Your Group Plan

University of California
Supplement to Medicare Plan

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The Plan described in the following pages of this Booklet is a benefit plan 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 Plan as outlined in the Administrative Services Contract between Aetna and the Contractholder.

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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.

Comprehensive Medical Expense Coverage

This Plan covers certain medical expenses which are not covered under **Medicare**. It does not cover those expenses excluded by **Medicare** because you did not comply with **Medicare** requirements.

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.

In figuring benefits under this Plan, each person will be treated as having full coverage under **Medicare**. This includes its optional coverage.

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

Charges a **hospital** makes for inpatient **hospital** services and supplies it furnishes, to the extent that no benefit is payable by **Medicare** because of these **Medicare** features:

- The inpatient **hospital** deductible.
- The inpatient **hospital** coinsurance amount.

- Benefits for inpatient **hospital** services end because a person has received them for the maximum period during a **benefit period**.
- Benefits for inpatient psychiatric **hospital** services end because a person has received them for the maximum period.

Under the last 2 items above, not included is any **charge** for **daily board and room** in a private room over the Private Room Limit.

Skilled Nursing Facility Expenses

Charges a **skilled nursing facility** makes for services and supplies, to the extent that no benefit is payable by **Medicare** because of these **Medicare** features:

- The post-**hospital** extended care coinsurance amount.
- The termination of benefits for post-**hospital** extended care services because a person has received them for the maximum period during a **benefit period**.

Any of these charges incurred after a person has been in a **skilled nursing facility** for the Maximum Number of Days during any one (1) **benefit period** are not included as a Covered Medical Expense.

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

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 Expenses Maximum will be paid for Covered Medical Expenses incurred for acupuncture services rendered to a person in a calendar year.

Immunization Expenses

Charges made by a **physician** for materials and the administration of routine and necessary immunizations are included as Covered Medical Expenses even though not incurred in connection with the treatment of a disease or injury, but only;

as to immunization charges which are covered under **Medicare**, those which are not payable by **Medicare** because of the deductible and coinsurance provisions of **Medicare;** or

as to all other immunization charges, to the extent no benefit is provided under **Medicare**.

Not included are charges made by a **physican** for an office visit for such administration.

Spinal Disorder Treatment (including Chiropractic Services)

Charges made by a **physician** for **spinal disorder treatment** are included as Covered Medical Expenses, but only;

as to charges which are covered under **Medicare**, those which are not payable by **Medicare** because of the deductible and coinsurance provisions of **Medicare;** or

as to all other charges, to the extent no benefit is provided under **Medicare** because the person has received benefits for the maximum number of visits covered under **Medicare**.

Other Medical Expenses

Charges for the following if they have not already been included as Covered Medical Expenses:

- Charges made by a **R.N**. or **L.P.N**. or a nursing agency for skilled nursing care to the extent that no benefit is provided for that care under **Medicare**.

  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 drugs and medicines which by law need a physician's prescription, to the extent that no benefits are provided under **Medicare**, including oral contraceptives, Norplant and diaphragms. Oral contraceptives are covered whether or not medically necessary.

- Charges made by a **physician** for services, but only to the extent that no benefits are payable under **Medicare** because of the deductible and coinsurance provisions of **Medicare**.
- Charges made by a **hospital** for outpatient services and supplies which are not payable by **Medicare** because of the deductible and coinsurance provisions of **Medicare**.
- Charges for **durable medical and surgical equipment** which are not payable by **Medicare** because of the deductible and coinsurance provisions of **Medicare**; or they are not considered covered services under **Medicare**.
- Charges for **hospice care** which are considered covered charges under **Medicare**, but for which no benefit is payable by **Medicare**.
- Charges for **home health care** which are considered covered charges under **Medicare**, but for which no benefit is payable by **Medicare**.
- Charges for 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, which are not payable by **Medicare** because of the deductible and coinsurance provisions of **Medicare**.
- Charges for the first three (3) pints of blood each time you receive blood.
- X-ray and lab charges to the extent no benefit is payable by **Medicare** because of the deductible and coinsurance provisions of **Medicare**.
- Charges made for routine screenings for cancer to the extent no benefit is payable by **Medicare** because of the deductible and coinsurance provisions of **Medicare**.
- Charges made for physical, occupational and speech therapy, to the extent that no benefits are payable under **Medicare** because of the deductible and coinsurance provisions of **Medicare**.

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

Treatment of Alcoholism, Drug Abuse or Mental Disorders

With the exception of the outpatient treatment of mental disorders described below, Covered Medical Expenses incurred for the treatment of alcoholism, drug abuse and mental disorders will be paid the same as charges incurred for the treatment of any other disease.

Outpatient Treatment of Mental Disorders

Expenses for the treatment of a **mental disorder** while a person is not a full-time inpatient in a **hospital** are Covered Medical Expenses. Benefits will not be payable for more than the maximum visits in any one (1) calendar year.

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.
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, except to the extent coverage for such procedures is specifically provided in your Booklet.
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 Dental work, surgery, and other 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; if such treatment is given more than twelve (12) months after the accident which causes the injury.
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.

    Comply with any applicable state or federal law (including the Women's Health and Cancer Rights Act).

    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) Services and supplies not covered by Medicare due to 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.

If **Medicare** is amended so as to increase liability under this Plan, the benefits of this Plan will be limited to those that would have been payable without the amendment unless otherwise agreed to by Plan.

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 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 insurance with benefits related to **Medicare** 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 this Plan will be in exchange for all privileges and benefits provided under any similar prior coverage. Any benefits provided under such prior coverage may reduce benefits payable under this Plan.

If any part of a person's Deductible under prior Aetna High Option Plan coverage has been applied against covered expenses, incurred by the person during the year in which he becomes covered under this Plan, that person's Deductible, if any, under this Plan for the year he becomes covered will be reduced by the same amount.

If benefits have been paid or accrued under a person's prior Aetna High Option Plan coverage, his or her Lifetime Maximum Benefit under this Plan will be reduced by the same amount.

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 benefits for persons eligible for **Medicare** terminate under the group contract.
- When you fail to make any required contribution.

Dependent Coverage Only

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

- Any of the events described in the termination section of the separate insert (Amendment 1).
- When all dependents coverage under the plan terminates.
- When a dependent becomes covered as an employee or annuitant.
- When coverage for the annuitant terminates, except if the annuitant ceases to be eligible for **Medicare**.

Health Expense Benefits After Termination

If a person is totally disabled when his or her Health Expense Coverage ceases due to discontinuance of the Plan, 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 a person 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 Plan, 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.)

Type of Coverage

Coverage under this Plan 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 this Plan. 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 this Plan because you are connected with more than one Employer.
- In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

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

Your Employer hopes to continue this Plan indefinitely but, as with all group plans, this Plan 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 this Plan for expenses incurred by a covered person due to injury or illness for which a third party may be liable:

- The Plan shall, to the extent of benefits it has paid, be subrogated to (has 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 Plan 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, this Plan has 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 this Plan 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, this Plan has 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.

This Plan 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.

Benefit Period

This means a period by which **Medicare** measures your use of services under **Medicare** hospital insurance.

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.

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 equipment that meets the definition of durable medical and surgical equipment under **Medicare**.

Durable Medical and Surgical Equipment

This means no more than one 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 persons 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.

This definition applies only to charges which are not considered covered expenses under **Medicare**.

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.

Employer

This means the University of California.

Home Health Care

This means home health care that meets the definition of home health care under **Medicare**.

Hospice Care

This means hospice care that meets the definition of hospice care under **Medicare**.

Hospital

This is a place that:

- meets the definition of hospital under **Medicare**; and
- participates under **Medicare**.

L.P.N.

This means a licensed practical nurse.

Medicare

This is the Health Insurance portion of the Social Security Act of the United States.

Mental Disorder

This is a disease that meets the definition of mental disorder under **Medicare**.

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 health care 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 speciality 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, a mental health 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.

Physician

This means only a person who meets the definition of physician under **Medicare**.

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.

R.N.

This means a registered nurse.

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.

Skilled Nursing Facility

This is a facility participating under **Medicare** as a Skilled Nursing Facility.

Spinal Disorder Treatment

This is:

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

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

Index

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 Supplement to Medicare 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 this Plan. Anyone enrolled in a non-University Medicare + Choice Managed Care contract is not eligible for this plan.

You and/or your Family Members are eligible if you are an Annuitant and the prospective plan member is enrolled in premium free Medicare Part A (Hospital Insurance) and in Medicare Part B (Medical Insurance).

Subscriber 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.

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 Plan reserves 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 enrolled Annuitant 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.

Please contact the University of California's Customer Service Center for information on enrolling any eligible children in the High Option Plan.

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 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.

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 new spouse becomes eligible on the date of marriage. Survivor Annuitants may not add spouses to their coverage.

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) Your spouse dies.

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

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

(e) 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.

Please contact the University of California's Customer Service Center for information on enrolling any eligible children in the High Option Plan.

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 the University of California's Customer Service Center 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

In the following circumstances, the effective date of coverage under this Plan will be determined by the University upon receipt and approval of your Medicare Declaration form.

- Coverage Under the Supplement to Medicare Plan for Annuitants Enrolling in Conjunction with Retirement
  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.

- Coverage Under the Supplement to Medicare Plan for Annuitants or Family Members Becoming Eligible for Medicare after Retirement
  Coverage will be transferred from the High Option plan for non-Medicare enrollees to the Supplement to Medicare plan for Medicare enrollees. Upon receipt by the University of confirmation of Medicare enrollment, the Annuitant/Family Member will be changed from the High Option plan to the Supplement to Medicare plan.

In the following circumstances, the effective dates apply provided the appropriate enrollment transaction (paper 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.

- 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 this 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 this Plan 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 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 the University of California's Customer Service Center.

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 Plan, 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.

BENEFITS OUTSIDE THE UNITED STATES AND ITS TERRITORIES

During a temporary absence of less than 6 months, you will receive the same benefits that Employees, Annuitants and Family Members who are not covered by Medicare receive under the High Option plan. If your absence is for more than six months, you are required to transfer from the Supplement to Medicare plan to the High Option plan. Contact the University of California's Customer Service Center for details.

Medicare benefits are limited to emergency care if traveling in Canada between Alaska and another continental State, or for certain United States residents in certain border states.

Medicare handbooks are available from any Social Security Office.

Issue Date: August 23, 2000

Supplement to Medicare Plan

Summary of Coverage

For: The University of California

ASC: 724665

SOC: 3A

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

Deductible Amounts

Calendar Year Deductible $ 50 per person*

* Does not apply to expenses which are considered covered services under Medicare Part A or Part B

Expenses not payable by Medicare because of the Part A (Hospital) and Part B (Medical) deductibles are covered expenses under this Plan.

Payment Percentage

100% as to expenses covered by Medicare, but not paid by Medicare because of the coinsurance and deductible provisions of Medicare

80% (after the calendar year deductible) as to Covered Medical Expenses not considered covered services under Medicare, including the following types of expenses:

Hospital expenses for inpatient services and supplies (including inpatient psychiatric services) in excess of the maximum benefit period allowed by Medicare
Acupuncture Expenses
Immunization Expenses not considered covered services under Medicare
Spinal Disorder Treatment (Chiropractic Services) in excess of the maximum visits covered under Medicare
Charges incurred for cosmetic surgery which are not considered covered services under Medicare, subject to the limitations described in the General Exclusions section of your Booklet
Charges incurred for the following described in the Other Medical Expenses section of your Booklet:

Skilled Nursing Care (including Private Duty Nursing)
Prescription drugs and medicines
Durable medical and surgical equipment not considered covered services under Medicare
Blood (the first 3 pints each time you receive blood)

Payment Limit

This limit applies to all Covered Medical Expenses which are payable at 80% after the Calendar Year Deductible, except those incurred for inpatient treatment of mental disorders.

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 $ 1,050 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.

Maximums

Skilled Nursing Facility Maximum Number of Days	The first one-hundred thirty (130) days of confinement during a **benefit period**
Private Duty Nursing Care Maximum	$ 10,000 per calendar year
Acupuncture Expenses Maximum	$ 500 per calendar year
Outpatient Treatment of Mental Disorders Maximum Visits	10 per calendar year
Private Room Limit	The institution's semiprivate rate.
Lifetime Maximum Benefit (for expenses not paid under Medicare Part A or B)	$ 1,000,000

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, contact the University of California'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 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 University's Customer Service Center.

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.) Individuals who are not enrolled in both Parts A and B of Medicare are not eligible for this plan.

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 the University's Customer Service Center.

Plan Administration

By authority of The Regents, University of California Human Resources and Benefits, located in Oakland, California, administers this plan 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 Plan is administered and what your rights are.

Sponsorship and Administration of the Plan

The University of California is the Plan sponsor and administrator for the Plan 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 Plan 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 this Plan is:
ASC-724665

Type of Plan
This Plan is a health and welfare plan that provides group medical care benefits. This Plan is one 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 Plan
The University of California intends to continue the Plan of benefits described in your booklet but reserves the right to terminate or amend it at any time. The plan is not a vested plan. 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 Plan, 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 shared between you and the University of California.

The following applies to the benefits under the Plan. Any dollar amounts remaining in a participant's account will be forfeited to the Plan 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 Plan 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 Plan
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 Plan
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.