UNIVERSITY OF CALIFORNIA
UNITEDHEALTHCARE SELECT EPO - NON-MEDICARE

Below is brief overview of the Select EPO plan benefits. Some benefits may have benefit maximums and/or have separate limitations or restrictions in addition to those shown. All services and supplies must be considered medically necessary by the plan to be covered. See plan's Summary Plan Description for details.

BENEFIT	MEMBER COST 2007 Plan
ELIGIBILITY	For employees and retirees of the University of California who reside in the UnitedHealthcare EPO Service Area in Washington D.C.(tri-state area).
DEDUCTIBLES[1]	
Individual	$150
Family	$450
OUT-OF-POCKET LIMIT[2]	
Individual	$2,000
Family	$6,000
HOSPITAL SERVICES	
Inpatient[3]	10% (includes maternity admissions)
Outpatient surgery	10%
Surgeon/assistant	10%
Admin. of Anesthetics	10%
Emergency room	Emergency: 10% (+ $75 copay, waived if admitted to the hospital) Non-Emergency: not covered
Ambulance[4]	10%
PHYSICIAN VISITS	
Office visit/surgery	$20
Home visit	$20
Hospital visit	No charge
Preventive physical exam	$20 (no charge up to age 2)
Preventive inoculations	No charge
Maternity	
Outpatient care	No charge ($20 for first visit to diagnose pregnancy)
Inpatient care	No charge
Well baby care	No charge up to age 2
ALTERNATIVE CARE	
Hospice[3] (maximum $7,400 per lifetime)	10%; no deductible
Home health care[3]	10%; no deductible
Skilled nursing facility[3]	10% (100 day maximum per calendar year); no deductible
Urgent care	$20 (10% for ancillary services)
OTHER BENEFITS	
Outpatient x-ray & laboratory	10%
Outpatient speech therapy (20 visits calendar year)	$20
Outpatient occupational therapy (20 visits calendar year)	$20
Outpatient physical therapy (20 visits per calendar year)	$20
Registered special duty nurse[3]	10%
Eye Exams	Medically necessary: $20. Routine eye exams not covered.
Eyeglasses, lenses and frames	Not covered
Hearing and vision screenings	$20 (through age 18). (No charge up to age 2).
Hearing Aids (every 36 months)	50% to $2,000 maximum, limited to one standard hearing aid per ear. Digital hearing aids are included.
Allergy testing/treatment/serum	$20 (no charge for allergy injections)

UNIVERSITY OF CALIFORNIA
UNITEDHEALTHCARE SELECT EPO - NON-MEDICARE

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BENEFIT	MEMBER COST 2007 Plan
Durable medical equipment & prosthetics [3]	10%
Orthotics [3]	10%
Chiropractor	$20 (20 visits per calendar year)
Acupuncture	$20 (20 visits per calendar year)
Cardiac and Pulmonary Rehabilitation	$20 (medically necessary)
Therapeutic Injections	10%
Therapy:	10%
Chemotherapy, Dialysis and Radiation Therapy	
TMJ Services [3]	usual cost sharing based on type of service
PRESCRIPTION DRUGS	
If member or doctor requests brand name drug when generic equivalent is available, member pays generic copayment plus cost difference between brand and generic. Member pays cost difference when selecting brand name over available generic.	
Retail Prescription Drugs	One copayment for up to a 31-day supply.
Generic	$15 copayment
Preferred Brand	$30 copayment
Non Preferred Brand	$45 copayment
Mail Prescription Drugs	One copayment for up to a 31-day supply. Two copayments for a 32 to 90-day supply.
Generic	two copayments or $30
Preferred Brand	two copayments or $60
Non Preferred Brand	two copayments or $90
BEHAVIORAL HEALTH Provided by PacifiCare Behavioral Health, Inc. (PBHI)	

[1] Visit copayments and the emergency room copayment are not subject to and do not apply to the calendar year deductible.

[2] Certain expenses do not apply toward the Annual Out-of-Pocket Limits under the Medical portion of the EPO plan. Examples include:
- Amounts not eligible under the plan;
- Expenses considered not eligible due to noncompliance with plan provisions (e.g., notification for air ambulance);
- For prescription drugs under the EPO program and behavioral health programs under PBHI, copayments, coinsurance or deductible amounts.

Under the Medical portion of the EPO plan, the calendar year deductible, visit copayments, the emergency room copayment and coinsurance amounts do apply to the Annual Out-of-Pocket Limit amount.

[3] Notification will be required by Physician. Notification is also required for Durable Medical Equipment and Prosthetics over $500 and for inpatient services for treatment of TMJ.

[4] Non-emergency ambulance is not covered. Air Ambulance transportation is provided to the closest facility that can provide service and notification is required. If notification is not received by UnitedHealthcare, no benefits will be paid.

Coordination of Benefits
Come Out Whole
Coverage will be paid at 100%. Member will receive the total amount of allowable charges coordinated between the primary plan and the secondary plan.

UnitedHealthcare: (800) 603-3816

PACIFICARE BEHAVIORAL HEALTH, INC. (PBHI)
Behavioral Health for UHC Select EPO Non-Medicare Members

Below is a brief overview of plan benefits. All services must be preauthorized and administered by PacifiCare Behavioral Health, Inc. (PBHI). Some benefits may have separate limitations or restrictions in addition to those shown. All services and supplies must be considered medically necessary by the plan to be covered. See plan's Summary Plan Description for details.

BENEFIT	2007 Plan
BEHAVIORAL HEALTH	
Mental Health	
Inpatient	No copayment
Outpatient	$15 per visit copayment
Substance Abuse	
Inpatient	
Detoxification	20% of authorized charges; no deductible
Rehabilitation	20% of authorized charges (50% for non-compliance) $250 calendar year deductible
Outpatient	
Rehabilitation	20% of authorized charges; no deductible
Plan Limits	Plan payments limited to one treatment episode per person per calendar year for inpatient and outpatient treatment (up to $10,000)
Lifetime Maximum	Inpatient per person: 130 days

Note: The Calendar Year Deductible, benefit level, and lifetime maximums are combined for a member who transfers between the UnitedHealthcare plans.

PacifiCare Behavioral Health, Inc.: (800) 817-8811

UNIVERSITY OF CALIFORNIA
UNITEDHEALTHCARE SELECT EPO - MEDICARE

Below is brief overview of the Select EPO plan benefits. Some benefits may have benefit maximums and/or have separate limitations or restrictions in addition to those shown. All services and supplies must be considered medically necessary by the plan to be covered. See plan's Summary Plan Description for details.

BENEFIT	MEMBER COST 2007 Plan
ELIGIBILITY	For employees and retirees of the University of California who reside in the UnitedHealthcare EPO Service Area in Washington D.C.(tri-state area).
DEDUCTIBLES[1]	
Individual	$150
Family	$450
OUT-OF-POCKET LIMIT[2]	
Individual	$2,000
Family	$6,000
HOSPITAL SERVICES	
Inpatient[3]	10% (includes maternity admissions)
Outpatient surgery	10%
Surgeon/assistant	10%
Admin. of Anesthetics	10%
Emergency room	Emergency:10% (+ $75 copay, waived if admitted to the hospital) Non-emergency: not covered
Ambulance[4]	10%
PHYSICIAN VISITS	
Office visit/surgery	$20
Home visit	$20
Hospital visit	No charge
Preventive physical exam	$20 (no charge up to age 2)
Preventive inoculations	No charge
Maternity	
Outpatient care	No charge ($20 for first visit to diagnose pregnancy)
Inpatient care	No charge
Well baby care	No charge up to age 2
ALTERNATIVE CARE	
Hospice[3] (maximum $7,400 per lifetime)	10%; no deductible
Home health care[3]	10%; no deductible
Skilled nursing facility[3]	10% (100 day maximum per calendar year); no deductible
Urgent care	$20 (10% for ancillary services)
OTHER BENEFITS	
Outpatient x-ray & laboratory	10%
Outpatient speech therapy (20 visits calendar year)	$20
Outpatient occupational therapy (20 visits calendar year)	$20
Outpatient physical therapy (20 visits per calendar year)	$20
Registered special duty nurse[3]	10%
Eye Exams	Medically necessary: $20. Routine eye exams not covered.
Eyeglasses, lenses and frames	Not covered
Hearing and vision screenings	$20 (through age 18). (No charge up to age 2).
Hearing Aids (every 36 months)	50% to $2,000 maximum, limited to one standard hearing aid per ear. Digital hearing aids are included.
Allergy testing/treatment/serum	$20 (no charge for allergy injections)
Durable medical equipment & prosthetics[3]	10%
Orthotics[3]	10%
Chiropractor	$20 (20 visits per calendar year)
Acupuncture	$20 (20 visits per calendar year)
Cardiac and Pulmonary Rehabilitation	$20 (medically necessary)
Therapeutic Injections	10%
Therapy: Chemotherapy, Dialysis and Radiation Therapy	10%
TMJ Services[3]	usual cost sharing based on type of service
PRESCRIPTION DRUGS	

UNIVERSITY OF CALIFORNIA
UNITEDHEALTHCARE SELECT EPO - MEDICARE

Below is brief overview of the Select EPO plan benefits. Some benefits may have benefit maximums and/or have separate limitations or restrictions in addition to those shown. All services and supplies must be considered medically necessary by the plan to be covered. See plan's Summary Plan Description for details.

BENEFIT	MEMBER COST 2007 Plan
If member or doctor requests brand name drug when generic equivalent is available, member pays generic copayment plus cost difference between brand and generic. Member pays cost difference when selecting brand name over available generic.	
Retail Prescription Drugs	One copayment for up to a 31-day supply.
Generic	$15 copayment
Preferred Brand	$30 copayment
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BEHAVIORAL HEALTH Provided by PacifiCare Behavioral Health, Inc. (PBHI)	

[1] Visit copayments and the emergency room copayment are not subject to and do not apply to the calendar year deductible.

[2] Certain expenses do not apply toward the Annual Out-of-Pocket Limits under the Medical portion of the EPO plan. Examples include:
Amounts not eligible under the plan;
Expenses considered not eligible due to noncompliance with plan provisions (e.g., notification for air ambulance);
For prescription drugs under the EPO program and behavioral health programs under PBHI, copayments, coinsurance or deductible amounts.

Under the Medical portion of the EPO plan, the calendar year deductible, visit copayments, the emergency room copayment and coinsurance amounts do apply to the Annual Out-of-Pocket Limit amount.

[3] Notification will be required by Physician. Notification is also required for Durable Medical Equipment and Prosthetics over $500 and for inpatient services for treatment of TMJ.

[4] Non-emergency ambulance is not covered. Air Ambulance transportation is provided to the closest facility that can provide service and notification is required. If notification is not received by UnitedHealthcare, no benefits will be paid.

Coordination of Benefits

Non-Duplication of Benefits
Normal benefits payable under the plan are determined. From that amount, the amount paid by Medicare is subtracted and the balance paid (if any).

UnitedHealthcare: (800) 603-3816

PACIFICARE BEHAVIORAL HEALTH, INC. (PBHI)
Behavioral Health for UHC Select EPO Medicare Members

Below is a brief overview of plan benefits. All services must be preauthorized and administered by PacifiCare Behavioral Health, Inc. (PBHI). Some benefits may have separate limitations or restrictions in addition to those shown. All services and supplies must be considered medically necessary by the plan to be covered. See plan's Summary Plan Description for details.

BENEFIT	2007 Plan
BEHAVIORAL HEALTH	
Mental Health	
Inpatient	No copayment
Outpatient	$15 per visit copayment
Substance Abuse	
Inpatient	
Detoxification	20% of authorized charges; no deductible
Rehabilitation	20% of authorized charges (50% for non-compliance) $250 calendar year deductible
Outpatient	
Rehabilitation	20% of authorized charges; no deductible
Plan Limits	Plan payments limited to one treatment episode per person per calendar year for inpatient and outpatient treatment (up to $10,000)
Lifetime Maximum	Inpatient per person: 130 days

Note: The Calendar Year Deductible, benefit level, and lifetime maximums are combined for a member who transfers between the UnitedHealthcare plans.

PacifiCare Behavioral Health, Inc.: (800) 817-8811