New Dimensions

Benefits Newsletter for UC Annuitants *Volume 19 Number 1, Spring 2002*

Meet Joe Lewis, Manager, UC Benefits Customer Service, Oakland

UC's busy Benefits Customer Service Center in Oakland has a new manager: Joe Lewis.

"I'm glad to be here at UC," Joe told us enthusiastically, "and to take up the challenge of overseeing the Customer Service Center. Our mission within UC is to develop a service organization that is responsive to the needs of the UC community."

The UC community includes 10 campuses, 5 medical centers, 3 national laboratories, a system-wide office in Oakland, and agricultural programs in every county of the state. Participants include some 150,000 faculty and staff, 37,000 annuitants and over 200,000 former employees who are University of California Retirement System participants.

"Customer Service is a one-stop shop for UC retirees and former employees," Joe stated. "We also get calls from active employees who are sometimes referred here by their local Benefits Office. Former employees call to get a retirement estimate, or to ask questions related to the Defined Contribution Plan or Tax-Deferred 403(b) Plan. Retirees' questions are often related to their medical, dental, or legal plan benefits.

"The questions that come in encompass a wide range of concerns," Joe said. "Customer Service receives some 15,000 calls each month—plus about 700 e-mail messages, 180 pieces of mail, and 100 walk-in appointments."

To meet the demand, the UC Customer Service Center staff currently includes 15 analysts, 5 researchers, and a training coordinator.

Joe Lewis, Manager UC Benefits Customer Service, Oakland, CA

Recently Joe made a presentation about UC at a national conference for Human Resource Executives. Conference attendees listened as he described the University of California Office of the President (UCOP) and the Human Resources and Benefits Department. "The HR community likes what we're doing at UCOP," Joe reports. "Not just Customer Service, but they enjoyed learning about the overall UCOP mission and structure." In fact, the organization has invited him back to speak at their next conference.

Away from the work place, Joe spends much of his time involved in community projects. This includes serving as Adjunct Professor at the University of Phoenix, where he specializes in Organizational Communications, Organizational Behavior, and Management and Supervision courses. He is also the current President of the School Board of the Catholic Diocese of Oakland. Joe has a BA in Management from St. Marys' College and a MA in Multicultural Education from the University of San Francisco.

UC Care, Core, High Option Plans: Aetna Plan Briefs

National Advantage Program Providers

If you live in the U.S. but outside of UC Care's California service area, your costs will be reduced if you select your providers—including specialists—from Aetna's Preferred Provider Option network, under the National Advantage Program (NAP).

You can find NAP providers on the UCbencom website (www.ucop.edu/bencom): From the menu bar at the top of the home page, select General Info; then Health & Welfare; scroll down to UC Care "DocFind;" select "Physicians and Other Health Care Professionals;" select UC Care Out-of-Area National Advantage Program; and follow the instructions.

"Usual and Customary"

If you have submitted a claim to UC Care under Tier 3 or Out-of-Area benefits and your reimbursement was less than you expected, it may be because your provider charged more than the "usual and customary" amount for your care. Your benefit for any given service is a percentage of the usual and customary amount for that service—as determined by Aetna, based on averages in the given geographical area. (Under Tier 3, you receive 60% of the usual and customary amount; Out-of-Area members receive 90% of the usual and customary amount.)

Aetna's New Claims Process

If you are a member of UC Care, High Option, or Core, don't be surprised if you receive a call one of these days from an Aetna representative. Aetna reports that many medical claims are submitted with missing information. Until recently, even the smallest omission could halt the process of claim resolution and result in a claim being returned to its sender for completion. However, Aetna's Los Angeles Service Center has found that many delays can be minimized by making a simple phone call. Under the new claims process, a plan representative is likely to call you—or your doctor—to obtain the missing information. The new process is expected to speed the payment process for many claims.

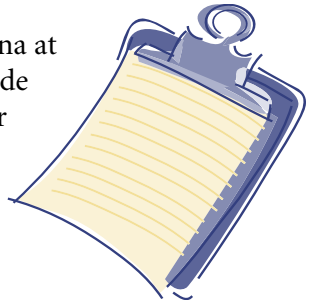
Foreign Claims

If you live abroad or if you need medical care while traveling in a foreign country, here are some tips for making sure your claim will be processed as quickly as possible:

- Submit your claim as soon as possible after services are received, or immediately upon return to your home.
- Your claim must include the name, address, and title of the provider; original invoices and receipts; and a complete copy of the provider's chart notes, including diagnosis and type of procedure or treatment.
- Submit your personal statement of the accident or illness, as well as your description of the treatment (in English).
- Submit proof of travel if the care was received in a country other than your residence.

Foreign claim processing usually takes about 30 days. However, if the claim exceeds $1,000 or if information is missing or unclear, additional time will be required.

If you have questions, call Aetna at 1-800-313-3804 or from outside the U.S. call (213) 988-8850 or fax (213) 988-5680.



California HMO Medical Plan Transfer Option

UC's policy to allow members to transfer from one California HMO plan to another was initiated as a pilot program in 2001 and continues for 2002. The program helps members minimize the disruptive effect when their PCP or other providers cancel their contract with their HMO, or when their medical plan's service area changes midyear. For a smooth transition, follow these important steps:

Before you transfer

- Verify that you are eligible for the medical plan you are interested in, based on your mailing address ZIP code. See "Health Pages" (under "Health and Welfare" on UCbencom—www.ucop.edu/bencom), check the plan's provider directory, or call the plan.
- Verify that the provider you choose is in the new plan's provider network. Again, see "Health Pages," check the plan's provider directory, or call the plan.
- Verify that the provider you choose is accepting new patients. For the most current information, call the provider.
- You may also want to ask the new plan about coverage for any specific benefits or prescription drugs, if you or your family have such needs.
- Complete and submit an *HMO Medical Plan Transfer* (UBEN 110) as directed on the form. The form is available on UCbencom under "Online Forms," or from UC HR/Benefits Customer Service.
- Confirm the effective date of your coverage under the new plan. Generally, this will be the first of the month after the form is processed.

After you enroll

- Call your new plan to ensure continuity of care, if you or a family member is currently undergoing treatment.
- Before seeking services—including pharmacy services—call the plan to verify that your coverage is in effect. You should do this on the first of the month for which your transfer is effective. If your new plan cannot yet verify your eligibility, call UC HR/Benefits Customer Service.
- Present your new ID card when seeking care. If you need to make an appointment before your card arrives, have your doctor's office contact your new plan's Member Services department.

Questions

For specific benefit questions, call the medical plan (see phone numbers below). If you have questions about making the transfer, call UC HR/Benefits Customer Service (1-800-888-8267).

California HMO Plans Toll-free Telephone Numbers

Health Net	1-800-522-0088
Health Net/Seniority Plus	1-800-596-6565
Kaiser Permanente—California	1-800-464-4000
Kaiser/Senior Advantage	1-800-464-4000
PacifiCare of California	1-800-624-8822
PacifiCare/Secure Horizons	1-800-228-2144
Western Health Advantage (WHA)	1-888-563-2251
WHA Care+	1-888-563-2251

Interested in Long-Term Care Information?

If you are interested in long-term care insurance, a wealth of information is available through various publications, and on the Internet.

Publications and Information

AARP (American Association of Retired Persons)

Go to the website (www.aarp.org/confacts/health/privltc.html) for indepth information on long-term care insurance: what it is, whether you should buy it, and if so, when.

California Department of Aging

Within California call 1-800-510-2020. This number connects you with the local Area Agency on Aging and the free information and referral service.

New Mexico Department of Aging

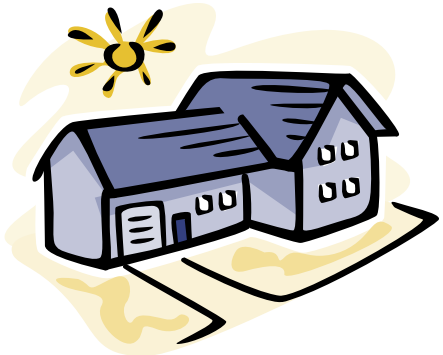
Within New Mexico call 1-800-432-2080. If you live outside of New Mexico and you wish to contact the department, please call 1-505-827-7640.

Policies

Many long-term care policies are available and we recommend you shop around. Programs to consider include:

CalPERS (California Public Employees' Retirement System)

All public employees and retirees as well as their spouses, parents, parents-in-law, and siblings (age 18 and over) can apply for coverage.



Enrollment runs April 1 through June 30, 2002. For an application kit, call 1-800-338-2244 or visit the CalPERS website (www.calpers.ca.gov/longtermcare).

TIAA-CREF

For complete information visit the website (www.tiaa-cref.org/ltc).

Long-Term Care Insurance policy from TIAA-CREF Life Insurance Company

This policy is available to any U.S. resident ages 18 through 84, providing the policy has been approved by the state insurance department when you reside. California is just one of many states where the policy has been approved.

Long-Term Care Insurance from Teachers Insurance and Annuity Association

This policy is available to full- or part-time employees of and retirees from nonprofit public or private schools, colleges, universities, teaching hospitals, and other qualifying education and research institutions.

Employee spouses, parents and parents-in-law are also eligible to apply, as is anyone who already owns a TIAA-CREF annuity or a TIAA individual insurance policy. You are eligible to apply for Teachers SelectCare if you are between 18 and 84 years old and live in the United States.

Prescription Drug Costs

Prescription drugs have been cited as one of the leading causes of health care cost increases in recent years. The Centers for Medicare and Medicaid Services report that from 1999 to 2000, nationwide prescription drug spending increased over 17 percent—far exceeding all other health service increases. Employers sponsoring group medical plans currently spend, on average, 20 percent of each health care dollar on prescription drug coverage.

Causes for Cost Increases

- Increased population: as an example, in recent years, UC has expanded family member coverage
- Increased drug usage, partly due to the availability of new types of medication, more prescriptions per person, and the large aging "baby boomer" population
- Increased direct-to-consumer advertising—from $791 million in 1996 to $2.5 billion in 2000—contributing to a greater popularity for specific drugs, especially newer, more expensive formulations
- Extended drug patent protection, delaying availability of cheaper alternatives

Three-Tier Copayment Program

In an effort to contain escalating prescription costs, UC introduced three-tier drug copayments for 2002. The three tiers (from least costly to most costly) are:

- Formulary (approved medications) generic
- Formulary brand-name (the first approved version of the drug)
- Non-formulary

You Can Minimize Your Costs

Mail Order Prescriptions

Most UC medical plans offer prescriptions through mail order at a reduced cost. If you have a long-term condition, consider using this option to obtain a larger supply of medications for your copayments, thus reducing your cost per dosage (see the Prescription Drug Benefits chart on pages 10–11).

Generic Drugs

Generic alternatives are equivalent to the brand-name drug in quality and performance. Not all brand-name drugs have generic equivalents due to patent protection, though the Federal Drug Administration (FDA) has approved several thousand generic drugs. The National Institute of Health Care Management (NIHCM) reports the average brand-name drug prescription is approximately three times a generic drug's price. Your copayment represents a small portion of the total prescription expenses. When you select lower-priced alternatives, you can save yourself money and help keep plan costs down.

Are Generics as Safe as the Brand-name?

Generics, like brand-name drugs, are strictly tested (ingredients and the actual product) and regulated by the FDA; much of the pre-approval process and after-market review is the same for both. FDA guidelines specify generics must be identical to the brand-name in the following ways:

- Safety, performance, dosage form, route of administration, and intended use
- The active (working) ingredient(s) must be the same and must be bioequivalent (absorbed into the body at the same rate)
- The manufacturing and packaging sites must have the same FDA quality standards. (The FDA reports that brand-name drug firms account for approximately 50 percent of generic drug production.)

Why are Generics Cheaper than the Brand-name?

Innovation and marketing are expensive. According to CNN, research and development costs for a drug can reach $200 to $300 million, at a minimum.

Brand name drug manufacturers incur high expenses for drug development (including costs for previous, unmarketable products and for future products) and

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Prescription Drug Costs *continued from page 5*

clinical tests for FDA approval, which are passed along to consumers. Brand-name drugs receive patents for a limited time (8 to 18 years) to protect the company's investment. Patents provide exclusive rights to market the drug; manufacturers price products at their discretion.

For generic drug companies, research and development are generally not as costly, because they are copying already existing drug formulas. Additionally, since generics are based on FDA-approved drugs with proven safety records, the FDA does not require duplication of expensive clinical tests prior to approval. Finally, generics can only be marketed after a patent has expired, which means there is more price competition.

In 1997, the FDA relaxed its guidelines for direct-to-consumer advertising, providing greater ease in linking a product with its medical use. The NIHCM reports that the amount spent on prescription drug advertising more than tripled from 1996 to 2000 and coincided with a rapid rise in consumer drug sale increases. The following may be of particular note:

Advertising Increase (1999–2000) The 50 most heavily advertised drugs accounted for 48 percent of the total advertising increase of $20.8 billion and the remaining 52 percent came from the other 9,850 drugs compared in their study.

Sales Increase (1999–2000) Prescriptions for the 50 most heavily advertised drugs rose 24.6 percent, while prescriptions for all other drugs combined increased only 4.3 percent.

Consumers are often influenced by ads and purchase unnecessarily. According to a *BusinessWeek* article, one study found that as many as two-thirds of those taking allergy medications don't even have allergies.

Things to consider:

If you are considering a change to a generic drug, consult your doctor or pharmacist to insure the drug is a good substitute for your condition and is appropriate for your treatment. Ask about any warnings and any risks of side effects or interactions with medications you may be taking. There are times when it may be important for you to continue with a certain medication for your specific needs. Doctors occasionally specify a brand name formulation for a patient because of better results: for example, an individual may have a negative reaction to a product or respond more favorably to another.

If you have questions, call your plan or the FDA at 1-888-INFO-FDA (1-888-463-6332)

For online information, go to:

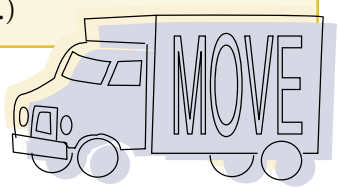
www.fda.gov/cder/ogd
www.nihcm.org

Are You Moving?

If you move, it is very important that you notify UC of your new mailing address. Your monthly benefit check or Surepay stub will be sent to the correct address; also we're able to keep you informed about the changes that affect your benefits, as well as sending this newsletter, semi-annual statements for retirement plan balances, and annual Open Enrollment mailings.

If you are enrolled in a UC-sponsored health plan, your address is provided to your health plan on a monthly basis. Your health plan uses this address when they send you plan materials and also to confirm that you are within their service area and are eligible for benefits.

You can change your address simply by calling UC HR/Benefits Customer Service (1-800-888-8267) or, if you have Internet access, go to the "Online Forms" section of UCbencom; print and complete form UBEN 131 (*UC Benefits Address Change Notice*) and mail it to UC HR/Benefits. (You'll need to download Adobe Acrobat Reader software to print the form.)



The Changing Health Care Environment—
What to Expect and What We Can Do

Recent editions of this newsletter have reported on the tremendous changes occurring in the health care field. The evolution—including the current instability of the managed health care environment—continues.

This article will provide an update on the current situation, how UC is addressing the challenges, and some changes UC members can anticipate over the next few years.

HMOs

A few decades ago, particularly in California, the health care field was revolutionized by the advent of health maintenance organizations (HMOs), primary care physicians (PCPs), and the payment system of "capitation." (Under capitation, providers receive a certain amount from the plan each month to provide each member's health care, regardless of the number of services required.) The member's access to care, as well as the provider's billing procedure, was governed by strict plan rules. As long as those strict guidelines held, the overall cost savings to the individual member—and to the employer sponsoring a group plan—were substantial.

But things change. Over the years, considerable pressure has been exerted on the system. A few of the forces exerting pressure on (or within) the health care system today are: advances in medical procedures, medications and technology; revised methods of provider reimbursements; and legal requirements. The HMO's financial platform, as originally conceived, is disappearing. Consequently, medical plans as well as providers are "drawing the line" regarding what they can or will provide. For members, the result can be that services are no longer available.

Disruptions in Service

Currently, disruptions in service have become more and more widespread. UC works with the plans to keep UC members informed and to minimize the impact of the disruptions, but sometimes members must change doctors or hospitals or transfer to another medical plan. Disruptions are generally of two types:

Provider disruption—This occurs when medical groups or other providers such as hospitals cancel their HMO contracts (e.g., Stanford Medical Center recently decided to forego its relationship with all HMO plans). In some cases, medical groups decide to go out of business and close their doors.

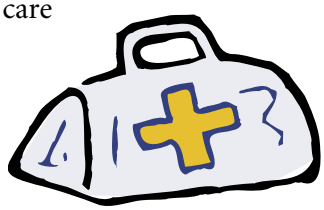
Coverage disruption—When an agreement between plan and providers cannot be reached, an HMO may find it necessary to pull out of an area altogether. This happens not only in remote areas where there are few doctors and limited facilities, but in urban areas as well (e.g., PacifiCare recently pulled its Medicare coverage from San Francisco).

As recently as two years ago, HMO plans boasted coverage that was virtually statewide; now service areas are scattered. As a result, more and more UC members live in areas not served by any HMO—yet, they continue to need medical coverage. Non-HMO medical plan options (such as Preferred Provider Organization plans) are available—although they are typically more expensive than HMOs.

Escalating Costs/Shrinking Budgets

UC's annual negotiations with medical plans become more complex and more challenging each year. Low costs are increasingly difficult to maintain for medical coverage. For 2002, UC covers 95% of monthly premiums for medical coverage overall; members pay the remaining 5%, on average. However, members are paying increased copayments and in some cases, increased monthly premiums also apply. It is anticipated that for 2003 and years beyond, costs will continue to increase by 15–20% or more annually.

At the same time, the state of California is facing budget cutbacks, directly impacting UC's funding for its medical plans. UC holds its commitment of maintaining quality health care at the lowest possible costs for the UC community. Yet, the "lowest possible costs" are rising each year.



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What Can UC Do?

Lily Pang, Director of UC's Health & Welfare Policy and Planning group in Oakland, says, "When we consider the environment of California's health care delivery system today, it is clear that we need to explore other alternatives for UC members. Increasingly, we are finding that one medical plan does not fit all.

"When we bid out the medical plans for 2000, we closely defined what we were looking for. However, in a field where change is rampant, strict definitions may not result in the most appropriate medical plan. Now we are taking a flexible approach, so that plans can offer creative solutions rather than having to conform to requirements that strain their ability to administer the plan effectively.

"Our standards for quality remain high. But we're not trying to pre-design the plan. We are actively pursuing answers among the available options," Pang continues. "We are asking insurance companies to submit their proposals for medical plans other than HMOs. We expect to have some viable options for the UC community." Further, Director Pang anticipates having the new options available for the 2003 calendar year.

What Can UC Employees/Annuitants Do?

First, while UC will work hard to keep costs down, employees and annuitants are encouraged to do the same. You can do this by learning about your benefits and how to make the best use of them. For example, see "Prescription Drug Costs" on page 5. For additional information, call the plan or refer to the plan booklets.

Second, Director Pang advises: "Our members should anticipate greater differences between plans in the future—in the plan design as well as their network of providers. UC may consider a more flexible approach to medical coverage which allows an individual a degree of core coverage, with optional copayment and deductible levels."

Plans Out to Bid

For 2002, all the UC-sponsored medical plans are in place. For 2003, UC plans to retain all the HMO plans, as well as BluePremier POS and BluePremier HMO in New Mexico.

UC is requesting insurance companies to submit their proposals for the following plans:

- UC Care Point-of-Service (POS) plan—medical component
- UC Care POS plan—behavioral health component
- High Option—for Medicare enrollees
- Core—California
- Core—New Mexico

To ensure that we offer the best available options in the market, UC is also requesting proposals for a Preferred Provider Option (PPO) plan, as well as one of the new consumer model alternatives.

Schedule

January: UC sent the Request for Proposals to prospective bidders. To maximize carrier response, UC also has placed a public advertisement, so that any qualified company can contact UC and submit their proposal.

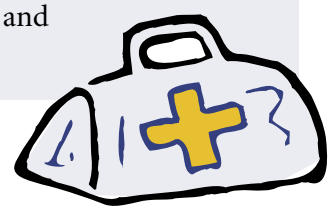
March: Insurance carriers responded by submitting their proposals.

April–June: UC, aided by consultants, will:

Evaluate the proposals
Conduct oral interviews
Conduct site visits
Select finalists
Conduct further evaluation

July: UC will award contracts for 2003.

Winners will be announced on UCbencom (www.ucop.edu/bencom) and in this newsletter.



Health Care Facilitator Update

Health Care Facilitators help active employees and retirees obtain the full benefits and services available from their UC-sponsored health care plans. As knowledgeable counselors, they provide confidential one-on-one assistance in resolving health care issues. Health Care Facilitators are also available to speak with campus groups. There is no charge for this service.

In the fall of last year, UC Santa Cruz welcomed their new Health Care Facilitator, Frank Trueba. Just recently, Davis announced the appointment of Guerren Solbach as the facilitator for the UC Davis campus and Medical Center. Mary Johnson was also recently appointed at the Riverside campus. An announcement about the UC San Diego appointee is expected shortly. Appointments at all the remaining UC locations are anticipated by the end of 2002.

Currently, Health Care Facilitators are in place at six UC locations:

Deborah Lloyd, Berkeley,
dblloyd@uclink4.berkeley.edu, 510-643-7547

Guerren Solbach, Davis
gpsolbach@ucdavis.edu, 530-752-4264

Joe Walsh, Irvine
jwalsh@uci.edu, 949-824-8921 (campus),
714-456-7289 UCI Medical Center

Laura Morgan, Santa Barbara
laura.morgan@hr.ucsb.edu, 805-893-4201

Frank Trueba, Santa Cruz
ftrueba@cats.ucsc.edu, 831-459-3573

Mary Johnson, Riverside
mary.johnson@ucr.edu, 909-787-4766, ext. 1425

In our next issue, we plan to introduce you to the newest campus representatives, and review the highlights of this popular program. By all indications, this program, which was piloted in the summer of 1999, is blossoming into one of the most valuable benefits available to UC employees and annuitants.

2002 Minimum Required Distributions (MRDs) for UCRS

The minimum distribution requirements apply to plan participants who are age $70^{1}/_{2}$ or older and have retired or left UC employment.

Plan participants who are subject to the minimum distribution requirements may recall that last year the Treasury Department issued new regulations that greatly affected the way Plan sponsors—such as the University of California Retirement System (UCRS)—calculate minimum required distributions. They're simpler now and, in most cases, allow participants to take less money out of the plans. At any rate, to comply with the new regulations, last year UC had to delay mailing participants' MRD statements and issuing checks, but this year, we're back on track.

Participants who are subject to the minimum distribution requirements can expect to receive their personalized MRD statement either in February or April, depending upon whether they've received an MRD in the past or if they're subject to the requirements for the first time this year. Participants who are subject to the requirements for the first time will also receive the *Minimum Distribution Factsheet*, which explains the rules and UC's policies for calculating MRDs.

Prescription Drug Benefits—Non-Medicare and Medicare

The following guide to retail and mail-order prescription drug benefits for UC-sponsored medical plans is provided for your convenience. Contact your plan for complete details of the prescription drug benefit.

The formularies for each plan are available from the medical plan. If you have questions about a particular brand-name drug or its generic equivalent, check with your doctor or contact the plan directly.

Formularies are updated frequently. A drug not on the formulary now may be added later. In addition, some brand-name drugs may not have a generic equivalent initially, but one may become available later. Ask your doctor or check with your plan for changes.

The chart below lists the retail drug copayment when you use participating plan pharmacies.

Kaiser of California members may use the mail-order service only for refills of prescriptions on file with a Kaiser pharmacy. Western Health Advantage members can use the Merck-Medco mail-order service for refills only after the initial prescription is dispensed by a participating pharmacy. All other plans offer mail-order service for first-time prescriptions.

Non-Medicare/ Medicare Plan	Kaiser/Senior Advantage of California	Health Net/ Seniority Plus	PacifiCare/Secure Horizons of California	Western Health Advantage/ WHA Care+
Customer Service Telephone Number	1-800-464-4000	1-800-522-0088	1-800-624-8822	1-888-563-2250
Retail Copayment/ Supply	**100-Day Supply**	**30-Day Supply**	**30-Day Supply**	**30-Day Supply**
Generic Drugs	$10.00 (at Kaiser pharmacy only)	$10.00	$10.00	$10.00
Brand-Name Drugs	$20.00 (at Kaiser pharmacy only)	$20.00	$20.00	$20.00
Non-formulary Drugs	N/A	$35.00	$35.00	$35.00
Mail-order Copayment/Supply	**Refills Only**	**90-Day Supply**	**90-Day Supply**	**90-Day Supply**
Generic Drugs	$10.00	$20.00	$20.00	$20.00
Brand-Name Drugs	$20.00	$40.00	$40.00	$40.00
Non-formulary Drugs	N/A	$70.00	$70.00	$70.00
Mail-order Contact	1-888-218-6245 Monday–Friday, 8am–6 pm, P.T.	1-888-858-2951 Walgreens Healthcare Plus P.O. Box 29061 Phoenix, AZ 85036-9061	1-800-562-6223 Prescription Solutions P.O.Box 9040 Carlsbad, CA 92018-9040	1-800-903-8664 (Merck-Medco)

Note: If drug cost is less than the copayment, the member pays the lesser amount.

You should know

Normally, members have the option of choosing a generic equivalent to substitute for a brand-name prescription. However, your doctor may write "DNS" (do not substitute) or "DAW" (dispense as written) to indicate that the brand name cannot be substituted with a generic or a formulary medication.

Doctors occasionally prefer a brand name formulation of a drug to the generic because they believe the brand-name formulation may produce better results for the individual. See "Prescription Drug Costs" beginning on page 5.

UC Care	High Option/ High Option Supplement	Core—CA	BluePremier HMO	BluePremier POS	Core —NM
1-800-313-3804	1-800-632-0524	1-800-632-0524	1-800-711-3795	1-800-711-3795	1-800-632-0524
30-Day Supply	**After Deductible***	**After Deductible****	**30-Day Supply**	**30-Day Supply**	**After Deductible*****
$15.00 participating pharmacy	20%	20%	$15.00	$15.00	20%
$25.00 participating pharmacy	20%	20%	$30.00	$30.00	20%
$40.00 participating pharmacy	20%	20%	$45.00	$45.00	20%
90-Day Supply	**90-Day Supply**	**90-Day Supply**	**31–90 Day Supply**	**31–90 Day Supply**	**90-Day Supply**
$30.00	20%	20%	$30.00	$30.00	20%
$50.00	20%	20%	$60.00	$60.00	20%
$80.00	20%	20%	$90.00	$90.00	20%

* Deductible = $200 for High Option (Non-Medicare); $50 for High Option Supplement
** Deductible = $3,000 for Core—CA (Non-Medicare); $150 for Medicare enrollees
*** Deductible = $3,000 for Core—NM (Non-Medicare); $300 for Medicare enrollees

Annual Copayment/Out-of-Pocket Maximum for 2002—Non-Medicare Plans

Each UC-sponsored medical plan has an annual copayment/out-of-pocket maximum. After your copayments and other out-of-pocket expenses reach this maximum, the plan will pay 100% of covered expenses.

This chart shows the maximums that apply to each plan, as well as the services and supplies that are not subject to the maximum. The chart is intended as a general guide only. For specific information, please call the plan.

Non-Medicare Plans	Annual Copayment/Out-of-Pocket Maximum		Services & Supplies not Subject to the Annual Copayment/Out-of-Pocket Maximum[a]
Health Net	One member	$1,000	• Prescription drugs • Mental disorders or substance abuse benefits except for treatment for severe mental illness or serious emotional disturbances of a child
	Two members	2,000	
	Family (three members or more)	3,000	
Kaiser Permanente—CA	Per member	1,500	• Copayments for supplies and services other than professional services, hospital care, physical, occupational, respiratory and speech therapy, and multidisciplinary rehabilitation services, and imaging, lab tests and special procedures. (For example, copayments for prescription drugs and hearing aids would not be included in the copayment maximum.)
	Family (subscriber and family)	3,000	
PacifiCare of CA	One member	1,000	• Prescription drugs • Allergy serum • Substance abuse • Hearing aids • Mental disorders or substance abuse benefits except for treatment for severe mental illness or serious emotional disturbances of a child
	Two members	2,000	
	Family (three members or more)	3,000	
PacifiCare of NV	One member	1,200	• Prescription drugs
	Two members	2,400	
	Family (three members or more)	2,700	
Western Health Advantage	Per member	1,000	• Prescription drugs
	Family (two members or more)	3,000	

Non-Medicare Plans	Annual Copayment/Out-of-Pocket Maximum		Services & Supplies not Subject to the Annual Copayment/Out-of-Pocket Maximum[a]
UC Care	**Tier 1:**		• Prescription drugs • In-area chiropractic and acupuncture services • Behavioral health program[c] • Hospital emergency room deductible under Tiers 2 & 3 and Out-of-Area
	Individual	$ 1,500	
	Family (three members or more)	4,500	
	Tier 2:		
	Individual	3,000[b]	
	Family (three members or more)	9,000[b]	
	Tier 3:		
	Individual	12,000[b]	
	Family (three members or more)	36,000[b]	
	Out-of-Area:		
	Individual	3,000[b]	
	Family (three members or more)	9,000[b]	
High Option	Per member	2,160[d]	Mental health care
Core	Per member	7,600	
BluePremier HMO NM	None		Not applicable
BluePremier Point-of-Service	**Tier 1:**		**Tier 1:** • Any amounts paid for behavioral health covered by PBHI • Prescription drugs **Tier 2:** • Expenses related to PCP-coordinated care • Emergency room copayments • Hospital admission copayments • Prescription drugs • Any amounts paid for behavioral health covered by PBHI • Coinsurance for services under the transplant provision **Worldwide:** • Emergency room copayments • Hospital admission copayments • Prescription drugs • Any amounts paid for behavioral health covered by PBHI[f] • Coinsurance for services under the transplant provision
	Individual	2,000	
	Family (three members or more)	6,000	
	Tier 2[e]:		
	Individual	6,000	
	Family (three members or more)	18,000	
	Worldwide[e]:		
	Individual	3000	
	Family (three members or more)	9,000	

(a) Expenses not covered under the plan; amounts in excess of usual & customary charges, where applicable; expenses considered not eligible due to noncompliance with plan provisions. These expenses will not be paid at 100% even after you reach your annual copayment/out-of-pocket maximum.

(b) Expenses incurred under Tiers 2 and 3 and out-of-area benefits will apply towards any of the three UC Care out-of-pocket maximums.

(c) A separate $1,000 individual/$3,000 family out-of-pocket maximum applies to all Mental Health benefits provided by the Behavioral Health Program.

(d) Includes deductible.

(e) Expenses incurred under Tier 2 and Worldwide benefits will be combined to apply towards either of these out-of-pocket maximums.

(f) A separate $3,000 individual/$9,000 family out-of-pocket maximum applies to all Mental Health Worldwide Benefits provided by PBHI.

Annual Copayment/Out-of-Pocket Maximum for 2002—Medicare Plans

Each UC-sponsored medical plan has an annual copayment/out-of-pocket maximum. After your copayments and other out-of-pocket expenses reach this maximum, the plan will pay 100% of covered expenses.

This chart shows the maximums that apply to each plan, as well as the services and supplies that are not subject to the maximum. The chart is intended as a general guide only. For specific information, please call the plan.

Medicare Plans	Annual Copayment/Out-of-Pocket Maximum		Services & Supplies not Subject to the Annual Copayment/Out-of-Pocket Maximum[a]
Health Net/Seniority Plus	Per member: Three (3) inpatient admissions per calendar year		
Kaiser Permanente/ Senior Advantage—CA	Per member Family (subscriber and family) Per member: Four (4) inpatient admissions per calendar year	$ 1,500 3,000	Copayments for supplies & services other than professional services, hospital care, physical, occupational, respiratory and speech therapy, and multidisciplinary rehabilitation services, and imaging, lab tests and special procedures. (For example, copayments for prescription drugs and hearing aids would not be included in the copayment maximum.)
PacifiCare/ Secure Horizons—CA	Per member: Three (3) inpatient admissions per calendar year		
PacifiCare/ Secure Horizons—NV	None		Not applicable
Western Health Advantage/ WHA Care+	Per member Family (two members or more)	1,000 3,000	• Prescription drugs
UC Care	**Tier 1:** Per member Per family (three members or more) **Tier 2:** Per member Per family (three members or more) **Tier 3:** Per member Per family (three members or more) **Out-of -Area:** Per member Per family (three members or more)	 1,500 4,500 3,000[b] 9,000[b] 12,000[b] 36,000[b] 3,000[b] 9,000[b]	• Prescription drugs • In-area chiropractic and acupuncture services • Behavioral Health Program[c] • Hospital Emergency Room deductible under Tiers 2 & 3 and Out-of-Area

Medicare Plans	Annual Copayment/Out-of-Pocket Maximum		Services & Supplies not Subject to the Annual Copayment/Out-of-Pocket Maximum[a]
High Option	Per member	$ 1,050[d]	• Mental Health Care
Core	Per member	2,260	
BluePremier HMO NM	None		Not applicable
BluePremier Point-of-Service	**Tier 1:**		**Tier 1:**
	Individual	2,000	• Any amounts paid for Behavioral Health covered by PBHI
	Family (three members or more)	6,000	• Prescription drugs
	Tier 2[e]:		**Tier 2:**
	Individual	6,000	• Expenses related to PCP coordinated care
	Family (three members or more)	18,000	• Emergency room copayments
			• Hospital admission copayments
			• Prescription drugs
			• Any amounts paid for Behavioral Health covered by PBHI
			• Coinsurance for services under the transplant provision
	Worldwide[e]:		**Worldwide:**
	Individual	3,000	• Emergency room copayments
	Family (three members or more)	9,000	• Hospital admission copayments
			• Prescription drugs
			• Any amounts paid for Behavioral Health covered by PBHI[f]
			• Coinsurance for services under the transplant provision

(a) Expenses not covered under the plan; amounts in excess of usual & customary charges, where applicable; expenses considered not eligible due to noncompliance with plan provisions. These expenses will not be paid at 100% even after you reach your annual copayment/out-of-pocket maximum.

(b) Expenses incurred under Tiers 2 and 3 and out-of-area benefits will apply towards any of the three UC Care out-of-pocket maximums.

(c) A separate $1,000 individual/$3,000 family out-of-pocket maximum applies to all Mental Health benefits provided by the Behavioral Health Program.

(d) Includes deductible.

(e) Expenses incurred under Tier 2 and Worldwide benefits will be combined to apply towards either of these out-of-pocket maximums.

(f) A separate $3,000 individual/$9,000 family out-of-pocket maximum applies to all Mental Health Worldwide Benefits provided by PBHI.

UC Receives a National Award for Use of Technology in Human Resources Administration

The University of California is proud to be honored with the Systems and Computing Technology Corporation (SCT) Award for its Retirement Process Project. The annual award, issued by the College and University Professional Association for Human Resources (CUPA-HR), recognizes demonstrated technological innovation that advances the human resource profession. Judith W. Boyette, Associate Vice President, Human Resources and Benefits, the project sponsor, accepted the award at the CUPA National Conference in October.

Retirement Process Project Team members include, from left to right: Esther Cheung, Danny Dimalanta, Mike Baptista, Lynne Kleven, Judy Boyette , Myrna Walton, Cindy Grissom (deceased), Donna Tamasaki, Sharon Perry, Lisa Hart, John Fox, Mary DeShaw.

UC's Retirement Process Project, first unveiled in January 1999, has dramatically improved both administrative operations and users' experiences. Prior to 1999, the University's retirement enrollment system was a manual, paper-based, time-consuming and error-prone process. Complex rules and multiple forms were often confusing to retiring employees, and the process required local Benefits Representatives to spend a lot of time helping employees to complete forms for retirement.

Now, thanks to the new Retirement Process, the process is fully automated and easy to use, and allows UC benefits counselors and pension administration staff to dedicate more time to their core functions: counseling prospective retirees and completing retirement processes on time, instead of performing manual calculations, filling out forms and tracking paper.

The UC Retirement Process Project came at a crucial turning point. The University had seen membership in its retirement and benefits program increase by 47 percent in only 10 years, from 108,000 individuals to 159,000. Annual disbursements to retirees and survivors had risen to more than $650 million by 1999, and the number of annual retirements had nearly tripled between 1992 and 2000. With the anticipated addition of thousands of new employees through 2010, the administration of the University's pension plan would be severely challenged.

Under the leadership of UCSC consultant Linda Kittle, Project Director Myrna Walton, and Project Manager Michael Baptista, two cross-functional teams were formed to review the University's existing pension administration process, envision a new process, and develop an implementation plan. The University's new process incorporates state-of-the-art technology to provide accurate, up-to-date information on pension benefits to administrators and retirees, with a minimum of time or paperwork. The new system is capable of processing many more retirements per month than the number possible under the old system. Processing of retirement requests has been reduced from an average of 120 days to less than 30 days. The new system has eliminated the backlog of requests and the need for cumbersome forms and staff overtime.

The development and implementation of the system required extensive research, planning, analysis, testing, trouble-shooting and training, and required the involvement of numerous staff from throughout the UC community.

In the early phases, which spanned about three months, approximately 20 staff members participated in mapping the existing process, researching best practices, and "visioning" the new process. The later phases involved further business analysis, prototyping the new application as well as communication pieces, actual systems development, and defining the new business process.

In the final phases, UC Benefits Representatives from every campus and national laboratory received extensive training and participated in a two-month trial period to learn how to use the new web application.

The Information Resources and Communications Department programmed the system. Bruce James, Manager of Maintenance, and Donna Yamasaki, UCBenS Technical Project Director, provided technical leadership. In all, the entire project spanned approximately 18 months.

The new retirement process was developed as part of the ongoing UC Benefit Systems (UCBenS) project; a comprehensive initiative to deliver efficient, cost-effective, and responsive retirement system services to employees, retirees, and campus and national laboratory administrators.

SCT will provide a $3,000 cash award to the endowment or scholarship fund of the University of California.

When a Loved One Dies

In times of grief, it is not always easy to attend to the tasks that need to be done. Many tasks associated with daily living will need some kind of adjustment.

This is offered as a reminder to notify UC HR/Benefits about the death of an annuitant or a family member who is enrolled in a UC-sponsored medical, dental, or legal plan. You don't need to notify your plans; we will pass the information to them.

When a loved one dies, call us at 1-800-888-8267. We will help you determine the actions to ensure that your University benefits are brought up to date—your retirement/savings benefits as well as health and welfare coverage. If the change affects your coverage level, you can verify the change on your monthly benefit check stub or Surepay statement.

No Exclusions for Preexisting Conditions

When you enroll in any UC-sponsored medical or dental plan, you will not be excluded from enrollment based on your health; nor will your premium or level of benefits be based on any health conditions. In fact, you are not asked for a statement of your health. The same applies to your eligible family members.

UC-Managed Investment Funds

Performance Results

Since October 31, 2001, the UC-managed investment funds have generated the following monthly unit values and interest factors:

At:	The unit value was:			The interest factor was:		
	Equity	Bond	Multi-Asset	Savings	ICC	Money Market
October 31, 2001	$250.348	$134.727	$28.909	.4620%	.5739%	.2633%
November 30, 2001	266.390	133.328	29.452	.4610	.5568	.2305
December 31, 2001	269.421	132.351	29.569	.4624	.5804	.2231
January 31, 2002	261.926	133.553	29.427	.4581	.5681	.2079
February 28, 2002	256.631	135.116	29.372	.4284	.5081	.1682
March 31, 2002	267.305	132.840	29.654	.5007	.5630	.1785

Rates of Return as of March 31, 2002

	Annualized		
	1-year	5-year	10-year
Total Return Funds			
Equity	-4.33%	9.59%	12.51%
Bond	5.49	9.58	10.57
Multi-Asset	2.18	8.15	9.26
Income Funds			
Savings	5.81%	6.01%	6.42%
Insurance Company Contract	6.93	7.13	7.59
Money Market	3.47	5.30	4.99

The investment returns shown here represent past performance and are not necessarily indicative of future results.

The UC-managed investment funds are valued monthly, around the tenth of each month. New unit values and interest factors can be obtained on our website (www.ucop.edu/bencom) or by calling UC's interactive telephone service, bencom.fone (1-800-888-8267).

Participants who choose to use the telephone can simply call bencom.fone (1-800-888-8267) for investment rates of return, account balances, and/or to request a distribution from the UC-managed funds. You can also request a Statement on Demand of your current account balances and transactions or transfer accumulations among the UC-managed funds.

If you have Internet access go to our website and first choose "Top Picks" on the left-hand side of our home page. From there you can view investment rates of return. Then go back to our home page and choose "Online Actions" on the right-hand side to make transfers among the UC-managed funds or take a distribution.

Both of these services are available 24 hours a day.

Annuitant Newsletter on Audio Cassette

This newsletter is available on audio cassette tape for visually impaired and disabled annuitants. If you are interested, call *New Dimensions* at 1-800-239-4002, extension 70270, and leave your name, address, and phone number. Please indicate that you want to receive *New Dimensions* on tape. Please note that audio cassette tapes are generally mailed four weeks after each *New Dimensions* mailing.

New Dimensions

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Write *New Dimensions* at:
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Human Resources and Benefits
P.O. Box 24570, Oakland, CA 94623-1570

Association Contacts

Use this listing if you're interested in joining an association, or to inform your association of an address change.

	Emeriti	**Retirees**
Berkeley	UCB Retirement Center 510-642-5461	UCB Retirement Center 510-642-5461
Davis	Paul Stumpf 530-753-5022 pkstump@ucdavis.edu	Arleen Kasmire 530-753-0898
Irvine	Sam McCulloch 949-650-5569	Emeriti/Retiree Office 949-824-6204 emeriti@uci.edu
LANL	N/A	Mary Mariner 505-672-1950 Chuck Mansfield 505-662-2115
LBNL	N/A	Bud Larsh 510-724-1202 almonlarsh2@juno.com
LLNL	N/A	Lawrence Livermore Employee Services Association 925-422-9402
Los Angeles	Emeriti/Retiree Relations Center 310-825-7456 emeriti@humnet.ucla.edu	Emeriti/Retiree Relations Center 310-825-7456
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Note to associations: To update a listing, write to *New Dimensions.*

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