University of California

UC Care
Out-of-Area

Effective January 1, 2001

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Your Group Coverage Plan

This Plan is underwritten by the Aetna Life Insurance Company, of Hartford, Connecticut (called Aetna). The benefits and main points of the group contract for persons covered under this Plan are set forth in this Booklet. They are effective only while you are covered under the group contract.

If you become covered, this Booklet will become your Certificate of Coverage. It replaces and supersedes all Certificates issued to you by Aetna under the group contract.

John W. Rowe
Chairman, President and Chief Executive Officer

Cert. Base: 1
Issue Date: October 1, 2001
Effective Date: January 1, 2001

This is an electronic version of the Booklet on file with your Employer and Aetna Life Insurance Company, Hartford, CT. In case of a discrepancy between this electronic version and the group insurance contract issued by Aetna Life Insurance Company, or in case of any legal action, the terms set forth by such group insurance contract will prevail. To obtain a printed copy of this Booklet, please contact your Employer.

Health Expense Coverage

Health Expense Coverage is expense-incurred coverage only and not coverage for the disease or injury itself. This means that Aetna 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.

Prescription Drug Expense Coverage

Prescription Drug Expense Coverage is merely a name for the benefits in this section. It does not provide benefits covering expenses incurred for all **prescription drugs**. There are exclusions, copayment features, and, if applicable to this Plan, deductible and maximum benefit features. They are described in the Booklet-Certificate.

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

Covered Prescription Drug Expenses

This Plan pays the benefits shown below for certain **prescription drug** expenses incurred for the treatment of a disease or injury. These benefits apply separately to each covered person.

If a **prescription drug** is dispensed by a **pharmacy** to a person for treatment of a disease or injury, a benefit will be paid, determined from the Benefit Amount subsection, but only if the **pharmacy's** charge for the drug is more than the **copay** per **prescription** or refill.

A benefit will be paid at the preferred level of coverage for a **prescription drug** dispensed by a **non-preferred pharmacy** for an **emergency condition**.

Benefit amounts provided under this section will not be subject to any provision under this Plan for coordination of benefits with other plans, except the provision for coordinating benefits under this Plan with any Medicare benefits.

Benefit Amount

The benefit amount for each covered **prescription drug** or refill dispensed by a **preferred pharmacy** will be an amount equal to the Payment Percentage of the total charges. The total charge is determined by:

- the **preferred pharmacy**; and
- Aetna.

Any amount so determined will be paid to the **preferred pharmacy** on your behalf.

In figuring the benefit amount, a Separate Brand Name Fee applies to **brand name drugs** dispensed by a **pharmacy** that is not a **mail order pharmacy** in addition to any applicable generic drug **copay**. The amount of the Separate Brand Name Fee will be equal to the difference between the cost of the **brand name drug** and the generic equivalent. The Separate Brand Name Fee will apply to any **brand name drug** dispensed unless:

- there is no generic equivalent to the **brand name drug**;
- the **pharmacy** is unable to supply the **generic drug** at the time the **prescription** is presented; or
- the **prescriber** indicates that the **generic drug** should not be dispensed.

The Benefit Amount for each covered **prescription drug** or refill dispensed by a **non-preferred pharmacy** will be an amount equal to the Payment Percentage of the **non-preferred pharmacy's** charge for the drug except for an **emergency condition**, in which case the benefit will be payable at the preferred level of coverage.

Explanation of Some Important Plan Provisions

Calendar Year Deductible

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

Family Deductible Limit

If Covered Prescription Drug Expenses incurred in a calendar year by you and your dependents and applied against the separate Calendar Year Deductibles equal the Family Deductible Limit, you and your dependents will be considered to have met the separate Calendar Year Deductibles for the rest of that calendar year.

Limitations

No benefits are paid under this section:

- For a device of any type unless specifically included as a **prescription drug**.
- For any drug entirely consumed at the time and place it is prescribed.
- For less than a thirty (30) day supply of any drug dispensed by a **mail order pharmacy**.
- For more than a thirty (30) day supply per **prescription** or refill. However, this limitation does not apply to a supply of up to ninety (90) days per **prescription** or refill for drugs which are provided by a **mail order pharmacy**.
- For the administration or injection of any drug.

- For the following injectable drugs: fertility drugs, allergy sera or extracts, and Imitrex, if it is more than the forty-eighth (48^{th}) such kit or ninety-sixth (96^{th}) such vial dispensed to the person in any year.
- For any refill of a drug that is more than the number of refills specified by the **prescriber**. Before recognizing charges, Aetna may require a new **prescription** or evidence as to need:

  if the **prescriber** has not specified the number of refills; or

  if the frequency or number of **prescriptions** or refills appears excessive under accepted medical practice standards.
- For any refill of a drug dispensed more than one (1) year after the latest **prescription** for it or as permitted by the law of the jurisdiction in which the drug is dispensed.
- For any drug provided by or while the person is an inpatient in any health care facility; or for any drug provided on an outpatient basis in any health care facility to the extent benefits are paid for it under any other part of this Plan or under any other medical or **prescription drug** expense benefit plan carried or sponsored by your Employer.
- For immunization agents.
- For biological sera and blood products.
- For nutritional supplements.
- For any fertility drugs.
- For more than four (4) unit doses per thirty (30) day supply for the following drugs used for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy:

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

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

  This limitation applies whether or not the **prescription drug** is delivered in oral, injectable, or topical (including, but not limited to, gels, creams, ointments, and patches) forms. If the drug is not taken orally, the dosage covered will be determined by Aetna based on the comparable cost for a thirty (30) day supply of pills.
- For more than a ninety (90) day supply of any smoking cessation aids or drugs in a person's lifetime.
- For a **prescription drug** dispensed by a **mail order pharmacy** that is not a **preferred pharmacy**.

Certification For Certain Prescription Drugs

Certification of the necessity of certain **prescription drugs** is required before the drug is dispensed by a **pharmacy**.

When one of the **prescription drugs** shown below is dispensed, expenses incurred will be payable as follows:

- If certification has been requested and the drug is **necessary**:

  Benefits will be payable at the applicable Payment Percentage.

- If certification has not been requested and the drug is **necessary**:

  No benefits will be payable.

- If the drug is not **necessary**:

  No benefits will be payable whether or not certification has been requested.

Certification Procedures

It is your responsibility to arrange for the **prescriber** of the drug to call the number shown on your ID card to request certification. This call must be made as soon as reasonably possible before the drug is to be dispensed. Copies of laboratory and/or medical records may be requested. If such information is requested, it must be provided in order to certify the necessity of the drug.

Written notice of the certification decision will be sent promptly to you. This notice will show:

- the approved period of certification, during which time any authorized refills of the drug may be dispensed; or
- when certification is denied, the procedure to follow if you choose to appeal the decision.

If the drug is to be dispensed after the certification period ends, certification must again be requested, as described above.

List of Prescription Drugs

The following **prescription drugs** require certification before the drug is dispensed:

- Accutane.
- Anorexiants.
- Avita (for persons over age 36 only).
- Avonex.
- Betaseron.
- Depo-Provera.
- Diflucan.
- Growth Hormones.
- Lamisil.
- Lupron Depot.
- Retin-A (for persons over age 36 only).
- Sporanox.

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-Certificate.

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.
- 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 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**.

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 Lifetime Maximum will be paid for all Hospice Care Expenses.

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.

Preventive Health Care Services Expenses

The charges below are included as Covered Medical Expenses even though they are not incurred in connection with an injury or disease. They are included only for a dependent child under seventeen (17) years of age.

Preventive Health Care Services Expenses: These are the charges incurred for Preventive Health Care Services.

Preventive Health Care Services: These are services provided for a routine physical exam of the child. Included are:

- A review and written record of the child's complete medical history.
- Taking measurements and blood pressure.
- Developmental and behavioral assessment.
- Vision and hearing screening.
- Other diagnostic screening tests including one (1) series of hereditary and metabolic tests performed at birth; and urinalysis, tuberculin test, and blood tests such as hematocrit and hemoglobin tests.
- Immunizations for infectious disease.
- Counseling and guidance of the child and the child's parents or guardian on the results of the physical exam.

Covered Medical Expenses will only include charges incurred for:

- The first nine (9) exams performed during the first three (3) years of the child's life.
- One (1) exam performed during each year of life from age three (3) through age sixteen (16).

Not covered are charges incurred:

- for services which are covered to any extent under any other part of this Plan or any other group plan sponsored by your employer;
- for services which are for diagnosis or treatment of a suspected or identified injury or disease;
- for services not performed by a **physician** or under his direct supervision;
- for medicines, drugs, appliances, equipment or supplies;
- for dental exams;
- for exams related in any way to employment;
- for pre-marital exams.

Routine Physical Exams

The charges made by a **physician** for a routine physical exam given to you, your spouse, or your dependent child age 17 and older 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 exams given to your dependent child age seventeen (17) 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.

Routine Hearing Care Expenses

Covered Medical Expenses include charges for the following hearing care services and supplies:

Charges for an audiometric exam performed by

a **physician** certified as an otolaryngologist or otologist; or

an audiologist who either:

is legally qualified in audiology; or

holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any applicable licensing requirements; and

who performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

Charges for an electronic hearing aid installed in accordance with a prescription written during such exam. If an eyeglass type hearing aid is installed, Covered Medical Expenses will not exceed the reasonable charge for a conventional hearing aid of similar capability.

Benefits will not be payable for a person during any one period of thirty-six (36) consecutive months for more than one (1) hearing aid per ear and more than the Hearing Aid Maximum.

Also not covered are charges for:

- any ear or hearing exam to diagnose or treat a disease or injury;
- any medical or surgical treatment, or for drugs or medicines;
- any hearing care service or supply which is a covered expense in whole or in part under any other part of this Plan or under any other plan of group benefits provided through your Employer;
- any hearing care service or supply for which a benefit is provided under any workers' compensation law or any other law of like purpose, whether benefits are payable as to all or only part of the charges;

- any hearing care service or supply which does not meet professionally accepted standards;
- any service or supply received while the person is not covered (except as provided below), or charges for hearing aids which are furnished or ordered as a result of a hearing exam which occurred prior to the date the person became covered;
- any hearing exam given while the person is confined in a **hospital** or other facility for medical care;
- any hearing exam required as a condition of employment, or which an employer is required to provide under a labor agreement or is required by any law of a government, or
- batteries, for replacement of lost, stolen or broken hearing aids, for replacement parts and repairs for hearing aids and for replacement of any hearing aid that was installed within the preceding thirty-six (36) month period.

Benefits After Termination of Coverage

This section applies to a person whose coverage ceases while not "totally disabled". This term is defined in the General Information About Your Coverage section.

Expenses incurred after the person's coverage ceases under this benefit section will be deemed to be covered if

the prescription for the hearing aid was written; and

the hearing aid was ordered;

during the thirty (30) days before the date the person's coverage ended.

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 Covered 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 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 shifts in excess of the Private Duty Nursing Care Maximum Shifts. Each period of private duty nursing of up to eight (8) hours will be deemed to be one (1) private duty nursing shift.

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 and for which no coverage is provided under the Prescription Drug Expense Coverage, 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 charges for:

eyeglasses;

vision aids;

communication aids; and

orthopedic shoes, foot orthotics, or other devices to support the feet, unless **necessary** to prevent complications of diabetes.*

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

National Medical Excellence Program ® (NME)

If a person is an **NME Patient**, this Plan will pay a benefit for Travel Expenses and Lodging Expenses but only to the extent described below and only if charges incurred for the NME Procedures and Treatment Types are Covered Medical Expenses.

NME Procedure and Treatment Types

Heart transplant	Heart/lung transplant
Lung transplant	Kidney transplant
Liver transplant	Pancreas transplant
Bone marrow transplant	Kidney/pancreas transplant

Travel Expenses

These are expenses incurred by an **NME Patient**, and approved in advance by Aetna, for transportation between his or her home and the facility to receive services in connection with any listed procedure or treatment.

Also included are expenses incurred by a **Companion**, and approved in advance by Aetna, for transportation when traveling with an **NME Patient** between the **NME Patient's** home and the facility to receive such services.

Lodging Expenses
These are expenses incurred by an **NME Patient**, and approved in advance by Aetna, for lodging away from home:

- while traveling between his or her home and the facility to receive services in connection with any listed procedure or treatment; or
- to receive outpatient services from the facility in connection with any listed procedure or treatment.

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

Also included are expenses incurred by a **Companion**, and approved in advance by Aetna, for lodging away from home:

- while traveling with an **NME Patient** between the **NME Patient's** home and the 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 on an inpatient or outpatient basis.

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

For the purpose of determining Travel Expenses or Lodging Expenses, a **hospital** or other temporary residence from which an **NME Patient** travels in order to begin a period of treatment at the NME facility, or to which he or she travels 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.

Healthy Outlook Program

This is a disease management program for covered persons with one or more of the following chronic conditions:

- asthma;
- congestive heart failure;
- coronary artery disease;
- diabetes; and
- low back pain.

A "participant" in this program is a covered person:

- who has identified himself or herself; or
- who has been identified by:

  his or her attending physician or other health care provider; or

  Aetna; and
- who is approved by Aetna as a participant.

Any visit or day calendar year maximum, or visit or day lifetime maximum under this Plan will not be reduced. However, any dollar calendar year maximum or dollar lifetime maximum under this Plan will be reduced. Any applicable deductible will be waived.

All such Covered Medical Expenses will reduce the overall Lifetime Maximum Benefit under this Plan.

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.

Family Deductible Limit

If Covered Medical Expenses incurred in a calendar year by you and your dependents and applied against the separate Calendar Year Deductibles equal the Family Deductible Limit, you and your dependents will be considered to have met the separate Calendar Year Deductibles for the rest of that calendar year.

Hospital Emergency Room Deductible

A separate Hospital Emergency Room Deductible applies to each visit by a person in a **hospital** emergency room unless the person is admitted to the **hospital** as an inpatient within twenty-four (24) hours after a visit to a **hospital** emergency room.

Lifetime Maximum Benefit

This is the most that will be payable for any person in his or her lifetime. It will be restored automatically each January 1 by the amount then charged against it. Not more than the Restoration Amount will be restored. It will not provide benefits for Covered Medical Expenses incurred before the date the Lifetime Maximum Benefit is restored.

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 for a routine mammogram; 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;

- for an annual occult blood test; and
- for any other routine cancer screening test recommended by the American Cancer Society.

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 **hospital** 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 in the calendar year of the accident or the next one.

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

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) To the extent allowed by the law of the jurisdiction where the group contract is delivered, 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, special education, or job training whether or not given in a facility that also provides medical or psychiatric treatment.
15) Those for therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
16) Those for or related to sex change surgery or to any treatment of gender identity disorders.
17) Those for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures.
18) 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-Certificate.
19) Those for or in connection with marriage, family, child, career, social adjustment, pastoral, or financial counseling.
20) 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.

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21) Those for treatment of alcoholism, drug abuse or a mental disorder. This exclusion does not apply to charges for drugs or medicines prescribed by a **physician** for such treatment, to the extent that benefits for such drugs or medicines would otherwise be payable under this Plan, nor does it apply to charges made for the treatment of the medical complications of alcoholism or drug abuse.

22) 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. Surgery must be performed in the calendar year of the accident which causes the injury, or in the next calendar year.

23) Those to the extent they are not **recognized charges**, as determined by Aetna; except that this will not apply if the charge for a service or supply does not exceed the **recognized charge** for that service or supply by more than $10.

24) Those for the reversal of a sterilization procedure.

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 group policy anniversary date after 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 Rider 1 for Medicare enrollment requirements.

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

- All health expenses covered under this Plan will be reduced by any Medicare benefits available for those expenses. This will be done before the health benefits of this Plan are figured.
- 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. Allowable Expenses will be reduced by any Medicare benefits available for those expenses.

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 amendment (Rider 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 amendment (Rider 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 amendment (Rider 1) for details.

The separate amendment (Rider 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 Rider 1; and
- subject to any limits shown in Rider 1.

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

In figuring when employment will stop for the purposes of termination of any coverage, Aetna will rely upon your Employer to notify Aetna. This can be done by telling Aetna or by stopping premium payments.

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 amendment (Rider 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.

Continuation of Coverage After COBRA Ceases

The terms of this Continuation of Coverage after COBRA Ceases apply to you and your spouse.

If you or you and your spouse:

- continued Health Expense Coverage under this Plan in accordance with COBRA for the maximum period for which such continuation is available; and
- you were sixty (60) years of age or over with five (5) continuous years of service with an Employer participating in this Plan when you terminated employment;

you may, prior to the date coverage under COBRA terminates, elect to further continue the same Health Expense Coverage for you and your spouse, or for you only or for your spouse only. If you die during the period in which you can elect this further continuation, your spouse who was covered under COBRA for the maximum period may elect to further continue coverage provided such election is made during the period in which you could elect the further continuation. The election must include an agreement to pay contributions. The contributions may be up to two-hundred thirteen (213)% of the cost to the Plan. Premium payments must be continued.

Coverage for a person will not be continued beyond the first to occur of:

- The date the person becomes covered for like coverage under any group plan.
- Failure to make any required contributions.
- The date Health Expense Coverage discontinues, and is not replaced, as to employees of the Eligible Class of which you were a member.
- The date you attain age sixty-five (65).
- As to any spouse, the date the spouse attains age sixty-five (65).
- As to any spouse, five (5) years from the date you terminated employment with an Employer participating in this Plan.

The Conversion Privilege will be available when coverage is no longer available under this section.

Health Expense Benefits After Termination

If a person is totally disabled when his or her Health Expense Coverage ceases due to discontinuance of the group contract as to the coverage, 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 group contract as to the coverage, 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

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 for any reason except ceasing to contribute or discontinuance of Medical Expense Coverage when succeeding group coverage is available within sixty (60) days of discontinuance.

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 terminates

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 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 insured 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.

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 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 Aetna's expense.

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.

Employee Statements

No statement by you, except a fraudulent statement, will be used in defense to a claim for loss incurred after the coverage under which claim is made has been in effect for two (2) years nor unless such statement is contained in a written application. This paragraph shall not operate so as to increase or reduce any coverage under this Plan.

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 group contract. 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 or, if you prefer, from the Home Office of Aetna.

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

Assignments

Coverage may be assigned only with the consent of Aetna.

Recovery of Benefits

If a person suffers a loss or an injury caused by the act or omission of a third party, the Health Expense Benefits in this Plan for such loss or injury will be paid only if that person, or his or her legally authorized representative, agrees in writing:

- To pay Aetna up to the amount of the benefits received under this Plan subject to applicable law if damages are collected. Damages may be collected by: action at law; settlement; or otherwise.
- To provide Aetna a lien in the amount of the benefit paid. This lien may be filed with: the third party; his or her agent; or a court which has jurisdiction in the matter.

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, Aetna 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 Aetna 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.

Notice of Claim-Claim Forms

Written notice of claim must be furnished to Aetna. This must be done within twenty (20) days after any loss covered by the group contract occurs, or as soon after that as is possible. Notice given, at Aetna's Home Office or to one of its agents, by or for a person making claim shall be deemed to be notice of claim, as long as the facts are clear enough to identify you.

Aetna will furnish the person making claim with claim forms within fifteen (15) days of the notice of claim. If forms are not furnished, written proof of loss must still be furnished as set forth in the next section.

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, Aetna 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.

Any unpaid balance will be paid within thirty (30) days of receipt by Aetna of the due written proof.

Aetna 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.

Contract Not A Substitute For Workers' Compensation Insurance

The group contract is not in lieu of and does not affect workers' compensation benefits.

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.

Brand Name Drug

A **prescription drug** which is protected by trademark registration

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.

Copay

This is a fee, charged to a person, which represents a portion of the applicable expense.

As to a **prescription drug** dispensed by a **preferred pharmacy**, this is the fee charged to a person at the time the **prescription drug** is dispensed payable directly to the **pharmacy** for each **prescription** or refill at the time the **prescription** or refill is dispensed.For drugs dispensed as packaged kits, the fee applies to each kit at the time it is dispensed. In no event will the copay be greater than the **prescription**, kit, or refill.

As to a **prescription drug** dispensed by a **non-preferred pharmacy**, this is the amount by which the total charge for the **prescription drug** is reduced before benefits are payable.

It is specified in the Summary of Coverage.

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, to the extent required by law a practitioner who performs a service for which coverage is provided when it is performed by a dentist.

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.

Generic Drug

A **prescription drug** which is not protected by trademark registration, but is produced and sold under the chemical formulation name.

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.

Mail Order Pharmacy

An establishment where **prescription drugs** are legally dispensed by mail.

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, 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.

Non-Preferred Pharmacy

A **pharmacy** which is not party to a contract with Aetna, or a **pharmacy** which is party to such a contract but does not dispense **prescription drugs** in accordance with its terms.

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.

Pharmacy

An establishment where **prescription drugs** are legally dispensed.

Physician

A legally qualified physician. Also, to the extent required by law, a practitioner who performs a service for which coverage is provided when it is performed by a physician.

Preferred Care Provider

This is a health care provider that has contracted to furnish services or supplies for a **Negotiated Charge**; but only if the provider is, with Aetna's consent, included in the **Directory** as a Preferred Care Provider for:

- the service or supply involved; and
- the class of employees of which you are member.

Preferred Pharmacy

A **pharmacy,** including a **mail order pharmacy**, which is party to a contract with Aetna to dispense drugs to persons covered under this Plan, but only:

- while the contract remains in effect; and
- while such a **pharmacy** dispenses a **prescription drug** under the terms of its contract with Aetna.

Prescriber

Any person, while acting within the scope of his or her license, who has the legal authority to write an order for a **prescription drug**.

Prescription

An order of a **prescriber** for a **prescription drug**. If it is an oral order, it must promptly be put in writing by the **pharmacy**.

Prescription Drugs

Any of the following:

- A drug, biological, or compounded **prescription** which, by Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription".
- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include insulin.
- Disposable needles and syringes which are purchased to administer a covered injectable **prescription drug**.
- Disposable diabetic supplies.

R.N.

This means a registered nurse.

Recognized Charge

Only that part of a charge which is recognized is covered. The recognized 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 Recognized Charge Percentage made for that service or supply.

The Recognized Charge Percentage is the charge determined by Aetna on a semiannual basis to be in the 90th percentile of the charges made for a service or supply by providers in the geographic area where it is furnished.

In some circumstances, Aetna may have an agreement, either directly or indirectly through a third party, with a provider which sets the rate that Aetna will pay for a service or supply. In these instances, in spite of the methodology described above, the recognized charge is the rate established in such agreement.

In determining the recognized 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 recognized 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.

Privacy Notice

The information in this Notice is not a part of either the group contract, your Certificate of Coverage or the Booklet. It is important to you as a covered person under the group contract. We have bound it into this document only as an aid to you in keeping insurance related material together.

This Notice describes certain aspects of Aetna U.S. Healthcare's insurance privacy policy which apply to you as a covered person in a plan of group insurance insured by Aetna. The policy does not apply where a different approach is required by law.

Information Which May be Collected

Aetna, in providing insurance services to you, relies mainly on the information you give on your group enrollment form and when you file claims.

Aetna may also collect information about you from other sources. This is information necessary for Aetna to perform its function with regard to the insurance transaction in question. For example, if the amount or type of coverage you are entitled to depends on your earnings or job class, Aetna would obtain that information from your Employer.

Disclosure of Information To Others

All of this information will be treated as confidential. It will not be disclosed to others without your authorization, except in some instances where such disclosure is necessary for the conduct of Aetna's business. Disclosure cannot be contrary to any law which applies.

The following sets forth the types of disclosure that may be made:

- Financial information (but not medical information) may be made available to your Employer or his or her representative in connection with the administration of the Plan. Information may also be made available in connection with policyholder audits.
- Information may be disclosed to other insurers if there may be duplicate coverage or a need to preserve the continuity of your coverage.
- Information may be disclosed to Peer Review Organizations and other agencies to determine whether health services were necessary and reasonably priced.

In addition, information may be given to regulators of Aetna's business and to others as may be required by law. It may also be given to law enforcement authorities when needed to prevent or prosecute fraud or other illegal activities.

Your Right of Access and Correction

In general, you have a right to learn the nature and substance of any information Aetna has in its files about you. You may also have a right of access to such files, except information which relates to a claim or a civil or criminal proceeding, and to ask for correction, amendment, or deletion of personal information. This can be done in states which provide such rights and which grant immunity to insurers providing such access. If you request any health information, Aetna may elect to disclose details of the information you request to your (attending) physician. If you wish to exercise this right or if you wish to have more detail on our information practices, please contact:

Aetna Life Insurance Company
Executive Response Team, MCAF
151 Farmington Avenue
Hartford, Connecticut 06156

Under New Mexico law, a resident of New Mexico has the right to register as a “protected person” in connection with disclosure of confidential domestic abuse information. If you wish to exercise this right, contact the Member Services number on your ID card, or write to the address shown above.

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Aetna Life Insurance Company

Hartford, Connecticut 06156

Amendment (Rider 1)

For: The University of California

Group Policy No.: GP-724666

Effective Date: January 1, 2001

The group policy specified above has been amended. The following summarizes the changes in the group policy in accordance with the University of California Group Insurance Regulations, and the Certificate of Insurance describing the policy terms is amended accordingly. This amendment is effective on the date shown above.

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.

Subscriber

Employee: You are eligible (in an eligible class) if you are appointed to work at least 50% time for twelve months or more or are appointed at 100% time for three months or more. To remain eligible, you must maintain an average regular paid time* of at least 20 hours per week and maintain an eligible appointment of at least 50% time. If your appointment is at least 50% time, your appointment form may refer to the time period as follows: "Ending date for funding purposes only; intent of appointment is indefinite (for more than one year)."

***** 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.

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.

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 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 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.

OUT-OF-AREA BENEFITS AND ELIGIBILITY

Your Booklet-Certificate describes the coverage available to persons who are located outside of the California HMO Service Area (Tier 1 service area) and are enrolled for UC Care out-of-area benefits. The coverage for persons enrolled for in-area benefits is described in a separate booklet. The following describes when out-of-area benefits are available to eligible Employees/Annuitants and their eligible Family Members.

You are eligible for out-of-area benefits if you are:

(a) An Employee or Annuitant permanently living outside the Tier 1 service area. All Family Members are eligible only for out-of-area benefits.

(b) A faculty member on sabbatical (not in residence) or participating in the Education Abroad Program, or staff member on professional leave outside the Tier 1 service area. Family Members are eligible for in-area benefits or may accompany you and be eligible for out-of-area benefits.

(c) A child who is a full-time student living away from home outside the Tier 1 service area during the academic year.

(d) A natural or adopted child living with a former spouse more than 50% of the year outside the Tier 1 service area.

If you are eligible for in-area benefits, your Family Members are eligible only for in-area benefits unless item (c) or (d) above applies. The rest of the family other than the children described in (c) and (d) will remain in-area.

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 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-Certificate.

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 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.

Leave of Absence or Layoff (including absence due to disease or injury)

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. If you are not at work due to disease or injury, coverage may be continued until stopped by the University, but not beyond thirty (30) months from the start of the absence.

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

John W. Rowe
Chairman, President and Chief Executive Officer

Rider: 1
Issue Date: October 1, 2001

UC Care Out-of-Area Plan

Summary of Coverage

For: The University of California

Group Policy: GP-724666

SOC: 1A

Issue Date: October 1, 2001

Effective Date: January 1, 2001

Employee:

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

This is an electronic version of the Summary of Coverage on file with your Employer and Aetna Life Insurance Company, Hartford, CT. In case of a discrepancy between this electronic version and the group insurance contract issued by Aetna Life Insurance Company, or in case of any legal action, the terms set forth by such group insurance contract will prevail. To obtain a printed copy of this Summary of Coverage, please contact your Employer.

Eligibility

Employees and Dependents (Eligible Class)

Please refer to the separate amendment (Rider 1) for a complete description of employee and dependent eligibility.

Enrollment Procedure

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

Health Expense Coverage

Employees and Dependents

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

Prescription Drug Expense Coverage

Prescription Drug Benefits

Calendar Year Deductible	$ 50 per person
Family Deductible Limit	$ 150 per calendar year

The Calendar Year Deductible applies to all Covered Prescription Drug Expenses for prescription drugs dispensed by a Non-Preferred Pharmacy.

Payment Percentage
100% as to:

Preferred Pharmacy	Copay per Prescription or Refill	
	Supply of up to thirty (30) days	Mail Order Drug Supply of over thirty (30) days*
Generic Drugs	$ 10	$ 25
Brand Name Drugs	$ 20	$ 35

* but no more than a ninety (90) day maximum supply.

90% as to:

Non-Preferred Pharmacy (after the Calendar Year Deductible)

NOTE: Diabetic supplies and self-injectible drugs are covered at no charge when obtained from a Preferred Pharmacy. The copay amounts and Calendar Year Deductible shown above do not apply to these items.

A Separate Brand Name Fee may apply to brand name drugs dispensed by a pharmacy that is not a mail order pharmacy. See your Booklet-Certificate for details. If you have requested a brand name drug and the Separate Brand Name Fee applies, you will pay the **generic** copay in addition to this fee, unless the prescriber indicates the generic drug should not be dispensed. In that case, you will pay the **brand name** copay only.

A list of drugs requiring certification is included in your Booklet-Certificate. This list is subject to change by the Plan. An updated copy of the list of drugs requiring certification is available on request.

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-Certificate for details on how to get the certification.

Non-Certification for Hospital Admissions	
Excluded Amount	$ 200

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-Certificate.

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

NOTE: This Plan's Calendar Year Deductibles, Coinsurance Limits and Calendar Year and Lifetime Benefit Maximums are combined for members who transfer between in-area and out-of-area status.

Deductible Amounts

Calendar Year Deductible	$ 250 per person

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

Convalescent Facility Expenses
Home Health Care Expenses
Hospice Care Expenses
Preventive Health Care Services Expenses
Routine Physical Exam Expenses
Routine Cancer Screening Expenses
National Medical Excellence Travel and Lodging Expenses
Expenses authorized under the Healthy Outlook Program

Family Deductible Limit	$ 750 per calendar year
Hospital Emergency Room Deductible	$ 50 per visit

This Hospital Emergency Room Deductible applies to all Hospital Expenses for emergency room care. It is waived if the person is admitted to a hospital as an inpatient within twenty-four (24) hours after a visit to a hospital emergency room.

Payment Percentage

For Other Covered Medical Expenses
100% up to plan maximums as to:

National Medical Excellence Travel and Lodging Expenses
Expenses authorized under the Healthy Outlook Program

90% up to plan maximums as to:

Hospital Expenses
Convalescent Facility Expenses
Home Health Care Expenses
Hospice Care Expenses
Preventive Health Care Services Expenses
Routine Physical Exam Expenses
Routine Hearing Care Expenses (exams only)
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-Certificate for details)

50% as to:

Routine Hearing Care Expenses (hearing aids only)

Payment Limits

These limits apply to all Covered Medical Expenses except expenses applied against the Hospital Emergency Room Deductible.

Payment Limit which Applies to Expenses for a Person
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 $ 3,000 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 Family
When a family's Covered Medical Expenses for which no benefits are paid because of the Payment Percentage (including expenses applied against the Family Deductible Limit) reach $ 9,000 in a calendar year, benefits will be payable at 100% for all of their 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 Certificate for a complete description of the benefits available.)

Convalescent Facility Maximum Days	Two-hundred forty (240) per calendar year
Home Health Care Maximum Visits	One-hundred (100) per calendar year
Hospice Care Lifetime Maximum	$ 10,000

Routine Hearing Care	
Hearing Aid Maximum	$ 2,000 per thirty-six (36) months (one hearing aid per ear)
Private Duty Nursing Care	
Maximum Shifts	Seventy (70) 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	$ 2,000,000 per person
Restoration Amount	$ 1,000 per year

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 48 hours following a vaginal delivery; and a minimum of 96 hours following a cesarean delivery. If, after consultation with the attending physician, a person is discharged earlier, benefits will be payable for 2 post-delivery home visits by a health care provider.

- Certification of the first 48 hours of such confinement following a vaginal delivery or the first 96 hours of such confinement following a cesarean delivery is not required. Any day of confinement in excess of such limits must be certified. You, your physician, or other health care provider may obtain such certification by calling the number shown on your ID Card.

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 the group contract as to the coverage, 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 group contract.

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 the group contract. Requests for coverage other than that to which you are entitled in accordance with this Summary of Coverage cannot be accepted.

The insurance described in this Booklet-Certificate will be provided under Aetna Life Insurance Company policy form GR-29.

KEEP THIS SUMMARY OF COVERAGE WITH YOUR BOOKLET-CERTIFICATE

Additional Information Provided by Aetna Life Insurance Company

Inquiry Procedure

The plan of benefits described in the Booklet-Certificate is underwritten by:

Aetna Life Insurance Company (Aetna)
151 Farmington Avenue
Hartford, Connecticut 06156

Telephone: (860) 273-0123

If you have questions about benefits or coverage under this plan, call Member Services at the number shown on your Identification Card. You may also call Aetna at the number shown above.

If you have a problem that you have been unable to resolve to your satisfaction after contacting Aetna, you should contact the

Consumer Service Division
Department of Insurance
300 South Spring Street
Los Angeles, CA 90013

Telephone: 1-800-927-4357 or 213-897-8921

You should contact the Bureau only after contacting Aetna at the numbers or address shown above.

Additional Information Provided by The University of California

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

Additional Information Regarding Eligibility, 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.

In-Area Eligibility
You are eligible for in-area benefits if you are an eligible Employee or Annuitant permanently living inside the California HMO Service Area (Tier 1 service area). These benefits are explained in a separate booklet.

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 this plan in accordance with applicable plan documents and regulations, custodial agreements, University of California Group Insurance Regulations, group insurance 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. All of the terms and conditions in your Booklet-Certificate, 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-Certificate. If you have a question, you may direct it to:

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

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

The Plan is administered through a group insurance policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Claims under the Plan are processed by Aetna Life Insurance Company at the following address:

Aetna U.S. Healthcare
P.O. Box 9220
Van Nuys, CA 91410-0220
800-632-0524

Group Policy Number
GP-724666

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-Certificate 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, premiums and what portion of the premiums the University will pay. The portion of the premium the University pays is subject to state appropriation which may change or be discontinued in the future.

Financial Arrangements
The cost of the premiums is currently shared between you and the University of California.

Agent for Serving of Legal Process
Legal process may be served on the Plan Administrator or on any of the plan claim 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 insurance contracts.

- 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-Certificate 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. Submit your request to the office of the Aetna Life Insurance Company to which you submitted your initial request for benefit payment.

Aetna will review your claim and ordinarily notify you of its 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.

United Behavioral Health

Mental Health and Substance Abuse Benefits

Effective January 1, 2001

Certification

INSURANCE BOOKLET

for Employees of

University of California

(called the Employer)

insured by

UNITED HEALTHCARE INSURANCE COMPANY
Hartford, Connecticut
(called the Company)

CERTIFICATE OF INSURANCE

United HealthCare Insurance Company has issued Group Policy No. GA-11280. It covers certain Employees of the Employer.

The policy provides Behavioral Health Benefits.

This Certificate of Insurance describes the benefits and provisions of the policy. Additional benefits and provisions may apply based on the requirements of the state where the Employee or Annuitant lives.

These state benefits and provisions are described in separate Amendments. See the Employer for details.

This is a Covered Person's Certificate of Insurance only while that person is insured under the policy. Dependents benefits apply only if the Employee or Annuitant is insured under the Employer's Plan for dependent benefits.

This Certificate describes the Plan in effect as of January 1, 2001.

This Certificate replaces any and all Certificates previously issued for Employees and Annuitants under the plan.

Any coverage provided under this certificate is not in place of Workers' Compensation insurance. It does not affect any requirement for coverage by Workers' Compensation insurance.

UNITED HEALTHCARE INSURANCE COMPANY

The Behavioral Health Benefits described in this Plan are administered by United Behavioral Health.

1-888-440-UCAL (8225)

C-CE2, C-SB1, C-MH3CA, C-CI1, C-CB3, C-RP1, C-GL1

Table of Contents

Schedule of Benefits

Effective Date of this Plan **January 1, 2001**

Behavioral Health Benefits

Mental Health Copayments	
Office Visit Copayment	**Visits 1-5: $0** **Visits 6+: $10***
Deductible and Out-of-Pocket Maximum	
Substance Abuse Inpatient and Intermediate Care Calendar Year Deductible	**$100**
Mental Health Out-of-Pocket Maximum	**$1,000 per person**** **$3,000 per family****
Percentage Payable after Copayments/Deductibles Satisfied	
Mental Health Inpatient and Intermediate Care	**100%**
Substance Abuse Inpatient: Detoxification	**80%**
Substance Abuse Inpatient and Intermediate Care: Rehabilitation	**80% with Treatment Plan Compliance** **50% without Treatment Plan Compliance**
Mental Health Outpatient	**100% after Copayment**
Substance Abuse Outpatient	**80%**
Maximum Benefits	**None**

*Copayment is waived for children to age six.

**The percentage payable is 100% when the Mental Health Out-of-Pocket Maximum is met each Calendar Year.

All benefits are paid in accordance with the Reasonable Charge. Refer to the Glossary for the definition of Reasonable Charge.

Behavioral Health Benefits

General Information About This Plan

The following sections located at the beginning of this booklet also apply to Behavioral Health Benefits:

--Additional Information Provided by the University of California, except for the section called "Plan Administration"
--Amendment (Rider 1)

Additionally, under "General Information About Your Coverage," the following sections also apply to Behavioral Health Benefits:

--Termination of Coverage
--Continuation of Coverage After COBRA Ceases
--Health Expense Benefits After Termination

What This Plan Pays

Behavioral Health Benefits are payable for Covered Expenses incurred by a Covered Person for Behavioral Health Services received from a Network Provider.

To receive benefits, the Covered Person must call United Behavioral Health (UBH) before Covered Expenses are incurred. (See **Notification Requirements and Utilization Review.**)

Each Covered Person must satisfy certain Copayments and/or Deductibles before any payment is made for certain Behavioral Health Services. The Behavioral Health Benefit will then pay the percentage of Covered Expenses shown in **Schedule of Benefits**.

A Covered Expense is incurred on the date that the Behavioral Health Service is given.

Covered Expenses are the actual cost to the Covered Person of the Reasonable Charge for Behavioral Health Services given. The Company, at its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with the methodologies:

- In the most recent edition of the Current Procedural Terminology and/or DSM IV Code;
- As reported by generally recognized professionals or publications.

Behavioral Health Services are services and supplies which are:

- Clinically Necessary, as defined below, for Mental Disorder Treatment.
- Given while the Covered Person is covered under this Plan.
- Given by one of the following providers:
    - Physician.
    - Psychologist.
    - Registered Nurse.
    - Licensed Counselor.
    - Health Care Provider.
    - Hospital.
    - Treatment Center.

Behavioral Health Services include but are not limited to the following:

- Assessment.
- Diagnosis.

- Treatment Planning.
- Medication Management.
- Individual, family and group psychotherapy.
- Psychological testing.

Telemedicine

Benefits for telemedicine services are payable same as Behavioral Health Benefits. No face-to-face contact is required between a provider and a patient for services appropriately provided through telemedicine, subject to all terms and conditions of the Plan.

"Telemedicine" means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. It is the above-covered medical services that an individual receives from a provider without person-to-person contact with the provider. It is not consultation by telephone or facsimile machine between providers or between patient and provider.

Services and supplies will not automatically be considered Clinically Necessary because they were prescribed by a provider.

"Clinically Necessary/Clinical Necessity" services or supplies are defined as services and supplies that meet all the following criteria:

- They are consistent with the symptoms and signs of diagnosis and treatment of the Covered Person's behavioral disorder, psychological injury or substance abuse.
- They are consistent in type and amount with regard to the standards of good clinical practice.
- They are not solely for the convenience or preference of the Covered Person, or his/her provider.
- They are the least restrictive and least intrusive appropriate supplies or level of service which can be safely provided to the Covered Person.

The Company may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations regarding whether particular services, supplies or accommodations provided or to be provided to a Covered Person were/are Clinically Necessary.

Notification Requirements and Utilization Review

Except for Emergency Care, to receive benefits under this Plan the Covered Person must call United Behavioral Health (UBH) before Behavioral Health Services are given. **The toll-free number is 1-888-440-UCAL (8225). UBH is ready to take the Covered Person's call 7 days a week, 24 hours a day.** This call starts the Utilization Review process. The Covered Person will be referred to a Network Provider who is experienced in addressing his/her specific issues.

If the Covered Person is not satisfied with a Network Provider, he/she may call UBH and ask for a referral to another Network Provider. The Covered Person may do this more than once, but he/she will only be referred to one Network Provider at a time.

UBH performs a Utilization Review to determine the Clinical Necessity of Behavioral Health Services. The Covered Person and his/her provider decide which Behavioral Health Services are given, but this Plan only pays for Behavioral Health Services that are Clinically Necessary and given by a Network Provider.

Appeals

The Covered Person may appeal a Utilization Review or benefit reduction. Call UBH for further information.

Emergency Care

Emergency Care does not require a referral from UBH to a UBH Network Provider.

When Emergency Care is required for Mental Disorder Treatment, the Covered Person (or his/her representative or

his/her provider) must call UBH within twenty-four (24) hours after the Emergency Care is given. If it is not reasonably possible to make this call within twenty-four (24) hours, the call must be made as soon as reasonably possible. The Company will pay for Emergency Care services regardless of the provider's contract status with the Company.

When the Emergency Care has ended, the Covered Person must get a referral from UBH before any additional services will be covered.

Copayments and Deductibles

Before Behavioral Health Benefits are payable, each Covered Person must satisfy certain Copayments and/or Deductibles.

A Copayment is the amount of Covered Expenses the Covered Person must pay to a Network Provider at the time services are given.

A Deductible is the amount of Covered Expenses the Covered Person must pay each Calendar Year before Behavioral Health Benefits are payable. After the Deductible has been met, Covered Expenses are payable at the percentages shown in **Schedule of Benefits**.

The amount of each Copayment/Deductible is shown in **Schedule of Benefits**. A Covered Expense can only be used to satisfy one Copayment or Deductible.

Mental Health Office Visit Copayment

The Mental Health Office Visit Copayment applies to all services and supplies given in connection with each office visit.

Substance Abuse Inpatient and Intermediate Care Calendar Year Deductible

The Substance Abuse Inpatient and Intermediate Care Calendar Year Deductible applies to all charges for services or supplies given in connection with Substance Abuse Inpatient and Intermediate Care services each Calendar Year.

Out-of-Pocket Feature

Covered Expenses for office visits for Mental Health are subject to the applicable copayments shown in the Schedule of Benefits until the Mental Health Out-of-Pocket Maximum shown in the Schedule of Benefits has been reached during a Calendar Year. Then, such Covered Expenses are payable at 100% for the rest of that year as shown below.

Individual Mental Health Out-of-Pocket Maximum

When the Individual Mental Health Out-of-Pocket Maximum is reached for any one Covered Person in a Calendar Year, all Covered Expenses for Mental Health are payable at 100% for that same person for the rest of that year.

Family Mental Health Out-of-Pocket Maximum

When the per Family Mental Health Out-of-Pocket Maximum is reached for an Employee and the Employee's family combined in a Calendar Year, all Covered Expenses for Mental Health are payable at 100% for the rest of that year.

Not Covered

This Plan does not cover any expenses incurred for services, supplies, medical care or treatment relating to, arising out of, or given in connection with, the following:

- Services or supplies given by a Non-Network Provider, except when care is received outside the United States.
- Services or supplies which are not Clinically Necessary, including any confinement or treatment given in connection with a service or supply which is not Clinically Necessary.
- Services or supplies received before the Covered Person becomes covered under this Plan.
- Expenses incurred by a Dependent if the Dependent is covered as an Employee or Annuitant for the same services under this Plan.
- Treatment given in connection with any of the following diagnoses: mental retardation (except initial diagnosis), chronic organic brain syndrome, learning disability, or transsexualism.
- Completion of claim forms or missed appointments.
- Custodial Care that has not been approved by UBH. This is care made up of services and supplies that meets one of the following conditions:
    - Care furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment.
    - Care that can safely and adequately be provided by persons who do not have the technical skills of a covered health care professional.

    Care that meets one of the conditions above is custodial care regardless of any of the following:
        - Who recommends, provides or directs the care.
        - Where the care is provided.
        - Whether or not the patient or another caregiver can be or is being trained to care for himself or herself.
- Ecological or environmental medicine, diagnosis and/or treatment.
- Education, training and bed and board while confined in an institution which is mainly a school or other institution for training, a place of rest, a place for the aged or a nursing home.
- Herbal medicine, holistic or homeopathic care, including drugs.
- Services, supplies, medical care or treatment given by one of the following members of the Employee's/Annuitant's immediate family:
    - The Employee's/Annuitant's spouse.
    - The child, brother, sister, parent or grandparent of either the Employee/Annuitant or the Employee's/Annuitant's spouse.
- Services or supplies, treatments or drugs which are considered investigational because they do not meet generally accepted standards of medical practice in the United States. This includes any related confinements, treatment, service or supplies.
- Services and supplies for which the Covered Person is not legally required to pay.
- Membership costs for health clubs, weight loss clinics and similar programs.
- Nutritional counseling.
- Occupational injury or sickness - an occupational injury or sickness is an injury or sickness which is covered under a workers' compensation act or similar law. For persons for whom coverage under a workers' compensation act or similar law is optional because they could elect it or could have it elected for them, occupational injury or sickness includes any injury or sickness that would have been covered under the workers' compensation act or similar law had that coverage been elected.

- Examinations or treatment ordered by a court in connection with legal proceedings unless such examinations or treatment otherwise qualify as Behavioral Health Services.
- Examinations provided for employment, licensing, insurance, school, camp, sports, adoption or other non-Clinically Necessary purposes, and related expenses for reports, including report presentation and preparation.
- Services given by a pastoral counselor.
- Personal convenience or comfort items including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners humidifiers, saunas, hot tubs.
- Private duty nursing services while confined in a facility.
- Sensitivity training, educational training therapy or treatment for an education requirement.
- Sex-change surgery.
- Stand-by services required by a Physician.
- Telephone consultations.
- Tobacco dependency.
- Services or supplies received as a result of war declared or undeclared, or international armed conflict.
- Weight reduction or control (unless there is a diagnosis of morbid obesity), special foods, food supplements, liquid diets, diet plans or any related products.
- Services given by volunteers or persons who do not normally charge for their services.

Network Provider Charges Not Covered

A Network Provider has contracted to participate in the Network and provide services at a negotiated rate. Under this contract a Network Provider may not charge for certain expenses, except as stated below. A Network Provider cannot charge for:

- Services or supplies which are not Clinically Necessary;
- Fees in excess of the negotiated rate.

A Covered Person may agree with the Network Provider to pay any charges for services and supplies which are not Clinically Necessary. In this case, the Network Provider may make charges to the Covered Person. The Covered Person will be asked to sign a patient financial responsibility form agreeing to pay for the services that are found to not be Clinically Necessary. However, these charges are not Covered Expenses under this Plan and are not payable by the Company.

Claims Information

How to File a Claim

A claim form does not need to be filed by the Covered Person when a Network Provider is used. The Network Provider will file the claim form on behalf of the Covered Person. All payments will be paid directly to the Network Provider.

The following steps should be completed when submitting bills for payment for services and supplies received outside the United States.

Claims are paid according to billed charges at the appropriate network benefit level based on the rate of exchange on the date that services are rendered. To process the claim, a complete billing statement is required. This billing statement can be combined with a receipt for services. The statement must include the following:

- The Employee/Annuitant's name, Social Security Number, address and phone number.
- The patients's name.
- The Plan number (11280).
- The name, address and phone number of the provider.
- The licensure of the provider.
- The date of service.
- The place of service.
- The specific services provided.
- The amount charged for the service.
- The diagnosis.

The claim/billing statement should be mailed to:

United Behavioral Health
P.O. Box 23250
Oakland, CA 94623-0250

All payments for services received outside the United States will be paid to the Employee/Annuitant.

When Claims Must be Filed

The covered Employee/Annuitant must give the Company written proof of loss within 15 months after the date the expenses are incurred.

The Company will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested.

No benefits are payable for claims submitted after the 15-month period, unless it can be shown that:

- It was not reasonably possible to submit the claim during the 15-month period.
- Written proof of loss was given to the Company as soon as was reasonably possible.

The Company will reimburse claims or any portion of any claim for Covered Expenses, as soon as possible, not later than 30 working days after receipt of the claim. However, a claim or portion of a claim may be contested by the Company. In that case the Employee/Annuitant will be notified in writing that the claim is contested or denied within 30 working days of receipt of the claim. The notice that the claim is being contested will identify the portion of the claim that is contested and the specific reasons for contesting the claim. If an uncontested claim is not reimbursed by delivery to the claimants' address of record within 30 working days after receipt, interest will accrue at the rate of 10% per year beginning with the first calendar day after the 30-working-day period.

United Behavioral Health will send an Explanation of Benefits (EOB) to the covered Employee/Annuitant. The EOB will explain how United Behavioral Health considered each of the charges submitted for payment. If any claims are denied or denied in part, the covered Employee/Annuitant will receive a written explanation.

Legal Actions

The covered Employee/Annuitant may not sue on a claim before 60 days after proof of loss has been given to the Company. The covered Employee/Annuitant may not sue after three years from the time proof of loss is required, unless the law in the area where the covered Employee/Annuitant lives allows for a longer period of time.

Incontestability of Coverage

This Plan cannot be declared invalid after it has been in force for two years. It can be declared invalid due to nonpayment of premium.

No statement used by any person to get coverage can be used to declare coverage invalid if the person has been covered under this Plan for two years. In order to use a statement to deny coverage before the end of two years, it must have been signed by the person. A copy of the signed statement must be given to the person.

Review Procedure for Denied Claims

In cases where a claim for benefits payment is denied in whole or in part, the claimant may appeal the denial. A request for review must be directed to Appeals Unit, United Behavioral Health - Employer Division at P.O. Box 32040, Oakland, California, 94604, within 60 days after the claim payment date or the date of the notification of denial of benefits. When requesting a review, the claimant should state the reason he or she believes the claim was improperly paid or denied and submit any data or comments to support the claim.

A review of the denial will be made and United Behavioral Health will provide the claimant with a written response within 60 days of the date the Company receives the claimant's request for review. If, because of extenuating circumstances, the Company is unable to complete the review process within 60 days, the Company will notify the claimant of the delay within the 60 day period and will provide a final written response to the request for review within 120 days of the date the Company received the claimant's written request for review.

If the denial is upheld, United Behavioral Health's written response to the claimant will cite the specific Plan provision(s) upon which the denial is based.

Coordination of Benefits

Coordination of benefits applies when a Covered Person has health coverage under this Plan and one or more Other Plans.

One of the plans involved will pay the benefits first: that plan is Primary. One of the Other Plans will pay benefits next: those plans are Secondary. The rules shown in this provision determine which plan is Primary and which plan is Secondary.

Whenever there is more than one plan, the total amount of benefits paid in a Calendar Year under all plans cannot be more than the Allowable Expenses charged for that Calendar Year.

Please refer to the section called "Coordination of Benefits" in the In Area EOC and the section called "Effect of Medicare" in the Out-of-Area EOC, for the effect of Medicare on this Plan.

Definitions

"Other Plans" are any of the following types of plans which provide health benefits or services for medical care or treatment:

- Group policies or plans, whether insured or self-insured. This does not include school accident-type coverage.
- Group coverage through HMOs and other prepayment, group practice and individual practice plans.
- Group-type plans obtained and maintained only because of membership in or connection with a particular organization or group.
- Government or tax supported programs. This does not include Medicare or Medicaid.

"Primary Plan": A plan that is Primary will pay benefits first. Benefits under that plan will not be reduced due to benefits payable under Other Plans.

"Secondary Plan": Benefits under a plan that is Secondary may be reduced due to benefits payable under Other Plans that are Primary.

"Allowable Expenses" means the necessary, reasonable and customary expense for health care when the expense is covered in whole or in part under at least one of the plans.

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as defined in the plan.

When a plan provides benefits in the form of services, instead of a cash payment, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

How Coordination Works

When this Plan is Primary, it pays its benefits as if the Secondary Plan or Plans did not exist.

When this Plan is a Secondary Plan, its benefits are reduced so that the total benefits paid or provided by all plans during a Calendar Year are not more than total Allowable Expenses. The amount by which this Plan's benefits have been reduced shall be used by this Plan to pay Allowable Expenses not otherwise paid, which were incurred during the Calendar Year by the person for whom the claim is made. As each claim is submitted, this Plan determines its obligation to pay for Allowable Expenses based on all claims which were submitted up to that point in time during the Calendar Year.

The benefits of this Plan will only be reduced when the sum of the benefits that would be payable for the Allowable Expenses under the Other Plans, in the absence of provisions with a purpose like that of this **Coordination of Benefits** provision, whether or not claim is made, exceeds those Allowable Expenses in a Calendar Year.

When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

Which Plan Pays First

When two or more plans provide benefits for the same Covered Person, the benefit payment will follow the following rules in this order:

- A plan with no coordination provision will pay its benefits before a plan that has a coordination provision.
- The benefits of the plan which covers the person other than as a dependent are determined before those of the plan which covers the person as a dependent.
- The benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent, if the person is also a Medicare beneficiary and both of the following are true:
    - Medicare is secondary to the plan covering the person as a dependent.
    - Medicare is primary to the plan covering the person as other than a dependent (example, an Annuitant).
- When this Plan and another plan cover the same child as a dependent of parents who are not separated or divorced, the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year. This is called the "Birthday Rule." The year of birth is ignored.

  If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

  If the other plan does not have a birthday rule, 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.
- If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
    - First, the plan of the parent with custody for the child.
    - Second, the plan of the spouse of the parent with the custody of the child.
    - Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This rule does not apply with respect to any claim for which any benefits are actually paid or provided before the entity has that actual knowledge.

- If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules that apply to dependents of parents who are not separated or divorced.
- The benefits of a plan which covers a person as an employee who is neither laid off nor an Annuitant are determined before those of a plan which covers that person as a laid off employee or an Annuitant. The same rule applies if a person is a dependent of a person covered as an Annuitant or an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

If none of the above rules determines the order of benefits, the benefits of the plan which covered a Covered Person for the longer period are determined before those of the plan which covered that person for the shorter period.

Right to Exchange Information

In order to coordinate benefit payments, the Company needs certain information. It may get needed facts from or give them to any other organization or person. The Company must get the consent of the Covered Person to do this.

A Covered Person must give the Company the information it asks for about other plans. If any other organization or person needs information to apply its coordination provision, the Company must get the consent of the Covered Person to do this.

Facility of Payment

It is possible for benefits to be paid first under the wrong plan. The Company may pay the plan or organization or person for the amount of benefits that the Company determines it should have paid. That amount will be treated as if it was paid under this Plan. The Company will not have to pay that amount again.

Right of Recovery

The Company may pay benefits that should be paid by another plan or organization or person. The Company may recover the amount paid from the other plan or organization or person.

The Company may pay benefits that are in excess of what it should have paid. The Company has the right to recover the excess payment.

Recovery Provisions

Refund of Overpayments

If the Company pays benefits for expenses incurred on account of a Covered Person, that Covered Person or any other person or organization that was paid must make a refund to the Company if:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment made by the Company exceeded the benefits under this Plan.

The refund equals the amount the Company paid in excess of the amount it should have paid under this Plan.

If the refund is due from another person or organization, the Covered Person agrees to help the Company get the refund when requested. If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the Company may reduce the amount of any future benefits that are payable under this Plan. The Company may also reduce future benefits under any other group benefits plan administered by the Company for the Employer. The reductions will equal the amount of the required refund. The Company may have other rights in addition to the right to reduce future benefits.

Reimbursement of Benefits Paid

If the Company pays benefits for expenses incurred on account of a Covered Person, the Covered Person or any other person or organization that was paid must make a refund to the Company if all or some of the expenses were recovered from or paid by a source other than this Plan as a result of claims against a third party for negligence, wrongful acts or omissions. The refund equals the amount of the recovery or payment, up to the amount the Company paid.

If the refund is due from another person or organization, the Covered Person agrees to help the Company get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the Company may reduce the amount of any future benefits that are payable under this Plan. The Company may also reduce future benefits under any other group benefits plan administered by the Company for the Employer. The reductions will equal the amount of the required refund. The Company may have other rights in addition to the right to reduce future benefits.

Subrogation

In the event a Covered Person suffers an injury or sickness as a result of a negligent or wrongful act or omission of a third party, the Company has the right to pursue subrogation where permitted by law.

The Company will be subrogated and succeed to the Covered Person's right of recovery against a third party. The Company may use this right to the extent of the benefits under this Plan.

The Covered Person agrees to help the Company use this right when requested.

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 insurance 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. All of the terms and conditions in your Booklet-Certificate, 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-Certificate. If you have a question, you may direct it to:

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

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

Mental Health & Substance Abuse Benefits

The Mental Health/Substance Abuse benefits described in this booklet are insured by United HeallthCare Insurance Company and administered by United Behavioral Health (UBH). If you have a question, you may direct it to the following address:

United Behavioral Health
P.O. Box 8250
Emeryville, CA 94662-8250
(888) 440-8225

Group Policy Number

11280

Type of Plan

This Plan is a health and welfare plan that provides group health 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-Certificate 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, premiums and what portion of the premiums the University will pay. The portion of the premium the University pays is subject to state appropriation which may change or be discontinued in the future.

Financial Arrangements

The benefits under the Plan are paid by United HealthCare Insurance Company, administered by United Behavioral Health, under an insurance contract. The cost of the premiums is currently shared between you and the University of California.

Agent for Serving of Legal Process

Legal process may be served on the Plan Administrator or on any of the plan claim processors at the 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 insurance contracts.

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

Mental Health/Substance Abuse

Claims under United Behavioral Health's Mental Health/Substance Abuse Benefit are filed by the United Behavioral Health provider. It is the responsibility of the members to obtain the pre-authorization necessary to receive services from a United Behavioral Health provider.

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.

Glossary

(These definitions apply when the following terms are used.)

Annuitant

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

Average Regular Paid Time

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

(a) A month with zero regular paid hours which occurred during the Employee's 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 the Employee was 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 the Employee 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 the Employee 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.

Calendar Year

A period of one year beginning with January 1.

Covered Person

The Employee or the Annuitant; his or her legal spouse, Domestic Partner or Adult Dependent Relative; and/or Dependent children who are covered under this Plan, except a Survivor Annuitant may not enroll his/her legal spouse.

Course of Treatment

A period of Mental Disorder Treatment during which Behavioral Health Services are received by a Covered Person on a continuous basis until there is a period of interruption (that is, the Covered Person is treatment-free) for more than:

- 30 days with respect to treatment for substance abuse
- 6 months with respect to treatment for mental illness

Emergency Care

Immediate Mental Disorder Treatment when the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

Employee

A person who is appointed to work at least 50% time for twelve months or more or is appointed at 100% time for three months or more. To remain eligible, an Employee must maintain an Average Regular Paid Time of at least 20 hours per week and maintain an eligible appointment of at least 50% time. If the appointment is at least 50% time, the Employee's appointment form may refer to the time period as follows: "Ending date for funding purposes only; intent of appointment is indefinite (for more than one year)."

Health Care Provider

A licensed or certified provider other than a Physician whose services the Company must cover due to a state law requiring payment of services given within the scope of that provider's license or certification.

Hospital

An institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets one of the following three tests:

- It is accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations.
- It is approved by Medicare as a hospital.
- It meets all of the following tests:
    - It maintains on the premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of duly qualified Physicians.
    - It continuously provides on the premises 24-hour-a-day nursing service by or under the supervision of registered graduate nurses.
    - It is operated continuously with organized facilities for operative surgery on the premises.

A psychiatric health facility shall also be deemed a Hospital if it fulfills one of the following requirements:

- It is licensed by the California State Department of Health Services.
- It operates under a waiver of licensure granted by the California State Department of Mental Health.

Intermediate Care

A treatment alternative to an acute inpatient Hospital stay. Intermediate Care includes partial hospitalization, residential care, day treatment and structured outpatient services.

Licensed Counselor

A person who specializes in Mental Disorder Treatment and is licensed as a Licensed Professional Counselor (LPC), Licensed Clinical Social Worker (LCSW), or Marriage, Family and Child Counselor (MFCC) by the appropriate authority.

Medicare

The Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act.

Mental Disorder Treatment

Mental Disorder Treatment is Clinically Necessary treatment for both of the following:

- Any sickness which is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence or addiction to alcohol or psychoactive drugs or medications, regardless of any underlying physical or organic cause, and
- Any sickness where the treatment is primarily the use of psychotherapy or other psychotherapeutic methods.

All inpatient services, including room and board, given by a mental health facility or area of a Hospital which provides mental health or substance abuse treatment for a sickness identified in the DSM, are considered Mental Disorder Treatment, except in the case of multiple diagnoses.

If there are multiple diagnoses, only the treatment for the sickness which is identified in the DSM is considered Mental Disorder Treatment.

Detoxification services given prior to and independent of a course of psychotherapy or substance abuse treatment is not considered Mental Disorder Treatment.

Prescription Drugs are not considered Mental Disorder Treatment.

Network Provider

A provider which participates in United Behavioral Health's network.

Non-Network Provider

A provider which does not participate in the network.

Physician

A legally qualified:

- Doctor of Medicine (M.D.).
- Doctor of Osteopathy (D.O.).

Plan

The group policy or policies issued by the Company which provide the benefits described in this Certificate of Insurance.

Psychologist

A person who specializes in clinical psychology and fulfills one of these requirements:

- A person licensed or certified as a psychologist.
- A Member or Fellow of the American Psychological Association, if there is no government licensure or certification required.

Reasonable Charge

As to charges for services rendered by or on behalf of a Network Physician, an amount not to exceed the amount determined by the Company in accordance with the applicable fee schedule.

As to all other charges, an amount measured and determined by the Company by comparing the actual charge for the service or supply with the prevailing charges made for it. The Company determines the prevailing charge. It takes into account all pertinent factors including:

- The complexity of the service.
- The range of services provided.
- The prevailing charge level in the geographic area where the provider is located and other geographic areas having similar medical cost experience.

Registered Nurse

A graduate trained nurse who is licensed by the appropriate authority and is certified by the American Nurses Association.

Substance Abuse Rehabilitation

Treatment for a substance abuse disorder in a twenty-four hour setting, or other setting outside of an acute care Hospital that is licensed to perform that service and where there is no danger of medical complications due to detoxification.

Treatment Center

A facility which provides a program of effective Mental Disorder Treatment and meets all of the following requirements:

- It is established and operated in accordance with any applicable state law.
- It provides a program of treatment approved by a Physician and the Company.
- It has or maintains a written, specific and detailed regimen requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services:
  - Room and board (if this Plan provides inpatient benefits at a Treatment Center).
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Treatment Center which qualifies as a Hospital is covered as a Hospital and not as a Treatment Center.

Treatment Plan Compliance

The completion of an authorized Inpatient or Intermediate Care Substance Abuse Rehabilitation treatment program.

Utilization Review

A review and determination by United Behavioral Health as to the Clinical Necessity of services and supplies.

End of Certificate

IMPORTANT NOTICE

CLAIM DISPUTES: SHOULD A DISPUTE CONCERNING A CLAIM ARISE, CONTACT THE COMPANY FIRST. IF THE DISPUTE IS NOT RESOLVED, CONTACT THE CALIFORNIA DEPARTMENT OF INSURANCE.

CALL THE COMPANY AT THE PHONE NUMBER SHOWN ON YOUR EXPLANATION OF BENEFITS.

CALL THE CALIFORNIA DEPARTMENT OF INSURANCE AT:

1-800-927-HELP (1-800-927-4357) IF THE COVERED PERSON RESIDES IN THE STATE OF CALIFORNIA.

(213) 897-8921 IF THE COVERED PERSON RESIDES OUTSIDE OF THE STATE OF CALIFORNIA.

A COVERED PERSON MAY WRITE THE CALIFORNIA DEPARTMENT OF INSURANCE AT:

CALIFORNIA DEPARTMENT OF INSURANCE
CLAIMS SERVICES BUREAU, 11TH FLOOR
300 SOUTH SPRING STREET
LOS ANGELES, CA 90013