Your Group Plan

University of California

Core Major Medical and
Medicare Enrollee Plans

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The Plans described in the following pages of this Booklet are benefit plans of the Employer. These benefits are not insured with Aetna Life Insurance Company ("Aetna") but will be paid from the Employer's funds. Aetna will provide certain administrative services under the Plans as outlined in the Administrative Services Agreement between Aetna and the Customer.

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Health Expense Coverage

Health Expense Coverage is expense-incurred coverage only and not coverage for the disease or injury itself. This means that this Plan* will pay benefits only for expenses incurred while this coverage is in force. Except as described in any extended benefits provision, no benefits are payable for health expenses incurred before coverage has commenced or after coverage has terminated; even if the expenses were incurred as a result of an accident, injury, or disease which occurred, commenced, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

When a single charge is made for a series of services, each service will bear a pro rata share of the expense. The pro rata share will be determined by Aetna. Only that pro rata share of the expense will be considered to have been an expense incurred on the date of such service.

Aetna assumes no responsibility for the outcome of any covered services or supplies. Aetna makes no express or implied warranties concerning the outcome of any covered services or supplies.

* The term "this Plan" as used in this Booklet, means the Core Major Medical Plan or the Core Medicare Enrollee Plan, as applicable.

Comprehensive Medical Expense Coverage

Comprehensive Medical Expense Coverage is merely a name for the benefits in this section. It does not provide benefits covering expenses incurred for all medical care. There are exclusions, deductibles, copayment features and stated maximum benefit amounts. These are all described in this Booklet.

The Summary of Coverage outlines the Payment Percentages that apply to the Covered Medical Expenses described below.

Covered Medical Expenses

They are the expenses for certain **hospital** and other medical services and supplies. They must be for the treatment of an injury or disease.

Here is a list of Covered Medical Expenses.

Hospital Expenses

Inpatient Hospital Expenses

Charges made by a **hospital** for giving **board and room** and other **hospital** services and supplies to a person who is confined as a full-time inpatient.

Not included is any **charge** for daily **board and room** in a private room over the Private Room Limit.

Outpatient Hospital Expenses
Charges made by a **hospital** for **hospital** services and supplies which are given to a person who is not confined as a full-time inpatient.

If a hospital or other health care facility does not separately identify the specific amounts of its room and board charges and its other charges, Aetna will use the following allocations of these charges for the purposes of the group contract:

Room and board charges:	forty (40)%
Other charges:	sixty (60)%

This allocation may be changed at any time if Aetna finds that such action is warranted by reason of a change in factors used in the allocation.

Convalescent Facility Expenses

Charges made by a **convalescent facility** for the following services and supplies. They must be furnished to a person while confined to convalesce from a disease or injury.

- Board and room. This includes charges for services, such as general nursing care, made in connection with room occupancy. Not included is any **charge** for daily **board and room** in a private room over the Private Room Limit.
- Use of special treatment rooms.
- X-ray and lab work.
- Physical, occupational or speech therapy.
- Oxygen and other gas therapy.
- Other medical services usually given by a **convalescent facility**. This does not include private or special nursing, or **physicians** services.
- Medical supplies.

Benefits will be paid for no longer than the Convalescent Facility Maximum Days during any one (1) calendar year.

Limitations To Convalescent Facility Expenses
This section does not cover charges made for treatment of:

- Drug addiction.
- Chronic brain syndrome.
- Alcoholism.
- Senility.
- Mental retardation.
- Any other mental disorder.

Home Health Care Expenses

Home health care expenses are covered if:

- the charge is made by a **home health care agency**; and
- the care is given under a **home health care plan**; and
- the care is given to a person in his or her home.

Home health care expenses are charges for:

- Part-time or intermittent care by an **R.N.** or by an **L.P.N.** if an **R.N.** is not available.
- Part-time or intermittent home health aide services for patient care.
- Physical, occupational, respiratory and speech therapy.
- Nutrition counseling supervised by a registered dietician.

- The following to the extent they would have been covered under this Plan if the person had been confined in a **hospital** or **convalescent facility**:

  medical supplies;

  drugs and medicines prescribed by a **physician**; and

  lab services provided by or for a **home health care agency**.

There is a maximum to the number of visits covered in a calendar year. Each visit by a nurse or therapist is one (1) visit. Each visit of up to four (4) hours by a home health aide is one (1) visit.

Limitations To Home Health Care Expenses
This section does not cover charges made for:

- Services or supplies that are not a part of the **home health care plan**.
- Services of a person who usually lives with you or who is a member of your or your wife's or husband's family.
- Services of a social worker.
- Transportation.

Hospice Care Expenses

Charges made for the following furnished to a person for **Hospice Care** when given as a part of a **Hospice Care Program** are included as Covered Medical Expenses.

Facility Expenses
The charges made in its own behalf by a:

- **hospice facility**;
- **hospital**;
- **convalescent facility**;

which are for:

- Board and room and other services and supplies furnished to a person while a full-time inpatient for:

  pain control; and

  other acute and chronic symptom management.

  Not included is any **charge** for daily **board and room** in a private room over the Private Room Limit. Also not included is the charge for any day of confinement in excess of the Maximum Number of Inpatient Days for all confinements for **Hospice Care**.
- Services and supplies furnished to a person while not confined as a full-time inpatient.

Other Expenses
Charges made by a **Hospice Care Agency** for:

- Part-time or intermittent nursing care by a **R.N.** or **L.P.N.** for up to eight (8) hours in any one (1) day.

- Medical social services under the direction of a **physician**. These include:

  assessment of the person's:

    social, emotional, and medical needs; and

    the home and family situation;

  identification of the community resources which are available to the person; and

  assisting the person to obtain those resources needed to meet the person's assessed needs.
- Psychological and dietary counseling.
- Bereavement counseling.
- Consultation or case management services by a **physician**.
- Physical and occupational therapy.
- Part-time or intermittent home health aide services for up to 8 hours in any one day. These consist mainly of caring for the person.
- Medical supplies.
- Drugs and medicines prescribed by a **physician**.

Charges made by the providers below, but only if: the provider is not an employee of a **Hospice Care Agency**; and such Agency retains responsibility for the care of the person.

- A **physician** for consultant or case management services.
- A physical or occupational therapist.

- A **Home Health Care Agency** for:

  physical and occupational therapy;

  part-time or intermittent home health aide services for up to eight (8) hours in any one (1) day; these consist mainly of caring for the person;

  medical supplies;

  drugs and medicines prescribed by a **physician**; and

  psychological and dietary counseling.

Not more than the Hospice Outpatient Maximum will be paid for all Hospice Care Expenses incurred while the person is not confined as a full-time inpatient.

Not included are charges made:

- For funeral arrangements.
- For pastoral counseling.
- For financial or legal counseling. This includes estate planning and the drafting of a will.
- For homemaker or caretaker services. These are services which are not solely related to care of the person. These include: sitter or companion services for either the person who is ill or other members of the family; transportation; housecleaning; and maintenance of the house.
- For respite care. This is care furnished during a period of time when the person's family or usual caretaker cannot, or will not, attend to the person's needs.

Routine Physical Exams

The charges made by a **physician** for a routine physical exam given to you, your spouse, or your dependent child may be included as Covered Medical Expenses. If charges made by a **physician** in connection with a routine physical exam given to a dependent child are Covered Medical Expenses under any other benefit section, no charges in connection with that physical exam will be considered Covered Medical Expenses under this section. A routine physical exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified injury or disease. Included as a part of the exam are:

- X-rays, lab, and other tests given in connection with the exam; and
- materials for the administration of immunizations for infectious disease and testing for tuberculosis.

For your dependent child:

- The physical exam must include at least:

  a review and written record of the patient's complete medical history;

  a check of all body systems; and

  a review and discussion of the exam results with the patient or with the parent or guardian.
- For all well baby exams given to your dependent child under age two (2), Covered Medical Expenses will not include charges for:

  more than six (6) exams performed during the first year of the child's life;

  more than two (2) exams performed during the second year of the child's life.
- For all exams given to your dependent child age two (2) up to age nineteen (19), Covered Medical Expenses will not include charges for more than one (1) exam in twelve (12) months in a row.
- For all exams given to your dependent child age nineteen (19) and over, Covered Medical Expenses will not include charges for more than one (1) exam in twenty-four (24) months in a row.

For all exams given to you and your spouse, Covered Medical Expenses will not include charges for more than:

- one (1) exam in twenty-four (24) months in a row, if the person is under age sixty-five (65); and
- one (1) exam in twelve (12) months in a row, if the person is age sixty-five (65) or over.

Also included as Covered Medical Expenses are charges made by a **physician** for one (1) annual routine gynecological exam.

Not covered are charges for:

- Services which are covered to any extent under any other group plan of your Employer.
- Services which are for diagnosis or treatment of a suspected or identified injury or disease.
- Exams given while the person is confined in a **hospital** or other facility for medical care.
- Services which are not given by a **physician** or under his or her direct supervision.
- Medicines, drugs, appliances, equipment, or supplies.
- Psychiatric, psychological, personality or emotional testing or exams.

- Exams in any way related to employment.
- Premarital exams.
- Vision, hearing, or dental exams.

Short-Term Rehabilitation Expenses

The charges made by:

- a **physician**; or
- a licensed or certified physical, occupational or speech therapist;

for the following services for treatment of acute conditions are Covered Medical Expenses.

Short-term rehabilitation is therapy which is expected to result in the improvement of a body function (including the restoration of the level of an existing speech function), which has been lost or impaired due to:

- an injury;
- a disease; or
- congenital defect.

Short-term rehabilitation services consist of:

- physical therapy;
- occupational therapy; or
- speech therapy,

furnished to a person who is not confined as an inpatient in a **hospital** or other facility for medical care. This therapy shall be expected to result in significant improvement of the person's condition within 60 days from the date the therapy begins.

Not covered are charges for:

- Services which are covered to any extent under any other part of this Plan.
- Any services which are covered expenses in whole or in part under any other group plan sponsored by an Employer.
- Services received while the person is confined in a **hospital** or other facility for medical care.
- Services not performed by a **physician** or under his or her direct supervision.
- Services rendered by a physical, occupational, or speech therapist who resides in the person's home or who is a part of the family of either the person or the person's spouse.
- Services rendered for the treatment of delays in speech development, unless resulting from:

  disease;

  injury; or

  congenital defect.
- Special education, including lessons in sign language, to instruct a person whose ability to speak has been lost or impaired to function without that ability.

Also, not covered are any services unless they are provided in accordance with a specific treatment plan which:

- details the treatment to be rendered and the frequency and duration of the treatment.
- provides for ongoing reviews and is renewed only if therapy is still necessary.

Spinal Disorder Treatment (including Chiropractic Services)

Covered Medical Expenses include those incurred for:

- manipulative (adjustive) treatment; or
- other physical treatment;

of any condition caused by or related to biomechanical or nerve conduction disorders of the spine.

Not covered are charges for expenses incurred:

- while the person is a full-time inpatient in a **hospital**;
- for treatment of scoliosis;
- for fracture care; or
- for surgery. This includes pre and post surgical care given or ordered by the operating **physician**.

Other Medical Expenses

- Charges made by a **physician**.
- Charges made by a **R.N.** or **L.P.N.** or a nursing agency for skilled nursing care.

As used here, "skilled nursing care" means these services:

Visiting nursing care by a **R.N.** or **L.P.N.** Visiting nursing care means a visit of not more than four (4) hours for the purpose of performing specific skilled nursing tasks.

Private duty nursing by a **R.N.** or **L.P.N.** if the person's condition requires skilled nursing services and visiting nursing care is not adequate.

Benefits will not be paid during a calendar year for private duty nursing for any charges in excess of the Private Duty Nursing Care Maximum.

Not included as "skilled nursing care" is:

that part or all of any nursing care that does not require the education, training, and technical skills of a **R.N.** or **L.P.N.**; such as transportation, meal preparation, charting of vital signs, and companionship activities; or

any private duty nursing care given while the person is an inpatient in a **hospital** or other health care facility; or

care provided to help a person in the activities of daily life; such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting; or

care provided solely for skilled observation except as follows:

for no more than one four (4) hour period per day for a period of no more than ten (10) consecutive days following the occurrence of:

change in patient medication;

need for treatment of an **emergency condition** by a **physician** or the onset of symptoms indicating the likely need for such treatment;

surgery; or

release from inpatient confinement; or

any service provided solely to administer oral medicines; except where applicable law requires that such medicines be administered by a **R.N.** or **L.P.N.**

- Charges for the following:

  Drugs and medicines which by law need a **physician 's** prescription, including oral contraceptives, Norplant and diaphragms. Oral contraceptives are covered whether or not medically necessary.

  Diagnostic lab work and X-rays.

  X-ray, radium, and radioactive isotope therapy.

  Anesthetics and oxygen.

  Rental of **durable medical and surgical equipment**. In lieu of rental, the following may be covered:

  The initial purchase of such equipment if Aetna is shown that: long term care is planned; and that such equipment: either cannot be rented; or is likely to cost less to purchase than to rent.

  Repair of purchased equipment.

  Replacement of purchased equipment if Aetna is shown that it is needed due to a change in the person's physical condition; or it is likely to cost less to purchase a replacement than to repair existing equipment or to rent like equipment.

  Professional ambulance service to transport a person from the place where he or she is injured or stricken by disease to the first **hospital** where treatment is given.

  Artificial limbs and eyes. Not included are such things as:

  eyeglasses;

  vision aids;

  hearing aids;

  communication aids; and

  orthopedic shoes, foot orthotics, or other devices to support the feet.*

  * In some cases, foot orthotics may be covered for the necessary treatment of a medical diagnosis or condition as determined by Aetna.

National Medical Excellence Program ® (NME) (Applies to Core Major Medical Plan only)

The NME program coordinates all solid organ and bone marrow transplants and other specialized care that can not be provided within an **NME Patient's** local geographic area. When care is directed to a facility ("Medical Facility") more than one-hundred (100) miles from the person's home, this Plan will pay a benefit for Travel and Lodging Expenses, but only to the extent described below.

Travel Expenses
These are expenses incurred by an **NME Patient** for transportation between his or her home and the Medical Facility to receive services in connection with a procedure or treatment.

Also included are expenses incurred by a **Companion** for transportation when traveling to and from an **NME Patient's** home and the Medical Facility to receive such services.

Lodging Expenses
These are expenses incurred by an **NME Patient** for lodging away from home while traveling between his or her home and the Medical Facility to receive services in connection with a procedure or treatment.

The benefit payable for these expenses will not exceed the Lodging Expenses Maximum per person per night.

Also included are expenses incurred by a **Companion** for lodging away from home:

- while traveling with an **NME Patient** between the **NME Patient's** home and the Medical Facility to receive services in connection with any listed procedure or treatment; or
- when the **Companion's** presence is required to enable an **NME Patient** to receive such services from the Medical Facility on an inpatient or outpatient basis.

The benefit payable for these expenses will not exceed the Lodging Expenses Maximum per person per night.

For the purpose of determining NME Travel Expenses or Lodging Expenses, **hospital** or other temporary residence from which an **NME Patient** travels in order to begin a period of treatment at the Medical Facility, or to which he or she travels after discharge at the end of a period of treatment, will be considered to be the **NME Patient's** home.

Travel and Lodging Benefit Maximum
For all Travel Expenses and Lodging Expenses incurred in connection with any one procedure or treatment type:

- The total benefit payable will not exceed the Travel and Lodging Maximum per episode of care.
- Benefits will be payable only for such expenses incurred during a period which begins on the day a covered person becomes an **NME Patient** and ends on the earlier to occur of:

    one (1) year after the day the procedure is performed; and

    the date the **NME Patient** ceases to receive any services from the facility in connection with the procedure.

Benefits paid for Travel Expenses and Lodging Expenses do not count against any person's Lifetime Maximum Benefit.

Limitations
Travel Expenses and Lodging Expenses do not include, and no benefits are payable for, any charges which are included as Covered Medical Expenses under any other part of this Plan.

Travel Expenses do not include expenses incurred by more than one (1) **Companion** who is traveling with the **NME Patient**.

Lodging Expenses do not include expenses incurred by more than one (1) **Companion** per night.

Explanation of Some Important Plan Provisions

Calendar Year Deductible

This is the amount of Covered Medical Expenses you pay each calendar year before benefits are paid. There is a Calendar Year Deductible that applies to each person.

Lifetime Maximum Benefit

This is the most that will be payable for any person in his or her lifetime.

Limitations

Routine Screening for Cancer

Even though not incurred in connection with a disease or injury, Covered Medical Expenses include charges incurred:

- by a female age thirty-five (35) or over for a routine mammogram; and as follows:

  one (1) baseline mammogram, for a person age thirty-five (35) but less than forty (40); and

  one (1) mammogram each calendar year for a person age forty (40) or over; and
- by a female for an annual Pap smear (including the related gynecological exam); and
- by a male age forty (40) or over in connection with an annual exam for screening for cancer of the prostate, including:

  a digital rectal exam; and

  a prostate specific antigen (PSA) test.

Mouth, Jaws, and Teeth

Expenses for the treatment of the mouth, jaws, and teeth are Covered Medical Expenses, but only those for:

- services rendered; and
- supplies needed;

for the following treatment of or related to conditions of the:

- teeth, mouth, jaws, jaw joints; or
- supporting tissues (this includes bones, muscles, and nerves).

For these expenses, **physician** includes a **dentist**.

Hospital services and supplies received for an inpatient confinement required because of the person's condition.

Surgery needed to:

- Treat a fracture, dislocation, or wound.
- Cut out cysts, tumors, or other diseased tissues.
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

Non-surgical treatment of infections or diseases. This does not include those of or related to the teeth.

Dental work, surgery, and **orthodontic treatment** needed to remove, repair, replace, restore, or reposition:

- natural teeth damaged, lost, or removed; or
- other body tissues of the mouth fractured or cut;

due to injury.

Any such teeth must have been:

- free from decay; or
- in good repair; and
- firmly attached to the jaw bone at the time of the injury.

The treatment must be done within twelve (12) months of the accident.

If:

- crowns (caps); or
- dentures (false teeth); or
- bridgework; or
- in-mouth appliances;

are installed due to such injury, Covered Medical Expenses include only charges for:

- the first denture or fixed bridgework to replace lost teeth;
- the first crown needed to repair each damaged tooth; and
- an in-mouth appliance used in the first course of **orthodontic treatment** after the injury.

Except as provided for injury, not included are charges:

- for in-mouth appliances, crowns, bridgework, dentures, tooth restorations, or any related fitting or adjustment services; whether or not the purpose of such services or supplies is to relieve pain;
- for root canal therapy;
- for tooth removal.

Not included are charges:

- to remove, repair, replace, restore, or reposition teeth lost or damaged in the course of biting or chewing;
- to repair, replace, or restore fillings, crowns, dentures, or bridgework;
- for periodontal treatment;
- for dental cleaning, in-mouth scaling, planing, or scraping;
- for myofunctional therapy; this is:

  muscle training therapy; or

  training to correct or control harmful habits.

Acupuncture Expenses

The charges made for acupuncture services given to a person by:

- a **physician**; or
- an acupuncturist certified by the American Association of Acupuncture and Oriental Medicine who is practicing within the scope of both his certification and the laws of the jurisdiction where treatment is given;

are Covered Medical Expenses:

Acupuncture services are those services rendered:

- as a form of anesthesia in connection with surgery that is covered under this Plan;
- to treat a disease or injury; or
- to alleviate chronic pain.

Not more than the Acupuncture Calendar Year Maximum will be paid for Covered Medical Expenses incurred for acupuncture services rendered to a person in a calendar year.

Certification For Hospital Admissions (Applies to Core Major Medical Plan only)

If:

- a person becomes confined in a **hospital** as a full-time inpatient; and
- it has not been certified that such confinement (or any day of such confinement) is **necessary**;

Covered Medical Expenses incurred on any day not certified during the confinement will be paid as follows:

- As to Hospital Expenses incurred during the confinement:

  If certification has been requested and denied:

    No benefits will be paid for Hospital Expenses incurred for board and room.

    Benefits for all other Hospital Expenses will be paid at the Payment Percentage.

  If certification has not been requested and the confinement (or any day of such confinement) is not **necessary**:

    No benefits will be paid for Hospital Expenses incurred for board and room.

    As to all other Hospital Expenses:

      Expenses, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

      Benefits for such expenses in excess of the Excluded Amount will be paid at the Payment Percentage.

  If certification has not been requested and the confinement (or any day of such confinement) is **necessary**:

    Hospital Expenses, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

Benefits for all other Hospital Expenses will be payable at the Payment Percentage.

- As to other Covered Medical Expenses:

  Benefits will be paid at the Payment Percentage.

Whether or not a day of confinement is certified, no benefit will be paid for expenses incurred on any day of confinement as a full-time inpatient if excluded by any other terms of this Plan; except that, if certification has been given for a day of confinement, the exclusion of services and supplies because they are not **necessary** will not be applied to expenses for **hospital** room and board.

Certification of days of confinement can be obtained as follows:

If the admission is a **non-urgent admission**, you must get the days certified by calling the number shown on your ID card. This must be done at least fourteen (14) days before the date the person is scheduled to be confined as a full-time inpatient. If the admission is an **emergency** or an **urgent admission**, you, the person's **physician**, or the **hospital** must get the days certified by calling the number shown on your ID card. This must be done:

- before the start of a confinement as a full-time inpatient which requires an **urgent admission;** or
- not later than forty-eight (48) hours following the start of a confinement as a full-time inpatient which requires an **emergency admission**; unless it is not possible for the **physician** to request certification within that time. In that case, it must be done as soon as reasonably possible. In the event the confinement starts on a Friday or Saturday, the forty-eight (48) hour requirement will be extended to seventy-two (72) hours.

If, in the opinion of the person's **physician**, it is necessary for the person to be confined for a longer time than already certified, you, the **physician**, or the **hospital** may request that more days be certified by calling the number shown on your ID card. This must be done no later than on the last day that has already been certified.

Written notice of the number of days certified will be sent promptly to the **hospital**. A copy will be sent to you and to the **physician**.

General Exclusions

General Exclusions Applicable to Health Expense Coverage

Coverage is not provided for the following charges:

1) Those for services and supplies not **necessary**, as determined by Aetna, for the diagnosis, care, or treatment of the disease or injury involved. This applies even if they are prescribed, recommended, or approved by the person's attending **physician** or **dentist**.
2) Those for care, treatment, services, or supplies that are not prescribed, recommended, or approved by the person's attending **physician** or **dentist**.
3) Those for or in connection with services or supplies that are, as determined by Aetna, to be experimental or investigational. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if:

   there are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or

   if required by the FDA, approval has not been granted for marketing; or

   a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or

   the written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental, investigational, or for research purposes.

   However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease; if Aetna determines that:

   the disease can be expected to cause death within one year, in the absence of effective treatment; and

   the care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved.

   Also, this exclusion will not apply with respect to drugs that:

   have been granted treatment investigational new drug (IND) or Group c/treatment IND status; or

   are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute;

   if Aetna determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.
4) Those for or related to services, treatment, education testing, or training related to learning disabilities or developmental delays.

5) Those for care furnished mainly to provide a surrounding free from exposure that can worsen the person's disease or injury.
6) Those for or related to the following types of treatment:
   primal therapy;
   rolfing;
   psychodrama;
   megavitamin therapy;
   bioenergetic therapy;
   vision perception training; or
   carbon dioxide therapy.
7) Those for treatment of covered health care providers who specialize in the mental health care field and who receive treatment as a part of their training in that field.
8) Those for services of a resident **physician** or intern rendered in that capacity.
9) Those that are made only because there is health coverage.
10) Those that a covered person is not legally obliged to pay.
11) Those, as determined by Aetna, to be for **custodial care**.
12) Those for services and supplies:

    Furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government.

    Furnished, paid for, or for which benefits are provided or required under any law of a government. (This exclusion will not apply to "no fault" auto insurance if it: is required by law; is provided on other than a group basis; and is included in the definition of Other Plan in the section entitled Effect of Benefits Under Other Plans Not Including Medicare. In addition, this exclusion will not apply to: a plan established by government for its own employees or their dependents; or Medicaid.)
13) Those for or related to any eye surgery mainly to correct refractive errors.
14) Those for education or special education or job training whether or not given in a facility that also provides medical or psychiatric treatment.
15) Those for hearing aids or their fitting; however, hearing aids may be covered in connection with certain necessary surgeries as determined by Aetna.
16) Those for therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
17) Those for any drugs or supplies used for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy, including but not limited to:

    sildenafil citrate;
    phentolamine;
    apomorphine;
    alprostadil; or
    any other drug that

      is in a similar or identical class,
      has a similar or identical mode of action or exhibits similar or identical outcomes.

    This exclusion applies whether or not the drug is delivered in oral, injectable, or topical (including but not limited to gels, creams, ointments, and patches) forms, except to the extent coverage for such drugs or supplies is specifically provided in your Booklet.
18) Those for performance, athletic performance or lifestyle enhancement drugs or supplies, except to the extent coverage for such drugs or supplies is specifically provided in your Booklet.
19) Those for or related to sex change surgery or to any treatment of gender identity disorders.

20) Those for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures.
21) Those for routine physical exams, routine vision exams, routine dental exams, routine hearing exams, immunizations, or other preventive services and supplies, except to the extent coverage for such exams, immunizations, services, or supplies is specifically provided in your Booklet.
22) Those for or in connection with marriage, family, child, career, social adjustment, pastoral, or financial counseling.
23) Those for or in connection with speech therapy. This exclusion does not apply to charges for speech therapy that is expected to restore speech to a person who has lost existing speech function (the ability to express thoughts, speak words, and form sentences) as the result of a disease or injury.
24) Those for treatment of alcoholism, drug abuse or a mental disorder. This exclusion does not apply to to charges made for the treatment of the medical complications of alcoholism or drug abuse.
25) Those for plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons; except to the extent needed to:

    Improve the function of a part of the body that is not a tooth or structure that supports the teeth, and is malformed:

    as a result of a severe birth defect; including harelip, webbed fingers, or toes; or

    as a direct result of disease; or surgery performed to treat a disease or injury.

    Repair an injury.

    Facings on molar crowns and pontics will always be considered cosmetic.
26) Those to the extent they are not **reasonable charges**, as determined by Aetna.
27) Those for the reversal of a sterilization procedure.
28) Under the Core Medicare Enrollee Plan, those not covered by Medicare because of non-compliance with Medicare requirements.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

These excluded charges will not be used when figuring benefits.

The law of the jurisdiction where a person lives when a claim occurs may prohibit some benefits. If so, they will not be paid.

Effect of Benefits Under Other Plans

Other Plans Not Including Medicare

Some persons have health coverage in addition to coverage under this Plan. When this is the case, the benefits from "other plans" will be taken into account. This may mean a reduction in benefits under this Plan. The combined benefits will not be more than the expenses recognized under these plans.

In a calendar year, this Plan will pay:

- its regular benefits in full; or
- a reduced amount of benefits. To figure this amount, subtract B. from A. below:

  A. 100% of "Allowable Expenses" incurred by the person for whom claim is made.
  B. The benefits payable by the "other plans". (Some plans may provide benefits in the form of services rather than cash payments. If this is the case, the cash value will be used.)

"Allowable Expenses" means any **necessary** and reasonable health expense, part or all of which is covered under any of the plans covering the person for whom claim is made.

The difference between the cost of a private **hospital** room and the **semiprivate rate** is not considered an Allowable Expense under the above definition unless the patient's stay in a private **hospital** room is medically necessary, either in terms of generally accepted medical practice or as specifically defined in this Plan.

To find out whether the regular benefits under this Plan will be reduced, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.

2. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, Medicare is:

   - secondary to the plan covering the person as a dependent; and
   - primary to the plan covering the person as other than a dependent;

   the benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which:

   - covers the person as other than a dependent; and
   - is secondary to Medicare.

3. Except in the case of a dependent child whose parents are divorced or separated; the plan which covers the person as a dependent of a person whose birthday comes first

in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.

If the other plan does not have the rule described in this provision (3) but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

4. In the case of a dependent child whose parents are divorced or separated:

   a. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (3) above will apply.

   b. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.

   c. If there is not such a court decree:

      If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

      If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

5. If 1, 2, 3 and 4 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:

   The benefits of a plan which covers the person on whose expenses claim is based as a:

   - laid-off or retired employee; or
   - the dependent of such person;

   shall be determined after the benefits of any other plan which covers such person as:

   - an employee who is not laid-off or retired; or
   - a dependent of such person.

   If the other plan does not have a provision:

   - regarding laid-off or retired employees; and
   - as a result, each plan determines its benefits after the other;

   then the above paragraph will not apply.

The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.

If the other plan does not have a provision:

- regarding right of continuation pursuant to federal or state law; and
- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

Aetna has the right to release or obtain any information and make or recover any payment it considers necessary in order to administer this provision.

When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during a calendar year, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limit of this Plan.

Other Plan

This means any other plan of health expense coverage under:

- Group insurance.
- Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.

Effect of A Health Maintenance Organization Plan (HMO Plan) On Coverage

If you are in an Eligible Class and have chosen coverage under an HMO Plan offered by your Employer, you and your eligible dependents will be excluded from Health Expense Coverage on the date of your coverage under such HMO Plan.

If you are in an Eligible Class and are covered under an HMO Plan, you can choose to change to coverage for yourself and your covered dependents under this Plan. If you:

- Live in an HMO Plan enrollment area and choose to change coverage during an open enrollment period, coverage will take effect on the first day of the contract period which follows the open enrollment period. There will be no rules for waiting periods or preexisting conditions.
- Move from an HMO Plan enrollment area or if the HMO discontinues and you choose to change coverage within thirty-one (31) days of the move or the discontinuance, coverage will take effect on the date you elect such coverage. There will be no restrictions for waiting periods or preexisting conditions.

Any extensions of benefits under this Plan for disability or pregnancy will not always apply on and after the date of a change to an HMO Plan. They will apply only if the person is not covered at once under the HMO Plan because he or she is in a **hospital** not affiliated with the HMO. If you give evidence that the HMO Plan provides an extension of benefits for disability or pregnancy, coverage under this Plan will be extended. The extension will be for the same length of time and for the same conditions as the HMO Plan provides. It will not be longer than the first to occur of:

- the end of a ninety (90) day period; and
- the date the person is not confined.

No benefits will be paid for any charges for services rendered or supplies furnished under an HMO Plan.

Effect of Medicare

Health Expense Coverage under this Plan will be changed for any person while eligible for Medicare.

A person is "eligible for Medicare" if he or she:

- is covered under it;
- is not covered under it because of:

  having refused it;

  having dropped it;

  having failed to make proper request for it.

If you are an active employee and you are eligible for Medicare, or if you have a dependent eligible for Medicare and federal law requires this Plan to remain primary, Plan benefits must be paid before Medicare Benefits are paid.

Employees and annuitants eligible for Medicare should see Amendment 1 for Medicare enrollment requirements. If you transfer to the Core Medicare Enrollee Plan, amounts accrued toward the deductible under the Core Major Medical Plan will be transferred to the Core Medicare Enrollee Plan.

If you are retired and covered under both Parts A and B of Medicare, claims will be paid by Medicare first before the Core Medicare Enrollee Plan will pay claims. If you are retired and covered by only one part of Medicare, only claims covered by that part must first be submitted to Medicare.

The following describes the process for how coverage under this Plan will be determined for any person while eligible for Medicare:

- The total amount of "regular benefits" under all Health Expense Benefits will be figured. (This will be the amount that would be payable if there were no Medicare benefits.) If this is more than the amount Medicare provides for the expenses involved, this Plan will pay the difference. Otherwise, this Plan will pay no benefits. This will be done for each claim.
- Charges used to satisfy a person's Part B deductible under Medicare will be applied under this Plan in the order received by Aetna. Two (2) or more charges received at the same time will be applied starting with the largest first.

- Medicare benefits will be taken into account for any person while he or she is eligible for Medicare.
- Any rule for coordinating "other plan" benefits with those under this Plan will be applied after this Plan's benefits have been figured under the above rules. Any benefits under Medicare will not be deemed to be an "Allowable Expense."

Effect of Prior Coverage - Transferred Business

If the coverage of any person under any part of this Plan replaces any prior coverage of the person, the rules below apply to that part.

"Prior coverage" is any plan of group accident and health coverage that has been replaced by coverage under part or all of this Plan; it must have been sponsored by your Employer (i.e., transferred business). The replacement can be complete or in part for the Eligible Class to which you belong. Any such plan is prior coverage if provided by another group contract or any benefit section of this Plan.

Coverage under any section of this Plan will be in exchange for all privileges and benefits provided under any like prior coverage. Any benefits provided under such prior coverage may reduce benefits payable under this Plan.

General Information About Your Coverage

Termination of Coverage

Coverage under this Plan terminates at the first to occur of:

- Any of the events described in the termination section of the separate insert (Amendment 1).
- When the group contract terminates as to the coverage.
- When you fail to make any required contribution.

Your Employer will notify Aetna of the date your employment ceases for the purposes of termination of coverage under this Plan. Your Employer will use the same rule for all employees. If you are not at work on this date due to one of the following, employment may be deemed to continue up to the limits shown below.

If you are not at work due to disease or injury, your employment may be continued until stopped by your Employer - please refer to the separate insert (Amendment 1) for details.

If you are not at work due to temporary lay-off or leave of absence, your employment may continue until stopped by your Employer - please refer to the separate insert (Amendment 1) for details.

The separate insert (Amendment 1) may show an Eligible Class of retired employees. If you are in that class, your employment may be deemed to continue:

- for any coverage shown in Amendment 1; and
- subject to any limits shown in Amendment 1.

If no Eligible Class of retired employees is shown, there is no coverage for retired employees.

If you cease active work, ask your Employer if any coverage can be continued.

Dependent Coverage Only

A dependent's coverage will terminate at the first to occur of:

- Any of the events described in the the termination section of the separate insert (Amendment 1).
- Termination of all dependents' coverage under the group contract.
- When a dependent becomes covered as an employee or annuitant.
- When coverage terminates for the employee or annuitant.

Health Expense Benefits After Termination

If a person is totally disabled when his or her Health Expense Coverage ceases due to discontinuance of the Plans, benefits will be available to such person while he or she continues to be totally disabled for up to the applicable period shown below, but, with respect to Medical Expense benefits, only as to expenses incurred in connection with the injury or disease that caused the total disability.

The words "totally disabled" mean that due to injury or disease:

- You are not able to engage in your customary occupation and are not working for pay or profit.
- Your dependent is not able to engage in most of the normal activities of a person of like age and sex in good health.

Medical Expense benefits will be available to him or her while disabled for up to twelve (12) months due to discontinuance of the Plans, but, with respect to Medical Expense benefits, only as to expenses incurred in connection with the injury or disease that caused the total disability.

Health Expense benefits will cease on the first to occur of the following:

- The person's Lifetime Maximum Benefit is paid.
- The person becomes covered under any group plan with like benefits. (This does not apply if his or her coverage ceased because the benefit section ceased as to your Eligible Class.)

If this provision applies to you or one of your covered dependents, see the section Conversion of Medical Expense Coverage for information which may affect you.

Conversion of Medical Expense Coverage (Not available for New Mexico employees and annuitants)

This Plan permits certain persons whose Medical Expense Coverage has ceased to convert to a personal medical policy. No medical exam is needed. You and your family members may convert when all coverage ceases because your employment ceases or you cease to be in an eligible class. You may not convert if coverage ceases because the group contract has discontinued as to your medical coverage.

The personal policy may cover:

- you only; or
- you and all of your family members who are covered under this Plan when your coverage ceases; or
- if you die before you retire, all your family members, or your spouse only, who are covered under this Plan when your coverage ceases.

Also, if your own coverage continues, your dependents can apply if they cease to be a dependent as defined in this Plan.

You may convert when you become a retired employee. If this Plan permits retired employees to continue Medical Expense Coverage, and you choose to do so, this conversion privilege will not again be available to you.

The personal policy must be applied for within thirty-one (31) days after coverage ceases or would otherwise cease without a provision to continue coverage for retired employees. The thirty-one (31) days start on the date coverage actually ceases even if the person is still eligible for benefits because the person is totally disabled.

Aetna may decline to issue the personal policy if:

- It is applied for in a jurisdiction in which Aetna cannot issue or deliver the policy.
- On the date of conversion, a person is covered, eligible or has benefits available under one of the following:

  any other hospital or surgical expense insurance policy;

  any hospital service or medical expense indemnity corporation subscriber contract;

  any other group contract;

  any statute, welfare plan or program;

  and that with the converted policy, would result in overinsurance or match benefits.

No one has the right to convert if you have been covered under this Plan or another University sponsored health plan for less than three (3) months. Also, no person has the right to convert if:

- he or she has used up the maximum benefit; or
- he or she becomes eligible for any other Medical Expense Coverage under this Plan; or
- he or she is age 65 or over.

The personal policy form, and its terms, will be of a type, for group conversion purposes:

- as required by law or regulation; or
- as then offered by Aetna under your Employer's conversion plan.

It will not provide coverage which is the same as coverage under this Plan. The level of coverage may be less and an overall Lifetime Maximum Benefit will apply.

The personal policy may contain either or both of:

- A statement that benefits under it will be cut back by any like benefits payable under this Plan after your coverage ceases.
- A statement that Aetna may ask for data about your coverage under any other plan. This may be asked for on any premium due date of the personal policy. If you do not give the data, expenses covered under the personal policy may be reduced by expenses which are covered or provided under those plans.

The personal policy will state that Aetna has the right to refuse renewal under some conditions. These will be shown in that policy.

If you or your dependent want to convert:

- You should call Aetna Customer Service at 1-800-632-0524 and request a copy of the "Notice of Conversion Privilege and Request" form.
- Send the completed form to the address shown on the form.

If a person is eligible to convert, information will be sent about the personal policy for which he or she may apply.

The first premium for the personal policy must be paid at the time the person applies for that policy. The premium due will be Aetna's normal rate for the person's class and age, and the form and amount of coverage.

The personal policy will take effect on the day after coverage terminates under this Plan.

Type of Coverage

Coverage under the Plans is non-occupational. Only **non-occupational** accidental **injuries** and **non-occupational diseases** are covered. Any coverage for charges for services and supplies is provided only if they are furnished to a person while covered.

Conditions that are related to pregnancy may be covered under the Plans. The Summary of Coverage will say if they are.

Physical Examinations

Aetna will have the right and opportunity to have a physician or dentist of its choice examine any person for whom certification or benefits have been requested. This will be done at all reasonable times while certification or a claim for benefits is pending or under review. This will be done at no cost to you.

Legal Action

No legal action can be brought to recover under any benefit after three (3) years from the deadline for filing claims.

Aetna will not try to reduce or deny a benefit payment on the grounds that a condition existed before a person's coverage went into effect, if the loss occurs more than two (2) years from the date coverage commenced. This will not apply to conditions excluded from coverage on the date of the loss.

Additional Provisions

The following additional provisions apply to your coverage.

- You cannot receive multiple coverage under the Plans because you are connected with more than one Employer.
- In the event of a misstatement of any fact affecting your coverage under the Plans, the true facts will be used to determine the coverage in force.

This document describes the main features of the Plans. Additional provisions are described elsewhere in the Plan Documents on file with your Employer. If you have any questions about the terms of the Plans or about the proper payment of benefits, you may obtain more information from your Employer.

Your Employer hopes to continue the Plans indefinitely but, as with all group plans, the Plans may be changed or discontinued as to all or any class of employees.

Assignments

Coverage may be assigned only with the written consent of Aetna.

Recovery of Benefits Paid

As a condition to payment of benefits under the Plans for expenses incurred by a covered person due to injury or illness for which a third party may be liable:

- The Plans shall, to the extent of benefits they have paid, be subrogated to (have the right to pursue) all rights of recovery of covered persons against:

  such third party; or

  a person's insurance carrier in the event of a claim under the uninsured or underinsured auto coverage provision of an auto insurance policy.
- The Plans shall have the right to recover from the covered person amounts received by judgment, settlement, or otherwise from:

  such third party or his or her insurance carrier; or

  any other person or entity, which includes the auto insurance carrier which provides the covered person's uninsured or underinsured auto insurance coverage.
- The covered person (or person authorized by law to represent the covered person if he or she is not legally capable) shall:

  execute and deliver any documents that are required; and

  do whatever else is necessary to secure such rights.

Recovery of Overpayment

If a benefit payment is made by Aetna, to or on behalf of any person, which exceeds the benefit amount such person is entitled to receive in accordance with the terms of the group contract, the Plans have the right:

- to require the return of the overpayment on request; or
- to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right does not affect any other right of recovery the Plans may have with respect to such overpayment.

Reporting of Claims

A claim must be submitted to Aetna in writing. It must give proof of the nature and extent of the loss. You should call Aetna Customer Service at 1-800-632-0524 and request a claim form.

All claims should be reported promptly. The deadline for filing a claim for any benefits is ninety (90) days after the date of the loss causing the claim.

If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims will not be covered if they are filed more than two (2) years after the deadline.

Payment of Benefits

Benefits will be paid as soon as the necessary written proof to support the claim is received.

All benefits are payable to you. However, the Plans have the right to pay any health benefits to the service provider. This will be done unless you have told Aetna otherwise by the time you file the claim.

The Plans may pay up to $ 1,000 of any benefit to any of your relatives whom it believes fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate.

Records of Expenses

Keep complete records of the expenses of each person. They will be required when a claim is made.

Very important are:

Names of **physicians**, **dentists** and others who furnish services.
Dates expenses are incurred.
Copies of all bills and receipts.

Glossary

The following definitions of certain words and phrases will help you understand the benefits to which the definitions apply. Some definitions which apply only to a specific benefit appear in the benefit section. If a definition appears in a benefit section and also appears in the Glossary, the definition in the benefit section will apply in lieu of the definition in the Glossary.

Board and Room Charges

Charges made by an institution for board and room and other **necessary** services and supplies. They must be regularly made at a daily or weekly rate.

Companion

This is a person whose presence as a **Companion** or caregiver is necessary to enable an **NME Patient**:

- to receive services in connection with an NME procedure or treatment on an inpatient or outpatient basis; or
- to travel to and from the facility where treatment is given.

Convalescent Facility

This is an institution that:

- Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or injury:

  professional nursing care by a **R.N.**, or by a **L.P.N.** directed by a full-time **R.N.**; and

  physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides twenty-four (24) hour a day nursing care by licensed nurses directed by a full-time **R.N.**
- Is supervised full-time by a **physician** or **R.N.**
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders.
- Makes charges.

Custodial Care

This means services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes board and room and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to:

- by whom they are prescribed; or
- by whom they are recommended; or
- by whom or by which they are performed.

Dentist

This means a legally qualified dentist. Also, a **physician** who is licensed to do the dental work he or she performs.

Durable Medical and Surgical Equipment
This means no more than one (1) item of equipment for the same or similar purpose, and the accessories needed to operate it, that is:

- made to withstand prolonged use;
- made for and mainly used in the treatment of a disease or injury;
- suited for use in the home;
- not normally of use to person's who do not have a disease or injury;
- not for use in altering air quality or temperature;
- not for exercise or training.

Not included is equipment such as: whirlpools; portable whirlpool pumps; sauna baths; massage devices; overbed tables; elevators; communication aids; vision aids; and telephone alert systems.

Emergency Admission
One where the **physician** admits the person to the **hospital** right after the sudden and, at that time, unexpected onset of a change in the person’s physical or mental condition:

- which requires confinement right away as a full-time inpatient; and
- for which if immediate inpatient care was not given could, as determined by Aetna, reasonably be expected to result in:

  placing the person’s health in serious jeopardy; or
  serious impairment to bodily function; or
  serious dysfunction of a body part or organ; or
  in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Emergency Care
This means the treatment given in a **hospital’s** emergency room to evaluate and treat medical conditions of a recent onset and severity, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- placing the person’s health in serious jeopardy; or
- serious impairment to bodily function; or
- serious dysfunction of a body part or organ; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Emergency Condition
This means a recent and severe medical condition, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- placing the person’s health in serious jeopardy; or
- serious impairment to bodily function; or
- serious dysfunction of a body part or organ; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Employer
This means the University of California.

Home Health Care Agency
This is an agency that:

- mainly provides skilled nursing and other therapeutic services; and
- is associated with a professional group which makes policy; this group must have at least one (1) **physician** and one (1) **R.N.**; and
- has full-time supervision by a **physician** or a **R.N**.; and
- keeps complete medical records on each person; and
- has a full-time administrator; and
- meets licensing standards.

Home Health Care Plan
This is a plan that provides for care and treatment of a disease or injury.
The care and treatment must be:

- prescribed in writing by the attending **physician**; and
- an alternative to confinement in a **hospital** or **convalescent facility**.

Hospice Care
This is care given to a **terminally ill** person by or under arrangements with a **Hospice Care Agency**. The care must be part of a **Hospice Care Program**.

Hospice Care Agency
This is an agency or organization which:

- Has **Hospice Care** available twenty-four (24) hours a day.
- Meets any licensing or certification standards set forth by the jurisdiction where it is.
- Provides:

  skilled nursing services; and

  medical social services; and

  psychological and dietary counseling.
- Provides or arranges for other services which will include:

  services of a **physician**; and

  physical and occupational therapy; and

  part-time home health aide services which mainly consist of caring for **terminally ill** persons; and

  inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has personnel which include at least:

  one (1) **physician**; and

  one (1) **R.N.**; and

  one (1) licensed or certified social worker employed by the Agency.
- Establishes policies governing the provision of **Hospice Care**.
- Assesses the patient's medical and social needs.
- Develops a **Hospice Care Program** to meet those needs.

- Provides an ongoing quality assurance program. This includes reviews by **physicians**, other than those who own or direct the Agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Utilizes volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

Hospice Care Program

This is a written plan of **Hospice Care**, which:

- Is established by and reviewed from time to time by:

  a **physician** attending the person; and

  appropriate personnel of a **Hospice Care Agency**.
- Is designed to provide:

  palliative and supportive care to **terminally ill** persons; and

  supportive care to their families.
- Includes:

  an assessment of the person's medical and social needs; and

  a description of the care to be given to meet those needs.

Hospice Facility

This is a facility, or distinct part of one, which:

- Mainly provides inpatient **Hospice Care** to **terminally ill** persons.
- Charges its patients.
- Meets any licensing or certification standards set forth by the jurisdiction where it is.
- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program; this includes reviews by **physicians** other than those who own or direct the facility.
- Is run by a staff of **physicians**; at least one such **physician** must be on call at all times.
- Provides, twenty-four (24) hours a day, nursing services under the direction of a **R.N.**
- Has a full-time administrator.

Hospital

This is a place that:

- Mainly provides inpatient facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons.
- Is supervised by a staff of **physicians**.
- Provides twenty-four (24) hour a day **R.N.** service.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home.
- Makes charges.

L.P.N.

This means a licensed practical nurse.

National Medical Excellence (NME) Patient

This is a person who:

- requires any of the NME procedure and treatment types for which the charges are a Covered Medical Expense; and

- contacts Aetna and is approved by Aetna as an **NME Patient**; and
- agrees to have the procedure or treatment performed in a **hospital** designated by Aetna as the most appropriate facility.

Necessary

A service or supply furnished by a particular provider is necessary if Aetna determines that it is appropriate for the diagnosis, the care or the treatment of the disease or injury involved.

To be appropriate, the service or supply must:

- be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition;
- be a diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition; and
- as to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration:

- information provided on the affected person's health status;
- reports in peer reviewed medical literature;
- reports and guidelines published by nationally recognized healthcare organizations that include supporting scientific data;
- generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment;
- the opinion of health professionals in the generally recognized health specialty involved; and
- any other relevant information brought to Aetna's attention.

In no event will the following services or supplies be considered to be necessary:

- those that do not require the technical skills of a medical or a dental professional; or
- those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any healthcare provider or healthcare facility; or
- those furnished solely because the person is an inpatient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined; or
- those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

Non-Occupational Disease

A non-occupational disease is a disease that does not:

- arise out of (or in the course of) any work for pay or profit; or
- result in any way from a disease that does.

A disease will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- is covered under any type of workers' compensation law; and
- is not covered for that disease under such law.

Non-Occupational Injury
A non-occupational injury is an accidental bodily injury that does not:

- arise out of (or in the course of) any work for pay or profit; or
- result in any way from an injury which does.

Non-urgent Admission
One which is not an **emergency admission** or an **urgent admission**.

Orthodontic Treatment
This is any:

- medical service or supply; or
- dental service or supply;

furnished to prevent or to diagnose or to correct a misalignment:

- of the teeth; or
- of the bite; or
- of the jaws or jaw joint relationship;

whether or not for the purpose of relieving pain.

Not included is:

- the installation of a space maintainer; or
- a surgical procedure to correct malocclusion.

Physician
This means a legally qualified physician.

R.N.
This means a registered nurse.

Reasonable Charge
Only that part of a charge which is reasonable is covered. The reasonable charge for a service or supply is the lowest of:

- the provider's usual charge for furnishing it; and
- the charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and
- the charge Aetna determines to be the prevailing charge level made for it in the geographic area where it is furnished.

In determining the reasonable charge for a service or supply that is:

- unusual; or
- not often provided in the area; or
- provided by only a small number of providers in the area;

Aetna may take into account factors, such as:

- the complexity;
- the degree of skill needed;
- the type of specialty of the provider;

- the range of services or supplies provided by a facility; and
- the prevailing charge in other areas.

Semiprivate Rate
This is the **charge** for **board and room** which an institution applies to the most beds in its semiprivate rooms with two (2) or more beds. If there are no such rooms, Aetna will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

Terminally Ill
This is a medical prognosis of six (6) months or less to live.

Urgent Admission
One where the **physician** admits the person to the **hospital** due to:

- the onset of or change in a disease; or
- the diagnosis of a disease; or
- an injury caused by an accident;

which, while not needing an **emergency admission**, is severe enough to require confinement as an inpatient in a **hospital** within two (2) weeks from the date the need for the confinement becomes apparent.

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Amendment 1:
Amendment to Plan of Benefits

For: The University of California

Administrative Services Agreement No.: ASC-724665

Effective January 1, 2001, if you are enrolled in the Core Major Medical Plan or Core Medicare Enrollee Plan, the following information is added to your booklet, in accordance with the University of California Group Insurance Regulations.

ELIGIBILITY

The following individuals are eligible to enroll in these Plans. Anyone enrolled in a non-University Medicare + Choice Managed Care contract is not eligible for these Plans.

Subscriber

Employee: You are eligible (in an eligible class) if you are (a) appointed to work at least 43.75% time and average regular paid time* is at least 17.5 hours per week, or (b) eligible to enroll in Career Plans but fail to enroll in a medical plan.

* For any month, your average regular paid time is the average number of regular paid hours per week (excluding overtime, stipend or bonus time) worked by you in the preceding twelve (12) month period.

(a) A month with zero regular paid hours which occurred during your furlough or approved leave without pay will not be included in the calculation of the average. If such absence exceeds eleven (11) months, the averaging will be restarted.

(b) A month with zero regular paid hours which occurred during a period when you were not on furlough or approved leave without pay will be included in the calculation of the average. After two consecutive such months, the averaging will be restarted.

For a partial month of zero regular paid hours due to furlough, leave without pay or initial employment the following will apply.

(a) If you worked at least 43.75% of the regular paid hours available in the month, the month will be included in the calculation of the average.

(b) If you did not work at least 43.75% of the regular paid hours available in the month, the month will not be included in the calculation of the average.

The Core Major Medical Plan covers active employees and their dependents, including those who have Medicare coverage.

Annuitant (including Survivor Annuitant):

Annuitant A former University Employee receiving monthly benefits from a University-sponsored defined benefit plan.

Survivor Annuitant A deceased Employee's or Annuitant's family member receiving monthly benefits from a University-sponsored defined benefit plan.

You may continue University medical plan coverage as an **Annuitant** when you start collecting retirement or disability benefits from a University-sponsored defined benefit plan, or as a **Survivor Annuitant** when you start collecting survivor benefits from a University-sponsored defined benefit plan. You must also meet the following requirements:

(a) you meet the University's service credit requirements for Annuitant medical eligibility;
(b) the effective date of your Annuitant status is within 120 calendar days of the date employment ends (or the date of the Employee/Annuitant's death for a Survivor Annuitant); and
(c) you elect to continue medical coverage at the time of retirement.

If you are eligible for Medicare, see "Effect of Medicare on Annuitant Enrollment" later in this document.

The Core Major Medical Plan covers Annuitants and their dependents who are covered for Part A or Part B of Medicare, but not both parts, or who have no Medicare Coverage.

The Core Medicare Enrollee Plan covers Annuitants and their dependents who are covered for both Part A and Part B of Medicare.

Contact your University of California Benefits Office for additional information about continuing your coverage when you retire.

Eligible Dependents (Family Members)

When you enroll any Family Member, your signature on the enrollment form or the confirmation number on your electronic enrollment attests that your Family Member meets the eligibility requirements outlined below. The University and/or the Plans reserve the right to periodically request documentation to verify eligibility of Family Members. Documentation could include a marriage certificate, birth certificate(s), adoption records, or other official documentation. In addition, you will be asked to submit a copy annually of your Federal income tax return (IRS form 1040 or IRS equivalent showing the covered dependent Family Member and your signature) to the University to verify income tax dependency for those categories where it is a condition of eligibility.

Spouse: Your legal spouse. (Note: if you are a Survivor Annuitant, you may not enroll your legal spouse.)

Child: All eligible children must be under the limiting age (18 for legal wards, 23 for all others), unmarried, and may not be emancipated minors. The following categories are eligible:

(a) your natural or legally adopted children;
(b) your stepchildren (natural or legally adopted children of your spouse) if living with you, dependent on you or your spouse for at least 50% of their support and are your or your spouse's dependents for income tax purposes;
(c) grandchildren of you or your spouse if living with you, dependent on you or your spouse for at least 50% of their support and are your or your spouse's dependents for income tax purposes;
(d) children for whom you are the legal guardian if living with you, dependent on you for at least 50% of their support and are your dependents for income tax purposes.

Any child described above (except a legal ward) who is incapable of self-support due to a physical or mental handicap may apply for continued coverage past age 23 provided:

- the incapacity began before age 23, the child was enrolled in a group medical plan before age 23 and coverage is continuous,
- the child is dependent on you for at least 50% of his or her support and is your dependent for income tax purposes, and
- the child lives with you if he or she is not your or your spouse's natural or adopted child.

Application must be made to the Plan 31 days before the child's 23rd birthday and is subject to approval by Aetna. Proof of your child’s handicap must be submitted to Aetna no later than thirty-one (31) days after the date your child reaches the maximum age. Aetna will have the right to require proof of the continuation of the handicap. Aetna also has the right to examine your child as often as needed while the handicap continues at its own expense. An exam will not be required more often than once each year after two (2) years from the date your child reached the maximum age. Incapacitated children approved for continued coverage under a University-sponsored medical plan are eligible for continued coverage under any other University-sponsored medical plan; if enrollment is transferred from one plan to another, a new application for continued coverage is not required.

If you are a newly hired Employee with an incapacitated child, you may also apply for coverage for that child. The child must have had continuous group medical coverage since age 23, and you must apply for University coverage during your Period of Initial Eligibility.

Coverage for a handicapped child will cease on the first to occur of:

- Cessation of the handicap.
- Failure to give proof that the handicap continues.
- Failure to have any required exam.
- Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age.

Other Dependents (Family Members): If you have completed and signed an affidavit of same–sex domestic partnership or adult dependent relationship, in lieu of a spouse, you may enroll an eligible adult dependent relative or same-sex domestic partner (and the same-sex domestic partner's children/grandchildren). For information on who qualifies and how to enroll, contact your University of California Benefits Office or the University of California's Customer Service Center.

No Dual Coverage

Eligible individuals may be covered under only one of the following categories: as an Employee, an Annuitant, a Survivor Annuitant or a Family Member, but not under any combination of these. If both husband and wife are eligible Subscribers, each may enroll separately or one may cover the other as a Family Member. If they enroll separately, neither may enroll the other as a Family Member. Eligible children may be enrolled under either parent's coverage but not under both.

ENROLLMENT

During a Period of Initial Eligibility (PIE)
A PIE ends 31 days after it begins.

If you are an Employee, you may enroll yourself and any eligible Family Members during your PIE. Your PIE starts the day you become an eligible Employee.

You may enroll any newly eligible Family Member during his or her PIE. The Family Member's PIE starts the day your Family Member becomes eligible, as described below. During this PIE you may also enroll yourself and/or any other eligible Family Member if not enrolled during your own or their own PIE. You must enroll yourself in order to enroll any eligible Family Member. Family members are only eligible for the same plan you are enrolled in.

(a) For a spouse, on the date of marriage. Survivor Annuitants may not add Spouses to their coverage.

(b) For a natural child, on the child's date of birth.

(c) For an adopted child, the earlier of:
  (i) the date you or your Spouse has the legal right to control the child's health care, or
  (ii) the date the child is placed in your physical custody.
  If the child is not enrolled during the PIE beginning on that date, there is an additional PIE beginning on the date the adoption becomes final.

(d) Where there is more than one eligibility requirement, the date all requirements are satisfied.

If you decline enrollment for yourself or your eligible Family Members because of other "creditable" medical plan coverage and you lose that coverage for one of the following reasons, you may be able to enroll yourself and those eligible Family Members during a PIE that starts on the day the other coverage is no longer in effect.

(a) Termination of employment in a class eligible for such coverage.

(b) Reduction in hours of employment.

(c) Your spouse dies.

(d) You and your spouse divorce or are legally separated.

(e) Such coverage was COBRA continuation and such continuation was exhausted.

(f) The other plan terminates due to the employer's failure to pay the premium or for any other reason.

As used above, "creditable coverage" is a person's prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Such coverage includes coverage issued on a group or individual basis; Medicare; Medicaid; military-sponsored health care; a program of the Indian Health Service; a state health benefits risk pool; the Federal Employees' Health Benefit Plan (FEHBP); a public health plan as defined in the regulations; and any health benefit plan under Section 5(e) of the Peace Corps Act.

At Other Times
You and your eligible Family Members may also enroll during a group open enrollment period established by the University.

If you or your eligible Family Members fail to enroll during a PIE or open enrollment period, you may enroll at any other time upon completion of a 90 consecutive calendar day waiting period. The 90-day waiting period starts on the date your enrollment form is received by your University of California Accounting or Benefits Office and ends 90 consecutive calendar days later.

If you have two or more Family Members enrolled in the Plan, you may add a newly eligible Family Member at any time. See "Effective Date".

If you are an Annuitant, you may continue coverage for yourself and your enrolled Family Members in the same plan you were enrolled in immediately before retiring. You must elect to continue enrollment before the effective date of retirement (or the date disability or survivor benefits begin).

Effective Date
The following effective dates apply provided the appropriate enrollment transaction (paper form or electronic) has been completed within the applicable enrollment period.

If you enroll during a PIE, coverage for you and your Family Members is effective the date the PIE starts.

If you are an Annuitant continuing enrollment in conjunction with retirement, coverage for you and your Family Members is effective on the first of the month following the first full calendar month of retirement income.

The effective date of coverage for enrollment during an open enrollment period is the date announced by the University.

For enrollees who complete a 90-day waiting period, coverage is effective on the 91st consecutive calendar day after the date the enrollment transaction is completed.

When you already have two or more Family Members enrolled and enroll another Family Member, coverage may be retroactive with the effective date limited to the later of:
(a) the date the newly added Family Member becomes eligible, or
(b) a maximum of 60 days prior to the date his or her enrollment transaction is completed.

Effect of Medicare on Annuitant Enrollment
If you are an Annuitant and you and/or an enrolled Family Member is or becomes eligible for premium free Medicare Part A (Hospital Insurance) as primary coverage, then that individual must also enroll in and remain in Medicare Part B (Medical Insurance). Once Medicare coverage is established, coverage in both Part A and Part B must be continuous. This includes anyone who is entitled to Medicare benefits through their own or their spouse's non-University employment. Individuals enrolled in both Part A and Part B are then eligible for the Medicare premium applicable to the Core Medicare Enrollee Plan.

MEDICARE PRIVATE CONTRACTING PROVISION

Federal Legislation allows physicians or practitioners to opt out of Medicare. Medicare beneficiaries wishing to continue to obtain services **(that would otherwise be covered by Medicare)** from these physicians or practitioners will need to enter into written "private contracts" with these physicians or practitioners requiring the beneficiary to be responsible for all payments to such providers. Services provided under "private contracts" are not covered by Medicare, and the Medicare limiting charge will not apply.

If you are classified as an Annuitant by the University (or otherwise have Medicare as a primary coverage) and enrolled in Medicare Part B, and choose to enter into such a "private contract" arrangement with one or more physicians or practitioners, under the law you have in effect "opted out" of Medicare for the services provided by these physicians or other practitioners. No benefits will be paid by the Plans for services rendered by these physicians or practitioners with whom you have so contracted, even if you submit a claim. You will be fully liable for the payment of the services rendered.

However, if you do sign a private contract with a physician or practitioner, you may see other physicians or practitioners without those private contract restrictions as long as they have not opted out of Medicare.

TERMINATION OF COVERAGE

The following termination of coverage provisions are established by the University of California. Additional termination provisions apply and are described in your booklet.

De-enrollment Due to Loss of Eligible Status
If you are an Employee and lose eligibility, your coverage and that of any enrolled Family Member stops at the end of the last month in which premiums are taken from earnings based on an eligible appointment.

If you are an Annuitant or Survivor Annuitant and your annuity terminates, your coverage and that of any enrolled Family Member stops at the end of the last month in which you are eligible for an annuity.

If your Family Member loses eligibility, you must complete the appropriate transaction to delete him or her within 60 days of the date the Family Member is no longer eligible. Coverage stops at the end of the month in which he or she no longer meets all the eligibility requirements. . For information on de-enrollment procedures, contact your University of California Benefits Office (or the University of California Customer Service Center if you are an Annuitant).

De-enrollment Due to Fraud
Coverage for you or your Family Members may be terminated for fraud or deception in the use of the services of the Plans, or for knowingly permitting such fraud or deception by another. Such termination shall be effective upon the mailing of written notice to the Subscriber (and to the University if notice is given by the Plan). A Family Member who commits fraud or deception will be de-enrolled, while any other Family Member or Subscriber will be de-enrolled for 18 months. If a Subscriber commits fraud or deception, the Subscriber and any Family Members will be de-enrolled for 18 months.

Leave of Absence or Layoff
If you are absent from work due to an authorized leave of absence, coverage may be continued until stopped by the University, but not beyond two (2) years from the start of the absence. If you are not at work due to temporary lay-off, coverage may be continued until stopped by the University, but not beyond four (4) months following the month in which the lay-off started.

Contact your University of California Benefits Office for additional information about continuing your coverage in the event of an authorized leave of absence or layoff.

Issue Date: August 23, 2000

Summary of Coverage

For: The University of California

ASC: 724665

SOC: 1B

Issue Date: August 23, 2000

Effective Date: January 1, 2001

The benefits shown in this Summary of Coverage are available for you and your eligible dependents.

Eligibility

Employees and Dependents (Eligible Class)

Please refer to the separate insert (Amendment 1: Amendment to Plan of Benefits referred to as Amendment 1) for a complete description of employee and dependent eligibility.

Enrollment Procedure

Please refer to the separate insert (Amendment 1) for more information about the enrollment procedures. Additional information follows this Summary of Coverage.

Effective Date of Coverage

Employees and Dependents

Please refer to the separate insert (Amendment 1) for a complete description of when employee and dependent coverage becomes effective.

Health Expense Coverage

Employees and Dependents

Your Booklet spells out the period to which each maximum applies. These benefits apply separately to each covered person. Read the coverage section in your Booklet for a complete description of the benefits payable.

Comprehensive Medical Expense Coverage

Certification Requirement

If you or one of your dependents require confinement in a hospital:

Days in the hospital must be certified if full plan benefits are to be available.

As soon as you or one of your dependents know confinement will be required, read the Comprehensive Medical Expense Coverage section of the Booklet for details on how to get the certification.

Non-Certification for Hospital Admissions Excluded Amount (Core Major Medical Plan only)	$ 500

The Benefits Payable

After any applicable deductible, the Health Expense Benefits payable under this Plan* in a calendar year are paid at the Payment Percentage which applies to the type of Covered Medical Expense which is incurred, except for any different benefit level which may be provided later in this Booklet.

If any expense is covered under one type of Covered Medical Expense, it cannot be covered under any other type.

* The term "this Plan" as used in this Booklet, means the Core Major Medical Plan or the Core Medicare Enrollee Plan, as applicable.

Deductible Amounts

Calendar Year Deductible

Core Major Medical Plan	$ 3,000 per person
Core Medicare Enrollee Plan	$ 300 per person

The Calendar Year Deductible applies to all Covered Medical Expenses except:

National Medical Excellence Travel and Lodging Expenses

Payment Percentage

100% up to plan maximums as to:

National Medical Excellence Travel and Lodging Expenses
(Core Major Medical Plan only)

80% up to plan maximums as to:

Hospital Expenses
Convalescent Facility Expenses
Home Health Care Expenses
Hospice Care Expenses
Routine Physical Exam Expenses
Short Term Rehabilitation Expenses
Spinal Disorder Treatment (including Chiropractic) Expenses
Acupuncture Expenses
Other Covered Medical Expenses for which a Payment Percentage is not otherwise shown (see your Booklet for details)

Payment Limit

This limit applies to all Covered Medical Expenses.

Payment Limit which Applies to Expenses for a Person (Core Major Medical Plan)
When a person's Covered Medical Expenses for which no benefits are paid because of the Payment Percentage (including expenses applied against the Calendar Year Deductible) reach $ 7,600 in a calendar year, benefits will be payable at 100% for all of his or her Covered Medical Expenses to which this limit applies and which are incurred in the rest of that calendar year.

Payment Limit which Applies to Expenses for a Person (Core Medicare Enrollee Plan)
When a person's Covered Medical Expenses for which no benefits are paid because of the Payment Percentage (including expenses applied against the Calendar Year Deductible) reach $ 2,260 in a calendar year, benefits will be payable at 100% for all of his or her Covered Medical Expenses to which this limit applies and which are incurred in the rest of that calendar year.

Benefit Maximums

(Read the coverage section in your Booklet for a complete description of the benefits available.)

Convalescent Facility Maximum Days	One-hundred twenty (120) per calendar year
Home Health Care Maximum Visits	One-hundred (100) per calendar year
Hospice Care	
Maximum Number of Inpatient Days	Thirty (30)
Outpatient Maximum	$ 5,000
Private Duty Nursing Care Maximum	$ 10,000 per calendar year
Acupuncture Expenses Maximum	$ 500 per calendar year

National Medical Excellence	
Lodging Expenses Maximum	$ 50.00 per night
Travel and Lodging Maximum	$ 10,000 per episode of care
Private Room Limit	The institution's semiprivate rate.
Lifetime Maximum Benefit (The Core Major Medical Plan and the Core Medicare Enrollee Plan have separate Lifetime Maximums)	
Core Major Medical Plan	$ 2,000,000
Core Medicare Enrollee Plan	$ 2,000,000

Pregnancy Coverage

Benefits are payable for pregnancy-related expenses of female employees and dependents on the same basis as for a disease.

In the event of an inpatient confinement, such benefits will be payable for inpatient care of the covered person and any newborn child for: a minimum of forty-eight (48) hours following a vaginal delivery; and a minimum of ninety-six (96) hours following a cesarean delivery. If a person is discharged earlier, benefits will be payable for two (2) post-delivery home visits by a health care provider.

Normally, the expenses must be incurred while the person is covered under this Plan. If expenses are incurred after the person's coverage ceases due to discontinuance of coverage as to your Eligible Class, they will be considered for benefits only if satisfactory evidence is furnished to Aetna that the person has been totally disabled since her coverage terminated.

Prior Plans: Any pregnancy benefits payable by previous group medical coverage will be subtracted from medical benefits payable for the same expenses under this Plan.

Sterilization Coverage

Health Expense Coverage: Benefits are payable for charges made in connection with any procedure performed for sterilization of a person, including voluntary sterilization, on the same basis as for a disease.

Adjustment Rule

If, for any reason, a person is entitled to a different amount of coverage, coverage will be adjusted as provided elsewhere in the plan document on file with your Employer.

Benefits for claims incurred after the date the adjustment becomes effective are payable in accordance with the revised plan provisions. In other words, there are no vested rights to benefits based upon provisions of this Plan in effect prior to the date of any adjustment.

General

This Summary of Coverage replaces any Summary of Coverage previously in effect under your plan of health benefits. Requests for coverage other than that to which you are entitled in accordance with this Summary of Coverage cannot be accepted.

KEEP THIS SUMMARY OF COVERAGE
WITH YOUR BOOKLET

Additional Information Provided by The University of California

The following information is not a part of your booklet. In furnishing this information, Aetna is acting on behalf of the University.

Additional Information Regarding Enrollment and Termination of Coverage

For information about enrolling yourself or an eligible Family Member, see the person at your location who handles benefits. If you are an Annuitant, contact the University's Customer Service Center. Enrollment transactions may be by paper form or electronic, according to current University practice. To complete the enrollment transaction, paper forms must be received by the local Accounting or Benefits office or by the University's Customer Service Center by the last business day within the applicable enrollment period; electronic transactions must be completed by midnight of the last day of the enrollment period.

If you are in an HMO and you move or are transferred out of that HMO's service area, or will be away from the HMO's service area for more than two months, you will have a PIE to enroll yourself and your eligible Family Members in another University medical plan. Your PIE starts with the effective date of the move or the date you leave the HMO's service area.

Change in Coverage

In order to change from individual to two-party coverage and from two-party to family coverage, or to add another Family Member to existing family coverage, contact the person who handles benefits at your location (or the University's Customer Service Center if you are an Annuitant).

Additional Information Regarding Effect of Medicare on Annuitant Enrollment

Annuitants and their Family Members who are eligible for premium free Medicare Part A, but decline to enroll in Part B of Medicare, will be assessed a monthly offset fee by the University to cover increased costs. Annuitants or Family Members who are not eligible for Part A will not be assessed an offset fee. A notarized affidavit attesting to their ineligibility for Medicare Part A will be required. Affidavits may be obtained from the University's Customer Service Center. (Annuitants/Family Members who are not entitled to Social Security and Medicare Part A will not be required to enroll in Part B.)

You should contact Social Security three months before your or your Family Member's 65th birthday to inquire about your eligibility and how you enroll in the Hospital (Part A) and Medical (Part B) portions of Medicare. If you qualify for disability income benefits from Social Security, contact a Social Security office for information about when you will be eligible for Medicare enrollment.

Upon Medicare eligibility, you or your Family Member must complete a University of California Medicare Declaration form. This notifies the University that you are covered by Part A and Part B of Medicare. The University's Medicare Declaration forms are available through the University's Customer Service Center. Completed forms should be returned to the Annuitant Insurance unit at Office of the President.

Optional Continuation of Coverage
If your coverage or that of a Family Member ends, you and/or your Family Member may be entitled to elect continued coverage under the terms of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended and if that continued coverage ends, specified individuals may be eligible for further continuation under California law. The terms of these continuation provisions are contained in the University of California notice "Continuation of Group Insurance Coverage", available from the UCbencom website (www.ucop.edu/bencom). The notice is also available from the person in your department who handles benefits and from the University's Customer Service Center. You may also direct questions about these provisions to your local Benefits Office or to the University's Customer Service Center if you are an Annuitant.

Plan Administration

By authority of The Regents, University of California Human Resources and Benefits, located in Oakland, California, administers the Plans in accordance with applicable plan documents and regulations, custodial agreements, University of California Group Insurance Regulations, group contracts/service agreements, 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. The terms of those documents apply if information in this document is not the same. The University of California Group Insurance Regulations will take precedence if there is a difference between its provisions and those of your booklet and/or the Administrative Services Agreement. All of the terms and conditions in your booklet, including but not limited to eligibility and enrollment requirements, must be met in order to be entitled to benefits. Particular rules and eligibility requirements must be met before benefits can be received. Health and welfare benefits are subject to legislative appropriation and are not accrued or vested benefit entitlements.

This section describes how the Plans are administered and what your rights are.

Sponsorship and Administration of the Plan
The University of California is the Plan sponsor and administrator for the Plans described in your booklet. If you have a question, you may direct it to:

University of California
Human Resources and Benefits
300 Lakeside Drive, 5th Floor
Oakland, CA 94612-3557
(800) 888-8267

Annuitants may also direct questions to the University's Customer Service Center at the above phone number.

Claims under the Plans are processed by Aetna Life Insurance Company at the following address and phone number:

Aetna U.S. Healthcare
P.O. Box 9220
Van Nuys, CA 91401-0220
800-632-0524

Administrative Services Agreement Number
The Administrative Services Agreement Number for the Plans is:
ASC-724665-11
ASC-724665-12

Type of Plans
The Plans are health and welfare plans that provides group medical care benefits. The Plans are part of the benefits offered under the University of California's employee health and welfare benefits program.

Plan Year
The plan year is January 1 through December 31.

Continuation of the Plans
The University of California intends to continue the Plans of benefits described in your booklet but reserves the right to terminate or amend them at any time. The Plans are not vested plans. The right to terminate or amend applies to all Employees, Annuitants and plan beneficiaries. The amendment or termination shall be carried out by the President or his or her delegates. The University of California will also determine the terms of the Plans, such as benefits, Plan Costs and what portion of the Plan Costs the University will pay. The portion of the Plan Costs the University pays is subject to state appropriation which may change or be discontinued in the future.

Financial Arrangements
The coverage described in your booklet is provided by the University of California on a self-funded basis under the University of California Employee Benefit Plan. Administrative Services are provided by Aetna Life Insurance Company under an Administrative Services Agreement between The Regents of the University of California and Aetna Life Insurance Company.

The cost of the coverage is currently paid entirely by the University of California.

The following applies to the benefits under the Plans. Any dollar amounts remaining in a participant's account will be forfeited to the Plans if the funds are not claimed within three years from the date of issue. If the participant has not accepted the distribution, corresponded in writing regarding the distribution or indicated an interest in the distribution within three years after it became distributable, the participant may make a claim to the Plans for reimbursement of the forfeited benefit.

Agent for Serving of Legal Process
Legal process may be served on the Plan Administrator or on any of the plan claims processors at the applicable address listed above.

Your Rights under the Plans
As a participant in a University of California medical plan, you are entitled to certain rights and protections. All Plan participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office, or instead of or in addition to, at other locations that may be specified by the Plan Administrator, all Plan documents, including the administrative services agreement.

Obtain copies of all Plan documents and other information for a reasonable charge upon written request to the Plan Administrator.

Claims under the Plans
Your booklet contains information on reporting claims. Claim forms may be obtained by calling Aetna Member Services at 1-800-632-0524. These forms tell you how and when to file a claim.

If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna Life Insurance Company. The notice will explain the reason for the denial and the review procedures.

You may request a review of the denied claim. The request must be submitted, in writing, within sixty (60) days after you receive the notice. Include your reasons for requesting the review.

Your claim denial will be reviewed and ordinarily you will be notified of the final decision within sixty (60) days of receipt of your request. If special circumstances require an extension of time, you will be notified of such extension during the sixty (60) days following receipt of your request.

Nondiscrimination Statement
In conformance with applicable law and University policy, the University of California is an affirmative action/equal opportunity employer.

Please send inquiries regarding the University's affirmative action and equal opportunity policies for staff to Director Mattie Williams and for faculty to Executive Director Sheila O'Rourke, both at this address: University of California Office of the President, 1111 Franklin Street, Oakland, CA 94607.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the forty-eight (48) hour or ninety-six (96) hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to forty-eight (48) hours or ninety-six (96) hours. However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

Notice regarding Women's Health and Cancer Rights Act

Under this health plan, coverage will be provided to a person who is receiving benefits for a medically necessary mastectomy and who elects breast reconstruction after the mastectomy, for:

(1) reconstruction of the breast on which a mastectomy has been performed;
(2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
(3) prostheses; and
(4) treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on the back of your ID card.