARTICIPATION TERMS AND CONDITIONS

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

If you are confirmed as eligible for participation in UC-sponsored plans, you are subject to the following terms and conditions:

- With the exception of benefits provided or administered by Blue Shield of California and Optum Behavioral Health, UC-sponsored medical plans require resolution of disputes through arbitration. With regard to each plan **it is understood that any dispute as to medical malpractice—that is, as to whether any medical services rendered under the contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered—will be determined by submission to arbitration as provided by California law and not by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Both parties to the contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury and instead are accepting the use of arbitration.** For more information about each plan's arbitration provision please see the appropriate plan booklet or call the plan.
- UC and UC health and welfare plan vendors comply with federal/state regulations related to the privacy of personal/confidential information including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as applicable. To fulfill their contracted responsibilities and services health plans and associated service vendors may share UC member health information between and among each other within the limits established by HIPAA and federal/state regulations for purposes of health care operations, payment, and treatment. A member's requested restriction on the sharing of specified protected health information for health care operations, payment, and treatment will be honored as required by HIPAA.
- By making an election with your written or electronic signature you are authorizing the University to take deductions from your earnings (employees)/monthly Retirement Plan income (retirees) to cover your contributions toward the monthly costs (if any) for the plans you have chosen for yourself and your eligible family members. You are also authorizing UC to transmit your enrollment demographic data to the plans in which you are enrolled.
- You are subject to all terms and conditions of the UC-sponsored plans in which you are enrolled as stated in the plan booklets and the University of California Group Insurance Regulations.
- By enrolling individuals as your family members you are certifying that those individuals are eligible for coverage based on the definitions and rules specified in the University of California Group Insurance Regulations and described in UC health and welfare plan eligibility publications. You are also certifying under penalty of perjury that all the information you provide regarding the individuals you enroll is true to the best of your knowledge.
- If you enroll individuals as your family members you must provide, upon request, documentation verifying that those individuals are eligible for coverage. The carrier may also require documentation verifying eligibility. Verification documentation includes, but is not limited to, marriage or birth certificates, domestic partner verification, adoption papers, tax records and the like.
- If your enrolled family member loses eligibility for UC-sponsored coverage (for example because of divorce or loss of eligible child status) you must notify UC by de-enrolling that individual. If you wish to make a permitted change in your health or flexible spending account coverage you must notify UC within 31 days of the eligibility loss event; for purposes of COBRA, eligibility notice must be provided to UC within 60 days of the family member's loss of coverage. However, regardless of the timing of notice to UC, coverage for the ineligible family member will end on the last day of the month in which the eligibility loss event occurs (subject to any continued coverage option available and elected).
- Making false statements about satisfying eligibility criteria, failing to timely notify the University of a family member's loss of eligibility, or failing to provide verification documentation when requested may lead to de-enrollment of the affected family members. Employees/retirees may also be subject to disciplinary action and de-enrollment from health benefits and may be responsible for any UC-paid premiums due to misuse of plan.
- Under current state and federal tax laws, the value of the contribution UC makes toward the cost of health coverage provided to domestic partners and certain other family members who are not "your dependents" under state and federal tax rules may be considered imputed income that will be subject to income taxes, FICA (Social Security and Medicare), and any other required payroll taxes. (Coverage provided to California registered domestic partners is not subject to imputed income for California state tax purposes.)
- If you specifically ask UC representatives to intercede on your behalf with your insurance plan, University representatives will request the minimum necessary protected health information required to assist you with your problem. If more protected health information is needed to solve your problem in compliance with state laws and federal privacy laws (including HIPAA), you may be required to sign an authorization allowing UC to provide the health plan with

Legal Notifications

relevant protected health information or authorizing the health plan to release such information to the University representative.

- Actions you take during Open Enrollment will be effective the following January 1 (unless otherwise stated)—provided all electronic and form transactions have been completed properly and submitted timely.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) NOTIFICATION FOR MEDICAL PROGRAM ELIGIBILITY

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 members¹ in a UC- sponsored medical plan if you or your 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 you or your family member's 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 or domestic partnership, birth, adoption, or placement for adoption, you may be eligible to enroll your newly eligible family member. If you are an employee you may be eligible to enroll yourself, in addition to your eligible family member(s). You must request enrollment within 31 days after the marriage or partnership, birth, adoption, or placement for adoption.

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

Also, if you are eligible for health coverage from UC but cannot afford the premiums, some states have premium assistance programs that can help pay for coverage. For details, contact the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services at www.cms.gov or 1-877-267-2323 ext. 61565.

If you do not enroll yourself and/or your family member(s) in medical coverage within the 31 days when first eligible, within a special enrollment period described above or within an Open Enrollment period, you may be eligible to enroll at a later date. However, even if eligible, each affected individual will need to complete a waiting period of 90 consecutive calendar days before medical coverage becomes effective and employee premiums may need to be paid on an after-tax basis (retiree premiums are always paid after-tax). Otherwise, you/they can enroll during the next Open Enrollment Period.

To request special enrollment or obtain more information, employees should contact their local Benefits Office and retirees should call the UC Retirement Administration Service Center (800-888-8267).

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.

¹ To be eligible for plan membership, you and your family members must meet all UC employee or retiree enrollment and eligibility requirements. As a condition of coverage, all plan members are subject to eligibility verification by the University and/or insurance carriers, as described above in the participation terms and conditions.

COBRA CONTINUATION

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

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

The COBRA administrator will send you a “Qualifying Event Notice,” which explains the procedure for continuing your participation. More information about COBRA continuation privileges, is available online at ucal.us/COBRA or contact your Benefits Office.

NOTICE REGARDING ADMINISTRATION OF BENEFITS

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

In conformance with applicable law and University policy, the University is an affirmative action/equal opportunity employer. Please send inquiries regarding the University’s affirmative action and equal opportunity policies for staff to Systemwide AA/EEO Policy Coordinator, University of California, Office of the President, 1111 Franklin Street, 5th Floor, Oakland, CA 94607, and for faculty to the Office of Academic Personnel, University of California, Office of the President, 1111 Franklin Street, Oakland, CA 94607.

