UNIVERSITY OF CALIFORNIA UCPath

2026 UNPAID LEAVE AND SHORT WORK BREAK OPEN ENROLLMENT FORM

*Indicates Required Fields

SECTION 1. KEY PERSONAL INFORMATION

EMPLOYEE NAME (Last, First, Middle Initial)*	EMPLOYEE ID NUMBER*	EMPLOYEE PHONE*

SECTION 2. DEPENDENTS

Please list each eligible dependent and provide their personal details. You must complete the following section for all dependents that will be added/removed. For each dependent, indicate whether you are adding (A) or removing (D) coverage in the appropriate benefit columns. Dependents may only be enrolled in plans in which you are currently enrolled. If you have more than five dependents, please use a second form. In accordance with the Affordable Care Act (ACA), employers are required to make reasonable efforts to obtain Social Security numbers for employees, spouses/domestic partners, and dependents.

NAME (Last, First, Middle Initial)	DATE OF BIRTH (mm/dd/yyyy)	GENDER (M/F/U[1])	RELATIONSHIP CODE[2]	EMPLOYEE TAX[3] DEPENDENT	SPOUSE/ DOMESTIC PARTNER TAX[4] DEPENDENT (Yes/No)	SOCIAL SECURITY NUMBER	MEDICAL	DENTAL	VISION	LEGAL
Dependent 1		-	-	-	-					
Dependent 2		-	-	-	-					
Dependent 3		-	-	-	-					
Dependent 4		-	-	-	-					

[1] **U** should be used to indicate any status other than Male or Female, including but not limited to Different Identity, Nonbinary, Genderqueer and Decline to State.
[2] Relationship Codes: **S**: Spouse, **R:** Registered Domestic Partner, **N:** Not Registered Domestic Partner, **C:** Child (biological or adopted), **P:** Stepchild, **G:** Grandchild, **W:** Legal Ward, **K**: Domestic Partner's Child or Grandchild, **O**: Overage Disabled Child. Must be a tax dependent of employee or spouse/domestic partner unless SSI exception applies.
[3] Dependent eligibility requirements may be found in the "Eligible Family Members" section of the Complete Guide to Your UC Health Benefits.
[4] If your domestic partnership is registered and you are the child's stepparent under state law, use Code **"P"** for Stepchild. If not, use Code **"K"**.

SECTION 3. TAX SAVINGS ON INSURANCE PREMIUMS (TIP)

Your medical premiums will automatically be deducted on a pre-tax basis. If you wish to decline and have deductions occur on a post-tax basis instead, check the box below and place your initials next to it.

☐ Decline /Opt out of TIP _____ Initials

SECTION 4. BENEFIT ELECTIONS

If you leave this section blank, your 2025 elections will carry forward to 2026, except for Health and Dependent Care Flexible Spending Accounts.

MEDICAL PLAN

ENROLL:

☐ UC Care
☐ HealthSavings+
☐ Kaiser Permanente[1]
☐ UC Blue & Gold HMO[1]
☐ DECLINE MEDICAL PLAN

[1] HMO plans require you to live or work in their service area.

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**Indicates Required Fields*

MEDICAL PLAN (CONTINUED)

If enrolling in **UC Blue & Gold HMO**, please provide the 9-10 digit ID Primary Physician Group (PPG) or Primary Care Physician (PCP) ID number to avoid auto-assignment. Also, list PCP ID number for each dependent if different than yours.

Employee PPG / PCP 9-10 digit ID#	☐ Check if current physician
Dependent 1 PPG / PCP 9-10 digit ID#	☐ Check if current physician
Dependent 2 PPG / PCP 9-10 digit ID#	☐ Check if current physician
Dependent 3 PPG / PCP 9-10 digit ID#	☐ Check if current physician
Dependent 4 PPG / PCP 9-10 digit ID#	☐ Check if current physician

☐ Check if same PPG/PCP for all dependents

HEALTH SAVINGS ACCOUNT (HEALTHEQUITY)

You are eligible for an HSA only if you enroll in the HealthSavings+ plan. If you elect the HSA, you cannot participate in a Health Flexible Spending Account (FSA). HSA contributions will take effect once you return to pay status.

HSA Contribution: $ _____ (Annual)

2026 Annual HSA Contribution Maximum:

	Employee	UC Contribution
Single Coverage:	$4,400	$750
Family Coverage:	$8,750	$1,500

Individuals age 55 and older can make an additional "catch-up" contribution of $1,000.

DENTAL (DELTA)

☐ ENROLL: DELTA DENTAL PPO ☐ ENROLL: DELTA CARE® USA DHMO ☐ DECLINE DENTAL PLAN

If enrolling in Delta Care® USA DHMO please provide the Primary Care Dentist (PCD) ID number to avoid auto-assignment.

Employee PCD ID#	☐ Check if same PCD for all dependents
Dependent 1 PCD ID#	Dependent 3 PCD ID#
Dependent 2 PCD ID#	Dependent 4 PCD ID#

VISION SERVICE PLAN (VSP)

☐ ENROLL ☐ DECLINE

LEGAL (ARAG)

☐ ENROLL ☐ DECLINE

FLEXIBLE SPENDING ACCOUNTS (FSA-Administered by WEX)

NOTE: You are not eligible to enroll at this time; you will have the opportunity to do so upon your return to pay status.

ACCIDENTAL DEATH & DISMEMBERMENT (PRUDENTIAL)

You are **only** eligible to Decrease or Waive current coverage. If you elect to Decrease current coverage, please check the applicable boxes provided below.
(***Note**: You will have an opportunity to Enroll or Increase coverage when you return from leave).*

☐ INCREASE/DECREASE:

- ☐ Employee Only
- ☐ Employee and Spouse/Domestic Partner
- ☐ Employee and Child(ren)
- ☐ Family

☐ DECLINE

☐ $10,000	☐ $60,000	☐ $125,000	☐ $400,000
☐ $20,000	☐ $70,000	☐ $150,000	☐ $500,000
☐ $30,000	☐ $80,000	☐ $175,000	
☐ $40,000	☐ $90,000	☐ $200,000	
☐ $50,000	☐ $100,000	☐ $300,000	

UNIVERSITY OF CALIFORNIA UCPath

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**Indicates Required Fields*

SUPPLEMENTAL HEALTH (PRUDENTIAL)

You are only eligible to make changes to a plan you are currently enrolled in. (***Note**: If you are not currently enrolled, you will have an opportunity to enroll or increase coverage when you return to pay status).*

ACCIDENT	HOSPITAL INDEMNITY	CRITICAL ILLNESS
☐ INCREASE/DECREASE ☐ Employee Only ☐ Employee and Spouse/Domestic Partner ☐ Employee and Child(ren) ☐ Family ☐ DECLINE	☐ INCREASE/DECREASE ☐ Employee Only ☐ Employee and Spouse/Domestic Partner ☐ Employee and Child(ren) ☐ Family ☐ DECLINE	Qualifying dependent children are automatically enrolled at no cost when you enroll in the plan. Coverage for a spouse or domestic partner is available only if you enroll yourself, and they will be enrolled at the same coverage level you select for yourself. ☐ INCREASE/DECREASE (Employee/Child(ren)): ☐ $10,000 ☐ $30,000 ☐ ENROLL (Spouse/Domestic Partner) ☐ DECLINE (Spouse/Domestic Partner) ☐ DECLINE (Employee/Child(ren))

SECTION 5. LATE ENROLLMENT

The Late Enrollment Request section is for employees who need to enroll in benefit plans once they have missed the Open Enrollment Period (OEP) or Period of Initial Eligibility (PIE), or for Faculty second PIE.

REASON FOR LATE ENROLLMENT

Please indicate the reason you are requesting late enrollment:

90 DAY WAITING PERIOD FOR MEDICAL OPTION

Per UC Policy, an employee who is not enrolled in any medical plan because a Period of Eligibility (PIE) or Open Enrollment Period was missed may enroll in a No TIP (after-tax) medical plan subject to a 90-day waiting period.

If your late enrollment request is denied, do you want to be enrolled in a medical plan subject to a 90-day waiting period?

☐ **Yes**, I would like to be enrolled in the 90-day waiting period medical plan

☐ **No**, I want to decline medical coverage.

SECTION 6. AUTHORIZATION AND SIGNATURE

My signature below indicates I have read and understand the "Terms and Conditions" on this form as well as the eligibility requirements of the benefit plans in which I have enrolled. I declare under penalty of perjury that all of the above information is true to the best of my knowledge. I understand that if I left a plan section blank, my current 2025 elections for that plan will carry over (with the exception of Health FSA and DepCare FSA). I agree it is my responsibility to check my earnings statements to verify my current benefits enrollments and deductions. I understand that if I am enrolling a domestic partner in medical, dental or vision benefits, upon submission of this form and successful completion of the Family Member Eligibility Verification process, my domestic partner will be recognized by the UC Retirement Plan as my Survivor, subject to additional eligibility requirements. I may be subject to federal taxes on imputed income for the value of coverage for a domestic partner.

Signature* _____ **Date*** _____

UNIVERSITY OF CALIFORNIA UCPath

2026 UNPAID LEAVE AND SHORT WORK BREAK OPEN ENROLLMENT FORM

Purpose:

The **2026 Open Enrollment** period runs from **October 30 - November 21, 2025**. The purpose of this form is to allow you, the employee who does not have access to UCPath online, to elect 2026 health and welfare benefits. Any benefits you elect using this form are effective **January 1, 2026**. There are some plans for the 2025 plan year that you cannot enroll in until you have returned from leave. You will be provided the opportunity to enroll in those plans upon your return. See the Health Benefits Enrollment Letter enclosed for additional information.

Use:

If you do not take action, your current 2025 benefit elections will automatically carry over to 2026, except for Flexible Spending Accounts (FSA) which require re-enrollment each year.

You will need to take action during Open Enrollment if you would like to:

- Make changes to your current benefit elections
- Add eligible family members
- Enroll or continue in the Health and/or DepCare Flexible Spending Accounts (FSA), which require enrollment every year

Please note: If you are currently enrolled in the CORE Medical Plan or the Health Savings Plan and do not make changes, you will be defaulted into the HealthSavings+ plan. Review your options carefully.

Instructions:

Section 1: Complete this section with your personal information.

Section 2: List yourself and all family members, including personal details. Then, check the box(es) of the benefit plan(s) in which your dependents will be enrolled. You may only enroll family members into plans in which you are enrolled. Please note: The Affordable Care Act (ACA) requires employers to make reasonable efforts to obtain Social Security numbers for employees, spouses/domestic partners and children.

Section 3: Opt Out of Tax Savings on Insurance Premiums: Complete this section only if you have enrolled in medical coverage online via UCPath and are declining/opting out of the Tax Savings on Insurance Premium (TIP) program. If you choose to decline/opt out, please check the box and initial next to it to confirm your selection. For more information, please refer to the TIP summary plan description.

Section 4: Select your 2026 benefits by checking the box(es) for the appropriate plan(s). For UC Blue & Gold HMO and Delta Care USA DHMO plans, please include the Primary Care Physician ID, which can be found on the applicable carrier's website or by calling customer service. Health Net and Delta Dental contact information is available on UCNet and in the Open Enrollment booklet you received in the mail.

Section 5: The late enrollment request section is for employees who need to enroll in benefit plans once they have missed the open enrollment period. Only fill out this section if you are completing this form after the Open Enrollment Period. Please also note that if you are selecting a medical plan to indicate if you would like to participate in the after tax 90-day waiting period.

Section 6: When you have completed your form, sign your first and last name in the signature area and date it.

Submission Instructions:

Use one of the following methods to submit your completed form. After your form is processed, you will receive an email confirming that your elections have been submitted. By the second week of December, UCPath will send you another email when your confirmation statement is available in UCPath.

UCPath:

- Log in to UCPath using your Single Sign On (SSO)
- Click **Ask UCPath**
- Select **Submit An Inquiry**
- Under "What can UCPath assist you with?"
  - Specify what UCPath can assist you with, be sure to include "**LWOP OE**"
- Under the detailed description section,
  - Include a detailed description of your issue, be sure to include the term "**LWOP Open Enrollment PDF Form**"

Email:

ucpath@universityofcalifornia.edu

- In the subject line, write: **LWOP OE**
  - If the subject line does not read "**LWOP OE,**" your open enrollment form may not be processed

Postal Mail:

UCPath
14350-1 Meridian Parkway
Riverside, CA 92518

Deadline:

All forms must be submitted on or before 5:00pm (PT) November 21, 2025. If submitted by mail, forms must be postmarked by November 21, 2025. If you need to make additional changes, please submit another fully-completed form. If you submit multiple forms, UCPath will process the most recently dated form as your final elections.

Contact Information:

If you have questions, contact UCPath at (855) 982-7284 Monday - Friday 8am - 5pm (PT).

Employees Eligible for Faculty/Staff Benefits Program

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:

ARBITRATION

With the exception of Optum Behavioral Health and UC Medicare Choice, all UC medical plans require resolution of disputes through arbitration.

This arbitration agreement applies to the following plans:
UC Care
HealthSavings+
UC Blue & Gold HMO
UC High Option Supplement to Medicare
UC Medicare PPO
UC Medicare PPO without Prescription Drugs.

By providing your written or electronic signature, it is understood and you agree 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.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.

☐ **BY CHECKING THIS BOX I AM ELECTRONICALLY SIGNING AND ACCEPTING THE ABOVE ARBITRATION TERMS PERTAINING TO ALL MEDICAL PLANS EXCEPT KAISER FOUNDATION HEALTH PLANS. AND OPTUM BEHAVIORAL HEALTH.**

This arbitration agreement applies to ONLY the Kaiser Foundation Health Plan in California.

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc., any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage.*

☐ **BY CHECKING THIS BOX AND ENROLLING IN A KAISER PERMANENTE CA HEALTH PLAN, I UNDERSTAND THAT THIS ACTION WILL SERVE AS MY ELECTRONIC SIGNATURE OF AGREEMENT TO THE CONDITIONS PROVIDED IN KAISER FOUNDATION HEALTH PLAN ARBITRATION AGREEMENT (ABOVE) AND THAT BY LAW, THIS ELECTRONIC SIGNATURE WILL HAVE THE SAME EFFECT AS A SIGNATURE ON A PAPER FORM.**

Note: If you do not wish to accept the arbitration agreement you must make a different non-Kaiser Health Plan selection.

For more information about each plan's arbitration provision please see the appropriate plan booklet or call the plan.

ADDITIONAL TERMS AND CONDITIONS APPLICABLE TO ALL PLANS

Except where specifically noted below, the following terms and conditions apply to the health and welfare benefit plans provided to benefits-eligible employees, retirees and family members, including medical, dental, vision, life, disability, accident, critical illness, hospital indemnity, accidental death and dismemberment, flexible spending accounts, identity theft protection, legal, pet, family care resources and adoption assistance plans.

1. By making an election with your written or electronic signature you are authorizing UC to take deductions from your earnings (employees)/monthly Retirement Plan income (retirees)/designated bank account(direct payment 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 and associated service vendors in which you are enrolled.

2. You are responsible for payment of any uncollected plan premiums that remain due and outstanding for any reason, including, but not limited to, changes in eligibility, retroactive, late, and other enrollment changes resulting in a change in plan premiums, insufficient bank funds or paycheck payment from which plan premiums were to be deducted, missed premium payments, or failure to make direct payments. Any unpaid plan premiums that remain due and outstanding may be recovered by UC, on behalf of the plan or for itself, to the extent permitted by law.
3. You are responsible for the repayment of any plan premiums paid by UC on the Member's behalf resulting in the overpayment of plan premiums for any reason, including, but not limited to, changes in eligibility, retroactive disenrollment, other enrollment changes resulting in changes to plan premiums. Any overpaid plan premiums that remain outstanding may be recovered by UC, on behalf of the plan or for itself, to the extent permitted by law.
4. 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.
5. 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.
6. 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.
7. 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 loss notice must be provided to UC within 60 days of the family member's loss of coverage. However, regardless of the timing of notice to UC, coverage for the ineligible family member will end on the last day of the month in which the eligibility loss event occurs (subject to any continued coverage option available and elected).
8. Making false statements about satisfying eligibility criteria, failing to timely notify UC of a family member's loss of eligibility, or failing to provide verification documentation when requested may lead to de-enrollment of the affected individuals. Employees/retirees may also be subject to disciplinary action and de-enrollment from health benefits and may be responsible for any cost of benefits provided and UC-paid premiums due to misuse of plan.
9. 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.)
10. If you specifically ask UC representatives to intercede on your behalf with your insurance plan, University representatives will request the minimum health information required to assist you with your problem. If more health information is needed to solve your problem, in compliance with state and federal privacy laws, you may be required to sign an authorization allowing UC to provide the health plan with relevant health information or authorizing the health plan to release such information to the UC representative.
11. Provided all electronic and form transactions have been completed properly and submitted timely actions you take during Open Enrollment will be effective the following January 1 unless otherwise stated
12. By enrolling in the Critical Illness, Hospital Indemnity or Accident plans you acknowledge that you have read and agree to the below Product Disclaimers, that you understand the terms and requirements of the fraud warnings included as part of the disclaimers, and you declare that all information given is true and complete to the best of your knowledge and belief.

Hospital Indemnity Product Disclaimers

https://gi.prudential.com/groupinsurance/forms/Disclaimers/HIP_DISCLAIMERS.pdf

Accident Product Disclaimers

https://gi.prudential.com/groupinsurance/forms/Disclaimers/ACCIDENT_DISCLAIMERS.pdf

Critical Illness Product Disclaimers

https://gi.prudential.com/groupinsurance/forms/Disclaimers/CRITICAL_ILLNESS_DISCLAIMERS.pdf

IMPORTANT NOTICES

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 members* 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 (1-800-888-8267).

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.

In addition to the special enrollment rights you have under HIPAA, the University's Group Insurance Regulations (GIRs) permit you to change medical plans under certain other conditions. See UC GIRs for additional detail.

* 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.

By authority of the Regents of the University of California, University of California Employee Benefits Administration Office located in Oakland administers all benefit plans in accordance with applicable plan documents and regulations, custodial agreements, University of California Group Insurance Regulations, group insurance contracts, and state and federal laws. No person is authorized to provide benefits information not contained in these source documents and information not contained in these source documents cannot be relied upon as having been authorized by the Regents. Source documents are available for inspection upon request (1-800-888-8267). What is written here does not constitute a guarantee of plan coverage or benefits--particular rules and eligibility requirements must be met before benefits can be received.

The University of California intends to continue the benefits described here indefinitely; however, the benefits of all employees, retirees, and plan beneficiaries are subject to change or termination at the time of contract renewal or at any other time by the University or other governing authorities. The University also reserves the right to determine new premiums, employer contributions, and monthly costs at any time. Health and welfare benefits are not accrued or vested benefit entitlements. UC's contribution toward the monthly cost of the coverage is determined by UC and may change or stop altogether and may be affected by the state of California's annual budget appropriation. If you belong to an exclusively represented bargaining unit some of your benefits may
differ from the ones described here. For more information employees should contact their Human Resources
Office and retirees should call the UC Retirement Administration Service Center (1-800-888-8267).

In conformance with applicable law and University policy, the University is an equal opportunity employer. Please send inquiries regarding the University's equal opportunity policies for staff to the Office of Systemwide Employee Relations, 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.

University of California Healthcare Plan Notice of Privacy Practices - Self-Funded Plans - Effective January 1, 2026

The privacy protections described in this notice reflect the requirements of federal regulations issued under the
Health Insurance Portability and Accountability Act (HIPAA).

THIS NOTICE DESCRIBES HIPAA PROTECTED HEALTH INFORMATION OR PHI MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The University of California ("Plan Sponsor") sponsors several Self-Funded Plans, including UC Care, HealthSavings+, UC High Option Supplement to Medicare, UC Medicare PPO, UC Medicare PPO without Prescription Drugs and the Dental PPO. ("Plans"). This Healthcare Notification of Privacy Practices applies to all of these Plans.

UC'S COMMITMENT

The University of California is committed to protecting the privacy of your PHI as required by law. The Plans:

• Are required by law to maintain the privacy and security of your PHI

• Must provide you with this Notice of our legal duties and privacy practices

• Must follow the terms of the Notice currently in effect

• Will notify you in the even of a breach of your unsecured PHI

How We May Use and Disclose Your Health Information

We may typically use and disclose your health information in the following ways.

- Treatment. A Self-Funded Plan may use and disclose your PHI to doctors, dentists, pharmacies, hospitals, and other health care providers who take care of you. For example, doctors may request medical information from us to supplement their own records.

- Payment. A Self-Funded Plan may use and disclose your PHI in the course of activities that involve reimbursement for healthcare, such as determination of eligibility for coverage, claims processing, billing, obtaining, and payment of premium, and utilization review.

- Healthcare Operations. Most Plan administration activities and duties are handled by third parties called Third Party Administrators, which must be fully compliant with HIPAA. The Plans operate a Health Care Facilitator (HCF) function which may assist enrollees with resolving issues with TPAs and help to navigate benefit coverage and appeals processes. The HCF function may only access PHI solely for health care operations of the Plan and only as permitted by HIPAA. As required by HIPAA, the HCF function may not share PHI with the Plan Sponsor functions

- Plan Sponsor. The Plan Sponsor employee benefits administration function may receive certain limited PHI from the Plans or the health insurance issuer (e.g., Elevance/Anthem) for two very narrow purposes:

1. Summary Health Information as defined by HIPAA [45 CFR 164.504(f)(1)] for the purpose of:

    • Obtaining Plan premium bids from health plans for future Plan coverage years, or

    • Modifying amending, or terminating the Plan; or

2. Whether an individual Plan enrollee is participating on the Plan, or is enrolled or had disenrolled form the Plan.

    • Obtaining Plan premium bids from health plans for future Plan coverage years, or

    • Modifying amending, or terminating the Plan; or

- As Required By Law. A Self-Funded Plan will disclose your PHI if required to do so by federal, state, or local law, or regulation.

- To Avert a Serious Threat to Health or Safety. A Self-Funded Plan may disclose your PHI when necessary to prevent or lessen a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

-Disaster Relief Efforts. A Self-Funded Plan may share your health information to an entity assisting in a disaster relief effort so that others can be notified about your condition, status and location.

- Military and Veterans. If you are or were a member of the armed forces, a Self-Funded Plan may release your PHI to military command authorities as authorized or required by law. A Self-Funded Plan may also release medical information about foreign military personnel to the appropriate military authority as authorized or required by law.

- Research. In limited circumstances, a Self-Funded Plan may use and disclose PHI for research purposes, subject to the confidentiality provisions of state and federal law. Your PHI may be important to further research efforts and the development of new knowledge. All research projects conducted by the University of California must be approved through a special review process to protect member safety, welfare, and confidentiality.

- Workers' Compensation. A Self-Funded Plan may release PHI for workers' compensation or similar programs as permitted or required by law. These programs provide benefits for work-related injuries or illness.

- Health Oversight Activities. A Self-Funded Plan may disclose PHI to governmental, licensing, auditing, and accrediting agencies as authorized or required by law.

- Legal Proceedings. A Self-Funded Plan may disclose PHI to courts, attorneys, and court employees in the course of conservatorship and certain other judicial or administrative proceedings.

- Lawsuits and Disputes. If you are involved in a lawsuit or other legal proceeding, a Self-Funded Plan may disclose your PHI in response to a court or administrative order, or in response to a subpoena, discovery request, warrant, summons, or other lawful process.

- Law Enforcement. If authorized or required by law, a Self-Funded Plan may disclose your PHI under limited circumstances to a law enforcement official in response to a warrant or similar process, to identify or locate a suspect, or to provide information about the victim of a crime.

- Department of Health and Human Services. A Self-Funded Plan may be required to disclose your PHI to the Department of Health and Human Services if the Secretary is conducting a compliance audit.

- National Security and Intelligence Activities. If authorized or required by law, a Self-Funded Plan may release your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities.

- Protective Services for the United States President and Others. A Self-Funded Plan may disclose your PHI to authorized federal and state officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or conduct special investigations as authorized or required by law.

- Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, a Self-Funded Plan may release your PHI to the correctional institution or law enforcement official, as authorized or required by law. This release would be necessary for the institution to provide you with healthcare; to protect your health and safety or the health and safety of others; or for the safety and security of the correctional institution.

- Marketing or Sale of Health Information. Most uses and sharing of your health information for marketing purposes or any sale of your health information are strictly limited and require your written authorization.

- Separation Between Covered Functions and Non-Covered Functions. To comply with the requirements of HIPAA, the University must maintain separation between covered functions (including the University's Group Health Plans), and non-covered functions (such as employer-related functions not associated with the University's Group Health Plans). The University prohibits the use or disclosure of member PHI for employment-related actions or decisions; nor may it be used or disclosed in connection with any other benefit or employee benefit plan of the University. A disclosure of PHI from the Single Health Plan Component to a non-covered function or unit may require written authorization.

- Other Uses and Disclosures of Health Information. Other ways we share and use your health information not covered by this Notice will be made only with your written authorization. If you authorize us to use or disclose your health information, you may cancel that authorization, in writing, at any time. However, the cancellation will not apply to information we have already used and disclosed based on the earlier authorization.

Special laws apply to certain kinds of health information considered particularly private or sensitive to a patient. This sensitive information includes psychotherapy notes, sexually transmitted diseases, drug and alcohol abuse treatment records, mental health records, and HIV/AIDS information. When required by law, we will not share this type of information without your written permission. In certain circumstances, a minor's health information may receive additional protections.

- Genetic Information is Protected Health Information. In accordance with the Genetic Information Nondiscrimination Act (GINA), a Self-Funded Plan will not use or disclose genetic information for underwriting purposes, which includes eligibility determinations, premium computations, applications of any pre-existing condition exclusions, and any other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

Your Rights

You have the following rights regarding the PHI that a Self-Funded Plan maintains about you:

- Right to Inspect and Copy. With certain exceptions you have the right to inspect and obtain a copy of your PHI that is maintained by or for a Self-Funded Plan. To inspect and obtain a copy of the PHI you must submit your request in writing to the UC Healthcare Plan Privacy Office, 1111 Franklin Street, Oakland, CA, 94607, Attention: Privacy Officer. You may be charged a fee for the costs of copying mailing or other supplies associated with your request.

A Self-Funded Plan may deny your request to inspect and/or obtain a copy in certain limited circumstances. For example, HIPAA does not permit you to access or obtain copies of psychotherapy notes. If your request is denied, you will be informed in writing, and you may request that the denial be reviewed. The person conducting the review will not be the person who denied your request. The plan will comply with the outcome of the review.

- Right to Request an Amendment. If you believe that the PHI maintained by a Self-Funded Plan is incorrect or incomplete, you may request that the plan amend the information. You have the right to request an amendment for as long as the information is kept by or for the plan. A request for an amendment should be made in writing and

submitted to the UC Healthcare Plan Privacy Office, 1111 Franklin Street, Oakland, CA 94607, Attention: Privacy Officer. In addition, you must provide a reason that supports your request. If a request applies to PHI that a TPA (BA) maintains, UC may assist the enrollee with reaching TPA responsible privacy office.

A Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the plan may deny your request if you ask to amend information that was not created by the plan; is not part of the PHI maintained by or for the plan; is not part of the information that you would be permitted to inspect and copy under the law; or if the information is accurate and complete. If the request is granted, the plan will forward your request to other entities that you identify that you want to receive the corrected information.

- Right to an Accounting of Disclosures. You have the right to receive an "accounting of disclosures", which is a list of disclosures such as those that were made of PHI about you, with the exception of certain documents, including those relating to treatment, payment, and healthcare operations and disclosures made to you or consistent with your authorization. To request an accounting of disclosures, you must submit your request in writing to the UC Healthcare Plan Privacy Office, 1111 Franklin Street, Oakland, CA 94607, Attention: Privacy Officer.

Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003.

Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, the plan may charge you for the costs of providing the list. You will be notified of any costs involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- Right to Request Restrictions. You have the right to request a restriction or limitation on the use and disclosure of your PHI for treatment, payment or healthcare operations, or to request a restriction on the PHI that the plan may disclose about you to someone who is involved in your care, or the payment for your care such as a family member or friend. The plan is not required to agree to your request. If the plan agrees to your request, it will comply with the requested restriction unless the information is needed to provide you emergency treatment or to assist in disaster relief efforts.
To request a restriction, you must submit your request in writing to the UC Healthcare Plan Privacy Office, 1111 Franklin Street, Oakland, CA 94607, Attention: Privacy Officer. Your request should state the information you want to limit; whether you want to limit the plan's use or disclosure or both; and to whom you want the limits to apply for example disclosures to your spouse.

- Right to Request Confidential Communications. You have the right to request that a Self-Funded Plan communicate with you about Plan matters in a certain way or at a certain location. For example, you can ask that the plan only contact you at work or by mail to a specific address. To request confidential communications, you must submit your request in writing to the UC Healthcare Plan Privacy Office, 1111 Franklin Street, Oakland, CA 94607, Attention: Privacy Officer. The plan will accommodate all reasonable requests and will not ask you the reason for your request. Your request must specify how or where you wish to be contacted.

- Right to a Paper Copy of This Notice. You may ask the Plan to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact the UC Healthcare Plan Privacy Office, 1111 Franklin Street, Oakland, CA 94607, Attention: Privacy Officer.

- Breach. You have the right to be notified, and your Self-Funded Plan has a duty to notify you, of the discovery of a breach of unsecured PHI.

- Right to Choose Someone to Act for You. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. The plan will make sure the person has this authority and can act for you before the plan takes any action.

Changes to this Notice

The Self-Funded Plans are required to abide by the terms of the Notice of Privacy Practices currently in effect. However, the Self-Funded Plans reserve the right to change this notice and to make the revised or changed notice effective for PHI your plan already maintains on you as well as any information the plan receives or creates in the future. A copy of the current notice will be posted at the UC website at http://ucnet.universityofcalifornia.edu/forms/pdf/uc-healthcare-plan-notice-of-privacy-practices-self-funded-plans.pdf. The effective date on the first page in the top right-hand corner. In addition, a copy of the notice that is currently in effect will be given to new health plan members and thereafter, available upon request.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with:

- UC Healthcare Plan Privacy Office, 1111 Franklin Street, Oakland, CA 94612, Attention: Privacy Officer. Email will not be accepted; all complaints must be submitted in writing.
- The Secretary of the Department of Health and Human Services for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201.

You will not be retaliated against for filing a complaint.

Questions

If you have questions or for further information regarding this privacy notice, contact the UC Healthcare Plan HIPAA Privacy Officer at 1-800-888-8267, press 1.