SPRING 2000
GRADUATE BALLOT

FEE MEASURES

Compulsory campus-based fees may be established, eliminated, or modified in an election in which a **two-thirds (66.6%) majority of a minimum voting pool of twenty percent (20%)** of the student body officially registered at the time of the election vote to approve or to modify the fee.

Abstentions will not count toward the establishment of minimum voting pool requirements. The establishment of the minimum voting pool will be determined on an individual basis for each measure on the ballot (i.e. the sum of "yes" and "no" votes on each individual measure must equal or exceed the minimum voting pool required).

Measure I: Graduate Student Health Insurance Plan (GSHIP) Increase
Shall the UCSC Graduate Student Health Insurance Plan (GSHIP) be expanded to include dental and vision insurance at an additional cost not to exceed $100 per student per quarter in the initial year, commencing fall 2000?
Yes
No

Click here for more information about Measure I
Click here for sample Dental Insurance Plan
Click here for sample Vision Insurance Plan

2nd Level Pages - Information Material

Measure I: Graduate Student Health Insure Plan (GSHIP) Increase

- New graduate compulsory fee: not to exceed $100/qtr. in the initial year
- Fee begins: fall quarter 2000, permanent fee (no ending date) and would be used for the sole purpose of providing dental and/or vision insurance for all graduate students.
- This question was approved for placement on the graduate ballot by the Dean of Graduate Studies with the endorsement of the GSA Council.
- If approved, this fee would generate approximately $31,605 in 1999-2000.

Measure I Ballot Statement
This measure would authorize the campus GSHIP Committee in cooperation with the UCSC Office of Community Development and Health and the Somerton Student Insurance agency to solicit bids for dental and vision insurance with coverage comparable to that outlined below and select the most advantageous policy or policies available within the cost limitation ($100 per student per quarter) specified in the text of the measure. If approved, this measure would impose an increase in the GSHIP Fee effective fall 2000, with the additional Fee revenue used for the sole purpose of providing dental and vision insurance for all graduate students. Normal annual increases in premium expense would be reflected in the GSHIP Fee and would not require additional student approval.

The new dental and vision coverage would take effect in fall quarter 2000. Any graduate student employed as a Graduate Student Researcher (GSR) at 25 percent or greater for the quarter would have the GSHIP Fee paid by the same fund source that pays the GSR's salary. Any student receiving a full Regents' Fellowship or other campus fellowship, or a major external award (e.g., NSF, GAANN, Mellon), would have the GSHIP Fee paid by the fellowship in addition to the normal fellowship stipend. Payment of the GSHIP Fee for Teaching Assistants, Teaching Fellows, and Associates-In would be subject to negotiation between the University and the Association of Student Employees (ASE/UAW).

Click here for sample Dental Insurance Plan
Click here for sample Vision Insurance Plan

SAMPLE Student Dental Insurance Plan

Following is an example of the coverage currently available in the student insurance market. Although any actual policy obtained by the campus may differ somewhat in the benefits provided and in the premium cost, depending on the coverage recommended by the GSHIP Committee after bids have been obtained, the benefits described below generally represent the *minimum* level of coverage that would be accepted.

DENTAL

Calendar Year Maximum: $1,500.00 Per Person
Calendar Year Deductible: $25.00 Per Person

- Student Dental is a dental assistance plan. Under this Plan, benefits for covered dental services are reimbursed on a "Usual and Customary" basis and pre-existing dental conditions are covered.
- You may obtain dental care from any dentist of your choice.
- Once you have satisfied the Continuous Coverage Limitation, no further Waiting Periods are required as long as you remain continuously insured under the Plan.
- Both you and your eligible dependents (spouse and unmarried children to age 19 – full-time student to age 25) can be insured under the Plan.
- Coverage remains in force, provided continuous Coverage Limitation has been met, even when you are no longer a student.

DENTAL PLAN RATES

	Semi-Annual
Student	$ 95.00
Student and One Dependent	$ 185.00
Student and Two or More Dependents	$ 261.50

DENTAL BENEFITS

PREVENTATIVE SERVICES BENEFITS - PLAN PAYS 80% USUAL AND CUSTOMARY

- Initial Oral Exam
- Periodic Oral Exam
- Emergency Oral Exam
- Panorex Film
- Full Mouth X-Ray
- Single Film
- Additional Films
- Bitewing-Single Film
- Bitewing-Two Films
- Bitewing-Four Films
- Prophy-Adult (a)
- Prophy-Child
- Prophy with Flouride-Child

BASIC SERVICES - PLAN PAYS 50% USUAL AND CUSTOMARY

SIMPLE RESTORATIVE/FILLINGS *

- One Surface Amalgam-Primary
- Two Surface Amalgam-Primary
- Three Surface Amalgam-Primary
- Four Surface Amalgam-Primary
- One Surface Amalgam-Permanent
- Two Surface Amalgam-Permanent
- Three Surface Amalgam-Permanent
- Four Surface Amalgam-Permanent

ORAL SURGERY *

- Simple Extraction
- Additional Extraction
- Surgical Extraction
- Impacted (soft tissue)
- Impacted (partial bony)

(a) Maximum 1 procedure per 6 months
(b) Maximum 1 procedure per 36 months

* These benefits are payable after 6 months of continuous coverage

GENERAL INFORMATION

ELIGIBILITY
All eligible students are guaranteed acceptance. An eligible student is one who (a) is enrolled at least 6 quarter/semester hours for credit in a junior college, college or university; or (b) enrolled in a graduate school program sponsored by the college or university.

DEDUCTIBLE AMOUNT
The Deductible amount is shown in the Coverage Schedule. The Deductible is an amount of covered dental charged incurred by an insured person for which no benefits will be paid. The Deductible amount will apply to each insured person.

CALENDAR YEAR MAXIMUM
The maximum amount payable for all Eligible Dental Expenses in any calendar year is shown in the Coverage Schedule. The Calendar Year Maximum will apply to each insured person.

USUAL AND CUSTOMARY
This means a charge that does not exceed the general level of charges being made by other providers of dental services in the state where the charge is incurred.

CONTINUOUS COVERAGE LIMITATION
This is the period of time the insured person must be continuously covered under the Policy before the insured is entitled to be reimbursed for covered dental charges.

ELIGIBLE EXPENSES
Expenses must be incurred while the Policy is in force and the person is covered by the Policy. To be an Eligible Expense, the dental service must be performed by: (1) a licensed Dentist acting within the scope of his license; (2) a licensed Physician performing dental services within the scope of his license; or (3) a licensed dental hygienist acting under the supervision and direction of a Dentist.

NOTE: Your coverage will become effective the first of the month following receipt and acceptance of your fully completed enrollment card and valid premium payment.

EXPENSES NOT COVERED
No benefit will be paid for expenses incurred:

1. Any portion of a charge for a service in excess of the Schedule of Benefits.
2. For procedures that are not included in the Schedule of Benefits.
3. For overdentures and associated procedures.
4. For cosmetic procedures.
5. For the replacement of bridges, full and partial denture, crowns, inlays or onlays that can be repaired and restored to natural function.
6. Implants; and for (a) the replacement of lost or stolen appliances; (b) the replacement of orthodontic retainers; (c) athletic mouthguards; (d) precision or semi-precision attachments; (e) prescription or take-home fluoride; or for (f) diagnostic photographs.
7. Oral hygiene instructions; and or (a) plaque control; (b) the completion of a claim form; (c) acid etch; (d) broken appointments; (e) prescription or take-home fluoride; or for (f) diagnostic photographs.
8. Services not completed by the end of the month in which insurance terminates.
9. Procedures that are begun but not completed.
10. Those services for which there would be no charge in the absence of insurance.
11. In connection with war or any act of war, whether declared or undeclared, or condition contracted or accident occurring while on full-time active duty in the armed forces of any country or combination of countries.

12. For care or treatment of a condition for which you are entitled to or eligible for benefits under any Workers' Compensation Act or similar law.

NOTICE: This brochure provides a very brief description of some important features of your Plan. It is not the insurance Contract, nor does it represent the insurance Contract. A full explanation of benefits, exceptions and limitations is contained in the Certificate of Insurance.

Click here to return to ballot.
Click here for sample Vision Insurance Plan

SAMPLE Student Vision Insurance Plan

Following is an example of the coverage currently available in the student insurance market. Although any actual policy obtained by the campus may differ somewhat in the benefits provided and in the premium cost, depending on the coverage recommended by the GSHIP Committee after bids have been obtained, the benefits described below generally represent the *minimum* level of coverage that would be accepted.

VISION PLAN RATES

	Semi-Annual
Student	$ 62.00
Student and One Dependent	$ 114.00
Student and Two or More Dependents	$ 166.00

The Plan provides full coverage, in excess of a $10 deductible for the examination and a $25 deductible for materials, when you go to a participating provider of The Eye Care Network for:

- One comprehensive examination in any 12 consecutive months
- One pair of standard lenses in any 24 consecutive months, or at a 12-month interval if the prescription change so indicates. **(Standard lenses fit any frame with an eyesize less then 56mm).
- One standard frame in any 24 consecutive months, or at a 12-month interval if the prescription change so indicates. **(This benefit is in lieu of lenses and frame).

If contact lenses are for cosmetic or convenience purposes, the plan will pay up to $100 toward their cost. Any balance is your responsibility.

If contact lenses are medically necessary, they are a fully covered benefit: following cataract surgery; or when visual acuity cannot be corrected to 20/70 in the better eye except through the use of contacts; or when necessitated by anisometropia or certain conditions of keratoconus. Prior authorization from Medical Eye Services is required.
** A prescription change means any of the following:

- A change in prescription of 0.50 diopter or more in one or both eyes
- A shift in axle of astigmatism of 15 degrees; or
- A difference in vertical prism greater than 1 prism diopter.

VISION PLAN BENEFITS PROVIDED BY NON-PARTICIPATING PROVIDERS

If covered services ad/or materials are provided by a non-participating provider, charges will be paid, in excess of a $10 deductible for the examination and a $25 deductible for the materials, but not to exceed the following Schedule of Allowances:

BENEFITS	ALLOWANCES
Comprehensive Examination	$ 40
Lenses (per pair)	
Single Vision	$ 30
Bifocal	$ 50
Trifocal	$ 65
Lenticular or Aphakic	$125
Contact Lenses (per pair)	
Medical Necessary	$250
Cosmetic Lenses (per pair)	$100
Frame	$ 40

HOW TO USE THIS PLAN

After you obtain your claim form, make an appointment with the eye care specialist of your choice. With Part 1 of the claim form completed, present it to the provider at the time of your visit.

Participating providers will submit the claim form to Medical Eye Services and are paid directly. If you do not bring y our claim form with you at the time of your visit, you may be required to pay in full for the services.

If services are received from a non-participating provider, reimbursement will be made to the Insured up to the Schedule of Allowances. You, or the provider, should submit an itemized billing and a copy of your prescription with the claim form to Medical Eye Services.

LIMITATIONS

Lenses or frames which were furnished under the Plan and which have been lost, stolen or broken will not be replaced, except when benefits are otherwise available.

Eyewear when there is no prescription change, except when benefits are otherwise available.

No-line (blended type) bifocal lenses, coated lenses or over-sized lenses will be limited to the Schedule of Allowances.

Contact Lenses will be limited to the Schedule of Allowances.

EXCLUSIONS

- Conditions covered by Workers' Compensation
- Services which begin prior to the Insured's effective date or after benefits have terminated
- Services and supplies in connection with special procedures such as orthoptics or vision training and subnormal vision aids
- Non-prescription (plano) eyewear

- Medical or surgical treatments of the eyes
- Charges for which the insures is not required to pay
- Eye examinations required by an employer as a condition of employment
- Any service or material provided by another vision plan

This is a brief outline of the Plan and is not to be accepted or construed as a substitute for the provisions of the contract.

Click here to return to ballot.
Click here for sample Dental Insurance Plan

Measure I -- Graduate Student Health Insurance Plan (GSHIP) Increase for Vision Plan **PASSED**

Votes	337	56	393
Percent	85.75%	14.25%	42.44%

Measure J -- Graduate Student Health Insurance Plan (GSHIP) Increase for Dental Plan **PASSED**

Votes	335	61	396
Percent	84.60%	15.40%	42.76%