

2017 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 offers a comprehensive overview of your health and welfare benefits options, including details about eligibility, enrollment and the plans available to you. It also explains how life changes and changes in your employment status can affect your benefits. Keep this booklet, and *Your Benefits at a Glance* (included in your Welcome Kit), for future reference.

UCnet (ucnet.universityofcalifornia.edu) offers additional tools and information, along with ongoing updates about your benefits. Visit UCnet whenever you have questions about your benefits or want to make changes. 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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General Eligibility Rules for UC Health and Welfare Benefits

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 10 to 12 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 for Full Benefits if you are an active UCRP member, an active Savings Choice participant or have begun the 90-day election period during which you can choose between Pension Choice and Savings Choice.¹

There are two ways to qualify for these primary retirement benefits:

- You are appointed to work in a retirement-eligible position at least 50 percent time for a year or more²
- You complete 1,000 hours in a retirement-eligible position within a rolling 12-month period (750 hours in certain instances³)

MID-LEVEL BENEFITS

You are eligible for Mid-Level Benefits if:

- 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 in a position that does not qualify you for the primary retirement benefits noted above.

CORE BENEFITS

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

¹ 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.

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

³ If you're a member of the Non-Senate Instructional Unit, you qualify for participation in the Retirement Choice Program after working 750 hours in an eligible position within a 12-month period.

⁴ 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 13 for more information on eligible plans.

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

CORE BENEFITS

You are eligible for Core Benefits if you are appointed to work at least 75 percent time 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.⁴

Eligibility requirements for UC Health and Welfare benefits differ for same-gender and opposite-gender domestic partners, as noted in the table below. No declaration form or documentation is needed to initially enroll, but you will be asked to submit documentation after enrollment (see “Supporting Documentation” on page 5 of *Benefits for Domestic Partners*) to establish ongoing eligibility for health and welfare benefits.

Requirements for same-gender domestic partners	Requirements for opposite-gender domestic partners
<p>One of the following:</p> <ul style="list-style-type: none"> • Registered with the State of California or other valid jurisdiction <p>OR</p> <ul style="list-style-type: none"> • Able to meet the requirements on page 13 for a partnership that has not been registered, with appropriate supporting documentation upon request 	<p>Either the employee or the domestic partner must be age 62 or older and eligible to receive Social Security benefits based on age AND satisfy one of the following requirements:</p> <ul style="list-style-type: none"> • Registered with the State of California or other valid jurisdiction <p>OR</p> <ul style="list-style-type: none"> • Able to meet the requirements on page 13 for a partnership that has not been registered, with appropriate supporting documentation upon request

General Eligibility Rules for UC Health and Welfare Benefits

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 13 and 14 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 dependent by you or your domestic partner. Also eligible are children UC is legally required by administrative or court order to provide with group health coverage.

Your children (or legal ward) are eligible for only the plans for which you are eligible and in which you have enrolled (See "Benefits Overview," pages 13–14).

Except as provided in the following paragraph, 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 coverage 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 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 opt out of your own employee coverage and remain covered as another employee's or retiree's family member or
- You can enroll in your own coverage; before you enroll, though, you must make sure the UC employee or retiree who has been covering you de-enrolls you from his or her UC-sponsored plan.

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 Period of Eligibility (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 form is received.

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 service⁵ 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 2017, it runs Nov. 6, 2016 until Nov. 4, 2017).

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

⁵ 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.).

General Eligibility Rules for UC Health and Welfare Benefits

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.

FAMILY CHANGES THAT RESULT IN LOSS OF COVERAGE

If your family member loses eligibility, you must complete the appropriate transaction to remove him or her from coverage within 31 days of the eligibility loss event.

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. Coverage for the family member ends at the end of the month in which the death occurs. It is important to contact your local Benefits Office for further 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 any family member(s) lose eligibility for UC-sponsored medical, dental and/or vision coverage, you may be able to continue group coverage through COBRA.

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.

If you lose eligibility, the COBRA administrator will send you a "Qualifying Event Notice," which explains the procedure for continuing your participation. If your family member loses eligibility, you must request COBRA through your local Benefits Office. More information about COBRA continuation privileges is available online at ucal.us/COBRA or from your Benefits Office.

Conversion: Within 31 days after UC-sponsored coverage ends (if your participation has been continuous), you may be able to convert your group 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 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 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							
HEALTH CARE										
Medical³ Choice of various options depending on your address, including health maintenance organization (HMO), preferred provider organization (PPO) or a PPO with a health savings account. See page 19.	•	•			•	•	•			You and UC
Medical — Core Fee-for-service plan with a high deductible. See page 19.	•	•	•		•	•	•			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 24.	•				•	•				UC
Vision³ Plan covers a variety of vision care services including eye exams, corrective lenses and frames. See page 28.	•				•	•				UC

DISABILITY INSURANCE

Basic 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 31.	•	•	•					•		UC
Voluntary Short-Term and/or Voluntary Long-Term Disability⁵ Provides short-term and/or long-term coverage for work and nonwork-related disabilities such as pregnancy/childbirth, injury or illness. Supplements employer-paid Basic Disability and other sources of disability income you may receive (e.g., Worker's Compensation or Social Security), up to 60% of eligible earnings (\$15,000 maximum monthly benefit). Enroll in Voluntary Short-Term Disability, Voluntary Long-Term Disability or both. See page 31.	•	•	•		•				•	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 19. 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, your Voluntary Long-Term Disability benefits will not be payable. For more information, see the insurance carrier's summary plan description.

	Benefits Packages			When You May Enroll			Premium Paid By	
	Full	Mid-Level	Core	During PIE	During OE	90-Day Wait	Automatic	With SOH
LIFE AND ACCIDENT INSURANCE								
Basic Life Provides employees eligible for Full Benefits with life insurance equal to annual base salary, up to \$50,000. Coverage is adjusted if appointment is less than 100% time. See page 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 Enrollment may be offered during Open Enrollment in some cases. 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. You may enroll at any time; see page 45.	•	•	•					You

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

Benefits Overview

TAX-SAVINGS PROGRAMS

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 46.

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 47.

	Benefits Packages			When You May Enroll					Pretax Salary Reduction
	Full	Mid-Level	Core	During PIE	During OE	90-Day Wait	Automatic	With SOH	
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 46.	•	•	•	•	•				•
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 47.	•	•	•	•	•				•

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

ELIGIBLE FAMILY MEMBERS	Eligibility	May enroll in	Medical	Dental	Vision	Dependent Life	AD&D	Legal
Legal Spouse¹	Eligible		•	•	•	•	•	•
<p>Domestic Partner (same gender/opposite gender) For opposite-gender domestic partners to be eligible for health and welfare benefits, 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.</p> <p>A domestic partnership is eligible if it is:</p> <ul style="list-style-type: none"> • Registered with the state of California or • A valid same-gender union, other than a marriage, entered into in another jurisdiction and recognized in California as substantially equivalent to a California registered domestic partnership or • Unregistered, but meets all of 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 	Eligible		•	•	•	•	•	•
Biological or adopted child, stepchild, domestic partner's child²	To age 26		•	•	•	•	•	•
<p>Grandchild, step-grandchild, domestic partner's grandchild²</p> <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		•	•	•	•	•	•
<p>Legal ward</p> <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 A legally separated or divorced spouse is not eligible for UC-sponsored coverage.

² Domestic partner must be eligible for UC-sponsored health coverage.

Benefits Overview

	Eligibility	May enroll in	Medical	Dental	Vision	Dependent Life	AD&D	Legal
<p>ELIGIBLE FAMILY MEMBERS</p> <p>Overage disabled child (except a legal ward) of employee</p> <ul style="list-style-type: none"> • 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 	Age 26 or older		•	•	•	•	•	•

Are you in a domestic partnership?
 Eligibility rules for domestic partners are different for health and welfare benefits and for UC Retirement Plan benefits. Check out “Establishing a domestic partnership” on UCnet (ucal.us/domesticpartnership) to make sure you've established your partner's eligibility for UCRP survivor and death benefits.

Enrollment

To be certain you get the benefits 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.

You should enroll online and complete the transaction by the last day of the applicable PIE. Paper enrollment forms are available and 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 newly eligible 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 registered or the date that you verify that the partnership meets UC's criteria (see page 13).
- 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, some plans allow you to also enroll yourself and/or any other eligible family member who was not already enrolled during an earlier PIE. See the plan-specific sections at the back of this booklet. Remember that family members are only eligible for coverage in medical, dental, vision, legal, AD&D and dependent 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 health plans. Other plans have different rules; see the plan-specific sections in this guide for details.

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, restrictions apply to Dependent Life insurance). There is no opportunity to enroll in Voluntary Short-Term or Voluntary Long-Term 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. Those paid through UCPath may enroll family members online.

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 enrollment form 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 the University of California to provide coverage for a dependent child under your UC-sponsored medical, dental or vision plan pursuant to applicable law. The child must 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.

Appeals

Any appeals regarding coverage denials that relate to eligibility or enrollment requirements are subject to the University of California Group Insurance Regulations. To obtain a copy of the Eligibility Claims Appeal Process, please contact the person who handles benefits for your location.



Medical Plans

Benefits packages: Full, Mid-Level, Core

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 5 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.

You may enroll in certain medical plans only if you meet the plan's geographic service area criteria.

If you or a covered family member is enrolled in Medicare, you are not eligible for the UC Health Savings 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 your form is received. Your premiums will 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 a plan service area, or will be away for more than two months, 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 in all plans; 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 20 to 22. The chart on page 23 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 You?* 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 the UCPath portal) 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 certain counties 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	Offers 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/mywha/welcome-to-wha/university-of-california

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 plan's deductible and then you pay coinsurance, which is a percentage of the cost of services. You pay a smaller percentage for in-network providers.

Anthem Blue Cross is the administrator of medical benefits for UC's PPO plans and OptumRx is the administrator of prescription drug benefits. The administrator of your plan processes claims, creates a network of health care providers or pharmacies and sets clinical policies and guidelines.

UC'S PPO

UC 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 anthem.com/ca/uc and healthequity.com/ed/uc
UC Care	This is a PPO plan with three tiers. 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 Anthem 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 catastrophic coverage plan. You can choose any doctor, hospital, clinic or behavioral health provider, but you pay less if you use a provider in the Anthem Blue Cross PPO network. After you have met the plan's annual deductible, the plan pays for part of the cost of services. If you use non-network providers, you must pay for services up front and submit a claim; you receive reimbursement if the plan covers the service. For more information, see anthem.com/ca/uc

ABOUT THE UC HEALTH SAVINGS PLAN (HSP) WITH HEALTH SAVINGS ACCOUNT (HSA)

The Health Savings Account (HSA), which is part of the UC Health Savings Plan (HSP), lets you pay for your out-of-pocket health care expenses with tax-free dollars, contributed by both UC and you.

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. Your HSA account balance rolls over annually; you keep the balance in the account, even if you don't use it or leave UC. When you're ready to use your funds for qualifying medical expenses, 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 \$1,000—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 2017, the IRS allows HSA contributions up to \$3,400 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 pretax 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 UC 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 UC 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

Behavioral health and substance abuse coverage is provided by Optum Behavioral Health for employees and retirees enrolled in:

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

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.

Behavioral health and substance abuse coverage is provided by Anthem Blue Cross for employees and retirees enrolled in:

- Core
- UC Care
- UC Health Savings Plan (HSP)

The first three in-network outpatient mental health visits are covered at no cost to you for all plans except UC Health Savings Plan.

If you enroll in Core, UC 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.

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

Medical Plans

- Disease management programs offered by UC's medical plans to help manage chronic conditions such as diabetes and heart disease

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).

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 plan 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

Please note that if you lose eligibility for medical coverage while you are hospitalized or undergoing treatment for a medical condition covered by your medical plan, benefits will cease and you may have to pay for the cost of those services yourself. If you or a family member loses eligibility for medical coverage, you can, however, continue coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) for a period of time. If you are laid off, you may transfer to UC's lowest cost medical plan through COBRA.

You may be able to convert your coverage to an individual policy if you apply within 31 days of the date your UC-sponsored coverage or COBRA continuation coverage ends. Conversion options are generally more expensive and may provide fewer benefits than UC-sponsored plans. See your medical plan

booklet or call your plan for more information. You may also seek individual coverage, including through the healthcare marketplace (coveredca.com).

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:

- UC Health Savings Plan with HSA
- Core
- Kaiser Permanente
- Western Health Advantage

If you want more flexibility in choosing doctors:

- UC 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:

- UC 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:

- UC 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:
Core You may use any doctor.	\$0	\$\$\$+ Except for certain preventive services, you pay the full cost until you reach the \$3,000 deductible. Then you pay 20%.	20%	<ul style="list-style-type: none"> • Want to pay no monthly premium • Want protection for catastrophic care • Are willing to risk incurring high out-of-pocket costs • Want direct access to all providers without need for referrals
Health Net Blue & Gold HMO Must use custom network of providers, except in emergencies	\$\$	\$ No deductible; you pay a copay for office visits and hospital stays; most other services have no charge.	Retail (30-day supply) \$5/\$25/\$40 Mail order (up to 90 days) \$10/\$50/\$80	<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
Kaiser Permanente—CA Must use network providers, except in emergencies	\$	\$ No deductible; you pay a copay for office visits and hospital stays; most other services have no charge.	Retail (30-day supply) \$5/\$25/NA Mail order (31–100 days) \$10/\$50/NA	<ul style="list-style-type: none"> • Want lower premium and cost per service • Are comfortable with getting medical care only within the Kaiser system
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.	\$\$\$	\$/\$\$ UC Select Network providers: no deductible and copay for office visits and hospital stays; Anthem Preferred providers: calendar year deductible and then 20% coinsurance; out-of-network: calendar year deductible and then 50% coinsurance.	Retail (30-day supply) \$5/ \$25/ \$40 Mail order (up to 90 days) \$10/\$50/\$80	<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
UC 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.	\$	\$\$\$ 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.	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
Western Health Advantage Must use network providers, except in emergencies	\$	\$ No deductible; you pay a copay for office visits and hospital stays; most other services have no charge.	Retail (30-day supply) \$5/\$25/\$40 Mail order (up to 90 days) \$10/\$50/\$80	<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 5.

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, so it makes sense to use a PPO dentist. 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. After a small deductible, basic dentistry (such as fillings and extractions) is 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 270,000 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, the plan will cover 75 percent of allowed basic dentistry costs, up to \$1,500 per year. However, you may have to pay the dentist's total fee and then submit your claim form to Delta Dental for reimbursement. Non-Delta Dental dentists have not agreed to Delta Dental's allowed costs and are free to bill you for any difference between what Delta Dental pays and the submitted fee.

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 25 to 27. You can also use the website uc2017.chooser2.pbgh.org/dental/uc2017.htm#costs 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**OPPORTUNITIES FOR CONTINUATION**

If you or a family member loses eligibility for dental coverage, you can continue coverage under COBRA for a period of time. There is no conversion option for dental coverage.

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

Service Area	Delta Dental PPO Plan	DeltaCare® USA HMO Plan
	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; additional routine exam is covered for members with identified risk factors)	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 5,000 providers in California and 33,000 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

OPPORTUNITIES FOR CONTINUATION

If you or a family member loses eligibility for vision coverage, you can continue coverage under COBRA. There is no conversion option for vision coverage.

FOR MORE INFORMATION

VSP website: vsp.com
VSP phone: 866-240-8344

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



Basic and Voluntary Disability

Benefits package: Full, Mid-Level or Core

Who's covered: You

Who pays the premium: You and UC

Time away from work for a pregnancy, illness or unexpected injury could mean months without a paycheck. While UC's basic employer-paid disability insurance offers some protection—a benefit capped at \$800 per month for six months—it probably won't be enough to cover your expenses. For a modest monthly premium, UC's Voluntary Disability Insurance replaces much more of your income—60 percent of your eligible pay up to a benefit of \$15,000 per month—for increased financial security when you need it most.

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 disability and the first few weeks after childbirth.

UC 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 based on their prior employment.

If you are eligible for Full, Mid-Level or Core Benefits, you are automatically enrolled in Basic Disability at no cost to you. If you choose to enroll in Voluntary Short-Term Disability (VSTD) and/or Voluntary Long-Term Disability (VLTD), you pay the premium.

WHEN TO ENROLL

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

For Voluntary Disability Insurance, you need to take action to enroll. To obtain coverage without submitting a statement of health, enroll during your PIE when you are first eligible. As a new employee, you may want to consider enrolling in both VSTD and VLTD for the most comprehensive coverage for all types of disabilities. You can discontinue your enrollment in VSTD and/or VLTD at any time.

ENROLLMENT WITH STATEMENT OF HEALTH

If you do not enroll in VSTD and/or VLTD when you are first hired, you must submit an application, along with 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 or add coverage outside of your initial period of eligibility. Generally, you cannot enroll in VSTD or VLTD during UC's annual Open Enrollment or due to family changes.

WHEN COVERAGE BEGINS

You must be actively at work in order for new or increased coverage to be effective.

WHAT THE PLANS COVER

BASIC DISABILITY

UC provides the Basic Disability plan at no cost to you.

Basic Disability insurance provides coverage if you are unable to work due to a pregnancy/childbirth or non-work-related disabling injury or illness. It pays 55 percent of your eligible earnings, up to a maximum benefit payment of \$800 per month, for up to six months. There is a standard 14-day waiting period before you can begin receiving benefits, and you must use up to 22 days of sick leave, if available. While you're receiving Basic Disability income, UC continues to pay its portion of your medical premiums. Your Basic Disability income is generally taxable.

VOLUNTARY DISABILITY

Voluntary Short-Term Disability (VSTD) and Voluntary Long-Term Disability (VLTD) plans work in conjunction with Basic Disability and other sources of disability income (for example, Social Security) you may receive as a result of your pregnancy/childbirth or disabling injury or illness.

VSTD offers more comprehensive coverage than Basic Disability—60 percent of your eligible earnings, with a maximum benefit of \$15,000 per month. After a 14-day waiting period, benefits only last for 6 months, making this a good option to cover short-term needs such as pregnancy, most illnesses, minor surgeries, etc. As with Basic Disability, you must use up to 22 days of sick leave, if available, before you can begin receiving benefits.

VLTD benefits don't start until six months after your date of disability or when VSTD benefits end, whichever is later. The plan pays 60 percent of your eligible earnings, with a maximum benefit payment of \$15,000 per month, and benefits can last until your Social Security normal retirement age. This type of plan doesn't pay for the first six months of disability, but offers long-term benefits in cases of catastrophic injury or illness, or permanently disabling conditions.

You pay the entire premium for VSTD and VLTD. The cost varies depending on your age, salary and your UC Retirement Plan eligibility. You may choose to purchase VSTD, VLTD or both. Voluntary Disability income is generally not taxable, since you pay the premiums with after-tax dollars.

Basic and Voluntary Disability

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
- California State Disability Insurance (only if you worked outside of UC and paid into the system within the past 18 months)

The Basic and VSTD plans do not pay benefits for work-related injuries or illnesses that cause disabilities. Instead, Workers' Compensation provides benefits. The VLTD plan pays benefits for work-related disabilities only in coordination with Workers' Compensation.

For Workers' Compensation claims, UC 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.

Any disability income you are eligible to receive from these other sources of disability benefits will be deducted from your disability benefits payable under UC's disability plans. If the other sources of income you receive exceed 60 percent of your eligible income, VLTD will pay a minimum of \$100 per month.

HOW THE PLANS WORK

In order to receive disability benefits, you must be under a doctor's direct, continuous care. For more information about how to apply for benefits, see *Your Guide to UC Disability Benefits* on UCnet (available with related publications at ucal.us/disabilitypubs) or contact your Benefits Office.

No one type of coverage 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:

- **Are you considering becoming pregnant?** If you think you may become pregnant, it's wise to sign up for VSTD. For most pregnancies, the disability period begins two weeks before birth and ends six weeks after birth (eight weeks for a Caesarian section), so a plan such as VLTD, which only covers disabilities lasting more than 6 months, wouldn't pay a benefit. Don't wait until you're pregnant to enroll. You'll be required to submit a statement of health, and if you're already pregnant, your enrollment application will not be accepted.
- **Do you have a lot of non-negotiable monthly expenses?** If you've recently purchased a new house, for instance, you may not want to risk a long period without income to help pay your mortgage. Enrolling in both VSTD and VLTD provides you with the most protection for all types of disabilities.
- **How much sick leave have you accrued?** If you have been with UC for a long time and have a lot of accrued sick leave that you could use during the first six months of a disability, or if you are eligible for faculty medical leave, you might only need VLTD. If you don't have much, you might consider VSTD.
- **How's your savings cushion?** If you have substantial savings that could tide you over the first six months of a disability, you might choose VLTD only. If not, you should consider both VSTD and VLTD for the most protection.

IMPORTANT CONSIDERATIONS AND LIMITATIONS TO COVERAGE

- **Definition of disability:** The definition of disability changes with the type of coverage you receive:
 - Basic and Voluntary Short-Term Disability—In order to receive benefits, you must be disabled from your job at UC, based on the demands and duties of your position.
 - Voluntary Long-Term Disability—For the first 24 months of VLTD benefits, in order to receive benefits, you must be disabled from your own occupation, based on the demands and duties that employers (throughout the national economy) ordinarily require for that occupation. From the 25th month onward, you must be disabled from any occupation (throughout the national economy) for which you are reasonably suited.

(Note that UCRP defines disability differently; for details, please see "Your Guide to UC Disability Benefits.")

- **Pre-existing conditions:** Once you are enrolled in the VSTD Plan and the Basic Disability Plan, there are no benefits limitations related to pre-existing conditions. Additionally, as soon as you've been covered by the VLTD Plan for more than 12 months there are no restrictions or limitations on the VLTD Plan related to the pre-existing condition.

However, your VLTD benefits will not be payable if:

- Your disability leave is related to a condition you were diagnosed with, or had treatment for, in the 90 days prior to your initial enrollment in VLTD (or into UC's previous Supplemental Disability Insurance plan, if you are continuing coverage without an interruption) and
- Your disability leave begins within one year of your initial enrollment into VLTD (or into UC's previous Supplemental Disability Insurance, if you are continuing coverage without an interruption).

You will, however, be eligible for VLTD benefits for conditions that were not pre-existing.

- **Mental Illness and Substance Abuse:** VLTD benefits for these issues are generally limited to a 24-month lifetime maximum benefit, unless you remain continuously hospitalized or in an extended treatment plan.

COST OF COVERAGE

The university provides the Basic Disability plan at no cost to you.

You pay a monthly premium if you enroll in voluntary coverage. The premium depends on your UCRP membership, your age and the level of coverage you choose (Voluntary Short-Term Disability, Voluntary Long-Term Disability or both). To estimate your premium, use the online Insurance Premium Estimator (ucal.us/premiuvestimator).

WHEN COVERAGE ENDS

Your coverage stops on your last day actively at work. You may not continue or convert these plans.

FOR MORE INFORMATION

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

- *Your 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*
- *Disability Insurance Policy*

Basic and Core 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.

WHEN COVERAGE BEGINS

You must be actively at work in order for new or increased coverage to be effective.

WHAT THE PLANS COVER

BASIC LIFE

If you are eligible for the Full Benefits package, 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.

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.

CORE LIFE

If you are eligible for the Mid-Level or Core Benefits package, 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

You may 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.

Supplemental Life Insurance

EXCEPTION TO DUPLICATE UC COVERAGE RULE

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

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 an application, along with evidence of insurability, 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

You must be actively at work in order for new or increased coverage to be effective. 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

Supplemental Life Insurance

current year, whichever is later—even if you work part time. If your full-time salary rate is reduced, coverage will not be reduced until the beginning of the next calendar year.

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

PLAN FEATURES

LIVING BENEFIT OPTION

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

WAIVER OF PREMIUM

If you become totally disabled before age 65 and your disability continues for six consecutive months, you may qualify for continuation 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 Premium Estimator for Life Insurance (ucal.us/lifepremiumestimator) to determine your monthly premium.

WHEN COVERAGE ENDS

If you leave UC employment, you are no longer eligible for Supplemental Life insurance. You may 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 may also convert to an individual policy without a statement of health.

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 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 only by submitting an application along with evidence of insurability, and the insurance company decides whether to approve the application. A spouse or domestic partner may not be enrolled during a PIE resulting from the birth or adoption of a child.

Children may be enrolled during their PIE or 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 an application along with evidence of insurability when enrolling a spouse or domestic partner. The insurance company decides whether to approve the application. This is not required for children—children may be enrolled at any time.

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 an application, along with a statement of health, for that person.

WHEN COVERAGE BEGINS

If your dependent is confined for medical care or treatment, his or her new or increased coverage will begin on the first day after medical release. This does not apply to your newborn child.

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 13 and 14 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 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 Life Insurance Premium Estimator (ucal.us/lifepremiumestimator) 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 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 convert your Dependent Life to an individual policy without a statement of health 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 (prudential.com/uc). 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 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

When you travel on official university business, you are automatically covered by UC's business travel insurance when you make your arrangements through any of UC's preferred travel agencies found in Connexus, UC's systemwide travel program. For all other travel, 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 and 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.

You may enroll during your PIE. Enrollment may also be offered during Open Enrollment in some cases.

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)
- Tax planning, preparation and audit support
- Assistance with administrative hearings including educational, building/zoning/easements, Social Security/veterans/Medicare benefits, and more
- Domestic violence protective orders
- 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 (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.

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.

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

Legal Insurance

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 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 CareDirect, a program that helps employees find the right match for their family care needs, including child care centers, nannies, babysitters, elder care planning, pet care, tutoring/test prep, and more. Their online resources help you find quality caregivers—especially on short notice—so that you can get to the office or classroom with minimal disruption.

Bright Horizons CareDirect includes access to:

- 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
- Preferred enrollment at select Bright Horizons centers nationwide, tuition discounts at partner centers and discounted tutoring and test prep through BrightStudy

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 Care Advantage website. You make arrangements with the providers you hire, including all payments to them.

WHEN COVERAGE ENDS

Your access to Bright Horizons CareDirect ends when you leave UC employment or move to an ineligible position. You may convert your account to an individual consumer membership for an annual fee (about \$140/year).

FOR MORE INFORMATION

careadvantage.com/universityofcalifornia
888-748-2489

¹ Participation in Bright Horizons CareDirect 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 CareDirect 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 UC 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 UC 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, based on Internal Revenue Service (IRS) regulations and plan rules, you may need to forfeit unclaimed funds in your account after the closing date for the plan year.

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 2017 plan year by April 15, 2018.**

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, medical plan premiums). Expenses reimbursed under the Health FSA may not be deducted on your federal income tax form.

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.

However, if you do not re-enroll in the Health FSA, you must have at least \$25 remaining in your account after the April 15 deadline to be able to carry over funds to the next plan year. Funds under \$25 are forfeited. If you do not re-enroll, you may only carry over funds (up to \$500) for one 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. As noted above, you may be required to forfeit some unclaimed funds in your account after the closing date for the plan year.

WHEN COVERAGE ENDS OPPORTUNITIES FOR CONTINUATION

If you lose eligibility for the Health FSA, you may continue your participation through COBRA.

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 filing deadline, which is April 15 following the plan year. The period from Jan. 1–April 15 is called the claims “run-out

Health and Dependent Care Flexible Spending Account Plans

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.

WHEN COVERAGE ENDS

If you lose eligibility for DepCare FSA, contributions and coverage end. There are no options to continue or convert your coverage.

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).



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 Optum Behavioral Health and OptumRx, 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 or, if later, the date the member receives a COBRA notice. 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

Legal Notifications

authorization allowing UC to provide the health plan with 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.

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.

