UNIVERSITY OF CALIFORNIA UCPath

HEALTH BENEFITS ENROLLMENT FORM FOR LIFE EVENT

FR.065

It is your responsibility to complete and submit this form to UCPath by 5pm PST on the 31st day of your PIE. Required fields outlined in red must be completed in order for your form to be processed.

SECTION 1. KEY PERSONAL INFORMATION

Enter your information. Your UCPath Employee ID# is provided in your new hire paperwork.

Employee Name (Last, First, Middle Initial):	Employee ID Number:

SECTION 2. QUALIFYING LIFE EVENT

Enter the date of the event and select the type of event by checking the applicable box shown below. See A Complete Guide to Your UC Health Benefits for more information on benefits eligibility.

Date Life Event Occurred: _____ (mm/dd/yyyy)

- ☐ Birth / Adoption
- ☐ Marriage
- ☐ Domestic Partnership
- ☐ Divorce, Legal Separation, Annulment, Termination of Domestic Partnership
- ☐ Death
- ☐ Child Turning Age 26
- ☐ Involuntary Loss of Coverage
- ☐ Adult Dependent Relative Legal Ward, Family Member
- ☐ Address Change (move in/out of a plan's service area)
- ☐ Other - Explain: _____

SECTION 3. DEPENDENTS

List each dependent and enter his or her personal details. You must complete the following section for all dependents that will be added/deleted. Put an A in the appropriate benefit column to add, or D to delete/cancel from your coverage. You may only enroll family members into plans in which you are enrolled. If you have more than five dependents, you may complete a second form and fill out sections 1, 3, & 5. The Affordable Care Act (ACA) requires employers to make reasonable efforts to obtain Socail Security numbers of employees, spouses/domestic partners, and dependents.

Name (Last, First, Middle Initial)	Birthdate (mm/dd/yyyy)	Gender (M / F)	Relationship Code[1]	Employee Tax[2] Dependent? (Yes / No)	Spouse / Dom Partner Tax[3] Dependent? (Yes / No)	Social Security Number	Medical	Dental	Vision	Legal	Hospital Indemnity	Critical Issues	Accident

1 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** = Overaged Disabled Child

2 Dependent eligibility requirements may be found in the "Eligible Family Members" section of the Complete Guide to Your UC Health Benefits.

3 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".

4 Must be a tax dependent of employee or spouse/domestic partner unless SSI exception applies.

SECTION 4. BENEFIT ELECTIONS

Select your benefits by checking the box for the appropriate plan. If you leave a plan section blank, it is the same as declining and you will not be enrolled in that plan. Therefore, you MUST re-affirm your enrollment in EACH plan or it will be assumed that you are declining your option to enroll.

MEDICAL PLAN

PPO Plans	or	HMO Plans
☐ UC Care		☐ Kaiser Permanente
☐ CORE		☐ UC Blue and Gold HMO
☐ Health Savings Plan		
☐ Decline Medical Plan		HMO plans require you to live or work within their service area.

If enrolling in Health Net, please provide the 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 from yours.

Employee	PPG / PCP 10-digit ID#	Check if current physician: ☐	Check if same PPG/PCP for all dependents: ☐	
Dependent 1	PPG / PCP 10-digit ID#	Check if current physician: ☐		
Dependent 2	PPG / PCP 10-digit ID#	Check if current physician: ☐		
Dependent 3	PPG / PCP 10-digit ID#	Check if current physician: ☐		
Dependent 4	PPG / PCP 10-digit ID#	Check if current physician: ☐		
Dependent 5	PPG / PCP 10-digit ID#	Check if current physician: ☐		

HEALTH SAVINGS ACCOUNT

You are eligible for HSA only if you elect the UC Health Savings Plan. For further information regarding IRS Regulations on maximum contribution, refer to Complete Guide to Your UC Health Benefits.

☐ HSA Contribution: $ _____ (Annual)

2023 Annual HSA Contribution Maximum:

Employee	UC Contribution
Single Coverage: $3,150	$500
Family Coverage: $6,300	$1,000

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

FLEXIBLE SPENDING ACCOUNTS (FSA)

If you elect the Health Savings Account, you are not eligible to participate in the Health FSA.

☐ Health FSA Contribution: $ _____ (Annual)

☐ DepCare FSA Contribution: $ _____ (Annual)

2023 Annual FSA Contribution Maximum:

Health FSA: $2,750

DepCare FSA: $5,000

The minimum annual contribution for each is $180.00.

DENTAL

☐ Delta Dental PPO ☐ Delta Care® USA DHMO ☐ Decline Plan

If enrolling in Delta Care® USA DHMO please provide the 6-digit Primary Care Dentist (PCD) ID number to avoid auto-assignment.

Employee	PCD ID#	Check if same PCD ID for all Dependents: ☐	
Dependent 1	PCD ID#	Dependent 4	PCD ID#
Dependent 2	PCD ID#	Dependent 5	PCD ID#
Dependent 3	PCD ID#	Dependent 6	PCD ID#

LIFE INSURANCE

The most important reason you choose to purchase life insurance is to protect your family financially in the event of your death. To that end, it is critical that you have established the correct beneficiary designation. The most important consideration is to make sure that the employee's wishes are fulfilled upon the insured's death and that legal complications are avoided. To name your beneficiaries, log into At Your Service (AYS) Online.

Supplemental Life Insurace

☐ Flat Amount $20,000
☐ 1x Annual Salary
☐ 2x Annual Salary
☐ 3x Annual Salary
☐ 4x Annual Salary
☐ Decline Plan

Dependent Life Insurance

☐ Basic Plan or Expanded Dependent Life
☐ Spouse/Domestic Partner
☐ Child(ren) Only
☐ Family
☐ Decline Plan

VOLUNTARY DISABILITY INSURANCE

The University of California does not participate in California State Disability Insurance, although employees who have worked at UC for less than 18 months may have some residual SDI benefits.

☐ Short-Term Disability (VSTD)
☐ Long-Term Disability (VLTD)
☐ Both VSTD and VLTD
☐ Decline Plan

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

Check the box of the individuals you would like to cover, as well as the dollar amount of your coverage.

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

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

TAX SAVINGS ON INSURANCE PREMIUMS (TIP)

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

☐ Decline / Opt out of TIP _____ Initials

SUPPLEMENTAL HEALTH PLANS (AFLAC)

For Accident and/or Hospital Indemnity coverage, please make your desired selections below. For Critical Illness coverage, check the box you would like as the dollar amount of your coverage ($10,000 or $30,000). Qualifying dependent children will be enrolled for free when you enroll yourself into the plan. Coverage for a Spouse/Domestic Partner is only available if you enroll yourself into the plan. Additionally, your Spouse/Domestic Partner will be enrolled at the same coverage level in which you enroll yourself.

Accident

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

Critical Illness (Employee/Child(ren))

☐ $10,000 ☐ $30,000

Critical Illness (Spouse/Domestic Partner)

Hospital Indemnity

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

PET INSURANCE

Enrollment for Pet Insurance is made directly with the vendor. To enroll in Pet Insurance, visit Nationwide: www.petinsurance.com/uc

SECTION 5. 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, it is the same as waiving and I will not be enrolled in that plan. I agree it is my responsibility to check my earnings statements to verify my current benefits enrollments and deductions.

Signature: **Date:**

Email: **Phone:**

Purpose:

The purpose of this form is to allow you, the employee, to elect health and welfare benefits.

Use:

You will need to take action after a qualifying life event if you would like to:

- Make changes to or continue 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.

Instructions:

Section 1: Complete this section with your personal information.

Section 2: Select the applicable event that determines your benefits eligibility.

Section 3: 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 4: Select your 2023 benefits by checking the box(es) for the appropriate plan(s).

Section 5: When you have completed your form, sign your first and last name in the signature area and date it.

Submit your form using one of the following methods:

UCPath: http://ucpath.universityofcalifornia.edu

- Log in using **Single Sign On (SSO)**
- Click **Ask UCPath**
- Select **Submit An Inquiry**
- Use the following drop-down selections:
  - Topic: **Open Enrollment**
  - Category: **Enrollment Form**
  - Subject: **Submitting OE Election Form**

Email: ucpath@universityofcalifornia.edu

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

Fax: (855) 982-2329

Mail: UCPath
14350-1 Meridian Parkway
Riverside, CA 92518

Note: Once your form has been processed, you will receive an email letting you know that your elections have been successfully submitted.

Deadline:

Your Period of Initial Eligibility (PIE) is thirty (30) days from the effective date of the qualifying event. Submissions made after your 30-day PIE deadline will require additional approvals.

Contact Information:

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

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:

1. With the exception of benefits provided or administered by Optum Behavioral Health, UC-sponsored medical plans require resolution of disputes through arbitration. With regard to each plan, by 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. For more information about each plan's arbitration provision please see the appropriate plan booklet or call the plan.
2. UC and UC health and welfare plan vendors comply with federal/state regulations related to the privacy of personal/confidential information including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as applicable. To fulfill the responsibilities and perform the service required under contracts with UC, health plans and associated service vendors may share UC member health information between and among each other within the limits established by HIPAA and federal/state regulations for purposes of health care operations, payment, and treatment. A member's requested restriction on the sharing of specified protected health information for health care operations, payment, and treatment will be honored as required by HIPAA.
3. By making an election with your written or electronic signature you are authorizing the University to take deductions from your earnings (employees)/monthly Retirement Plan income (retirees)/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 in which you are enrolled.
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 the University of a family member's loss of eligibility, or failing to provide verification documentation when requested may lead to de-enrollment of the affected family members. Employees/retirees may also be subject to disciplinary action and de-enrollment from health benefits and may be responsible for any 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 necessary protected health information required to assist you with your problem. If more protected health information is needed to solve your problem, in compliance with state laws and federal privacy laws (including HIPAA), you may be required to sign an authorization allowing UC to

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

11. By enrolling in the Critical Illness, Hospital Indemnity or Accident plans you agree to and are consenting to the following:
    • If you have other coverage with Aflac and you intend for the group coverage with UC to replace any similar existing Aflac individual policy, please be aware that it may be in your best interest to maintain your individual guaranteed-renewable policy via direct bill.
    • You have considered all of your existing health insurance coverage with Aflac and believe this additional coverage is appropriate for your insurance needs. You further understand that you can contact Aflac at 1-800-992-3522 regarding your individual policy and for assistance in evaluating the suitability of your insurance coverage.
    • Any false statement or misrepresentation in the application that was made with actual intent to deceive Continental American Life Insurance Company may result in loss of coverage under the certificate. Any false statement or misrepresentation that was made in the Employee Application/Statement of Insurability shall not bar the right to recovery under the Certificate unless such statement was made with intent to deceive Continental American Life Insurance Company or unless it materially affected either the acceptance of the risk or the hazard assumed by the Company (Note: coverage sponsored by UC is guaranteed issue and no application or statement of insurability is required to enroll).
    • California law prohibits an HIV test from being required or used by Continental American Life Insurance Company as a condition for obtaining health insurance coverage (Note: coverage sponsored by UC is guaranteed issue and no medical information is required to enroll).

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/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/Medi-Cal 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 1-877-267-2323 ext. 61565
or www.cms.gov.

IF YOU DO NOT ENROLL YOURSELF AND/OR YOUR FAMILY MEMBER(S) IN MEDICAL COVERAGE WITHIN THE 31 DAYS WHEN FIRST ELIGIBLE, WITHIN THE 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 at 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 details.

* 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, University of California Human Resources located in Oakland administers all benefit plans in accordance with applicable plan documents and regulations, custodial agreements, University of California Group Insurance Regulations (GIRs), 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 at 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 at 1-800-888-8267.

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

University of California Healthcare Plan Notice of Privacy Practices - Self-Funded Plans - January 1, 2022

ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The University offers various healthcare options to its employees and retirees and their eligible family members through the UC Healthcare Plan. Several options are self-funded group health plans for which the University acts as its own insurer and directly pays the claims. This notice describes the privacy practices that the University has established for these options which are referred to as the "Self-Funded Plans." They are managed for the University by business associates, which are third party administrators that interact with the healthcare providers and handle members' claims.

The other healthcare options offered under the UC Healthcare Plan are fully insured group health plans for which the insurance company or health maintenance organization (HMO) assumes the financial risk of paying for the plan benefits. The notices of privacy practices for those plans are available directly from the insurance carrier or HMO.

For a current list of options, please go to: http://ucnet.universityofcalifornia.edu/compensation-and-benefits/.

UC's Commitment

The University is committed to protecting the privacy of your protected health information or PHI. PHI refers to health information that a Self-Funded Plan creates or receives that relates to your physical or mental health, your healthcare, or payment for your healthcare. In most cases, your PHI is maintained by the business associate that serves as the third party administrator for the Self-Funded Plan in which you participate, but the University may also hold health-related information. Generally, the University-held information is limited to enrollment data, but in limited instances, it may include information you provide to designated UC staff to help with coordination of benefits, or resolving complaints.

The privacy protections described in this notice reflect the requirements of federal regulations issued under the Health Insurance Portability and Accountability Act (HIPAA). They require the Self-Funded Plans to:

- comply with HIPAA privacy standards and other federal laws;
- make sure that your PHI is protected;
- give you this notice of the Self-Funded Plans' legal duties and privacy practices with respect to your PHI; and
- follow the terms of the notice that is currently in effect.

How the Self-Funded Plans Will Use and Disclose Protected Health Information About You

The following sections describe different ways that a Self-Funded Plan might use and disclose your PHI. Not every use or disclosure will be listed. All of

the ways that a Self-Funded Plan is permitted to use and disclose PHI, however, will fall within one of the listed categories. Use and disclosure of some PHI, such as certain drug and alcohol information, HIV information, and mental health information, is further restricted.

Treatment. A Self-Funded Plan may use and disclose your PHI to doctors, nurses, technicians, and other personnel who are involved in providing you with medical treatment or services. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. The doctor may then tell the dietitian if you have diabetes so the dietitian can meet any special menu needs. Different departments may share your PHI so they can coordinate services you need, such as lab work, x-rays, and prescriptions.

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, utilization review, medical necessity determinations, and pre-certifications.

Healthcare Operations for a Self-Funded Plan. Self-Funded Plans may use and disclose your PHI to carry out business operations and to assure that all enrollees receive quality care. For example, a Self-Funded Plan may disclose your PHI to a business associate who handles claims processing or administration, data analysis, utilization review, quality assurance, benefit management, practice management or referrals to specialists, or provides legal, actuarial, accounting, consulting, data aggregation, management, or financial services.

Healthcare Operations for the UC Healthcare Plan. The University may also engage a business associate to carry out healthcare operations on behalf of the entire UC Healthcare Plan in its role as an organized healthcare arrangement of a single plan sponsor under HIPAA. The group health plans participating in the University's organized healthcare arrangement as of the date of this notice include UC Care, UC Health Savings Plan, Optum Behavioral Health, UC Blue & Gold HMO, Kaiser Permanente, Core, UC High Option Supplement to Medicare, UC Medicare PPO Plan with Prescription Drug, UC Medicare PPO Plan without Prescription Drug, UC Medicare Choice Kaiser Permanente Senior Advantage, UC Medicare Coordinator Program Health Reimbursement Account, Post-Deductible Health Reimbursement Account,

Stand Alone Health Reimbursement Account, Delta Dental, Delta Care USA Plan, and Vision Service Plan.
You can find a current list of options at http://ucnet.universityofcalifornia.edu/compensation-and-benefits/.

Plan Sponsor. A Self-Funded Plan may disclose summary health information (that is claims data that is stripped of most individual identifiers) to the University in its role as plan sponsor in order to obtain bids for health insurance coverage or to facilitate, modifying, amending, or terminating a plan. A Self-Funded Plan may also provide the University enrollment or disenrollment information. In addition, if you request help from the University in coordinating your benefits or resolving a complaint, a Self-Funded Plan may disclose your PHI to designated University staff, but no PHI may be disclosed to facilitate employment-related actions or decisions or for matters involving other benefits or benefit plan. The University may not further disclose any PHI that is disclosed to it in these limited instances.

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.

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.

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

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: HIPAA 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, 300 Lakeside Drive, 6th Floor, Oakland, CA 94612, Attention: HIPAA Privacy Officer. In addition, you must provide a reason that supports your request. A Self-Funded 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. For example, if your PHI has been disclosed to the UC staff so that it may help to coordinate benefits or resolve a complaint, you may direct the plan to share the correction with the designated staff members.

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, 300 Lakeside Drive, 6th Floor, Oakland, CA 94612, Attention: HIPAA 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, 300 Lakeside Drive, 6th Floor, Oakland, CA 94612, Attention: HIPAA 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 medical 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, 300 Lakeside Drive, 6th Floor, Oakland, CA 94612, Attention: HIPAA 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 University 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, 300 Lakeside Drive, 6th Floor, Oakland, CA 94612.

Breach. You have the right to be notified of the discovery of a breach of unsecured PHI.

Changes to this Notice

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 notice will contain 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:
- 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.
- UC Healthcare Plan Privacy Office, 1111 Franklin Street, Oakland, CA 94607, Attention: HIPAA Privacy Officer. Email will not be accepted; all complaints must be submitted in writing.

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.