Service Request # 80919

Purpose

The purpose of this document is to request that data elements associated with DepCare and HCRA information be captured for display in the History data base.

Background

SHPS frequently requests historical information regarding DepCare/HCRA enrollments or deductions. Campuses must manually reconstruct this information because it is not contained in the History data base. Therefore, campuses have requested that PPS be modified to include historical data regarding these plans in the History data base.

Requested Changes

Currently, the DepCare/HCRA annual amount, monthly amount, effective date, and termination date are not captured for history processing. It is requested that the history process be modified to capture the DepCare/HCRA data for history processing and displayed on a history screen.

The DepCare/HCRA data elements are displayed below:

<table>
<thead>
<tr>
<th>Data Element Name</th>
<th>Data Element Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>DepCare Annual</td>
<td>6335U</td>
</tr>
<tr>
<td>DepCare Monthly</td>
<td>6335G</td>
</tr>
<tr>
<td>Effective Date</td>
<td>7335E</td>
</tr>
<tr>
<td>Termination Date</td>
<td>0315</td>
</tr>
<tr>
<td>HCRA Annual</td>
<td>6338U</td>
</tr>
<tr>
<td>HCRA Monthly</td>
<td>6338G</td>
</tr>
<tr>
<td>Effective Date</td>
<td>7338E</td>
</tr>
<tr>
<td>Termination Date</td>
<td>0314</td>
</tr>
</tbody>
</table>

Screens

Screen samples will be provided when it is determined which HDB tables will carry the DepCare/HCRA information.

Summary of UC Benefits Enrollment (IDOC)

The IDOC for Benefits Enrollment should be modified to include the coverage effective date and the coverage end dates for both DepCare/HRCA. Please note that the annual amount and monthly contribution are already displayed. Attached is a copy of the IDOC displaying the suggested placement and format of these data elements.
You are enrolled in the following health and welfare plans:

* Kaiser North
  Family Coverage
  Coverage Effective date: 01/01/90
  Your monthly cost for this coverage is: $ 74.92
  Your contribution base is: 117

* Delta Dental
  W/Adult Coverage
  Coverage Effective date: 01/01/90
  Your monthly cost for this coverage is: $ 0.00

* Vision Services Plan
  W/Adult Coverage
  Coverage Effective date: 01/01/90
  Your monthly cost for this coverage is: $ 0.00

* ARAG Legal Plan
  Family Coverage
  Coverage Effective date: 01/01/04
  Your monthly cost for this coverage is: $ 12.73

The following family members are enrolled:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Enrolled/Effective Date/End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S1 POWERS</td>
<td>Spouse</td>
<td>Yes/Yes/Yes</td>
</tr>
<tr>
<td>S1</td>
<td>01</td>
<td>01/02/42 Female 543-76-8091</td>
</tr>
<tr>
<td></td>
<td></td>
<td>01/01/93 01/01/93 01/01/93 01/01/94</td>
</tr>
<tr>
<td>C1 POWERS</td>
<td>Child</td>
<td>Yes/No/No</td>
</tr>
<tr>
<td>C1</td>
<td>02</td>
<td>10/09/82 Female 489-03-9281</td>
</tr>
<tr>
<td></td>
<td></td>
<td>02/01/00</td>
</tr>
<tr>
<td>C2 POWERS</td>
<td>Child-Disabled</td>
<td>Yes/No/No</td>
</tr>
<tr>
<td>C2</td>
<td>03</td>
<td>12/28/51 Male 489-02-8048</td>
</tr>
<tr>
<td></td>
<td></td>
<td>02/01/00</td>
</tr>
</tbody>
</table>

(It is your responsibility to ensure that all family members meet UC eligibility requirements. Contact your campus Benefit Representative for more information.)

Additionally, you are enrolled in the following:

* Accidental Death & Dismemberment Insurance
  Your coverage type is: Modified Family Plan
  Amount of Coverage: $ 200,000.00

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Coverage Effective Date: 01/01/90
Your monthly cost for this coverage is: $ 4.40

* Short Term Disability Insurance

* Supplemental Disability Insurance
  Waiting period: 7 days
  Salary Base: $ 9750.00
  Coverage Effective Date: 02/01/04
  Your monthly cost for this coverage is: $ 114.08

* Basic Life Insurance in the amount of $ 50,000.00

* Supplemental Life Insurance
  Plan Type: 3 times your most recent January 1 Annual Salary Base
  Annual Salary Base: $ 117,000.00
  Coverage Effective Date: 01/09/00
  Your monthly cost for this coverage is: $ 438.75

* Dependent Care Assistance Program
  You have signed up for a $ 4800.00 annual payment
  Your monthly pre-tax contribution is: $ 400.00
  Coverage Effective Date: xx/xx/xx Coverage End Date: xx/xx/xx

* Health Care Reimbursement Account
  You have signed up for a $ 4800 annual amount
  Your monthly pre-tax contribution is: $ 400.00
  Coverage Effective Date: xx/xx/xx Coverage End Date: xx/xx/xx

You are participating in the Executive Life Insurance Plan for 2 times your most recent January 1 annual salary.

You are participating in the Tax Savings on Insurance Premium (TIP) Plan. Any premiums you pay as an employee for health will be on a pre-tax basis.