University of California – UC Care Plan

Prescription Drug Plan

and

Summary Plan Description

The Regents of University of California ("Employer") maintains the UC Care Plan ("Plan" or "UC Care Plan") for the benefit of its eligible employees and their eligible dependents. This document provides a summary of the prescription benefits under the UC Care Plan. For Medical Plan benefits, including information about eligibility, are summarized in the UC Care Plan Booklet and Group Insurance Regulation (GIR). These documents are available to members through UCnet (ucnet.universityofcalifornia.edu). The Regents of University of California is the named Plan Administrator for this self-funded group prescription drug benefit Plan.

The purpose of this document is to provide you and your covered Dependents, if any, with summary information on your prescription benefits along with information on your rights and obligations under this Plan. As a valued employee of University of California, we are pleased to provide you with benefits that can help meet your health care needs.

The Employer assumes the sole responsibility for funding the employee benefits out of general assets, however employees help cover some of the costs of covered benefits through premiums, deductibles, pays and participation amounts as described in the Schedule of Benefits.

The requirements for being covered under this Plan, the provisions concerning termination of coverage, a description of the Plan benefits (including limitations and exclusions), cost sharing, the procedures to be followed in submitting claims for benefits and remedies available for appeal of claims denied are outlined in the following pages of this document. Please read this document carefully and contact your supervisor or Human Resources department if you have questions.

This document constitutes the Plan Document and Summary Plan Description for prescription benefits under the UC Care Plan.

This document is effective January 1, 2027.

PLAN DESCRIPTION INFORMATION

Effective 01/01/2027

1. Plan Name: University of California – UC Care Plan

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2. Name and Address of Employer: The Regents of University of California
   1111 Franklin Street
   Oakland, CA 94607

3. Plan Sponsor: The Regents of University of California
   1111 Franklin Street
   Oakland, CA 94607

4. Plan Administrator: The Regents of University of California
   1111 Franklin Street
   Oakland, CA 94607

5. Named Fiduciary: The Regents of University of California
   1111 Franklin Street
   Oakland, CA 94607

6. Pharmacy Benefit Manager: Navitus Health Solutions, LLC
   361 Integrity Drive
   Madison, WI 53717

7. Type of Benefit Plan Provided: The Plan provides prescription drug benefits for participating employees and their enrolled dependents. The Plan is a self-funded plan, and benefits are payable solely from the Plan Sponsor's general assets. The Plan Sponsor, as Plan Administrator, has delegated to the Pharmacy Benefit Manager responsibility for prior authorization and claims appeals decisions and the administration of payment of the claims using the Plan Sponsor's general assets. The Pharmacy Benefit Manager is not responsible for decisions made pursuant to external review or mandatory arbitration.

8. Benefit Plan Year: January 1 – December 31

9. Fiscal Year Ending Date: December 31

10. Agent for Service of Legal Process: Plan Sponsor

11. Type of Administration: The Plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the Plan.

12. Funding of the Plan: Employer and Employee Contributions
    Benefits are provided by a benefit plan maintained on a selfinsured, unfunded basis by your employer.

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13. State and Federal Compliance: It is intended that the Plan meets all applicable requirements under state and federal law. In the event of a conflict between the Plan and state or federal law, refer to your Plan documents and applicable regulations for details which will be deemed controlling, and any conflicting part of the Plan shall be deemed superseded to the extent of the conflict. The Plan Administrator has the authority to interpret disputed provisions.

14. Discretionary Authority: Except for prior authorizations and claim appeal decisions, the Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion, shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, except for prior authorizations and claim appeal decisions, the Plan Administrator shall have full and sole discretionary authority to interpret all Plan documents, and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any Plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties. Any interpretation, determination or other action of the Plan Administrator shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes, in its sole discretion, and further, constitutes agreement to the limited standard and scope of review described by this section.

15. Discretionary Authority- Claim Appeal Decisions: The Plan Sponsor has delegated the Pharmacy Benefits Manager the duties of determining claim appeals, except for external review of appeals and mandatory arbitration. The Pharmacy Benefit Manager shall have discretionary authority to interpret all claim appeals, and make interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan.

16. Fiduciary Liability: To the extent permitted by law, the Plan Administrator and other parties assuming a Fiduciary role shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

ELIGIBILITY AND ENROLLMENT

The University establishes its own medical plan eligibility, enrollment and termination criteria based on the University of California Group Insurance Regulations and any corresponding Administrative Supplements.

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Employees

Information pertaining to your eligibility, enrollment, cancellation or termination of coverage and conversion options can be found in the "Complete Guide to Your UC Health and Welfare Benefits". A copy of this booklet is available in the HR Forms & Publications section of UCnet (ucnet.universityofcalifornia.edu). Additional resources are also available in the Compensation and Benefits section of UCnet to help you with your health and welfare plan decisions.

Retirees

Information pertaining to your eligibility, enrollment, cancellation or termination of coverage and conversion options can be found in the "Group Insurance Eligibility Fact Sheet for Retirees and Eligible Family Members". A copy of this fact sheet is available in the HR Forms & Publications section of UCnet (ucnet.universityofcalifornia.edu). Additional resources are also available in the Compensation and Benefits section of UCnet to help you with your health and welfare plan decisions.

HERE ARE SOME IMPORTANT THINGS TO KEEP IN MIND ABOUT YOUR PRESCRIPTION DRUG BENEFIT:

- A drug formulary is a list of prescribed drugs and medications approved for use and covered under the Plan. The Navitus Pharmacy & Therapeutics (P&T) Committee meets quarterly to review new and existing drugs for addition to the Navitus formulary. Drugs are reviewed based on therapeutic value, effectiveness and possible side-effects. After determining which drugs are comparable, cost is considered. The intent is to provide you with the best quality and most cost-effective drug therapies that follow current medical practices.

- The Plan covers prescribed drugs and medications according to a drug formulary, organized by tiers. Certain prescription drugs included in the formulary require prior authorization to increase appropriate utilization, promote treatment or step therapy protocols, actively "risk manage" drugs with serious side effects and influence the process of managing costs. Drugs with a prior authorization requirement are designated on the formulary with a "PA" indicator. **If prior authorization is not obtained when required, no benefits are available.** The drug prior authorization process may be initiated by your treating physician by filling out a Drug prior authorization Request form. Upon receipt of the request form, a determination notification will be mailed to you and the prescribing physician. You can access the formulary, learn what tier a particular drug falls under, download prior authorization forms and learn more by accessing the Navitus Member Portal via single sign-on at member.accolade.com or contacting the Navitus Customer Care Center at 833-837-4308.

- In cases where you are prescribed a prescription drug that is not on the formulary, it may be necessary to obtain a non-formulary exception in order for the prescription to be a covered benefit. You may request an exception to coverage (ETC) for prescription drugs that are not

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typically covered on your formulary (NC), have a quantity limit (QL), are gender specific or new/not reviewed drugs by submitting an exception to coverage form and return it to Navitus. In addition, if office administered injections are included in coverage, products not included on the Medically Administered Formulary (MAP) formulary will be routed through the Exception to Coverage process for review of medical necessity. Please contact Navitus Customer Care at 833-837-4308 for more information on how to complete and submit the form.

- Updates to the drug formulary may be obtained by accessing the Navitus Member Portal or contacting the Navitus Customer Care Center. Outpatient prescription drugs purchased in connection with emergency or urgent care services will be paid according to in-network pharmacy benefits.

- Reimbursement: If you receive prescription drugs from an out-of-network pharmacy in an emergency or urgent situation, please submit your receipts along with the Direct Member Claim Form found by accessing the Navitus Member Portal or contacting the Navitus Customer Care Center.

- Any covered drug is also covered when provided in connection with a Clinical Trial, if prior authorization is obtained.

- If a pharmacy fills a prescription for a higher tier drug when a generic equivalent is available on the formulary, then payment is based on the available generic tier. Regardless of whether the Member or physician makes the request for the higher tier prescription, the tier 3 (nonpreferred) cost-sharing amount plus any difference in cost will apply. Cost-sharing does not apply to the maximum out-of-pocket cost.

- Certain drugs have quantity limits. Please refer to the formulary for these limits.

- Point of Sale Tablet Splitting: With the benefit of tablet splitting, you may pay as little as onehalf of your standard copayment on a select group of drugs. Drug selection is based on specific criteria such as: formulary status, propriety/safety of split, and daily dosing designation. Eligible medications are designated on the formulary with a "¢" symbol.

Outpatient Prescription Drugs

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Covered Expenses:

- Coverage includes drugs which by law require a written prescription and are prescribed for treatment of a diagnosed illness or injury. This includes Investigational drugs for the treatment of HIV.

- Cost-sharing amounts are calculated for each 30-day supply or course of treatment. For each course of treatment or 30-day supply, the Member is required to pay (1) copay. If a prescription is more than a 30-day supply but less than a 60-day supply, the Member will be required to pay two (2) copays. If a prescription is more than a 60-day supply but less than or equal to a 90-day supply, the Member will be required to pay (3) copays. Members may also obtain up to a 90-day supply at once through mail order and through some retail pharmacies for two (2) Copays.

- Single-packaged items are limited to two items or a one-month supply, whichever is less.

    - A single-packaged item includes, but is not limited to: inhalers, blood glucose strips, eye drops and ear drops. If a single-packaged item will last 30 days or longer, the Member is limited to one single package per Copay. If the singlepackaged item lasts less than 30 days, the member is limited to two single packages per copay. Ointments, creams, gels, solutions and other topical medications are dispensed in the smallest tube or package size that will last 30 days.

- Certain oral inhalants are limited to one item for up to three copays, depending on the day's supply for which the product will last based on drug instructions.

- Oral chemotherapy drugs listed on the formulary, member pays a max of $200 per 30 day fill, in-network.

- Drugs dispensed in connection with mandated home health care as listed in the Certificate.

- Diabetic supplies (including alcohol swabs, lancets and formulary test strips) are covered at $0 at preferred retail pharmacies, participating pharmacies, and Costco mail order pharmacy.

- Blood glucose monitors.

- Medications related to a diagnosis of gender identity disorder or gender dysphoria.
- Medication for the treatment of sexual dysfunction (quantitative limits are required).

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- Medications used for acne/skin disease (prior authorization is required for members age 35 or older).

- Compounds (subject to prior authorization threshold of $200).

- Dengvaxia is approved for use in patients aged 9 through 16 years who have laboratoryconfirmed previous dengue infection and reside in endemic areas. The Advisory Committee on Immunization Practices (ACIP) recommends Dengvaxia for children living in areas where dengue is endemic (e.g., U.S. Virgin Islands, Puerto Rico, and American Samoa), but it is not approved for individuals traveling to endemic regions.

- ERVEBO®, the Zaire Ebloavirus vaccine, is only available through the Strategic National Stockpile. There is no pharmacy benefit billing for Ervebo because it is not commercially available. The CDC will provide ERVEBO® upon request from licensed healthcare providers at institutions or sites with eligible patients. The Center for Disease Control and Prevention (CDC) provides ERVEBO® under the expanded access Investigational New Drug (IND) program at no cost.

- Affordable Care Act Drug Coverage: Per the Affordable Care Act, all of the drug categories listed below are covered with $0 copay:

    - A&B Recommendations by the U.S. Preventive Services Task Force
    - Smoking cessation products* (all legend & over-the-counter products) (90 days of all FDA-approved smoking cessation medications
    - Vaccines, including COVID-19, Hepatitis A, Hepatitis B, human papillomavirus (HPV), influenza (flu), measles, mumps & rubella (MMR), pneumococcal, tetanus toxoid-diphtheria-pertussis (TDAP), varicella, zoster, and meningococcal. ○ Select travel vaccines included: Meningitis, Polio, Japanese Encephalitis, Rabies, Typhoid, and Yellow Fever (if not covered by medical benefit). If out-of-network, then 50% coinsurance per prescription
    - Folic acid* ○ Liquid iron* ○ Fluoride* ○ Aspirin* ○ Statins
    - Breast Cancer Prevention*
    - Coverage of FDA-approved contraceptives, up to a 12-month supply when dispensed or furnished at one time
    - Bowel preparations for colorectal cancer screening* ○ HIV PrEP
      *specific guidelines apply

Unless otherwise specified, drugs will be dispensed in maximum quantities as follows:

TIER 1:

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Retail Pharmacy – Preferred generics and some lower cost brand drugs for up to a 30-day supply as indicated on the formulary, up to a 30-day supply. If a retail provider fills prescriptions with more than a 30-day supply, cost-sharing amounts will apply for each 30-day supply obtained. Preferred retail pharmacies allow up to a 90-day supply for two copays. Participating retail pharmacies allow up to a 90-day supply for three copays.

Mail Order – A 90-day supply of prescription medication for two Copays. Mail order is available for maintenance medications as defined by Navitus.

Specialty Generic Products – A select group of specialty generic drugs are available on Tier 1. Additional specialty generic drugs may be added at a future date. Up to a 30-day supply of specialty generic drugs that require coordination of care, close monitoring, or extensive patient training that generally cannot be met by a retail pharmacy. Specialty generic drugs may require special handling or manufacturing processes, restriction to certain physicians or pharmacies, or reporting of certain clinical events to the FDA.

TIER 2:

Retail Pharmacy – Preferred brand and some high cost non-preferred generic drugs as indicated on the formulary, up to a 30-day supply. If a retail provider fills prescriptions with more than a 30-day supply, a copay will apply for each 30-day supply obtained. Preferred retail pharmacies allow up to a 90-day supply for two copays. Participating retail pharmacies allow up to a 90-day supply for three copays.

Mail Order – A 90-day supply of prescription medication for two copays. Mail order is available for maintenance medications as defined by Navitus.

TIER 3:

Retail Pharmacy – Non-preferred drugs (could include some high cost non-preferred generic drugs) as indicated on the formulary up to a 30-day supply. If a retail provider fills prescriptions with more than a 30-day supply, a copay will apply for each 30-day supply obtained. Preferred retail pharmacies allow up to a 90-day supply for two copays. Participating retail pharmacies allow up to a 90-day supply for three copays.

Mail Order – A 90-day supply of prescription medication for three copays. Mail order is available for maintenance medications as defined by Navitus.

TIER 4

Specialty Brand Products – Up to a 30-day supply of specialty brand drugs that require coordination of care, close monitoring, or extensive patient training that generally cannot be met by a retail pharmacy. Specialty brand drugs may require special handling or manufacturing processes, restriction to certain physicians or pharmacies, or reporting of certain clinical events to the FDA. If a specialty brand drug is not covered, then the drug may be approved through the exception to coverage process.

Non-Covered Expenses:

- Charges for prescription drugs that require prior authorization, if prior authorization is not obtained.
- Charges for medications used for cosmetic purposes with the exception of medication for acne/skin disease.
- Added dispensing fees for unit dose medications. A unit dose medication is an individually wrapped and labeled drug typically used in hospitals and nursing homes.
- Weight Loss Medications, except when medically necessary for the treatment of obesity. In such cases, the drug will be subject to prior authorization.
- Over-the-counter (OTC) drugs, except for preventive prescription drugs covered under this Plan
- Infertility medications are **not covered** under your UC pharmacy benefit. This means that they are **not available through Navitus** at specialty, mail order, or at retail pharmacies. The Navitus-administered formulary **excludes all infertility drugs**. For coverage of infertility medications and information on how to obtain them, please contact **WINFertility**, UC's care management vendor for infertility benefits, at (**877) 451-3077**.

BENEFITS SNAPSHOT

BENEFIT TYPE	
Signature Select Formulary Four-Tier Pharmacy Benefit	
DAYS SUPPLY DISPENSED	
Preferred Retail Pharmacy - Costco, CVS, Safeway/Vons, select UC pharmacies, Walgreens, and Walmart	Up to 90 Days
Participating Retail Pharmacy	Up to 90 Days

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DAYS SUPPLY DISPENSED	
Mail Order Pharmacy – Costco Pharmacy	Up to 90 Days
Specialty Pharmacy – Select UC Pharmacies and Lumicera Health Services	Up to 30 Days

BENEFIT STRUCTURE						
Drug Type	**Preferred Retail Pharmacy, Participating Retail Pharmacy, Mail Order Up to 30 Day Supply**	**Preferred Retail Pharmacy, Participating Retail Pharmacy, Mail Order 31-60 Day Supply**	**Preferred Retail Pharmacy & Mail Order Pharmacy and Mail Order 61-90 Day Supply**	**Participating Retail Pharmacy 61-90 Day Supply**	**Specialty Pharmacy Up to 30 Day Supply**	**Out of Network Pharmacies Up to 30 Day Supply**
Tier 1	$10 copay per prescription drug	$20 copay per prescription drug	$20 copay per prescription drug	$30 copay per prescription drug	N/A	50% coinsurance per prescription drug
Tier 2	$30 copay per prescription drug	$60 copay per prescription drug	$60 copay per prescription drug	$85 copay per prescription drug	N/A	50% coinsurance per prescription drug
Tier 3	$50 copay per prescription drug	$100 copay per prescription drug	$100 copay per prescription drug	$130 copay per prescription drug	N/A	50% coinsurance per prescription drug

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Tier 4	N/A	N/A	N/A	N/A	30% coinsurance, up to $150 per prescription drug	N/A

ANNUAL OUT-OF-POCKET MAXIMUM (includes medical and pharmacy)	
In-Network	Out-of-Network
Individual $6,100	Individual $9,600
Family $9,700	Family $20,200

* For additional Plan specific detail, please call the Customer Care number at 833-837-4308

Pharmacy Discount Cards

If you use a pharmacy discount card to purchase your prescription, any amounts paid through the discount card in addition to amounts you paid out of pocket for your prescription will not count towards your annual deductible or out-of-pocket.

Access Guidance Services

The Plan works with Navitus to provide access guidance services to assist you in obtaining copay assistance for certain drugs that have manufacturer-funded copay assistance programs.

If the drug has copay assistance available, the amount you pay for that drug may vary. It may be set to the maximum of the current benefit design, $0, or the amount determined by the manufacturer-funded copay assistance programs. To take advantage of the lowest available pricing through the Plan, you will be required to remain enrolled in the manufacturer copay assistance program.

Amounts paid by manufacturers on your behalf or directly reimbursed to you (including manufacturer coupons) will not count toward your annual out-of-pocket maximum or deductible. Instead, only those payments made directly by you, and not reimbursed by the manufacturer, will count toward your out-of-pocket maximum or deductible. Once manufacturer-funded copay assistance is exhausted, the amount you pay will be no more than your benefit design. Your copay will default to the formulary's current tiered coinsurance/copay if you are not eligible for manufacturer copay assistance or if the drug is removed from or does not qualify for these services.

Preferred Retail Pharmacies

Preferred retail pharmacies are pharmacies which participate in the Navitus Pharmacy Network and offer Members lower copays for a 90-day supply.

Participating Retail Pharmacies

Participating retail pharmacies are pharmacies which participate in the Navitus Pharmacy Network. These Participating pharmacies have agreed to a contracted rate for covered prescriptions for Navitus Members.

Specialty Pharmacy – Navitus SpecialtyRx

Using a specialty pharmacy service offers affordable, high quality care for complex chronic conditions. This service includes a broad range of services to address provider coordination and care delivery. The Navitus SpecialtyRx Pharmacy Program is offered through a partnership with Lumicera Health Services and select UC pharmacies. Included as a part of specialty program management, Navitus offers a split fill program. This program is intended to reduce waste for high cost medications; our split-fill program reduces day's supply to 15 day intervals for qualifying high cost drugs with a significant discontinuation rate within the first three months of therapy. This allows for the opportunity to prevent the unnecessary dispensing of 2 weeks of therapy should therapy be discontinued within the first half of each of the initial three months of newly prescribed therapy.

You will be able to utilize your Navitus pharmacy benefit for more specialty drug coverage via the Navitus MAP Formulary. There are certain specialty drugs that may need to be infused or administered by a medical professional. When you use your Navitus pharmacy benefit for these drugs, you can ask a SpecialtyRx pharmacy to send your medication directly to your doctor's office for your appointment. Utilizing your Navitus pharmacy benefit for these medications may also help you save money. So, if your doctor is considering prescribing a specialty drug that may require administration from a medical professional, please discuss your benefit options with your doctor and have them review your Navitus MAP Formulary.

Please call Navitus Customer Care at 833-837-4308, a Lumicera patient care specialist at 855-8463553 or visit www.LUMICERA.com if you would like to know more about SpecialtyRx. To find out what drugs are covered, refer to your formulary after logging in to Navitus Member Portal via single sign-on at member.accolade.com and look for products that are identified with a "SP" in the Special Code column. If there is a "MSP" or "UMSP" Special Code, please contact Lumicera

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Health Services at 855-847-3553 or work with your provider to find select UC Pharmacies to fill your specialty drugs. You can also visit Lumicera online at www.lumicera.com.

Obtaining Prescriptions through Costco Mail Order Services

Using Costco Mail Order Service is convenient and can save you time and money. If you take a consistent dose of a covered maintenance medication drug for a chronic condition, such as diabetes or high blood pressure, you can receive up to a 90-day supply through home delivery with a reduced copayment.

Mail order prescriptions are managed through the Costco Member Portal. Register online at pharmacy.costco.com. It takes 10 to 14 calendar days from the day you submit your order to receive your medication(s). You do not need to be a Costco member to use Costco Pharmacy. Call Costco Pharmacy Customer Service at 1-800-607-6861 if you need assistance with registering or ordering prescriptions through the Costco Pharmacy website at pharmacy.costco.com.

COORDINATION OF BENEFITS

If you are covered by more than one health plan, your benefits under this Plan will be coordinated with the benefits of those other plans.

When Coordination Is Needed

Coordination of benefits is needed when you and/or your dependents have coverage under:

- More than one employer-provided health plan.
- An individually purchased plan and an employer-sponsored plan.
- A university-sponsored student plan and an employer-sponsored plan.
- Medicare and an employer plan.

An individual may become eligible for Medicare based on age, disability, or End-Stage Renal Disease. It is your responsibility to know if and when you or a dependent become eligible for Medicare and the steps, if any, required to enroll for Medicare benefits. **Your eligibility for Medicare benefits may impact your eligibility for Plan benefits**. If you have any questions regarding Medicare eligibility and the impact on your Plan benefits, call your campus Human Resources Department or Retirement Administration Service Center (800-888-8267). Detailed information regarding Medicare is available at www.medicare.gov.

How Coordination of Benefit Rules Work

If a health care expense is covered by two plans, one plan is the “primary” plan and has first responsibility for the expense. When the primary plan has paid its normal benefits, the other, or “secondary” plan may make an additional payment based on its provisions.

If UC Care Plan Is Primary. When the Plan is primary, it pays full benefits according to its rules. After you’ve received an explanation of benefits (EOB) from the Plan, you can submit any remaining expenses to the secondary plan for consideration.

If UC Care Plan is Secondary. When the Plan pays benefits as the secondary plan, the primary plan pays its benefits first. The Plan’s claims administrator then determines whether any additional benefit is payable. The claims administrator compares the primary plan’s benefit with the amount the Plan would have paid as your only source of coverage. The Plan makes up the difference, if any, between the amount you’ve already received and the amount the Plan would have paid had it been primary. The Plan will not pay a benefit if the primary plan paid the amount the Plan would have paid had it been the primary plan.

This type of coordination of benefits provision is often referred to as non-duplication.

If the Expense Is for You

The Plan is the primary plan for you (as an employee of the employer) and pays benefits without regard to other coverage, except if you are an acquired employee who remains covered under another plan for a period of time.

If the Expense Is for a Dependent

If a covered dependent is an employee of another employer and is covered by that employer's plan, the other employer's plan will be primary.

If a child is covered under both parents' plans, the primary plan will be that of the parent who has the earlier birthday during the calendar year.

If a child is covered under both plans of parents who are divorced or separated and not remarried, the plan of the parent with custody of the child is primary. An exception applies if the court has decreed that financial responsibility for medical and dental care expenses belongs with the other parent.

If the parent with custody has remarried and a stepparent's plan also covers the child, the plan of the parent with custody pays first and then the plan of the stepparent pays. The plan of the parent without custody pays last.

If the Other Plan Has No Coordination Rules

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If the other plan has no provision regarding coordination of benefits, that plan is primary.

If You Are Eligible for Medicare as an Active Employee or Dependent

If you're eligible for both Medicare and benefits from the employer as an active employee, the Plan will be primary for you and your covered Medicare eligible dependents, although certain Medicare exceptions may apply. For example, if you have End-Stage Renal Disease, Medicare is the secondary payer to the Plan for a specified coordination period. After the coordination period, Medicare becomes the primary payer and the Plan becomes the secondary payer. You must enroll in Medicare (for example, Medicare Parts A and B) before the end of the coordination period to prevent a gap in coverage. Detailed information regarding Medicare is available at www.medicare.gov.

When None of the Rules Apply

If none of the rules above determine the primary plan, the primary plan is the one that has covered the person for the longest period of time.

For Questions Regarding Coordination of Benefits

For detailed information regarding the coordination of your plan benefits with other coverage (or Medicare eligibility), call your campus Human Resources Department or Retirement Administration Service Center (800-888-8267).

CLAIMS PROCEDURES

Filing Claims

To begin the process, simply present your member ID card at the pharmacy. Your ID card contains information the pharmacy needs to fill your prescription and charge the correct copayment.

To file a paper claim to obtain a reimbursement from the Plan for any prescription that is paid in full at the time that is filled, follow the instructions below:

1. Log on to the Member Section of www.navitus.com to obtain the Direct Member Claim Form.
2. Complete all the information on the form. Please note: forms missing information are returned without payment.
3. Sign and date the Certification Statement.
4. Submit a separate form for each family member.
5. If the member has other insurance coverage, attach a copy of the "Explanations of Benefits" or "Denial Notification" from the primary insurance carrier.
6. Keep a copy for your records. Documents submitted will not be returned.

7. Mail or fax the claim form and the original receipt for processing. The mailing address and fax number are listed on the claim form.

Appealing a Claim Denial

When you have a concern about a benefit, claim or other service, please call Navitus Customer Care at the toll-free number listed on your card. Customer Care Specialists will answer your questions and resolve your concerns quickly.

A Navitus Health Solutions pharmacist carefully reviews all of the information that is provided and applies the terms of your pharmacy benefit Plan to Your request for review. All information is reviewed on a case by case basis, specific to each Member and the circumstances surrounding the request. The pharmacist who conducts the review of your appeal is not involved in the original determination and is not a subordinate of the person who made the original denial.

If your issue or concern is not resolved by calling Customer Care, you have the right to file a written appeal with Navitus. Please send this appeal, along with any related information from your doctor, to:

Mail:

Navitus Health Solutions
Attn: Appeals Department
P.O. Box 999
Appleton, WI 54912-0999

Fax:

Navitus Health Solutions
855-668-8550
Attn: Appeals Department

The appeal must be resolved within 30 calendar days for a standard appeals and 72 hours for an expedited appeal from the date the appeal is received by Navitus.

External Review

If the outcome of the mandatory first level appeal is adverse to you and it was based on medical judgment, or if it pertained to a rescission of coverage, you may be eligible for an independent external review pursuant to federal law.

If your final internal appeal is denied, you will be notified in writing that your claim is eligible for external review and you will be informed of the steps necessary to request an external review. If

you decide to seek external review, an independent external review organization ("IRO") will be assigned your claim, and the IRO will work with a neutral, independent clinical reviewer with appropriate medical expertise.

You must submit your request for external review to Navitus within four (4) months of the notice of your final internal adverse determination.

A request for an external review must be in writing unless Navitus determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

For pre-service claims involving urgent/concurrent care, you may proceed with an expedited external review without filing an internal appeal or while simultaneously pursuing an expedited appeal through Navitus' internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including Navitus' decision, can be sent between Navitus and you by telephone, facsimile or other similar method. To proceed with an expedited external review, you or your authorized representative must contact Navitus Customer Care at 833-837-4308.

All other requests for external review should be submitted in writing unless Navitus determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

Mail:
Navitus Health Solutions
Attn: Appeals Department
P.O. Box 999
Appleton, WI 54912-0999

Fax:
Navitus Health Solutions
855-668-8550
Attn: Appeals Department

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek external review will not affect your rights to any other benefits under this health care plan. There is no charge for you to initiate an independent external review.

Requirement to file an Appeal before taking further legal action

No legal action of any kind related to a benefit decision may be filed by you in any other forum, unless it is commenced within three years of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's internal appeals procedure but not including any voluntary level of appeal, before taking other legal action of any kind against the Plan.

Navitus reserves the right to modify the policies, procedures and timeframes in this section upon further clarification from Department of Health and Human Services.

Binding Arbitration

Following a continued denial of your request for coverage after exhaustion of the mandatory appeals process as described in this document, and, if filed timely, the external review, you can submit your claim to binding arbitration as allowed under the Federal Arbitration Act. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, state law governing agreements to arbitrate shall apply.

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

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

The arbitration is begun by the Member making written demand on UC. The arbitration will be conducted by Judicial Arbitration and Mediation Services (“JAMS”) according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the Member and UC, or by order of the court, if the Member and UC cannot agree that has completed the internal appeals process.

By authority of the Regents, University of California Human Resources, located in Oakland, administers all benefit plans in accordance with applicable Plan documents and regulations, custodial agreements, University of California Group Insurance Regulations, group insurance contracts, 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. Source documents are available for inspection upon request (800-888-8267). What is written here does not constitute a guarantee of Plan coverage or benefits— particular rules and eligibility requirements must be met before benefits can be received. The University of California intends to continue the benefits described here indefinitely; however, the benefits of all employees, retirees and Plan beneficiaries are subject to change or termination at the time of contract renewal or at any other time by the University or other governing authorities. The University also reserves the right to determine new premiums, employer contributions and monthly costs at any time. Health and welfare benefits are not accrued or vested benefit entitlements. UC's contribution toward the monthly cost of the coverage is determined by UC and may change or stop altogether, and may be affected by the state of California's annual budget appropriation. If you belong to an exclusively represented bargaining unit, some of your benefits may differ from the ones described here. For more information, employees should contact their Human Resources Office and retirees should call the UC Retirement Administration Service Center (800-888-8267).

In conformance with applicable law and University policy, the University is an action/equal opportunity employer. Please send inquiries regarding the University's action and equal opportunity policies for staff to Systemwide AA/EEO Policy Coordinator, University of California, Office of the President, 1111 Franklin Street, 5th Floor, CA 94607, and for faculty to the Office of Academic Personnel and Programs, University of California, Office of the President, 1111 Franklin Street, Oakland, CA 94607.

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