University of California

Summary Plan Description

The Definity HRA California Plan

Amended and Restated Effective

January 1, 2007

CONTENTS

The Sections of the Summary Plan Description appear in the order set forth below:

CONTENTS

DEFINITY HRA CALIFORNIA – 2007 PLAN CHANGES

The following change applies to immunization:

Six doses of Pnuemococcal Conjugate,

The following change applies to Well Child Care

- Human papillomavirus (HPV) vaccine for girls ages 9 through 18 years of age at the following intervals:
  - One complete dosage per lifetime consisting of 3 shots given within a 6 month timeframe.
  - Women over the age of 18 years but under the age of 26 years who have not yet received the HPV may also receive the vaccine.

HIGHLIGHTS OF THE DEFINITY HRA CALIFORNIA PLAN

Your employer has established a medical benefit plan (referred to as "the Plan") administered by Definity Health, a private health care administrator contracted by your Employer, providing you comprehensive health coverage and preventive care that gives you a unique, consumer-driven healthcare approach (referred to as "The Definity Health Reimbursement Account") to pay routine health expenses **and** provides a safety net of coverage for major healthcare expenses.

The Definity HRA California Plan

- lets **you** choose your provider (no referrals required);
- allows you to save or spend employer allocated Benefit Dollars in your Health Reimbursement Account (HRA) for Covered Expenses including Coinsurance and Deductibles;
- provides additional health coverage after you've depleted your Benefit Dollars in your HRA and satisfied your Member Responsibility phase of the Deductible;
- covers qualifying preventive care services at 100% at an In-Network Provider; not subject to the Deductible and with no charge to your HRA Benefit Dollars;
- provides four coverage categories—Employee Only, Employee/Adult Family Member, Employee plus Child(ren) or Employee plus Family—so you can pick a coverage category appropriate for you and your family; and
- offers the added benefit of health resources to help you make informed decisions about your family's health care purchases (for more information, visit www.myuhc.com).

The Definity HRA California Plan is a combination of the following four key components:

- Health Expense Reimbursement – allows your employer to annually allocate HRA Benefit Dollars to an HRA;
- Health Coverage – additional protection for more expensive medical care;
- Preventive Care Services – 100% In-Network coverage for qualifying Preventive Care Services; and
- Health Resources – providing Health Coaches and a personal private website.

HIGHLIGHTS OF THE DEFINITY HRA CALIFORNIA PLAN

For a detail description of each component, refer to the section entitled, "How the Plan Works".

> ☞ **Important Note**
>
> This Summary Plan Description (SPD) is a summary only. It does not alter the Plan that it describes, and the actual text of the Plan control in all instances. If there should be an inconsistency between the contents of this Summary and the contents of the Plan, your rights shall be determined under the Plan and not under this Summary.

The University of California has retained Definity Health as the administrator for the Definity HRA California Plan. United HealthCare Insurance Company, an affiliate of Definity Health, is the Claims Administrator of the Plan. The Claims Administrator does not guarantee any benefits. The Plan is not funded through an insurance policy, trust or otherwise. The University of California is solely responsible for paying the health benefits described in this summary from its general assets.

Please read this booklet thoroughly to learn how the Definity HRA California Plan works. If you have questions contact your local Benefits Office or call the number on the back of your ID card.

HOW THE PLAN WORKS

Health Reimbursement Account

Your Health Reimbursement Account (HRA) will be established under the Health Reimbursement Account component. The Health Reimbursement Account component of the Plan allows your employer to annually allocate a specified amount of Benefit Dollars into an HRA on a Plan Year basis in your name, as shown below, as determined by your employer. The amount of Benefit Dollars allocated to your HRA monthly is determined by your employer and depends on the coverage category you choose. Amounts allocated are per coverage category and not per family member.

Coverage Category	***HRA Benefit Dollars***
• Employee Only	**$950**
• Employee/Adult Family Member	**$1,400**
• Employee plus Child(ren) or	**$1,450**
• Employee plus Family	**$1,900**

EARNING EXTRA HRA BENEFIT DOLLARS

You and your spouse or domestic partner may each earn an additional $50 deposit (up to $100 total) into your HRA by completing the online Health Assessment offered by Claims Administrator. The Health Assessment is an interactive questionnaire designed to help you identify your healthy habits as well as your health risks.

All assessments are kept confidential and your participation in this assessment will not impact your benefits or eligibility for benefits in any way.

Only the enrolled employee and/or enrolled spouse/eligible partner are eligible to participate in the Health Assessment incentive program.

To find the Health Assessment, log in to your personal website at www.myuhc.com, click on the Health Resources tab, then click the Health Assessment icon. If you need assistance with the online assessment, please call the number on the back of your ID card.

Health Reimbursement Account – cont'd

EARNING EXTRA HRA BENEFIT DOLLARS – cont'd

The $50 HRA deposit (or $100 per couple) is only valid for the first three months of 2007 and ends March 31, 2007. This means you only have three months to take the Health Assessment. Upon completion of the assessment, $50 will be deposited into your HRA. It may take several weeks for you to see this credit in My Account on your website.

If you do not complete the Health Assessment within the first three months of the calendar year, your opportunity to participate for 2007 will expire.

Benefit Dollars (not real dollars) are used **FIRST** and pay 100% of the cost of Covered Expenses, up to the allocation in your HRA.

If you don't spend all your Benefit Dollars in a Plan Year, any unused HRA balance rolls over into the next Plan Year. In this manner your HRA may "grow" almost like a savings account.

Your HRA Benefit Dollars are subject to two restrictions: 1) they may only be used for Covered Expenses as defined in this SPD, and 2) you will forfeit your HRA Benefit Dollars if you terminate employment for any reason or retire, and the Benefit Dollars in your HRA will revert back to your employer, unless you elect COBRA coverage. If you elect COBRA coverage, any HRA Benefit Dollars remaining at the time employment terminates will assist you in paying your medical expenses and COBRA premiums while COBRA coverage is in effect.

You can keep track of the Benefit Dollars in your HRA by going online to www.myuhc.com, by calling the number on the back of your ID card, or by checking your member statement sent to you on a monthly basis by Claims Administrator.

Health Reimbursement Account - cont'd

When you go to the provider (In-Network or out-of-network), show your ID card. This is proof of your health coverage. In-Network Providers will submit the claim to Claims Administrator and the Covered Expense will be deducted from your HRA based on your balance at the time Claims Administrator processes your claim. However, Out-of-Network Providers may require you to pay "up front" for services performed. If so, you may file for reimbursement from Claims Administrator for such Covered Expenses. You use your HRA to pay for: 1) traditional medical Covered Expenses; 2) Member Responsibility phase of Deductible, 3) prescription drugs; 4) Coinsurance; 5) Coinsurance Maximum; and 6) certain "extra" non-traditional Covered Expenses, referred to as HRA only Covered Expenses, such as infertility treatment, or smoking cessation programs – that typically are not covered by other health plans.

☞ **Important Note**

However, keep in mind that Benefit Dollars in your HRA used to pay for "extra" non-traditional Covered Expenses ("HRA Only Covered Expenses") do not apply toward the satisfaction of the Deductible. For a complete listing of such non-traditional Covered Expenses, refer to the section entitled, "Covered Under the Health Reimbursement Account - Only".

Health Reimbursement Account - cont'd

☞ **Important Note: The HRA and Flexible Spending Accounts**

While your HRA is similar to the flexible spending account in your cafeteria plan, they are not the same thing—and are used for different purposes. You may participate in both if you feel that best meets your family's needs. Keep in mind:

- The HRA is only available if you enroll in the Definity HRA California Plan —you cannot elect it separately and you can't drop out of it unless you drop out of the Definity HRA California Plan as well. Your participation in the flexible spending account is not related to your participation in one or more of your employer's health programs.
- While the HRA and the flexible spending account may cover some of the same types of expenses, the flexible spending account may be funded with pre-tax contributions under a salary reduction arrangement. You are not permitted to contribute any amount of your income to the HRA.
- Expenses reimbursed through the HRA cannot also be reimbursed through the flexible spending account.

HOW THE PLAN WORKS – Health Coverage, Deductible, Coinsurance, Coinsurance Maximum

Health Coverage

The Health Coverage component provides additional protection, if you need more expensive medical care. Under the Health Coverage component, you may see any doctor, specialist or health care facility you wish; however, the Health Coverage component will pay a greater percentage of Covered Expenses when In-Network Providers are utilized.

Deductible

The Health Coverage component requires you to satisfy a Plan Year Deductible. Benefit Dollars in your HRA can be used toward satisfaction of Your Plan Year Deductible so in essence your employer pays part of your Plan Year Deductible (or all of your Plan Year Deductible in subsequent Plan Years in which you roll over an applicable amount of HRA Benefit Dollars – see below for explanation). After you satisfy the Deductible your Health Coverage component begins.

Member Responsibility Phase of Deductible

If you deplete the Benefit Dollars in your HRA, you enter the Member Responsibility phase of the Plan Year Deductible. This means you as a Covered Person and/or Covered Dependent are responsible for paying additional health care expenses you incur during that Plan Year up to the amount of your Plan Year Deductible. This is referred to as "Bridging Your HRA and Health Coverage".

The amount of your Member Responsibility can vary each Plan Year, as explained below.

Your Initial Plan Year

The Member Responsibility amount is your Plan Year Deductible minus your HRA Benefit Dollars. If you choose to spend your HRA Benefit Dollars on HRA Only Covered Expenses, the Member Responsibility amount will increase by such amount up to the amount of your Plan Year Deductible.

Member Responsibility Phase of Deductible – cont'd

Subsequent Plan Year(s)

The Member Responsibility amount is your Plan Year Deductible minus your HRA Benefit Dollars adjusted (if applicable) as follows:

- If you roll over HRA Benefit Dollars from the previous Plan Year, the Member Responsibility amount is decreased by such amount;
- If you choose to spend your HRA Benefit Dollars on HRA Only Covered Expenses, the Member Responsibility amount will increase by such amount up to the amount of your Plan Year Deductible;
- If the date on which Claims Administrator processes your claim falls within any subsequent Plan Year for expenses you incurred from a previous Plan Year, a deduction from your HRA Benefit Dollars in such amount will occur thus increasing your Member Responsibility amount up to the amount of your Plan Year Deductible (assuming you have depleted your HRA Benefit Dollars in such previous Plan Year).

IMPORTANT NOTE: It is important to note that your Member Responsibility amount can vary each Plan Year; however, it will never increase above your Plan Year Deductible amount, nor will it decrease to a negative amount.

HOW THE PLAN WORKS – Health Coverage, Deductible, Coinsurance, Coinsurance Maximum

Coinsurance and Coinsurance Maximum

Once you deplete the Benefit Dollars in your HRA and meet the Member Responsibility, Health Coverage pays the percentage, as shown in the Schedule of Benefits, for additional health care Covered Expenses for an In-Network Provider as well as an Out-of-Network Provider. You pay any remaining percentage - referred to as Coinsurance. The Coinsurance has a dollar cap referred to as Coinsurance Maximum and is based on the Plan Year. After you incur and pay Covered Expenses in Coinsurance that meet the Plan's Coinsurance Maximum, the Plan pays 100% of Covered Expenses for the rest of the Plan Year, for an In-Network Provider and 100% of Usual and Customary for an Out-of-Network Provider, subject to any Maximum Individual Limit, Plan Year limit, or other exclusions shown in the Plan. Please note that expenses paid due to satisfaction of the Plan Year Deductible will not be used to meet the Coinsurance Maximum.

PREVENTIVE CARE SERVICES

The Health Coverage component of the Definity HRA California Plan covers annual qualifying Preventive Care Services at 100% at an In-Network Provider. You do not need to spend your Benefit Dollars under your HRA for qualifying In-Network Preventive Care Services and benefits are covered with no Deductible. For a complete list of qualifying Preventive Care Services, see the section entitled, "What's Covered under the Plan, Preventive Care Services – Schedule of Benefits". You may receive additional non-qualifying Preventive Care Services or choose to receive Preventive Care Services from an Out-of-Network Provider; however any such services will be considered as any other claim and will be processed through your HRA, Deductible or Health Coverage.

PERSONAL CARE SUPPORT

Claims Administrator provides a program called Personal Care Support designed to encourage personalized, efficient care for you and your Covered Dependents.

Personal Care Support health coaches center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available. A Personal Care Support health coach is notified when you or your provider calls the toll-free number on your ID card regarding an upcoming treatment or service.

Personal Care Support health coaches provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components and notification requirements are subject to change without notice. As of the publication of this SPD, the Personal Care Support program includes:

- **Admission counseling** – For upcoming inpatient Hospital admissions for certain conditions, a Personal Care Support health coach may call you to help answer your questions and to make sure you have the information and support you need for a successful recovery.
- **Inpatient care advocacy** – If you are hospitalized, a Personal Care Support health coach will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- **Welcome Home!**[SM] – This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Care Support health coach to confirm that medications, needed equipment, or follow-up services are in place. The health coach will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.

If you do not receive a call from a Personal Care Support health coach but feel you could benefit from any of these programs, please call the toll-free number on your ID card.

PERSONAL CARE SUPPORT

Notifying Personal Care Support

There are some services for which you are encouraged to notify Personal Care Support prior to receiving these services from an In-Network or Out-of-Network Provider. In general, an In-Network Provider is responsible for notifying Personal Care Support before they provide these services to you.

The services that suggest notification are:

- all inpatient admissions, including admissions for an overnight stay in a Hospital, Inpatient Rehabilitation Facility, Skilled Nursing Facility, mental health or substance abuse facilities;
- outpatient treatments including, but not limited to:
  - CT or CAT scans (computer aided tomography);
  - Durable Medical Equipment;
  - imaging cardiac stress tests;
  - MRI scans (magnetic resonance imaging); and
  - home health care.

Contacting Personal Care Support is easy.
Simply call the toll-free number on your ID card.

PERSONAL CARE SUPPORT

RESOURCES TO HELP YOU STAY HEALTHY

Your employer believes in giving you the tools you need to be an educated health care consumer. To that end, your employer has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- take care of yourself and your family members;
- manage a chronic health condition; and
- navigate the complexities of the health care system.

NOTE:

Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. Claims Administrator and your employer are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text.

www.myuhc.com

UnitedHealthcare's member website, **www.myuhc.com**, provides information at your fingertips anywhere and anytime you have access to the Internet. **myuhc.com** opens the door to a wealth of health information and convenient self-service tools to meet your needs.

Health Information

With **myuhc.com** you can:

- receive personalized activation messages that are posted to your own website;
- search for In-Network Providers available in your Plan through the online provider directory;
- research a health condition and treatment options to get ready for a discussion with your Physician;
- access all of the content and wellness topics from Health Coaches;
- complete a health assessment to identify health habits you can improve, learn about healthy lifestyle techniques and access health improvement resources;

Health Information – cont'd

With **myuhc.com** you can:

- use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
- use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Self-Service Tools

Visit **myuhc.com** and:

- make real-time inquiries into the status and history of your claims;
- view eligibility and Plan benefit information, including Plan Year Deductibles;
- view and print all of your Explanation of Benefits (EOBs) online; and
- order a new or replacement ID card, print a temporary ID card, or check on an ID card request.

Registering on myuhc.com
If you have not already registered as a **myuhc.com** subscriber, simply go to **myuhc.com** and click on "Register Now." Have your ID card handy. The enrollment process is quick and easy.

United Healthy Living Programs

This web-based program, which can be accessed through myuhc.com provides you with a lifestyle action plan tailored to your risk, preferences and lifestyle. Action plans are available for:

- physical activity;
- nutrition;
- stress management;
- weight management;
- blood pressure;
- cholesterol;
- smoking cessation,
- diabetes; and
- cancer prevention.

PERSONAL CARE SUPPORT

In addition, you will receive a personalized weekly e-mail to help you in your personal health management.

Health Assessment

You and your spouse or domestic partner are eligible to participate in the online health assessment. The health assessment is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

All assessments are kept confidential and your participation in this assessment will not impact your Benefits or eligibility for Benefits in any way.

To find the health assessment, log in to your personal website at myuhc.com, click on the Health Resources tab, then click the health assessment icon. If you need assistance with the online assessment, please call the number on the back of your ID card.

Next Steps

Individuals that complete a health assessment and are identified with three or more high risks will be provided with telephonic outbound coaching. Coaching will be provided on the following topics:

- exercise,
- blood pressure management;
- smoking cessation,
- nutrition
- stress management;
- cholesterol management; and
- back care/ergonomics.

PERSONAL CARE SUPPORT

Health Coaches

Health Coaches is a toll-free telephone service that puts you in immediate contact with an experienced health coach any time, 24 hours a day, seven days a week. Health Coaches can provide health information for routine or urgent health concerns. Call any time when you want to learn more about:

- a recent diagnosis;
- a minor Sickness or Injury;
- men's, women's, and children's wellness;
- how to take Prescription Drugs safely;
- self-care tips and treatment options;
- healthy living habits; or
- any other health related topic.

Depending on your situation, you may receive follow up calls from symptom support, acute or complex care nurses.

Health Coaches is available to you at no cost. To use this convenient service, simply call the toll-free number on the back of your ID card.

Note: If you have a medical emergency, call 911 instead of calling Health Coaches.

Your child is running a fever and it's 1:00 AM. What do you do?
Call Health Coaches toll-free at the number on your ID card, any time, 24 hours a day, seven hours a day, seven days a week. You can count on Health Coaches to help answer your health questions.

Want to learn more about a condition or treatment?
Log on to **myuhc.com** and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

PERSONAL CARE SUPPORT

Chronic Condition Coaching

Claims Administrator provides responsive disease management programs that identify, assess, and support members with specific chronic conditions. Chronic Condition Support is available for:

- asthma;
- diabetes;
- coronary artery disease (CAD);
- congestive heart failure (CHF);
- chronic obstructive pulmonary disease (COPD);
- co-morbidity management of depression;
- end stage renal disease (ESRD); and
- hypertension.

If you are interested in one of these programs you may request information from a Health Coach.

Patient Safety

Claims Administrator addresses the issue of patient safety by identifying potential errors in your medical care by using a software program that provides retrospective, claims-based identification of potential medical errors of omission and commission of care. Through this process patients are identified whose care is inconsistent with established standards of clinical excellence. This information can include problems with omissions of effective preventive care, testing or medications, and treatments that may be inappropriate or harmful. Claims Administrator will notify you if potential errors are identified.

Health Buyer's Guide

Claims Administrator provides you with quality and efficiency information regarding facilities to give you important tools when choosing a provider. To access the Health Buyer's Guide log onto myuhc.com. Or you may call the toll-free number on your ID card for additional information at the Health Buyer's Guide.

PERSONAL CARE SUPPORT

Healthy Pregnancy Program

If you are pregnant and enrolled in the medical Plan, you can get valuable educational information and advice by calling the toll-free number on your ID card. This program offers:

- maternity nurses on duty 24 hours a day;
- a free copy of *The Healthy Pregnancy Guide*;
- a phone call from a maternity nurse halfway through your Pregnancy, to see how things are going;
- a phone call from a nurse approximately four weeks postpartum to give you information on infant care, feeding, nutrition, immunizations and more; and
- a copy of an available publication, for example, *Healthy Baby Book*, which focuses on the first two years of life.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first 12 weeks of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the toll-free number on the back of your ID card.

As a program participant, you can call any time, 24 hours a day, seven days a week, with any questions or concerns you might have.

Activation Campaigns

To help support you in your health care decisions, Claims Administrator may send you and your covered Dependents materials focused on the following topics:

- your health care experience;
- your health and wellness; and
- value for your health care dollar.

SCHEDULE OF BENEFITS – Health Coverage

	IN-NETWORK AND OUT-OF-NETWORK (COMBINED)
Plan Year Deductible: ***(The sum of your HRA and Member Responsibility)***	
Employee Only	$950 HRA* + $550** Mem. Resp. = $1,500 Plan Year Deductible
Employee/Adult Family Member	$1,400 HRA* + $850** Mem. Resp = $2,250 Plan Year Deductible
Employee plus Child(ren)	$1,450 HRA* + $800** Mem. Resp = $2,250 Plan Year Deductible
Employee plus Family	$1,900 HRA* + $1,100** Mem. Resp = $3,000 Plan Year Deductible

*If you or your spouse/eligible partner choose to participate in the HRA incentive program, an additional $50 per employee/eligible partner will be allocated to your HRA for the Plan Year. This will reduce your Member Responsibility for such Plan Year per participant (up to a maximum of $100).

** The amount of your Member Responsibility (your portion of the Plan Year Deductible) can vary from your initial Plan Year to subsequent Plan Year(s). See the section entitled "Member Responsibility Phase of Deductible" for further details.

	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS (UP TO U&C[1])
Plan Year Coinsurance Maximum: (excludes Plan Year Deductible)		
Employee Only	$1,500	$8,500
Employee/Adult Family Member	$2,250	$12,750
Employee plus Child(ren)	$2,250	$12,750
Employee plus Family	$3,000	$17,000

[1] U&C refers to usual and customary charges. Usual and customary means the lesser of:

- The Provider's usual charge for furnishing the service or supply, or
- The charge Claims Administrator determines is reasonable based on the cost of providing the same or similar service or supply in the same geographical area.

Important note regarding the Health Reimbursement Account (HRA):	**For all benefits listed below, the HRA pays first at 100% of the Covered Expense. Once the HRA is depleted and the Deductible is satisfied, the Plan will pay the percentage, as shown below, of the Covered Expense, unless otherwise noted.**	
COVERED EXPENSES	**IN-NETWORK AND OUT-OF-NETWORK COMBINED**	
Maximum Individual Limit For: Transplants	Two transplant procedures for the same condition, per person	
Infertility treatment and related prescription drugs (Note: Infertility and related prescription drugs are payable ONLY under the HRA. Once the HRA is depleted, there is no further coverage for infertility and related prescription drugs for that Plan Year. Such Covered Expenses will not count toward satisfaction of the Plan Year Deductible)	$10,000 per person	
Transgender Surgery Benefits (including transgender surgery travel benefits)	$50,000 per person	
All Other Covered Expenses includes any other Maximum Individual Limits	$5,000,000 per person In-Network	$2,000,000 per person Out-of-Network

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COVERED EXPENSES	**IN-NETWORK PLAN PAYS**	**OUT-OF-NETWORK PLAN PAYS (UP TO U&C[1])**
Accidental Dental Care Treatment must begin within 6 months of accident to sound, natural teeth for accident occurring while covered under the Definity HRA California Plan	80%	60%
Acupuncture	80%	60%
Ambulance a) Ground transportation licensed to provide basic or advanced life support to the nearest medical facility equipped to treat illness b) Emergency air ambulance c) Medically Necessary, prearranged or scheduled air or ground ambulance transportation requested by an attending Physician or nurse	80%	80% when rendered in connection with Emergency Care; 60% when rendered in connection with non-Emergency Care
Chiropractic Care Limited to $500 per Plan Year (In-Network and out-of-network combined)	80%	60%
Durable Medical Equipment	80%	60%
Emergency Care	80%	80% if care received meets criteria for Emergency Care; otherwise 60%
Hearing aids and related supplies, includes digital devices Limited to $2,000 for two hearing aids every 36 months (In-Network and out-of-network combined)	80%	60%

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COVERED EXPENSES	**IN-NETWORK PLAN PAYS**	**OUT-OF-NETWORK PLAN PAYS (UP TO U&C[1])**
Home Health Care Limited to 180 visits per Plan Year One visit = four consecutive hours in a 24 hour period (In-Network and out-of-network combined)	80%	60%
Home Infusion Therapy	80%	60%
Hospice Care	80%	60%
Inpatient Hospital Care Semi-private room required	80%	60%
Inpatient Rehabilitation Limited to 90 days per Plan Year (In-Network and out-of-network combined)	80%	60%
Lab & X-Ray	80%	60%
Maternity Care 48 hour stay for normal vaginal births, 96 hour stay for normal cesarean birth	80%	60%
Medical Supplies	80%	60%
Occupational Therapy	80%	60%
Office Visits	80%	60%
Outpatient Hospital Care	80%	60%

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COVERED EXPENSES		**IN-NETWORK PLAN PAYS**	**OUT-OF-NETWORK PLAN PAYS (UP TO U&C[1])**
Physical Therapy		80%	60%
Licensed Physician Services		80%	60%
Prescription Drugs			
Retail: Mail Order:	up to a 30 day supply up to a 90 day supply (In-Network and out-of-network combined)	Plan pays 80% of Covered Expenses after Plan Year Deductible if you use: • a network pharmacy • your ID card • generic substitution when available	You pay 100% of cost of prescription when dispensed; then you submit reimbursement form along with receipt(s) to Claims Administrator; Plan pays 80% of the *In-Network contracted rate* for a Covered Expense – the difference between the actual cost and what you would have paid if you'd used an In-Network pharmacy.
Your pharmacist or Physician may impose additional limits as they deem appropriate			
Preventive Care Services		Plan pays 100% of Covered Expense of Scheduled Benefits (as listed under the Preventive Care Schedule); Deductible and HRA do not apply	Plan pays 60% of Covered Expense of Scheduled Benefits (as listed under the Preventive Care Schedule); however, the Plan Year Deductible and HRA DO apply
Radiation/Chemo Therapy		80%	60%
Skilled Nursing Facility Limited to 120 days per Plan Year (In-Network and out-of-network combined)		80%	60%

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COVERED EXPENSES	**IN-NETWORK PLAN PAYS**	**OUT-OF-NETWORK PLAN PAYS (UP TO U&C[1])**
Speech Therapy	80%	60%
Special Duty Nursing received on an outpatient basis only Limited to 20 visits per Plan Year One visit = 8 consecutive hours in a 24 hour period (In-Network and out-of-network combined)	80%	60%
Surgery for Morbid Obesity	80%	60%
TMJ	80%	60%
Transgender Surgery Benefits $50,000 Maximum Individual Limit See "Transgender Surgery Benefits" section for list of Covered Expenses	80%	60%
Transplants	80%	60%
Urgent Care	80%	60%
All Other Covered Expenses	80%	60%

[1] U&C refers to usual and customary charges. Usual and customary means the lesser of:

- The provider's usual charge for furnishing the service or supply, or
- The charge Claims Administrator determines is reasonable based on the cost of providing the same or similar service or supply in the same geographical area.

COVERED EXPENSES FROM NON-NETWORK PROVIDERS PAID AS IN-NETWORK PROVIDERS

If you require a specific Covered Expense that is not available from an In-Network Provider within 30 miles of your home, the Plan will pay for such Covered Expense at the In-Network Provider benefit level (subject to the Deductible and other restrictions) from an Out-of-Network Provider, subject to limitation below. Requests for this benefit should be made before services are utilized by calling the number on the back of your ID card.

LIMITATIONS ON SELECTION OF PROVIDERS

Your selection of an Out-of-Network Provider is limited when you require a specific Covered Expense that is not available from an In-Network Provider within 30 miles from your home. The Plan will not pay for a Covered Expense at the In-Network Provider benefit level from an Out-of-Network Provider when you must travel a greater distance to an Out-of-Network Provider when an In-Network Provider is available to you at the same or shorter distance.

GENERAL DEFINITIONS / KEY TERMS

Benefit Dollars

Benefit Dollars represent the amount your employer allocates for you for payment of Covered Expenses. Benefit Dollars are used **FIRST** for your health care needs and pays 100% of Covered Expenses, up to the allocated balance in your HRA. Your employer does not set aside any actual dollars into a fund or account, and claims for benefits from your HRA will be paid from your employer's general assets. You will lose your Benefit Dollars when you stop participating under the Plan.

Birth Services

Means antepartum (before labor); intrapartum (during labor); and postpartum (after birth) care. This care is given with respect to: 1) uncomplicated pregnancy and labor; and 2) spontaneous vaginal delivery.

Birthing Center

Means an inpatient or outpatient facility which:

1. complies with licensing and other legal requirements in the jurisdiction where it is located;
2. is engaged mainly in providing a comprehensive Birth Services program to pregnant individuals who are considered normal low risk patients;
3. has organized facilities for Birth Services on its premises;
4. has Birth Services performed by a Physician specializing in obstetrics and gynecology, or at his or her direction, by a nurse midwife; and
5. has 24-hour-a-day Registered Nurse Services.

Coinsurance Maximum

Means the specified maximum amount of percentage you pay out-of-pocket under the Health Coverage component – referred to as Coinsurance. Such Coinsurance has a dollar cap - defined here as Coinsurance Maximum. After you meet the Plan's Coinsurance Maximum for that Plan Year, the Plan pays 100% of Covered Expenses for the remainder of the Plan Year, for an In-Network Provider and 100% of Usual and Customary for an Out-of-Network Provider, subject to any limits under the Plan. Coinsurance you pay out-of-pocket for Covered Expenses from all covered family members are combined to reach the Coinsurance Maximum. Satisfaction or partial satisfaction of the out-of-network Coinsurance Maximum, will be considered towards satisfaction or partial satisfaction of the In-Network Coinsurance Maximum and vice versa. Coinsurance Maximum is in addition to the Member Responsibility.

Covered Expense

Means the expenses as defined and listed within the sections entitled, "What's Covered under the Plan, Covered under the Health Reimbursement Account - Only, and Covered Under the Health Reimbursement Account and the Health Coverage."

Covered Dependent

Means an Eligible Dependent whose coverage under the Plan: 1) became effective; and 2) has not terminated.

Covered Person

Means an eligible employee whose coverage under the Plan: 1) became effective; and 2) has not terminated.

GENERAL DEFINITIONS / KEY TERMS

Deductible: Means the amount of Covered Expenses that each Covered Person must incur in a Plan Year before the Plan will pay benefits. In the case of family coverage, it means the amount of Covered Expenses that two or more family members together must incur in a Plan Year before the Plan will pay benefits. Satisfaction or partial satisfaction of the Non-Network Deductible will be considered towards satisfaction or partial satisfaction of the Network Deductible and vice versa.

Durable Medical Equipment

Means equipment which is: 1) prescribed by a Physician as essential in the treatment of a medical condition; 2) able to withstand repeated use; 3) not useful generally to you in the absence of a medical condition; and 4) manufactured or sold by a medical supply company.

Eligible Dependent

Refer to section entitled, "Eligibility and How to Enroll", for specific definition.

Emergency Care

Means medical and health services provided for a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. placing the health or survival of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

Employer

Means the University of California.

GENERAL DEFINITIONS / KEY TERMS

Experimental / Investigational Services

Means at the time a determination is made regarding coverage in a particular case, a drug, device, diagnostic or screening procedure, or a medical treatment or procedure will be determined to be "investigative" if reliable, authoritative evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes as compared with the standard means of treatment or diagnosis.

The Plan will base its determination upon an examination of one or more of the following kinds of reliable evidence, none of which shall be determinative in and of itself:

1. Published reports, articles, or consensus expert panel opinions and recommendations in the authoritative peer reviewed medical and scientific literature
2. Written protocol(s) used by the treating provider; or the protocol(s) of another provider studying substantially the same service; or the written informed consent used by the treating provider or by another provider studying substantially the same service
3. Review by a financially disinterested, external, specialty appropriate board-certified expert medical reviewer

All determinations of reliable evidence shall be made by the Plan.

Notwithstanding the above, a drug, device, diagnostic or screening procedure, or a medical treatment or procedure will not be determined to be "investigative" and will be considered a covered benefit when it is being administered or performed as part of a Phase III clinical investigational trial where all treatment arms involve covered services for covered conditions.

Home Health Care Agency

Means a public or private agency that provides skilled nursing functions or activities in the Covered Person's or Covered Dependent's home. It is licensed as such (or if no license is required, approved as such) by a state department or agency having authority over home health agencies.

GENERAL DEFINITIONS / KEY TERMS

Hospice

Means a facility operated by a Hospital or other licensed health care institution. It is not a convalescent home; a nursing home or similar institution. Its purpose is to provide an alternative environment with palliative and supportive care for terminally ill patients either directly or on a consulting basis with the patient's Physician or another community agency, such as a visiting nurses' association. For purposes hereof, a terminally ill patient is any patient whose life expectancy, as determined by a Physician, is not greater than 6 months.

Hospital

Means an institution which:

1. is legally operated in the jurisdiction where it is located;
2. is engaged mainly in providing inpatient medical care and treatment for Injury and Illness/Sickness in return for compensation;
3. has organized facilities for diagnosis and major surgery on its premises;
4. is supervised by a staff of at least two Physicians;
5. has 24-hour-a-day nursing service by Registered Nurses; and
6. is not a facility specializing in dentistry; or an institution which is mainly a rest home; a home for the aged; a place for drug addicts; a place for alcoholics; a convalescent home; a nursing home; an extended care or Skilled Nursing Facility or similar institution; or a Long Term Acute Care Facility (LTAC).

Illness

Means a sickness or a disease of a Covered Employee or Covered Dependent. Illness will include congenital defects or birth abnormalities.

Injury

Means accidental bodily injury of a Covered Person or Covered Dependent.

In-Network Provider

Means a participating provider that Claims Administrator has contracted with or made arrangements with to provide health services to covered persons. An In-Network Provider has agreed to charge participants a discounted rate, therefore making your Covered Person's or Covered Dependent's HRA go further by using an In-Network Provider. To determine if a provider is an In-Network Provider log onto www.myuhc.com and click under the *Find a Provider* tab. You may also call the number of the back of your ID card and a customer service representative can locate an In-Network Provider.

Intensive Care Unit

Means a section, ward or wing within the Hospital which:

1. is separated from other Hospital facilities;
2. is operated exclusively for the purpose of providing professional care and treatment for critically ill patients;
3. has special supplies and equipment necessary for such care and treatment available on a standby basis for immediate use;
4. provides room and board; and
5. provides constant observation and care by Registered Nurses or other specially trained Hospital personnel.

Licensed Practical Nurse

Means an individual who has received: 1) specialized nursing training; and 2) practical nursing experience. He or she is licensed to perform nursing service by the state in which he or she performs such service. This definition will include licensed vocational nurses with the above qualifications.

GENERAL DEFINITIONS / KEY TERMS

Maximum Individual Limit

The Plan will pay benefits limited to the Maximum Individual Limit shown in the Schedule of Benefits. This applies individually to each Covered Person and Covered Dependent. When benefits in such amount have been paid or are payable under this benefit for you or your eligible dependents, all coverage for that person under this benefit will terminate.

Medically Necessary

Means that the service or supply is:

1. consistent with the diagnosis of and prescribed course of treatment* for the patient's condition or mental disorder,
2. supported by evidence based medical research using valid scientific methods that demonstrate a health benefit from the service, or when none is available based on nationally accepted standards of care,
3. provided by a licensed provider with the appropriate training and experience for the service,
4. not otherwise excluded in this plan.

The fact that a provider has performed, prescribed or recommended a service or that a service is available does not mean that the service is Medically Necessary or a covered benefit.

*For transgender surgery benefits, the criteria for diagnosis and treatment are based on the guidelines stated in The Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders.

Member Responsibility

The Member Responsibility is your portion of the Deductible that you must pay out-of-pocket on Covered Expenses after you deplete the Benefit Dollars in your HRA and before the Health Coverage component "kicks" in - often referred to as "Bridging your HRA and Health Coverage". Such portion is specified in the Schedule of Benefits. Your Member Responsibility will be less if you roll over HRA Benefit Dollars from the previous Plan Year. However, the Member Responsibility could increase, up to the amount of your Deductible, if you choose to spend your HRA Benefit Dollars on "extra" non-traditional Covered Expenses – refer to "Covered Under the Health Reimbursement Account - Only" for a listing of such expenses.

Out-of-Network Provider

Means a provider not under contract as an In-Network Provider.

Physician

Means a person who has successfully completed the prescribed course of studies in medicine in a medical school officially recognized and who has acquired the requisite qualifications for license in the state in which the treatment is received in the practice of medicine. He or she must be practicing within the scope of that license.

Plan Year

Plan Year means a 12-month period of time that follows the Plan's Effective Date and each subsequent twelve-month period this Plan remains in force. For purposes of this Plan the Plan Year is January 1 through December 31.

GENERAL DEFINITIONS / KEY TERMS

Qualified Medical Child Support Orders (QMCSOs)

QMCSOs are state court orders requiring a parent to provide medical support to a child often because of legal separation or divorce. A QMCSO may require the Plan to make coverage available to your child even though, for income tax or plan purposes, the child is not your dependent. To qualify, a medical support order must be a judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or by an administrative agency, which:

- specifies your last known name and address and the child's last known name and address,
- describes the type of coverage to be provided, or how the type of coverage will be determined,
- states the period to which it applies, and
- specifies each plan to which it applies.

The QMCSO cannot require the plans to cover any type or form of benefit that they do not currently cover. The plans must pay benefits directly to the child, or to the child's custodial parent or legal guardian, consistent with the terms of the order and plan provisions.

Qualified Medical Child Support Orders – cont'd

You and the affected child will be notified if an order is received and will be provided with a copy of your employer's QMCSO procedures.

Registered Nurse

Means a professional nurse who has the right to use the title Registered Nurse (R.N.) in the state in which services are provided.

GENERAL DEFINITIONS / KEY TERMS

Skilled Nursing Facility or Extended Care Facility

Means an institution or a distinct part thereof, including an intermediate nursing facility, which:

1. is licensed pursuant to state and local laws;
2. is operated primarily for the purpose of providing skilled nursing care and treatment for individuals convalescing from Injury or Illness/Sickness;
3. is approved by and is a participating facility with Medicare;
4. has organized facilities for medical treatment;
5. provides 24-hour-a-day nursing service under the full-time supervision of a Physician or Registered Nurse;
6. maintains daily clinical records on each patient;
7. has available the services of a Physician under an established agreement;
8. provides appropriate methods for dispensing and administering drugs and medicines;
9. has transfer arrangements with one or more Hospitals; a utilization review plan in effect; and operational policies developed with the advice of and reviewed by a professional group including at least one Physician; and
10. is not an institution which is mainly a rest home; a home for the aged; a place for drug addicts; a place for alcoholics; or a place for the treatment of mental illness.

Urgent Care Center

Means a facility operated to provide health care services in emergencies or after hours. It is not part of a Hospital.

GENERAL DEFINITIONS / KEY TERMS

Usual and Customary

Usual and customary means the lesser of:

1. the provider's usual charge for furnishing the service or supply; or
2. the charge the Claims Administrator determines is reasonable based on the cost of providing the same or similar service or supply in the same geographical area.

To determine the reasonable charge for a service or supply that is unusual, not often provided in the area, or provided by only a small number of providers, the Claims Administrator will consider:

1. the complexity of the service or supply;
2. the degree of skill needed;
3. the provider's specialty;
4. the range of services or supplies provided by a facility; and
5. similar charges in other areas.

The Plan covers Covered Expenses up to the "usual and customary" amount when an Out-of-Network Provider is used.

ELIGIBILITY AND HOW TO ENROLL

The following information applies to the University of California plan and supersedes any corresponding information that may be contained elsewhere in the document to which this insert is attached. The University establishes its own medical plan eligibility, enrollment and termination criteria based on the University of California Group Insurance Regulations ("Regulations") and any corresponding Administrative Supplements. Portions of these Regulations are summarized below.

Who Is Eligible

Subscriber - Employee:

You are eligible to participate in the Plan 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; or
- have accumulated 1,000* hours while on pay status in a twelve-month period.

To remain eligible, you must maintain an average regular paid time** of at least 17.5 hours per week and continue in an eligible appointment. 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)."

*****Lecturers – see your benefits office for eligibility.

****** 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.

ELIGIBILITY AND HOW TO ENROLL

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.

Who Is Eligible – cont'd

If you are eligible for Medicare, see "Effect of Medicare on Enrollment" below

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 including any who are required to be your tax dependent(s). Documentation could include a marriage certificate, birth certificate(s), adoption records, Federal Income Tax Return, or other official documentation.

Spouse: 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.

Eligible Dependents (Family Members) – cont'd

Any child described above (except a legal ward) who is incapable of self-support due to a physical or mental handicap may continue to be covered 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 claimed as your dependent for income tax purposes or is eligible for Social Security Income or Supplemental Security Income as a disabled person or working in supported employment which may offset the Social Security or Supplemental Security Income; 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 at least 31 days before the child's 23rd birthday and is subject to approval by the Plan. The Plan may periodically request proof of continued disability. 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.

Other partner's Eligible Dependents

You may enroll a same-sex domestic partner (and the same-sex domestic children/grandchildren/stepchildren) as set forth in the University of California Group Insurance Regulations.

(Family

(Members): Effective January 1, 2005, the University will recognize an opposite-sex domestic partner as a family member that is eligible for coverage in UC-sponsored benefits if the employee or domestic partner is age 62 or older and eligible to receive Social Security benefits and both the employee and domestic partner are at least 18 years of age.

An adult dependent relative is no longer eligible to receive coverage effective January 1, 2004. Only an adult dependent relative who was enrolled as an eligible dependent as of December 31, 2003, may continue coverage in UC-sponsored plans.

For information on who qualifies and how to enroll, contact your local Benefits Office.

No Dual Coverage

Eligible individuals may be covered under only one of the following categories: as an Employee or a Family Member, but not under any combination of these. If an Employee and the Employee's spouse, or AB205 California Domestic Partner Rights and Responsibilities Act of 2003 covering opposite-sex domestic partners under certain conditions, or domestic partner are both 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 or eligible domestic partner's coverage but not under both. Additionally, a Child who is also eligible as an Employee may not have dual coverage through two University-sponsored medical plans.

ELIGIBILITY AND HOW TO ENROLL

Enrollment

For information about enrolling yourself or an eligible Family Member, see the person at your location who handles benefits. Enrollment transactions may be completed by paper form or electronically, according to current University practice. To complete the enrollment transaction, paper forms must be received by the local Accounting or Benefits office 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.

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, or AB205 California Domestic Partner Rights and Responsibilities Act of 2003 covering opposite-sex domestic partners under certain conditions.

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

During a Period of Initial Eligibility (PIE) – cont'd

(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 group medical plan coverage and you lose that coverage involuntarily, 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.

If you are in an HMO, POS or EPO Plan and you move or are transferred out of that Plan's service area, or will be away from the Plan'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 Plan's service area.

At Other Times

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

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

At Other Times – cont'd

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

If you are an Employee and there is a lifetime maximum for all benefits under this plan, and you or a Family Member reaches that maximum, you and your eligible Family Members may be eligible to enroll in another UC-sponsored medical plan. Contact the person who handles benefits at your location.

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.

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.

An employee already enrolled in employee and child(ren) or family coverage may add additional children at any time after their PIE. Retroactive coverage is limited to the later of:

(a) the date the Child becomes eligible, or

(b) a maximum of 60 days prior to the date your Child's enrollment transaction is completed.

Change in Coverage

In order to change from single to adult plus (child)ren coverage, or two adult coverage, or family coverage, or to add another Child to existing family coverage, contact the person who handles benefits at your location.

Effect of Medicare on Enrollment

If 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. Beginning January 1, 2004, you and/or your Family Member(s) who become eligible for premium free Medicare Part A and do not enroll in Part B, will permanently lose your UC-sponsored medical coverage.

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 submit documentation of Medicare enrollment to your local benefits office. This notifies the University that you are covered by Part A and Part B of Medicare.

Any individual enrolled in a University-sponsored Medicare Advantage Managed Care Contract must assign his/her Medicare benefit to that plan or lose UC-sponsored medical coverage.

ELIGIBILITY AND HOW TO ENROLL

Medicare Secondary Payer Law (MSP)

The Medicare Secondary Payer (MSP) Law affects the order in which claims are paid by Medicare and an employer group health plan. UC Annuitants hired into positions making them eligible for UC-sponsored medical coverage, including CORE and mid-level benefits, are subject to MSP. For Employees or their spouses who are age 65 or older and eligible for a group health plan due to employment, Medicare becomes secondary payer and the employer plan becomes the primary payer.

Medicare Private Contracting Provision

Federal Legislation allows Licensed 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 Licensed Physicians or practitioners will need to enter into written "private contracts" with these Licensed 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.

Some physicians and practioners have never participated in Medicare. There services (that would be covered by Medicare if they participated) will not be covered by Medicare or this Plan, and the Medicare limiting charge will not apply.

If you or a Family Member has Medicare as a primary coverage, are enrolled in Medicare Part B, and choose to enter into such a "private contract" arrangement with one or more Licensed Physicians or practitioners, under the law you have in effect "opted out" of Medicare for the services provided by these Licensed Physicians or other practitioners. No benefits will be paid by this Plan for services rendered by these Licensed 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 Licensed Physician or practitioner, you may see other Licensed Physicians or practitioners without those private contract restrictions as long as they have not opted out of Medicare.

Termination of Coverage

The termination of coverage provisions that are established by the University of California in accordance with its Regulations are described below. Additional Plan provisions apply and are described elsewhere in the document.

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.

This plan cannot be continued into retirement. If you retire, you will be provided a 31-day Period of Eligibility (PIE) prior to your retirement date in which to transfer into another University Medical Plan.

If your Family Member loses eligibility, you must complete the appropriate transaction to delete him or her within 60 days of the date the Family Member is no longer eligible. Coverage stops at the end of the month in which he or she no longer meets all the eligibility requirements. For information on de-enrollment procedures, contact the person who handles benefits at your location.

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 permanently de-enrolled while any other Family Member and the 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 12 months.

Leave of Absence, Layoff or Retirement

Contact your local Benefits Office for information about continuing your coverage in the event of an authorized leave of absence, layoff or retirement.

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 University's "At Your Service" website (http://atyourservice.ucop.edu). 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.

Coverage Categories

You can choose from the following coverage categories:

- Employee Only;
- Employee/Adult Family Member;
- Employee plus Child(ren); and
- Employee plus Family.

Benefit Dollars and Deductibles for Mid-Year Enrollments

If you are hired during the Plan Year and enroll in the Plan, your employer will allocate a pro-rated number of Benefit Dollars to your HRA and you will be subject to a prorated Deductible under the Health Coverage Plan.

Benefit Dollars and Deductibles for Mid-Year Enrollment of Special Enrollees under HIPAA

If you experience a mid-year status change during the Plan Year, (as stated in section entitled, "Optional Continuation of Coverage") resulting in an allowable change to your Coverage Category (see section entitled, "Coverage Categories" for available coverage levels), your Plan Year Benefit Dollars in your HRA and your Plan Year Deductible will be adjusted. When your Coverage Category is increased (employee to employee +1) your HRA and Plan Year Deductible is immediately adjusted to your new Coverage Category minus any amounts used in that Plan Year. Any HRA Benefit Dollars that had rolled over from previous Plan Years will remain with you. When your Coverage Category decreases (employee +1 to employee) your HRA Benefit Dollars are *not* adjusted to your new Coverage Category – your Coverage Category remains the same for the remainder of the Plan Year. However, your Plan Year Deductible is immediately adjusted to the new Coverage Category minus any amounts used in that Plan Year. Any HRA Benefit Dollars that had rolled over from previous Plan Years will remain with you.

Transition of Care

If you are in the midst of a cycle of treatment or are in your third trimester of pregnancy when your coverage through the Plan begins, you may request that your care continue from your current provider for up to 120 days. If approved, your HRA and the Health Coverage Plan will pay Covered Expenses at the In-Network level (subject to Deductibles and other restrictions), regardless of your provider's network status, until your pregnancy or cycle of treatment is complete. This benefit is not automatic. For more information on how to qualify please call the number on the back of your ID card to speak with a representative.

COST

You have the option for your Plan premiums to be deducted on a pretax, salary reduction basis. You are not permitted to make any contribution to your HRA, whether made on a pre-tax or after tax basis. Your HRA is an "unfunded" account, and benefits are payable solely from the general assets of your employer.

WHAT'S COVERED UNDER THE PLAN

As shown below, the Plan covers many Medically Necessary services and supplies, subject to any limits or exclusions in the Plan. Please note: the Plan only covers care provided by health care professionals or facilities licensed, certified or otherwise qualified under state law to provide health care services.

Preventive Care Services – Schedule of Benefits

The Health Coverage component covers the Preventive Care Services – Schedule of Benefits. The following is a list of items that are considered to be qualifying Preventive Care Services Covered Expenses under the Health Coverage payable at 100% at an In-Network Provider, with no need to use the HRA or satisfy the Plan Year Deductible. Out-of-Network is payable at 60% of the Covered Expense; however, you will need to use the HRA or satisfy the Plan Year Deductible.

Well-Child Care

Well-child care includes routine office visits and examination, as follows:

- six visits 0 – 12 months;
- three visits 12 – 24 months; and
- annual visits from 24 months through age 18.

Included immunizations and screenings associated with the above routine office visits are as follows:

- Immunizations
  - Two doses of Hepatitis A;
  - Three doses of Hepatitis B;
  - Six doses of Diptheria, Tetanus, Pertussis (DtaP);
  - Four doses of Haemophilus Influenza type b;
  - Four doses of Polio;
  - Four doses of Pnuemococcal Conjugate;
  - Two doses of Varicella;

Well-Child Care – cont'd

- Two doses of Measles, Mumps, Rubella; and
- Influenza vaccine (flu shot) one dose each Plan Year for children over the age of 8 years; two doses (administered separately by at least 4 weeks) each Plan Year for children up through 8 years of age.
- Human papillomavirus (HPV) vaccine for girls ages 9 through 18 years of age at the following intervals:
    - One complete dosage per lifetime consisting of 3 shots given within a 6 month timeframe.
    - Women over the age of 18 years but under the age of 26 years who have not yet received the HPV may also receive the vaccine.
- Meningococcal conjugated vaccine (MCV4) at the following intervals:
    - One dose between the ages of 11 and 12 years; or
    - One dose before high school entry or at age 15 years, whichever occurs first, for children who have not previously received the MCV4 vaccine.

- Screenings and Exams
    - Lead level testing, one between ages 9 to 12 months and one at 24 months or after;
    - Vision screening conducted as part of Well-Child Care at ages 3, 4, 5, 6, 8, 10, 12, 15, and 18;
    - Hearing screening conducted as part of Well-Child Care at ages 4, 5, 6, 8, 10, 12, 15, and 18; and
    - Pap smear and routine pelvic exam, one each Plan Year beginning at age 18 or the onset of sexual activity, whichever comes first.

Well-Adult Care

One OB/GYN visit is covered each Plan Year for women when the visit occurs separately from the woman's routine office visit and examination.

Well-adult care for men and women includes one routine office visit and examination at the intervals as shown below:

- beginning at age 19 years of age and through 39 years of age, limited to once every 3 years;

- beginning at age 40 years of age and through 64 years of age, limited to once every 2 years; and
- beginning at age 65 years of age and over, one each Plan Year.

Well-Adult Care – cont'd

Included immunizations and screenings associated with the above routine office visits are as follows:

- Immunizations
  - Tetanus / Diptheria (Td) Booster once every 10 years;
  - Influenza Vaccination (flu shot), one shot each Plan Year; and
  - Pneumococcal Vaccination (Pneumovaz) one dose for persons 65 years of age and over,
  - Meningococcal conjugated vaccine (MCV4), one dose for college freshmen living in dormitories
- Screenings
  - Cholesterol screening including triglycerides, LDL, HDL, or lipid panel once every 5 years beginning at age 20 years of age;
  - Routine Mammogram, one each Plan Year starting at 40 years of age;
  - Pap Smear and Routine Pelvic Exam, one each Plan Year beginning at age 18 years of age;
  - Bone density test for osteoporosis once for women age 50 years and over,,
  - Colorectal Cancer Screenings, you have the choice of the following:
    - Fecal occult blood test (FOBT), one each Plan Year and flexible sigmoidoscopy once every 5 years both beginning at age 50 years of age; or
    - Colonoscopy once every 10 years beginning at age 50 years of age; or
    - Double contrast barium enema once every five years starting at age 50 years of age; and
  - Digital rectal examination (DRE) and prostate specific antigen (PSA) test, one per Plan Year starting at age 45 years of age.

It is important to note that any qualifying Preventive Care Services that fall outside of the above well child and well adult lists, including all prescriptions, or received from an Out-of-Network Provider will not be payable at 100%; however, they will be considered for coverage under the HRA, Member Responsibility phase of the Plan Year Deductible, or Health Coverage component of the Plan.

WHAT'S COVERED UNDER THE PLAN

Standard Services

The Plan covers a wide range of medical expenses provided they are determined to be Medically Necessary or usual to the treatment of an Illness or Injury, as determined by the Claims Administrator's medical staff or an independent medical Physician review panel. Some Covered Expenses are payable ONLY under the HRA, while others are payable under both the HRA and the Health Coverage.

Covered Under the Health Reimbursement Account - Only

The following is a listing of Covered Expenses payable only under your Health Reimbursement Account and will **not** count toward satisfaction of your Plan Year Deductible. The Internal Revenue Service has specific guidelines that must be followed for many of these items. For more information on a specific benefit please call the number on the back of your ID card.

- amounts in excess of any Health Coverage limits;
- amounts over Usual and Customary;
- difference between brand and generic prescription drugs when member chooses brand over generic;
- infertility treatment, limited to $10,000 per person per Maximum Individual Limit. This includes related prescription drugs and hormone therapy;
- smoking cessation programs. This includes prescription drugs related to program; and
- weight loss program when recommended by a Physician to treat an existing disease, such as heart disease. This includes prescription drugs related to program.

Covered Under The Health Reimbursement Account and Health Coverage

The following is a listing of Covered Expenses under your Health Reimbursement Account **and** the Health Coverage and **will** count towards satisfaction of your Plan Year Deductible.

- abortions (elective);
- accidental dental care, subject to Exclusions under the Plan;
- acupuncture;
- allergy injections, testing and serum;

Covered Under Your Health Reimbursement Account and Health Coverage - cont'd

- alternative care settings (such as Skilled Nursing Facilities, Hospice or Home Health Care);
- anesthesia;
- blood and blood plasma transfusions and blood not donated or replaced;
- chemotherapy;
- chiropractic care with a $500 Plan Year maximum (in and out-of-network combined);
- circumcision;
- Christian Science practitioners;
- cochlear implants;
- contraception (oral contraceptives, emergency products and contraceptive services and devices, such as IUDs, sponges, diaphragms, Norplant insertion and removal, Depo-Provera injections);
- diabetic supplies and insulin;
- dialysis;
- durable medical equipment including: orthotic devices, prosthetic appliances, rental (not more than the purchase price) or, if less costly, purchase, of durable medical equipment and related supplies. Certain types of durable medical equipment may need to be reviewed by the Claims Administrator to determine if the equipment is Medically Necessary
- Emergency Care;
- eye exam, when Medically Necessary (other than a routine eye exam);
- genetic testing and counseling;
- hearing aids and related supplies, including digital devices, up to $2,000 every 36 months;
- hearing exam, when Medically Necessary (other than a routine hearing exam);
- home infusion therapy when ordered by Physician, including solutions and pharmaceutical additives; pharmacy compounding and dispensing services; ancillary medical supplies; nursing services to train you or your caregiver or to monitor the home infusion therapy, provide emergency care, collection, analysis and reporting of lab tests to monitor response to home infusion therapy, enteral feedings, or other eligible home health supplies and services provided during home infusion therapy;
- hormonal therapy injections related to a Gender Identity Disorder;

Covered Under Your Health Reimbursement Account and Health Coverage - cont'd

- Hospital charges for use of its surgical room on an outpatient basis
- Hospital services such as nursing care (R.N. and LPN), x-rays and laboratory tests;
- impotence prescription drugs;
- inhalation therapy (provided by a registered or licensed therapist) when needed to correct a functional disorder due to an Illness or Injury;
- inpatient Physician care;
- inpatient rehabilitation, up to the annual maximum in the Schedule of Benefits;
- mammography, other than a routine screening, subject to age requirements for routine only;
- maternity care and reproductive care (including services and supplies provided by a Birthing Center or licensed midwife);
- medical supplies and services as deemed Medically Necessary by a Physician and charged by a Hospital and administered during any Hospital confinement or received for treatment on an outpatient basis;
- nutritionists, when required to treat a medical condition;
- occupational therapy (by a licensed therapist);
- outpatient (ambulatory) surgery;
- outpatient cardiac rehabilitation services;
- outpatient x-ray and laboratory charges;
- oxygen and other gases;
- physical therapy (provided by a licensed physical therapist);
- Physician services;
- podiatric care;
- pre-admission testing. This is limited to diagnostic, x-ray, and laboratory exams made during a Hospital outpatient visit. The exams must be made prior to a Hospital confinement for which a room and board change is made;
- prescription drugs lawfully obtainable only upon a Physician's written prescription. For drugs and medicines that are not covered, see section entitled "Prescription Drug Coverage";

Covered Under Your Health Reimbursement Account and Health Coverage - cont'd

- pulmonary rehabilitation;
- semi-private room and board for Hospital stays, Intensive Care Unit for Hospital stays, and alternative care settings (private rooms are covered only if Medically Necessary);
- speech therapy to restore speech lost due to a congenital condition for which corrective surgery cannot be performed, or due to Injury or Illness;
- special duty nursing, as performed by a Registered Nurse or Licensed Practical Nurse, approved by attending Physician, not to exceed limit stated in Schedule of Benefits;
- sterilization;
- surgery for morbid obesity, provided it is determined to be Medically Necessary by your Physician **and** you meet clinical criteria as determined by your Plan Administrator
- surgical care;
- TMJ (temporomandibular joint syndrome) treatment by a dentist or Physician (excludes orthodontic treatment);
- transgender surgery benefits as described in this SPD section titled "Transgender Surgery Benefits";
- transportation by a professional licensed ambulance service to and form the nearest facility where you can receive needed medical care and services to provide basic or advance life support, when rendered in connection with Emergency Care, as requested by the attending Physician or nurse (R.N. or LPN) (air ambulance will be covered when it is the only acceptable means of transporting the patient and is Medically Necessary);
- Transplants, see section entitled, Organ, Bone Marrow and Tissue Transplants for more information;
- Urgent Care Center;
- virtual colonoscopy for men and women age 50 and over when performed in connection with diagnostic testing only;
- vision exam, other than a routine exam and if Medically Necessary;
- vision professional services. This is limited to an IOL (intraocular lens) procedure as an alternative to corneal replacement;

Covered Under Your Health Reimbursement Account and Health Coverage - cont'd

- wigs (when needed for hair loss due to cancer or alopecia areata);
- x-ray, radium, radio, isotope treatments;

See the section entitled, "Benefit Limits" for limitations and the section entitled, "Exclusions Under the Plan" for exclusions.

☞ **Important Note**

The Newborns' and Mothers' Health Protection Act of 1996 provides that no group health plan or health insurer that provides Hospitalization benefits in connection with childbirth may restrict the period of Hospitalization after birth for which benefits are payable to less than 48 hours for a vaginal delivery and 96 hours for a cesarean delivery.

Exception: The minimum length of stay provisions shall not apply in any case in which the decision to discharge the mother or her newborn child prior to these stated minimums is made by an attending provider in consultation with the mother.

☞ **Important Note**

The Women's Health and Cancer Rights Act of 1998 states that health plans that provide mastectomy coverage must also provide coverage for reconstructive surgery, including:

- reconstruction of the breast that has been removed,
- reconstruction of the other breast for a symmetrical appearance, and
- prostheses and treatment of any physical complications of the mastectomy.

Coverage must be provided in a manner determined in consultation with the attending Physician and the patient.

☞ **What if I'm traveling?**

If you are traveling outside your network and you need medical care, you should contact Customer Service at the number shown on the back of your ID card or log onto the website at www.myuhc.com for assistance is locating the nearest In-Network Provider. If you need emergency care, however, go ahead and get the care you need. The Plan will pay your claim at the In-Network Provider level (based on billed charges) regardless of the provider's network status.

Prescription Drug Coverage

Your pharmacy benefit is designed to cover medications for most diseases, including short-term illness such as an ear infection, as well as long-term diseases, such as high blood pressure. You will receive maximum value from your pharmacy benefit if you bring your prescription and ID card to an In-Network pharmacy.

You will need to pay for your prescription up front when:

- you do not have your ID card with you when you fill you prescription; or
- you choose to use an Out-of-Network pharmacy; or
- if the prescription drug is payable only under your Health Reimbursement Account.

In each of these cases, you will be reimbursed by Claims Administrator as if you had used an Out-of-Network pharmacy (see Scenario #4 below).

Your prescription drug benefit encourages the use of generic drugs. If you select a brand name drug at the pharmacy, you must pay the difference between the generic and brand name drugs (this amount will not apply to the Deductible or Coinsurance Maximum). Your doctor, however, can request that a specific brand be dispensed instead of the available generic, in this case you will not be required to pay any extra out of your pocket.

Prescription Drug Coverage – cont'd

Prescription Drugs are covered under the Plan based upon one of the following scenarios:

Scenario One: **When you go to an In-Network pharmacy,** if you have a HRA balance, the prescription will be paid from your HRA and the amount will be applied to your Plan Year Deductible.

Scenario Two: **When you go to an In-Network pharmacy, you do not have a HRA balance and you have not met your Plan Year Deductible,** the cost becomes part of your Deductible. The Plan will not advance the cost of the drug and the amount will be applied to your Plan Year Deductible. You will have to pay the entire cost at the time you purchase your prescription. The monthly statement you receive from Claims Administrator will identify how the cost of the drug was applied to your Plan Year Deductible.

Scenario Three**: When you go to an In-Network pharmacy and you do not have a balance in your HRA but you have met the Plan Year Deductible,** the Plan will pay according to the Schedule of Benefits. You will pay your applicable coinsurance amount at the time your purchase your prescription.

Scenario Four**: When you fill your prescription at an Out-of-Network pharmacy,** you will have to pay the entire cost at the time you purchase your prescription. You may then file a claim for reimbursement with Claims Administrator from your HRA (assuming you have a HRA balance) or from your Health Coverage (assuming you have depleted your HRA and met your Plan Year Deductible). You will be reimbursed by the Plan as shown in the Schedule of Benefits at the *In-Network contracted rate* for a Covered Expense. You are responsible for any difference between the Out-of-Network pharmacy's price and the Plan's level of reimbursement. **If you have depleted your HRA balance, and have not met the Member Responsibility phase of Plan Year Deductible, the cost becomes part of your Deductible.** The monthly statement you receive from Claims Administrator will identify how the cost of the drug was applied to your Plan Year Deductible.

Prescription Drug Coverage – cont'd

Please note: If your prescription drug is for a brand name drug, the same processes as described above will be followed, except that you may also be responsible for the difference in cost between a generic and brand name drug.

Your prescriptions can be filled through a retail pharmacy, or through mail order services. It is important to know that not every prescription drug is available with your ID card through the pharmacy. Your prescriptions will be covered based on the design of your Plan (see the Schedule of Benefits) and in accordance with state and federal regulations of dispensing pharmacy.

ⓘ Where to Call for In-Network Pharmacies and Claim Reimbursement Forms

Most pharmacies participate in the network. To find a pharmacy near you, or to request a claim reimbursement form call the number on the back of your ID card.

If you are covered through another employer as a dependent under your spouse's medical plan and incur a pharmacy expense, you may file a claim with Claims Administrator for reimbursement of such pharmacy expense under this Plan provided such expense is considered a Covered Expense under this Plan. Claims Administrator will take Benefit Dollars from your HRA, if available, and submit a check to you for reimbursement.

What's Not Covered Under the Prescription Drug Coverage

The prescription drug plan does not cover every drug, but some of the drugs it excludes may be provided under another portion of the Health Coverage component (i.e., immunizations, see section entitled, "Preventive Care Services – Schedule of Benefits") or the HRA (i.e., smoking cessation prescriptions or infertility drugs, see section entitled, "Covered Under the Health Reimbursement Account - Only"). **Items that are excluded from the prescription drug plan are as follows:**

- anti-wrinkle medications;
- blood and blood plasma;
- cosmetic therapies;
- durable medical equipment such as crutches, wheelchairs, or mobility aids
- growth hormones except for the following indications: a) adults with hypophyseal dysfunction resulting in symptomatic growth hormone deficiency; b) pediatric human growth hormone deficiency; c) Gonadal dysgenesis (Turner Syndrome); d) growth failure secondary to chronic renal failure/insufficiency in children who have not received a renal transplant; e) Prader-Willi Syndrome; f) adult growth hormone deficiency syndrome; g) AIDS related cachexia (Serostim only); h) Small for Gestational Age (SGA) for children over age two years; and i) Gender Identity Disorder (GID);
- hair growth and hair removal treatments;
- hearing aids
- infertility medications except for the following indications: endometriosis, uterine leiomyomata (fibroids), (central) precocious puberty, prostate cancer, hypogonadotropic hypogonadism in males, prepubertal cryptorchidism;
- immunizations, vaccines, allergy agents for injection;
- medical devices or equipment
- non-legend nutritional supplements, except as required for the treatment of PKU (phenylketonuria);
- non-prescription or over the counter medications;
- non-self administered injectable medications (except for insulin and depo provera);

What's Not Covered Under the Prescription Drug Coverage – cont'd

- prescriptions exceeding a reasonable quantity as designed by the plan (i.e. Imitrex tablets, 18 per month);
- products used at or dispensed at an outpatient or inpatient facility, clinic, or doctor's office, including Hospitals, extended/nursing care homes, home care service, home infusion services;
- products not approved for use in the United States, or experimental therapy. Products purchased outside the United States unless in an emergency situation;
- smoking cessation products;
- therapy for anyone other than the recipient of the prescription, as eligibility permits;
- weight loss medications.

Alternative Care Settings

There are often times when care can be delivered more comfortably and cost-effectively in an alternative setting, such as a Skilled Nursing Facility, your home, or a Hospice.

Skilled Nursing Facility

The Plan pays up to the benefits shown in the Schedule of Benefits for Covered Expenses while the patient is confined as a bed patient in a Skilled Nursing Facility as long as:

- 24-hour-a-day nursing care is necessary for recuperation from the Injury or Illness;
- the care is ordered and approved by a Physician and is not custodial care; and
- such confinement takes the place of a Hospital confinement or immediately follows a Hospital confinement for the same Illness.

Covered Expenses include the facility's charge for a semiprivate room and all other eligible services and supplies provided by the facility when the patient is entitled to room and board allowance. Coverage is limited to 120 days per Plan Year of inpatient care.

WHAT'S COVERED UNDER THE PLAN

Home Health Care

The Plan pays for Covered Expenses for treatment of an Illness or Injury in the patient's home instead of a Hospital or Skilled Nursing Facility. The charge must be made by a "Home Health Care Agency." Home healthcare must be prescribed by a Physician and given under a "Home Health Care plan" in the patient's home. Coverage is limited to 180 visits in a Plan Year with one visit equal to four consecutive hours in a 24-hour period by a home health care professional. Custodial care is not covered.

The Plan covers the following home Home Health Care expenses (up to the Plan maximums):

- part-time or occasional care by a licensed nurse (R.N. or LPN);
- intermittent home health aide services;
- services of a medical social worker;
- physical, occupational, speech and inhalation therapy;
- medical supplies and medicines prescribed by a Physician; and
- services of a nutritionist.

The Plan does not cover services provided by a person who usually lives with you or is a member of your or your spouse's family or transportation costs.

Hospice Care

Hospice care provides supportive care to terminally ill individuals and their families. This care may be provided instead of a Hospital confinement when a covered individual is terminally ill and has less than six months to live. The Plan pays for the following services:

- confinement in a licensed Hospice facility or Skilled Nursing Facility;
- home Hospice care provided by an approved Hospice team;
- nursing care by or under supervision of a Registered Nurse (R.N.);
- physical and/or occupational therapy;
- medical social services;
- home health aide services;
- counseling; and
- drugs or medical supplies.

WHAT'S COVERED UNDER THE PLAN

Emergency Care

If you need emergency medical care and cannot arrange for care from an In-Network Provider, the Plan will pay your claims at the In-Network level, regardless of the provider's network status. Once you are able to direct your care, you must use an In-Network Provider in order to receive the highest benefit level.

Other Covered Expenses

In addition, the Plan covers certain special services such as podiatric and chiropractic care, organ and tissue transplants, and transgender surgery benefits.

Podiatric Care

The Plan covers treatment of any condition resulting from weak, unstable or flat feet when an open cutting operation is performed or for treatment of corns, calluses or toenails, when at least part of the nail root is removed. Treatment of bunions is covered when an open cutting operation or arthroscopy is performed.

Chiropractic Care

The Plan covers chiropractic care provided by a licensed chiropractor, including Medically Necessary exams, manipulations, diagnostic x-rays and laboratory services, up to $500 per Plan Year.

Organ, Bone Marrow and Tissue Transplants

Services, supplies, drugs, organ procurement and/or acquisition, and related aftercare are covered for the following human organ and bone marrow transplant which are determined to be Medically Necessary, and which are not investigational or experimental in nature. An investigational or experimental procedure is one in which the medical use of a service or supply is still under study and the service or supply is not yet recognized throughout the provider's profession in the U.S. as safe and effective for the diagnosis and treatment of the Illness or Injury. This includes but is not limited to all phases of clinical trials, all treatment protocols based on or similar to those used in clinical trials; drugs approved by the FDA under its Treatment Investigational New Drug regulation

- allogeneic and syngeneic bone marrow transplants;
- autologous bone marrow transplants;
- heart or heart/lung;
- liver (cadaver or living);
- lung (single or double);
- pancreas for a diabetic with end stage renal disease who has received a kidney transplant or will receive a kidney transplant during the same operative session or a medically uncontrollable, labile diabetic with one or more secondary complications, but whose kidneys are not seriously impaired;
- kidney (cadaver or living);
- cornea; and
- small bowel.

Bone marrow transplants include stem cells from bone marrow, peripheral blood, and umbilical cord blood sources.

Organ, Bone Marrow and Tissue Transplants – cont'd

In addition, the transplant program provides living donor coverage for kidney, liver, and bone marrow transplants, testing of potential donors, donor evaluation and workup, and Hospital and professional services related to organ procurement. In the case of living donors, the Plan will coordinate benefits with the donor's health coverage (see section entitled, "Coordination of Benefits").

Coverage is limited to two transplant procedures for the same condition per person per lifetime.

When care is provided by a United Resource Network (URN) facility more than 50 miles from the patient's home, the Plan will pay for certain travel and lodging expenses for one person (if the patient is a minor, both parents will receive travel benefits). A per diem allowance of $50 per person for lodging and $32 per person for meals will be allowed up to a maximum of $5,000 per transplant. Claims Administrator must approve all travel and lodging expenses in advance. Travel and lodging expenses that are not approved in advance will not be paid. This travel benefit is not applicable for non-URN facilities.

Maternity and Reproductive Care

The Plan pays maternity-related benefits the same as any eligible medical expense. The Plan will cover a 48-hour stay for a normal vaginal birth and a 96-hour stay for a normal cesarean birth.

Transgender Surgery Benefits

The Plan covers many of the charges incurred for transgender surgery (also known as sex reassignment surgery) for Covered Persons who meet **ALL** of the Conditions for Coverage listed below. Transgender surgery benefits, including any transgender surgery travel benefits, are limited to $50,000 Maximum Individual Limit per Covered Person.

NOTE: Not all charges are Covered Expenses under the Plan. Review the next sections for specifics on what is covered and excluded. Call the Claims Administrator at the number on the back of your ID card if you have any questions.

Transgender Surgery Benefits - continued

Conditions for Coverage:

1. The Covered Person is at least 18 years old; and
2. The Covered Person has criteria for the diagnosis of "true" transsexualism[1]; and
3. The member has completed a recognized program at a specialized gender identity treatment center

Transgender Surgery Covered Expenses:

When all of the Conditions for Coverage listed above are met, the Plan will provide Medically Necessary[1] benefits in connection with transgender surgery. The following is a list of Covered Expenses under your Health Reimbursement Account and the Health Coverage and **will** count towards satisfaction of your Plan Year Deductible.

- Physician services
- Outpatient diagnostic imaging and laboratory services
- Blood transfusions, including blood processing and the cost of unreplaced blood and blood products. Charges for the collection, processing and storage of self-donated blood are covered, but only when specifically collected for a planned and covered surgical procedure.
- Hospital
  - medical services and supplies as deemed Medically Necessary by a Physician and charged by a Hospital and administered during any Hospital confinement
  - Hospital services such as nursing care (R.N. and LPN), x-rays, and laboratory tests
  - semi-private room and board for Hospital stays and Intensive Care Unit for Hospital stays. Private rooms are covered only if Medically Necessary.
  - outpatient services and supplies provided by a Hospital, including outpatient surgery, deemed Medically Necessary by a Physician.

[1] For transgender surgery benefits, the criteria for diagnosis and treatment are based on the guidelines stated in The Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders.

Transgender Surgery Benefits – cont'd

Transgender Surgery Covered Expenses – cont'd:

- Hormone therapy, both before and after transgender surgery, that is deemed Medically Necessary by a Physician
- Mastectomy and mastectomy scar revision for a female to male transition
- Skilled Nursing Facility
  - coverage is limited to 120 days per Plan Year of inpatient care
  - charges for a semiprivate room and all other eligible services and supplies provided by the facility when the patient is entitled to room and board allowance

Transgender Surgery Exclusions:

No payment will be made under any benefit of the Plan for expenses incurred in connection with the following, unless specifically stated otherwise in this Plan.

- any transgender surgery or related services for a Covered Person who does not meet all of the Conditions for Coverage listed above
- cosmetic surgery or other services performed solely for beautification or to improve appearance, such as breast augmentation or reduction, tracheal shaving, and electrolysis. This exclusion does not apply to mastectomy and mastectomy scar revision for a female to male transition as noted above.
- charges for services or supplies not listed as Transgender Surgery Covered Expenses above
- charges for services or supplies that are not Medically Necessary
- charges in excess of the $50,000 Maximum Individual Limit

Transgender Surgery Travel Expenses

When Transgender Surgery Services Covered Expenses are provided by a health care facility more than 50 miles from the patient's home, the Plan will pay for certain travel and lodging expenses for one person. **Claims Administrator must approve all travel and lodging expenses in advance.** Travel and lodging expenses that are not approved in advance will not be paid. Transgender surgery travel expenses are included in the $50,000 Maximum Individual Limit for Transgender Surgery Benefits.

Transgender Surgery Travel Expenses – cont'd

The Plan covers the following travel expenses for up to six trips:

- Round trip coach airfare to the health care facility providing transgender surgery services up to $250 per person per trip
- Hotel accommodations, one room (double occupancy), up to $100 per day for up to 21 days per trip
- Other expenses, such as meals, up to $25 per day for each person, for up to 21 days per trip

BENEFIT LIMITS

Usual and Customary

The Plan covers Covered Expenses up to the "usual and customary" amount when an Out-of-Network Provider / facility is used. See "General Definitions / Key Terms" section for a detailed explanation of the term.

Benefit Maximums

In addition to the exclusions listed below, refer to the Schedule of Benefits for the Maximum Individual Limit(s) and any Plan Year limit applicable to certain Covered Expenses. Plan Year limits are met by: a) days/visits/dollar limits paid by your HRA under the Plan; or b) days/visits/dollar limits paid by you as part of your Member Responsibility phase of Plan Year Deductible, and c) days/visits/dollar limits paid by the Health Coverage under the Plan.

Exclusions Under the Plan

No payment will be made under any benefit of the Plan for expenses incurred in connection with the following, unless specifically stated otherwise in this Plan.

- adoption or surrogate expenses
- amounts in excess of any Health Coverage limits, except as specified in the section entitled "Covered Under the Health Reimbursement Account - Only"
- any care not recommended and approved by a Physician
- any charges of a Physician or health professional for services he or she provides to herself or himself or to any close relative (close relative means spouse, brother, sister, parent, grandparent or child and the spouse's brothers, sisters, parents, grandparent or child)
- any charges for treatment, services or supplies that are not Medically Necessary or usual to the treatment of an Illness or Injury as determined by the Claims Administrator's medical staff or an independent medical Physician review panel. This does not apply to Preventive Care Services or other health care services specifically covered under the Plan that are not required to preserve your health

Exclusions Under the Plan – cont'd

- any dental care, treatment, implants, surgery, or supplies under the medical portion of the Plan, except for the following:
  - repair within six months of accidental injuries to sound natural teeth caused from being accidentally struck from outside the mouth and while covered under the Plan; or
  - Hospital and anesthesia expenses related to dental work if the primary reason for such confinement (inpatient or outpatient) is deemed to be an underlying serious and hazardous medical condition
- any diagnostic admission test if the test can be performed on an outpatient basis
- any Illness or Injury for which benefits or payments are received (or could be received if claims were made) under any worker's compensation law, employer's liability law or similar act
- any Illness or Injury for which any benefits are received or could be received if claims were made under any automobile insurance policy to the extent that the policy provides benefits for covered services under the Plan
- any treatment, equipment, drug or device that does not meet generally accepted standards of practice in the medical community
- arch supports, foot orthotics not prescribed by a medical doctor**,** and orthopedic shoes, such as biomechanical evaluation, range of motion measurements and reports, and negative mold foot impressions, unless the shoe is an integral part of a brace or when required following surgery or is a part of the initial care for treatment of a Medically Necessary condition
- augmentative communications devices
- autopsies
- breast pumps
- charges for duplicating and obtaining medical records
- charges for or related to fetal tissue transplants

Exclusions Under the Plan – cont'd

- charges related to organ transplants except as specified in the section entitled, "Organ, Bone Marrow and Tissue Transplants"
- charges related to transgender surgery services and supplies except as specified in the section entitled, "Transgender Surgery Benefits"
- charges for artificial organs or systems used to assist or replace a natural body organ (such as an artificial heart) and any related services or supplies. Artificial support machines while awaiting a human organ or tissue transplant and other approved devices such as pacemakers and kidney dialysis machines are eligible
- charges for reconstructive surgery and related services, except for the following:
  - reconstructive surgery following a covered mastectomy
  - surgery to repair a defect caused by an accidental Injury resulting in a functional impairment
  - reconstructive surgery related to an Injury, Sickness, or other disease of that part of the body
  - reconstructive surgery following surgery that was needed due to an Injury, Sickness, or other disease of that part of the body
  - cosmetic or reconstructive surgery or treatment to repair a dependent child's congenital or developmental defect
- charges for telephone consultation by a health professional or to keep a scheduled visit, mailing, shipping and handling expenses, completing any form, or for medical information
- charges for the treatment of compulsive gambling
- charges for a drug, device, diagnostic or screening procedure, or a medical treatment or procedure of an Experimental or Investigative nature or an Unproven Service as determined by the Claims Administrator. This does not include drugs that: a) have been granted treatment investigational new drug (IND) or Group C/treatment IND status; b) are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or c) for which available scientific evidence demonstrates, that the drug is effective or shows promise of being effective for the disease as determined by Claims Administrator.

Exclusions Under the Plan – cont'd

- charges that exceed the allowed amounts and/or the Usual and Customary Charge, except as specified in the section entitled "Covered Under the Health Reimbursement Account - Only"
- cosmetic surgery and related services
- custodial care that includes services to assist in activities of daily living and personal care which do not seek to cure or do not need to be provided by a skilled medical professional
- enteral feeding formulas, except for the following:
  - prescription and over the counter enteral feeding formulas when considered a sole source of nutrition and given via a feeding tube. This includes tube feeding supplies; or
  - oral prescription enteral formulas when considered a sole source of nutrition. Over the counter enteral feeding formulas are not covered when given orally
- expenses for care or treatment received outside the United States or its territories, except for unexpected, emergency situations while traveling
- expenses eligible for consideration under any other plan, including Medicare
- expenses not specifically listed as Covered Expenses under this Plan
- expenses used to satisfy plan Deductibles and/or coinsurance
- full body scans, EBCT (heart scans)
- gene therapy as a treatment for inherited or acquired disorders
- health services performed before the effective date or after the termination of coverage under this Plan
- homeopathic visits
- health services needed from attempting to commit or committing a felony, or engaging in an illegal occupation
- home construction needed for the installation of special, Medically Necessary equipment
- hypnotism
- Injury or Illness/Sickness contracted while on duty with any military, naval, or air force of any country or international organization

Exclusions Under the Plan – cont'd

- lenses, frames and contact lenses; other fabricated optical devices or related professional services including the treatment of refractive errors such as radial keratotomy and laser refractive surgery regardless of medical condition, except when determined to be Medically Necessary following cataract surgery.
- liposuction
- marriage counseling
- massage therapy or rolfing
- mental health care treatment
- non-prescription drugs or medicines; prescription drugs that have not been classified as effective by the FDA; bio-engineered drug therapy that has not received FDA approval for the specific use being requested; prescription drugs that are not administered according to generally accepted standards of practice in the medical community.
- non-emergency admissions greater than 24 hours in advance of procedure unless specified by your Physician.
- non-medical counseling or training services
- personal comfort items while Hospitalized such as telephone or television; Hospital room and board expenses that exceed the semiprivate room rate unless a private room is approved as Medically Necessary
- Physician charges for injections that can be self-administered
- phototherapy devices for Seasonal Affective Disorder
- products purchased outside of the U.S., unless in an unexpected, emergency situation
- recreational or educational therapy or forms of non-medical self care or self-help training including health club memberships, biofeedback, behavior modification therapy and any related services or diagnostic testing
- routine physical exams and immunizations for employment, travel or insurance purposes
- sales tax, unless required by law
- services of the clergy
- services for reversal of sterilization

Exclusions Under the Plan – cont'd

- services that are prohibited by law or regulations
- services or confinements ordered by a court or law enforcement officers that are determined not Medically Necessary (an initial court-ordered exam for a dependent child under age 18 is considered Medically Necessary)
- services rendered by anyone other than a covered health care provider
- services provided mainly for rest cures, the ease of a household, or sanitarium care
- services or supplies for common household use, such as exercise cycles, air purifiers, air conditioners, water purifiers, allergenic mattresses, computer equipment and related devices, or supplies of a similar nature, whether or not prescribed by a Physician
- services for, or related to, systemic candidasis, multiple chemical sensitivities, homeopathy, immunoaugmentative therapy or chelation therapy determined to be not Medically Necessary
- services, chemotherapy, supplies, drugs and aftercare for or related to an organ, tissue, or bone marrow transplant or stem cell transplant that is not covered
- substance abuse treatment
- travel and/or lodging expenses of a Physician or a patient, except as specified in the SPD sections entitled "Organ, Bone Marrow and Tissue Transplants" and "Transgender Surgery Travel Expenses"
- treatment while confined in a state, federal or Veterans Administration Hospital for which charges are not imposed
- transportation other than local ambulance service for a medical emergency to the nearest Hospital that can provide care
- ventilator-dependent communication services while confined in a Hospital or other medical facility
- vision therapy
- vocational or training services except approved diabetic education programs, cardiac rehabilitation, pre-term birth prevention for high risk pregnancies, asthma, or cancer programs.

FILING CLAIMS

How a claim for benefits is processed depends on the type of claim it is. There are several categories of claims:

- *Concurrent Care Claim* -- A concurrent care claim is a claim for an extension of the duration or number of treatments provided through a previously-approved benefit claim. When possible, this type of claim should be filed at least 24 hours before the expiration of the course of treatment for which an extension is being sought.
- *Pre-Service Care Claim* -- A pre-service claim is a claim for a benefit with respect to which the terms of the HRA and/or health coverage require notification of the benefit in advance of obtaining medical care.
- *Post-Service Care Claim* -- A post-service claim is a claim for a benefit that is not a pre-service claim. Most claims are post-service claims.
- *Urgent Care Claim* --An urgent care claim is any claim for medical care or treatment with respect to which the failure to process the claim immediately could seriously jeopardize the life or health of you or your dependent or subject you or your dependent to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. This type of claim generally includes those situations commonly treated as emergencies.

When you receive care from your health care provider, you will present your ID card. Your provider should submit a claim for payment directly to Claims Administrator. This amount will be deducted from your Health Reimbursement Account based on your balance at the time Claims Administrator processes your claim. Once you have depleted the Benefit Dollars in your Health Reimbursement Account, any additional Covered Expenses you incur during that year will be applied to your Deductible. Once your Member Responsibility phase of the Deductible is met, the Plan will pay a percentage of your Covered Expenses until you meet the Coinsurance Maximum —after which the Plan will pay 100% of any additional Covered Expenses you incur during that Plan Year from an In-Network Provider and 100% of Usual and Customary from an Out-of-Network Provider. If your provider does not file a claim on your behalf, follow the procedures under S*ubmitting a Claim*, below.

FILING CLAIMS

☞ **Important Note:**

When your claim is processed at Claims Administrator two important dates are used:

- The date on which you received a service from your provider is used to process claims for the Health Coverage. This allows your Deductible, coinsurance, and Coinsurance Maximum to account for the moment in time when you receive healthcare services.
- The date on which Claims Administrator processes your claim is used when deducting benefit dollars from your HRA. This allows the benefit dollars in your HRA to act like a savings account, available for your use when your claim is paid.

Submitting a Claim

There may be times when you will be responsible for submitting a claim directly to Claims Administrator. For example, if you use an Out-of-Network Provider or facility, if you use an out-of- network pharmacy, or if you incur a health expense that is only eligible under your HRA. You may download traditional claim forms from UnitedHealthcare web site at myuhc.com or by calling the number on the back of your ID card. If you are unable to print a claim form, ask your local Benefits Office for a copy. You must include a receipt from your provider (a cancelled check is not sufficient).

Submit your claims to:

Definity Health

P.O. Box 740810

Atlanta, GA 30374-0810

Attn: DefinityClaims Submission

You must report claims to Claims Administrator promptly but no later than 18 months after the date of the service. If, through no fault of your own, you can not meet the filing deadline, 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 years after the deadline

FILING CLAIMS

Claims Decisions

If your claim involves pre service urgent care, you or your authorized representative will be notified of Claims Administrator's decision on the claim, whether adverse or not, as soon as is feasible, but in no event more than 72 hours after receiving the claim. If the claim does not include sufficient information for Claims Administrator to make a decision, you or your representative will be notified within 24 hours after receipt of the claim of the need to provide additional information. You will have at least 48 hours to respond to this request. Claims Administrator then must inform you of its decision within 48 hours of receiving the additional information.

If your claim is one involving concurrent care, Claims Administrator will notify you of its decision, whether adverse or not, within 24 hours after receiving the claim. You will be given time to provide any additional information required to reach a decision.

If your claim is for a pre-service authorization, Claims Administrator will notify you of its initial determination, whether adverse or not, as soon as possible, but not more than 15 days from the date it receives the claim. Claims Administrator may extend this 15-day period for an additional 15 days if the extension is required due to matters beyond Claims Administrator's control. You will have at least 45 days to provide any additional information requested of you by Claims Administrator.

If you have filed a post-service claim for reimbursement of medical care services that already have been rendered, you will be notified of Claims Administrator's decision on your claim. This notification will be issued no more than 30 days after Claims Administrator receives the claim. Claims Administrator may extend this 30-day period one for up to 15 days if the extension is required due to matters beyond Claims Administrator's control. You will have at least 45 days to provide any additional information requested of you by Claims Administrator.

FILING CLAIMS

Important Note: By your application (claim application) you have agreed to allow all providers to give Claims Administrator needed information about the care they provide to you. Claims Administrator keeps all such information strictly confidential. If a provider requires specific authorization to release records, you agree to provide this authorization. Your failure to provide authorization or requested information may result in denial of your claim.

Benefits will be paid as soon as the necessary proof to support the claim is received. All benefits are payable to you. However, Claims Administrator has the right to pay any health benefits to the service provider and will do so, unless you have informed Claims Administrator otherwise by the time you file the claim.

You must file separate claims for each covered individual.

COORDINATION OF BENEFITS

Coordination of Benefits

If you have healthcare coverage available through another employer, this section is for you. For example, you may be covered as a dependent under your spouse's medical plan. This "coordination of benefits" provision prevents duplicating benefit payments when you or your dependent(s) also have coverage through another group plan. Coordination of benefits also determines which plan pays first.

Covered expenses not reimbursed by the primary plan (see below) will first coordinate with your Health Reimbursement Account. If there isn't enough money in your HRA to cover those expenses, the remaining expenses will be submitted to the Health Coverage portion of the Definity HRA California Plan for payment.

How Coordination of Benefits Works

Here's how coordination of benefits works: The first step is to determine which plan is primary and which plan is secondary. The primary plan always pays benefits first. When the Plan is secondary, benefits are coordinated so that the total benefits from all the plans are no more than the maximum allowed by the Plan.

An Example

Assume your spouse is covered under his or her own employer's plan and as your dependent under the Plan, and incurs a $100 expense for an office visit. Let's also assume the Plan considers the allowable expense for the office visit is the full $100. If your spouse's plan covers the visit at 80% ($80), the Plan will pay $20 ($100 - $80). In this example you would be reimbursed a total of $100 ($80 + $20).

COORDINATION OF BENEFITS

Order of Coverage—Employee and Spouse

- If one of the plans does not have a coordination of benefits provision, that plan will pay first.
- If you (or your spouse) are covered as an employee by one plan and as a dependent by another, the plan that covers the person as employee will pay benefits first. If you or your spouse are also covered by Medicare and are not working:
  - the plan that covers a person as a dependent of an employee is primary,
  - Medicare is secondary, and
  - the plan that covers a person as a retired employee pays third.
- If you or your spouse are covered as an employee and also as a retired or laid off employee (one of them through another employer) the plan that covers the person as an employee (or a dependent of an employee) is primary.

Order of Coverage—Dependent Children

For a covered dependent child whose parents are not divorced or separated and who is covered as a dependent under both parents' plans:

- The plan of the parent whose birthday is first in a calendar year will pay benefits first for the covered child. For example, if the father's birthday is in March and the mother's birthday is in September, the father's plan is primary for the child. This is called the "birthday rule."
- If the parents have the same birthday, the plan that has covered a parent longer will pay benefits first for the child. For example, if the father has had coverage under his plan for five years and the mother has had coverage under her plan for seven years, the mother's plan is primary for the child.
- If the other plan does not use the birthday rule but bases the order of benefits on the gender of the parent so that the plans don't agree on order, the rules of the other plan will determine which plan pays first.

If two or more medical plans cover a dependent child of divorced or separated parents, benefits for the child are determined as follows:

COORDINATION OF BENEFITS

Order of Coverage—Dependent Children – cont'd

- If under a court decree the parents have joint custody but the decree doesn't state who is responsible for the child's healthcare expenses, benefits will be coordinated the same as for the children of married parents, described previously.
- The medical plan of the parent who has a court decree of financial responsibility will be primary.
- If no court decree exists, and
  - — the parent with custody has not remarried, the medical plan of the custodial parent will be primary.
  - — the parent with custody has remarried:
    - the plan of the custodial parent will be primary,
    - the plan of the stepparent will be secondary, and
    - the plan of the non-custodial parent will be third.

Coordination with Medicare

If you keep working for your current employer and you or a covered dependent becomes eligible for Medicare, the Plan will remain your primary plan and Medicare will be secondary.

Right of Recovery

The Plan has the right to recover benefits it has paid on you or your dependent's behalf that were: a) made in error; b) due to a mistake in fact; c) advanced during the time period of meeting the Member Responsibility phase of the Plan Year Deductible; or d) advanced during the time period of meeting the Coinsurance Maximum for the Plan Year. Benefits paid because you or your dependent misrepresented facts are also subject to recovery.

Right of Recovery – cont'd

If the Plan provides a benefit for you or your dependent that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested, or
- reduce a future benefit payment for your or your dependent by the amount of the overpayment.

If the Plan provides an advancement of benefits to you or your dependent during the time period of: a) meeting the Member Responsibility phase of the Plan Year Deductible, and/or b) meeting the Coinsurance Maximum for the Plan Year, the Plan will send you or your dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover benefits it has advanced by:

- submitting a reminder letter to you or a covered dependent that details any outstanding balance owed to the Plan; and
- conducting courtesy calls to you or a covered dependent to discuss any outstanding balance owed to the Plan.

Third Party Liability

In situations where a third party (person or organization) is responsible for your or a covered dependent's Illness or Injury (for example, injuries caused by a car accident or on someone's property), the Plan has the right to:

- pursue all rights of recovery against the third party or your insurance carrier (in case of a claim under the an auto insurance policy), and
- obtain from you any amount received by judgment, settlement, or otherwise from the third party, your insurance carrier or any other person or entity (including the auto insurance carrier).

If a third party is at fault for an Injury or Illness, you must notify the Claims Administrator. You (or, if you are not legally capable, your legal representative) are responsible for providing the information, assistance and/or documents to help the Plan obtain the rights under this provision.

CONTINUING YOUR COVERAGE

Continuing Coverage During a Leave of Absence

Depending on your situation, you may be eligible to continue participating in the plans under the Plan during a leave or disability. Contact your local Benefits Office for more information.

The Family and Medical Leave Act

If you are on an approved leave of absence covered by the Family and Medical Leave Act of 1993 (the "FMLA"), you may continue to participate in and receive coverage under the Plan during the leave if the following conditions are met:

- any required contribution for the cost of your coverage is paid by you when due; and
- your leave has been approved by the employer.

You may continue to participate in the Plan until the end of the leave period required by the FMLA. If you cancel your coverage while you are on an approved FMLA leave and you return to work as an eligible employee immediately following your approved FMLA leave or your approved leave of absence that includes an approved FMLA leave, you can restore coverage as an employee. Coverage will be restored as soon as you return to work for one full day.

If you do not return to work following an approved FMLA leave, you and your enrolled dependents (if any) may be eligible for COBRA continuation coverage as of the date you terminate. Please contact your local Benefits Office for more information.

CONTINUING YOUR COVERAGE

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

Contact your local Benefits Office for more information.

Continued Health Care Coverage

Under federal law—the Consolidated Omnibus Budget Reconciliation Act (COBRA)—you and your dependents may be eligible to extend group healthcare benefits under the Plan for a certain period of time. This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This section gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should get a copy of the Plan Document from the Plan Administrator.

An election of COBRA continuation coverage under the Plan applies to both the Health Coverage and your Health Reimbursement Account.

COBRA continuation coverage for the Plan is administered by:

Acclaim Benefits

P.O. Box 9105

CB0078

Minneapolis, MN 55480-9105

1.800.777.4925

CONTINUING YOUR COVERAGE

COBRA

To continue coverage, you or your covered dependents must pay the full cost of that coverage (your share and your employer's share) plus a 2% administrative fee, if applicable. COBRA continuation coverage is a continuation of coverage under the Plan when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses or domestic partners of employees, and dependents of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced (includes leave without pay or layoff), or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse or the domestic partner of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse or domestic partner dies;
- Your spouse's or domestic partner's hours of employment are reduced (includes leave without pay or layoff);
- Your spouse's or domestic partner's employment ends for any reason other than his or her gross misconduct;
- Your divorce, legal separation, annulment or termination of domestic partnership;

CONTINUING YOUR COVERAGE

COBRA – cont'd

Your dependents will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- The employee dies;
- The employee's hours of employment are reduced (includes leave without pay or layoff);
- The employee's employment ends for any reason other than his or her gross misconduct;

COBRA Notification

COBRA continuation coverage is offered to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, or death of the employee, the employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events.

For the other qualifying events (divorce, legal separation, annulment, termination of domestic partner relationship; or a dependent's loss of eligibility) you (or your qualified beneficiary) must notify your Benefits Office, or the person handling benefits for your department, in writing within 60 days after the qualifying event occurs or the date coverage is lost, whichever is later. The employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events.

The Plan Administrator will notify you, your spouse, domestic partner or dependent(s) of their right to purchase continuation coverage. To elect COBRA continuation coverage, you have 60 days after the date of the notice to decide whether you want to elect COBRA continuation coverage. If the procedures are not followed, **YOU AND YOUR DEPENDENTS WILL LOSE YOUR RIGHT TO ELECT CONTINUATION COVERAGE THROUGH COBRA.**

CONTINUING YOUR COVERAGE

How Long COBRA Coverage Can Continue

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that coverage would otherwise have been lost. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse or domestic partner may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or all dependents who are qualified beneficiaries.

COBRA continuation coverage is a temporary continuation of coverage. When Plan coverage is lost due to the death of the employee, the covered employee's divorce, legal separation, annulment, termination of domestic partner relationship, or a dependent's loss of eligibility, COBRA coverage can last for up to a total of 36 months.

When Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA coverage under the Plan for his spouse and children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction of hours.

Otherwise, when Plan coverage is lost due to the end of employment or reduction of hours of employment COBRA coverage generally can last for only up to a total of 18 months.

There are two ways in which this 18-month period of COBRA continuation coverage can be extended: (1) if a qualified beneficiary is disabled; or (2) a secondary qualifying event occurs.

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that you notify the Plan Administrator in writing and follow the proper procedures below.

Notice Procedures For Notice Of Disability

The deadline for providing this notice is 60 days after the latest of (1) the date of the Social Security Administration's disability determination; (2) the date of the covered employee's termination of employment or reduction of hours; and (3) the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the termination of employment or reduction of hours. Your Notice of Disability must also be provided within 18 months after the covered employee's termination of employment or reduction of hours.

You must notify the Plan Administrator <u>in writing</u> of a qualified beneficiary's disability (see general procedures below for contact information).

Your notice must contain the following information:

- the name of the Plan **(University of California);**
- the name and address of the employee or former employee who is or was covered under the Plan;
- the initial qualifying event that started your COBRA coverage (the covered employee's termination of employment or reduction of hours, including leave without pay or layoff);
- the date that the covered employee's termination of employment or reduction of hours happened;
- the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage due to the termination or reduction of hours and who are receiving COBRA coverage at the time of the notice;

Your notice must contain the following information: - cont'd

- the name and address of the disabled qualified beneficiary;
- the date that the qualified beneficiary became disabled;
- the date that the Social Security Administration made its determination of disability;
- a statement as to whether or not the Social Security Administration has subsequently determined that the qualified beneficiary is no longer disabled; and
- the signature, name, and contact information of the individual sending the notice.

Your Notice of Disability must include a copy of the Social Security Administration's determination of disability.

Second Qualifying Event Extension for 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse or domestic partner and dependent's in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse or domestic partner and dependent's if the former employee dies, becomes entitled to Medicare (Part A, Part B, or both), or due to the employee's divorce, legal separation, annulment, termination of domestic partnership, or a dependent's loss of eligibility. In all of these cases, you must make sure that the Plan Administrator is notified in writing of the second qualifying event and follow the procedures outlined in the section below entitled "Notice Procedures for Notice of Second Qualifying Event."

Notice Procedures For Notice Of Second Qualifying Event

The deadline for providing this notice is 60 days after the later of (1) the date of the second qualifying event (i.e., a divorce, legal separation, annulment, or termination of domestic partnership, the covered employee's death, or a dependent losing eligibility); and (2) the date on which the covered spouse or domestic partner or dependent would lose coverage under the terms of the Plan as a result of the second qualifying event (if this event had occurred while the qualified beneficiary was still covered under the Plan).

Notice Procedures For Notice Of Second Qualifying Event – cont'd

You must notify the Plan Administrator in writing of a second qualifying event (i.e., a divorce, legal separation**,** annulment, or termination of domestic partnership, the covered employee's death, or a dependent losing eligibility) (see general procedures below for contact information).

Your notice must contain the following information:

- the name of the Plan **(University of California)**;
- the name and address of the employee or former employee who is or was covered under the Plan;
- the initial qualifying event that started your COBRA coverage (the covered employee's termination of employment or reduction of hours, including leave without pay or layoff).
- the date that the covered employee's termination of employment or reduction of hours happened, including leave without pay or layoff);
- the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage due to the termination or reduction of hours and who are receiving COBRA coverage at the time of the notice;
- the second qualifying event (a divorce, legal separation, annulment or termination of domestic partnership, the covered employee's death, or a dependent losing eligibility);
- the date that the divorce, legal separation, annulment or termination of domestic partnership, the covered employee's death, or a dependent losing eligibility status happened; and
- the signature, name, and contact information of the individual sending the notice.

If you are notifying the Plan Administrator of a divorce, legal separation, annulment, or termination of domestic partnership, your notice, if the Plan Administrator request it, must include a copy of the decree of divorce, legal separation, annulment or a copy of the filed California *State Notice of Termination of Domestic Partnership* or documentation of the date of the qualifying event that is satisfactory to the Plan Administrator.

Notice Procedures For Notice Of Second Qualifying Event – cont'd

If your notice was regarding a dependent's loss of eligibility, you must, if the Plan Administrator requests it, provide documentation of the date of the qualifying event that is satisfactory to the Plan Administrator (for example, a birth certificate to establish the date that a child reached the limiting age, a marriage certificate to establish the date that a child married, or a transcript showing the last date of enrollment in an educational institution). This will allow the Plan Administrator to determine if you gave timely notice of the second qualifying event and were consequently entitled to an extension of COBRA coverage.

If your notice was regarding the death of the covered employee, you must, if the Plan Administrator requests it, provide documentation of the date of death that is satisfactory to the Plan Administrator (for example, a death certificate or published obituary). This will allow the Plan Administrator to determine if you gave timely notice of the second qualifying event and were consequently entitled to an extension of COBRA coverage.

Notice Procedures For Notice Of Other Coverage, Medicare Entitlement, Or Cessation Of Disability

If you are providing a Notice of Other Coverage (a notice that a qualified beneficiary has become covered, after electing COBRA, under other group health plan coverage), the deadline for this notice is 30 days after the other coverage becomes effective or, if later, 30 days after exhaustion or satisfaction of any preexisting condition exclusions for a preexisting condition of the qualified beneficiary.

If you are providing a Notice of Medicare Entitlement (a notice that a qualified beneficiary has become entitled, after electing COBRA, to Medicare Part A, Part B, or both), the deadline for this notice is 30 days after the beginning of Medicare entitlement (as shown on the Medicare card).

Notice Procedures For Notice Of Other Coverage, Medicare Entitlement, Or Cessation Of Disability – cont'd

If you are providing a Notice of Cessation of Disability (a notice that a disabled qualified beneficiary whose disability resulted in an extended COBRA coverage period is determined by the Social Security Administration to be no longer disabled), the deadline for this notice is 30 days after the date of the Social Security Administration's determination.

You should notify the Plan Administrator in writing of any of these events (see general procedures below for contact information).

Your notice should contain the following information:

- the name of the Plan (**University of California);**
- the name and address of the employee or former employee who is or was covered under the Plan;
- the name(s) and address(es) of all qualified beneficiary(ies);
- the qualifying event that started your COBRA coverage;
- the date that the qualifying event happened; and
- the signature, name, and contact information of the individual sending the notice.

If you are providing a Notice of Other Coverage, your notice should include the name and address of the qualified beneficiary who obtained other coverage, the date that the other coverage became effective (and, if there were any preexisting condition exclusions applicable to the qualified beneficiary, the date that these were exhausted or satisfied), and evidence of the effective date of the other coverage (such as a copy of the insurance card or application for coverage).

If you are providing a Notice of Medicare Entitlement, your notice should include the name and address of the qualified beneficiary who became entitled to Medicare, the date that Medicare entitlement occurred, and a copy of the Medicare card showing the date of Medicare entitlement.

Notice Procedures For Notice Of Other Coverage, Medicare Entitlement, Or Cessation Of Disability – cont'd

If you are providing a Notice of Cessation of Disability, your notice must include the name and address of the disabled qualified beneficiary, the date of the Social Security Administration's determination that he or she is no longer disabled, and a copy of the Social Security Administration's determination.

If a qualified beneficiary first becomes covered by other group health plan coverage after electing COBRA, that qualified beneficiary's COBRA coverage will terminate **(retroactively if applicable)**, regardless of whether or when a Notice of Other Coverage is provided.

If a qualified beneficiary first becomes entitled to Medicare Part A, Part B, or both after electing COBRA, that qualified beneficiary's COBRA coverage will terminate **(retroactively if applicable)**, regardless of whether or when a Notice of Medicare Entitlement is provided.

If a disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled, COBRA coverage for all qualified beneficiaries whose COBRA coverage is extended due to the disability will terminate **(retroactively if applicable),** regardless of whether or when a Notice of Cessation of Disability is provided.

General Notice Procedures Applicable To Notice Of Disability, Notice Of Second Qualifying Event, Notice Of A Qualifying Event, & Notice Of Other Coverage, Medicare Entitlement, Or Cessation Of Disability

You must mail any of the above required notices to:

Acclaim Benefits

P.O. Box 9105

Minneapolis, MN 55480-9105

1.800.777.4925

Your notice must be in writing and must be mailed. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable. Your notice must be postmarked no later than the deadline described above.

General Notice Procedures Applicable To Notice Of Disability, Notice Of Second Qualifying Event, Notice Of A Qualifying Event, & Notice Of Other Coverage, Medicare Entitlement, Or Cessation Of Disability – cont'd

If your notice does not contain all of the required information, the incomplete notice will be rejected and COBRA or any COBRA extension will not be offered.

The covered employee (i.e., the employee or former employee who is or was covered under the Plan), a qualified beneficiary with respect to the qualifying event, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries: (1) who either lost coverage due to the qualifying event described in the notice; (2) who may be entitled to an extension of the maximum COBRA coverage period; or (3) with respect to other coverage, Medicare entitlement, or cessation of disability reported in the notice.

If You Have Questions

Questions concerning your Plan or your COBRA rights should be addressed to the contact or contacts identified below. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

CONTINUING YOUR COVERAGE

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

You may obtain information about the Plan and COBRA coverage on request from:

Acclaim Benefits

P.O. Box 9105

CB0078

Minneapolis, MN 55480-9105

1.800.777.4925

The contact information for the Plan may change from time to time. The most recent information will be included in the Plan's most recent SPD (if you are not sure whether this is the Plan's most recent SPD, you may request the most recent one from the Plan Administrator).

When COBRA Coverage Ends

Continuation coverage ends when:

- Any required premium is not paid in full or on time;
- a qualified beneficiary becomes entitled to Medicare (under Part A, Part B, or both) after electing continuation coverage;
- a qualified beneficiary becomes covered, after electing COBRA, under another group health plan (unless the other group medical plan has a pre-existing condition limitation that affects that person);
- in the case of a maximum 29-month extension due to disability, a determination is made that the individual is no longer disabled (after the first 18 months), or
- your employer ceases to provide any group health plan for its employees.
- A qualified beneficiary notifies the Plan Administrator that he or she wishes to cancel continuation coverage.

When COBRA Coverage Ends – cont'd

Your local Benefits Office can provide you and your dependents with more information about COBRA and what it will cost to continue coverage.

NOTIFICATION OF ADDITIONAL CAL-COBRA CONTINUATION OF COVERAGE

You and your dependents are entitled to rights under Cal-COBRA continuation coverage to further extend group healthcare benefits under the Plan, up to but not exceeding 36 months from the date of the beginning of your Federal COBRA coverage period. Additional Cal-COBRA Continuation of Coverage is offered to qualified beneficiaries under the Plan. To be considered a qualified beneficiary of this additional continuation of coverage, you or your dependents: 1) lost coverage due to termination of the employee's employment for reasons other than gross misconduct; 2) lost coverage due to reduction of the employee's hours; or 3) are determined by the Social Security Administration to be disabled at any time during the first 60 days of Federal COBRA continuation coverage and eligible for the 11 month extension. Qualified Beneficiaries must have:

- have exhausted their Federal COBRA coverage,
- have had less than 36 months of Federal COBRA coverage,
- began Federal COBRA continuation coverage on or after January 1, 2003,
- primary living residence in California.

You or your dependents must elect to purchase the extended coverage in writing to the Plan, no later than 30 days prior to the end of 18-month or 29-month Federal COBRA continuation period.

NOTIFICATION OF ADDITIONAL CAL-COBRA CONTINUATION OF COVERAGE – cont'd

The maximum total continuation period (Federal COBRA and Cal-COBRA) is 36 months. There is no extension available to those who are already entitled to 36 months of coverage under Federal COBRA coverage.

This entitlement does not change Senior COBRA (formerly "California Continuation Coverage") that entitles University of California active employees who terminate employment at age 60 years of age or older, and who have at least 5 years of employment with University of California, the right to elect continuation coverage for up to 5 years from the time of termination.

NOTE: Effective January 1, 2005, terminating University of California employees (age 60 or older with five years of continuous service with the University) will no longer be eligible to extend continuation coverage under Senior COBRA once Federal COBRA or Cal-COBRA continuation coverage ends. They will instead be eligible for guaranteed issue HIPAA coverage.

Individuals currently receiving coverage under Senior COBRA or who became eligible for it before January 1, 2005, will not be able to elect HIPAA guaranteed issued coverage because they will not have exhausted their state law COBRA rights.

OTHER PLAN INFORMATION

Plan Changes and Termination

Your employer may terminate, suspend, withdraw, amend, or modify the plans comprising the Plan or any portion of such plans at any time.

Contributions and Benefits

Payments of benefits from the Health Coverage component and the Health Expense Reimbursement component (your Health Reimbursement Account) are made by the employer from its general assets. The cost of providing benefits under the Health Coverage may be shared by you and the Employer. Your share of the cost of your coverage under the Health Coverage will be determined by your employer on a uniform basis.

No Employment Rights

Neither the adoption of the Plan, nor your status as a Participant in any underlying plan shall constitute a guarantee of continued employment with the employer. Also, you cannot sell, transfer or assign either voluntarily or involuntarily the value of your benefit under the plans.

Tax Effect

Neither your employer nor Claims Administrator makes any warranty or other representation as to whether any payments or benefits you receive from the Plan will be treated as includable in gross income for federal or state income tax purposes.

Financial Records

The financial records of the Plan are kept on a Plan Year basis ending on each December 31.

Plan Year

January 1 through December 31

Effective Date

January 1, 2004. The Plan has been amended since its original effective date, most recently as of January 1, 2007.

OTHER PLAN INFORMATION

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. The terms of those documents apply if information in this document is not the same. The University of California Group Insurance Regulations will take precedence if there is a difference between its provisions and those of this document and/or the Group Insurance Contracts/Administrative Services Agreement. What is written in this document does not constitute a guarantee of plan coverage or 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 this booklet. If you have a question, you may direct it to:

University of California

Human Resources and Benefits

300 Lakeside Drive, 5th Floor

Oakland, CA 94612

(800) 888-8267

OTHER PLAN INFORMATION

Claims Administrator

The Plan Administrator has retained UnitedHealthcare to administer and process claims for benefits according to the Plan and consistent with a framework of rules, policies, interpretations, practices and procedures adopted by the Plan Administrator.

The Plan Administrator has also appointed UnitedHealthcare as the Plan Fiduciary, but solely for the purpose of providing a full and fair review of claims. To this **end,** the Plan Administrator has delegated to UnitedHealthcare the discretionary authority to construe and interpret the terms of the Health Coverage component and the Health Expense Reimbursement component (your Health Reimbursement Account), and to make final, binding determinations concerning availability of benefits under these components.

You may contact the Claims Administrator by phone at the number on your ID card or in writing at:

UnitedHealthcare
450 Columbus Blvd.
Hartford, CT 06115-0450

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. Your group number is 709555.

OTHER PLAN INFORMATION

Continuation of the Plan

The University of California intends to continue the Plan of benefits described in this booklet but reserves the right to terminate or amend it at any time. Plan benefits are not accrued or vested benefit entitlements. 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 (ASO: Plan costs) and what portion of the premiums (ASO: Plan costs) the University will pay. The portion of the premiums (ASO: Plan costs) that the University pays is determined by UC and may change or stop altogether, and may be affected by the State of California's annual budget appropriation.

Financial Arrangements

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

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

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 and other specified sites, all Plan documents, including the Group Contracts, at a time and location mutually convenient to the participant and the Plan Administrator.

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

OTHER PLAN INFORMATION

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 of Diversity and Employee Programs, University of California Office of the President, 300 Lakeside Drive, Oakland, CA 94612, and for faculty to Director of Academic Affirmative Action, University of California Office of the President, 1111 Franklin Street, Oakland, CA 94607.

Cost of Administering the Plan

The administrative costs of the Program are paid by your employer.

Appealing a Claim

If your claim for benefits is denied in whole or in part, you or your authorized representative may appeal the decision. If you appeal the decision, Claims Administrator will notify you or your authorized representative of the benefit determination on review according to the schedule described in this section.

If you are denied a claim for benefits, you will receive in writing:

- an explanation of the specific reason(s) for the denial;
- specific references to pertinent plan provisions on which the denial is based;
- a description of any additional material or information necessary for you to properly establish the claim and an explanation of why such material or information is necessary and
- an explanation of the steps you or your beneficiary can take to submit the claim for review.

Appealing a Claim – cont'd

To appeal a denied claim, you or your authorized representative must, within 180 days after receiving the notice of denial, submit a written request to Claims Administrator or the Plan Administrator asking that your claim be reconsidered. At that time, you or your authorized representative will have the right to review all pertinent plan documents and submit issues and comments in writing. Whenever possible, you should send copies of any documents or records that support your appeal.

A decision regarding your appeal will be made according to the timeframes described below, beginning when your appeal is received by Claims Administrator or your Plan Administrator. The final decision will be provided to you in writing and will include the reasons for the decision with reference to those plan provisions upon which the final decision was based.

Urgent Care Claims Appeal

An urgent care claim appeal refers to a claim for which the standard appeal timeframes could seriously jeopardize your life or health or your ability to regain maximum function, or, in the judgment of your Physician, would subject you to severe pain that cannot be adequately managed without the treatment you are seeking. An urgent care claim appeal is a verbal or written request to have another provider reconsider the decision. An urgent care claim appeal decision will be issued within 72 hours after Claims Administrator receives the request for an expedited appeal.

Standard Appeal

There are two types of standard appeals: pre-service and post-service. A pre-service claim appeal refers to any claim for a benefit under the Plan whereby the terms of the Plan require approval of the benefit in advance of obtaining the medical care. In these cases Claims Administrator will notify you or your authorized representative within 15 days of receiving your first level appeal request.

If you are not satisfied with the decision in your first level appeal, you may appeal again for a second determination. Second level pre-service appeal decisions will be made by Claims Administrator and communicated to you within 15 days.

Standard Appeal – cont'd

A post-service claim appeal refers to any claim for a benefit under the Plan that is not a pre-service claim. In these cases Claims Administrator will notify you or your authorized representative within 30 days of receiving your first level appeal request. If you are not satisfied with the decision in your first level appeal, you may appeal again for a second determination. Second level post-service appeal decisions will be made by Claims Administrator and communicated to you within 30 days.

Second level claim appeal requests requiring clinical review are reviewed by an independent review organization. If the adverse benefit determination was based in whole or part on a medical judgment, the independent review organization will consult with a health care professional that has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional consulted for this purpose may not be the individual consulted by the Claims Administrator in the first level appeal, or a subordinate of such individual.

Claims Administrator reviews second level post service claims appeals that do not require a clinical review.

Binding Arbitration

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this Plan, or in relation to claims for benefits under the Plan, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute or claim within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act will govern the interpretation and enforcement of all proceedings under this Binding Arbitration provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, state law governing agreements to arbitrate will apply.

Binding Arbitration – cont'd

The member and the Plan Sponsor agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

The member and the Plan Sponsor agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class arbitration, the member waives any right to pursue, on a class basis, any such controversy or claim against the Plan Sponsor waives any right to pursue on a class basis any such controversy or claim against the member. The arbitration findings will be final and binding except to the extent that California or Federal law provides for the judicial review of arbitration proceedings.

The arbitration is begun by the member making written demand on Claims Administrator. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the member and Plan Sponsor, or by order of the court, if the member and Plan Sponsor cannot agree. The arbitration shall be held in the State of California.

Plan Sponsor and the member will each be responsible for paying their own shares of the fees and expenses of the arbitration; however, the Plan Sponsor may pay the member's share of these fees in cases of extreme hardship, as determined by JAMS. An application to claim extreme hardship under this section may be obtained from JAMS.

Employer Identification Number

The Internal Revenue Service has assigned the Employer Identification Number (EIN) 94-3067788 to University of California. If you need to correspond with a government agency about a benefit plan, use this number along with the plan name and your employer's name.

OTHER PLAN INFORMATION

Plan Documents Control

This summary is provided in accordance with federal law. It is intended to be a summary of the plan documents identified above, and may not always be consistent with the terms of those documents. To the extent that this summary is inconsistent with the terms of the plan documents above, the plan documents will control. The plan documents will also control over inconsistent verbal statements or written communications from the employer or Claims Administrator.

Agent for Service of Legal Process

The agent for service of legal process is:

University of California

300 Lakeside Drive

5th Floor

Oakland, CA 94612-3557

UNITEDHEALTH ALLIES

ADDENDUM - UNITEDHEALTH ALLIES

Introduction

This Addendum to the Summary Plan Description provides discounts for select non-Covered Expenses from Physician's and health care professionals.

When we use the words "you" and "your" we are referring to people who are Covered Persons as the term is defined in the Summary Plan Description.

NOTE:
UnitedHealth Allies is not a health plan. You are responsible for the full cost of any services purchased, minus the applicable discount. Always use your health plan for Covered Expenses described in the Summary Plan Description (see "What's Covered Under the Plan") when a benefit is available.

WHAT IS UNITEDHEALTH ALLIES?

UnitedHealth Allies is a health value program that offers savings on products and services that are **not** Covered Expenses under your health plan.

Because this is not a health plan, you are not required to receive a referral or submit any claim forms.

Discounts through UnitedHealth Allies are available to you and your dependents as defined in the Summary Plan Description (see "Eligibility and How to Enroll" section).

Receiving and Activating Your Health Value Card

You will automatically receive a Health Value Card. Before using the Health Value Card, you must activate the card online at www.healthallies.com and create a new account or by calling the toll-free phone number on your Health Value Card.

UNITEDHEALTH ALLIES

Selecting a Discounted Product or Service

A list of available discounted products or services can be viewed online at www.healthallies.com or by calling the UnitedHealth Allies customer service center.

After selecting a health care professional and product or service, reserve the preferred rate and print the rate confirmation letter. If you have reserved a product or service with a UnitedHealth Allies customer service representative, the rate confirmation letter will be faxed or mailed to you.

IMPORTANT:
You must present the rate confirmation at the time of receiving the product or service in order to receive the discount.

Visiting Your Selected Health Care Professional

After reserving a preferred rate, make an appointment directly with the health care professional. Your appointment must be within ninety (90) days of the date on your rate confirmation letter. Present the rate confirmation and your Health Value Card at the time you receive the service. You will be required to pay the preferred rate directly to the health care professional at the time the service is received.

Additional UnitedHealth Allies Information

Additional information on the UnitedHealth Allies program and the Health Value Card can be obtained online at www.healthallies.com or by calling the toll-free phone number on your Health Value Card between 9 am and 9 pm Eastern Time, Monday through Friday.