

DEPARTMENT OF INSURANCE

CLAIMS SERVICES BUREAU

300 SOUTH SPRING STREET, SOUTH TOWER
LOS ANGELES, CA 90013
www.insurance.ca.gov

CCB-010 P
Revised: 10/25/05



RECEIVED
DEPT. OF INSURANCE
LOS ANGELES

06 MAR 20 AM 10:09

REQUEST FOR ASSISTANCE

Work Phone: [Redacted]
Home Phone: [Redacted]

Name: [Redacted]
Address: [Redacted]
City: [Redacted] Zip: [Redacted]

Before you file a complaint with the Department of Insurance, you should first contact your insurance company, agent or broker in an effort to resolve the issue(s). If you do not receive a satisfactory response, then complete this form, attach copies of any important papers that relate to your complaint and mail to address shown above.

Please be aware that a copy of this Request for Assistance and other documentation submitted by you may be provided to the insurance company, agent or broker unless you indicate that you do not want a copy of your correspondence forwarded by checking the box:

Do not forward a copy of the completed form and the documentation provided. However, please contact the insurance company and investigate the complaint on my behalf.

1. Complete name of insurance company involved:
Pacificare Life and Health Insurance Company

2. Type of Insurance: Auto Home Life Health Other

3. (a) Name of policyholder if different from your name:
[Redacted]

(b) If a group policy, provide the group name:
Opus One Laboratories

4. Policy identification or certificate number:
074092600-3

5. Claim number (if applicable) _____

6. Date loss occurred or began (if applicable) December 2, 2005

7. Broker/Agent (if applicable) _____ Broker/Agent License number _____
Street address P.O. Box 6098 City/State Cypress CA Zip 90630

8. Have you contacted your company or broker/agent? Yes No

If yes, state the date(s) and person(s) contacted 12-05-05 (or 12-06-05), and 03-01-06, and
(Provide copies of all correspondence) 03-02-06

(COMPLETE REVERSE SIDE)

01-MAR-06 6162313

10745

9. Have you reported this to any other governmental agency? Yes No

If yes, please give:

(1) Name of agency: _____

(2) File number, if known: _____

10. Have you previously written to the Department of Insurance about this matter?

Yes No File number (if available) _____ Date _____

11. Is there attorney representation in this matter? Yes No

12. Is a lawsuit currently on-going or pending? Yes No

If yes, our ability to mediate this matter is limited, but we will investigate your inquiry for any regulatory issues. We may defer the regulatory investigation until the finality of the litigation. We ask that you still complete this form so we have a record of your issue. Once the matter is concluded, we would welcome any information regarding violations of law by the insurer that you or your attorney are willing to provide.

13. Briefly, describe your problem (use additional paper if needed):

See attached letter

14. What do you consider to be a fair resolution to your problem?

See end of attached letter

(Signature)

Mother (_____) is 3/16/08
authorized to act as my agent (Date)
in all matters pertaining to this investigation

(mother)

13. Briefly describe problem:

We are filing this grievance with the California Department of Insurance as a result of ongoing frustration with resolving claims payments for medical services, as well as arbitrary unwritten policies by PacifiCare Health Insurance, our health insurance PPO through [REDACTED] father's employer.

Background information:

On December 2, 2005, [REDACTED], a full-time student at University of California, Santa Cruz, was admitted to Santa Cruz Dominican Hospital for emergency surgery for an abscessed rectal fistula, a complication of Crohn's Disease. This was during finals for the fall quarter and [REDACTED] was unable to take his last two finals. His college advisor was notified, as was the Regents Scholarship office for which he is a recipient, and the insurance coordinator for student health services at UC Santa Cruz. At the beginning of January, [REDACTED] returned to school to take the remaining two finals (as previously arranged) and to attend the winter quarter. On January 5, 2006, [REDACTED] was seen at Santa Cruz Urgent Care for severe pain and complications related to his Crohn's disease. It was decided at that point that he should come home for the quarter on a medical leave of absence to seek treatment for his illness and would return for the spring quarter. Again, he notified the proper authorities of this change in plans. After several weeks of doctors appointments, tests and medication, it was decided that [REDACTED] should go on Remicade, a genetically engineered and very expensive medication, administered by infusion every other month for the rest of his life (or until a cure or a better treatment for Crohn's is found). Treatment begins with an initial three doses given over six weeks, to begin March 10. To keep the costs down, we found a preferred provider in PacifiCare's PPO network that could administer the Remicade for 80 - 85% less than the cost of having the infusions at a hospital, the normal venue for Remicade administration, but we will have to fly [REDACTED] home every other month for his treatments. Once he begins treatment, he cannot stop for risk of rejection or allergic reaction to future Remicade infusions. For this reason, we do not want [REDACTED] to start this medication until we are absolutely sure the problems with PacifiCare are straightened out.

Problem Explained:

[REDACTED] father along with the Human Resources Manager at his place of employment, Opus One Laboratories, called PacifiCare the Monday after [REDACTED] surgery (12-05-06), as we were concerned if [REDACTED] not being able to complete his finals would disqualify him for medical benefits as a student. They spoke with the small account manager who handled Opus One's health insurance account at that time. With both of them on speaker phone, they were told that PacifiCare had changed it's policy some months earlier and no longer required dependents to be students, ending at age 25.

From December 15th on, we received Explanation of Benefits (EOB) Statements, first requesting clarification if we had secondary insurance. As of December 1, 2005, the only other insurance we had was [REDACTED] additional student health insurance by Blue Cross through his university. On January 3, 2006, I ([REDACTED] mom) called PacifiCare and spoke with a customer service representative, who told me to call them with [REDACTED] secondary insurance information (call reference# 2640008, customer service

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representative Stacey) and they would record it. We continued to receive notices requesting clarification of secondary insurance. In January 13, 2006, I called back (call reference# 2639817, representative Sonya) and then faxed the requested information. Twenty minutes later, I called back to confirm fax, which wasn't received and refaxed to Sharon, who confirmed receipt of fax.

Early January through late January, the focus of PacifiCare's delay of claims payments involved a required certificate of creditable coverage, as PacifiCare was a new provider for us. Several calls were made to customer service beginning on January 13 through January 25 (01-13-06, call reference # 2639817, Sonya - as above; 01-20-06, # 2639817, Cheryl; 01-24-06, # 2700140, Shanitha; and 01-25-06, Tamica), each call followed by a fax of the certificate of creditable coverage as requested. I was told each time that it would take 15 - 30 days to reprocess the claims in question. It was not until the fourth attempt with agent Tamica standing by the fax machine, that acknowledgement of receipt of certificate of creditable coverage was received.

Once receipt of the certificate of creditable coverage was finally recorded at the end of January, PacifiCare began arbitrarily rejecting some claims including those from his original surgery in December, due to [REDACTED] not meeting the student eligibility requirement. They did not ask for verification of fulltime enrollment as a student or proof of disabled status on the BOBs, like they had asked for clarifications of previous compliance issues. Another call was made to PacifiCare customer service on February 24, 2006 (call reference # 2806808, Angela) to resolve this matter. I was told that I had to provide proof of student standing from his university. I told the customer service representative that [REDACTED] was on medical leave of absence due to his illness and was returning in April for spring quarter. She still instructed me to provide the requested information. Thoroughly frustrated by what I was being told, my [REDACTED] father and his HR representative who made the initial phone call back in December, once again called their small account representative (Erik Caughern) at PacifiCare to which they explained the problems. I was told to contact this gentleman and he could help expedite the claims. When I spoke with him on March 1, 2006, he informed me that [REDACTED] claims from December should not have been held up due to student status, as he was obviously a student at that time; however, he told me that [REDACTED] was not covered for the costs incurred while on medical leave of absence in January, February, or now March because he was not a fulltime student, and we would have to pay for COBRA to keep him on the plan. He confirmed this with a fellow counterpart in his office. I then questioned him as to whether [REDACTED] would qualify as a disabled dependent? He was going to check this out with their legal department and get back to me. I faxed him all the documentation he requested including the application for medical leave of absence approved by the university, [REDACTED] physician's statement as to [REDACTED] medical status, a letter from the university acknowledging [REDACTED] medical status, as well as all known rejected claims to that point due to the question of student standing. I also told him that I was having the California Department of Insurance launch an investigation. He sent the information on to a special department that expedites claims. The next day I was contacted by a claims adjuster (call reference # 2814200, Trenise), who informed me that none of the claims, including the most recent claims submitted since [REDACTED] was on

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medical leave of absence, should have been rejected, because PacifiCare had changed their policy back on August 5, 2005, for small business accounts, whereby student standing was not required. When I questioned this representative, she clarified that to say student standing no longer needed to be verified. I asked her why so many people in her company had no clue that this policy existed, including the now account manager for my husband's business who tried to get me to pay for COBRA for my son, and all the claims adjusters who had rejected the claims, as well as the customer service representatives who required me to send student verification. She didn't really have an explanation except to say that she wasn't sure whether the claims were rejected by the computer or a person. I asked her if a policy letter had been sent out last August to the small businesses carrying their health insurance and if I could receive a copy of that letter. She said it was an "internal thing" and that no policy letter was available. She is however working on processing the claims through.

On two levels, we are requesting an investigation be done:

- 1) Unnecessary delay of claims payments.
- 2) Arbitrary, ambiguous, misrepresented, and extremely misleading policies that PacifiCare won't disclose to the public for clarification and consistency.

Because of the contradictions in PacifiCare's unwritten "internal" policy, the medical providers that have taken care of [REDACTED] have been delayed payment from both PacifiCare and Blue Cross (who had to wait for PacifiCare to process claims before they could proceed). They have caused me hours and hours of time and heartache in an exasperating effort to set things right, while at the same time having the stress of a sick child. Had I not been so persistent, we would have been denied claims, incurred medical expenses that should have been covered, and paid for COBRA that wasn't required.

14. What do you consider to be fair resolution to the problem?

As of 03-08-06, we were informed by claims adjuster, Trenise, that all claims submitted to date have been paid and assured that "our family will not have any further problems in having claims paid." However because of the contradictory, ambiguous, and arbitrary nature of PacifiCare's "internal" policy regarding student standing, we would like a clear, written policy statement sent to all PacifiCare personnel, as well as to PacifiCare's small group clients (to whom this policy applies). This way PacifiCare can disseminate accurate, consistent information to its clients and clients can make intelligent, well-informed decisions based on facts instead of hearsay.

Thank you for your help in resolving these matters.

Respectfully,

[REDACTED] (mother) [REDACTED]

CalDepIns

Call Reference # 2814200

03-08-06

Trenise

All claims submitted to PacifiCare as of this date have been processed / reprocessed and paid to all medical service providers for [REDACTED]

Our family should not have anymore problems with claims being paid.

Request made again for letter of policy statement regarding no more requirement for student verification.

- This is an "internal thing" that doesn't require a policy statement. No letter went out to small business clients in August when the policy changed because they didn't want to signal the small business that dependents didn't have to be students. No policy statement letter exists explaining the change.
- Erik, small accounts manager for Opus One has been notified of policy change whereby verification of student status is no longer required.
- She can tell her supervisor to send out to other supervisors to inform representatives of policy change.

Trenise - Pacific Care

03-03-06

All Claims sent back that are being held up due to Patient Status

Claims should ^{Never have been} ~~Rejected~~ Max. out of Pocket

800-947-1672

EX 78713

Max. Benefit

Call Ref. # 281 4200

Requirements for full time Students as of August 3 2005

~~no longer required~~

Verification no longer needed At time of enrollment hours

a student - Annual Verification no longer needed on

small group plan.

Remicade must be provided by Rx solutions NOT Physicians' office. Trenise Rechecked this and found Authorization is on file

Pacific Care will not ship Rx Because Dr. Providing Remicade -> Does not have to go through Rx solutions Credit Card not charged -> Refund Issued

PacifiCare®
Life and Health Insurance Company

P.O. Box 6098
Cypress, California 90630
Tel 866-316-9776

December 15, 2005

|||||

[REDACTED]

Employee: [REDACTED]
Patient: [REDACTED]
Claim #: 15130497-01
Services By: DOMINICAN SANTA CRUZ HOSPITAL
Date of Service: 12/02/2005 - 12/03/2005

Dear [REDACTED]

Additional information is required in order to process the above referenced claim. Please answer the following questions to update our files.

Do you or any other family members on this plan have other health care coverage, other than PacifiCare?
Yes X No _____

If YES, complete the following:

- 1. Name of other carrier or benefit plan: Blue Cross
- 2. Address and phone number for this other policy:

800-888-2108

- 3. Group number/Member number: UCO121373 @RA# 175095
- 4. Name, date of birth and relationship of the policy holder who is the primary subscriber for this other coverage: [REDACTED] 01/17/85 Son

Sincerely, [REDACTED] is primary subscriber on this policy through UC Santa Cruz
Claims Department

Called PacifiCare
on 01/03/06
Information given to
Stacy Ref. Call # 2640008
15-30 days to reprocess

800000101730000000000000000004

PacifiCare
 Life and Health Insurance Company
 P.O. Box 6098
 Cypress, CA 90630

This Claim was paid to Provider:
 QUEST DIAGNOSTICS

CLAIM NUMBER
 15134821-01

CHECK NUMBER
 nochk1340034

CHECK DATE
 12/15/2005

CHECK AMOUNT
 0.00



PacifiCare
 Life and Health Insurance Company

EXPLANATION OF BENEFITS

Retain for Your Records.
 (866) 316-9776

Date(s) of Service: 12/01/2005-12/01/2005

Patient: [REDACTED]

Insured: [REDACTED]

Patient Account #: 0032115607

Provider: QUEST DIAGNOSTICS

Group: OPUS ONE LABORATORIES

Contract Name: California Network

Check Date: 12/15/2005

Check Number: nochk1340034

Check Amount: 0.00

Group #: 90176583

Claim #: 15134821-01

It is your responsibility to pay: 0.00
 It is NOT your responsibility to pay: \$175.76

Please pay the amount to the provider of service.

| SERVICE DATE(S) | TYPE OF SERVICE | BILLED AMOUNT | INELIGIBLE AMOUNT | | | CO-PAYMENT/ADDITIONAL DEDUCTIBLE AMOUNT | APPLIED TO ANNUAL DEDUCTIBLE | PATIENT COINSURANCE AMOUNT | PAY % | CLAIMS PAYMENT AMOUNT |
|-----------------|-----------------|---------------|-------------------|--------------------|----------------------------|---|------------------------------|----------------------------|-------|-----------------------|
| | | | RMK CODE | INSURED'S DISCOUNT | Not Patient Responsibility | | | | | |
| 12/01/05 | Ineligible | 34.42 | iq | | 34.42 | | | | | |
| 12/01/05 | Ineligible | 41.73 | iq | | 41.73 | | | | | |
| 12/01/05 | Ineligible | 45.61 | iq | | 45.61 | | | | | |
| 12/01/05 | Ineligible | 3.60 | iq | | 3.60 | | | | | |
| 12/01/05 | Ineligible | 50.40 | iq | | 50.40 | | | | | |
| TOTALS | | 175.76 | | | 175.76 | | | | | |

TOTAL PAID FOR THIS CLAIM

REMARK CODE(S) DESCRIPTIONS AND CLAIM COMMENTS

iq Claim was closed due to a lack of response to a prior request for other insurance information. Services will be reconsidered and patient responsibility will be calculated upon receipt. Please refer to your Certificate, "Payment Responsibility, Right to Receive and Release Information".

Claim submitted not clean. Processed with information available.

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 P.O. Box 6098
 Cypress, CA 90630

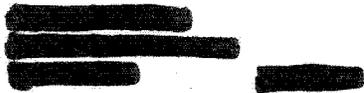
This Claim was paid to Provider:
 QUEST DIAGNOSTICS

CLAIM NUMBER
 15135019-01

CHECK NUMBER
 nochk1340046

CHECK DATE
 12/15/2005

CHECK AMOUNT
 0.00



PacifiCare®
 Life and Health Insurance Company

EXPLANATION OF BENEFITS

Retain for Your Records.
 (866) 316-9776

Date(s) of Service: 12/01/2005-12/01/2005

Patient: [Redacted]
 Insured: [Redacted]

Check Date: 12/15/2005

Check Number: nochk1340046

Check Amount: 0.00

Patient Account #: 0032115607

Group: OPUS ONE LABORATORIES

Group #: 90176583

Provider: QUEST DIAGNOSTICS

Contract Name: California Network

Claim #: 15135019-01

It is your responsibility to pay: 0.00
 It is NOT your responsibility to pay: \$413.23

Please pay the amount to the provider of service.

| SERVICE DATE(S) | TYPE OF SERVICE | BILLED AMOUNT | INELIGIBLE AMOUNT | | | | COPAYMENT/ADDITIONAL DEDUCTIBLE AMOUNT | APPLIED TO ANNUAL DEDUCTIBLE | PATIENT COINSURANCE AMOUNT | PAY % | CLAIMS PAYMENT AMOUNT |
|-----------------|-----------------|---------------|-------------------|--------------------|----------------------------|------------------------|--|------------------------------|----------------------------|-------|-----------------------|
| | | | RMK CODE | INSURED'S DISCOUNT | Not Patient Responsibility | Patient Responsibility | | | | | |
| 12/01/05 | Ineligible | 21.00 | iq | | 21.00 | | | | | | |
| 12/01/05 | Ineligible | 18.74 | iq | | 18.74 | | | | | | |
| 12/01/05 | Ineligible | 28.99 | iq | | 28.99 | | | | | | |
| 12/01/05 | Ineligible | 19.01 | iq | | 19.01 | | | | | | |
| 12/01/05 | Ineligible | 46.00 | iq | | 46.00 | | | | | | |
| 12/01/05 | Ineligible | 39.39 | iq | | 39.39 | | | | | | |
| 12/01/05 | Ineligible | 51.42 | iq | | 51.42 | | | | | | |
| 12/01/05 | Ineligible | 51.42 | iq | | 51.42 | | | | | | |
| 12/01/05 | Ineligible | 51.42 | iq | | 51.42 | | | | | | |
| 12/01/05 | Ineligible | 51.42 | iq | | 51.42 | | | | | | |
| TOTALS | | | | | | | | | | | |

TOTAL PAID FOR THIS CLAIM

REMARK CODE(S), DESCRIPTIONS AND CLAIM COMMENTS

iq Claim was closed due to a lack of response to a prior request for other insurance information. Services will be reconsidered and patient responsibility will be calculated upon receipt. Please refer to your Certificate, "Payment Responsibility, Right to Receive and Release Information".

Claim submitted not clean. Processed with information available.

PacifiCare
 Life and Health Insurance Company
 P.O. Box 6098
 Cypress, CA 90630

This Claim was paid to Provider:

QUEST DIAGNOSTICS

CLAIM NUMBER
 15135008-01

CHECK NUMBER
 nochk1340045

CHECK DATE
 12/15/2005

CHECK AMOUNT
 0.00



PacifiCare
 Life and Health Insurance Company

EXPLANATION OF BENEFITS

Retain for Your Records.

(866) 316-9776

Date(s) of Service: 12/01/2005-12/01/2005

Patient: [REDACTED]
 Insured: [REDACTED]

Patient Account #: 0032115607

Provider: QUEST DIAGNOSTICS

Group: OPUS ONE LABORATORIES

Contract Name: California Network

Check Date: 12/15/2005

Check Number: nochk1340045

Check Amount: 0.00

Group #: 90176583

Claim #: 15135008-01

| | | |
|---|----------|--|
| If it is your responsibility to pay | 0.00 | Please pay this amount to the provider of service. |
| If it is NOT your responsibility to pay | \$662.26 | |

| SERVICE DATE(S) | TYPE OF SERVICE | BILLED AMOUNT | INELIGIBLE AMOUNT | | | COPAYMENT/ADDITIONAL DEDUCTIBLE AMOUNT | APPLIED TO ANNUAL DEDUCTIBLE | PATIENT COINSURANCE AMOUNT | PAY % | CLAIMS PAYMENT AMOUNT |
|-----------------|-----------------|---------------|-------------------|--------------------|----------------------------|--|------------------------------|----------------------------|-------|-----------------------|
| | | | RMK CODE | INSURED'S DISCOUNT | Not Patient Responsibility | | | | | |
| 12/01/05 | Ineligible | 53.00 | iq | | 53.00 | | | | | |
| 12/01/05 | Ineligible | 59.00 | iq | | 59.00 | | | | | |
| 12/01/05 | Ineligible | 110.00 | iq | | 110.00 | | | | | |
| 12/01/05 | Ineligible | 32.00 | iq | | 32.00 | | | | | |
| 12/01/05 | Ineligible | 17.00 | iq | | 17.00 | | | | | |
| 12/01/05 | Ineligible | 68.25 | iq | | 68.25 | | | | | |
| 12/01/05 | Ineligible | 59.00 | iq | | 59.00 | | | | | |
| 12/01/05 | Ineligible | 108.25 | iq | | 108.25 | | | | | |
| 12/01/05 | Ineligible | 38.00 | iq | | 38.00 | | | | | |
| 12/01/05 | Ineligible | 72.00 | iq | | 72.00 | | | | | |
| TOTALS | | | | | | | | | | |

TOTAL PAID FOR THIS CLAIM

REMARK CODE(S) DESCRIPTIONS AND CLAIM COMMENTS:

iq Claim was closed due to a lack of response to a prior request for other insurance information. Services will be reconsidered and patient responsibility will be calculated upon receipt. Please refer to your Certificate, "Payment Responsibility, Right to Receive and Release Information".

Claim submitted not clean. Processed with information available.

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 Life and Health Insurance Company
 P.O. Box 6098
 Cypress, CA 90630

This Claim was paid to Provider:
 DOMINICAN SANTA CRUZ HOSPITAL

CLAIM NUMBER
 15130497-01

CHECK NUMBER
 nochk1339790

CHECK DATE
 12/15/2005

CHECK AMOUNT
 0.00



PacifiCare®
 Life and Health Insurance Company

EXPLANATION OF BENEFITS
 Retain for Your Records.
 (866) 316-9776

Date(s) of Service: 12/02/2005-12/03/2005

Patient: [REDACTED]
 Insured: [REDACTED]

Check Date: 12/15/2005

Check Number: nochk1339790

Check Amount: 0.00

Patient Account #: 035671528E325010

Group: OPUS ONE LABORATORIES

Group #: 90176583

Provider: DOMINICAN SANTA CRUZ HOSPITAL

Contract Name: California Network

Claim #: 15130497-01

It is your responsibility to pay 0.00 Please pay this amount to the provider of service.
 It is NOT your responsibility to pay \$19,059.14

| SERVICE DATE(S) | TYPE OF SERVICE | BILLED AMOUNT | INELIGIBLE AMOUNT | | | COPAYMENT/ ADDITIONAL DEDUCTIBLE AMOUNT | APPLIED TO ANNUAL DEDUCTIBLE | PATIENT COINSURANCE AMOUNT | PAY % | CLAIMS PAYMENT AMOUNT |
|-----------------|-----------------|---------------|-------------------|--------------------|----------------------------|---|------------------------------|----------------------------|-------|-----------------------|
| | | | RMK CODE | INSURED'S DISCOUNT | Not Patient Responsibility | | | | | |
| 12/02/05 | Ineligible | 19,059.14 | iq | | 19,059.14 | | | | | |
| TOTALS | | 19,059.14 | | | 19,059.14 | | | | | |

TOTAL PAID FOR THIS CLAIM

REMARKS CODE(S) DESCRIPTIONS AND CLAIM COMMENTS:
 iq Claim was closed due to a lack of response to a prior request for other insurance information. Services will be reconsidered and patient responsibility will be calculated upon receipt. Please refer to your Certificate, "Payment Responsibility, Right to Receive and Release Information".
 Claim submitted not clean. Processed with information available.



UC 0121373

Phone #
800-888-2108

Group #
175095

09-17-05

PacifiCare®
 Life and Health Insurance Company
 P.O. Box 6098
 Cypress, CA 90630

This Claim was paid to Provider:
 SANTA CRUZ EMERG PHYS

CLAIM NUMBER
 16030813-01

CHECK NUMBER
 nochk1362155

CHECK DATE
 01/04/2006

CHECK AMOUNT
 0.00

*Called PacifiCare
 on 01-13-06, 11:03 am.
 Sonya*

*Call Reference
 # 2639817*

*Called back
 w/ updated info
 on [redacted] (Blue
 cross policy info)
 11/24 01-03-06
 Sharon*

[Redacted]

PacifiCare®
 Life and Health Insurance Company

EXPLANATION OF BENEFITS
 Retain for Your Records.
 (866) 316-9776

Date(s) of Service: 12/02/2005-12/02/2005
 Patient: [Redacted]
 Insured: [Redacted]
 Patient Account #: 04154443
 Provider: SANTA CRUZ EMERG PHYS

Group: OPUS ONE LABORATORIES
 Contract Name: NON-PAR PAID AT PAR LEVEL

Check Date: 01/04/2006
 Check Number: nochk1362155
 Check Amount: 0.00
 Group #: 90176583
 Claim #: 16030813-01

It is your responsibility to pay 0.00
 It is NOT your responsibility to pay \$393.00
Please pay the amount to the provider of service.

| SERVICE DATE(S) | TYPE OF SERVICE | BILLED AMOUNT | INELIGIBLE AMOUNT | | | CO-PAYMENT/ADDITIONAL DEDUCTIBLE AMOUNT | APPLIED TO ANNUAL DEDUCTIBLE | PATIENT COINSURANCE AMOUNT | PAY % | CLAIMS PAYMENT AMOUNT |
|---------------------------|-----------------|---------------|-------------------|--------------------|----------------------------|---|------------------------------|----------------------------|-------|-----------------------|
| | | | RMK CODE | INSURED'S DISCOUNT | Not Patient Responsibility | | | | | |
| 12/02/05 | Ineligible | 393.00 | iq | | 393.00 | | | | | |
| TOTALS | | 393.00 | | | 393.00 | | | | | |
| TOTAL PAID FOR THIS CLAIM | | | | | | | | | | |

REMARK CODE(S) DESCRIPTIONS AND CLAIM COMMENTS:
 iq Claim was closed due to a lack of response to a prior request for other insurance information. Services will be reconsidered and patient responsibility will be calculated upon receipt. Please refer to your Certificate, "Payment Responsibility, Right to Receive and Refuse Information".

THIS IS NOT A BILL

Gino

15-20 for
den 5/1 updated
process claims mine, 1/2 [redacted] FWD.
No other insurance
but Pacificare

Needs:

Member ID: UCO121373

Group # 175095

Phone # @ 800-888 2108

Blue Cross -

517-19-9992

Confirmed
Continuation of

Benefits if expenses
can be proven (deductible
met)
Call Reference

263 9817

Canoga Park, CA 91303
Fax: (818) 992-4

Stacy -
Ref. call #
2640008

[Click here and type address]

Please call me at

Ask for

To: Pacific Care PPO Fax: 1-866-392-7066
 Attention Cheryl R. Badge #1031 West ~~XXXXXXXXXX~~ Attention: Shenitha

From: ~~XXXXXXXXXX~~ Date: 1/20/2006

Re: Certificate of Continuous Coverage Pages: 3 (including cover page), certifs,
 and original Fax coverpage from 01-13-06

CC:

Urgent For Review Please Comment Please Reply Please Recycle



Call reference # 2639817 & # 2700140 - This e-mail includes the Certificate of Continuous Coverage as required by Pacific Care to process claims submitted on ~~XXXXXXXXXX~~, as well as claims submitted by any other member of this group plan covered under subscriber ~~XXXXXXXXXX~~ (ID #074092600 / Group#

90176583), including: ~~XXXXXXXXXX~~ Date of Birth: 03-22-55

~~XXXXXXXXXX~~ Date of Birth: 04-02-55

~~XXXXXXXXXX~~ Date of Birth: 01-17-85

~~XXXXXXXXXX~~ Date of Birth: 10-08-86

Please note this in your computer as soon as possible, as claims are pending.

Thank you!

~~XXXXXXXXXX~~

Lexapro
 escitalopram oxalate

Shenitha
 01-24-06 10:00
 Call Ref #
 2700140
 Refaxed 3rd time

Call Ref # 2700140
Lexapro
 escitalopram oxalate
 Tainica said to
 Faxed to direct line
 210-474-5325
 on 01-25-06 @
 12:57 pm. She
 retrieved from Fax
 and scanned to their
 system to forward to
 Claims Dept.

Faxed to "Tawca" @

210-4745385

on 01-25-06 @ 12:57pm

She retrieved from

Fax machine

Call Ref. #

[Click here and type address]

From Original Fax
1/13/06

Facsimile Transmittal

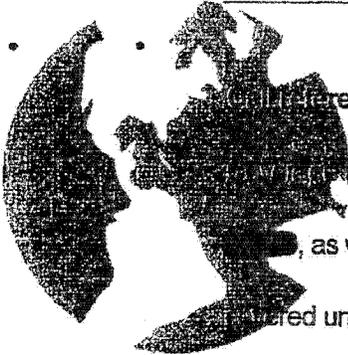
To: Pacific Care PPO Fax: 1-866-392-7066

From: [REDACTED] Date: 1/13/2006

Re: Certificate of Continuous Coverage Pages: 2 (including cover page)

CC:

Urgent For Review Please Comment Please Reply Please Recycle



Reference # 2639817 – This e-mail includes the Certificate of Continuous Coverage as required by Pacific Care to process claims submitted on [REDACTED], as well as claims submitted by any other member of this group plan [REDACTED] under subscriber [REDACTED] (ID #074092600 / Group# 90176583),

including: [REDACTED] Date of Birth: 03-22-55
 [REDACTED] Date of Birth: 04-02-55
 [REDACTED] Date of Birth: 01-17-85
 [REDACTED] Date of Birth: 10-08-86

Please note this in your computer as soon as possible, as claims are pending.

Thank you!

[REDACTED]

.....

CERTIFICATE OF GROUP HEALTH PLAN COVERAGE

IMPORTANT - This certificate provides evidence of your prior health coverage. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for certain conditions that you have before you enroll. This certificate may need to be provided if medical advice, diagnosis, care, or treatment was recommended or received for the condition within the 6-month period prior to your enrollment in the new plan. If you become covered under another group health plan, check with the plan administrator to see if you need to provide this certificate. You may also need this certificate to buy, for yourself or your family, an insurance policy that does not exclude coverage for medical conditions that are present before you enroll.

1. Date of this certificate: January 13, 2006
2. Name of group health plan: Aetna PPO Medical
Medical Group Policy #: 100424
3. Name of participant: [REDACTED]
4. Identification number of participant: [REDACTED]
5. Name of any dependents to which this certificate applies: [REDACTED] (spouse);
[REDACTED] (daughter); [REDACTED] (son)
6. Name, address, and telephone number of plan administrator or issuer responsible for providing this certificate:

Chris Lauer
InSight Health Corp.
26250 Enterprise Ct., Ste. 100
Lake Forest, CA 92630
7. For further information call: (800) 874-8634 x6117
8. If the individual(s) identified in line 3 and line 5 has at least 18 months of creditable coverage (disregarding periods before a 63-day break), check here and skip lines 9 and 10.
9. Date waiting period or affiliation period (if any) began:
10. Date coverage began: 04/01/2003
11. Date coverage ended: 11/30/2005 (or check if coverage is continuing as of the date of this certificate:).

Note: Separate certificates will be furnished if information is not identical for the participant and each beneficiary.

```

*****
*
*                               TRANSACTION REPORT
*
*                               JAN-24-2006 10:22 AM
*   FOR: INTERSCOPE PATHOLOGY      818 992 1218
*
*-----*
*   SEND
*
*   DATE   START   RECEIVER          PAGES   TIME   NOTE
*-----*
*   JAN-24 10:19 AM 18663927066          4      2'52"  OK
*-----*
*****

```

```

*****
*
*           TRANSACTION REPORT
*
*           FOR: INTERSCOPE PATHOLOGY           818 992 1218
*
*           JAN-20-2006 01:11 PM
*
* _____
*   SEND
*
* _____
*   DATE   START   RECEIVER           PAGES   TIME   NOTE
* _____
*   JAN-20 01:08 PM 18663927066           3       2'19"  OK
* _____
*
*****

```

PacifiCare®
 Life and Health Insurance Company
 P.O. Box 6098
 Cypress, CA 90630

This Claim was paid to Provider:
 ANESTHES MED GROUP SANTA CRUZ

| CLAIM NUMBER |
|--------------|
| 16154192-01 |

| CHECK NUMBER |
|--------------|
| nochk1375777 |

| CHECK DATE |
|------------|
| 01/12/2006 |

| CHECK AMOUNT |
|--------------|
| 0.00 |



PacifiCare®
 Life and Health Insurance Company

EXPLANATION OF BENEFITS
 Retain for Your Records.
 (866) 316-9776

Date(s) of Service: 12/03/2005-12/03/2005

Patient: [REDACTED]

Insured: [REDACTED]

Patient Account #: [REDACTED]

Provider: ANESTHES MED GROUP SANTA CRUZ

Group: OPUS ONE LABORATORIES

Contract Name: NON-PAR PAID AT PAR LEVEL

Check Date: 01/12/2006

Check Number: nochk1375777

Check Amount: 0.00

Group #: 90176583

Claim #: 16154192-01

| | | |
|--------------------------------------|--------|---|
| It is your responsibility to pay | 0.00 | File to pay this amount to the provider of service. |
| It is NOT your responsibility to pay | 880.00 | |

| SERVICE DATE(S) | TYPE OF SERVICE | BILLED AMOUNT | INELIGIBLE AMOUNT | | | | COPAYMENT/ADDITIONAL DEDUCTIBLE AMOUNT | APPLIED TO ANNUAL DEDUCTIBLE | PATIENT COINSURANCE AMOUNT | PAY % | CLAIMS PAYMENT AMOUNT |
|-----------------|-----------------|---------------|-------------------|--------------------|----------------------------|------------------------|--|------------------------------|----------------------------|-------|-----------------------|
| | | | RMK CODE | INSURED'S DISCOUNT | Not Patient Responsibility | Patient Responsibility | | | | | |
| 12/03/05 | Ineligible | 720.00 | px | | 720.00 | | | | | | |
| 12/03/05 | Ineligible | 160.00 | px | | 160.00 | | | | | | |
| TOTALS | | 880.00 | | | 880.00 | | | | | | |

| | |
|---------------------------|--|
| TOTAL PAID FOR THIS CLAIM | |
|---------------------------|--|

REMARK CODE(S), DESCRIPTIONS AND CLAIM COMMENTS:

px This claim is being denied due to lack of required information. Please forward the Certificate of Creditable Coverage from your prior carrier. If unavailable, please submit names and addresses of doctors who have treated you in the past year. Refer to your Certificate, "Exclusionary period for pre-existing conditions."

Claim submitted not clean. Processed with information available.

[REDACTED]

January 27, 2006

Claims Correspondence
PacifiCare
P.O. Box 6098
Cypress, CA 90630

RE: PacifiCare PPO
Policy ID #074092600
Group# 90176583
Subscriber [REDACTED] - Opus One Laboratories
Effective Date 11-01-05

To Whom It May Concern:

In a call to your Customer Service Department, December 1, 2005 (call reference # 2564773), I was told to provide documentation that our deductible was met with our prior health insurance carrier and show proof of continuous coverage in order to have the deductible waived for remaining medical expenses submitted to PacifiCare through the end of the year 2005, on insured [REDACTED]. Enclosed please find verification that our individual and family deductibles were met for calendar year 2005 with Aetna. Though our deductible was \$250 per person, our out-of-pocket medical expenses well exceeded \$500 per person (see documentation). I also submitted in a fax the Certificate of Creditable Coverage (please see call reference #2700140), scanned and noted on 01-24-06. This should complete the necessary evidence you require to waive the deductible requirements. If you need anything further, please contact me at [REDACTED] 8:30 - 4:30, Tue - Fri. or [REDACTED] after 4:30 p.m. daily.

Respectfully,

[REDACTED]

*Receipt of
this letter &
verification as
of 2/23/06
per Angela
Call Ref. #
2806835*

PacifiCare®
 Life and Health Insurance Company
 P.O. Box 6098
 Cypress, CA 90630

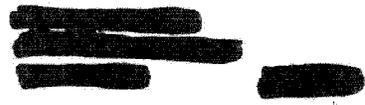
This Claim was paid to Provider:
 ROBERT K NAKAMURA MD

CLAIM NUMBER
 16471507-01

CHECK NUMBER
 006003169757

CHECK DATE
 02/04/2006

CHECK AMOUNT
 ****\$113.70



PacifiCare®
 Life and Health Insurance Company

EXPLANATION OF BENEFITS
 Retain for Your Records.
 (866) 316-9776

*To be submitted to
 Blue Cross when
 Pacific Care pays*

Date(s) of Service: 01/12/2006-01/12/2006
 Patient: [REDACTED]
 Insured: [REDACTED]
 Patient Account #: 0850618
 Provider: ROBERT K NAKAMURA MD

Group: OPUS ONE LABORATORIES

Check Date: 02/04/2006
 Check Number: 006003169757
 Check Amount: \$113.70
 Group #: 90176583
 Claim #: 16471507-01

It is your responsibility to pay: \$281.50
 It is NOT your responsibility to pay: \$113.70
 Please pay the amount to the provider of service.

| SERVICE DATE(S) | TYPE OF SERVICE | BILLED AMOUNT | INELIGIBLE AMOUNT | | | | COPAYMENT/ ADDITIONAL DEDUCTIBLE AMOUNT | APPLIED TO ANNUAL DEDUCTIBLE | PATIENT COINSURANCE AMOUNT | PAY % | CLAIMS PAYMENT AMOUNT |
|-----------------|-----------------|---------------|-------------------|--------------------|----------------------------|------------------------|---|------------------------------|----------------------------|----------|-----------------------|
| | | | RMK CODE | INSURED'S DISCOUNT | Not Patient Responsibility | Patient Responsibility | | | | | |
| 01/12/06 | Lab | 20.00 | ld | | | 8.00 | | 4.80 | 60 | 7.20 | |
| 01/12/06 | Lab | 235.00 | ld | | | 156.70 | | 31.32 | 60 | 46.98 | |
| 01/12/06 | Lab | 120.00 | ld | | | 40.80 | | 31.68 | 60 | 47.52 | |
| 01/12/06 | Lab | 20.00 | sa | | | | | 8.00 | 60 | 12.00 | |
| TOTALS | | 395.00 | | | | 205.50 | | 75.80 | | \$113.70 | |

PRIMARY CODE(S) DESCRIPTIONS AND CLAIM COMMENTS

ld This amount exceeds the PacifiCare maximum allowable fee or limited fee schedule for Plan Benefits. Please refer to your Schedule of Benefits.
 sa Dependent has not met student status requirements. Please refer to your Certificate, Section 4, "Definitions," Dependent.

PATIENT'S ANNUAL (CALENDAR/PLAN) DEDUCTIBLE REMAINING: 0.00

TOTAL PAID FOR THIS CLAIM \$113.70

PacifiCare®
 Life and Health Insurance Company
 P.O. Box 6098
 Cypress, CA 90630

This Claim was paid to Provider:
 TARZANA MEDICAL CENTER

CLAIM NUMBER
 16521725-01

CHECK NUMBER
 006003188813

CHECK DATE
 02/09/2006

CHECK AMOUNT
 ***\$1,973.96

[REDACTED]

PacifiCare®
 Life and Health Insurance Company

EXPLANATION OF BENEFITS
 Retain for Your Records.
 (866) 316-9776

*to be Submitted
 to Blue Cross*

Date(s) of Service: 01/12/2006-01/12/2006
 Patient: [REDACTED]
 Insured: [REDACTED]
 Patient Account #: 0004122743
 Provider: TARZANA MEDICAL CENTER

Group: OPUS ONE LABORATORIES
 Contract Name: California Network

Check Date: 02/09/2006
 Check Number: 006003188813
 Check Amount: \$1,973.96
 Group #: 90176583
 Claim #: 16521725-01

Is your responsibility to pay: **\$493.49**
 If it is NOT your responsibility to pay: **\$1,973.96**
 Please pay this amount to the provider's Office.

| SERVICE DATE(S) | TYPE OF SERVICE | BILLED AMOUNT | INELIGIBLE AMOUNT | | | | COPAYMENT/ ADDITIONAL DEDUCTIBLE AMOUNT | APPLIED TO ANNUAL DEDUCTIBLE | PATIENT COINSURANCE AMOUNT | PAY % | CLAIMS PAYMENT AMOUNT |
|-----------------|-----------------|-----------------|-------------------|--------------------|----------------------------|------------------------|---|------------------------------|----------------------------|-------------------|-----------------------|
| | | | RMK CODE | INSURED'S DISCOUNT | Not Patient Responsibility | Patient Responsibility | | | | | |
| 01/12/06 | Lab | 395.00 | sa | | | | | 79.00 | 80 | 316.00 | |
| 01/12/06 | Lab | 445.38 | sa | | | | | 89.08 | 80 | 356.30 | |
| 01/12/06 | Lab | 284.97 | sa | | | | | 56.99 | 80 | 227.98 | |
| 01/12/06 | Lab | 139.09 | sa | | | | | 27.82 | 80 | 111.27 | |
| 01/12/06 | Lab | 139.09 | sa | | | | | 27.82 | 80 | 111.27 | |
| 01/12/06 | Lab | 167.10 | sa | | | | | 33.42 | 80 | 133.68 | |
| 01/12/06 | Lab | 190.92 | sa | | | | | 38.18 | 80 | 152.74 | |
| 01/12/06 | Lab | 224.15 | sa | | | | | 44.83 | 80 | 179.32 | |
| 01/12/06 | Lab | 305.71 | sa | | | | | 61.14 | 80 | 245.37 | |
| 01/12/06 | Lab | 175.04 | sa | | | | | 35.01 | 80 | 140.03 | |
| TOTALS | | 2,467.45 | | | | | | 493.49 | | \$1,973.96 | |

TOTAL PAID FOR THIS CLAIM \$1,973.96

REMARK CODE(S) DESCRIPTIONS AND CLAIM COMMENTS
 sa Dependent has not met student status requirements. Please refer to your Certificate, Section 4, "Definitions," Dependent.

PATIENT'S ANNUAL (CALENDAR/PLAN) DEDUCTIBLE REMAINING: 0.00

Angela - Call Ref. # 2806808

Feb 24 or 28

1/26/06 Valley Endoscopy - outstanding

1/16 Tarzana Hospital - Outstanding

All claims to be resubmitted for

2/12 Interscope not filed correctly 225 \$275

2/6 Interscope Dr. NMen Other Ins. Info Outstanding

12/12-12/13 - Santa Cruz Dominican Paid but deduct. needs adjust.

Received documentation of deduct. met, records 2/23/06 Per Angela

12/18 Dr. NMen Other Ins Info

Anesthesia not paid - outstanding

Santa Cruz Emerg. - Paid ~~(393)~~ 182.68 (2pb)

Dr. Schwartz not paid - outstanding

Call Ref # 2806835

On my Unilab Claim

Being resubmitted to adjust for deductible

Student Verification Form
Calendar year
Attend. Angela@west units
F 866-~~392~~392-7066 add
Ref. # above #2806808

1/15/06
HMO -

EOB Explanation of Benefits

Discussion w/ Erik Caughern

11:30 AM.

03-01-06

Pacific Care Small Group Acct. Mgmt.

800-858-9168 Ext. 67736

5701 Katella Ave

Cypress, CA 90630 - MSCy 24-280

 not considered a student
on medical leave of absence

Needs to go on COBRA
COBRA ^{was} not offered by Pacific Care - No notification
That we need COBRA

Gloria - Policy Provisions
Dept. of Insurance - Full time Student Requirement
- Disabled dependent
10 working days to send acknowledgement

[REDACTED]

FACSIMILE TRANSMITTAL SHEET

TO: Erik Caughern FROM: [REDACTED] for [REDACTED]
COMPANY: PacifiCare DATE: 3/2/2006
FAX NUMBER: 1-800-926-2951 TOTAL NO. OF PAGES INCLUDING COVER: 4
PHONE NUMBER: 1-800-858-9168 ext. 67736 SENDER'S REFERENCE NUMBER: ID # 074092600-03
RE: Eligibility for [REDACTED] YOUR REFERENCE NUMBER:

URGENT FOR REVIEW PLEASE COMMENT PLEASE REPLY PLEASE RECYCLE

NOTES/COMMENTS:

Erik - Per our conversation yesterday, 03-01-06, I am faxing you the information originally sent to UC Santa Cruz from [REDACTED] GI physician to document his disability from Crohn's disease, which necessitated his taking a medical leave of absence from school, winter quarter 2006. Because of [REDACTED] emergency surgery December 3, 2005, he was unable to complete his finals. When he returned to school to take his finals and attend the winter quarter, he had further complications and went to Urgent Care of Santa Cruz, on January 5, 2006. He came home that weekend and first saw Dr. Lori Kam on 01-12-06. She continues to treat him. As I mentioned in our discussion, [REDACTED] is recognized as an enrolled student at the university by the school registrar and the Regents scholarship department, as well as the Department of Student Health Services. [REDACTED] will be undergoing treatment with Remicade to hopefully put the Crohn's disease into remission. Initially he will have three infusions over a six-week period beginning Friday, March 10, with an infusion two weeks later, then one month later, and then infusions every other month after that. Once he starts this treatment, he cannot stop, as he will build up immunity/allergic reaction to the medication and that leaves him no other effective way to treat his condition. It is a lifetime commitment. Recognizing the expense that this treatment will involve, with estimates from \$4,500 just for the medication from PacifiCare's Prescription Solutions not including infusion costs, up to \$20,000 - \$25,000 to have his infusions at Santa Cruz Dominican Hospital (figures gathered from their billing department), we tried to find the most cost effective way to have this medication administered. Dr. Boris Ratiner (a preferred provider for both PacifiCare and Blue Cross) has an infusion center in Tarzana, California, for which I am told the Remicade and infusion costs will total approximately \$3000 per infusion. Having Andrew receive his infusions at this center will save your company, as well as Blue Cross [REDACTED] secondary insurance through his university) and us a substantial amount of money. The problem is that the infusion nurse is there only twice a month on Fridays. I am going to have to fly [REDACTED] back home for every infusion. He has to arrange his school schedule so that he can come down here to receive his infusions. [REDACTED] treatment has already been held up stemming from PacifiCare's preauthorization for the Remicade administration, so that he can only receive two of the first three infusions before he leaves for school on April 2. I do not want it delayed any further, as he could develop another fistula / abscess while he's waiting, which will require additional surgical intervention. This needs to be cleared up immediately. I appreciate your taking care of this and look forward to hearing from you by Monday. I can be reached at work on Monday at Tarzana Hospital Department of Pathology, between the hours of 8:00 - 3:00 (818-708-5528). Thank you again.

[REDACTED]

[REDACTED]

[REDACTED]
[REDACTED]

FACSIMILE TRANSMITTAL SHEET

| | |
|---------------------------------|--|
| TO: Lupe | FROM: [REDACTED] (mother of [REDACTED]) |
| COMPANY: UC Santa Cruz | DATE: 2/14/2006 |
| FAX NUMBER: 831-459-3189 | TOTAL NO. OF PAGES INCLUDING COVER: 3 |
| PHONE NUMBER: | SENDER'S REFERENCE NUMBER: |
| RE: Medical leave of absence | YOUR REFERENCE NUMBER: |

URGENT FOR REVIEW PLEASE COMMENT PLEASE REPLY PLEASE RECYCLE

NOTES/COMMENTS:

At your request, medical information is being faxed to you from Lori Kam, M.D., [REDACTED] GI doctor. [REDACTED] has been battling Crohns disease for almost three years, including surgery in December 2003 and emergency surgery at Santa Cruz Hospital, on December 3, 2005. As a result of his most recent surgery, Andrew was unable to complete his finals. When he tried to return to school for the winter quarter, he had another flair up and went to Urgent Care in Santa Cruz, on January 5, 2006. He came home that weekend and first saw Dr. Kam on 01-12-06. She continues to treat him. [REDACTED] will be starting infusions of Remicade later this week, which will hopefully put the condition into remission. [REDACTED] is planning on returning to school for the spring quarter and is excited to do so. Your patience and understanding while [REDACTED] works to regain his health is sinceretely appreciated. It has been difficult for him.

Respectfully,

[REDACTED]
[REDACTED]

[REDACTED]

([REDACTED] mother)

[CLICK HERE AND TYPE RETURN ADDRESS]



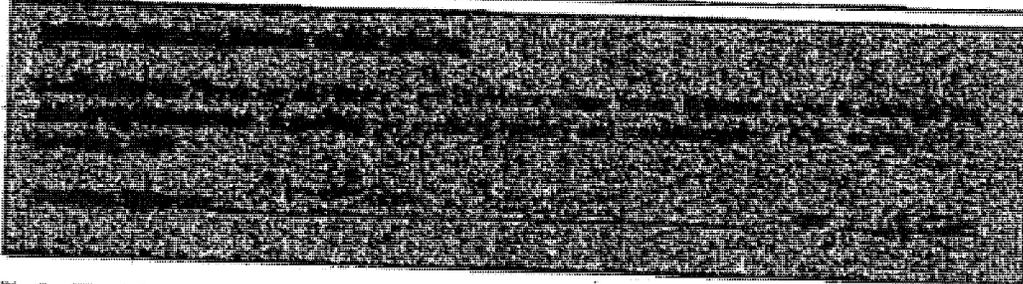
University of California, Santa Cruz
REQUEST FOR MEDICAL INFORMATION

Student Name: [REDACTED] SID#: [REDACTED]

Name of Physician or Health Care Provider: Lori Kam, M.D.

Office Address: 18425 Burbank Blvd, #500
Tarzana, CA 91356

Telephone Number: 818-708-6000



To the Physician or Health Care Provider:

The above named student is requesting that s/he be excused from the customary academic responsibilities due to his or her medical condition. S/he requests that you respond to the following questions to the best of your ability so that the college can take into account the effects of his or her condition during the periodic review of academic records. When completed, please return this form to the student who will then submit it to his or her College Academic Preceptor or Adviser.

Dates seen by you for the condition: 1/12/06

Please describe the condition in brief (non-technical terms would be appreciated):

Cholera disease & anal involvement.
Severe inflammation of intestinal tract.

* The student number requested on this form may be your Social Security Number. In accordance with the Federal Privacy Act of 1974 you are hereby notified that disclosure of your Social Security Number is voluntary. This record keeping system was established pursuant to the authority of the Regents of the University of California under Article IX, Section 9 of the California constitution. The principal use of the number shall be to verify your identity in the Academic Information System and to locate and maintain your academic records.

Please describe the likely effect of the medical condition on the student's ability to:

1. Attend classes

Beginning on or about 1/12/06 the student has been (or will be) unable to attend classes for a period of: (date)

- A few days
- 1 week
- 2 weeks
- 3 weeks or more
- Unknown
- Not Applicable

(Check only if applicable)

During the specified period, the student may be able to attend some (but not all) classes. I would estimate that the student's capacity in this regard would be _____% of normal.

Please note any other impact of the medical condition (including effects of medications) on the student's ability to attend classes (optional):

2. Complete course work (outside of the classroom)

Beginning on or about 1/12/06 the student has been (or will be) unable to complete course work for a period of: (date)

- A few days
- 1 week
- 2 weeks
- 3 weeks or more
- Unknown
- Not Applicable

(Check only if applicable)

During the specified period, the student may be able to complete some (but not all) course work assigned. I would estimate that the student's capacity in this regard would be _____% of normal.

Please note any other impact of the medical condition (including effects of medications) on the student's ability to complete course work (optional):

Resumption of studies

After the period specified in 1 and 2 above, the student should be able to attend classes and complete course work as follows (check one):

- Student will likely be able to resume full-time studies after the above recuperation period has elapsed (40 hours/week workload, roughly equivalent to 15 quarter credits)
- Student will likely be able to attend classes and complete the work required but at a somewhat reduced level (20-30 hours/week workload, roughly equivalent to 10 quarter credits)
- Student will likely be able to attend classes and complete the work required but at a greatly reduced level (10-15 hours/week workload, roughly equivalent to 5 quarter credits)
- Unknown

Additional Comments (optional):

Signature of Physician or Health Care Provider: _____

Date: 2/10/06

Degree: MD State: CA

License No.: 6059318



University of California, Santa Cruz
College Ten
1156 High Street, Santa Cruz, CA 95064

Date: 2-28-06

FROM: Lupe M. Allen
TITLE: Academic Adviser
DEPT.: College Ten
LOC: Social Sciences 2,
Room 150
Fax #: (831) 459-3189
PHONE: (831) 459-3943

TO: [Redacted]
TITLE: [Redacted]
DEPT.: Attn: Mrs. [Redacted]
LOC: [Redacted]
FAX#: [Redacted]
PHONE: [Redacted]

Total pages including cover page 2

Please call Lupe M. Allen at 831 459-3943 if you receive this fax in error. Thank you.

- FYI
- Please respond ASAP
- For your records
-

my UCSD.edu

Password

Student Portal
Academic Progress

- Student Advising Summary Link
- Current Quarter

Senior - withdrawal
Leave of Absence
Ret. Spring 2006

(lower case)

UNIVERSITY OF CALIFORNIA, SANTA CRUZ

BERKELEY • DAVIS • IRVINE • LOS ANGELES • MERCED • RIVERSIDE • SAN DIEGO • SAN FRANCISCO



SANTA BARBARA • SANTA CRUZ

COLLEGE TEN
ACADEMIC ADVISER

SANTA CRUZ, CALIFORNIA 95064

March 1, 2006

Re: [REDACTED]

To Whom It May Concern,

I am writing this letter on behalf of [REDACTED] a student at UC Santa Cruz. [REDACTED] requested a Leave of Absence from UC Santa Cruz for winter quarter 2006, due to a medical emergency that necessitated surgery. Additionally, [REDACTED] informed us that his medical condition would require continued medical care during the winter quarter to stabilize his health. College Ten approved [REDACTED] Leave of Absence Petition for winter quarter 2006, with the expectation of his return in spring quarter 2006.

[REDACTED] is planning to return to UC Santa Cruz for spring quarter, and is currently enrolled for spring quarter 2006.

If you require additional information, please do not hesitate to contact me.

Sincerely,

Lupe M. Allen
Academic Adviser, College Ten

Attention! Erik Caughern 03-02-06
Re: [REDACTED] ID# 074092600-03

Erik; This letter is supposed to go with prior fax for [REDACTED] from earlier today. If you could catch it up with the other documents I'd appreciate it. Thank you,

Sincerely,

[REDACTED]

FACSIMILE TRANSMITTAL SHEET

| | |
|--|---|
| TO: Erik Caughern | FROM: [REDACTED] for [REDACTED] |
| COMPANY: PacifiCare | DATE: 3/2/2006 |
| FAX NUMBER: 1-800-926-2951 | TOTAL NO. OF PAGES INCLUDING COVER: * 5 |
| PHONE NUMBER: 1-800-858-9168 ext. 67736 | SENDER'S REFERENCE NUMBER: ID # 074092600-03 |
| RE: Unpaid claims and adjustments | YOUR REFERENCE NUMBER: |

URGENT
 FOR REVIEW
 PLEASE COMMENT
 PLEASE REPLY
 PLEASE RECYCLE

NOTES/COMMENTS:

Erik - Per our conversation yesterday, 03-01-06, I am faxing you the EOBs and pertinent information regarding unpaid claims and adjustments on both [REDACTED] and me (my ID# 074092600-02).

EOBs faxed:

| Doctor | Date of Service |
|-------------------------------------|--|
| Anesthesia Medical Group Santa Cruz | 12-03-05 |
| Arthur Schwartz, M.D. (surgeon) | 12-03-05 (Andrew was also seen in the doctor's office on 12-05-05) |
| Tarzana Medical Center (CT scan) | 01-16-06 |
| Valley Endoscopy (colonoscopy) | 01-26-06 |

Additional services performed, but I do not have EOBs for :

| | |
|----------------------------|--|
| Prometheus Laboratory | 01-12-06 |
| Lori Kam, M.D. (GI doctor) | 01-12-06 - present, including colonoscopy (01-26-06) |

Adjustments required for deductible met with prior insurance carrier (supporting documents received 02-23-06, per Angela in PacifiCare customer service, call reference #2806808)

| | |
|------------|---------------------------|
| [REDACTED] | 12-02-05 through 12-03-05 |
|------------|---------------------------|

| | |
|--------|----------|
| Unilab | 12-01-06 |
|--------|----------|

Also as mentioned in our discussion, Blue Cross ([REDACTED] secondary insurance carrier through his university) hasn't received EOBs from PacifiCare on claims that have been paid by PacifiCare. Could you look into this so that all the doctors and medical centers that have provided services for [REDACTED] over the last three months can be paid by insurance and I can pay the remaining balance? Thank you again Erik for your help in getting these matters resolved.

[REDACTED]

[REDACTED]

PacifiCare®
 Life and Health Insurance Company
 P.O. Box 6098
 Cypress, CA 90630

This Claim was paid to Provider:
 ANESTHES MED GROUP SANTA CRUZ

CLAIM NUMBER
 16154097-01

CHECK NUMBER
 nochk1375764

CHECK DATE
 01/12/2006

CHECK AMOUNT
 0.00

[REDACTED]

*Requesting Student
 Status Form
 Per Angela
 in Customer Service*

PacifiCare®
 Life and Health Insurance Company

EXPLANATION OF BENEFITS
 Retain for Your Records.
 (866) 316-9776

Date(s) of Service: 12/03/2005-12/03/2005

Patient: [REDACTED]

Insured: [REDACTED]

Patient Account #: [REDACTED]

Provider: ANESTHES MED GROUP SANTA CRUZ

Group: OPUS ONE LABORATORIES
 Contract Name: NON-PAR PAID AT PAR LEVEL

Check Date: 01/12/2006
 Check Number: nochk1375764
 Check Amount: 0.00
 Group #: 90176583
 Claim #: 16154097-01

It is your responsibility to pay: 0.00
 It is NOT your responsibility to pay: 880.00
Have pay furnished to the provider of service.

| SERVICE DATE(S) | TYPE OF SERVICE | BILLED AMOUNT | INELIGIBLE AMOUNT | | | | CO-PAYMENT/ADDITIONAL DEDUCTIBLE AMOUNT | APPLIED TO ANNUAL DEDUCTIBLE | PATIENT COINSURANCE AMOUNT | PAY % | CLAIMS PAYMENT AMOUNT |
|-----------------|-----------------|---------------|-------------------|--------------------|----------------------------|------------------------|---|------------------------------|----------------------------|-------|-----------------------|
| | | | RMK CODE | INSURED'S DISCOUNT | Not Patient Responsibility | Patient Responsibility | | | | | |
| 12/03/05 | Ineligible | 720.00 | pk | | | 720.00 | | | | | |
| 12/03/05 | Ineligible | 160.00 | pk | | | 160.00 | | | | | |
| TOTALS | | 880.00 | | | | 880.00 | | | | | |

REMARK CODE(S) DESCRIPTIONS AND CLAIM COMMENTS:

pk This claim is being denied due to lack of required information. Please forward the Certificate of Creditable Coverage from your prior carrier. If unavailable, please submit names and addresses of doctors who have treated you in the past year. Refer to your Certificate, "Exclusionary period for pre-existing conditions."
 Claim submitted not clean. Processed with information available.

Can't find recent EOB with Remark about continuing coverage for student & disabled dependent. But Angela in customer service said this hasn't been paid for that reason. Call PacifiCare made of that.

THIS IS NOT A BILL

000000201184097019991375764D

Confidential

CDI00225123

PacifiCare®
 Life and Health Insurance Company
 P.O. Box 6098
 Cypress, CA 90630

This Claim was paid to Provider:
 VALLEY ENDOSCOPY CENTER

CLAIM NUMBER
 16710372-01

CHECK NUMBER
 nochk1451085

CHECK DATE
 02/21/2006

CHECK AMOUNT
 0.00

[REDACTED]

*Send Student
 Status Form
 Per Angela
 in Customer
 Service*

PacifiCare®
 Life and Health Insurance Company

EXPLANATION OF BENEFITS

Retain for Your Records.
 (866) 316-9776

Date(s) of Service: 01/26/2006-01/26/2006

Patient: [REDACTED]

Insured: [REDACTED]

Patient Account #: 020245 P 34

Provider: VALLEY ENDOSCOPY CENTER

Group: OPUS ONE LABORATORIES

Contract Name: California Network

Check Date: 02/21/2006

Check Number: nochk1451085

Check Amount: 0.00

Group #: 90176583

Claim #: 16710372-01

If it is your responsibility to pay: \$1,050.00
 If it is NOT your responsibility to pay: 0.00
 Please pay the amount to the provider of service.

| SERVICE DATE(S) | TYPE OF SERVICE | BILLED AMOUNT | INELIGIBLE AMOUNT | | | | COPAYMENT/ADDITIONAL DEDUCTIBLE AMOUNT | APPLIED TO ANNUAL DEDUCTIBLE | PATIENT COINSURANCE AMOUNT | PAY % | CLAIMS PAYMENT AMOUNT |
|---------------------------|-----------------|---------------|-------------------|--------------------|----------------------------|------------------------|--|------------------------------|----------------------------|-------|-----------------------|
| | | | RMK CODE | INSURED'S DISCOUNT | Not Patient Responsibility | Patient Responsibility | | | | | |
| 01/26/06 | Ineligible | 1,050.00 | As | | | 1,050.00 | | | | | |
| TOTALS | | 1,050.00 | | | | 1,050.00 | | | | | |
| TOTAL PAID FOR THIS CLAIM | | | | | | | | | | | |

REMARK CODE(S) DESCRIPTIONS AND CLAIM COMMENTS:
 As Dependent has not met student status requirements. Please refer to your Certificate, "Covered Person Eligibility, Continuing Coverage for Student and Disabled Dependents".

PacifiCare
 Life and Health Insurance Company
 P.O. Box 6098
 Cypress, CA 90630

This Claim was paid to Provider:
 ARTHUR SCHWARTZ MD

CLAIM NUMBER
 16275060-01

CHECK NUMBER
 nochk1391665

CHECK DATE
 01/20/2006

CHECK AMOUNT
 0.00

[REDACTED]

*Requesting Student
 Status Form
 Per Angela in
 Customer service*

PacifiCare
 Life and Health Insurance Company

EXPLANATION OF BENEFITS
 Retain for Your Records
 (866) 316-9776

Date(s) of Service: 12/03/2005-12/03/2005
 Patient: [REDACTED]
 Insured: [REDACTED]
 Patient Account #: [REDACTED]
 Provider: ARTHUR SCHWARTZ MD

Group: OPUS ONE LABORATORIES
 Contract Name: California Network

Check Date: 01/20/2006
 Check Number: nochk1391665
 Check Amount: 0.00
 Group #: 90176583
 Claim #: 16275060-01

If it is your responsibility to pay: 0.00
 If it is NOT your responsibility to pay: \$675.00
 Please pay the amount to the provider of service.

| SERVICE DATE(S) | TYPE OF SERVICE | BILLED AMOUNT | RMK CODE | INELIGIBLE AMOUNT | | | CO-PAYMENT/ ADDITIONAL DEDUCTIBLE AMOUNT | APPLIED TO ANNUAL DEDUCTIBLE | PATIENT COINSURANCE AMOUNT | PAY % | CLAIMS PAYMENT AMOUNT |
|-----------------|-----------------|---------------|----------|--------------------|----------------------------|------------------------|--|------------------------------|----------------------------|-------|-----------------------|
| | | | | INSURED'S DISCOUNT | Not Patient Responsibility | Patient Responsibility | | | | | |
| 12/03/05 | Ineligible | 300.00 | px | | 300.00 | | | | | | |
| 12/03/05 | Ineligible | 125.00 | px | | 125.00 | | | | | | |
| 12/03/05 | Ineligible | 250.00 | px | | 250.00 | | | | | | |
| TOTALS | | 675.00 | | | 675.00 | | | | | | |

TOTAL PAID FOR THIS CLAIM

REMARK CODE(S) DESCRIPTIONS AND CLAIM COMMENTS

px This claim is being denied due to lack of required information. Please forward the Certificate of Creditable Coverage from your prior carrier. If unavailable, please submit names and addresses of doctors who have treated you in the past year. Refer to your Certificate, "Exclusionary period for pre-existing conditions."

Claim submitted not clean. Processed with information available.

*Don't Find
 EOB with Remark
 about continuing
 coverage for student
 and dependent child,
 Angela in PacifiCare
 customer service said
 it was being held
 up for being held
 reason.
 (call made
 02-25-06)*

THIS IS NOT A BILL

0000002013750600159913916653

PacifiCare®
 Life and Health Insurance Company
 P.O. Box 6098
 Cypress, CA 90630

This Claim was paid to Provider:
 TARZANA MEDICAL CENTER

CLAIM NUMBER
 16514711-01

CHECK NUMBER
 nechk1425438

CHECK DATE
 02/07/2006

CHECK AMOUNT
 0.00

[REDACTED]

PacifiCare®
 Life and Health Insurance Company

EXPLANATION OF BENEFITS

Retain for Your Records.
 (866) 316-9776

Date(s) of Service: 01/16/2006-01/16/2006

Patient: [REDACTED]

Insured: [REDACTED]

Patient Account #: 0004129276

Provider: TARZANA MEDICAL CENTER

Group: OPUS ONE LABORATORIES

Contract Name: California Network

Check Date: 02/07/2006

Check Number: nechk1425438

Check Amount: 0.00

Group #: 90176583

Claim #: 16514711-01

If it is your responsibility to pay: \$5,845.20
 If it is NOT your responsibility to pay: 0.00
 Please pay this amount to the provider(s) service.

| SERVICE DATE(S) | TYPE OF SERVICE | BILLED AMOUNT | INELIGIBLE AMOUNT | | | | COPAYMENT/ADDITIONAL DEDUCTIBLE AMOUNT | APPLIED TO ANNUAL DEDUCTIBLE | PATIENT COINSURANCE AMOUNT | PAY % | CLAIMS PAYMENT AMOUNT |
|-----------------|-----------------|---------------|-------------------|--------------------|----------------------------|------------------------|--|------------------------------|----------------------------|-------|-----------------------|
| | | | RMK CODE | INSURED'S DISCOUNT | Not Patient Responsibility | Patient Responsibility | | | | | |
| 01/16/06 | Ineligible | 5,845.20 | As | | | 5,845.20 | | | | | |
| TOTALS | | 5,845.20 | | | | 5,845.20 | | | | | |

TOTAL PAID FOR THIS CLAIM

REMARK CODE(S) DESCRIPTIONS AND CLAIM COMMENTS:
 As Dependent has not met student status requirements. Please refer to your Certificate, "Covered Person Eligibility, Continuing Coverage for Student and Disabled Dependents".

THIS IS NOT A BILL

0000002019647110199914254386