YOUR UC CARE MEDICAL PLAN

This booklet consists of eight separate sections and describes your medical/hospital/surgical plan of benefits for your UC Care Plan.

Section I -	General Information which applies to Prudential HealthCare Point of Service; American Specialty Health Plans; United Behavioral Health; Prudential HealthCare Point-of-Service; Prescription Drug Benefits; and includes: Who Pays For The Plan, Eligibility, COBRA Information.
Section II -	Prudential HealthCare Point-of-Service for medical/hospital/surgical benefits.
Section III -	Prudential HealthCare Point-of-Service prescription drug benefits.
Section IV -	American Specialty Health Plans for chiropractic benefits.
Section V-	Certificate of Coverage.
Section VI -	American Specialty Health Plans for acupuncture benefits.
Section VII -	United Behavioral Health for mental health/substance abuse benefits.
Section VIII-	Plan Administration.

The following pages present the most important features of the Plan. Please read them carefully so you become familiar with the benefits that are available to you and your family.

This booklet describes the Plan benefits in everyday terms whenever possible. Not all details are included in every case. The extent of coverage for each person enrolled is governed at all times by the terms of the Group Contracts and the University of California Group Insurance Regulations. Copies of the Group Contracts will be furnished upon request. (See Plan Administration section.)

The medical Out-of-Area benefits are described in a booklet provided to you separately.

PCP Coordinated Benefits (Tier 1) Prudential HealthCare Point of Service medical and prescription drug benefits are provided by Prudential Health Care Plan of California, Inc. (herein called Prudential HealthCare).

Self-Coordinated Benefits (Tier 2 and Tier 3) Prudential HealthCare Point of Service medical and prescription drug benefits are provided by The Prudential Insurance Company of America.

Chiropractic benefits are provided by Prudential Health Care Plan of California, Inc., through an arrangement with American Specialty Health Plans. Primary Care Physician authorization is not required for this benefit.

Acupuncture benefits are provided by American Specialty Health Plans. Primary Care Physician authorization is not required for this benefit.

The Tier 1 benefit descriptions in this booklet serve as your Combined Evidence of Coverage and Disclosure Form.

The Tier 2 and Tier 3 benefit descriptions in this booklet serve as your Booklet Certificate.

IMPORTANT NOTICE: *This is an important document and should be kept in a safe place. Sign your name in the space below when you receive this document.*

THE PRUDENTIAL INSURANCE PORTION OF THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT POLICY.

____

Signature of Member

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SECTION I

GENERAL INFORMATION

(Unless stated otherwise, the information in Section I applies to all benefits provided under the UC Care Plan)

INTRODUCTION

A Point-of-Service plan allows you to choose the benefit level you want each time you get medical care – that is at the "point-of-service."

Under the UC Care Plan you have three Tiers of coverage to choose from:

- **Tier 1 provides HMO coverage**. You select a Primary Care Physician (PCP) from the Tier 1 network. Benefits are provided by Prudential Health Care Plan of California, Inc. (an HMO). All your care is provided through your Primary Care Physician (PCP), including referral to specialists and hospitalizations when necessary. Tier 1 provides the highest level of benefits at the lowest cost to you.

- **Tier 2 provides self-coordinated care in the HMO/PPO networks.** You can use any doctor or health care provider from the Tier 2 network of preferred providers. Tier 2 benefits also apply if you go directly to a provider in the HMO (Tier 1) network, without going through your PCP. When you use Tier 2 coverage you have more freedom of choice, but you also share more of the cost.

- **Tier 3 provides self-coordinated non-network coverage.** You can go to any licensed non-network health care provider – that is, a health care provider who is not in either the HMO network or the PPO network. Tier 3 provides maximum freedom of choice, but in return you must share even more of the cost. Tier 3 has the highest out-of-pocket costs.

Note:

Tiers 1, 2 and 3 do not apply to United Behavioral Health mental health/substance abuse benefits, American Specialty Health Plan chiropractic and acupuncture benefits or Prudential HealthCare Point-of-Service prescription drug benefits.

WHO PAYS FOR THE PLAN

The Coverage under this Plan is Contributory Coverage. You will be informed of the amount of your contribution when you enroll.

IN-AREA BENEFITS

This booklet describes the coverage available to persons enrolled in the in-area benefits. The out-of-area benefits are described in a separate booklet. The following describes which benefits (in-area or out-of-area) are available to eligible Employees/Annuitants and their eligible Dependents.

IN-AREA ELIGIBILITY

You are eligible for in-area benefits if you are an eligible Employee or Annuitant permanently living inside the Tier 1 service area.

If you are eligible for in-area benefits, your Dependents are eligible only for in-area benefits unless item 3 or 4 below applies.

OUT-OF-AREA ELIGIBILITY

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

1. An Employee or Annuitant permanently living outside the Tier 1 service area. All Dependents are eligible only for out-of-area benefits.

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

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

4. A natural or adopted child living with an ex-spouse more than 50% of the year outside the Tier 1 service area.

The rest of the family of the children described in 3 and 4 will remain in-area.

The UC Care plan's calendar year deductibles/benefit maximums/benefit limits and its lifetime maximums are combined for members who transfer between in-area and out-of-area status.

WHO IS ELIGIBLE

Covered Classes: The Covered Classes are these Employees of the Contract Holder:

All Employees who are: (a) located in the State of California and whose permanent residence is in the Service Area; and (b) not covered under an Alternate Health Care Plan designated by the Contract Holder.

1. **Employee**
   a. Persons appointed and paid by the Employer at least 50% time for one year or more, or are appointed at 100% time for three (3) months or more. A person appointed at least 50% time with the following notation on the appointment form is eligible: "Ending date is for funding purposes only; intent of employment is indefinite (for more than one year)".
   b. To remain eligible, you must maintain an average regular paid time of at least twenty (20) hours per week and maintain an eligible appointment of at least 50% time.
2. **Annuitant/(including Survivor Annuitant)**

   Anyone enrolled in a non-University Medicare+Choice Plan is not eligible for the UC Care Plan.

   You may continue Plan coverage upon retirement or collection of disability or survivor benefits from the University of California retirement plan, or any other defined benefit plan to which the University contributes. These conditions apply provided:

   a. you were in a University medical plan immediately before retiring;
   b. the effective date of your Annuitant Status is within one hundred twenty (120) calendar days of the date employment ends (or the date of your death in the case of a Survivor Annuitant);
   c. medical coverage is continuous from the date employment ends;

d. the monthly annuity check is large enough to cover your portion of the medical plan premium;

e. the Annuitant elects to continue coverage at the time of retirement; and

f. the University's service credit requirements for Annuitant medical eligibility are met.

3. **Qualified Dependents**

a. Your legal spouse, except if you are a Survivor Annuitant you may not enroll your legal spouse.

b. An unmarried child under age twenty-three (23). This means your natural or legally adopted child. It also includes your natural or legally adopted child who is living with a former spouse.

c. An unmarried grandchild under age twenty-three (23) or an unmarried stepchild under age twenty-three (23) who meets all of the following requirements:

- lives with you, and
- is dependent on you or your spouse for at least 50% of his or her support, and
- is your or your spouse's Dependent for federal income tax purposes.

Your signature on the enrollment form, or, if you enroll electronically, your electronic enrollment, attests to these conditions.

d. An unmarried child under age eighteen (18) for whom you are the legal guardian and who meets all of the following requirements:

- lives with you, and
- is dependent on you for at least 50% of his or her support, and
- is your Dependent for federal income tax purposes.

Your signature on the enrollment form, or, if you enroll electronically, your electronic enrollment, attests to these conditions.

e. An unmarried child over age twenty-three (23) who is and continues to be :

   1. incapable of self-support for reasons of mental or physical handicap, and

   2. chiefly dependent upon you for at least 50% of his/her support. The child must be your Dependent for federal income tax purposes, and

   3. living with you if a stepchild.

   Your signature on the enrollment form, or, if you enroll electronically, your electronic enrollment, attests to these conditions.

f. An adult dependent relative or same-sex domestic partner and their eligible children as set forth in the University of California Group Insurance Regulations. For information on who qualifies and on the requirements to enroll an adult dependent relative or same sex domestic partner, contact your local Benefits Office.

Application, including proof of incapacity, must be made to Prudential HealthCare/Prudential within thirty-one (31) days before the child's attainment of the applicable limiting age and is subject to approval by Prudential HealthCare/Prudential. The child must have been incapacitated and continuously covered under a University-sponsored medical plan before attaining the limiting age. Prudential HealthCare/Prudential may periodically require proof of incapacity during the covered period, but not more frequently than once a year after the child's attainment of the limiting age. Medical coverage may be continued as long as the child remains incapacitated, unmarried and dependent upon you for at least 50% of his/her support.

A newly hired Employee with an overage Dependent child may apply for coverage under the same general terms as a current Employee.

If the overage Dependent child is not the Employee’s, Annuitant’s or Survivor Annuitant’s natural or legally adopted child, the child must reside with the Employee, Annuitant or Survivor Annuitant in order for the coverage to be continued past age twenty-three (23).

Disabled children approved for continued coverage under one 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 at that time. Prudential HealthCare/Prudential may periodically request proof of continued incapacity.

Where federal income tax dependency is required for Dependent’s Coverage, you will be asked to submit annually a copy of your federal income tax return (IRS form 1040 or IRS equivalent) showing the covered Dependent and your signature to the University to verify income tax dependency.

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

The University and/or the Plan reserve the right to periodically request documentation to verify eligibility of Dependents. Such documentation could include a marriage certificate, birth certificates, adoption records, or other official documents.

Special Dependent's Coverage Rules for Newborn Children and Children Placed for Adoption:

Notwithstanding the above, if a child is born to you or is placed for adoption, while you are covered for Employee Coverage under the Plan, you will become covered for that child:

(a) in the case of a newborn child, from the moment of the child's birth; and

(b) in the case of a child who is placed with you for adoption, from the moment the child is placed in your physical custody for adoption. A child will be considered "placed in your physical custody for adoption" on the date on which the adoptive child's birth parent or other appropriate legal authority signs a written document (including, but not limited to, a health facility minor release report, a medical authorization form, or a relinquishment form) granting you (or your spouse) the right to control health care of the child placed for adoption or, absent this written document, on the date there exists evidence of your (or your spouse's) right to control the health care of the child placed for adoption. Coverage for the child is subject to the When Coverage Stops section and to the following provisions:

(1) The coverage for the child will not end during the thirty-one (31)-day period following the date you become covered for that child because you fail to pay any required contribution for that coverage.

(2) The coverage for the child will not continue beyond the end of that thirty-one (31)-day period unless:

    (a) the child is a qualified Dependent; and

    (b) before the end of that period, you have complied with the above rules for becoming covered for Dependent's Coverage for that child.

If your Dependent's Coverage with respect to the child ends at the end of that thirty-one (31)-day period, as provided above, no benefits will be available for any service or supply furnished for the child's health care after that period.

ENROLLMENT

You may enroll yourself and your eligible Dependents during your "Period of Initial Eligibility" (PIE). The PIE starts the day you become eligible for benefits or acquire a newly eligible Dependent.

You may enroll any newly eligible Dependent below during his or her PIE which starts the day your Dependent becomes eligible for benefits.

1. For a new spouse, eligibility begins on the date of marriage. Survivor Annuitants may not add new spouses to their coverage.

2. For a newborn child, eligibility begins on the child's date of birth.

3. For newly adopted children, eligibility begins on the earlier of:

    a. the date the Employee or Employee's spouse has the legal right to control the child's health care, or

    b. the date the child is placed in the Employee's physical custody.

    If not enrolled during the PIE beginning on that date, there is an additional PIE beginning on the date that the adoption becomes final.

If you decline enrollment for yourself or your eligible Dependents because of other medical plan coverage and that coverage ends, you may in the future be able to enroll yourself or your eligible Dependents in a medical plan for which you are eligible provided that you enroll within the PIE. The PIE starts on the day the other coverage is no longer in effect.

A PIE ends on the date thirty-one (31) days after it begins (or on the preceding business day for the local Accounting or Benefits Office if the thirty-first (31st) day is on a weekend or a holiday).

To enroll yourself or an eligible Dependent, submit the appropriate enrollment form to the local Accounting or Benefits Office (or enroll electronically) during the PIE.

You and your eligible Dependents may also enroll in the Plan during an announced Open Enrollment Period established by the University.

If you or your eligible Dependent fails to enroll during a PIE or Open Enrollment Period, you may enroll at any other time upon completion of a ninety (90) consecutive calendar day waiting period. The ninety (90) day waiting period starts on the date the enrollment form is received by the local Accounting or Benefits office and ends ninety (90) consecutive calendar days later.

An Employee who currently has two or more covered Dependents may add a newly eligible Dependent after the PIE. Retroactive coverage for such enrollment is limited to the later of:

a. maximum of three hundred sixty-five (365) days prior to the date your Dependent is enrolled (either by receipt of their enrollment form by the local Accounting or Benefits Office or by electronic enrollment), or

b. the date the Dependent became eligible.

Coverage cannot begin before the first day of eligibility.

EFFECTIVE DATE OF COVERAGE

Coverage for newly eligible Employees and their eligible Dependents is effective on the date of eligibility provided they are enrolled (either by receipt of an enrollment form by the local Accounting or Benefits Office or by electronic enrollment) within the PIE.

Coverage for newly eligible Dependents is effective on the date the Dependent becomes eligible provided they are enrolled (either by receipt of the enrollment form by the local Accounting or Benefits Office or by electronic enrollment) within the PIE. There is one exception to this rule: coverage for a newly eligible adopted child enrolling during the additional PIE (explained on page 18) is effective on the date the adoption becomes final.

For enrollees who complete a ninety (90) day waiting period, coverage is effective on the ninety-first (91st) consecutive calendar

day after the date the enrollment form is received by the local Accounting or Benefits Office.

The effective date of coverage for enrollment during an Open Enrollment Period is the date announced by the University.

CHANGES IN COVERAGE

In order to change from Single-party coverage to Two-party, or from Two-party to Family coverage, you need to complete a new enrollment form at the local Accounting or Benefits Office (or enroll electronically) within the PIE following the event, e.g., marriage, birth, adoption, etc.

WHEN COVERAGE STOPS

Employee: Except as provided in any Extension of Benefits provision, your coverage will end on the earliest of:

1. the last day of the last pay period for which a premium is paid based on earnings as an eligible Employee;

2. the date you cease to be in a class of Employees eligible for coverage;

3. the date you or the University fails to make contributions;

4. the date the Plan ends.

Dependents: Except as provided by any Extension of Coverage provision, your Dependent's Coverage will end on the earliest of:

1. the date your coverage ends;

2. the date you or the University fails to make contributions for Dependent's Coverage;

3. the date you cease to be in a class for Dependent's Coverage;

4. the last day of the month in which a Dependent ceases to meet the definition of "Dependent".

A Dependent child, upon reaching the termination age, may be incapable of self-support because of mental retardation or physical handicap. If you notify Prudential HealthCare/Prudential in writing within thirty-one (31) days before a Dependent child reaches such age, Prudential HealthCare/Prudential will continue a Dependent child's coverage as long as your coverage continues and the child continues to be handicapped and dependent upon you for support. This child must have been incapacitated and covered under the Plan prior to age twenty-three (23). See other requirements under Who Is Eligible.

A Dependent's Coverage stops on the first of the month following the date he or she is no longer eligible as a Dependent. You are required to complete a new enrollment form deleting your Dependent when he or she is no longer eligible.

When a Dependent is no longer eligible due to marriage, death, divorce, legal separation or annulment, you need to notify the Benefits Office to remove the Dependent from coverage. Your Dependent may be eligible to continue benefits. See the section entitled "Optional Continuation Of Coverage - COBRA". You must contact your Benefits Office within sixty (60) days of the Dependent's loss of eligibility.

LEAVE OF ABSENCES

With regard to your health care expense insurance under the Group Contract, your employment in the Covered Classes will not be considered to end while you are absent from work due to leave for which insurance is required to be continued under the Federal Family and Medical Leave Act of 1993 or a state law requiring similar continuation, as reported to Prudential HealthCare by the Employer.

FRAUD

Coverage for you or a covered Dependent 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 by the Plan to the Employee and the University. Termination of coverage of a Dependent for fraud shall not cancel the coverage of

other family members. Termination of your coverage shall automatically cancel the coverage for all covered Dependents.

REVIEW OF CANCELLATION

If a person alleges that coverage under the Prudential HealthCare Point of Service In-network Coverage (Tier 1) was ended because of the person's health status or requirements for health care services, the person may request a review of cancellation by the California Commissioner of Corporations.

EXTENSION OF COVERAGE

A Covered Person's Coverage under the Plan may be extended after the date that person ceases to be a Covered Person. Coverage will be extended if, on that date, the Covered Person is Totally Disabled from a Sickness or Injury and is under a Participating Physician's (for Tier 1) or a doctor's (Tiers 2 and 3) care. The extension is only for that and any related Sickness or Injury. Coverage will be extended for the time the person remains so disabled from any such Sickness or Injury and under such care, but not beyond twelve (12) months. The extension only applies if the person's coverage ends because the Group Contract ends (or the Group Contract ends for an entire employer unit).

NOTE:
See What Terms Mean for the definition of Totally Disabled.

The Coverage for a disabling condition will apply during an extension as if the person were still a Covered Person. There are these exceptions:

(1) The Coverage will apply only to the extent that other coverage for its Eligible Services and Supplies is not provided for the person through the Employer.

(2) The Plan will not provide coverage for a disabling condition that is being covered under an extension of benefits provision of another plan.

OPTIONAL CONTINUATION OF COVERAGE - COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, Enrolled Persons who would lose coverage under the UC Care Medical Plan due to certain "Qualifying Events" are entitled to elect, without submitting evidence of good health, continued coverage at their own expense.

Benefits of the continuation plan are identical to this group medical plan and the cost is explained at the end of this section under "Cost of Continuation Coverage." Your American Specialty Health Plans, United Behavioral Health and Prudential HealthCare Prescription Drug Benefits will not be available to you under COBRA unless you have first elected to continue your Prudential HealthCare/Prudential medical benefits.

Continued coverage shall be the same as for active eligible Employees and their eligible Dependents under the University group plan. If coverage is modified for active eligible Employees and their eligible Dependents, it shall also be modified in the same manner for persons with continued coverage (Qualified Beneficiaries) and an appropriate adjustment in premiums may be made.

Right to Continue Benefits - A right under this part is subject to the rest of these provisions:

You have the right to continue benefits under the Plan if your coverage under the Plan would have ended for either of the following Qualifying Events:

(1) because your employment ended for a reason other than gross misconduct; or

(2) because your work hours were reduced (including approved leave without pay or layoff).

Each of your eligible Dependents has the right to continue benefits under the Plan if coverage would have ended for any of the following Qualifying Events:

(1) because your employment ended for a reason other than gross misconduct; or

(2) because your work hours were reduced (including layoff or approved leave without pay); or

(3) at your death; or

(4) because you became entitled to Medicare benefits; or

(5) when your spouse or Dependent child ceases to be an eligible qualified Dependent as a result of divorce, legal separation or annulment (see **Notice** below); or

(6) in the case of a Dependent child, when the child ceases to be an eligible Dependent under the rules of the Plan (see **Notice** below)

Notice - If coverage for your spouse or Dependent child ends due to an event shown in (5) or (6) immediately above, you or your eligible Dependent must give written notice of the event to the Plan within sixty (60) days after the event or eligibility to elect continuation of benefits will be lost.

NOTE: For the Qualifying Event (1) or (2), if you become entitled to Medicare due to age within eighteen (18) months before the Qualifying Event, your eligible Dependent spouse or your eligible Dependent child may continue COBRA coverage for up to thirty-six (36) months counted from the date you become entitled to Medicare.

If a second "Qualifying Event" occurs to a Qualified Beneficiary who already has continuation coverage because employment ended or work hours were reduced, that Qualified Beneficiary's coverage may be continued for up to a maximum of thirty-six (36) months from the date of the first "Qualifying Event".

Continuation - Once aware of a Qualifying Event, the Employer will give a written election notice of the right to continue the coverage to you (or to the Qualified Beneficiary in the event of your death). Such notice will state the amount of the payments, if any, required for the continued coverage. If a person wants to continue the coverage, the Election Notice must be completed and returned to the address below, along with the first month's premium, within sixty (60) days of the later of: (1) the date of the Qualifying Event; or (2) the date the Qualified Beneficiary received the notice informing the person of the right to continue.

Sykes HealthPlan Services
COBRA/IBS
P.O. Box 34640
Louisville, KY 40232-4640

Benefits of the continuation plan are identical to this group medical plan and cost is explained below under "Cost of Continuation Coverage."

When Continuation of Coverage Ends

The continued coverage period runs concurrently with any other University continuation provisions (e.g., during leave without pay) except continuation under the Family Medical Leave Act (FMLA). Coverage will be continued from the date it would have ended until the first of these events occur:

(1) With respect to yourself and any other Qualified Beneficiaries, the day eighteen (18) months from the earlier of the date:

(a) your employment ends for a reason other than gross misconduct, or

(b) your work hours are reduced. But, coverage may continue for all Qualified Beneficiaries for up to eleven (11) additional months while a person is determined to be disabled under Title II or XVI of the United States Social Security Act if:

(i) the disability was determined to exist at the time, or during the first sixty (60) days of the first eighteen (18) months of COBRA coverage; and

(ii) the person gives the Plan written notice of the disability within sixty (60) days after the determination of disability is made and within eighteen (18) months after the date employment ended or work hours were reduced.

If you are entitled to the eleven (11) month extension and have nondisabled qualified Dependents who are also entitled to continuation, those nondisabled qualified Dependents are also entitled to eleven (11) additional months of continuation.

The Plan must be notified if there is a final determination under the United States Social Security Act that the person is no longer disabled. The notice must be provided within thirty (30) days after the final determination. The coverage will end on the first of the month that starts more than thirty (30) days after the determination.

(2) With respect to Qualified Beneficiaries other than yourself, the day thirty-six (36) months from the earliest of the date:

(a) of your death; or

(b) of your entitlement to Medicare benefits; or

(c) of your divorce, annulment, or legal separation from your spouse; or

(d) your Dependent child ceases to be a qualified Dependent under the rules of the Plan.

The thirty-six (36) months will be counted from the date of the earliest Qualifying Event.

(3) With respect to any Qualified Beneficiaries (you or any eligible Dependent), if the person fails to make any payment required for the continued coverage, the end of the period for which the person has made required payments.

(4) With respect to any qualified Beneficiaries (you or any eligible Dependent), the day the person becomes covered (after the day the person made the election for continuation coverage) under any other health plan for persons in a group, on an insured or uninsured basis. This item (4) by itself will not prevent coverage from being continued until the end of any period for which pre-existing conditions are excluded or benefits for them are limited under the other health plan.

(5) The day the person becomes entitled to Medicare benefits.

(6) The day the Employer no longer provides group health coverage for any of its Employees.

While Employee Benefits are continued under this part, all other terms of the Group Plan will apply, except that the When You Become Covered section of this booklet will not apply.

Additional Options for Continued Coverage - California Continuation Coverage - These provisions apply only to the Coverages of the Group Contract under the plan of an employer that provides hospital, surgical, or Group Health Care Coverage. They describe who has the right to continue coverage under those Coverages and how it may be continued. The provisions are concerned with continuation of your coverage beyond the date it would otherwise have ended as described in the previous Section "Optional Continuation of Coverage - COBRA" on page 23. These provisions only apply to a person who is entitled to continue coverage under the provision entitled "Optional Continuation of Coverage - COBRA."

Right to Continue Coverage: A right under this part is subject to the rest of these provisions:

You have the right to further continue your Employee or Employee and Dependent's Coverage for you and your spouse under the Group Health Care Coverage of the Group Contract if you:

(1) Have been continuously employed by the Contract Holder and covered under the Group Contract during the period of five continuous years immediately prior to the date of your termination; and

(2) Are sixty (60) years of age or older on the date employment terminates; and

(3) Are eligible for and have elected to continue your Employee or Employee and Dependent's Coverage under the provision entitled "Optional Continuation of Coverage - COBRA."

The former spouse of an Employee or former Employee is entitled to California Continuous Coverage, provided the former spouse continued coverage under COBRA as a Qualified Beneficiary. The California Continuation Coverage does not apply to the children of a former Employee.

California Continuation Coverage: The Contract Holder will give notice of the right to continue the coverage under the California law. If a person wants to continue the coverage, the person must elect to do so by notifying the Contract Holder in writing within thirty (30) calendar days prior to the date the continuation under the provision "Optional Continuation of Coverage - COBRA" would otherwise have ended, and sending the premium payment to the Plan at that time. If this is done, the coverage will be continued until the first of these events occur:

(1) The date the person reaches the age of sixty-five (65) years;

(2) The date the University no longer maintains the group health plan including any replacement plan;

(3) The day the person is covered for benefits under any arrangement of Coverage for persons in a group, not maintained by the University;

(4) If a person fails to make any payment required by the Contract Holder for the continued coverage, the end of the period for which the person has made the required payments;

(5) The day that the person becomes entitled to Medicare under Title VIII of the Social Security Act;

(6) For a spouse or former spouse covered under Dependent's Coverage, the day that is five (5) years from the date COBRA ends for the spouse or former spouse.

If the Employee's coverage terminates, the spouse may continue coverage under California Continuation Coverage if one of the Qualifying Events applies to the spouse.

Under the Group Contract all benefits for Employee and Dependents coverage are paid to the Employee. While Dependent's Coverage is continued under this part, all other terms of the Group Contract will apply, except that benefits under the Group Health Care Coverages will be paid to the person who elected the continuation right.

If an amount is so paid, the Plan will not have to pay that part of your coverage again. Any benefits already paid to a Dependent will not be paid again to the Employee.

Please note: When your continuation coverage ends, you may be able to convert your coverage to an individual conversion plan if you wish.

Cost of Continuation Coverage: The cost of the coverage will include any portion previously paid by the Employer and shall not be more than 102% of the applicable group rate during the period of basic COBRA coverage; or not more than 150% any time during the eleven (11)-month disability extension period (i.e., during the nineteenth (19th) through the twenty-ninth (29th) months) described on page 25; or not more than 213% during the extension period allowed by California Continuation Coverage, described on page 27.

For information on annual Open Enrollment actions for which you may be eligible and/or any applicable plan modifications and premium adjustments, contact University of California Customer Service at (800) 888-8267, extension 7-0651 before Open Enrollment.

LEAVE OF ABSENCE, LAYOFF OR RETIREMENT

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

CONVERSION PRIVILEGE - TIER 1

CONVERTING TO AN INDIVIDUAL HEALTH CARE COVERAGE CONTRACT -- Applicable to Persons under Age 65

This section describes when and how you, or your spouse or child, may get an individual health care coverage contract (called the Converted Contract below) when your Employee Coverage, or your Dependent's Coverage for your spouse or child, under the Group Health Care Coverage or Optional Continuation of Coverage ends. There are no conversion privileges available for the American Specialty Health Plans Benefits, United Behavioral Health Mental Health/Substance Abuse Benefits and Prudential HealthCare Prescription Drug Benefit.

Right to Convert

A right under this section is subject to the rest of this Conversion Privilege.

You have the right to get a Converted Contract if both of these conditions are met:

(1) Your Group Health Care Coverage ends for any reason other than:

  (a) your failure to pay, when due, any contribution required for the Coverage; or

  (b) the end of your employment (other than retirement), if you then have the right to elect to continue your group health care coverage.

(2) You have been covered for at least three (3) months, under any UC-sponsored group medical plan.

Your spouse or each of your children has the right to get a Converted Contract if both of these conditions are met:

(1) Your Dependent's Coverage for your spouse or child under the Group Health Care Coverage ends for one of these reasons:

  (a) Your death.

(b) Your spouse ceases to be a qualified Dependent, due to divorce or annulment of your marriage.

(c) Your spouse or child ceases to be a qualified Dependent for any other reason, and you do not have the right to get a Converted Contract at that time.

(2) You have been covered for at least three (3) months, under any UC-sponsored group medical plan.

Application and First Premium Payment

The Covered Person who has the right to get the Converted Contract must apply for it and pay the first premium to Prudential HealthCare within thirty-one (31) days after the Group Health Care Coverage for that person ends. Evidence of good health is not required.

Effective Date

The Converted Contract will take effect on the day after the Group Health Care Coverage ends.

Converted Contract

The Converted Contract's form and premiums, and the persons covered by it, will be as stated below.

Form: Any form of Converted Contract that Prudential HealthCare then makes available. The benefits need not be the same as those of the Group Health Care Coverage but will comply with any state laws or regulations that may apply.

Premiums: For the Converted Contract, these will be based on Prudential HealthCare's rates for:

(1) the age, sex and place of permanent residence (zip code) of each person covered under it; and

(2) the type and amount of coverage it provides; and

(3) its premium period. This is the usual one for the Converted Contract. But premiums will not be due less often than quarterly unless the person to be covered agrees.

Persons Covered: Subject to the exceptions below, these are:

(1) If the Converted Contract is issued to you, you and your qualified Dependents whose Group Health Care Coverage ended when yours did.

(2) If your spouse has the right to get a Converted Contract and it is issued to your spouse, your spouse and any of your qualified Dependent children whose Group Health Care Coverage ended at the same time.

(3) If your child has the right to get a Converted Contract and it is issued to your child, only that child.

These are the exceptions to the above rules:

(a) Prudential HealthCare may issue a separate Converted Contract to any person.

(b) Prudential HealthCare does not have to issue a Converted Contract covering these persons:

 (i) A person whose permanent residence is outside the Service Area, (refer to the following section entitled "Conversion to an Individual Health Care Expense Insurance Contract").

 (ii) A person age sixty-five (65) or over who is or could be covered by Medicare.

 (iii) A person whose Group Health Care Coverage ends because all Group Health Care Coverage for a class, by amendment or otherwise ends, if it is replaced for the class by similar benefits under a group contract within the next sixty (60) days.

 (iv) A person to whom one or more of the items below applies, when the benefits of the Converted Contract, together with the similar benefits provided or available from the sources shown in those items, would result in excess coverage under Prudential HealthCare's standards.

(A) The person is covered by an insurance or other contract, plan or a program.

(B) The person is eligible for coverage (whether or not covered) under any insured or uninsured arrangement for coverage of persons in a group.

(C) A law requires that benefits be provided or made available to that person.

(v) A person whose coverage was terminated for cause.

CONVERSION TO AN INDIVIDUAL HEALTH CARE EXPENSE INSURANCE CONTRACT

This section applies if a Covered Person (you, your spouse or child) **resides outside the Service Area** and would otherwise have the right to get a Converted Contract as stated in the section called Converting To An Individual Health Care Coverage Contract. That Covered Person may get an individual health care expense insurance contract (an indemnity medical conversion policy only) issued by Aetna Life Insurance Company, subject to the same rules and conditions that apply to a Converted Contract issued by Prudential HealthCare, as stated in the section, Converting To An Individual Health Care Coverage Contract.

CONVERSION AT RETIREMENT

This applies if your Group Health Care Coverage would be continued after your retirement, but before you are or could be covered by Medicare. In place of that continuation, you may get a Converted Contract under the same rules and conditions stated in the section, Converting To An Individual Health Care Coverage Contract, as if that coverage ended at retirement.

CONVERSION PRIVILEGE -TIER 2 and TIER 3

CONVERSION PRIVILEGE UNDER HEALTH CARE EXPENSE INSURANCE -- Applicable to Persons under Age 65

This Conversion Privilege applies only to health care expense insurance under the Group Contract (called group health care insurance below).

It describes when and how you, or your spouse or child, may get an individual health care expense insurance contract (called the Converted Contract below) when your group health care insurance, or that of your spouse or child, ends. There are no conversion privileges available for the American Specialty Health Plans Benefits, United Behavioral Health Mental Health/Substance Abuse Benefits and Prudential HealthCare Prescription Drug Benefits

Right to Convert

A right under this section is subject to the rest of this Conversion Privilege.

You have the right to get a Converted Contract if both of these conditions are met:

(1) Your group health care insurance ends for any reason other than:

  (a) your failure to pay, when due, any contribution required for insurance under the Group Contract; or

  (b) the end of your employment (other than retirement) if you then have the right to elect to continue your group health care insurance.

(2) You have been insured for at least three (3) months, under any UC-sponsored group medical plan.

Your spouse or each of your children has the right to get a Converted Contract if both of these conditions are met:

(1) Your Dependent's Insurance for your spouse or child under the group health care insurance ends for one of these reasons:

  (a) Your death.

  (b) Your spouse ceases to be a qualified Dependent, due to divorce or annulment of your marriage.

  (c) Your spouse or child ceases to be a qualified Dependent for any other reason, and you do not have the right to get a Converted Contract at that time.

(2) You have been insured for at least three (3) months, under any UC-sponsored group medical plan.

A child does not have the right to get a Converted Contract while your spouse has that right.

Application and First Premium Payment

The person who has the right to get the Converted Contract must apply for it, and pay the first premium, to Aetna within thirty-one (31) days after the group health care insurance for that person ends. Evidence of insurability is not required.

Effective Date

The Converted Contract will take effect on the day after the group health care insurance ends.

Converted Contract

The Converted Contract's form and premiums, and the persons covered by it, will be as stated below.

Form: Any form of Converted Contract that Aetna then makes available. The benefits will not be the same as those of the group health care insurance but will comply with any state laws or regulations that may apply.

Premiums: For the Converted Contract, these will be based on Aetna's rates for:

(1) the age and class of risk (but not health) of each person covered under it; and

(2) the type and amount of insurance it provides; and

(3) its premium period. This is the usual one for the Converted Contract. But premiums will not be due less often than quarterly unless the insured agrees.

Persons Covered: Subject to the exceptions below, these are:

(1) If the Converted Contract is issued to you, you and your qualified Dependents whose group health care insurance ended when yours did.

(2) If your spouse has the right to get a Converted Contract and it is issued to your spouse, your spouse and any of your qualified Dependent children whose group health care insurance ended at the same time.

(3) If your child has the right to get a Converted Contract and it is issued to your child, only that child.

These are the exceptions to the above rules:

(a) Aetna may issue a separate Converted Contract to any person.

(b) Aetna does not have to issue a Converted Contract covering these persons:

  (i) A person age sixty-five (65) or over who is covered by Medicare.

  (ii) A person whose group health care insurance ends because all group health care insurance for a class, by amendment or otherwise ends, if it is replaced for the class by similar benefits under a group contract within the next thirty-one (31) days.

  (iii) A person to whom one or more of the items below applies, when the benefits of the Converted Contract, together with the similar benefits provided or available from the sources shown in those items, would result in overinsurance under Aetna's standards.

    (A) The person is covered by an insurance or other contract, a plan or a program.

    (B) The person is eligible for coverage (whether or not covered) under any insured or uninsured arrangement for coverage for persons in a group.

    (C) A law requires that benefits be provided or made available to that person.

PRUDENTIAL HEALTHCARE'S RIGHT OF REIMBURSEMENT AND LIMITED RIGHT OF RECOVERY UNDER THE PLAN - TIER 1

A. REIMBURSEMENT

(1) The following will apply if any Covered Person receives any services, supplies or other benefits to which the person is not entitled by the terms of the Plan and of the Group Contract. The Covered Person will be charged for the reasonable cash value of any such services or supplies or for the amount of any such benefits. The Covered Person must reimburse Prudential HealthCare for such reasonable cash value or amount.

(2) Each Covered Person agrees to the following in return for Prudential HealthCare's providing services, supplies or benefits for a Covered Person's Sickness or Injury that :

(a) is caused as a result of an accident; or

(b) arises out of, or in the course of, any work for wage or profit and is covered by any workers' compensation law, occupational disease law or similar law.

(3) Immediately upon receipt of any payments or collection of damages (as a settlement award, judgment or in any other way) with respect to such Sickness or Injury, the Covered Person involved (or if incapable, that person's legal representative) will reimburse Prudential HealthCare for:

(a) the reasonable cash value of any benefits provided directly by Prudential HealthCare as a result of the Sickness or Injury; and

(b) the actual costs paid by Prudential HealthCare for medical services required by the Covered Person as a result of the Sickness or Injury.

(4) The Covered Person involved (or if incapable, that person's legal representative) will provide Prudential HealthCare with an assignment of such payments or damages when required by Prudential HealthCare.

Any reimbursement under (a) above will be made only to the extent of any such payments actually received or any such damages actually collected.

B. LIMITED RIGHT OF RECOVERY

In return for Prudential HealthCare's providing benefits for a Covered Person's Sickness or Injury for which another person, corporation, or other entity (called Third Party below) is considered responsible, each Covered Person agrees to the following. The Covered Person involved (or if incapable, that person's legal representative) will assign to Prudential HealthCare the right of recovery against the responsible Third Party to the extent of the reasonable cash value of benefits received from or through Prudential HealthCare, plus costs of suit and attorneys' fees. When such benefits are provided, or later as Prudential HealthCare may request, the Covered Person (or if incapable, that person's legal representative) agrees to:

(1) Execute a formal written Injury report, if benefits are provided for an Injury.

(2) Execute an assignment to Prudential HealthCare of the right to bring suit in its name or in the Covered Person's name against the Third Party responsible for the Sickness or Injury to recover:

(a) the reasonable cash value of benefits provided directly by Prudential HealthCare as a result of the Sickness or Injury; and

(b) the actual costs paid by Prudential HealthCare for medical services required by the Covered Person as a result of the Sickness or Injury.

Recovery under this (2) will include costs of suit and attorneys' fees.

(3) Reimburse Prudential HealthCare for:

(a) the reasonable cash value of any benefits provided directly by Prudential HealthCare; and

(b) the actual costs paid by Prudential HealthCare for medical services required by the Covered Person as a result of the Sickness or Injury. Such reimbursement will be made immediately upon receipt of any payments for the Sickness or Injury made by or for the responsible Third Party (as a settlement, judgment or in any other way), but only to the extent of any such payments actually received.

Such reimbursement will be made:

(i) whether or not liability for the payments is admitted by the Third Party; and

(ii) whether or not such payments are itemized. A reasonable share of fees and costs incurred to obtain such payments may be deducted from the reimbursements to be made to Prudential HealthCare.

Prudential HealthCare will have a lien on extent of the amount or reimbursement to which it is entitled under this (3). In determining the reasonable cash value of benefits provided by Prudential HealthCare for an Eligible Service or Supply, Prudential HealthCare will consider the range of charges generally made by providers in the area for a like service or supply.

The area and that range are as determined by Prudential HealthCare. Prudential HealthCare will also take into account: any unusual circumstances; and any medical complications that require additional time or special skill, experience and/or facilities in connection with a particular service.

(4) Execute and deliver such papers and provide such reasonable help (including making court appearances) as may be needed to enable Prudential HealthCare to recover the reasonable cash value of benefits provided by Prudential HealthCare, including costs of suit and attorneys' fees.

BENEFIT MODIFICATION FOR THIRD PARTY LIABILITY - TIERS 2 AND 3

This modifies any Coverage of the Plan that is a health care expense Coverage.

A. This Modification applies when a person, other than the person for whom a claim is made, is considered responsible for a Sickness or Injury. To the extent payment for the Sickness or Injury is made, or may be made in the future, by or for that responsible person (as a settlement judgment or in any other way):

   (1) charges arising from that Sickness or Injury are not covered; and

   (2) benefits for any period of Total Disability resulting (in whole or in part) from that Sickness or Injury are not payable.

B. But when a claim is received by Prudential HealthCare, benefits which would be payable except for A. above will be paid if:

   (1) payment by or for the responsible person has not yet been made; and

   (2) the covered individual(s) involved (or if incapable, that individual's legal representative) agrees in writing to pay back promptly the benefits paid as a result of the sickness or injury to the extent of any future payments made by or for the responsible person for the Sickness or Injury. The agreement is to apply whether or not:

      (a) liability for the payment is admitted by the responsible person; and

      (b) such payments are itemized. A reasonable share of fees and costs incurred to obtain such payments may be deducted from amounts to be repaid to Prudential.

C. Amounts due Prudential HealthCare to repay benefits, agreed to as described in B. above, may be deducted from other benefits payable by Prudential after payments by or for the responsible person are made.

EFFECT OF MEDICARE ON TIER 1 COVERAGE

A. ELIGIBILITY PROVISIONS FOR COVERED PERSONS AGE SIXTY-FIVE (65) OR MORE WHO ARE ELIGIBLE FOR MEDICARE

"Medicare" means Title XVIII (Health Insurance for the Aged and Disabled) of the United States Social Security Act, as amended from time to time.

"Part A of Medicare" means the program of Hospital Insurance for the Aged and Disabled under Part A of Medicare.

A Covered Person age sixty-five (65) or more who is eligible for Part A of Medicare may have the Plan as that person's primary benefit program, pursuant to the Federal Age Discrimination in Employment Act, as amended. The Plan for such Covered Person will continue only while the Covered Person is meeting the following conditions:

(1) In the case of an Employee, the Employee is not retired.

(2) In the case of a qualified Dependent, the Covered Person is the qualified Dependent of an Employee who meets condition (1) above.

(3) The Covered Person has not elected Medicare, in writing, as the primary benefit program.

B. SPECIAL PROVISIONS FOR OTHER COVERED PERSONS WHO ARE ELIGIBLE FOR MEDICARE

For a Covered Person who is eligible for Medicare and to whom Section A. above does not apply, the Plan will continue only subject to the following conditions:

(1) The Covered Person, if eligible, has enrolled in Parts A and B of Medicare.

(2) Annuitants or their Dependents who first became eligible for Medicare hospital insurance (Part A) as primary coverage prior to July 1, 1991, enrolled and remained in the hospital (Part A) portion of Medicare.

(3) The Covered Person has completed such consents, releases, assignments and other documents reasonably requested by Prudential HealthCare to obtain or assure Medicare reimbursements.

C. BENEFITS

The benefits of the Plan provided to Covered Persons are not designed to duplicate any benefit for which they are enrolled and entitled to under Medicare. All sums payable under Medicare for services and supplies that are provided under the Plan will be payable to, and retained by, Prudential HealthCare and United Behavioral Health.

EFFECT OF MEDICARE ON TIER 2 AND TIER 3 COVERAGE

Active Employees

If you are either an active Employee age sixty-five (65) or over or the Dependent spouse age sixty-five (65) or over of an active Employee, and you have elected to retain this Plan as primary coverage, claims must be paid under this Plan before Medicare Benefits are paid. For more information regarding how this may affect you or your spouse's claim filing, contact your Benefits Representative.

Retired Employees - Medicare Enrollment

Annuitants or their Dependents who first become eligible for Medicare hospital insurance (Part A) as primary coverage on or after July 1, 1991, must enroll and remain in both the hospital (Part A) and the medical (Part B) portions of Medicare. This includes those who are entitled to Medicare benefits through non-University employment.

You should visit your local Social Security Office three (3) months before your sixty-fifth (65th) birthday to inquire about how you can enroll in Medicare. If you qualify for disability income benefits from Social Security, contact your local Social Security Office for information about when you will be eligible for Medicare enrollment.

To enroll in a University-sponsored Medicare plan, simply complete a Medicare declaration form. This notifies the University that you are covered by Part A and B of Medicare.

Medicare declaration forms are available from the University of California's Customer Service Center.

Annuitants or Dependents who are eligible for, but decline to enroll in, both parts of Medicare, will be assessed a monthly offset fee by the University to cover the increased cost of remaining in the non-Medicare plan.

Annuitants or Dependents who are not entitled to Social Security and Medicare Part A, will not be required to enroll in Part B. A notarized affidavit attesting to their ineligibility for Medicare Part A will be required. Forms may be obtained from the University of California Customer Service Center.

This requirement does not apply to active Employees and their Dependents who are age sixty-five (65) or older and who are currently eligible for medical care through their Employer.

For further information, please contact the University of California's Customer Service Center at (800) 888-8267.

If you are retired and covered under both Parts A and B of Medicare, you or the health care provider must first file claims with Medicare before filing claims under the UC Care Plan. If you are retired and covered by only one Part of Medicare, only claims covered by that Part must first be submitted to Medicare. In either case you will receive an Explanation of Medicare Benefits detailing the claim decision. This must be submitted when claiming benefits under the UC Care Plan.

If you receive care from a Medicare participating provider or one that accepts Medicare assignment, Medicare pays the provider directly and, consequently, Plan benefits are based on Medicare's determination of usual and prevailing charges. However, in certain instances, Medicare issues payment directly to you. In this situation, Plan benefits are based on the Plan's determination of usual and prevailing charges.

UC Care Plan benefits for eligible Plan expenses are reduced by payments made by Medicare. Plan benefits are also reduced by any amount not paid by Medicare due to noncompliance with Medicare's benefit rules.

EFFECT OF MEDICARE UNDER ALL TIERS

Medicare Private Contracting Provision

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

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

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

WHAT TERMS MEAN

1. **Annuitant:**

   (1) A Retired or disabled University Employee.

(2) A deceased Employee's (Annuitant's) family member, receiving a monthly income from a defined benefit plan to which the University contributes (i.e. a Survivor Annuitant).

2. **Average Regular Paid Time:** For any month, your average 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.

   (1) 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.

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

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

   (1) 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.

   (2) 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.

3. **Bereavement Counseling Services:** Supportive services provided under a Hospice Care Program by members of the Hospice Team in counseling sessions with the Family Unit. These services are to assist the Family Unit in dealing with the death of a Terminally Ill Person.

4. **Calendar Year:** Means the period of time commencing at 12:01 a.m., on January 1 and ending at 12:01 a.m. on the next January 1. Each succeeding like period will be considered a new Calendar Year.

5. **Charitable Research Hospital:** A hospital that meets all of the following criteria:

   (1) It is internationally recognized as devoting itself primarily to medical research.

   (2) It expends not less than 10% percent of its operating budget in each fiscal year exclusively on medical research activities which are not directly related to the provision of services to patients.

   (3) It derives not less than one-third of its gross revenues in each fiscal year from contributions, donations, grants, gifts, or other gratuitous forms from individuals, groups, persons, or entities unrelated to the hospital. Contributions, donations, grants, gifts or other gratuitous sources of revenue received as compensation for medical services provided to patients shall not be considered for purposes of this item (3).

   (4) It accepts patients without regard to the patient's ability to pay for medical services.

   (5) Not less than two-thirds of the patients admitted have a primary diagnosis or suspected disease or condition directly related to the specific area or areas in which the hospital conducts research. Patients admitted because of an emergent life-threatening condition who could not be safely transported to another hospital shall not be considered as patients for purposes of this item (5).

6. **Close Relative:** This means you, your spouse, or a child, brother, sister, parent or other relative of you, your spouse or your other Dependents.

7. **Contract Holder:** The Employer Group.

8. **Contributory Coverage, Non-contributory Coverage:** Contributory Coverage is coverage for which the Contract Holder has the right to require Employee contributions. Non-contributory Coverage is coverage for which the Contract Holder does not have the right to require Employee contributions.

9. **Convalescent Nursing Home:** An institution that meets all of these requirements:

   (1) It is legally operated.

   (2) It mainly provides short-term nursing and rehabilitation services for persons recovering from Sickness or Injury. The services are provided for a fee from its patients, and include both:

      (a) Room and board; and

      (b) Twenty-four (24) hour a day skilled nursing services.

   (3) It provides the services under the full-time supervision of a Physician or registered graduate nurse (R.N.); if full-time supervision by a Physician is not provided, it has the services of a Physician available under a fixed agreement.

   (4) It keeps adequate medical records.

   However, “Convalescent Nursing Home" does not include an institution or part of one that is used mainly as a place for rest or for the aged.

10. **Copayment:** A copayment is an amount that you are required to pay to a Participating Tier 1 Provider at the time of service. Copayments are the sole responsibility of the Covered Person.

11. **Counseling Services:** Supportive services provided after the death of the Terminally Ill Person, by members of the Hospice Team in counseling sessions with the Family Unit.

12. **Coverage:** The Plan included in the Group Contract.

13. **Covered Person:** An Employee (or Annuitant/Survivor Annuitant) as defined in Who is Eligible who is covered for Employee Coverage under the Plan; a qualified Dependent for whom you are covered for Dependent’s Coverage under that Coverage.

14. **Custodial Care:** Care that provides a level of routine maintenance for the purpose of meeting personal needs and care that can be provided by a lay person who does not have professional qualifications, skills or training. Custodial Care includes, but is not limited to: help in walking and getting into or out of bed; help in bathing, dressing and eating; help in other functions of daily living of a similar nature; administration of or help in using or applying medications, creams and ointments; routine administration of medical gasses after a regimen of therapy has been set up; routine care of a patient,

    including functions such as changes of dressings, diapers and protective sheets and periodic turning and positioning in bed; routine care and maintenance in connection with casts, braces and other similar devices, or other equipment and supplies used in treatment of a patient, such as colostomy and ileostomy bags and indwelling catheters; routine tracheotomy care; general supervision of exercise programs of repetitive exercises that do not need the skills of a therapist and are not skilled rehabilitation services.

15. **Dependent's Coverage:** Coverage on the person of a dependent.

16. **Doctor/Physician:** Any licensed practitioner of the healing arts acting within the scope of his or her practice. The term doctor also includes the personal services of a Christian Science Practitioner authorized by the Mother Church, The First Church of Christ, Scientist, in Boston, Massachusetts.

17. **Employee:** A person employed by the Employer; a proprietor or partner of the Employer. The term also applies to that person for any rights after coverage ends.

18. **Employee Coverage:** Coverage on the person of an Employee or Annuitant/Survivor Annuitant.

19. **The Employer:** Collectively, all Included Employers.

20. **Employer Group:** The Regents of the University of California.

21. **Experimental or Investigational:** A service, supply or drug will be considered "Experimental or Investigational" if the carriers determine that one or more of the following is true:

   (a) The service or supply is under study or in a clinical trial to evaluate its toxicity, safety or efficacy for a particular diagnosis or set of indications. Clinical trials include but are not limited to phase I, II and III clinical trials.

   (b) The prevailing opinion within the appropriate specialty of the United States medical profession is that the service or supply needs further evaluation for the particular diagnosis or set of indications before it is used outside clinical trials or other research settings. The carriers will determine if this item (b) is true based on:

      (i) Published reports in authoritative medical literature; and

      (ii) Regulations, reports, publications and evaluations issued by government agencies such as the Agency for Health Care Policy and Research, the National Institutes of Health, and the FDA.

   (c) In the case of a drug, device or other supply that is subject to FDA approval:

      (i) It does not have FDA approval; or

      (ii) It has FDA approval only under its Treatment Investigational New Drug regulation or a similar regulation; or

(iii) It has FDA approval, but it is being used for an indication or at a dosage that is not an accepted off-label use. The carriers will determine if a use is an accepted off-label use based on published reports in authoritative medical literature and entries in the following drug compendia: The American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information and Volume I of the United States Pharmacopoeia Convention Drug Information for the Health Care Professional.

(d) The provider's institutional review board acknowledges that the use of the service or supply is Experimental or Investigational and subject to that board's approval.

(e) The provider's institutional review board requires that the patient, parent or guardian give an informed consent stating that the service or supply is Experimental or Investigational or part of a research project or study; or federal law requires such a consent.

(f) Research protocols indicate that the service or supply is Experimental or Investigational. This item (f) applies for protocols used by the patient's provider as well as for protocols used by other providers studying substantially the same service or supply.

22. **Family Unit:** You and your Dependents who are Covered Persons.

23. **Federal Legend Drugs:** Medications which under federal law must bear the label (legend) “Caution: Federal Law Prohibits Dispensing Without a Prescription." Therefore, “legend" refers to those drugs which can be purchased only by prescription.

24. **Group Contract:** The Group Contract defines the terms of the agreement between the University of California and Prudential to provide health insurance coverage to Employees and Annuitants of the University of California and their Dependents and includes this description of plan benefits as part of the contract.

25. **Home Health Care:** A program, prescribed in writing by a Participating Physician and administered by a Home Health Care Agency, that provides for the care and treatment of a person's Sickness or Injury in the person's home.

26. **Home Health Care Agency:** Any of the following:

    (1) a home health agency licensed by the State in which it is located, or

    (2) a home health agency as defined under Medicare, or

    (3) an organization which is certified by the patient's physician as an appropriate provider of home health services, has a full-time administrator, keeps written medical records and has at least The Registered Nurse (R.N.) or services of a Registered Nurse (R.N.) available.

27. **Hospice:** A facility which provides short periods of stay for a Terminally Ill Person in a home-like setting for either direct care or respite. This facility may be either free-standing or affiliated with a Hospital. It must operate as an integral part of a Hospice Care Program. If such a facility is required by a state to be licensed, certified or registered, it must also meet that requirement to be considered a Hospice.

28. **Hospice Care Program:** A formal program directed by a Physician to help care for a Terminally Ill Person. This may be through either (1) or (2) below:

    (1) A centrally administered, medically directed and nurse coordinated plan which:

        (a) provides a coherent system primarily of home care; and

(b) uses a Hospice Team; and

(c) has the care available at any time, day or night, seven days a week.

(2) Confinement of the Terminally Ill Person in a Hospice. The program must meet standards set by the National Hospice Organization or be approved by Prudential HealthCare. If such a program is required by a state to be licensed, certified or registered, it must also meet that requirement to be considered a Hospice Care Program.

29. **Hospice Services:** Services and supplies furnished to a Terminally Ill Person by: (1) a Hospice; and/or (2) Hospice Team.

30. **Hospice Team:** A team of professionals and volunteer workers who provide care to:

(a) reduce or abate pain or other symptoms of mental or physical distress; and

(b) meet the special needs arising out of the stresses of a terminal illness. The team must include a Participating Physician and a registered graduate nurse, and may include one or more of the following: a social worker; a clergyman/counselor; volunteers; a clinical psychologist; a physiotherapist; an occupational therapist.

31. **Hospital:** An institution that meets one of these requirements:

(1) It is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on the Accreditation of Health Care Organizations, or

(2) It is legally operated, has twenty-four (24)-hour-a-day supervision by a staff of Doctors, has twenty-four (24)-hour-a-day nursing service by registered graduate nurses, and complies with (a) or (b):

(a) It mainly provides general inpatient medical care and treatment of sick and injured persons by the use of medical, diagnostic and major surgical facilities. All such facilities are in it or under its control.

(b) It mainly provides specialized inpatient medical care and treatment of sick or injured persons by the use of medical and diagnostic facilities (including X-ray and laboratory). All such facilities are in it, under its control, or available to it under a written agreement with a Hospital (as defined above) or with a specialized provider of these facilities.

(3) It is a Christian Science Sanatorium, or other institution approved by the Committee on Christian Science Nursing Home of the Mother Church, The First Church of Christ, Scientist, in Boston, Massachusetts. However, confinement in such a sanatorium will not be considered

confinement in a Hospital, unless for a condition which would require a person who is not a Christian Scientist to become confined in a Hospital as defined in (1) and (2) of this definition.

However, Hospital does not include a nursing home. Neither does it include an institution or part of one which:

(a) is used mainly as a place for convalescence, rest, nursing care or for the aged; or

(b) furnishes mainly homelike or Custodial Care, or training in the routines of daily living; or

(c) is mainly a school.

32. **Hospital Inpatient Stay:** A Hospital stay for which a room and board charge is made by the Hospital.

33. **Hospital Outpatient Stay:** A Hospital stay for which no room and board charge is made by the Hospital.

34. **Injury:** Injury to the body of a Covered Person.

35. **Medicaid/Medi-Cal:** Title XIX (Grants to States for Medical Assistance Programs) of the United States Social Security Act, as amended from time to time. In the State of California, the Medicaid Program is known as Medi-Cal.

36. **Medicare:** Title XVIII (Health Insurance for the Aged and Disabled) of the United States Social Security Act, as amended from time to time.

37. **Member:** You or your Dependents who are enrolled, covered and eligible, as described under the Plan.

38. **Month:** A period of time beginning and ending with the same date each calendar Month. If a succeeding Month has no such date, the last day of the Month will be used.

39. **Non-Participating Prudential HealthCare Health Care Provider: (applies to Tiers 2 and Tiers 3)** A Physician, Hospital or other provider of medical services or supplies which is not a Participating Health Care Provider or which is not participating in Prudential HealthCare's Participating Health Care Provider Network Program.

40. **Non-Preferred Provider Organization (applies to Tier 3)** is a provider of medical care services or supplies not participating in Prudential's Preferred Provider Network Program.

41. **Nurse:** A Registered Nurse (R.N.) or a Licensed Vocational Nurse (L.V.N.). Under Tier 3 only, such term also includes a Christian Science nurse authorized by the Mother Church, The First Church of Christ, Scientist, in Boston, Massachusetts.

42. **Participating Prudential HealthCare Health Care Provider: (applies to Tier I)** A Physician, Hospital or other provider of medical services or supplies which is licensed or certified in the state in which it is located and which has agreed with Prudential HealthCare, directly or indirectly, to arrange or provide for furnishing services and supplies for medical care and treatments to Covered Persons.

43. **Patient Care Manager:** The Patient Care Manager is a licensed Registered Nurse (R.N.) who is responsible for pre-certification of recommended hospital stays and/or surgical procedures or the concurrent review of such procedures already in process as part of Prudential HealthCare's Precertification Program.

44. **Physician:** See definition for doctor/physician.

45. **Plan:** The UC Care Medical Plan, a health and welfare plan that provides group health care benefits through this Prudential HealthCare Point of Service coverage.

46. **Pregnancy:** Pregnancy, including resulting childbirth, abortion or miscarriage, shall be considered as if it were a sickness and a bodily disorder for all purposes of the Plan.

47. **Primary Attending Doctor:** The doctor who: (1) is treating the Terminally Ill Person; and (2) recommends admittance to a Hospice Care Program.

48. **Primary Care Physician (PCP):** A Physician who is a Participating Prudential HealthCare Health Care Provider and who is chosen by a Covered Person to have the responsibility for:

    (1) providing initial and primary medical care to the Covered Person;

    (2) maintaining the continuity of the Covered Person's medical care; and

(3) initiating referrals to Consulting Physicians, Specialty Care Physicians and other Participating Health Care Providers. However, a Primary Care Physician (PCP) referral is not required for a visit to a participating direct access Obstetrician/Gynecologist (OB/GYN). Primary medical care includes these medical specialties: Internal Medicine (General), Pediatrics, Family Practice and Obstetrics/Gynecology, provided the Obstetrician/Gynecologist meets all the eligibility criteria established for all specialists seeking Primary Care Physician Status. If you are eligible for Coverage you may choose a Primary Care Physician in the Service Area where you live or work.

49. **Preferred Provider Organization** is a network of providers of medical care services or supplies (i.e., practitioners and hospitals,) established and maintained for Covered Persons in accordance with policies and procedures agreed upon by the provider and Prudential.

50. **Preferred Provider Organization Provider** is a provider of medical care services or supplies participating in Prudential's Preferred Provider Network Program.

51. **Remission:** A halt in the progression of a terminal disease; or an actual reduction in the extent to which the disease has already progressed.

52. **Service Area (Tier 1 Service Area):** The geographical areas within which services and supplies for medical care and treatment are provided under the Group Contract for Covered Persons by Participating Health Care Providers.

53. **Sickness:** Any disorder of the body of a Covered Person, but not an Injury; or Pregnancy of a Covered Person, including abortion, miscarriage or childbirth.

54. **Supervising Doctor:** The doctor directing the Hospice Care Program.

55. **Surgical Procedure:** This means only cutting, suturing, treatment of burns, correction of fracture, reduction of dislocation, manipulation of joint under general anesthesia, electrocauterization, tapping (paracentesis), application of plaster casts, administration of pneumothorax, endoscopy or injection of sclerosing solution.

56. **Terminally Ill Person:** A person whose life expectancy is six months or less, as certified by the Primary Care Physician or the primary attending doctor.

57. **Totally Disabled:** You will be considered to be Totally Disabled when you are not working for wage or profit and due to the Sickness or Injury, you are not able to perform for wage or profit, the material and substantial duties of any job for which you are reasonably fitted by your education, training or experience.

    A qualified Dependent will be considered Totally Disabled, when the qualified Dependent is not able because of the Sickness or Injury, to carry on the regular and customary activities of a person in good health and of the same age and family status.

58. **Usual and Prevailing Charge or Usual and Customary Charge:** A Usual and Prevailing or Usual and Customary Charge is the charge usually made for a service or supply when there is no benefit plan, not to exceed the prevailing charge in the area for a service of the same nature and charge in the area for a service of the same nature and duration and performed by a person of similar training and experience or for a substantially equivalent supply. The Plan makes the determination of what is the Usual and Prevailing allowance for a particular service or supply.

59. **War:** This means declared or undeclared war and includes resistance to armed aggression.

60. **You:** An Employee, Annuitant or a Survivor Annuitant.

SECTION II

PRUDENTIAL HEALTHCARE POINT OF SERVICE

(Medical/Hospital/Surgical Benefits)

Group Health Care Combined Evidence of Coverage and Disclosure Form

(herein called Evidence of Coverage)

Prudential Health Care Plan of California, Inc. (herein called **Prudential HealthCare**), certifies that Group Health Care Coverage, as described in the Tier 1 in-network benefit description of this Section II, is provided according to the Group Contract for each Covered Person. The Contract Holder and the Group Contract Number are shown below.

Covered Person: You are eligible to become covered under the Group Contract if you are in the Covered Classes shown on the next page and meet the requirements in the Who is Eligible under Section I of this Evidence of Coverage. The Enrollment and Effective Date of Coverage sections state how and when you may become covered. Your coverage will end when the rules in the When Coverage Stops section so provide.

Contract Holder:	THE REGENTS OF THE UNIVERSITY OF CALIFORNIA
Associated Companies:	NONE
Group Contract No.:	GH-97300
Evidence of Coverage Date:	January 1, 2000. This Evidence of Coverage describes the benefits under the Group Health Care Coverages as of the Evidence of Coverage Date.
Prudential HealthCare's Address and Phone Number:	Prudential HealthCare 5800 Canoga Avenue Woodland Hills, California 91367 Telephone: (818) 712-5399
Local Member Services Phone Number:	(800) 313-3804

This Group Health Care Combined Evidence of Coverage and Disclosure Form describes the terms and conditions of the Coverage. It constitutes a part of the Group Health Care Contract between Prudential HealthCare and your Employer. All benefits are subject in every way to the entire Group Contract which includes this Evidence of Coverage.

This Evidence of Coverage replaces any older Evidences of Coverage issued to you for the Group Health Care Coverage described in this Evidence of Coverage.

Covered Classes: The Covered Classes are these Employees of the Contract Holder (and its Affiliates):

All Employees or Annuitants who are:

(a) located in the State of California and whose permanent residence is in the Service Area; and

(b) not covered under an Alternate Health Care Plan, designated by the Contract Holder. Refer to the definition of Employee and Annuitant under Who Is Eligible on page 13. Anyone enrolled in a Medicare+Choice Plan is not eligible for this Plan.

Service Area (Tier 1 Service Area): The geographical areas, designated by Prudential HealthCare and approved by the California Department of Corporations, within which Prudential HealthCare shall provide health care services. A complete description of the Service Area is included with your enrollment materials.

INFORMATION FOR PCP COORDINATED BENEFITS -- TIER 1 (PRUDENTIAL HEALTHCARE)

Other Charges/Copayments:

A Copayment is an amount that you are required to pay to a Participating Tier 1 Provider at the time of service. Copayments are the sole responsibility of the Covered Person.

The list of services and supplies for which there are Copayments and the Copayment amounts are shown beginning on page 82.

Liability of Covered Person for Payment:

A Covered Person will be financially liable to the provider for:

1. All Copayments for Eligible Services and Supplies;

2. All services and supplies which are not eligible services or supplies under the terms of the Plan;

3. All services and supplies received from Non-Participating Health Care Providers unless authorized by a Primary Care Physician and, where required, approved by the Medical Director. But, for a Medical Emergency, this only applies as described in this Section II beginning on page 79.

Renewal Provisions

The services and benefits covered under the Group Contract as Eligible Services and Supplies, and the Copayments that may be charged to you, may not be changed by Prudential HealthCare without at least two hundred ten (210) days notice by Prudential HealthCare to the Group Contract Holder. Your Employer will notify you of any changes that affect you.

If you have Contributory Coverage, your Employer may change the amount of your contribution in accordance with your Employer's plan of benefits.

You do not need to renew your coverage each year. Your coverage under the Group Contract will continue automatically unless and until your coverage is terminated for any of the reasons described in the Section When Coverage Stops or the Group Contract terminates for your Employer in accordance with the Group Contract's terms.

IMPORTANT NOTE REGARDING PROVIDERS AND FACILITIES -- TIER 1

Your choice of a Primary Care Physician is a very important one since Prudential HealthCare only covers health care services which your Primary Care Physician provides or specifically authorizes. Except in the case of direct access to a Participating Obstetrical and Gynecological (OB/GYN) Physician and Certain Medical Emergencies, any health care services you receive **without** your

Primary Care Physician's specific authorization are **not covered** by Prudential HealthCare.

Your Primary Care Physician should be your **first** contact for **all** your health care needs. Through his or her specific referral, you will have access to Participating Specialty Care Physicians, Hospitals and other Health Care Providers. In most cases, your Primary Care Physician's referral will specify a particular Participating Health Care Provider or Facility. If your Primary Care Physician is part of a participating Medical Group or Individual Practice Association (IPA), the referral will normally be to a Participating Health Care Provider or Facility which is affiliated with that Medical Group or IPA. You should carefully consider this when selecting your Primary Care Physician.

CHOICE OF PRUDENTIAL HEALTHCARE PRIMARY CARE PHYSICIAN

To be eligible under Tier 1, services and supplies furnished in connection with your medical care and treatment must be:

- furnished by your Primary Care Physician; or
- furnished by another Participating Health Care Provider and authorized by your Primary Care Physician; or
- furnished by a Non-Participating Health Care Provider and authorized by your Primary Care Physician.

In addition, certain services and supplies must be authorized by the Medical Director to be eligible.

There are certain exceptions in the case of direct access to a Participating OB/GYN Physician and Medical Emergencies, as explained later in this booklet beginning on page 79.

SELECTING A PRUDENTIAL HEALTHCARE PRIMARY CARE PHYSICIAN

When you enroll in the Plan, you will select a Primary Care Physician for yourself and each of your eligible dependents. The UC Care Provider Directory included with your enrollment materials lists the physicians from which you may choose.

You may choose a different Primary Care Physician for each covered member of your family if desired.

After you enroll, you will receive a UC Care Identification Card (UC Care ID Card) for yourself and each of your enrolled family members. This card provides the name and phone number of the Primary Care Physician, and information concerning emergency procedures.

Your UC Care ID Card also includes the phone number of your Prudential HealthCare Member Services Department and The Prudential National Service Hotline. Member Services should be used when you need health care services or provider information when you are in the Service Area. The Hotline should be used when you are out of the service area and need urgent medical care.

CHANGING YOUR PRUDENTIAL HEALTHCARE PRIMARY CARE PHYSICIAN

You may change your Primary Care Physician or the Primary Care Physician of any of your eligible dependents at any time without explaining why. Simply call Member Services at the number indicated below:

Prudential HealthCare
P.O. Box 54280
Los Angeles, CA 90054-0280
Telephone: (800) 313-3804

If you call before the fifteenth (15th) of the month, the change will be effective the first day of the following month. Changes made after the fifteenth (15th) of the month will not be effective until the first of the month following the next month. A new UC Care ID Card will be issued listing the new Primary Care Physician's name and telephone number.

You, or any of your eligible dependents, may also change your Primary Care Physician during your Employer's open enrollment period, with the change effective the following January 1.

IF PRUDENTIAL HEALTHCARE MUST CHANGE YOUR PRIMARY CARE PHYSICIAN, SPECIALTY CARE PHYSICIAN OR OTHER PARTICIPATING HEALTH CARE PROVIDER

Prudential HealthCare will give you prompt written notice if its agreement with a Participating Provider (your Primary Care Physician or any Specialty Care Physician or other Participating Health Care Provider from whom you are then receiving treatment) ends or, if for some other reason, the Participating Provider can no longer furnish your health care. But a health care service which was started before that change may be completed by the same Provider, unless Prudential HealthCare makes reasonable and medically appropriate provision for the assumption of such services by another Participating Provider. If the change affects your Primary Care Physician, you must then choose a new Primary Care Physician. That change will take effect on the first day of the next month.

CONTINUITY OF CARE

If a provider has been terminated from Prudential HealthCare's network, members undergoing a course of treatment with that provider for an acute condition, serious chronic condition, or a pregnancy that has reached the second trimester or is considered high risk may request that Prudential HealhtCare authorize continued care from that terminated provider. To obtain additional information, call Prudential HealthCare Customer Service.

PRUDENTIAL HEALTHCARE'S AGREEMENTS WITH PARTICIPATING HEALTH CARE PROVIDERS -- TIER 1

Prudential HealthCare's agreement with each Participating Health Care Provider provides that, except for any copayments required under Tier 1, a Covered Person will not be required to pay any additional charge for services which are covered under Tier 1.

Participating Health Care Providers may provide appropriate health care services and supplies to Covered Persons which are not covered under Tier 1. Prior to providing such services, the Participating Health Care Provider will inform the Covered Person that such services are not covered under Tier 1 and that the Covered Person is entirely responsible for making payment for such services.

Under California law, Prudential HealthCare's agreement with each Participating Health Care Provider also provides that a Covered Person will not be liable for amounts owed to the Participating Health Care Provider by Prudential HealthCare, but not paid. But if a

Non-Participating HealthCare Health Care Provider furnishes health care services for a Covered Person, the Covered Person may be liable to the non-participating provider for the cost of the services.

PROVIDER COMPENSATION, FINANCIAL BONUSES OR INCENTIVES.

Providers are generally compensated in one of two main ways. They may be paid negotiated fees for services rendered, or they may be paid a capitation (a predetermined, prepaid, fixed dollar amount per member per month). Either of the above payment methods may be supplemented by bonus payments made to providers based on performance in accordance with pre-set criteria, including quality of care and services and financial budgets.

If you wish to know more about Prudential HealthCare's compensation of its contracting providers, you may request additional information from Prudential HealthCare, your Primary Care Physician or from your Primary Care Physician's medical group or independent physician association. The information available to you includes a general description of how Prudential HealthCare compensates providers with any applicable bonuses or other incentive arrangements. In addition, you may obtain a description regarding whether, and in what manner, such bonuses and applicable incentives are related to a provider's use of referral services.

IDENTIFICATION CARDS

Any identification cards (called UC Care ID Cards) issued by Prudential HealthCare in connection with the UC Care Medical Plan are for identification only and remain the property of Prudential HealthCare. Possession of a UC Care ID Card does not convey any rights to benefits under the Plan. Any person who receives services, supplies or other benefits to which the person is not entitled by the terms of the Group Contract will be charged for the reasonable cash value of any such services or supplies or for the amount of any such benefits. If any Covered Person permits another person to use the Covered Person's UC Care ID Card, Prudential HealthCare may:

(a) invalidate that Covered Person's UC Care ID Card; and

(b) terminate that Covered Person's coverage under the Plan as provided in the When Coverage Stops section.

CONFIDENTIAL NATURE OF MEDICAL RECORDS

Any information from a Covered Person's medical records or received from Physicians or Hospitals incident to the physician-patient or hospital-patient relationships will be kept confidential. Such information may not be disclosed without the consent of the Covered Person, except as is reasonably necessary in connection with the administration of the Plan. Each Covered Person agrees that Participating Health Care Providers or Consulting Physicians may release medical records to Prudential HealthCare and Prudential Insurance Company of America, as is reasonably necessary for claim determination, litigation or other normal business activities. Medical records may also be disclosed to others but only to the extent authorized by law.

ASSIGNMENTS

Benefits provided to a Covered Person under the Plan are personal to the Covered Person and are not assignable or otherwise transferable, except as provided in this booklet.

RELATION AMONG PARTIES AFFECTED BY THE GROUP CONTRACT

The relationship between Prudential HealthCare and any Hospital, Participating Physician, Consulting Physician, or other Participating Health Care Provider is that of an independent contractor. Each Hospital, Participating Physician, Consulting Physician, or other Participating Health Care Provider has an independent professional responsibility to provide services to its patients. Each Hospital, Participating Physician, Consulting Physician, or other Participating Health Care Provider is responsible to each Covered Person to whom it provides services or supplies. No Hospital, Participating Physician, Consulting Physician, or other Participating Health Care Provider is an agent or Employee of Prudential HealthCare, nor is Prudential HealthCare an agent or Employee of any Hospital, Participating Physician, Consulting Physician, or other Participating Health Care Provider.

Neither the Contract Holder nor any Covered Person under the Group Contract is the agent or representative of Prudential HealthCare. Neither the Contract Holder nor any Covered Person under the Group Contract will be liable for any acts or omissions of Prudential HealthCare, its agents or Employees, or of any Hospital, Physician or other health care provider with which Prudential HealthCare, its agents or Employees make arrangements for furnishing supplies and services to Covered Persons.

A Covered Person may, for personal reasons, refuse to accept procedures or courses of treatment recommended by Participating Physicians. Participating Physicians will use their best efforts to render all needed, appropriate professional services in a manner compatible with the Covered Person's wishes. Each Participating Physician will do this to the extent it is consistent with the Physician's judgment as to the needs of proper medical practice. If a Covered Person refuses to follow a recommended treatment or procedure and the Participating Physician believes that there is no professionally acceptable alternative, the Covered Person will be so advised.

NOTICES AND OTHER INFORMATION

Any notices, documents, or other information under the Group Contract may be sent by United States Mail, postage prepaid, addressed as follows:

> If to Prudential HealthCare: At its address shown on page 64 of this booklet or to the address shown on page 73.
>
> If to a Covered Person: To the last address provided by the Covered Person on a change of address form actually delivered to the Employer.

UTILIZATION REVIEW PROCESS

State law requires health care service plans to disclose to subscribers and network health care providers the process used to authorize or deny health care service under the plan.

Prudential HealthCare has completed documentation of the Utilization Review process as required under Section 1363.5 of the California Health and Safety Code. To request a copy of the documentation describing this process, please call Member Services at (800) 313-3804.

SECOND MEDICAL OPINIONS

Prudential HealthCare has a policy regarding second medical opinions. If you want to request a second medical opinion, contact your Primary Care Physician or the Prudential HealthCare Member Services Department responsible for your Service Area.

MEMBER GRIEVANCE/APPEALS PROCESS--TIER I

The purpose of the grievance/appeals procedure is to provide an equitable, timely and effective mechanism to resolve member concerns and appeals regarding services provided by the Plan and/or care delivered by Plan providers.

A member may initiate the grievance/appeals procedure by contacting Prudential HealthCare Member Services Department with the question, problem or complaint. Contact may be made by telephone or by mail as indicated below.

Prudential HealthCare
P.O. Box 54280
Los Angeles, California 90054-0280
Telephone: (800) 313-3804

The Appeals process includes two levels, Level I (Standard and Expedited) and Level II.

<u>Level I - (Standard)</u>

Your request will be acknowledged within seven (7) business days. Written notice of the Level I decision will be sent to you within thirty (30) days of receipt of your request for review. If the decision cannot be reached within thirty (30) days, a letter will be sent to you indicating the reason for the delay and offering an anticipated resolution date.

Level I - (Expedited)

If your appeal involves an Experimental or Investigational issue and you have a terminal illness, Prudential HealthCare shall provide you within five (5) business days our grievance procedures and/or complaint form which shall provide an opportunity for you to request a conference.

Upon receiving a request to attend a conference, Prudential HealthCare will provide to you, within thirty (30) calendar days, an opportunity to attend a conference to review information regarding your appeal. The conference shall be held within five (5) business days if the treating participating physician determines, after consultation with Prudential HealthCare's Medical Director, that the effectiveness of either the proposed treatment, services, or supplies or any alternative treatment services or supplies covered by Prudential HealthCare, would be materially reduced if not provided at the earliest possible date.

Our decision will be sent to you as soon as possible after the conference.

If your appeal involves an imminent and serious threat to your health, including, but not limited to, the potential loss of life, limb or major body function, we will provide you with an expedited review of the appeal including written response to you no later than five days from our receipt of the grievance/appeal.

Level II

If you are not satisfied with Prudential HealthCare's Level I decision, you may then request that the matter be reviewed at Level II by Prudential HealthCare's Level II Appeals Committee. All requests for review at Level II must be in writing to Prudential HealthCare. The procedures for requesting review by Level II will be given to you with the written notice of the Level I decision. You will be permitted to appear before the Level II Appeals Committee if you so desire.

You will be sent written notice of the Level II decision within thirty (30) days of your request for Level II review. If a decision cannot be reached within thirty (30) days, a letter will be sent to you indicating the reason for the delay and offering an anticipated resolution date.

Under Tier 1, if you are not satisfied with the Level II decision, you may then request that the matter be submitted to an independent arbitrator for review. All requests for arbitration must be in writing to Prudential HealthCare. The procedures for requesting arbitration will be given to you with the Level II decision. The arbitration will be conducted though the American Arbitration Association (AAA) in conformity with its rules and the decision(s) will be binding on both parties. Any fees payable to the AAA for the arbitration will be borne equally by you and Prudential HealthCare. Should an arbitrator determine that an extreme hardship exists, Prudential HealthCare may contribute a portion or all of your share of the arbitration fees, as allocated by the arbitrator.

The California Department of Corporations is responsible for regulating health care service plans which includes Prudential HealthCare. The department's Health Plan Division has a toll-free telephone number **(1-800-400-0815)** to receive complaints regarding health plan. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers **(1-800-735-2929) (TTY))** to contact the department. The Department's Internet website **(http://www.corp.ca.gov)** has complaint forms and instructions online. If you have a grievance against Prudential HealthCare, you should first telephone Prudential HealthCare at (800) 313-3804 and use the Prudential HealthCare's grievance process before contacting the Health Plan Division. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by Prudential HealthCare, or a grievance that has remained unresolved for more than sixty (60) days, you may call the Health Plan Division for assistance. Prudential HealthCare grievance process and the Health Plan Division's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

If your appeal involves an imminent and serious threat to your health, including, but not limited to, the potential loss of life, limb or major body function, or in any other case where the Department determines that an earlier review is warranted, you are not required to wait sixty (60) days before submission of the case to the

California Department of Corporations. We will respond to such appeals on an expedited basis.

External Review Process of Experimental or Investigational Therapies

In addition to the above Grievance/Appeal Process, there is an additional external review process to examine Prudential HealthCare's decision regarding experimental or investigational therapies. To be eligible for this external review, you must meet all of the following criteria:

1. Your provider has certified that the condition is terminal, with a high probability of causing death within two years from the date of the request for the independent review.

2. Your provider certifies that the standard therapies:

   (a) have not been effective in improving,

   (b) would not be medically appropriate for you, or

   (c) would be more beneficial than those standard therapies covered by the Plan.

3. Either your Primary Care Physician must have recommended a drug, device, procedure or other therapy that the Primary Care Physician certifies in writing will be likely to be more beneficial to you, or your physician, who is qualfied, licensed and board-certified or board-eligible to treat your condition has requested a therapy that, based on two documents from the medical and scientific evidence, is likely to be more beneficial to you than any available standard therapy.

4. You have been denied coverage by Prudential HealthCare for a drug, device, procedure or other therapy recommended or requested pursuant to (3) above.

5. The specific drug, device, procedure or other therapy recommended pursuant to (3) above would be an eligible service or supply, except for Prudential HealthCare's determination that the therapy is Experimental or Investigational.

If you have any questions about this External Review Process, contact Prudential HealthCare's Customer Services Representative at (800) 313-3804 or write to:

Appeal Coordinator
Grievance and Appeal Department
Prudential Health Care Plan of California, Inc.
P.O. Box 10169
Van Nuys, California 91410

PUBLIC POLICY PARTICIPATION BY COVERED PERSONS

Prudential Health Care Plan of California, Inc. (PHCPC) has established a Public Policy Committee which will participate in formulating the public policies of PHCPC to assure the comfort, dignity and convenience of Covered Persons, their families and the public under its DMO Dental Plan and its Prudential HealthCare Health Care Coverage Plan. The membership of the Public Policy Committee shall at all times be composed of four Covered Persons (two of which are Covered Persons under its DMO Dental Plan and two of which are Covered Persons under its Prudential HealthCare Health Care Coverage Plan), one DMO Participating Dental Provider, one Prudential HealthCare Participating Medical Provider, and one member of the Board of Directors.

The Public Policy Committee reports directly to PHCPC's Board of Directors on a quarterly basis. The Board's action on reports and recommendations made by the Public Policy Committee are recorded in the Board's minutes. The members of the Public Policy Committee shall have access to information available from PHCPC regarding public policy, including financial information and information about the specific nature and volume of complaints received by PHCPC and their disposition.

PRUDENTIAL HEALTHCARE BENEFITS (TIER 1)

This Coverage provides benefits for many of the services and supplies needed for care and treatment of your or your qualified Dependent's Sicknesses and Injuries, or to maintain your or your qualified Dependent's good health, as determined by your Primary Care Physician. Not all services and supplies are eligible; some are eligible only to a limited extent.

A person's protection under this Coverage may be extended after the date that person ceases to be a Covered Person. See the section called Extension of Coverage. That section applies to this Coverage.

Many of the terms used below are defined in the section called What Tier 1 Terms Mean which begins on page 85.

Prudential HealthCare will arrange or provide for benefits for the Eligible Services and Supplies set forth in the section called Eligible Services and Supplies which begins on page 89.

All Eligible Services and Supplies must be furnished to a person:

(a) by a Primary Care Physician; or

(b) by another Participating Health Care Provider and authorized by a Primary Care Physician; or

(c) by a Non-Participating Health Care Provider and authorized by a Primary Care Physician. In addition, certain services and supplies must be authorized by the Medical Director to be eligible.

    Exceptions to these requirements for Eligible Services and Supplies furnished in connection with:

    (i) direct access to a participating direct access Obstetrical/Gynecological (OB/GYN) Physician, and

    (ii) a Medical Emergency occurring inside or outside the Service area, are set forth below.

All Eligible Services and Supplies must be furnished while a person is a Covered Person.

Direct Access to A Participating Direct Access Obstetrical/Gynecological (OB/GYN) Physician: Prudential HealthCare lets a woman see a participating direct access OB/GYN (see Note below) without a referral from their Primary Care Physician. The participating direct access OB/GYN Physician must be affiliated with the same medical group as her Primary Care Physician. Please see your provider directory for additional information. The Services that a direct access OB/GYN may provide

without a referral from the Primary Care Physician include the following:

- Annual well woman exam.
- Family planning physician services.
- Diagnosis and/or treatment of conditions of the female reproductive system.
- Prenatal care, delivery and post natal care.

Note: Direct Access OB/GYNs may also include family practice Physicians who have been designated by Prudential HealthCare to provide OB/GYN services. If a family practice Physician has been so designated, her or she will be listed with the Direct Access OB/GYNs in your Provider Directory.

Medical Emergencies: An Eligible Service or Supply that is furnished to a person:

(a) in connection with a Medical Emergency occurring inside or outside the Service Area including Coverage for urgently needed Services to prevent serious deterioration of a Covered Person's health resulting from unforeseen illness or injury for which treatment cannot be delayed until the Covered Person returns to the Plan's Service Area; and

(b) within the first forty-eight (48) hours following the onset of the Medical Emergency does not have to be authorized by a Primary Care Physician to be paid on a Tier 1 basis. However, no service or supply in connection with the Medical Emergency will be eligible to be paid on a Tier 1 basis after those first forty-eight (48) hours unless:

  (i) the person notifies Prudential HealthCare or its designee of the emergency incident within those first forty-eight (48) hours; and

(ii) the service or supply is authorized by a Primary Care Physician. If, because of the patient's condition, it is not reasonably possible to give such notice within this time limit, Prudential HealthCare or its designee must be notified as soon as reasonably possible.

(a) **IMPORTANT NOTE ABOUT PREGNANCY:**

In connection with the pregnancy of a Covered Person, a normal delivery (including cesarean section) occurring after the eighth month of gestation is a foreseeable event which can and should be adequately planned for. Expectant mothers should fully discuss with their Primary Care Physician and Specialty Care Physician (OB/GYN) the arrangements for the delivery well before the ninth (9th) month of gestation (who to call, what facility to go to, and so on). Because delivery can normally be anticipated to occur at any time after the eighth (8th) month of gestation, travel outside the Service Area at that time should only occur if required by extreme personal emergency or circumstances beyond the expectant mother's control.

Accordingly, Prudential HealthCare will not consider a Covered Person's normal delivery (including cesarean section) occurring after the eighth (8th) month of gestation to be a “Medical Emergency" unless:

(a) The Covered Person had been under the care of a Participating Physician for the pregnancy and had made prior arrangements with the Participating Physician for the delivery (including designation of the appropriate facility(ies) for the delivery); and

(b) One of the following applies:

(i) If the delivery occurs within the Service Area, the Covered Person's (mother's or baby's) condition required immediate medical care and use of a pre-arranged facility(ies) would cause a delay which could put the person's life in danger or cause serious harm to the person's bodily functions; or

(ii) If the delivery occurs outside the Service Area, Prudential HealthCare determines that the Covered Person was outside the Service Area due to extreme personal emergency or circumstances beyond her control.

WHAT TO DO WHEN YOU ARE AWAY FROM HOME:

With Prudential HealthCare POS, you're assured of being covered for the eligible care you need, even if you become sick or injured while you're away from home. The plan's network of doctors and hospitals operate inside the plan's "Service Area." If you're traveling outside the Service Area and need medical attention, here's what to do:

- **In Medical Emergency, call 911 if the service is available where you are or go to the nearest emergency facility.**
- If it is not a Medical Emergency, but you cannot wait for treatment until you return home, call the Prudential HealthCare National Service Hotline, at the number on your UC Care ID card.

If there is a Prudential HealthCare POS network where you are, one of our representatives can put you in touch with a local participating Doctor or facility.

If Prudential HealthCare does not have any participating health care providers where you are, the Hotline representative will tell you to receive care from a nearby provider. You will need to call the Hotline again after receiving care, because Prudential HealthCare will need certain information from you to arrange in-network coverage.

If you are traveling outside the U.S., get the treatment you need and call Prudential HealthCare's Customer Service department when you return. If you have questions while you are out of the country and need to speak with Customer Service please call (213) 988-8850 (please note that this is not a toll free number). You may request that the Customer Service representative call you back to avoid call charges.

You should keep in mind that if you receive *routine* care while you're traveling, the care will be covered at the out-of-network level, either Tier 2 or Tier 3, depending on the participating status of the provider/facility. If you need ongoing care for a particular condition while traveling, your PCP can arrange for your care by contacting us.

COPAYMENTS

Certain Eligible Services and Supplies are subject to a Copayment. A Copayment is an amount that you are required to pay to a Participating Tier 1 Provider at the time of service. Copayments are the sole responsibility of the Covered Person.

The Copayments for Basic Health Care Services are described below.

Copayments

(1) **Provider's Office Visits - Subject to a $10.00 Provider's Office Visit Copayment:**

All Eligible Services and Supplies furnished during a Health Care Provider's office visit are subject to a $10.00 Provider's Office Visit Copayment. The Copayment must be paid for each visit except for maternity-related visits after the first visit and office visits for children under the age of six (6).

(2) **Emergency Room Visits - Subject to a $50.00 Emergency Room Visit Copayment:**

Eligible Services and Supplies furnished by a Hospital for medical care during a visit to the Hospital's emergency room are subject to a $50.00 Emergency Room Visit Copayment. That Copayment must be paid for each emergency room visit. The Emergency Room Copayment is waived if the visit results in hospital admission.

(3) **Outpatient Speech, Physical and Occupational Therapy - Subject to a $10.00 Visit Copayment**:

Outpatient visits for short term speech, physical or occupational therapy (whether in a Provider's office or in an outpatient facility) are subject to a $10.00 Visit Copayment. That Copayment must be paid for each visit.

(4) **Urgent Care Facility Visits - subject to a $10.00 Visit Copayment**:

Eligible Services and Supplies furnished during a visit to an urgent care facility are subject to a $10.00 Copayment. That Copayment must be made for each visit. All other urgent care is subject to the provider's office visit copayment.

(5) **Hearing Aid Devices - subject to a 50% Copayment**:

Eligible hearing aid devices authorized by a Primary Care Physician as a supplemental benefit under the terms of the Group Health Care Coverage and furnished in accordance with those terms are subject to a hearing aid devices Copayment equal to 50% of the reasonable cash value of those supplies. That Copayment must be paid for each hearing aid device.

Calendar Year Copayment Limit:

The total amount of a Covered Person's Copayments shown above will not exceed $1,000 per individual and $3,000 per family in any Calendar Year. The Copayment Limit does not include or apply to any copayments for hearing aid devices.

For the purposes of the Calendar Year Copayment Limit, Covered Persons should retain complete, accurate records of all copayments made by them during the Calendar Year. Each Covered Person is responsible for providing Prudential HealthCare with proof that the Copayment Limit has been reached. When Prudential HealthCare receives that proof, Prudential HealthCare will give the Covered Person a letter confirming that the Copayment

Limit has been reached. After the Copayment Limit is reached, Participating Health Care Providers may still require copayments. If that happens, the Covered Person may submit the receipts for those copayments to Prudential HealthCare and Prudential HealthCare will reimburse the Covered Person.

Major Disaster or Epidemic. Prudential HealthCare will consistently make a good faith effort to provide or arrange for Eligible Services and Supplies, taking into account existing conditions and events. If there is a major disaster or an epidemic, Prudential HealthCare will provide or arrange for Eligible Services and Supplies to the extent possible or practical according to its best judgment. In doing this, Prudential HealthCare will take into account the facilities and personnel that are then available to provide Eligible Services and Supplies. Neither Prudential HealthCare nor any Participating Health Care Provider will have any liability or obligation on account of delay or failure to provide or arrange for Eligible Services and Supplies if:

(a) such delay or failure is due to lack of available facilities or personnel; and

(b) such lack is the result of a major disaster or an epidemic.

Circumstances Beyond the Control of Prudential HealthCare or Participating Health Care Providers. Due to circumstances not reasonably within the control of Prudential HealthCare or Participating Health Care Providers, there may be a delay in providing or arranging for Eligible Services and Supplies, or it may not be practical or possible to do so. In that event, neither Prudential HealthCare nor any Participating Health Care Provider will have any liability or obligation on account of delay or failure to provide or arrange for Eligible Services and Supplies if a good faith effort has been made to do so. Some examples of such circumstances are: complete or partial destruction of facilities because of war, riot, or civil insurrection; the disability of a significant number of Participating Health Care Providers; and other similar causes.

WHAT TIER 1 TERMS MEAN

1. **Consulting Physician:** A Physician, other than a Participating Physician, to whom a Covered Person is referred for care in writing by a Participating Prudential HealthCare Physician and whose services have been approved, in advance, by the Medical Director and confirmed in writing by the Medical Director.

2. **Copayment:** An amount that you are required to pay to a Participating Tier 1 Provider at the time of service. Copayments are the sole responsibility of the Covered Person.

3. **Medical Director:** A Physician who is a consultant retained by Prudential HealthCare to coordinate and supervise the delivery of health care services for Covered Persons through Participating Physicians and Participating Health Care Providers.

4. **Medical Emergency:** A person's sudden and unforeseeable Sickness or Injury of such a nature that failure to get immediate medical care could put the person's life in danger or cause serious harm to the person's bodily functions, as determined by the Medical Director. Medical Emergency includes Out-of-Area Coverage, as defined in this section of this Evidence of Coverage. Some examples of a Medical Emergency are:

   apparent heart attack; cerebral vascular accidents; severe shortness of breath or difficulty in breathing; severe bleeding; sudden loss of consciousness; convulsions; severe or multiple injuries, including obvious fractures; sudden and severe pain; severe allergic reactions; apparent poisoning. Some examples of conditions that are not usually Medical Emergencies: colds; influenza; ordinary sprains; children's ear infections; nausea; and headaches. In connection with the pregnancy of a Covered Person, a normal delivery (including cesarean section) occurring after the eighth month of gestation is a foreseeable event which can and should be adequately planned for. Expectant mothers should fully discuss with their Primary Care Physician and Specialty Care Physician (OB/GYN) the arrangements for the delivery well before the ninth (9th) month of gestation (who to call, what facility to go to, and so on).

Because delivery can normally be anticipated to occur at any time after the eighth (8th) month of gestation, travel outside the Service Area at that time should only occur if required by extreme personal emergency or circumstances beyond the expectant mother's control. Accordingly, Prudential HealthCare will not consider a Covered Person's normal delivery (including cesarean section) occurring after the eighth (8th) month of gestation to be a “Medical Emergency” unless:

(a) The Covered Person had been under the care of a Participating Physician for the Pregnancy and had made prior arrangements with the Participating Physician for the delivery (including designation of the appropriate facility(ies) for the delivery); and

(b) One of the following applies:

(i) If the delivery occurs within the Service Area, the Covered Person’s (mother’s or baby’s) condition required immediate medical care and use of a pre-arranged facility(ies) would case a delay which could put the person’s life in danger or cause serious harm to the person’s bodily functions; or

(ii) If the delivery occurs outside the Service Area, Prudential HealthCare determines that the Covered Person was outside the Service Area due to extreme personal emergency or circumstances beyond her control.

5. **Medicare:** Title XVIII (Health Insurance for the Aged and Disabled) of the United States Social Security Act, as amended from time to time.

6. **Non-Participating Health Care Provider:** A Physician, Hospital or other provider of medical services or supplies which is not a Participating Health Care Provider.

7. **Out-of-Area Coverage:** Coverage while a Covered Person is anywhere outside the Service Area of the Plan, and includes coverage for urgently needed services to prevent serious deterioration of a Covered Person's health resulting from unforeseen illness or injury for which treatment cannot be delayed until the Covered Person returns to the Plan's Service Area.

8. **Participating Health Care Provider:** A Physician, Hospital or other provider of medical services or supplies which is licensed or certified in the state in which it is located and which has agreed with Prudential HealthCare, directly or indirectly, to arrange or provide for furnishing services and supplies for medical care and treatments to Covered Persons.

9. **Participating Physician:** A Physician who is either a Primary Care Physician or a Specialty Care Physician.

10. **Primary Care Physician (PCP):** A Physician who is a Participating Health Care Provider and who is chosen by a Covered Person to have the responsibility for:

    (1) providing initial and primary medical care to the Covered Person;

    (2) maintaining the continuity of the Covered Person's medical care; and

    (3) initiating referrals to Consulting Physicians, Specialty Care Physicians and other Participating Health Care Providers. Primary medical care includes these medical specialties: Internal Medicine (General), Pediatrics, Family Practice and Obstetrics/Gynecology, provided the Obstetrician/Gynecologist meets the eligibility criteria established for all specialists seeking Primary Care Physician status. If you are eligible for Coverage, you may choose a Primary Care Physician in the Service Area where you live or work.

Note: You no longer need to select an Obstetrician/Gynecologist as your "secondary PCP" when you enroll. You may self-refer to any Obstetrician/Gynecologist who is affiliated with your PCP's Medical Group for any Obstetrical/Gynecological related care and receive Tier 1 benefits.

Your PCP will continue to provide your general care. Your PCP will also continue to provide referrals for testing outside the Obstetrician's/Gynecologist's office, as well as for other types of specialty care or hospitalization.

11. **Prudential HealthCare:** Prudential Health Care Plan of California, Inc.

12. **Specialty Care Physician:** A Physician who is a Participating Health Care Provider and who provides certain specialty medical care to Covered Persons upon referral by a Primary Care Physician as approved by the Medical Director. Specialty medical care does not include these specialties: Internal Medicine (General), Pediatrics, and Family Practice.

    Referrals by medical groups participating in the Prudential HealthCare Rapid Referral program can be obtained from a Primary Care Physician without approval by the Medical Director.

ELIGIBLE SERVICES AND SUPPLIES (APPLICABLE TO TIERS 1, 2, AND 3)

Under Tier 1: The Eligible Services and Supplies under this Coverage are those that are in the list below, subject to the "Generally Excluded Charges." Certain of the Services and Supplies in the list below have limits. To the extent that a service or supply falls outside any Eligible Services and Supplies limit described in that list, it is also not covered.

Under Tiers 2 and 3: Eligible expenses described below are paid in accordance with the Benefit Summary. **Consult the Benefit Summary pages (60-63) to determine the rate of payment, deductible requirements, and benefit maximums that apply.** Eligible expenses under Tiers 2 and 3 are the Usual and Prevailing charges for the following services and supplies that are needed to treat Injuries and Sickness, and are ordered by a Physician. Some procedures and services require precertification; refer to the Prudential Patient Care Management and Outpatient Precertification Program sections.

ELIGIBLE SERVICES AND SUPPLIES

(1) Hospital semi-private room and board.

Under Tier 1: This includes normal daily services and supplies furnished by the Hospital.

For any day on which a Primary Care Physician authorizes the Covered Person's stay in a private room in a Hospital that has no semi-private rooms, Hospital private room and board, including normal daily services and supplies, will be included as Eligible Services and Supplies. Hospital private room and board, including normal daily services and supplies, will also be included as Eligible Services and Supplies for any day on which:

(a) the Covered Person is being isolated in a private room because of the Covered Person's communicable disease; or

(b) use of a private room is medically necessary, as determined by a Participating Physician, for treatment of the Covered Person's Sickness or Injury.

Under Tiers 2 and 3: Charges for room and board. Eligible expenses for room and board are limited to the hospital's standard semi-private room rate. However, this limit does not apply in case of isolation of the patient because of a communicable disease, or for necessary confinement in an intensive care unit.

Note: Under Tiers 2 and 3, hospital room and board and other hospital charges are subject to the Patient Care Management and Outpatient Precertification Review requirements.

(2) **Under all Tiers:** All other supplies and non-professional services furnished by the Hospital during a Hospital Inpatient Stay.

(3) **Under Tier 1:** Convalescent Nursing Home (skilled nursing facility) services and supplies for the following:

(a) Convalescent Nursing Home (skilled nursing facility) room and board. This includes normal daily services and supplies furnished by the Convalescent Nursing Home.

(b) Other supplies and non-professional services furnished by the Convalescent Nursing Home (skilled nursing facility) for medical care in it.

But these services and supplies are included in this list of Eligible Services and Supplies only if all of these conditions are met:

(a) A Participating Physician recommends the Covered Person's Convalescent Nursing Home (skilled nursing facility) Stay:

(i) for recovery from a Sickness or Injury that caused a prior Hospital stay, or from a related Sickness or Injury; or

(ii) in place of a Hospital stay that would be required in the absence of these services and supplies for care and treatment of the Covered Person's Sickness or Injury.

(b) The Covered Person is under the continuous care of a Participating Physician.

(c) A Participating Physician certifies that the Covered Person needs twenty-four (24)-hour-a-day nursing care.

These Convalescent Nursing Home (skilled nursing facility) services and supplies are limited to the first one hundred (100) days of all of the Covered Person's stays in a Convalescent Nursing Home (skilled nursing facility) that are due to the same or related causes and are separated by less than three months.

Under Tiers 2 and 3: Convalescent Nursing Home care or skilled nursing facility benefit: If confinement follows a Hospital stay of at least three (3) days for which Plan benefits are payable and starts within fifteen (15) days after discharge, the Plan will consider as an eligible charge an amount up to 50% of the standard semi-private room rate of the Hospital from which the patient was transferred. In addition, to qualify for benefits, nursing home care must be recommended by the patient's doctor for the condition which caused the hospitalization; the patient must be under the doctor's continuous care and must require twenty-four (24)-hour nursing care. Benefits are payable for up to seventy (70) days for care due to the same or related causes. Nursing Home expenses will be combined with the bills for the prior Hospital confinement in determining Plan benefits. Custodial care is not covered.

(4) **Under all Tiers:** Anesthetics and their administration.

(5) **Under all Tiers:** Ambulance services for medically necessary local travel.

(6) **Under all Tiers:** Physicians' services for Surgical Procedures (including Reconstructive Surgery, but not Cosmetic Surgery) and for other medical care. (Under Tiers 2 and 3, certain services are subject to the Outpatient Precertification Program.)

"Reconstructive surgery" means surgery performed to correct or repair abnormal structure of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to do either of the following:

(i) to improve function; or

(ii) to create normal appearance, to the extent possible

Cosmetic Surgery is not covered (see item (12) Cosmetic Surgery, under Generally Excluded Charges). "Cosmetic Surgery" means surgery that is performed to alter or reshape normal structure of the body in order to improve appearance.

(7) **Under Tier 1:** Private duty professional nursing by a registered graduate nurse, if such care:

(a) is authorized by a Participating Physician;

(b) is furnished while the patient is not in either:

(i) a Hospital; or

(ii) any other health care institution that provides nursing care; and

(c) is not mainly Custodial Care.

Under Tiers 2 and 3: Private duty professional nursing by a registered graduate nurse, a Licensed Vocational Nurse (L.V.N.), or a Christian Science nurse (Tier 3 only), if such care is furnished while:

(a) intensive nursing care by such nurse is required in the treatment of an acute Sickness or Injury;

(b) the patient is not in either:

(i) a Hospital; or

(ii) any other health care institution that provides nursing care.

For any one covered individual, not more than $8,000 in a Calendar Year will be paid for private duty nursing services. Requirement (a) above will in no event be considered to be met if the care actually furnished is mainly Custodial Care. For private duty professional nursing, the benefits and services received under Tier 1 do not count towards Tier 2 and Tier 3 limits. Tier 2 and Tier 3 limits are combined, and do not reduce Tier 1 benefits.

(8) **Under Tier 1:** Short term speech therapy, when medically necessary and ordered by a Participating Physician for a Covered Person's condition which is judged by the Physician to be subject to significant improvement through such therapy.

Under Tiers 2 and 3: Speech Therapy, by a qualified speech therapist to restore or rehabilitate any speech loss or impairment caused by Sickness or Injury (except a mental, psychoneurotic or personality disorder) or by surgery for that Sickness or Injury. In the case of congenital defect, speech therapy expenses will be considered only if incurred after corrective surgery for the defect.

(9) **Under Tier 1:** Short term physical and/or occupational therapy, when medically necessary and ordered by a Participating Physician for a Covered Person's condition which is judged by the Physician to be subject to significant improvement through such therapy.

Under Tiers 2 and 3: Treatment by a licensed physiotherapist and/or licensed occupational therapist for a medically diagnosed condition.

(10) **Under all Tiers:** Inhalation therapy.

(11) **Under all Tiers:** X-ray exams and laboratory exams.

(12) **Under all Tiers:** Treatment by X-ray, radium or any other radioactive substance, or by chemotherapy.

(13) **Under Tier 1:** Oxygen and rental of equipment for use of oxygen; blood and blood plasma not replaced by or for the patient; collection and storage of autologous blood if:

(a) authorized by the Medical Director; and

(b) in connection with a Surgical Procedure authorized by a Primary Care Physician. The storage of blood is limited to three months. Rental or purchase of durable medical equipment (including prosthetic and orthotic devices) which is approved by the Medical Director. For equipment

purchased at the Medical Director's option, this item includes repair and necessary maintenance of purchased equipment that is not provided under a manufacturer's warranty or a purchase agreement.

Under Tiers 2 and 3: Medical supplies, when prescribed by a physician; blood and blood plasma not replaced by or for the patient; artificial limbs, eyes and larynx; electronic heart pacemaker; surgical dressings; casts; splints; trusses; braces; crutches; orthopedic appliances; rental of wheelchair, hospital bed, or iron lung; oxygen and rental of equipment for its administration; orthotic devices when Needed or Appropriately Provided.

(14) **Under all Tiers:** Any of the services and supplies shown above that are required for a live donor as a result of a surgical transplant procedure which is not an Experimental or Investigational procedure. (The terms Experimental or Investigational are defined under What Terms Mean.) This applies whether the Covered Person is the donor or the recipient of the transplant. But in the case of a Covered Person who is the recipient of the transplant, both of the following will apply:

(a) The services and supplies will be considered to be furnished on account of the recipient's Sickness or Injury.

(b) There is an Eligible Services and Supplies Limit for those services and supplies. That limit is the extent to which benefits for the services and supplies are not provided by reason of the donor's coverage.

(15) **Under Tier 1:** Home Health Care services for part-time or intermittent home nursing care, other than Custodial Care, given or supervised by a Registered Nurse (R.N.), or a Licensed Vocational Nurse (L.V.N.), but only if the services:

(a) are authorized by a Participating Physician; and

(b) are furnished to the person while under a Participating Physician's care.

Under Tiers 2 and 3: Charges for care furnished by a Home Health Care Agency. Benefits are subject to the following conditions:

(a) The patient is under the care of a doctor who submits a “home health care plan" (a written program for care and treatment in the patient's home and certification that inpatient confinement in a hospital, convalescent nursing home or skilled nursing facility would be required if the home care were not provided).

(b) The services and supplies furnished by the Home Health Care Agency are covered if they would be required for inpatient confinement in a hospital, convalescent nursing home or skilled nursing facility.

The eligible expenses are the charges for the following services and supplies ordered by the doctor under the home health care plan and furnished in the patient's home:

1. The following services and supplies furnished by the agency:

   a. Part-time or intermittent nursing provided or supervised by a Registered Nurse (R.N.) or Licensed Vocational Nurse (L.V.N.)

   b. Part-time or intermittent home health aide services which provide supportive services in the home under the supervision of a Registered Nurse (R.N.) or a physical, speech, occupational or respiratory therapist.

   c. Physical, occupational, speech, or respiratory therapy.

d. Nutrition counseling provided or supervised by a registered dietitian.

2. Services of visiting nurses rendered in place of services of a Home Health Care Agency when the patient resides in a rural area which is not served by any Home Health Care Agency or where the services of Home Health Care Agencies are not sufficient to meet the needs of the community.

3. Medical supplies, drugs and medications prescribed by a Doctor, and related pharmaceutical and laboratory services.

Not more than one hundred (100) Home Health Care visits will be included in the eligible expenses for any one person in a calendar year. Each visit by a representative of a Home Health Care Agency, other than a home health aide, shall be counted as one visit. In the case of visits by home health aides, each visit lasting four (4) hours or less is counted as one visit. If a visit exceeds four (4) hours, each four (4) hours or fraction thereof is counted as a separate visit.

(16) **Under Tier 1:** Newborn baby care provided or authorized by a Primary Care Physician.

Under Tiers 2 and 3: CHILD HEALTH SUPERVISION SERVICES EXPENSE COVERAGE FOR YOUR DEPENDENTS--This Coverage pays benefits, without a deductible, for charges incurred for Child Health Supervision Services for your qualified Dependent child under age nineteen (19). The amount payable is the Covered Percent of the Eligible Charges for the services furnished at any one Doctor visit. Child Health Supervision Services include a history, physical examination, developmental assessment, anticipatory guidance and appropriate immunizations and laboratory tests performed solely to monitor a child's health on a periodic check-up basis. The services must be furnished by a Doctor or under a Doctor's direct control, while the qualified Dependent child is a Covered Person. One Doctor visit may be made at each of the age intervals shown below up to a maximum of twenty (20) visits.

A charge is not an Eligible Charge if it is described in the Generally Excluded Charges section starting on page 123.

Intervals of Eligible Visits:

Birth	15 months	6 years
2 months	18 months	8 years
4 months	2 years	10 years
6 months	3 years	12 years
9 months	4 years	14 years
12 months	5 years	16 years
		17 years
		18 years

(17) **Under Tier 1:** Routine health assessments arranged or authorized by a Primary Care Physician.

(18) **Under Tier 1:** Immunizations given or authorized by a Physician.

(19) **Under all Tiers:** Injectables (other than prescribed self-injectables covered by the prescription drug benefit including insulin) given or authorized by a Physician.

(20) **Under All Tiers:** Allergy serum and biological serum given or authorized by a Physician.

(21) **Under Tier 1:** The following Hospice Care services and supplies if authorized by a Participating Physician as part of a Hospice Care Program for a Terminally Ill Person:

(a) Hospice room and board, while the Terminally Ill Person is an inpatient in a Hospice.

(b) Other Hospice Services furnished by a Hospice or a Hospice Team.

(c) Counseling Services provided by members of a Hospice Team.

These services and supplies are included in this list of Eligible Services and Supplies only if each service or supply is furnished within seven (7) months from the date the Terminally Ill Person entered the Hospice Care program or re-entered such program.

These Hospice Care services and supplies are limited. For any one period of care in Hospice Care Programs, Prudential HealthCare will provide Hospice Care services and supplies up to a benefit maximum of $7,400. For the purposes of this benefit maximum, all care in Hospice Care Programs is considered one (1) period of care, except as follows: Care will be treated as starting a separate period of care if furnished after there has been no care in Hospice Care Programs for at least three (3) consecutive months.

Bereavement Counseling Services furnished to a Family Unit after the death of a Terminally Ill Person are included in this list of Eligible Services and Supplies only if all of these conditions are met:

(a) The Bereavement Counseling Services are authorized by the Medical Director and received under a Hospice Care Program within three (3) months after the death of the Terminally Ill Person.

(b) On the day before the date of death, the Terminally Ill Person was:

(i) in the Hospice Care Program; and

(ii) a member of the Family Unit; and

(iii) a Covered Person for the benefits of this Coverage.

These Bereavement Counseling Services are limited. For each Covered Person, Bereavement Counseling Services are provided up to a maximum of three (3) visits.

Under Tiers 2 and 3: Charges incurred for a Terminally Ill Person while in a Hospice Care Program are covered subject to the following:

Certification of the terminal illness must be given to Prudential by the primary attending doctor in order for a Terminally Ill Person to be considered in a Hospice Care Program.

The benefits are paid if the hospice services are:

1. provided while the Terminally Ill Person is a covered individual;

2. ordered by the supervising doctor as part of the Hospice Care Program;

3. charged for by the Hospice Care Program; and

4. provided within six (6) months of the Terminally Ill Person's entry or re-entry (after a remission period) into the Hospice Care Program.

While Not An Inpatient In a Hospice - The Plan pays the charges incurred for all hospice services for one period of care in the Hospice Care Program.

While An Inpatient In a Hospice - The Plan pays the charges incurred for all hospice services for one (1) period of care in the Hospice Care Program.

All periods of care in a Hospice Care Program will be considered related and to have occurred in the one period of care unless separated by at least three (3) consecutive months.

The following charges are not covered:

1. Charges in connection with:

   (a) injury arising out of, or in the course of, any employment for wage or profit (whether or not with the University), or

(b) disease covered, with respect to such employment, by any workers' compensation law, occupational disease law or similar legislation.

2. Charges for services or supplies:

   (a) furnished by or for the U.S. government or any other government unless payment of the charge is legally required; or

   (b) to the extent provided under any governmental program or law under which the individual is or could be covered. Item (b) does not apply to state plans under Medicaid or to any law or plan which states that its benefits are excess to those of any private program or other non-governmental program.

3. Charges incurred during a remission period. This applies if, during remission, the Terminally Ill Person is discharged from the Hospice Care Program. These Hospice Care benefits are limited.

For any one period of care in Hospice Care Programs, the maximum Hospice Care benefit is $7,400. For the purpose of this benefit maximum, all care in Hospice Care Programs is considered one period of care unless separated by at least three (3) consecutive months.

Bereavement Benefits: The Plan also provides benefits for charges incurred for counseling services for the Family Unit, if ordered and received under the Hospice Care Program.

The benefits are paid if:

(1) on the day prior to death the Terminally Ill Person was in the Hospice Care Program, a member of the Family Unit, and a covered person; and

(2) the charges are incurred by the Family Unit within three months following the date the Terminally Ill Person dies.

The following charges are not covered under the bereavement benefits:

1. Charges for the treatment of a diagnosed Sickness or Injury of a Family Unit member to the extent that benefits are payable under another part of the Plan. If such benefits are expressed as a percent of charges, this exclusion will apply as if the percent were 100%.

2. Charges for services or supplies provided by a Close Relative. "Close Relative" means you, your spouse, or a child, brother, sister, parent, or other relative of you, your spouse or your other Dependents.

A charge is considered to be incurred on the date of the service or purchase for which the charge is made.

(22) **Under Tier 1:** The following preventive health services when provided or authorized by a Participating Physician:

(a) Voluntary family planning.

(b) Vision screening (not including refractive testing) to determine the need for vision correction for Covered Persons under age eighteen (18).

(c) Screening to determine the need for hearing correction for Covered Persons under age eighteen (18).

(23) **Under Tier 1:** The following Hearing Services and supplies are covered as a supplemental benefit under this Evidence of Coverage when authorized by your Primary Care Physician in accordance with the terms of this Evidence of Coverage.

Audiological exams necessary to determine the need for hearing correction and hearing aid devices.

Audiological exams include screening, audiological evaluation, tympanometry and acoustic reflex. Examinations must be performed by a contracting audiologist and are subject to the Provider's Office Visit Copayment.

Hearing aid devices are limited to one (1) hearing aid device per ear in any thirty-six (36) month period. These hearing aid devices are subject to a benefit maximum of $2,000 every thirty-six (36) months. Benefits provided under all Tiers will count toward this maximum.

(24) **Under Tiers 2 and 3:** Audiological exams necessary to determine the need for hearing correction and hearing aid devices.

Audiological exams include screening, audiological evaluation, tympanometry and acoustic reflex.

Hearing aid devices are limited to one (1) hearing aid device per ear in any thirty-six (36) month period. These hearing aid devices are subject to a benefit maximum of $2,000 every thirty-six (36) months. Benefits provided under all Tiers will count toward this maximum.

(25) **Under Tier 1:** Infertility Services, when authorized by the Medical Director. Surgical management, such as: cervical dilation, excision of endometria from ovaries, laparoscopy and micro-surgical excision and repair of tubes. But infertility services will not include the services shown in items (17), (18) and (24) of the section Generally Excluded Charges, unless otherwise included in a specific modification to the Medical Contract.

(26) **Under Tier 1:** The following health education services when provided or authorized by a Participating Physician:

(a) Instruction in personal health care.

(b) Information about Prudential HealthCare's Eligible Services, including recommendations on generally accepted medical standards for the use and frequency of such services.

(27) **Under Tier 1:** Diagnostic procedures for the prenatal diagnosis of genetic disorders of the fetus, when authorized by a Participating Physician in the case of high-risk pregnancy.

(28) **Under Tier 3:** Charges for healing purposes made by a Christian Science practitioner accredited by the Mother Church, The First Church of Christ, Scientist, in Boston, Massachusetts, subject to the same terms and conditions as if such charges had been made by a physician.

Charges for private duty nursing services by a Christian Science nurse accredited by the Mother Church, The First Church of Christ, Scientist, in Boston, Massachusetts, subject to the same terms and conditions as a Registered Nurse (R.N.).

Charges in a Christian Science Sanatorium currently maintained by the Mother Church, The First Church of Christ, Scientist, in Boston, Massachusetts, subject to the same terms and conditions as if such charges had been incurred in a Hospital.

(29) **Under all Tiers:** Treatment required because of accidental injury to natural teeth including replacement of such teeth. Related X-rays are also covered.

(30) **Under all Tiers:** Post-delivery inpatient care in a Hospital as needed for the medical treatment of a mother and her newborn child, but for not less than the Minimum Hospital Stay defined below.

But, if the Prudential HealthCare Doctor(s) for the mother and child confer with the mother and determine that the mother and child can be discharged from the Hospital before the end of the Minimum Hospital Stay, then post-delivery care will also include coverage for a follow-up visit. The visit will include at least the Postpartum Services defined below, and will be made by a licensed health care provider whose scope of practice includes postpartum and newborn care.

"Minimum Hospital Stay" means these periods of inpatient Hospital Stay:

(a) forty-eight (48) hours after a vaginal delivery; or

(b) ninety-six (96) hours after a delivery by cesarean section.

"Postpartum Services" means:

(a) parent education;

(b) help and training in breast or bottle feeding;

(c) a physical assessment of the child and mother.

Any requirement that a service or supply be for the diagnosis or treatment of a Sickness or Injury does not apply to:

(a) the Minimum Hospital Stay; or

(b) the post-delivery visit described above.

(31) **Under all Tiers:** Birthing Center charges incurred at a birth center for delivery of a child or children may be considered as Hospital expenses to the same extent as they would be recognized if performed in a Hospital, provided all of the following are met:.

1. The facility is certified or approved by the legally constituted State of California regulatory authority.

2. The facility meets every one of the following tests:

   (a) It is equipped and operated primarily for the purpose of providing an alternative method of childbirth.

   (b) It operates under the direction of a Doctor as defined in the Plan.

   (c) It permits a surgical procedure to be performed only by a Doctor as defined by the Plan.

   (d) It requires an examination by an obstetrician at least once prior to delivery, to screen out high risk pregnancies.

   (e) It offers prenatal and postpartum care.

   (f) It provides at least two (2) birthing rooms.

(g) It has available the necessary equipment and trained personnel to handle foreseeable emergencies. Such equipment shall include a fetal monitor, incubator and resuscitator.

(h) It provides the services of registered graduate nurses (R.N.s) for patient care.

(i) It does not provide beds or other accommodations for patients to stay more than twenty-four (24) hours.

(j) It maintains written agreements with one (1) or more hospitals in the area for immediate acceptance of patients who develop complications or who require postdelivery confinement.

(k) It provides for periodic review by an outside agency.

(l) It maintains adequate medical records for each patient.

(32) **Under all Tiers:** Mastectomy and Related Services. Coverage for a mastectomy and lymph node dissections shall include the following:

(a) Coverage for all complications of a mastectomy, including lymphedema; and

(b) Coverage for prosthetic devices or reconstructive surgery, including devices or surgery to restore and achieve symmetry for the patient incident to the mastectomy.

"Prosthetic devices" means and includes the provision of initial and subsequent prosthetic devices pursuant to an order of the patient's physician.

"Mastectomy" means the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician and surgeon.

"To restore and achieve symmetry" means that , in addition to coverage of prosthetic devices and reconstructive surgery for the diseased breast on which the mastectomy was performed, prosthetic devices and reconstructive surgery for a healthy breast is also covered if, in the opinion of the attending physician and surgeon, this surgery is necessary to achieve symmetrical appearance.

The length of the hospital stay for mastectomies and lymph dissections shall be determined by the attending physician and surgeon in consultation with the patient and consistent with sound clinical practices.

Item (12) of Generally Excluded Charges, does not apply to this item (32).

(33) **Under all Tiers:** Over the counter diabetic supplies (test strips, lancets, alcohol swabs, and syringes).

(34) **Under all Tiers:** Contraceptive devices and implants. Under Tiers 2 and 3 these contraceptives and devices are subject to medical necessity

(35) **Under Tier 1:** IUD device and insertion. **Under all Tiers,** Removal is covered based on medical necessity.

INSTITUTES OF QUALITY AND COMPANION TRAVEL BENEFITS

With the Institutes of Quality (IQ) benefit, you or a covered family member can be eligible for enhanced benefits for specialized medical care, such as a heart transplant, when it is performed through a particular, high-quality facility with which Prudential HealthCare contracts. The IQ benefit is designed to decrease the costs of certain procedures while increasing their availability to you on a nationwide basis. You can be referred to an IQ network facility by your Primary Care Physician, a Specialty Care Physician or an out-of-network physician.

The Companion Travel benefit covers the cost of travel if it's more than fifty (50) miles to the IQ facility. This benefit is described in detail starting on page 110.

All of the Institutes of Quality and Companion Travel benefits are subject to Section IV of this benefit.

All of the terms and provisions of the Group Contract apply to the Institutes of Quality and Companion Travel Benefits, except as specifically altered by this benefit.

I. DEFINITIONS FOR INSTITUTES OF QUALITY AND COMPANION TRAVEL BENEFITS

For the purpose of the benefit, the following terms will have the meaning set forth below:

Health Care Services means the medical care rendered to a Covered Person by a Provider for Procedures.

Institute of Quality means a Provider who has entered into an Agreement with Prudential to provide Health Care Services for specific procedures. The Covered Person should call Prudential Member Services at the number on the UC Care ID and request a listing of Institutes of Quality.

Negotiated Fees means a specific dollar amount to be charged by an institutional Provider per stay, regardless of the actual itemized services and supplies furnished by the Provider. Negotiated Fees are set forth in the reimbursement schedule in the Agreement between Prudential and the Provider.

Pre-Screening Evaluation means the review of past and present medical records and current X-ray and laboratory results by the Institute of Quality to determine whether the Covered Person is an appropriate candidate for the Procedure.

Primary Care Physician means a Physician affiliated with a managed medical health care delivery system who is chosen by a Covered Person to have the responsibility for:

(1) providing initial and primary medical care to the Covered Person;

(2) initiating referral to the Institute of Quality to perform a Procedure; and

(3) coordinating aftercare.

Procedure means one or more surgical procedures or medical therapy performed in an Institute of Quality.

Provider means an individual, organization or institution licensed by the state in which it is located and that is an Institute of Quality.

Travel Companion means that person chosen by a Covered Person to accompany the Covered Person to an Institute of Quality and to remain there for all or a portion of the duration of the Covered Person's stay. In the event the Covered Person is incapable of making this choice, the selection may be made by the person responsible for the welfare of the Covered Person.

II. INSTITUTES OF QUALITY BENEFIT

Each Institute of Quality has agreed to furnish services and supplies for one or more Procedures to Covered Persons under the terms of the Agreement. The charges for Health Care Services under the Agreement are reimbursed on the basis of a Negotiated Fee. The Negotiated Fee is generally lower than the Institute of Quality's usual charge for other patients.

Under the Institutes of Quality Benefit, the Covered Person, the Covered Person's Primary Care Physician or, in the case of a physician who is not affiliated with a managed medical health care delivery system, the Covered Person's Physician, may elect to use the services of and initiate the referral to an Institute of Quality for the Procedures covered by the Agreement. The Institute of Quality selected by the Covered Person is subject to approval by Prudential. Covered Persons do not have to use an Institute of Quality, in which case, the provisions of this modification shall not apply to the Procedure.

If a Covered Person elects to use the Institute of Quality Program to provide Health Care Services for a Procedure, any requirements for early determination of need for hospital stay or for second surgical opinions that may be part of the Group Contract will not apply.

The Institute of Quality Program covers eligible charges incurred for the Covered Person's travel to and from the Institute of Quality in which the Procedure is performed.

Changes Made in the Coverage

Benefits for Eligible Charges for services and supplies furnished at an Institute of Quality are described below. For the charges to be eligible, the Institute of Quality must perform a Pre-Screening Evaluation on the Covered Person and determine that the Procedure is appropriate for the treatment of the Covered Person. In the case where the Covered Person initiates the referral, the Primary Care Physician or the Covered Person's Physician, if any, will be notified prior to the Pre-Screening Evaluation being completed.

Benefits under the Coverage for Eligible Charges incurred for services and supplies at an Institute of Quality are modified as follows:

(1) The Calendar Year Deductible Amount will not apply to Eligible Charges for services and supplies furnished by an Institute of Quality.

(2) The reduction in benefit amount for any one period of Hospital stays, as stated in the Prudential Patient Care Management, shall not apply to stays in an Institute of Quality.

(3) The Covered Percent for Eligible Charges for services and supplies furnished by an Institute of Quality is increased to 100%, and not the Covered Percent shown in the Schedule of Benefits of the Coverage.

(4) 100% of the eligible charges incurred for the transportation, by air, ambulance or otherwise, of a Covered Person to and from the Institute of Quality in which the Procedure is to be performed will be payable. Unless otherwise approved by

Prudential HealthCare, the Institute of Quality in which the Procedure is performed must be the one that is nearest to the Covered Person's home.

III. COMPANION TRAVEL BENEFIT

Under the Companion Travel Benefit, the Coverage is changed to pay benefits for some of the charges incurred by a person to accompany a Covered Person to an Institute of Quality. It also pays benefits for some of the charges a Travel Companion incurs to remain with the Covered Person for all or a portion of the duration of the Covered Person's stay in the Institute of Quality. Not all charges are eligible; some are excluded entirely or included to a limited extent. The itinerary the Travel Companion uses must be approved by Prudential HealthCare before any charges are incurred. Itinerary includes mode of transportation and hotel accommodations. There are Companion Travel maximums and limits which apply to each Covered Person's stay in an Institute of Quality.

Changes Made in the Coverage

Benefits under the Coverage are payable according to the terms of this section. Benefits are payable for Eligible Charges incurred for services and supplies by a Travel Companion while accompanying a Covered Person to an Institute of Quality located fifty (50) or more miles from the Travel Companion's home.

A charge is an Eligible Charge under this Section if it is for a service or supply that meets all of these conditions:

(1) It is in the list below, and

(2) It is furnished while the Travel Companion is accompanying a Covered Person to or from an Institute of Quality or while the Covered Person is confined in an Institute of Quality. The Institute of Quality must be located fifty (50) or more miles from the Travel Companion's home, and

(3) It is furnished as a part of a Travel Companion's itinerary which has been approved by Prudential HealthCare.

Following is the list of Companion Travel Program Services and Supplies, subject to the Limits below.

(1) Transportation as a passenger in or on a public vehicle provided by a common carrier for passenger service to the Institute of Quality; or

(2) Transportation to the Institute of Quality by a Travel Companion using a motor vehicle; and

(3) Hotel accommodations necessary for a Travel Companion to remain in the immediate area of the Institute of Quality for all or a portion of the duration of the Covered Person's stay; and

(4) Other reasonable and necessary services and supplies furnished to a Travel Companion.

Limits:

(1) The following Eligible Charge Limits apply for Companion Travel Program Services and Supplies above:

  (a) There is an Eligible Charge Limit for each trip to an Institute of Quality. That limit is the amount equal to the cost of a round trip coach air fare to the Institute of Quality. This limit applies whether the transportation is as a passenger in or on a public vehicle provided by a common carrier for passenger service or while using a motor vehicle.

  (b) There is a Hotel Accommodation Daily Eligible Charge Limit for charges incurred for each day of a Travel Companion's stay. That limit is an amount equal to the usual and prevailing daily charge for a room in a mid-range priced hotel.

  (c) There is an Other Eligible Charges Daily Limit of the reasonable and necessary charges incurred each day, not to exceed $25.00 per day.

(2) A service or supply which is a Companion Travel Program Service or Supply will be considered included in the list of services and supplies in the Eligible Charges section of the Coverage only by reason of these Companion Travel Program provisions.

Amount Payable

For each stay by a Covered Person in an Institute of Quality, the amount payable for Eligible Charges for Companion Travel Services and Supplies incurred by a Travel Companion will be:

(1) The amount of the Eligible Charges incurred for transportation as a passenger in or on a public vehicle to the Institute of Quality, up to the Companion Travel Transportation Maximum. The Maximum is an amount equal to the cost of one round trip coach air fare to the Institute of Quality except if the Covered Person's stay in an Institute of Quality is for three (3) or more weeks. In that case, the Maximum will be the cost of two (2) round trip coach air fares to the Institute of Quality.

(2) For transportation to the Institute of Quality while using a motor vehicle, the amount equal to:

    (a) the number of miles to the Institute of Quality times

    (b) $.15 per mile, up to the Companion Travel Transportation Maximum, as defined in item (1) above.

    Mileage will be determined by Prudential HealthCare in accordance with the most current edition of the Rand McNally guide.

(3) The amount of the Eligible Charges incurred for Companion Travel Hotel Accommodations, not to exceed an amount of $50.00 per day, nor more than a total of twenty-one (21) days during each stay by a Covered Person in an Institute of Quality.

(4) The amount of the Eligible Charges for Other Travel Companion services and supplies not to exceed the Other Eligible Charges Maximum of $500.00.

Charges Not Covered:

(1) Charges for personal comfort and convenience items.

(2) Charges in connection with the Companion Travel Benefit that are not incurred during a Covered Person's stay in an Institute of Quality, except travel days.

(3) Charges in connection with the Companion Travel Benefit that have not been included in the itinerary approved by Prudential HealthCare prior to the date they were incurred.

(4) Charges in connection with transportation for the Travel Companion other than the trip required to accompany the Covered Person to and from the Institute of Quality, except as stated above in item (1), Amount Payable.

(5) Charges in connection with the repair or maintenance of a motor vehicle.

(6) Charges for personal expenses incurred by the Travel Companion to maintain the Companion's home during the Covered Person's stay in the Institute of Quality. These expenses include, but are not limited to: child care charges; house sitting charges; and kennel charges.

(7) Reimbursement of any wages lost by the Travel Companion during the Covered Person's stay in the Institute of Quality.

IV. CHARGES NOT COVERED UNDER INSTITUTES OF QUALITY AND COMPANION TRAVEL BENEFITS

The Generally Excluded Charges section of the Coverage is expanded to include the following:

Charges incurred at an Institute of Quality or for Companion Travel will not be considered eligible charges for any condition that has been treated by a Covered Person's Primary Care Physician and for which the Primary Care Physician has not initiated a referral to an Institute of Quality.

V. APPLICATION OF GENERALLY EXCLUDED CHARGES TO THE COMPANION TRAVEL BENEFIT

Charges incurred for Companion Travel are not subject to the Generally Excluded Charges section of the Group Contract.

VI. LISTING OF INSTITUTES OF QUALITY AND PROCEDURES

The Covered Person should call Prudential HeatlhCare Member Services at the phone number on the UC Care ID Card to receive a listing of the institutes which are taking part in the Institutes of Quality Benefit. The listing shall include the institute's name, address, telephone number, and the procedure(s) for which the institute is participating in the benefit.

The relationship between Prudential HealthCare and the Institute of Quality is that of independent contractors, and Prudential HealthCare, by virtue of the Institutes of Quality or Companion Travel Benefits, is not responsible for the acts or omissions of the Institute of Quality involved in this benefit.

SELF-COORDINATED BENEFITS (TIERS 2 AND 3)

100% Benefit Provision: If any person incurs the applicable amount of out-of-pocket expenses shown below (including the individual deductible but not the emergency room deductible) during a calendar year, the Plan pays 100% of the eligible expenses incurred by that person during the remainder of the calendar year. The following do not count toward meeting the out-of-pocket expenses requirement, called the Annual Out-of-Pocket Maximum, and will continue to apply even after the Plan starts paying at 100%:

- Amounts reduced due to non-compliance with plan provisions.
- Amounts over Usual and Prevailing or Usual and Customary Charges.
- Amounts not eligible under the Plan.
- Amounts used to satisfy Hospital Emergency Room Deductible.
- Charges not covered under this Plan.

Annual Out-of-Pocket Maximum:

The amount of the member's eligible out-of-pocket expenses will vary depending on whether network or non-network providers are used.

- If the member self-coordinates care with all network providers, the eligible out-of-pocket cost will be $3,000 per individual and $9,000 per family.
- If the member self-coordinates care with all non-network providers, the eligible out-of-pocket cost will be $12,000 per individual and $36,000 per family.

- If a combination of providers are used, the eligible out-of-pocket costs will fall between these amounts.

Deductible:

Tier 2: $250 per individual/$750 per family, per Calendar Year for Network Providers. (But not more than $250 per individual per Calendar Year.)

Tier 3: $500 per individual/$1,500 per family, per Calendar Year for Non-Network Providers. (But not more than $500 per individual per Calendar Year.)

Once the Covered Persons in a Family have incurred the applicable Family Deductible shown above in a Calendar Year, each Covered Person in that family will be considered to have met the Deductible for the remainder of that Calendar Year. “Family" means you and your qualified Dependents.

An expense must be eligible in order to count toward the Deductible.

Under Tiers 2 and 3, the Annual Deductible, Annual Out-of-Pocket Maximum and Lifetime Maximum will be combined.

Lifetime Maximum Benefit:

Each Covered Person has a maximum lifetime benefit of $2,000,000.

Restoration of Benefits:

On each January 1 up to $1,000 in benefits that were used in the prior year will be added to the remaining maximum of any participant. For example, if you receive $5,000 of benefits this year, $1,000 of that amount will be restored automatically on January 1.

PRUDENTIAL PATIENT CARE MANAGEMENT (APPLICABLE TO TIERS 2 AND 3)

The Patient Care Management Program (the Program) is a combination of two health care plan services: (1) Patient Care Management (PCM); and (2) the Outpatient Precertification Program

(OPP). The Program is designed to evaluate certain outpatient procedures, treatments, services, supplies, all inpatient and outpatient hospital admissions and non-emergency elective surgical procedures that you or your eligible Dependents may require. Details about when the Program must be used, and the penalty for noncompliance, are provided on the following pages.

The purpose of the Program is to make sure that you understand the length of hospital stay, and elective surgical procedures and services and supplies that will be considered necessary under your health care plan, before you incur the expense. The services provided by PCM and OPP are described in detail on the following pages.

To receive the benefits of the Patient Care Management Program, you or your eligible Dependent must call Member Services before scheduling certain outpatient procedures, treatments, services, supplies, surgery or entering the hospital. PCM will advise you regarding how many days of an inpatient hospital confinement are approved as needed and appropriately provided or will arrange for a further review.

In addition, some hospital stays and procedures are not covered under the Plan. By calling Member Services you will find out which services are covered. The Member Service Representative can also explain the benefit plan and answer any questions you may have.

PATIENT CARE MANAGEMENT FOR HOSPITAL SERVICES

Early Determination of Need for Hospital Stay

Under the terms of the Coverage, Eligible Charges do not include charges for Services or Supplies that are not needed or not appropriately provided. Those Services or Supplies are ones which are not needed and appropriately provided for medical care of a diagnosed Sickness or Injury. The Generally Excluded Charges section includes the requirements which a Service or Supply, including a Hospital stay, must meet in order to be considered needed and appropriately provided. Prudential HealthCare will make a Determination of Need for each day of an Inpatient Hospital Stay. That Determination of Need is solely for the purpose of determining Eligible Charges under the Coverage, and is not medical advice.

For days of Inpatient Hospital Stay not approved as needed and appropriately provided under a Determination of Need, no benefits are payable under the Coverage. This could include all days of an Inpatient Hospital Stay or some of them.

Section C describes the procedures and time limits that apply to a request for an early Prudential Determination of Need for days of an Inpatient Hospital Stay. Unless such a request is made and complies with Section C within those time limits, the Eligible Charges for approved days of Inpatient Hospital Stay are subject to the Eligible Charge Limit in Section A. This can result in a smaller benefit under the Coverage, since benefits are based upon Eligible Charges.

Section B defines many of the terms used in Patient Care Management.

A. EFFECT WHEN A REQUEST FOR PRUDENTIAL'S DETERMINATION OF NEED IS NOT MADE ON TIME

Charges incurred for a listed outpatient service/procedure, or for each day of Inpatient Hospital Stay that Prudential HealthCare approves as needed and appropriately provided for medical care of the patient's condition are subject to the Eligible Charge Limit below under the following conditions:

- If you call fewer than seven (7) days before the day of a non-emergency admission, the Eligible Charge Limit will apply for one day of the hospitalization.

- If you call after you've been admitted to the hospital, the Eligible Charge Limit will apply up to and including the day of the call.

- If you don't call at all, the Eligible Charge Limit will apply for the entire Inpatient Hospital Stay.

- If you do not call before a listed outpatient service/procedure or for a diagnostic procedure, the Eligible Charge Limit will apply for the service/procedure.

Eligible Charge Limit: The Eligible Charges for each such day will be only 80% of the charges that would be considered Eligible Charges without regard to this provision.

That Eligible Charge Limit does not apply to an Inpatient Hospital Stay when there is full compliance with Section C (Request For Early Prudential Determination of Need), nor to an outpatient service/procedure when there is full compliance with the Outpatient Precertification Program. The request procedures are those of the Prudential Patient Care Management program, a program for early Determination of Need for Hospital stays.

B. DEFINITIONS

Inpatient Hospital Stay: A Hospital stay for which a room and board charge is made by the Hospital.

Determination of Need: A determination by Prudential HealthCare, under the terms of the Coverage, that approves or disapproves a day or days of an Inpatient Hospital Stay (including Hospital services and supplies) as needed and appropriately provided for medical care of a diagnosed Sickness or Injury.

Eligible Charges: These are the charges that may be used as the basis for a claim under the terms of the Coverage.

Non-Emergency Admission: A Hospital admission which is for an Inpatient Hospital Stay but is not an Emergency Admission.

Emergency Admission: A Hospital admission for an Inpatient Hospital Stay for a condition which, unless promptly treated on an inpatient basis, would:

(1) put the patient's life in danger; or

(2) cause serious damage to a bodily function of the patient.

Workday: Any day of the week excluding Saturday, Sunday and legal holidays.

C. REQUEST FOR EARLY PRUDENTIAL HEALTHCARE DETERMINATION OF NEED FOR HOSPITAL SERVICES

1. Non-Emergency Admission

You or the patient must arrange for a request for Prudential HealthCare's Determination of Need to be made. The request must meet these requirements:

(a) It must be made by phone call to Prudential HealthCare from the Doctor, patient or a member of the patient's family at least (7) seven Workdays before the Hospital stay starts. However, the time frame for the notice will be reduced if Prudential HealthCare determines that it is not medically appropriate for the Hospital stay to be delayed for seven (7) Workdays; or

(b) It must include the facts required by Prudential HealthCare for its Determination of Need. If the request does not include all such facts, Prudential HealthCare has the right to ask you or the patient's Doctor for them. The request for Determination of Need will not be considered complete unless all required facts are supplied by the end of the second Workday after Prudential HealthCare requests such facts.

If the above requirements are met, Prudential HealthCare will tell the patient's Doctor and the Hospital, by phone, the number of days of Inpatient Hospital Stay that Prudential HealthCare approves as needed and appropriately provided for medical care of the patient's condition. This will be confirmed by written notice sent to you, to the Doctor, and to the Hospital.

2. Emergency Admission

The rules for Non-Emergency Admission apply, except that:

(a) The request for Prudential HealthCare's Determination of Need must be made by phone on a Workday not later than the first Workday after the Hospital stay starts.

(b) The phone call may be made by the patient's Doctor, the Hospital, or a member of the patient's family.

3. Extension of Length of Hospital Stay

It may be possible to extend the number of days of Inpatient Hospital Stay that Prudential HealthCare had approved as needed

and appropriately provided for medical care of the patient's condition under the terms of the Coverage.

Prudential HealthCare will make a new Determination of Need on the basis of information given by the Doctor.

The Doctor will be told how many more days, if any, Prudential HealthCare approves as needed and appropriately provided for medical care of the patient's condition. The number of approved days will be confirmed by written notice sent to you, to the Doctor, and to the Hospital.

D. EARLY PRUDENTIAL HEALTHCARE DETERMINATION OF NEED DOES NOT GUARANTEE BENEFITS

Prudential HealthCare's Determination of Need under Section C does not guarantee either payment of benefits or the amount of benefits. Eligibility for, and payment of, benefits are subject to all of the terms of the Coverage. But Prudential HealthCare's Determination of Need under that section is binding on the Plan, unless Prudential HealthCare has been misled by the information furnished.

OUTPATIENT PRECERTIFICATION PROGRAM (OPP) (APPLICABLE TO TIERS 2 AND 3)

The UC Care Medical Plan includes an Outpatient Precertification Program (OPP) for certain outpatient treatments, services, supplies and Elective Surgical Procedures listed on the following page. The object of OPP is to evaluate these treatments, services, supplies and procedures that you or your eligible Dependent may require in order to make sure you understand what will be considered “needed" under the Plan before incurring expenses.

A. REQUEST FOR PRECERTIFICATION REVIEW

If one of the Elective Surgical Procedures, treatments, services or supplies included on the following list has been recommended for you or one of your eligible Dependents, you or your Doctor should contact the Patient Care Manager. If you are uncertain whether a service requires precertification, call the Member Services phone number on the UC Care ID Card. The request for precertification should include all the facts required by the Patient Care Manager to evaluate the proposed treatment, service, supply or surgery. If all the facts are not included, the Patient Care Manager has the right to contact your doctor for additional information. The Patient Care Manager will notify you and your doctor of its determination by telephone and in writing.

OUTPATIENT PRECERTIFICATION PROGRAM LIST

SKILLED NURSING CARE
TOTAL PARENTERAL NUTRITION AND OTHER INFUSION THERAPY
MAGNETIC RESONANCE IMAGING (MRI)
HOME HEALTH CARE
SPEECH THERAPY
PHYSICAL THERAPY
GASTROSCOPY
COLONSCOPY
CARDIAC EXERCISE TESTING
ECHOCARDIOGRAPHY
HOLTER MONITOR

SURGICAL PROCEDURES

a) Cataract Removal
b) Repair of Deviated Septum
c) Hemorrhoidectomy
d) Bunionectomy
e) Hammertoe Repair
f) Tympanoplasty (PE Tubes)
g) Tonsillectomy
h) Adenoidectomy
i) Sclerotherapy of Leg Veins
j) Blepharoplasty
k) Knee Arthroscopy

B. EFFECT ON BENEFITS WHEN A REQUEST FOR PRECERTIFICATION REVIEW IS NOT MADE

If a request for Precertification Review is not made, the Eligible Expenses for the listed outpatient procedures, treatments, services and supplies will be only 80% of the charges that would be considered Eligible Expenses otherwise.

C. PRECERTIFICATION REVIEW DOES NOT GUARANTEE BENEFITS

Precertification Review under Section A. does not guarantee either payment of benefits or the amount of benefits. Eligibility for, and payment of benefits are subject to all of the terms of the Plan. But a determination by the Outpatient Precertification Review that certain surgical procedures, treatment, services or supplies are “needed" is binding on the Plan unless the Outpatient Precertification Review has been provided incorrect information.

D. DEFINITIONS FOR THE PURPOSE OF THE OUTPATIENT PRECERTIFICATION PROGRAM

Eligible Expenses: These are the expenses that may be used as the basis for a claim under the terms of the Plan.

Elective Surgical Procedure: A non-emergency surgical procedure scheduled at the patient's convenience without jeopardizing the patient's life or causing serious impairment to the patient's bodily functions. Of course, a procedure will not be considered elective if the operation is of an emergency nature (that is, it must be scheduled without delay) as determined by the patient's surgeon.

GENERALLY EXCLUDED CHARGES

The Plan does not cover these things:

1. Charges incurred while not covered.

2. Charges for services and supplies in connection with:

   (a) an injury arising out of, or in the course of, any employment for wage or profit; or

   (b) a disease covered, with respect to such employment, by any workers' compensation law, occupational disease law or similar legislation.

3. Charges for services or supplies:

   (a) furnished by or for the U.S. Government or any other government unless payment of the charge is required by law; or

   (b) to the extent that the service or supply, or any benefit for the charge, is provided by any law or governmental plan under which the patient is, or could be, covered. This (b) does not apply to a state plan under Medicaid or Medi-Cal or to any law or plan when, by law, its benefits are in excess to those of any private program or other non-governmental program.

4. Charges for Services or Supplies that are Not Needed or Not Appropriately Provided: A charge for a service or supply is not covered to the extent that it is not needed or not appropriately provided. Charges for services or supplies furnished in connection with a service or supply that is not needed or not

appropriately provided are also not covered. For the purpose of this exclusion a service or supply will be considered both “needed and appropriately provided" if it meets each of these requirements:

(a) It is ordered by the patient’s Primary Care Physician for the maintenance of the patient’s good health.

(b) It is ordered by a Doctor for the diagnosis or the treatment of a Sickness or Injury.

(c) The prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use, and that its omission would adversely affect the person's medical condition.

(d) It is furnished by a provider with appropriate training, experience, staff and facilities to furnish that particular service or supply.

Prudential or Prudential HealthCare will determine whether these requirements have been met based on:

- Published reports in authoritative medical literature;
- Regulations, reports, publications or evaluations issued by government agencies such as the Agency for Health Care Policy and Research, the National Institutes of Health, and the Food and Drug Administration (FDA);
- Listings in the following drug compendia: The American Medical Association Drug Evaluations, the American Hospital Formulary Service Drug Information and The United States Pharmacopoeia Dispensing Information; and
- Other authoritative medical sources to the extent that Prudential determines them to be necessary.

A service or supply furnished to a newborn child will not be considered needed and appropriately provided for medical care of a diagnosed Sickness or Injury unless the service or supply meets either of these conditions:

(a) It is furnished for the medical care of a diagnosed Sickness (including a congenital defect or birth abnormality) or Injury and meets all of the tests above; or

(b) It is furnished during the first seven (7) days after the child's birth and is in the list below:

(i) Hospital room and board.

(ii) Other supplies and non-professional services furnished by the Hospital for medical care in that Hospital.

The following mammograms will be considered needed and appropriately provided for medical care if they are ordered by a Doctor:

(a) For women thirty-five (35) to thirty-nine (39) years old, inclusive: one (1) baseline mammogram.

(b) For women forty (40) years old or more: one (1) mammogram every two (2) years.

An annual cervical cancer screening test will be considered needed and appropriately provided for the purpose of medical care if it is provided by a Doctor.

Under Tier 1: Newborn baby care provided or authorized by a Primary Care Physician will be considered needed and appropriately provided for medical care.

Under Tiers 2 and 3: Child Health Supervision Services will be considered needed and appropriately provided for medical care.

Under Tiers 2 and 3: Routine health assessments for persons over age eighteen (18) will not be considered needed and appropriately provided for medical care.

5. Services and supplies to the extent that they are Experimental or Investigational. See What Terms Mean for the definition of Experimental or Investigational.

6. Charge for Educational Services or Supplies: A charge for a service or supply is not covered to the extent that it is determined by Prudential or Prudential HealthCare to be educational. Charges for other services or supplies furnished in connection with an educational service or supply are also not covered. “Educational" means:

   (a) That the primary purpose of the service or supply is to provide the person with any of the following: training in the activities of daily living; instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities; or

   (b) That the service or supply is being provided to promote development beyond any level function previously demonstrated.

   "Training in the activities of daily living" does not include training directly related to treatment of a Sickness or Injury that resulted in loss of a previously demonstrated ability to perform those activities. In the case of a Hospital stay, the length of the stay and Hospital services and supplies are not covered to the extent they are determined to be allocable to the scholastic instruction or vocational training of the patient.

7. Charge Above the Usual Charge: A charge for a service or supply to the extent that it is above the usual charge made by the provider for the service or supply when there is no insurance.

   But this seven (7) will not apply to charges from a non-governmental Charitable Research Hospital located in California. As used here, a Charitable Research Hospital means only a Hospital that meets all of these requirements:

   (a) It is internationally recognized to be devoted mainly to medical research.

   (b) At least one-tenth of its annual operating budget is spent solely on medical research not directly related to patient care.

(c) It derives a third or more of its annual gross income from persons, groups or other entities not related to the Hospital. This income is in the form of contributions, donations, gifts, grants or other gratuitous forms. Any income in the above forms which is also received as compensation for medical services provided to patients will not be counted for the purpose of this (c).

(d) It accepts patients without regard to the patients' ability to pay for medical services.

(e) At least two-thirds of its patients have a diagnosed or suspected Sickness directly related to the specific areas of the Hospital's research. Patients who are admitted due to an emergency condition that threatens their lives and who could not have been safely transported to another Hospital will not be considered for the purpose of this (e).

8. Charge Above the Prevailing Charge: A charge for a service or supply to the extent that it is above the prevailing charge in the area for a like service or supply. A charge is above the prevailing charge to the extent that it is above the range of charges generally made in the area for a like service or supply. The area and that range are as determined by Prudential.

9. **Under Tier 3:** Christian Science practitioner treatment through the use of communications media (including telephone consultations) or group treatment is not covered, nor is confinement for spiritual refreshment or any other service except as listed under Eligible Services and Supplies (Applicable to Tiers 1, 2, and 3).

10. Charges for services or supplies furnished by a Close Relative.

11. **Under Tiers 2 and 3:** Expenses applied toward satisfaction of the deductible(s) previously described.

12. A service or supply furnished in connection with Cosmetic Surgery. “Cosmetic Surgery” means surgery that is performed to alter or reshape normal structure of the body in order to improve appearance. It includes surgery to treat mental, psychoneurotic or personality disorder through change in appearance.

13. Charges for Doctors' services or X-ray exams involving one or more teeth, the tissue or structure around them, the alveolar process or the gums. This applies even if a condition requiring any of these services involves a part of the body other than the mouth such as the treatment of Temporomandibular Joint Disorders (TMJD) or malocclusion involving joints or muscles by methods including, but not limited to, crowning, wiring or repositioning teeth. This does not apply to a charge made for (a) or (b) below:

    (a) Treatment or removal of a malignant tumor.

    (b) Treatment of accidental injury to natural teeth when the charges:

        (1) are for Doctors’ services or X-ray exams; and

        (2) are incurred within twelve (12) months of the accident. Treatment includes the replacement of those teeth within that time.

14. **Under Tier 1:** A service or supply furnished in connection with foot care, unless medically necessary and authorized by a Primary Care Physician.

    Under Tiers 2 and 3: A charge for Doctors' services for:

    (a) A weak, strained, flat, unstable or imbalanced foot or for a metatarsalgia or a bunion. This (a) does not apply to a charge for an open cutting operation.

    (b) One or more corns, calluses or toenails. This (b) does not apply to a charge for:

        (i) removal of part or all of one or more nail roots; and

(ii) services in connection with treatment of metabolic or peripheral vascular disease.

15. A service or supply for or in connection with:

    (a) Exams to determine the need for (or changes of) eyeglasses or lenses of any type. Under Tier 1 only, this (a) does not apply to vision screening of a Covered Person under age eighteen (18) to determine the need for vision correction.

    (b) Eyeglasses or lenses of any type (except replacements for loss of the natural lens).

    (c) Eye surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).

16. Blood or blood plasma that is replaced by or for the patient.

17. Services or supplies furnished in connection with any procedures for the treatment of infertility which involve harvesting, storage and/or manipulation of eggs and sperm. The procedures not covered include, but are not limited to, the following:

    (a) in vitro fertilization;

    (b) embryo transfer; and

    (c) embryo freezing.

    Under Tier 1, artificial insemination is not considered to be manipulation of sperm.

18. Drug therapy for infertility which involves:

    (a) indications not consistent with generally accepted medical standards; or

    (b) non-standard dosages, length of treatment, or cycles of therapy.

19. Charges in connection with Custodial Care.

20. **Under Tier 1:** In connection with a Medical Emergency, a charge for any service or supply furnished by a Non-Participating Health Care Provider, to the extent that the charge is greater than either the Usual and Prevailing or the Usual and Customary Charge for that service or supply. For the purposes of this exclusion the reasonable charge shall be the prevailing charge for the service or supply in the geographic area in which the service or supply is provided, as determined by Prudential HealthCare.

21. Services and supplies in connection with mental, psychoneurotic and personality disorders or for abuse of or addiction to alcohol and drugs. But **under Tier 1**, this exclusion twenty-one (21) does not apply to services and supplies for detoxification.

22. Services and supplies furnished in connection with military service connected disabilities for which the person is legally entitled to services and for which facilities are reasonably available to the person.

23. Personal comfort and convenience items and services.

24. Services and supplies furnished in connection with Surgical Procedures for sex changes or for reversal of a previous voluntary sterilization Surgical Procedure.

25. **Under Tier 1:** For a Covered Person's pregnancy, services or supplies furnished outside the Service Area in connection with delivery after eight (8) months of gestation, unless it is a Medical Emergency. Refer to page 80, Important Note About Pregnancy, for more details.

26. **Under Tiers 2 and 3:** A charge for either of the following that involves either a Covered Person or a surrogate as a donor or recipient:

    (a) Actual or attempted impregnation.

    (b) Actual or attempted fertilization.

27. **Under Tier 1:** Services or supplies, or any charges for services or supplies, that are furnished:

    (a) by a Participating Health Care Provider or a Non-Participating Health Care Provider;

    (b) in connection with a Medical Emergency occurring inside or outside the Service Area; and

    (c) after the first forty-eight (48) hours following the onset of the Medical Emergency.

    But this item (27) will not apply if Prudential HealthCare or its designee is given notice of the emergency incident within those first forty-eight (48) hours and the service or supply is authorized by a Primary Care Physician. If, because of the patient's condition, it is not reasonably possible to give such notice within this time limit, Prudential HealthCare or its designee must be notified as soon as reasonably possible.

28. Chiropractic services.

29. Acupuncture services.

30. Prescription drugs prescribed for sexual dysfunction are excluded unless filled at a participating pharmacy.

31. A charge for a service or supply listed in items (1) through (30) above.

Also see Patient Care Management and Outpatient Precertification Program provisions on pages 116 and 121, respectively.

RULES FOR COORDINATION OF TIER 1 BENEFITS OF THE GROUP CONTRACT WITH OTHER PLANS

Under certain conditions, the benefits of the Group Health Care Coverage that would be provided for your or your qualified Dependent's health care may be reduced so that the total benefits from this Program and all other Programs (defined below) will not be more than the total Allowable Expenses (defined below). That reduction will be made only if these rules so state. This coordination

with other Programs helps to control the cost of benefits for everyone.

These rules for coordination apply to This Program, but only with respect to services and supplies furnished, or expenses incurred, on or after the date these rules take effect. “This Program" and other terms used in these rules are defined in Section A. Section B describes the effect of other health care benefits on those of the Group Contract, subject to Sections C, D and E.

A. DEFINITIONS

(1) Program: Any of these which provide benefits or services for, or by reason of medical, dental, vision care or treatment:

(a) Coverage under a governmental plan or required or provided by law. This does not include a state plan under Medicaid or Medi-Cal or any law or plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.

(b) Group insurance or other coverage for persons in a group, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. But this does not include school accident-type coverage for grammar school, high school, and college students.

For the purposes of these rules, each Program will be treated as one of these three (3) types of Programs:

(i) A Dental Program is one that mainly provides benefits or services for, or because of dental care or treatment.

(ii) A Vision Care Program is one that mainly provides benefits or services for, or because of vision care or treatment.

(iii) A Medical Program is one that mainly provides benefits or services for, or because of medical care or treatment, and is not a Dental Plan or a Vision Care Plan.

Separate Programs:

Each contract or other arrangement for coverage under (a) or (b) above is a separate Program. But each part of a contract or other arrangement for coverage that is a Dental Program, or a Medical Program is a separate Program.

Also, rules for coordination of benefits may apply only to part of a Dental Program, Vision Program, or Medical Program. If so, the part to which the rules apply is a separate Program from the part to which the rules do not apply.

(2) This Program: The part of the Group Contract that provides health care benefits.

The term This Program applies separately to each part of the Group Contract that is a Dental Program, Vision Care Program, or a Medical Program.

(3) Allowable Expense: For any Health Care Coverage described in the Evidence of Coverage, the Usual and Prevailing Charge for services or supplies which are needed and appropriately provided when the charge, service or supply is covered at least in part by one or more Medical Programs, or Vision Care Programs covering the person for whom claim is made.

"Usual and Prevailing Charge" and "needed and appropriately provided" have the same meanings as in the Generally Excluded Charges section and What Terms Mean section of this Evidence of Coverage.

For any Dental Expense Coverage described in the Evidence of Coverage, an Allowable Expense is the reasonable cash value for a reasonably necessary service or supply, when the charge, service or supply is covered at least in part by one (1) or more Dental Programs covering the person for whom claim is made.

When a Program, including This Program, provides benefits in the form of services, the reasonable cash value for each service rendered will be considered both an Allowable Expense and a benefit paid. When payment under a Program is based on a

contracted fee, that fee or the physician's usual charge, whichever is less, will be considered the Allowable Expense.

If a person covered by This Program has expenses for a stay in a Hospital private room, the term Allowable Expense does not include the difference between the charge for the Hospital private room and the Eligible Charge for a Hospital room under This Program, unless:

(a) the Hospital private room charges are a covered expense under one (1) of the Programs; or

(b) the person’s stay in a Hospital private room is medically necessary in terms of generally accepted medical practice.

The term Allowable Expense does not include any amount that is not payable under another Program because a person covered by This Program does not adhere to the Cost Containment Provisions of the other Program. This applies only if the other Program determines its benefits first.

Cost Containment Provisions are those provisions of a contract that are intended to reduce unnecessary medical care or to make medical services and supplies available at a reduced cost. Examples of Cost Containment Provisions include, but are not limited to, second surgical opinion programs, precertification programs, and preferred provider arrangements

(4) Claim Determination Period: A Calendar Year, but, for a person, this does not include any part while the person has no coverage under This Program or any part before the date these or similar rules take effect.

B. EFFECT ON BENEFITS

(1) **When this Section Applies:** This Section B. applies when the sum of the benefits in (a) and (b) below for a person's Allowable Expenses in a Claim Determination Period would be

more than those Allowable Expenses. In that case, the benefits of This Program will be reduced so that they and the benefits in (b) do not total more than those Allowable Expenses.

(a) The reasonable cash value of the benefits that would be provided for the Allowable Expenses under This Program in the absence of this Section B.

(b) The benefits that would be payable for the Allowable Expenses under all other Programs of the same type as This Program, in the absence of rules with a purpose like that of these rules, whether or not claim is made. But this (b) does not include the benefits of a Program if:

(i) It has rules coordinating its benefits with those of This Program; and

(ii) Those rules have Claim Determination Period and Facility of Payment items similar to those in these rules; and

(iii) Its rules and This Program's rules both require This Program to determine benefits before it does.

(2) **This Program's Rules for the Order in which Benefits are Determined:** When a person's health care is the basis for a claim, This Program determines its order of benefits using the first of the following rules that applies:

(a) **Non-dependent/Dependent:** The benefits of a Program that covers the person other than as a Dependent are determined before those of a Program that covers the person as a Dependent. But if the person is also covered under Medicare and, if, by its rules, Medicare is:

(i) secondary to the Program covering the person as a Dependent; and

(ii) primary to the Program covering the person as other than a Dependent.

Then the benefits of the Program covering the person as a Dependent are determined before those of the Program covering that person as other than a Dependent.

(b) **Dependent Child/Parents Not Separated or Divorced:** When this Program and another Program cover the same child as a Dependent of parents who are not legally separated or divorced:

(i) the benefits of the Program of the parent whose birthday falls earlier in the Calendar Year are determined before those of the Program of the parent whose birthday falls later in the Calendar Year; but

(ii) if both parents have the same birthday, the benefits of the Program which covered the parent longer are determined before those of the Program which covered the other parent for a shorter period of time.

However, if the other Program does not have this rule (b), and if, as a result, the Programs do not agree on the order of benefits, the rule in the other Program will determine the order of benefits.

(c) **Dependent Child/Separated or Divorced Parents:** If two (2) or more Programs cover a person who is a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

(i) first, the Program of the parent with custody of the child;

(ii) then, the Program of the spouse of the parent with custody of the child; and

(iii) finally, the Program of the parent not having custody of the child.

However, the following exceptions apply:

(A) If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Program of that parent has actual knowledge of those terms, the benefits of that Program are determined first. This paragraph does not apply when any benefits are actually paid or provided before the entity has that actual knowledge.

(B) If the specific terms of a court decree state that the parents shall share joint custody, without stating that one (1) of the parents is responsible for the health care expenses of the child, benefits for the child are determined in accordance with rule B.(2)(b) above.

(d) **Active/Inactive Employee:** The benefits of a Program which covers a person as an Employee who is neither laid off nor retired, or as that Employee's Dependent, are determined before those of a Program which covers that person as a laid off or retired Employee or as that Employee's Dependent. If the other Program does not have this rule, and if, as a result, the Programs do not agree on the order of benefits, this rule (d) is ignored.

(e) **Continuation Coverage:** If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Program, benefits for the person are determined in this order:

(i) first, the benefits of the Program covering the person as an Employee, or as that person's Dependent;

(ii) second, the benefits under the continuation coverage.

If the other Program does not have this rule, and if, as a result, the Programs do not agree on the order of benefits, this rule (e) is ignored.

(f) **Longer/Shorter Length of Coverage:** If none of the above rules determine the order of benefits, the benefits of the Program which covered an Employee longer are determined before those of the Program which covered the Employee for the shorter time.

(3) **Effect of Reduction in Benefits:** When these rules reduce This Program's benefits, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Program.

C. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply these coordination of benefits rules. Prudential Health Care Plan of California, Inc. has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Prudential Health Care Plan of California, Inc. need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Program must give Prudential Health Care Plan of California, Inc. any facts it needs to pay the claim.

D. FACILITY OF PAYMENT

A payment made under another Program may include an amount for a benefit which should have been provided under This Program. If it does, Prudential Health Care Plan of California, Inc. may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit provided under This Program. Prudential Health Care Plan of California, Inc. will have no further liability with respect to that amount. The term "payment made" includes providing benefits in the form of services, in which case the payment made shall be deemed to be the reasonable cash value of any benefits provided in the form of services.

E. RIGHT OF RECOVERY

If the reasonable cash value of the benefits provided by Prudential Health Care Plan of California, Inc. is more than the reasonable cash value it should have provided under This Program, it may recover the excess. It may get such recovery or payment from one (1) or more of:

(1) the persons to whom or for whom it has provided such benefits;

(2) insurance companies; or

(3) other organizations.

RULES FOR COORDINATION OF TIER 2 AND TIER 3 BENEFITS OF THE GROUP CONTRACT WITH OTHER PLANS

The purpose of a group health care program is to help you pay for covered expenses, but not to result in total benefits greater than the covered expenses incurred. Thus, the Group Contract's benefits that, without these rules, would be payable for your or your qualified Dependent's health care expenses may be reduced so that the total benefits from this and all of the other Programs (defined below) will not be more than the total Allowable Expenses (defined below). That reduction will be made only if these rules so state. This coordination with other Programs helps to control the cost of benefits for everyone.

These rules for coordination apply to This Program, but only with respect to expenses incurred on or after the date these rules take effect. “This Program" and other terms used in these rules are defined in Section A. Section B. describes the effect of other health care benefits on those of the Group Contract, subject to Sections C., D. and E.

A. DEFINITIONS

(1) Program: Any of these which provide benefits or services for, or by reason of, medical, dental or vision care or treatment:

   (a) Coverage under a governmental plan or required or provided by law. This does not include a state plan under Medicaid or any law or plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.

(b) Group insurance or other coverage for persons in a group, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. But this does not include school accident-type coverage for grammar school, high school, and college students.

For the purposes of these rules, each Program will be treated as one of these three (3) types of Programs:

A Dental Program is one (1) that mainly provides benefits or services for, or because of, dental care or treatment.

A Vision Care Program is one (1) that mainly provides benefits or services for, or because of, vision care or treatment.

A Medical Program is one (1) that mainly provides benefits or services for, or because of, medical care or treatment, and is not a Dental Program or a Vision Care Program.

Separate Programs:

Each contract or other arrangement for coverage under (a) or (b) is a separate Program. But each part of a contract or other arrangement for coverage that is a Dental Program, a Vision Care Program, or a Medical Program is a separate Program.

Also, rules for coordination of benefits may apply only to part of a Dental Program, Vision Care Program, or Medical Program. If so, the part to which the rules apply is a separate Program from the part to which the rules do not apply.

(2) This Program: The part of the Group Contract that provides benefits for health care expenses.

The term “This Program" applies separately to each part of the Group Contract that is a Dental Program, a Vision Care Program, or a Medical Program.

(3) Allowable Expense: For any health care expense insurance Coverages described in the Booklet, the Usual and Prevailing

charge for a needed service or supply, when the charge, service or supply is covered at least in part by one (1) or more Medical Programs or Vision Care Programs covering the person for whom claim is made. “Usual Charge", “Prevailing Charge" and “needed service or supply" have the same meanings as in the Generally Excluded Charges.

For any dental expense insurance Coverage described in the Booklet, an Allowable Expense is the usual and prevailing charge for a reasonably necessary service or supply, when the charge, service or supply is covered at least in part by one (1) or more Dental Programs covering the person for whom claim is made. “Usual Charge" and “Prevailing Charge" have the same meanings as described in the dental expense insurance Coverage.

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

If a person covered by This Program has expenses for a stay in a Hospital private room, the term Allowable Expense does not include the difference between the charge for the Hospital private room and the Eligible Charge for a Hospital room under This Program, unless:

(a) the Hospital private room charges are a covered expense under one of the Programs; or

(b) the person's stay in a Hospital private room is medically necessary in terms of generally accepted medical practice.

The term Allowable Expense does not include any amount that is not payable under another Program because a person covered by This Program does not adhere to the Cost Containment Provisions of the other Program. This applies only if the other Program determines its benefits first.

Cost Containment Provisions are those provisions of a contract that are intended to reduce unnecessary medical care or to make medical services and supplies available at a reduced cost. Examples of Cost Containment Provisions include, but

are not limited to, second surgical opinion programs, precertification programs, and preferred provider arrangements.

(4) Claim Determination Period: A Calendar Year, but, for a person, this does not include any part while the person has no coverage under This Program or any part before the date these or similar rules take effect.

B. EFFECT ON BENEFITS

(1) **When this Section Applies:** This Section B. applies when the sum of the benefits in (a) and (b) below for a person's Allowable Expenses in a Claim Determination Period would be more than those Allowable Expenses. In that case, the benefits of This Program will be reduced so that they and the benefits in (b) do not total more than those Allowable Expenses.

   (a) The benefits that would be payable for the Allowable Expenses under This Program in the absence of this Section B.

   (b) The benefits that would be payable for the Allowable Expenses under all other Programs of the same type as This Program, in the absence of rules with a purpose like that of these rules, whether or not claim is made. But this (b) does not include the benefits of a Program if:

      (i) It has rules coordinating its benefits with those of This Program; and

      (ii) Those rules have Claim Determination Period and Facility of Payment items similar to those in these rules; and

      (iii) Its rules and This Program's rules both require This Program to determine benefits before it does.

(2) **This Program's Rules for the Order in which Benefits are Determined:** When a person's health care is the basis for a claim, This Program determines its order of benefits using the first of the following rules that applies:

(a) **Non-dependent/Dependent:** The benefits of a Program that covers the person other than as a Dependent are determined before those of a Program that covers the person as a Dependent. But if the person is also covered under Medicare and, if, by its rules, Medicare is:

(i) secondary to the Program covering the person as a Dependent; and

(ii) primary to the Program covering the person as other than a Dependent.

Then the benefits of the Program covering the person as a Dependent are determined before those of the Program covering that person as other than a Dependent.

(b) **Dependent Child/Parents Not Separated or Divorced:** When this Program and another Program cover the same child as a Dependent of parents who are not legally separated or divorced:

(i) the benefits of the Program of the parent whose birthday falls earlier in the calendar year are determined before those of the Program of the parent whose birthday falls later in the calendar year; but

(ii) if both parents have the same birthday, the benefits of the Program which covered the parent longer are determined before those of the Program which covered the other parent for a shorter period of time.

However, if the other Program does not have this rule (b), and if, as a result, the Programs do not agree on the order of benefits, the rule in the other Program will determine the order of benefits.

(c) **Dependent Child/Separated or Divorced Parents:** If two (2) or more Programs cover a person who is a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

(i) first, the Program of the parent with custody of the child;

(ii) then, the Program of the spouse of the parent with custody of the child; and

(iii) finally, the Program of the parent not having custody of the child.

However, the following exceptions apply:

(A) If the specific terms of a court decree state that one (1) of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Program of that parent has actual knowledge of those terms, the benefits of that Program are determined first. This paragraph does not apply when any benefits are actually paid or provided before the entity has that actual knowledge.

(B) If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, benefits for the child are determined in accordance with rule B.(2)(b) above.

(d) **Active/Inactive Employee:** The benefits of a Program which covers a person as an Employee who is neither laid off nor retired, or as that Employee's dependent, are determined before those of a Program which covers that person as a laid off or retired Employee or as that Employee's dependent. If the other Program does not have this rule, and if, as a result, the Programs do not agree on the order of benefits, this rule (d) is ignored.

(e) **Continuation Coverage:** If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Program, benefits for the person are determined in this order:

(i) first, the benefits of the Program covering the person as an Employee, or as that person's Dependent;

(ii) second, the benefits under the continuation coverage.

If the other Program does not have this rule, and if, as a result, the Programs do not agree on the order of benefits, this rule (e) is ignored.

(f) **Longer/Shorter Length of Coverage:** If none of the above rules determine the order of benefits, the benefits of the Program which covered an Employee longer are determined before those of the Program which covered the Employee for the shorter time.

(3) **Effect of Reduction in Benefits:** When these rules reduce This Program's benefits each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Program.

C. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply these coordination of benefits rules. Prudential HealthCare has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Prudential HeathCare need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Program must give Prudential HealthCare any facts it needs to pay the claim.

D. FACILITY OF PAYMENT

A payment made under another Program may include an amount which should have been paid under This Program. If it does, Prudential HealthCare may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Program. Prudential HealthCare will not have to pay that amount again. The term “payment made" includes providing benefits in the form of services, in which case the payment made shall be deemed to be the reasonable cash value of any benefits provided in the form of services.

E. RIGHT OF RECOVERY

If the amount of the payments made by Prudential HealthCare is more than it should have paid under This Program, it may recover the excess. It may get such recovery or payment from one or more of:

(A) the persons it has paid or for whom it has paid;

(B) insurance companies; or

(C) other organizations.

The “amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

HOW TO FILE A CLAIM

REIMBURSEMENT RULES UNDER TIER 1

These rules apply to charges made to a Covered Person for covered Eligible Services and Supplies furnished to the Covered Person by a Non-Participating Health Care Provider in connection with a Medical Emergency.

Filing Claim for Reimbursement: To obtain payment you should submit a claim for reimbursement, in writing, within one hundred twenty (120) days after you receive Medical Emergency care. Failure to submit a claim within the time required shall not invalidate nor reduce any claim if it was not possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.

Claim forms can be obtained from your Employer. Fully complete and sign the claim form and attach itemized bills.

Each bill should show:

(a) Patient's full name.

(b) Date or dates the service was furnished or purchase was made.

(c) Nature of the Medical Emergency.

(d) Type of service or supply furnished.

(e) Itemized charges.

If you need assistance in filing a claim, please call Member Services at **(800) 313-3804**

The completed claim form should be sent to the appropriate claim office.

Prudential HealthCare
P.O. Box 54280
Los Angeles, California 90054-0280

When Benefits are Paid: Benefits are paid when Prudential HealthCare receives written proof of the claim.

All benefits for charges for a covered service or supply under the Plan will be paid by Prudential HealthCare to the provider of the service or supply, except as stated below. If you furnish Prudential HealthCare with satisfactory evidence that payment has been made to that provider for those charges, benefits for those charges will be paid to you. But if Prudential HealthCare has paid the benefits to the provider before it receives such evidence, Prudential HealthCare will not have to pay that amount again.

A benefit that is payable to you in accordance with the above paragraph but remains unpaid at the time of your death will be paid to your estate.

Note: For information on the Member Grievance/Appeals process for Tier 1 services, please refer to that section on page 73.

Legal Action: No action at law or in equity may be brought to recover on the Plan until sixty (60) days after the written proof of the claim is furnished. No such action may be brought more than three (3) years after the end of the time permitted for the filing of a claim.

ALTERNATE BENEFIT PAYMENT

Under all Tiers, whenever a law or court order requires coverage of health care expense benefits under the Group Contract of a person, coverage will be provided according to that law or court order.

HOW TO FILE A CLAIM UNDER SELF-COORDINATED CARE (TIER 2)

UC Care Provider Directory

The UC Care provider directory has been prepared for your geographic area to identify physicians and hospitals participating in the Preferred Provider Organization. The directories are distributed to all participating providers and new enrollees. The directory is updated periodically. You may obtain future copies of the directory from your Benefits Office.

Making Appointments

Be sure to identity yourself as a Preferred Provider Organization participant when making an appointment. In addition, if hospital admission is required, be sure to identify your Preferred Provider Organization participation at the time of admission and notify the hospital of your Patient Care Management requirement, if you have not already received prior authorization from PCM. Also, notify your doctor of your Outpatient Precertification Program requirement.

Filing a Claim

To obtain payment you should submit a claim for reimbursement, in writing, within one hundred twenty (120) days after you receive medical care. Failure to submit a claim within the time required shall not invalidate nor reduce any claim if it was not possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.

Complete, date and sign the claim form. To assure prompt payment, please be sure all questions are answered.

Your physician may complete the Attending Physician's Statement on the back of the claim form, or you may send the itemized physicians' bills to Prudential.

For hospital claims, sign the Assignment of Benefits form provided by the hospital and the hospital will submit the claim on your behalf.

The providers will bill their normal fees and Prudential will make the necessary adjustments to reflect the Preferred Provider Organization amount.

- These Claim Rules also apply to Prudential HealthCare when you do not obtain authorization from your Primary Care Physician.

  Prudential HealthCare
  P.O. Box 54280
  Los Angeles, California 90054-0280
  Telephone: (800) 313-3804

Claim Payment

All claims should be assigned to the providers, if possible. The assignment ensures the provider will receive a copy of the Explanation of Benefits to facilitate correct billing of any deductible and copayment. If the claim does not contain an assignment of benefits the provider will not receive a copy of the Explanation of Benefits.

You will receive a copy of the Explanation of Benefits which shows the Preferred Provider Organization adjustment. Your liability is the difference between the adjusted Total Charges and the Benefit Payment. In addition, you are responsible for any non-covered items, such as: television, telephone, etc. Also, if you do not comply with an Outpatient Precertification Program (OPP) or Patient Care Management (PCM) Program, you are financially responsible for that excluded amount.

Questions and claim submissions should be directed to:

Prudential HealthCare
P.O. Box 54280

Los Angeles, California 90054-0280
Telephone: (800) 313-3804

HOW TO FILE A CLAIM UNDER SELF-COORDINATED CARE (TIER 3)

It is to your advantage to file a claim as soon as eligible expenses are incurred. Claims for eligible expenses should be filed within one hundred-twenty (120) days of the date the service or supply is received. Failure to submit a claim within the time required shall not invalidate nor reduce any claim if it was not possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Claim forms are available from your Benefits Representative or from Prudential. In addition, if hospital admission is required, be sure to notify the hospital of your Patient Care Management requirement, if you have not already received prior authorization from PCM. Also, notify your doctor of your Outpatient Precertification Program requirement. Here are the steps to follow:

1. Complete the Patient & Employee Information section of the form. Use a separate form for each family member. Be sure to answer all questions.

2. Have the doctor complete the Physician or Supplier Information statement on the form, and/or attach itemized bills. In case of multiple doctors, use the one who rendered the most service. In case of surgery, use the primary surgeon.

3. This information must be shown on all bills:

   - Name of patient
   - Type of service rendered
   - Date of service rendered
   - Amount charged for each service provided
   - Diagnosis

4. Please keep a copy of all bills for your records.

5. For hospital admission, present your Identification Card to the admission clerk who may confirm your benefits by contacting the office listed below. Notify the admission clerk of your Patient Care Management (PCM) requirement, if you have not already received prior authorization from PCM.

Send your completed claim form and all bills and receipts to:

Prudential HealthCare
P.O. Box 54280
Los Angeles, California 90054-0280
Telephone: (800) 313-3804

CLAIM REVIEW

You should receive timely written notification from Prudential HealthCare whether benefits will be received under the Plan. Once you have provided all required information, if Prudential HeathCare needs more time to make a determination, you will be notified within ninety (90) days and an explanation of the delay will be provided by Prudential HealthCare. No more than an additional ninety (90) days will be required to process the claim.

IF A CLAIM IS DENIED

If a claim is denied, in whole or in part, you or your authorized representative will receive a written notice from Prudential HealthCare . The written notice will include:

- the specific reason or reasons for the denial

- reference to the pertinent plan provision upon which the denial is based.

- a description of any additional material or information necessary to process the claim and an explanation of why such material or information is needed.

Prudential HealthCare will send you the written notice within ninety (90) days of the date it receives your claim, unless special circumstances require an extension of time for processing the claim. If an extension of time is required, Prudential HealthCare will notify you in writing before the end of the initial ninety (90)-day period. If you are not notified at all within the ninety (90)-day period, this may be considered a claim denial for the purpose of the Claim Denial Appeal and Review Procedures below.

When you receive a written notice of claim denial (or if your claim is considered denied because you are not notified at all within the initial ninety (90)-day period), you are then entitled, upon request, to a review of the claim denial by Prudential HealthCare.

Your request for a review of the claim denial must be made in writing to:

Prudential HealthCare
P.O. Box 54280
Los Angeles, California 90054-0280
Telephone: (800) 313-3804

Your request must be made within ninety (90) days of the date of the written notice of claim denial. With your request, you may submit issues and comments in writing regarding your claim.

Your claim denial appeal will be reviewed and decided upon by Prudential HealthCare. Prudential HealthCare has sixty (60) days from the date the formal request for review is received to reply in writing to you stating the specific reasons for its decision and specific references to pertinent Plan provisions. Again, circumstances may require Prudential HealthCare to use additional time to evaluate your request. No more than an additional sixty (60)

days may be used in this case, and you will be notified before the end of the initial sixty (60) day period if the extension of time is needed and why. Prudential HealthCare's decision is final.

CLAIM FRAUD

When filing a claim, it is fraudulent to knowingly provide false information or omit relevant facts. Criminal and/or civil penalties can result from such acts.

SECTION III

PRUDENTIAL HEALTHCARE

(Point-of-Service Prescription Drug Benefits)

YOUR UC CARE PRESCRIPTION DRUG BENEFITS AT A GLANCE

Plan Feature	Retail Pharmacy Benefit Prudential HealthCare.	Mail Service Benefit Integrated Pharmacy Solutions, Inc.
When to Use	Short-term prescription drugs (up to a 30-day supply)	Long term prescription (up to a 90-day supply)
Cost to you (copay)	**At a Participating Pharmacy** You pay lesser of the actual price or $10 per generic prescription, and $20 per brand prescription (when there is no generic equivalent). You'll receive generic medication unless your physician has indicated that a brand name drug is medically necessary. If your physician has indicated that a brand name drug is medically necessary, you pay $20. If you request a brand name, you pay $10 plus the difference in cost between brand name and generic. **At a Non-Participating Pharmacy** If you purchase your prescription from a non-participating pharmacy, you must pay the full cost of the prescription at the time of purchase and then submit a medical claim form to Prudential HealthCare for reimbursement. You will be reimbursed at 80% for Eligible	$25 per generic prescription $35 per brand name prescription You'll receive generic medication unless your physician has indicated that a brand name drug is medically necessary or you request a brand name drug. If your physician has indicated that a brand name drug is medically necessary or you request a brand name drug, you pay $35.
Plan Feature	Retail Pharmacy Benefit	Mail Service Benefit

YOUR UC CARE PRESCRIPTION DRUG BENEFITS AT A GLANCE

	Prudential HealthCare	Integrated Pharmacy Solutions, Inc.
	Charges, after you satisfy an annual prescription drug deductible of $50 per individual or $150 per family.	
Claim form required?	**At a Participating Pharmacy:** No **At a Non-Participating Pharmacy:** Yes	No
Customer Service	1-800-313-3804	1-800-732-2165

	TIER 1 PLAN PAYS	TIER 2 PLAN PAYS	TIER 3 PLAN PAYS
Diabetic Supplies	100% (1)	100% (1)	100% (1)
Medical Supplies (excluding Diabetic Supplies)	100%	80%	80%
Injectable Medications (other than Insulin)	100% (1)(2)	100% (1)(2)	100% (1)(2)

(1) Benefit is 100% if purchased at a participating pharmacy, otherwise the benefit is 80% after an annual $50 individual/$150 family deductible.

(2) Requires Pre-authorization.

PRESCRIPTION DRUG BENEFITS

Employees, Annuitants and their Dependents who are covered under the UC Care Medical Plan are automatically covered for prescription drug benefits. The prescription drug retail benefits are administered by Prudential HealthCare. The mail service prescription drug benefits are provided by Integrated Pharmacy Solutions, Inc.

You may receive your prescription drugs from participating pharmacies with whom Prudential HealthCare has made special arrangements to provide you with covered services or, if you prefer, from non-participating pharmacies. Generally, for most covered services from non-participating pharmacies, the plan pays lower benefits. Please see page 159 for more information. You may also receive your mail service prescription drugs from Integrated Pharmacy Solutions, Inc.

Prescriptions filled during a stay in a hospital or convalescent nursing home (skilled nursing facility) are covered under the UC Care Plan's Medical/Hospital/Surgical benefits.

Understanding Your Prescription Drug Benefits

The UC Care Prescription Drug benefits have been designed to cover a wide range of prescription drug services while keeping your costs affordable.

The Plan keeps your costs affordable by charging a copayment. A copayment is a specified portion of the eligible charge that is not paid as a benefit under this plan for covered services. You owe this amount to the provider of the services.

As specified in this document, a prescription drug is a medication which is under Federal control, and by Federal law can only be dispensed upon a physician's prescription. However, if a particular medication is available as both a prescription drug and a nonprescription drug (i.e., with the same ingredients and strength), then that drug is not considered a prescription drug under this plan.

A generic drug is medication which is prescribed or dispensed under its commonly used generic (chemical) name and which is no longer protected by patent laws. Generic equivalent medications contain the same active ingredients and are subject to the same rigid FDA standards for quality, strength and purity as their brand name counterparts. Generally, a generic drug costs less than a brand name drug. Please ask your doctor to prescribe generic drugs whenever appropriate.

A brand name drug is a medication which is marketed under its distinctive trade name and which is, or at one time was, protected by patent laws.

Knowing what services the plan covers and using them only as needed are ways of making the most effective use of your plan. When you need prescription drugs, talk to your physician about different drugs, and generic or brand-name drugs, and their cost. Together you and your physician can make the right decisions about your health care.

CHOICE OF PRESCRIPTION DRUG PROVIDERS

You may use any pharmacy you choose and receive coverage under this plan. However, we suggest that you choose a Prudential HealthCare participating pharmacy or Integrated Pharmacy Solutions, Inc., the mail service pharmacy, to receive the maximum benefits of this plan.

RETAIL PHARMACIES

Use your local participating pharmacy for your short term, acute prescription drug needs. The plan will cover up to a thirty (30)-day supply per prescription or refill at a retail pharmacy. A refill may be obtained, as allowed by the prescribing physician, when ten (10) days or less remain on your prescription. If you are planning a trip, please read the section called “Planning For Prescription Needs When Traveling.”

Participating Pharmacies

Prudential HealthCare has contracted with retail pharmacies throughout the country to provide you with the prescription drug services covered under this plan. When you use a participating pharmacy, we send the provider the benefit payment and you owe only the copayments shown in this booklet. When you use participating pharmacies you do not have to file a claim form.

To use a participating pharmacy:

1. Present your UC Care ID Card and your original prescription(s) to the pharmacist.
2. The pharmacist will tell you the amount to pay. There are no claim forms to file.

To locate a participating pharmacy, use one of the following methods:

- Refer to your participating pharmacy directory provided at the time of enrollment. If you require an additional copy, please call Customer Service at the number below for more information.
- Call UC Care Customer Service number: 1-800-313-3804.
- An At-a-Glance listing of nationally participating chain pharmacies can also be accessed through the internet by visiting **www.aetnaushc.com/pruhealthcare.**

Non-Participating Pharmacies

When you purchase your prescriptions at a non-participating pharmacy, you will be required to pay in full and submit a medical claim form to Prudential HealthCare. You'll be reimbursed for 80% of Eligible Charges, after you satisfy an annual $50 per individual or $150 per family prescription drug deductible.

To use a non-participating pharmacy:

1. Present your original prescription(s) to the pharmacist.
2. Pay the pharmacy's full, regular price. Obtain a prescription drug receipt (not a cash register receipt).
3. Fill out a medical claim form, attach the receipt(s) and mail to Prudential HealthCare at the following address:

   Prudential HealthCare
   P.O. Box 54280
   Los Angeles, California 90054-0280

4. Your reimbursement will be based on 80% of Eligible Charges, after you satisfy an annual $50 per individual or $150 per family prescription drug deductible.

Claims Outside of the United States

It is important to consider prescription needs well in advance of traveling to receive the maximum benefits of this plan. If you are planning to travel outside of the United States, please read the section called "Planning For Prescription Needs When Traveling." For eligible prescriptions filled outside the United States, you'll receive the same benefits as if you had purchased prescriptions at a non-participating pharmacy in the United States. To be eligible for reimbursement, a prescription must be a U.S. Food and Drug Administration (FDA) approved drug. Pay in full for your prescription and submit a medical claim form with the prescription drug receipts to Prudential HealthCare. The claim will be reimbursed at 80% after deductible, based on the U.S. dollar conversion rate on the date the prescription was filled.

MAIL SERVICE

Mail Service should be used to purchase medications that are prescribed on an ongoing, long-term basis. You may order up to a ninety (90)-day supply of medication with up to three (3) refills (as prescribed by your physician) from Integrated Pharmacy Solutions, Inc. The copayment schedule is detailed on page 155. A mail order prescription may be refilled as allowed by the prescribing physician. Refills may be requested when twenty-two (22) days or less remain on a prescription. If you are planning a trip, please read the section

called “Planning For Prescription Needs While Traveling.” **Please note: All Mail Service prescriptions must be written by a physician in the United States, and can only be mailed to a United States address.**

To obtain a ninety (90)-day supply of medication, your physician must write your prescription for a quantity equal to ninety (90) days with the appropriate refills. For example, if you are taking two pills a day, your physician should write a prescription for one hundred eighty (180) pills: your physician should also indicate the number of allowable refills. Please note that if your prescription is written for a thirty (30)-day supply, Integrated Pharmacy Solutions, Inc. must dispense the lesser quantity -- you will still be responsible for the $25 or $35 copayment for that prescription. Certain controlled substances and other medications are subject to dispensing limitations due to Federal limitations, manufacturer’s limitations, or due to the professional judgment of the pharmacist.

To use the mail service:

1. If you need to take medication on a regular basis, ask your doctor to write a new prescription for up to a ninety (90)-day supply, with as many as three (3) refills. If your doctor prescribes a long term medication that you need to begin taking immediately, you may still use the mail order service program. Just ask your doctor for two (2) prescriptions; (1) one prescription that you can fill at a participating pharmacy until your mail order service comes in, and a second prescription to send to Integrated Pharmacy Solutions, Inc.
2. Mail the original copy of the prescription, the completed Prescriptions by Mail Program Order Form (if you haven’t already done so) and the applicable copayment in the special pre-addressed order envelope. You may pay by check or money order, or charge your order to your Mastercard ® , VISA ®, American Express ®, or DISCOVER ® card. Order envelopes may be obtained by calling Customer Service at 1-800-732-2165.
3. Your medication will be mailed to you via U.S. Mail or Airborne Express along with instructions for future refills, if applicable. Please allow approximately fourteen (14) days for delivery from the date your order is received by Integrated

Pharmacy Solutions, Inc. A leaflet explaining the purpose of the drug, correct dosages and other helpful information will also be included.

4. If you are requesting a brand name drug, be sure to indicate this request on your order envelope and include the appropriate copayment. Integrated Pharmacy Solutions, Inc. will dispense quality generics where medically appropriate unless you or your physician indicates that a brand name drug is necessary.
5. You may call in your prescription refills and charge them to your Mastercard ® , VISA ®, American Express ® or DISCOVER ® account. To do so, call Customer Service at 1-800-732-2165. Please note: by Federal law, certain controlled substances can not be refilled. A new prescription would be required for each order.
6. The fastest way to request refills, and to check on the status of your order is to utilize the Interactive Voice Response (IVR) feature by calling Integrated Pharmacy Solutions, Inc. Customer Service. Be sure to have on hand the following: your member ID number, the prescription number (it's the twelve (12)-digit number on your refill slip) and your credit card number and expiration date.

PLANNING FOR PRESCRIPTION NEEDS WHEN TRAVELING

It is important to consider prescription needs well in advance of traveling. The following options are available to UC Care members:

Mail Order

Mail Order is the safest and most reliable means for members to ensure that their prescription drug travel needs are met. You can order up to a ninety (90)-day supply of the prescription, when twenty-two (22) days or less of the prescription remain. For extensive travel **out of the country**, you can submit an explanation of the need for an extended supply with a new mail order prescription and receive up to a one (1) year supply of prescription drugs. Include the days supply needed, where you are traveling, and when you expect to leave and to return. Please allow two (2) weeks to receive your prescription. A prescription can only be shipped to an address

within the U.S. In the event you have not allowed enough time for ordering, you can arrange to have the prescription shipped to a friend or relative within the U.S.

Retail Pharmacy

You can routinely obtain a prescription from your physician and refill it, as allowed by the prescribing physician, at a participating pharmacy when there are ten (10) days or less of the prescription remaining. An additional thirty (30)-day supply may be obtained by calling UC Care Customer Service and requesting a "vacation override." You will be asked to provide an explanation of the need for the extended supply.

General Benefit Plan Exclusions

1. The Plan does not contain a Coordination of Benefits provision, i.e., the Plan does not cover secondary reimbursement of prescription drugs.

2. Replacements for lost, stolen, or misplaced prescription drugs are not covered.

BENEFITS FOR COVERED PRESCRIPTION DRUGS

Participating Retail Pharmacies

At participating pharmacies you pay the lesser of the actual price or $10 per prescription. You'll receive a generic drug if one (1) is available unless your physician has indicated on the prescription that a brand-name drug is medically necessary. If your physician has indicated on the prescription that a brand-name drug is medically necessary, the copay will be $20. Otherwise, if you purchase a brand-name drug when a generic drug is available, you will be responsible for the price difference between the brand-name drug and generic drug plus the $10 copayment. The copayment for a prescription drug with no generic equivalent is $20. You are not required to file a claim form when using a participating pharmacy.

Non-Participating Pharmacies

At non-participating pharmacies you'll be required to pay the pharmacy's full, regular price and then submit a medical claim form to Prudential HealthCare for reimbursement. You will be reimbursed at 80% for Eligible Charges, after you satisfy an annual prescription drug deductible of $50 per individual or $150 per family.

The Mail Service Benefit

When you order your prescriptions from Integrated Pharmacy Solutions, Inc., your cost is $25 per generic prescription and $35 per brand-name prescription. If a generic drug is available it will be dispensed unless you request or your physician indicates that a brand name drug is medically necessary. In this event the copay will be $35.

PRESCRIPTION DRUG COVERAGE, DISPENSING LIMITATIONS AND EXCLUSIONS

This Coverage pays benefits for eligible outpatient Prescription Drugs and Maintenance Drugs furnished for the medical care of your or your Dependent's Sickness or Injury.

WHAT TERMS MEAN

"Prescription Drug" means only: (1) an FDA-approved medicinal substance that, by Federal law, can be dispensed only by a prescription; (2) a compound medication that includes a substance described in (1); (3) prescribed injectable insulin and insulin syringes. It does not include allergy and biological sera; injectables, other than prescribed injectable insulin; or therapeutic devices or appliances, such as: heating pads; thermometers; walkers; and durable medical equipment.

"Outpatient Prescription Drug" means a Prescription Drug furnished other than during a stay in a Hospital or other institution as a registered bed patient.

“Maintenance Drug” means only a Prescription Drug used for the treatment of the following chronic medical conditions; Chronic obstructive pulmonary disease; clotting disorders; congestive heart failure; coronary artery disease (angina); diabetes (oral agents only); glaucoma; hypertension; thyroid disease; seizure disorders; and others as determined by Prudential HealthCare.

“Brand Name Drug” means a drug that is customarily recognized throughout the pharmacist’s profession as the original or trademarked preparation of a drug entity and for which the food and Drug Administration (FDA) has given New Drug Application (NDA) approval.

“Generic Drug” means a drug product which is pharmaceutically equivalent and bioequivalent to another drug product which is customarily recognized as the brand name product by the FDA and throughout the pharmacist’s profession. A drug is pharmaceutically equivalent to another drug if it contains identical amounts of the same active drug ingredients in the same dosage form. A drug is bioequivalent to another drug if a given amount of a drug has demonstrated comparable bioavailability when tested under similar conditions.

“Formulary” means a list of medications determined to be safe and effective that is regularly reviewed and updated to reflect current medical standards of drug therapy. When one (1) or more equivalent drugs or brands of drugs exist that reflect current medical standards of drug therapy, the Formulary need not include more than one such drug or brand.

“Participating Pharmacy” means a licensed and registered pharmacy operated by Prudential HealthCare or with whom Prudential HealthCare has a signed pharmacy service agreement.

"Participating Mail Order Drug Program" means a program agreed to by Prudential HealthCare and a Participating Pharmacy under which a Covered Person can obtain Maintenance Drugs or oral contraceptive drugs from the Pharmacy through the mail by placing a mail order.

A. ELIGIBLE CHARGES

A charge is an Eligible Charge if it is made for a Prescription Drug, an oral contraceptive drug or a Maintenance Drug that meets all of these conditions:

(1) It is prescribed by a Participating Physician or non-participating Physician and dispensed by a Participating Pharmacy.

(2) It is furnished while the person is covered under Prudential HealthCare's Prescription Drug Benefits.

(3) It is not excluded by the Charges Not Covered section below. However, a Prescription Drug will be considered medically necessary when its purpose is to prevent conception.

B. DISPENSING LIMITATIONS

Solely for the purpose of determining the Copayments that apply to a prescription or a refill of a prescription, each of the following will be considered a separate prescription or refill of a prescription:

(1) up to a thirty (30)-day supply of an original or refill prescription of an oral medication, an oral contraceptive drug or an oral Maintenance Drug furnished through a Participating Pharmacy; or

(2) up to a ninety (90)-day supply of an original or refill prescription of an oral contraceptive drug or a Maintenance Drug furnished through a Participating Mail Order Drug Program; or

C. CHARGES NOT COVERED.

The following are not covered under Prudential HealthCare's Prescription Drug Benefits:

(1) A prescription or prescription refill for an oral contraceptive drug or a Maintenance Drug that is more than (a) the amount prescribed by the doctor or (b) a ninety (90)-day supply.

(2) A prescription or prescription refill for all other drugs that is more than (a) the amount prescribed by the doctor or (b) a thirty (30) day supply.

(3) Certain Prescription Refills: A prescription refill that is:

(a) dispensed more than twelve (12) months after the date of the physician's original order of the Prescription Drug; or

(b) dispensed more than ten (10) days before the date the prior prescription or refill would be consumed when taken as directed, except in those circumstances in which Prudential HealthCare determines that a refill should for medically appropriate reasons be dispensed at an earlier time. Call Member Services to arrange for a refill to be dispensed at an earlier time. This item (b) does not apply to oral contraceptive drugs and Maintenance Drugs furnished through a Participating Mail Order Drug Program.

(4) Certain Prescription Drugs: A Prescription Drug that is prescribed for injectable use, other than injectable insulin or prescription only.

(5) Allergy and Biological Sera and Oxygen.

(6) Therapeutic Devices or Appliances, including durable medical equipment (e.g., diabetic blood glucose testing machines and insulin pump).

(7) Products for aging of the skin: all products used to prevent aging of the skin.

(8) Cosmetic and Dietary Aids: Cosmetic products, health or beauty aids, depigmenting or repigmenting agents, and dietary or nutritional products.

(9) Blood and blood products.

(10) Experimental or investigational: any drug labeled “Caution: limited by Federal Law to Investigational Use.” or considered or experimental or investigational by Prudential HealthCare.

(11) Contraceptive devices and implants.

(12) Over-the-counter (OTC) Medications: OTC drugs (except insulin) which can be obtained without a prescription or have a prescription equivalent.

(13) Hair Loss: Drugs used in the treatment of hair loss.

(14) Homeopathic medications.

(15) Services and Supplies included in the Generally Excluded Charges beginning on page 123.

PRIOR AUTHORIZATION

Prior Authorization requirements are administered by Prudential HealthCare for a limited number of oral, nasal and topical medications (e.g., weight loss medications, dermatology agents, etc.) which have a propensity to be improperly or inappropriately prescribed. For these drugs, your physician must first call Prudential HealthCare to discuss the purpose of using the drug. The primary, but not only, purpose of Prior Authorization is to determine that the drug’s use is medically necessary. If the drug is medically necessary, this process will allow us to put a special note in the claim system used by Participating Pharmacies so that your drug will be covered when you show up at the pharmacy. Making sure drugs are used only for medically necessary reasons helps everyone control the cost of your benefits plan.

Please note: Prior Authorization is also administered for many injectable drugs that are covered under the medical benefit. Prior Authorization for these agents is coordinated between your physician and Prudential HealthCare's Utilization Management unit.

THE PRUDENTIAL HEALTHCARE FORMULARY

The UC Care Prescription Drug Benefit includes a "voluntary" formulary feature. A drug formulary is a list of preferred prescription medications which promotes clinically useful and cost-effective drug therapy. Decisions regarding formulary inclusions are made by the Prudential HealthCare National Pharmacy & Therapeutics (P&T) Committee. This committee, comprised of experienced physicians and pharmacists, evaluates FDA-approved drugs and makes policy concerning formulary management and other drug matters impacting patient care. By asking your doctor to prescribe formulary medications, you can help control rising health care costs while maintaining high-quality care. Use of a formulary drug is voluntary; there is no financial penalty if your physician does not prescribe a formulary drug. A copy of the formulary may be obtained by contacting UC Care Customer Service at 1-800-313-3804.

Sometimes your physician may prescribe a medication to be dispensed as written when a preferred brand or generic alternative drug is available. As part of your prescription drug plan, the pharmacist may discuss with your physician whether an alternative drug might be appropriate for you. Your physician always makes the final decision on your medication and you can always choose to keep the original prescription.

MEMBER RIGHTS

If you have a question or problem regarding the UC Care Prescription Drug benefit, call UC Care Customer Service at 1-800-313-3804. You may also consult with your Benefits Representative or refer to this booklet.

GRIEVANCE AND APPEALS PROCEDURES

If you make a claim for prescription drug benefits and that claim is denied, you or your covered Dependent may contact UC Care Customer Service at 1-800-313-3804 to request a review of the claim. If the Customer Service Representative determines that the correct procedures were followed, and you are dissatisfied with the explanation, you will be advised of the Benefit Appeal Process, which will outline the Plan's process to request a review of the decision for denial.

SECTION IV

AMERICAN SPECIALTY HEALTH PLANS

(Chiropractic Benefits)

CHIROPRACTIC CARE COVERAGE

This Coverage pays benefits for many of the charges incurred for care and treatment of your or your qualified Dependent's Neuromuscular-skeletal Disorders. Except for the initial examination by an ASHP Provider and Emergency Chiropractic Services, all services require pre-authorization by the American Specialty Health Plans (ASHP).

Office Visit Copayment: $10 per visit.

TERMINATION OF PROVIDERS

Prudential HealthCare will give written notice to the Contract Holder within a reasonable period of time if (1) an ASHP Participating Chiropractor will no longer provide chiropractic services to Covered Persons for one of the reasons listed below, and (2) this would materially and adversely affect the Contract Holder or Covered Persons. Such notice will be given if the provider will no longer provide care due to:

(1) End of a contract between the provider and ASHP; or

(2) The provider's breach of such contract; or

(3) The provider's permanent inability to perform such a contract.

The Contract Holder agrees to give written notice of the change to you not later than thirty (30) days after receipt of notice from Prudential HealthCare.

Chiropractic Care Coverage

This Coverage pays for care and treatment of your or your qualified Dependent's Neuromuscular-skeletal Disorders. All services (except Emergency Chiropractic Services) must be obtained from an ASHP Participating Chiropractor for network benefits to be payable. Also, except for the initial examination or Emergency Chiropractic Services, all services require pre-authorization from the American Specialty Health Plans for network benefits to be payable.

When this coverage is added to a Prudential HealthCare Point of Service (point-of-service) plan or a Preferred Provider Organization (PPO) plan, the network chiropractic benefit is provided by this Coverage.

You may select an ASHP Participating Chiropractor from the ASHP Provider section of the UC Care Provider Directory.

A person's protection under this Coverage may be extended after that person ceases to be covered. See the Extension of Coverage page in this booklet for details. That page applies to this Coverage.

TERMS USED IN THIS COVERAGE

ASHP: American Specialty Health Plans.

Chiropractic Appliances: these support devices prescribed by an ASHP Participating Chiropractor: elbow supports, back supports (thoracic), cervical collars, cervical pillows, heel lifts, hot or cold packs, support/lumbar braces/supports, lumbar cushions, orthotics, wrist supports, rib belts, home traction units (cervical or lumbar), ankle brace, knee brace, rib supports, and wrist brace.

Chiropractic Services: those for treatment or diagnosis of Neuromuscular-skeletal Disorders.

Covered Services: those listed in the Eligible Charges section below, documented in an ASHP Participating Chiropractor's Treatment Plan, and authorized by ASHP.

Emergency Chiropractic Services: those rendered for the sudden, unexpected onset of an injury or condition affecting the neuromuscular-skeletal system which manifests itself by acute symptoms of sufficient severity, including severe pain, requiring immediate chiropractic attention.

Medically Necessary Chiropractic Services: Covered Services which are:

(1) necessary for treatment of Neuromuscular-skeletal Disorders;

(2) established as safe and effective and furnished according to generally accepted standards of chiropractic treatment;

(3) appropriate for the symptoms, consistent with the diagnosis, and otherwise in accordance with generally accepted standards of chiropractic practice and professionally recognized standards; and

(4) authorized by ASHP, except for an initial examination by an ASHP Participating Chiropractor or for Emergency Chiropractic Services.

Neuromuscular-skeletal Disorders: misalignments of the skeletal structure, and muscular weakness, osteopathic imbalances and disorders related to the spinal cord, neck and joints.

ASHP Participating Chiropractor: one with an agreement with ASHP to provide Covered Services and a license to practice chiropractic in California.

Treatment Plan: a written plan of services and supplies to be furnished by an ASHP Participating Chiropractor which requires pre-authorization by ASHP.

A. BENEFITS

The benefits for a person are described below.

Copayments: A Copayment is an amount that must be paid by the Covered Person in connection with office visits. Copayments are the sole responsibility of the Covered Person.

Amount Payable: After any Copayment has been met, the remaining Eligible Charges are payable.

B. ELIGIBLE CHARGES

Eligible charges are those used as the basis for a claim under the Coverage. A charge is eligible if:

- it is made for a service or supply furnished to you or your qualified Dependent;

- it is in the list of “Services and Supplies" below; and
- except for Emergency Chiropractic Services, it is made for a service or supply obtained from an ASHP Participating Chiropractor and is part of a Treatment Plan written by the ASHP Participating Chiropractor and authorized by ASHP.

A charge is considered incurred on the date of the service or purchase for which the charge is made. A charge is not an Eligible Charge if excluded. A charge is excluded if it is described in Charges Not Covered.

Services and Supplies:

(1) Office visits, including the initial examination to determine the need for chiropractic care.

(2) Conjunctive Therapy, including ultrasound, hot packs, cold packs, electrical muscle stimulation, and other therapies.

(3) Reexamination by the ASHP Participating Chiropractor to assess the need to continue, extend, or change the Treatment Plan.

(4) X-rays, lab tests, and radiological consultations by a licensed Chiropractic Radiologist or Radiology Group.

(5) These Chiropractic Appliances: elbow supports, back supports (thoracic), cervical collars, cervical pillows, heel lifts, hot or cold packs, support/lumbar braces/supports, lumbar cushions, orthotics, wrist supports, rib belts, home traction units (cervical or lumbar), ankle brace, knee brace, rib supports, and wrist brace.

Charges Not Covered:

(1) A charge to the extent payable under another coverage--including one (1) described in this Booklet--provided by the Employer for the person's class.

(2) Services or supplies furnished by Non-participating Chiropractors. But certain Chiropractic Emergency Services may be covered.

(3) Examinations or treatments for conditions not related to Neuromuscular-skeletal Disorders.

(4) Physical therapy not associated with spinal, muscle, or joint manipulation.

(5) Hypnotherapy, behavior training, sleep therapy, or weight programs.

(6) Thermography.

(7) Lab tests, X-rays, and other treatments classified as Experimental or Investigational.

(8) Services and supplies not documented as chiropractically necessary.

(9) Magnetic Resonance Imaging, CAT scans, and any type of diagnostic radiology, other than radiological X-rays.

(10) Transportation costs, including local ambulance charges.

(11) Educational programs, non-medical self-care, help training, or any related diagnostic testing.

(12) Vitamins, minerals, nutritional supplements, or similar products.

(13) Durable medical equipment.

(14) Prescription drugs or medicines, or non-legend or proprietary medicines not requiring a prescription.

(15) Services provided by a chiropractor practicing outside California.

(16) Hospitalization, anesthesia, manipulation under anesthesia, or related services.

C. EMERGENCY SERVICES

American Specialty Health Plans covers emergency services. However, because of the limited scope of Chiropractic Services, American Specialty Health Plans strongly recommends that members contact their Physician before seeking emergency services from a chiropractor. American Specialty Health Plans will not cover any services as emergency services unless the chiropractor rendering such services can show the services were rendered in an emergency. If you have questions about emergency services, please contact ASHP Members Services at 1-800-678-9133.

SECTION V

CERTIFICATE OF COVERAGE

(Tier 2 and Tier 3 Benefits)

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

Employee: The Employee whose signature appears on the Foreword.

Certificate of Coverage

Prudential certifies that insurance is provided according to the Group Contract(s) for each Insured Employee. The Contract Holder and the Group Contract Number are shown below.

Insured Employee: You are eligible to become insured under the Group Contract if you are in the Covered Classes of the Booklet's Section I and meet the requirements in the Booklet's Who is Eligible section. The Enrollment and Effective Date of Coverage sections of the Booklet state how and when you may become insured for each Coverage. Your insurance will end when the rules in the When Coverage Stops section so provide. The Tier 2 and Tier 3 benefit descriptions in Sections I, II and III of your Booklet and this Certificate of Coverage together form your Group Insurance Certificate.

Contract Holder: THE REGENTS OF THE UNIVERSITY OF CALIFORNIA

Group Contract No.: GM-97300

Effective Date of Coverage: January 1, 2000.

Coverages and Amounts: The available Coverages and the amounts of insurance are described in the Tier 2 and Tier 3 benefit descriptions in Sections I, II and III of your Booklet.

If you are insured, the Tier 2 and 3 benefit descriptions in Sections I, II and III of your Booklet and this Certificate of Coverage form your Group Insurance Certificate. Together they replace any older booklets and certificates issued to you for the Coverages. All Benefits are subject in every way to the entire Group Contract.

SECTION VI

AMERICAN SPECIALTY HEALTH PLANS

Acupuncture Benefits

(Combined Evidence of Coverage and Disclosure Form)

NOTE: THIS COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM CONSTITUTES ONLY A SUMMARY OF THE HEALTH PLAN CONTRACT BY AMERICAN SPECIALTY HEALTH PLANS ("ASHP"). THE HEALTH PLAN CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE. A SPECIMEN COPY OF THE CONTRACT IS AVAILABLE FROM YOUR EMPLOYER GROUP OR ASHP UPON REQUEST.

ACUPUNCTURE CARE COVERAGE

This Coverage pays benefits for many of the charges incurred for care and treatment of your or your qualified Dependent's Neuromusculo-skeletal Disorders, Pain or Nausea. Except for the initial examination by an ASHP Participating Acupuncturist and Emergency Acupuncture Services, all services require pre-authorization by the American Specialty Health Plans (ASHP).

SCHEDULE OF BENEFITS

Office Visit Copayment: $10 per visit for Acupuncture Services that are Medically Necessary Services.

Note: For a complete list of covered benefits, exclusions, and/or limitations under this Acupuncture Care Coverage, please refer to the "Covered Services" and "General Exclusions and Limitations" sections below.

DEFINITIONS

ASHP: American Specialty Health Plans, Inc.

Acupuncture Services: Services rendered or made available to a Member by an acupuncturist for treatment or diagnosis of Neuromusculo-skeletal Disorders, Nausea, or Pain. Acupuncture Services include services rendered by an acupuncturist for treatment of carpal tunnel syndrome, headaches, menstrual cramps, osteoarthritis, stroke rehabilitation and tennis elbow. Acupuncture Services do not include any other services, including, without limitation, services for treatment of asthma or addiction (including, without limitation, smoking cessation).

Administrative Review Program: The program and procedures utilized by ASHP to review administrative decisions, such as the denial of authorization forms or claims due to late or untimely submission to ASHP by Participating Acupuncturists.

Copayments: Payments to be collected directly by a Participating Acupuncturist for a Member for Covered Services.

Covered Services: Acupuncture Services as described in the Schedule of Benefits that are Medically Necessary Services.

Dependent: Dependents are defined in Section I General Information of this UC Care Plan Booklet.

Emergency Services: Acupuncture Services rendered for the sudden and unexpected onset of an injury or condition affecting the neuromusculo-skeletal system, nausea or pain which manifests itself by acute symptoms of sufficient severity requiring immediate acupuncture attention.

Employer Group: An employer group, union, association or other entity which contracts with ASHP for the provision of Covered Services to Members.

Experimental or Investigational: Acupuncture care that is investigatory or an unproved acupuncture procedure or treatment regimen that does not meet professionally recognized standards of practice.

Grievance Procedures: ASHP's procedures for reviewing Member complaints.

Health Plan: The health plan contract offered by ASHP and described in this brochure.

Health Plan Premiums: The monthly amounts paid by an Employer Group, or it's designated representative, on behalf of Members for the benefits provided under the Health Plan.

Medically Necessary Services: Acupuncture Services which are:

(1) Necessary for the treatment of Neuromusculo-skeletal Disorders, Pain or Nausea.

(2) Established as safe and effective and furnished in accordance with professionally recognized standards of

practice for acupuncture treatment of Neuromusculo-skeletal Disorders, Pain or Nausea.

(3) Appropriate for the symptoms, consistent with the diagnosis and otherwise in accordance with professionally recognized standards of practice.

(4) Pre-authorized by ASHP, except for an initial examination by a Participating Acupuncturist or for Emergency Services.

Medicare: The name commonly used to describe health insurance benefits for the aged and disabled provided under Public Law 89-97, as amended.

Member: Any Subscriber or Dependent.

Member Services Department: The person or persons designated by ASHP to whom oral and written Member questions, concerns or complaints may be addressed. The Member Services Department may be contacted by telephone at 1-800-678-9133 or by writing to the Member Services Department at:

American Specialty Health Plans, Inc.
P.O. Box 509002
San Diego, CA 92150-9002

Nausea: An unpleasant sensation in the abdominal region associated with the desire to vomit that may be appropriately treated by a Participating Acupuncturist in accordance with professionally recognized standards of practice and includes adult post-operative nausea and vomiting, chemotherapy nausea and vomiting, and nausea of pregnancy.

Neuromusculo-skeletal Disorders: Conditions with associated signs and symptoms related to the nervous, muscular and/or skeletal systems. Neuromusculo-skeletal Disorders are conditions typically categorized as structural, degenerative, or inflammatory disorders, or biomechanical dysfunction of the joints of the body and/or related components of the motor unit (muscles, tendons,

fascia, nerves, ligaments/capsules, discs and synovial structures) and related neurological manifestations or conditions.

Pain: A sensation of hurting or strong discomfort in some part of the body caused by an injury, illness, disease, functional disorder or condition. Pain includes low back pain, post-operative pain and post-operative dental pain.

Participating Acupuncturist: An acupuncturist duly licensed to practice acupuncture in California and who has entered into an agreement with ASHP to provide Covered Services to Members.

Quality Management Program: The procedures and standards established and administered by ASHP to ensure that Covered Services rendered by a Participating Acupuncturist comply with professionally recognized standards of practice.

Schedule of Benefits: The schedule of Covered Services on page 182.

Service Area: The geographic area which is defined in Section I General Information of this UC Care Plan Booklet and in which ASHP is licensed to provide or arrange for Acupuncture Services in the State of California by the California Department of Corporations.

Subscriber: The person whose employment or other status, except for family dependency, is the basis for eligibility for membership under the Health Plan.

Utilization Management Program: An ASHP program to promote the efficient use of resources and maintain the quality of care which includes, but is not limited to, the prospective, concurrent and retrospective review of Covered Services.

ACCESS TO PARTICIPATING ACUPUNCTURISTS

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS YOU MAY RECEIVE COVERED SERVICES.

A Member will have direct access to Participating Acupuncturists without obtaining a physician referral. A Member may simply call a Participating Acupuncturist to schedule an initial examination. After the initial examination, except for Emergency Services, the Member's Participating Acupuncturist must obtain pre-authorization for any additional Covered Services for a Member. The Participating Acupuncturist will be responsible for filing all claims with ASHP.

ASHP’s Director of Acupuncture Services will decide whether Acupuncture Services are or were Medically Necessary Services and therefore are or were Covered Services. ASHP may use utilization review procedures that it has developed for this purpose. ASHP will disclose to a Member, on request, the process that it uses to approve or deny services under the Health Plan. ASHP must approve the provision of any services other than an initial examination or Emergency Services, including without limitation, any referral of a Member for x-ray services, radiological consultations or laboratory services.

If a Member would like a second opinion with regard to Covered Services provided by a Participating Acupuncturist, the Member will have direct access to any other Participating Acupuncturist. The Member’s visit to a Participating Acupuncturist for purposes of obtaining a second opinion will count as one visit and the Member must pay any Copayment that applies for that visit on the same terms and conditions as a visit to any other Participating Acupuncturist. However, a visit to a second Participating Acupuncturist to obtain a second opinion will not count as a visit if you were referred to the second Participating Acupuncturist by another Participating Acupuncturist (the first Participating Acupuncturist) during a visit to the first Participating Acupuncturist if the first Participating Acupuncturist informed you at that time that he or she did not have the training or experience to determine the nature of your problem through the provision of Acupuncture Services and that the second Participating Acupuncturist would have the training and experience.

CHOICE OF PARTICIPATING ACUPUNCTURISTS

A Member may receive Acupuncture Services from any Participating Acupuncturist. Except for Emergency Services, ASHP will not pay non-Participating Acupuncturists for any services. A non-Participating Acupuncturist is an acupuncturist who has not entered into an agreement with ASHP to provide Covered Services to Members.

ASHP pays each Participating Acupuncturist a set fee for Covered Services provided to ASHP's Members. ASHP's agreements with the Participating Acupuncturist may allow ASHP to withhold a part of the payment. After the end of each year, ASHP will decide whether to pay an additional amount to the Participating Acupuncturist from the withhold amounts. ASHP will do so in its sole and absolute discretion.

ASHP limits the extent to which a Participating Acupuncturist may face exposure in this regard. In addition, ASHP will not pay a bonus to anyone to deny, reduce, limit or delay the provision of Covered Services that are Medically Necessary Services.

A Member may request additional information about these issues from ASHP. A Member may also request such information from a Participating Acupuncturist. To request information from ASHP, please call 1-800-678-9133 or please write to the Member Services Department, American Specialty Health Plans, P.O. Box 509002, San Diego, CA 92150-9002.

CONTINUITY OF CARE

A Member receiving Covered Services from a Participating Acupuncturist at the time the Participating Acupuncturist's contract terminates with ASHP may be able to continue to receive Covered Services from that provider for a period of time. The Member must be receiving Covered Services for an acute condition, a serious chronic condition or a pregnancy at the time the provider's contract with ASHP terminates. A Member's ability to receive continuity of care in these situations will depend on a number of other factors, including whether the provider voluntarily terminated his or her

contract with ASHP and whether the provider agrees in writing to be subject to the same contract terms that existed prior to termination. A Member should contact ASHP in writing or by telephone to request continuity of care in such a situation. ASHP can be reached by calling 1-800-678-9133 or by writing to the Member Services Department, American Specialty Health Plans, P.O. Box 509002, San Diego, CA 92150-9002.

ELIGIBILITY & ENROLLMENT

Please refer to Section I General Information of this UC Care Plan Booklet for information on eligibility and enrollment.

TERMS OF COVERAGE

Prepayment Fees: The Employer Group will pay the Health Plan Premium on Member's behalf. A Subscriber should contact his or her Employer Group regarding any required employee contribution.

ASHP will cover only Acupuncture Services that are Covered Services. Please note that the services listed in the "General Exclusions and Limitations" section below are not covered.

ASHP may change any provision of the Health Plan, including the Covered Services, Health Plan Premiums and Copayments, after two hundred ten (210) days notice of such change has been given to the Employer Group.

OTHER CHARGES

A Member receiving Covered Services will only be responsible for applicable Copayments. Such Copayments must be paid by the Member to the Participating Acupuncturist when the services are rendered. Copayments are listed in the Schedule of Benefits. A Member may also obtain services not covered by ASHP at the Member's own expense.

REIMBURSEMENT PROVISIONS

If a Member receives Emergency Services from a non-Participating Acupuncturist, the Member may have out-of-pocket expenses. If a Member has such expenses as a result of Emergency Services, the Member should mail claims for these expenses to ASHP, P.O. Box 509002, San Diego, CA 92150-9002 or should call ASHP's Member Services Department at 1-800-678-9133. If ASHP determines that the services rendered were Emergency Services, ASHP will reimburse the Member for the cost of such expenses, less any applicable Copayment.

COORDINATION OF BENEFITS

If a Member is covered by ASHP and another plan or contract providing acupuncture benefits or services, including Medicare, ASHP's benefits and services shall be coordinated with such other plan or contract in accordance with state and federal laws and regulations. Members must inform ASHP if they are covered by any other acupuncture benefit plan, including Medicare. If ASHP pays benefits in excess of those required under coordination of benefits laws and regulations, ASHP or a Participating Acupuncturist may recover an excess payment from a Member or the other plan.

CHAMPUS

ASHP may require a Member to furnish ASHP with information concerning any applicable benefits from the Civilian Health and Medical Program of the Uniformed Services ("CHAMPUS") to which the Member may be entitled, upon request by ASHP. ASHP shall not furnish benefits under this Agreement which duplicate CHAMPUS benefits to which Member is entitled.

If ASHP's payment duplicates CHAMPUS benefits available to the Member, ASHP may seek reimbursement up to the amount ASHP has paid for benefits which duplicate such CHAMPUS coverage.

AUTOMOBILE, ACCIDENT & LIABILITY COVERAGE

ASHP shall not furnish benefits under this Agreement which duplicates the benefits to which a Member is entitled under any other automobile accident or liability coverage. The Member shall be responsible for taking whatever action is necessary to obtain the benefits of such coverage and shall notify ASHP of such coverage. If payment of services are provided by ASHP in duplication of the benefits available to Member under other automobile, accident or liability coverage, ASHP may seek reimbursement to the extent of the reasonable value of the benefits provided by ASHP from the insurance carrier, provider and Member.

If the cost of Covered Services exceeds any other applicable coverage pursuant to this Section, ASHP benefits shall be provided over and above such coverage.

THIRD PARTY LIABILITY

In the case of injuries caused by any act or omission of a third party, and any complications incident thereto, the benefits of this Agreement shall be furnished by ASHP to Member. The Member shall reimburse ASHP, or its nominee, for the cost of all such services and benefits immediately upon obtaining a monetary recovery, whether due to settlement or judgment, on account of such injury. The Member shall hold any such sum in trust for ASHP, but said sum shall not exceed the lessor of, the amount of the recovery obtained by the Member or the reasonable value of all such services and benefits furnished to the Member or on the Member's behalf by ASHP on account of such incident.

Reimbursement of ASHP under this Section shall be the first priority claim against any third party. This means that ASHP shall be reimbursed from any recovery from a third party before payment of any other existing claims, including any claim by the Member for general damages. ASHP may collect from the proceeds of any settlement or judgment recovered by the Member or his or her legal representative regardless of whether the Member has been fully compensated.

ASHP may require the Member to cooperate in protecting ASHP's interests under this Section and to execute and deliver to ASHP or its nominee any and all liens, assignments or other documents which may be necessary or proper to fully and completely effectuate and protect ASHP's rights, or its nominee, including, but not limited to, the granting of a lien right in any claim or action made or filed on Member's behalf and the signing of documents evidencing the same.

The Member shall not be entitled to settle any claim, or release any person from liability, without ASHP's prior written consent, if such release or settlement will extinguish or act as a bar to ASHP's right of reimbursement.

In the event ASHP employs an attorney for the purpose of enforcing any part of this Section against a Member based on the Member's failure to cooperate with ASHP, the prevailing party in any legal action or proceeding shall be entitled to reasonable attorney's fees from the other party.

In lieu of payment as indicated above, ASHP, at it's option, may choose subrogation to the Member's rights to the extent of the benefits received under this Agreement. ASHP's subrogation right shall include the right to bring suit in the Member's name. ASHP may require the Member to cooperate with ASHP when ASHP exercises its right of subrogation, and the Member shall not be entitled to take any action or refuse to take any action which should prejudice the rights of ASHP under this Section.

RENEWAL PROVISIONS

The health plan contract entered into by ASHP and the Employer Group sets forth the Member's rights and benefits. That contract will automatically renew unless terminated by ASHP or the Employer Group. Members should contact their Employer Group with questions regarding the renewal or termination of that contract. At the time of renewal, ASHP has the right to change the Health Plan Premiums or any other provision of that contract with two hundred ten (210) days prior written notice to the Employer Group.

COVERED SERVICES

For a detailed listing of Covered Services, Members should review the Covered Services below. Please note that the amount of Covered Services will be limited based on the Schedule of Benefits chosen by a Member's Employer Group. Generally, however, the following are Covered Services:

Examination:

Initial Examination
Re-Examination

Treatment:

Office Visit/Acupuncture
Adjunctive Therapy

Other Services:

X-Rays
Laboratory Tests

All Covered Services, except for the initial examination and Emergency Services, require pre-authorization by ASHP.

Emergency Services:

ASHP covers Emergency Services. Because of the limited scope of Covered Services, ASHP strongly recommends that a Member contact his or her primary care physician before seeking Emergency Services from an acupuncturist. ASHP will not cover any services as Emergency Services unless the acupuncturist rendering such services can show that the services were in fact Emergency Services. If a Member believes he or she is experiencing an emergency medical condition that requires an emergency response, a Member is encouraged to use appropriately the “911” emergency response system, in areas where the system is established and operating.

Copayments:

A Member must pay Copayments at the time Covered Services are rendered. The Copayment may be a specific dollar amount or a percentage of the Participating Acupuncturist's charge, depending on the service provided.

ASHP Payments:

ASHP will pay each Participating Acupuncturist directly. CALIFORNIA LAW PROVIDES THAT MEMBERS ARE NOT LIABLE FOR ANY AMOUNT OWED BY ASHP TO A PARTICIPATING ACUPUNCTURIST.

Member's Liability:

A Member may be liable to a Participating Acupuncturist for services not covered under the Health Plan. A Member may be liable to a non-Participating Acupuncturist for the cost of services if a Member chooses to receive services from a non-Participating Acupuncturist, other than Emergency Services.

GENERAL EXCLUSIONS AND LIMITATIONS

Please note that ASHP will not pay for the following services:

(1) Any services or treatments not authorized by ASHP, except for an initial examination and Emergency Services.

(2) Any services or treatments not delivered by a Participating Acupuncturist or other ASHP contracted provider for the delivery of acupuncture care to Members, except for Emergency Services.

(3) Services for examinations and/or treatments for conditions other than those related to Neuromusculo-skeletal Disorders, Pain or Nausea.

(4) Hypnotherapy, behavior training, sleep therapy and weight programs.

(5) Thermography.

(6) Services, lab tests, x-rays and other treatments not documented as clinically necessary and appropriate or classified as Experimental or Investigational and/or as being in the research stage, as determined in accordance with professionally recognized standards of practice. If ASHP denies coverage for a therapy for a Member who has a life-threatening or seriously debilitating condition based on a determination by ASHP that the therapy is Experimental or Investigational, the Member may be able to request an external, independent review of ASHP's determination. The Member should contact ASHP's Member Services Department at 1-800-678-9133 for more information.

(7) Services and/or treatments which are not documented as Medically Necessary Services.

(8) Magnetic resonance imaging, CAT Scans and any other type of diagnostic radiology.

(9) Transportation costs including local ambulance charges.

(10) Educational programs, non-medical self-care or self-help or any self-help physical exercise training or any related diagnostic testing.

(11) Services or treatments for pre-employment physicals or vocational rehabilitation.

(12) Any services or treatments caused by or arising out of the course of employment or covered under any public liability insurance.

(13) Air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices or appliances; all durable medical equipment.

(14) Prescription drugs or medicines including a non-legend or proprietary medicine or medication not requiring a prescription order.

(15) Services provided by an acupuncturist practicing outside the State of California, except for Emergency Services.

(16) Hospitalization, anesthesia or other related services.

(17) All auxiliary aids and services, including, but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids.

(18) Adjunctive therapy not associated with spinal, muscle or joint manipulations.

(19) Vitamins, minerals, nutritional supplements or other similar products.

(20) Services for examinations and/or treatments for allergies.

TERMINATION OF BENEFITS

Termination of Employer Group's Coverage:

A Member's coverage will terminate when the Employer Group terminates coverage.

Termination of Member's Coverage:

A Member's coverage will also terminate as follows:

(1) Employer Group fails to pay Health Plan Premium on Member's behalf.

(2) Member's employment terminates, if ASHP coverage was conditioned on such employment.

(3) Member's eligibility for ASHP coverage terminates.

(4) Member moves outside of the Service Area permanently.

(5) Member provides false information to ASHP.

(6) Member assists a person who is not a Member to fraudulently obtain benefits from ASHP.

(7) Member voluntarily disenrolls.

REINSTATEMENT OF BENEFITS

A Member may re-enroll in ASHP if his or her coverage has terminated and the Member is eligible for re-enrollment through an Employer Group.

INDIVIDUAL CONTINUATION OF BENEFITS

Upon request by an Employer Group, ASHP shall make available continuation coverage under the Health Plan to Members entitled to continuation coverage based upon the requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as amended.

MEMBER RIGHTS

Questions, Concerns or Complaints?

If a Member has a question, concern or complaint regarding the services received from ASHP or a Participating Acupuncturist, the Member should call ASHP at 1-800-678-9133 or write ASHP at the following address:

American Specialty Health Plans, Inc.
Member Services Department
P.O. Box 509002
San Diego, CA 92150-9002

A Member may also obtain a Member complaint form from any Participating Acupuncturist.

Grievance Procedures and Arbitration

If a Member calls ASHP, the Member Services Department is ready to assist the Member with filing a complaint. Such assistance includes helping the Member in writing the complaint.

ASHP will work with the Member to resolve the complaint. ASHP will follow its Grievance Procedures in this regard.

If the Member disputes ASHP's resolution of the complaint, the Member may seek a different resolution by submitting it to binding arbitration after the Member completes ASHP Grievance Procedures. The requirement that a Member submit a dispute to binding arbitration applies broadly, including to settle any claim of malpractice against ASHP. A Member's claims against a Participating Acupuncturist are not subject to ASHP Grievance Procedures, except to the extent the Member and the Acupuncturist agree to follow and/or be bound by ASHP's Grievance Procedures.

The Member and ASHP will follow applicable law with regard to arbitration and ASHP's arbitration policies. California law may require, for a dispute involving $200,000 or less, that the Member and ASHP select a single, neutral arbitrator. In that situation, the arbitrator will not have the power to award more than $200,000.

At a Member's request, ASHP will send the Member a copy of ASHP's arbitration policies, including information about how to begin an arbitration. Those policies, as ASHP may amend them from time to time, will bind the Member and ASHP. Any arbitration under the Health Plan will be held in accordance with the Commercial Arbitration Rules of the American Arbitration Association and will be held in San Diego County. In cases of extreme hardship, ASHP will pay all or a part of a Member's fees and expenses for a neutral arbitrator.

In some cases, a Member may file a complaint with the Department of Corporations. California law sets forth this right in the following statement:

The California Department of Corporations is responsible for regulating health care service plans. The department's Health Plan Division has a toll-free telephone number **(1-800-400-0815)** to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers **(1-800-735-2929 (TTY) or 1-888-877-5378 (TTY))** to contact the department. The department's Internet website **(http://www.corp.ca.gov)** has complaint forms and instructions online. If you have a grievance against your health plan, you should first telephone your plan at **1-800-678-9133** and use the plan's grievance process before contacting the Health Plan Division. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your plan or a grievance that has remained unresolved for more than thirty (30) days, you may call the Health Plan Division for assistance. The plan's grievance process and the Health Plan Division's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

A Member may submit a complaint or grievance to the Department of Corporations for review after the Member has participated in ASHP's grievance process for at least thirty (30) days. If the Member's grievance involves an imminent and serious threat to his or her health – including, but not limited to, severe pain, potential loss of life, limb or major bodily functions – the Member may submit the grievance to the Department of Corporations without waiting thirty (30) days. In such a situation, ASHP will also provide the Member and, as appropriate, the Department of Corporations with a written statement of the status or disposition of the complaint within three (3) days of receipt of the complaint.

External, Independent Review

Covered Services do not include services, lab tests, x-rays and other treatments not documented as medically necessary as appropriate or classified as Experimental or Investigational and/or as being in the research stage, as determined in accordance with professionally recognized standards of practice. If ASHP denies coverage for a therapy for a Member who has a life-threatening or seriously debilitating condition based on a determination by ASHP that the therapy is Experimental or Investigational, the Member may be able to request an external, independent review of ASHP's determination. The Member should contact ASHP's Member Services Department at 1-800-678-9133 for more information.

Cancellation

If a Member believes that his or her Health Plan enrollment was terminated because of the Member's health status or health requirements, such Member may seek a review of the termination by the California Commissioner of Corporations under California Health and Safety Code Section 1365(b).

Member Participation in ASHP Public Policy

ASHP has established a Public Policy Committee to make recommendations regarding ASHP's public policy. To participate in this committee or to request additional information regarding the development of ASHP's public policies, please call ASHP at 1-800-678-9133.

SECTION VII
UNITED BEHAVIORAL HEALTH

(MENTAL HEALTH/SUBSTANCE ABUSE BENEFITS)

Schedule of Benefits

Effective Date of this Plan

January 1, 2000

Behavioral Health Benefits

Mental Health Copayments	
Office Visit Copayment	Visits 1-5: $0 Visits 6-20: $20 Visits 21+: $50
Deductible	
Inpatient and Intermediate Care Calendar Year Deductible (Combined for Mental Health and Substance Abuse)	**$100**
Percentage Payable after Copayments/Deductibles Satisfied	
Mental Health Inpatient and Intermediate Care	80%
Substance Abuse Inpatient: Detoxification	80%
Substance Abuse Inpatient and Intermediate Care: Rehabilitation	**80% with Treatment Plan Compliance** **50% without Treatment Plan Compliance**

Percentage Payable after Copayments/Deductibles Satisfied	
Mental Health Outpatient	100% after Copayment
Substance Abuse Outpatient	80%
Maximum Benefits	**None**

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

Behavioral Health Benefits

What This Plan Pays

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

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

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

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

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

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

Behavioral Health Services are services and supplies which are:

- Clinically Necessary, as defined below, for Mental Disorder Treatment.

- Given while the Covered Person is covered under this Plan.
- Given by one of the following providers:
    - Physician.
    - Psychologist.
    - Registered Nurse.
    - Licensed Counselor.
    - Health Care Provider.
    - Hospital.
    - Treatment Center.

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

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

Telemedicine

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

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

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

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

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

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

Notification Requirements and Utilization Review

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

If the Covered Person is not satisfied with a Network Provider, he/she may call UBH and ask for a referral to another Network

Provider. The Covered Person may do this more than once, but he/she will only be referred to one Network Provider at a time.

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

Appeals

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

Emergency Care

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

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

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

Copayments and Deductibles

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

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

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

The amount of each Copayment/Deductible is shown in **Schedule of Benefits**. A Covered Expense can only be used to satisfy one (1) Copayment or Deductible.

Mental Health Office Visit Copayment

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

Inpatient and Intermediate Care Calendar Year Deductible

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

Not Covered

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

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

    Care that meets one of the conditions above is custodial care regardless of any of the following:

        - Who recommends, provides or directs the care.
        - Where the care is provided.
        - Whether or not the patient or another caregiver can be or is being trained to care for himself or herself.
- Ecological or environmental medicine, diagnosis and/or treatment.

- Education, training and bed and board while confined in an institution which is mainly a school or other institution for training, a place of rest, a place for the aged or a nursing home.
- Herbal medicine, holistic or homeopathic care, including drugs.
- Services, supplies, medical care or treatment given by one of the following members of the Employee's/Annuitant's immediate family:
  - The Employee's/Annuitant's spouse.
  - The child, brother, sister, parent or grandparent of either the Employee/Annuitant or the Employee's/Annuitant's spouse.
- Services or supplies, treatments or drugs which are considered investigational because they do not meet generally accepted standards of medical practice in the United States. This includes any related confinements, treatment, service or supplies.
- Services and supplies for which the Covered Person is not legally required to pay.
- Membership costs for health clubs, weight loss clinics and similar programs.
- Nutritional counseling.
- Occupational injury or sickness - an occupational injury or sickness is an injury or sickness which is covered under a workers' compensation act or similar law. For persons for whom coverage under a workers' compensation act or similar law is optional because they could elect it or could have it elected for them, occupational injury or sickness includes any injury or sickness that would have been covered under the workers' compensation act or similar law had that coverage been elected.
- Examinations or treatment ordered by a court in connection with legal proceedings unless such examinations or treatment otherwise qualify as Behavioral Health Services.
- Examinations provided for employment, licensing, insurance, school, camp, sports, adoption or other non-Clinically Necessary purposes, and related expenses for reports, including report presentation and preparation.

- Services given by a pastoral counselor.
- Personal convenience or comfort items including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners humidifiers, saunas, hot tubs.
- Private duty nursing services while confined in a facility.
- Sensitivity training, educational training therapy or treatment for an education requirement.
- Sex-change surgery.
- Stand-by services required by a Physician.
- Telephone consultations.
- Tobacco dependency.
- Services or supplies received as a result of war declared or undeclared, or international armed conflict.
- Weight reduction or control (unless there is a diagnosis of morbid obesity), special foods, food supplements, liquid diets, diet plans or any related products.
- Services given by volunteers or persons who do not normally charge for their services.

Network Provider Charges Not Covered

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

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

A Covered Person may agree with the Network Provider to pay any charges for services and supplies which are not Clinically Necessary. In this case, the Network Provider may make charges to the Covered Person. The Covered Person will be asked to sign a patient financial responsibility form agreeing to pay for the services

that are found to not be Clinically Necessary. However, these charges are not Covered Expenses under this Plan and are not payable by the Company.

Claims Information

How to File a Claim

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

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

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

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

- The diagnosis.

The claim/billing statement should be mailed to:

United Behavioral Health
P.O. Box 8250
Emeryville, CA 94662-8250

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

When Claims Must be Filed

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

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

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

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

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

beginning with the first calendar day after the thirty (30)-working-day period.

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

Legal Actions

The covered Employee/Annuitant may not sue on a claim before sixty (60) days after proof of loss has been given to the Company. The covered Employee/Annuitant may not sue after three (3) years from the time proof of loss is required, unless the law in the area where the covered Employee/Annuitant lives allows for a longer period of time.

Incontestability of Coverage

This Plan cannot be declared invalid after it has been in force for two (2) years. It can be declared invalid due to nonpayment of premium.

No statement used by any person to get coverage can be used to declare coverage invalid if the person has been covered under this Plan for two (2) years. In order to use a statement to deny coverage before the end of two (2) years, it must have been signed by the person. A copy of the signed statement must be given to the person.

Review Procedure for Denied Claims

In cases where a claim for benefits payment is denied in whole or in part, the claimant may appeal the denial. A request for review must be directed to Appeals Unit, United Behavioral Health - Employer Division at P.O. Box 32040, Oakland, California, 94604, within sixty

(60) days after the claim payment date or the date of the notification of denial of benefits. When requesting a review, the claimant should state the reason he or she believes the claim was improperly paid or denied and submit any data or comments to support the claim.

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

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

Coordination of Benefits

Coordination of benefits applies when a Covered Person has health coverage under this Plan and one (1) or more Other Plans.

One of the plans involved will pay the benefits first: that plan is Primary. One (1) of the Other Plans will pay benefits next: those plans are Secondary. The rules shown in this provision determine which plan is Primary and which plan is Secondary.

Whenever there is more than one (1) plan, the total amount of benefits paid in a Calendar Year under all plans cannot be more than the Allowable Expenses charged for that Calendar Year.

Please refer to Section I, General Information, for the effect of Medicare on this Plan.

Definitions

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

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

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

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

"Allowable Expenses" means the necessary, reasonable and customary expense for health care when the expense is covered in whole or in part under at least one (1) of the plans.

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

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

How Coordination Works

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

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

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

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

Which Plan Pays First

When two (2) or more plans provide benefits for the same Covered Person, the benefit payment will follow the following rules in this order:

- A plan with no coordination provision will pay its benefits before a plan that has a coordination provision.
- The benefits of the plan which covers the person other than as a dependent are determined before those of the plan which covers the person as a dependent.
- The benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as

other than a dependent, if the person is also a Medicare beneficiary and both of the following are true:

- Medicare is secondary to the plan covering the person as a dependent.
- Medicare is primary to the plan covering the person as other than a dependent (example, an Annuitant).

- When this Plan and another plan cover the same child as a dependent of parents who are not separated or divorced, the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year. This is called the "Birthday Rule." The year of birth is ignored.

  If both parents have the same birthday, the benefits of the plan which covered one (1) parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

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

- If two (2) or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

  - First, the plan of the parent with custody for the child.
  - Second, the plan of the spouse of the parent with the custody of the child.
  - Finally, the plan of the parent not having custody of the child.

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

- If the specific terms of a court decree state that the parents shall share joint custody, without stating that one (1) of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules that apply to dependents of parents who are not separated or divorced.
- The benefits of a plan which covers a person as an employee who is neither laid off nor an Annuitant are determined before those of a plan which covers that person as a laid off employee or an Annuitant. The same rule applies if a person is a dependent of a person covered as an Annuitant or an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

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

Right to Exchange Information

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

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

Facility of Payment

It is possible for benefits to be paid first under the wrong plan. The Company may pay the plan or organization or person for the amount of benefits that the Company determines it should have paid. That

amount will be treated as if it was paid under this Plan. The Company will not have to pay that amount again.

Right of Recovery

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

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

Recovery Provisions

Refund of Overpayments

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

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

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

If the refund is due from another person or organization, the Covered Person agrees to help the Company get the refund when requested. If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the Company may reduce the amount of any future benefits that are payable under this Plan. The Company may also reduce future benefits under any other

group benefits plan administered by the Company for the Employer. The reductions will equal the amount of the required refund. The Company may have other rights in addition to the right to reduce future benefits.

Reimbursement of Benefits Paid

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

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

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

Subrogation

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

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

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

Glossary

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

Annuitant

A retired or disabled University Employee or a deceased Employee's family member, receiving a monthly income from a defined benefit plan to which the University contributes ("Survivor Annuitant").

Calendar Year

A period of one (1) year beginning with January 1.

Covered Person

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

Course of Treatment

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

- thirty (30) days with respect to treatment for substance abuse
- six (6) months with respect to treatment for mental illness

Emergency Care

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

Employee

A person who is appointed to work at least 50% time for one (1) year or more or is appointed at 100% time for three (3) months or more. To remain eligible, an Employee must maintain an average regular paid time of at least twenty (20) hours per week and maintain an eligible appointment of at least 50% time. If the appointment is at least 50% time, the Employee's appointment form may refer to the time period as follows: "Ending date is for funding purposes only; intent of appointment is indefinite (for more than one (1) year)."

Health Care Provider

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

Hospital

An institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets one of the following three (3) tests:

- It is accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations.
- It is approved by Medicare as a hospital.
- It meets all of the following tests:
  - It maintains on the premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of

sick and injured persons by or under the supervision of a staff of duly qualified Physicians.

- It continuously provides on the premises twenty-four (24)-hour-a-day nursing service by or under the supervision of registered graduate nurses.
- It is operated continuously with organized facilities for operative surgery on the premises.

A psychiatric health facility shall also be deemed a Hospital if it fulfills one (1) of the following requirements:

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

Intermediate Care

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

Licensed Counselor

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

Medicare

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

Mental Disorder Treatment

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

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

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

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

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

Prescription Drugs are not considered Mental Disorder Treatment.

Network Provider

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

Non-Network Provider

A provider which does not participate in the network.

Physician

A legally qualified:

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

Plan

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

Psychologist

A person who specializes in clinical psychology and fulfills one (1) of these requirements:

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

Reasonable Charge

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

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

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

Registered Nurse

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

Substance Abuse Rehabilitation

Treatment for a substance abuse disorder in a twenty-four (24)-hour setting, or other setting outside of an acute care Hospital that is licensed to perform that service and where there is no danger of medical complications due to detoxification.

Treatment Center

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

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

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

Treatment Plan Compliance

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

Utilization Review

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

End of Certificate

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IMPORTANT NOTICE

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

Call the Company at the phone number shown on your Explanation of Benefits.

Call the California Department of Insurance at:

1-800-927-HELP (1-800-927-4357) if the Covered Person resides in the State of California.

(213) 897-8921 if the Covered Person resides outside of the State of California.

A Covered Person may write the California Department of Insurance at:

California Department of Insurance
Claims Services Bureau, 11th Floor
300 South Spring Street
Los Angeles, CA 90013

SECTION VIII

PLAN ADMINISTRATION

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 booklet 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 booklet and/or the group insurance contracts/service agreements. What is written in this booklet 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 94612-3557
(800) 888-8267, extension 70651

Medical

The Prudential HealthCare Point of Service and American Specialty Health Plans Chiropractic benefits of the Plan described in this booklet are provided by Prudential Health Care Plan of California, Inc., and The Prudential Insurance Company of America.

Claims are processed by Prudential HealthCare at the following address and phone number:

Prudential HealthCare
P.O. Box 54280
Los Angeles, California 90054-0280
(800) 313-3804

Acupuncture Benefits

The Acupuncture benefits described in this booklet are provided through, and administered by American Specialty Health Plans, Inc. (ASHP). If you have a question, you may direct it to ASHP at the following address:

American Specialty Health Plans
P.O. Box 509002
San Diego, CA 92150-9002
(800) 678-9133

Mental Health/Substance Abuse Benefits

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

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

Prescription Drugs

The Prudential HealthCare Point-of-Service Prescription Drug Benefits described in this booklet are provided by Prudential HealthCare Plan of California, Inc. and The Prudential Insurance Company of America. If you have a question, you may direct it to the University of California at the address on page 230 or as follows:

Retail Service **Mail Order Drug Service**

Prudential HealthCare
P.O. Box 54280
Los Angeles, California 90054
(800) 313-3804

Integrated Pharmacy Solutions, Inc.
4411 Louetta Street, Suite 400
Spring, Texas 77388
(800) 732-2165

GROUP CONTRACT NUMBERS

Contract Numbers: GH-97300 and GM-97300

TYPE OF PLAN

This Plan is a health and welfare plan that provides group health care benefits. This Plan is one of the benefits offered under the University of California's Employee health and welfare benefits program.

Plan Year

The plan year is the period of time commencing at 12:01 a.m., on January 1 and ending at 12:01 a.m. on the next January 1.

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. The Plan is not a vested plan. The right to terminate or amend applies to all Employees, Annuitants and plan beneficiaries. The amendment or termination shall be carried out by the President or his or her delegates. The University of California will also determine the terms of the Plan, such as benefits, premiums and what portion of the premiums the University will pay. The portion of the premium the University pays is subject to state appropriation which may change or be discontinued in the future.

Financial Arrangements

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

Agent for Serving of Legal Process

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

Your Rights under the Plan

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

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

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

Claims under the Plan

Medical

Please review the section of this booklet called “How to File a Claim” which begins on page 146 and ends on page 151.

Prescription Drug Benefits

Please refer to the prescription drug section (non-participating pharmacies on page 159) and for information on filing a claim for prescription drug benefits.

Acupuncture

Claims for services provided under the American Specialty Health Plans (ASHP) Acupuncture Benefit are filed by the ASHP provider. It is the responsibility of the ASHP provider to obtain the necessary authorizations from ASHP for all services provided, other than services provided in an initial office visit or for emergency services.

Mental Health/Substance Abuse

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

Binding Arbitration

The following applies to Tier 1 under the Prudential HealthCare Point of Service benefits of the Plan described in this booklet.

After exhaustion of the Appeals Review Procedures under Tier 1, unresolved matters may be submitted to an independent arbitrator for review. The procedures for requesting arbitration will be given to you in the final stage of the appeals process. Any costs associated with review by an arbitrator will be borne equally by the person requesting arbitration and the Plan. Should an arbitrator determine that an extreme hardship exists, Prudential HealthCare may contribute a portion or all of your share of the arbitration fees, as allocated by the arbitrator. The arbitration will be conducted in conformity with the rules of the American Arbitration Association and the decision(s) of the arbitrator will be binding on both parties.

Nondiscrimination Statement

In conformance with applicable law and University policy, the University is an affirmative action/equal opportunity employer. Please send inquiries regarding the University's affirmative action and equal opportunity policies for staff to Director Mattie Williams and for faculty to Executive Director Sheila O'Rourke, both at this address: University of California Office of the President, 1111 Franklin Street, Oakland, California 94607.

BENEFIT CHANGES EFFECTIVE JANUARY 1, 2000

Hearing aids under All Tiers

One hearing aid per ear up to a total benefit maximum of $2,000 every thirty-six (36) months with a 50% copayment/co-insurance, will now be provided.

Hearing exams under All Tiers

Hearing exams are eligible under all tiers and covered at the applicable Office Visit benefit level.

Physical, Occupational and Speech Therapy

The ninety (90) consecutive day maximum will be removed. All treatment is still subject to medical necessity and pre-authorization requirements.

Diaphragms and Norplant

For Tier 1, diaphragms and Norplant will be covered at 100% after $10.00 Office Visit copayment has been paid. For Tiers 2 and 3 the applicable deductible and coinsurance will apply and are subject to medical necessity.

Prescription Drug Benefit

Effective January 1, 2000, The University of California has selected Prudential HealthCare to administer Prescription Drug Benefits for Retail and Mail Order.

The following Retail Pharmacy benefit will now be provided:

Participating Pharmacy Benefit: $10 Generic Copayment/$20 Brand Name Copayment

If a generic drug is available and a brand drug is requested by the Member, the Member is required to pay the generic copay plus the difference between the cost of the brand and the generic. If the Member's Physician indicates that a brand name is medically necessary when a generic equivalent is available, the member will pay the brand copay for the drug.

Non-Participating Pharmacy Benefit: Covered at 80% after an annual $50 individual/$150 family prescription drug deductible.

Prescription drugs prescribed for sexual dysfunction are no longer excluded. Coverage for Viagra requires pre-authorization and is limited to 4 pills per 30 day period and must be filled by a participating pharmacy at the appropriate copayment.

Behavioral Health

Effective January 1, 2000, UC has selected United Behavioral Health (UBH) to administer behavioral health care benefits on behalf of UC Care plan members.

There is no out-of-area plan through UBH, since their provider network is available throughout the U.S. Out-of-Area plan participants will receive the same benefits as in-area plan members for Mental Health and Substance Abuse (MHSA) services.

The $100 mental health deductible and $250 substance abuse deductible is being replaced with a $100 annual deductible combined for inpatient and intermediate MHSA services.

There are no plan maximums with regard to the number of visits or hospital admissions that are covered, as long as care is clinically necessary and authorized by United Behavioral Health.

Clinically necessary services are expanded to include:

Short-term outpatient counseling, Acute inpatient care, and Alternatives to inpatient treatment which include the following intermediate levels of care:
Partial hospitalization,
Residential care,
Day treatment, and
Structured outpatient services.

Acupuncture

Acupuncture Benefits are provided through American Specialty Health Plans (ASHP). A $10.00 Office Visit Copay applies. Services require authorization from ASHP.

UC CARE

January 1, 2000

PRUDENTIAL HEALTHCARE ®
A member company of
Aetna U.S. Healthcare ®
Point-of-Service (CA)

Prudential HealthCare is a brand name licensed for a transition period from The Prudential Insurance Company of America ("Prudential") for health and dental products and services: (1) offered by former subsidiaries of Prudential acquired by Aetna Inc. and its subsidiaries, or (2) for which Aetna Life Insurance Company serves as reinsurer and administrator in accordance with agreements with Prudential.

1-2000

GRP 40650
CAT 497064T
8104128-C

BENEFIT SUMMARY

	TIER 1 HIGHEST BENEFIT LEVEL • Copay Plan • No Deductible • Physician's office files claims • Physician responsible for prior approvals and preadmission review	TIER 2 HIGH BENEFIT LEVEL • Deductible • Coinsurance • You are responsible for prior approvals and preadmission review	TIER 3 LOWEST BENEFIT LEVEL • Deductible • Coinsurance • You are responsible for prior approvals, preadmission review, charges above the maximum allowable fee
	TIER 1 PCP COORDINATED PRUDENTIAL HEALTHCARE PROVIDERS	**TIER 2 SELF-COORDINATED PRUDENTIAL HEALTHCARE/ PREFERRED PROVIDER ORGANIZATION PROVIDERS**	**TIER 3 SELF-COORDINATED NON-PRUDENTIAL HEALTHCARE/ PREFERRED PROVIDER ORGANIZATION PROVIDERS**
	Services and Supplies must be provided or authorized by your Primary Care Physician.	All Eligible Charges are subject to an annual deductible, except as otherwise indicated.	All Eligible Charges are subject to an annual deductible, except as otherwise indicated.
	PLAN PAYS	**PLAN PAYS**	**PLAN PAYS**
DEDUCTIBLES, OUT-OF-POCKET AND INDIVIDUAL LIFETIME MAXIMUM			
Annual Deductible (Per Calendar Year)	None	$250 per person $750 per family	$500 per person $1,500 per family
Annual Out-of-Pocket Maximum (Limit includes Deductible)	$1,000 per person $3,000 per family	$3,000 per person $9,000 per family	$12,000 per person $36,000 per family
Individual Lifetime Maximum	Unlimited	$2,000,000	$2,000,000
		Under Tiers 2 and 3, the Annual Deductible, Annual Out-of-Pocket and Individual Lifetime Maximum Limits will be combined.	
PRESCRIPTION DRUG BENEFIT - Refer to your UC Care Prescription Drug Benefits At A Glance on Page 155			
PREVENTIVE CARE			
		Under Tiers 2 and 3, preventive care is not covered except for children under age 19. Preventive care is not subject to the annual deductible.	
Well Baby Care (up to age 2)	100%	80%	60%

	TIER 1 PLAN PAYS	TIER 2 PLAN PAYS	TIER 3 PLAN PAYS
Immunizations	100% after $10 copayment per visit. No copayment for children age 2 to 6. No copayment if office visit copayment applies.	80%	60%
Routine Health Assessments	100% after $10 copayment per visit. No copayment for children age 2 to 6. No copayment if office visit copayment applies.	80%	60%

PHYSICIAN SERVICES

Office Visits to Health Care Providers (Primary Care and Specialty Care).	100% after $10 copayment per visit. No copayment for children to age 6.	80%	60%
Surgical procedures (other than during office visit):			
Surgeon and Assistant Surgeon	100%	80%	60%
Anesthesiologist	100%	80%	80%
Maternity Care	100% after $10 copayment for the 1st visit.	80%	60%
Hospital Visits (including well newborn care)	100%	80% (only 1st visit for well newborn care covered)	60% (only 1st visit for well newborn care covered)

NOTE: Copayment waived if physician isn't seen during office visit.

Chiropractic Services: provided through American Specialty Health Plans (See Section IV)

Acupuncture Services: provided through American Specialty Health Plans (See Section VI)

HOSPITAL SERVICES

See Prudential Patient Care Management on page 63.

	TIER 1 PLAN PAYS	TIER 2 PLAN PAYS	TIER 3 PLAN PAYS
Inpatient Services (semi-private room & related charges)	100%	80%	60%
Outpatient Services	100%	80%	60%
Emergency Services	100% after $50 copayment (waived if admitted)	80% after $50 additional deductible per visit (waived if admitted)	60% after $75 additional deductible per visit (waived if admitted)
OTHER SERVICES			
Convalescent Nursing Home(skilled nursing facility) Care (including Physician Services)	100% up to 100 days per period of care	80% up to 70 days per period of care (1)(2)	80% up to 70 days per period of care (1)(2)
Durable Medical Equipment	100%	80%	80%
Home Health Care Visits	100%	80% up to 100 visits per calendar year (1)(2)	80% up to 100 visits per calendar year (1)(2)
Hospice Care (maximum benefit per period of care $7,400)	100%	80% (1)(2)	80% (1)(2)
Outpatient Private Duty Nursing	100%	80% ($8,000 maximum calendar year benefit) (1)	80% ($8,000 maximum calendar year benefit) (1)
Ambulance	100%	80%	80%
Outpatient Surgical Facility	100%	80%	80%
Outpatient Diagnostic X-ray and Laboratory Facility	100%	80%	80%
Hearing Exam	100% after $10 copayment	80%	60%
Hearing Aids	50% ($2,000 benefit maximum) (3)	50% ($2,000 benefit maximum) (3)	50% ($2,000 benefit maximum) (3)
Outpatient Chemo/Radiation Treatment Facility	100%	80%	80%
Short-term Outpatient Speech Therapy	100% after $10 copayment per visit	80%	80%
Short-term Outpatient Physical and Occupational Therapy	100% after $10 copayment per visit	80%	80%
Urgent Care Facility Visits	100% after $10 copayment per visit	80%	80%
Diaphragms and Norplant	100% aft $10 copayment per visit (4)	80% (4)	60% (4)

See page 156 for the benefit description of diabetic supplies, medical supplies and injectable medications.

(1) All benefits and services, other than outpatient private duty nursing, received under Tier 1 count toward Tier 2 and Tier 3 limits. However, Tier 2 and Tier 3 limits are combined, and do not reduce Tier 1 benefits.
(2) Not subject to deductible
(3) Limited to 1 hearing aid per ear during every thirty-six (36) months. Benefits provided under all tiers will count towards the $2,000 Plan limit.
(4) Subject to medical necessity.

Prudential Patient Care Management (PCM) and Self-Coordinated Benefits - Tiers 2 and 3
(Applicable to members not enrolled for Parts A and B of Medicare)

- All hospital stays and certain outpatient services and procedures are subject to precertification.
- Call Member Services (the phone number is on your ID card) before elective surgery or seven (7) days in advance of hospital stay arranged through a Tier 2 or 3 health care provider.
- The Member Services staff will confirm the need for surgery or precertify the initial length of your hospital stay.
- For emergencies, call within one workday.
- If you don't call, call late or don't follow Member Services' instructions, eligible charges for hospital care or specified outpatient services and procedures will be reduced by 20%.

Definitions

Coordination of Benefits

All benefits are subject to Coordination of Benefits. The total benefits payable under this plan for a Covered Person when combined with other group health plan benefits will not be more than 100% of allowable expenses.

Copayment (applies to Tier 1 PCP Coordinated benefits)

A copayment is an amount that you are required to pay to a Participating Tier 1 Provider at the time of service. Copayments are the sole responsibility of the Covered Person.

Deductible (applies to Tiers 2 and 3 Self-Coordinated Care benefits)

The amount of the covered charges which a patient must pay before benefits are paid by the plan.

Coinsurance Expenses (applies to Tiers 2 and 3 Self-Coordinated Care benefits)

The amount of Eligible expenses you incur. This does not include deductibles or eligible charges already payable at 100%.

Covered Percent (applies to Tiers 2 and 3 Self-Coordinated Care benefits)

A percent of Eligible Charges used to determine the benefits payable for those charges. The Covered Percent is not applied to charges used to meet any deductible.

Medical Emergency

A Medical Emergency is generally defined as a sickness or injury of such a nature that failure to get immediate medical care could put a person's life in danger or cause serious harm to bodily functions.

Out-of-Area Coverage: Coverage while a Covered Person is anywhere outside the Service Area of the Plan including coverage for urgently needed services to prevent serious deterioration of a Covered Person's health resulting from unforeseen illness or injury for which treatment cannot be delayed until the Covered Person returns to the Plan's Service Area.

Tier 1: Whether inside or outside the service area, prior authorization by a Primary Care Physician isn't necessary for care in connection with a Medical Emergency to be considered on a Tier 1 basis within the first forty-eight (48) hours. But you must notify Prudential HealthCare and your PCP within forty-eight (48) hours so that any continued care can be authorized and paid on a Tier 1 basis. If the medical condition does not require immediate medical care, your Primary Care Physician or the National Hotline should be contacted first. See page 79 for full definition of Medical Emergency.

Tiers 2 and 3: If you do not have emergency care authorized by your Primary Care Physician or through the National Hotline and you are hospitalized, you must call Member Services within one workday or eligible charges will be reduced by 20%.